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Call for Applicants

The History and Archives Committee (HAC) of the American College of Surgeons (ACS) is continuing an exciting initiative.

A $2,000 stipend will be awarded to support research in surgical history that uses the archival resources of the ACS Archives. The award recipient will hold the Archives Fellowship from July 1 to June 30 of each year.

Applications for this fellowship will be accepted from February 1, 2020, through April 1, 2020. This opportunity is open to ACS members and those willing to join if selected.

Visit facs.org/archives to apply.
The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

Letters to the Editor should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to dschneidman@facs.org, or via mail to Diane S. Schneidman, Editor-in-Chief, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.
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In October 2014, the American College of Surgeons (ACS) and the U.S. Department of Defense (DOD) formed the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS) in order to share information in the areas of surgical education, trauma and combat casualty care, systems-based practice, and research capabilities. In just five years, the MHSSPACS has evolved rapidly under the leadership of my co-authors this month, Drs. Knudson, Elster, and Rich.

Quality
An initial goal of the MHSSPACS was to address the perception that the quality of surgical care provided at Military Treatment Facilities (MTFs) was inferior to that of other public and private hospitals in the U.S. With the assistance of the ACS Division of Research and Optimal Patient Care, a military quality consortium was formed to include all of the major MTFs in the U.S., as well as a few abroad. This consortium, including both the Surgeon Champions and their surgical clinical case reviewers, meets twice a year to discuss issues that relate to the challenges unique to MTFs.

The recent cumulative data across the entire military medical enterprise demonstrate measurable improvement in surgical quality care indices, with several MTFs now among the top performing hospitals in the nation. In addition, Walter Reed National Military Medical Center, Bethesda, MD, was among the first to be formally reviewed by the ACS using the ACS Red Book, *Optimal Resources for Surgical Quality and Safety*. These military quality initiatives have recently been highlighted in a paper published in *Health Affairs.*

**Trauma centers and trauma systems**
In 2016, the National Academies of Sciences, Engineering, and Medicine released the report *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury.*† Members of the MHSSPACS and the ACS Committee on Trauma (COT) were actively involved in its rollout. In addition, the College advocated for the passage of the National Defense Authorization Act for fiscal year 2017, which requires all major MTFs to either participate in their regional civilian trauma system or to form partnerships with civilian trauma centers to ensure that military trauma teams always are prepared for deployment.

The legislation that would provide grant funding for the development and sustainment of these partnerships (the Mission Zero Act) was passed in June 2019, but the funding has yet to be allocated. In preparation for these grants, the MHSSPACS has developed the “Blue Book,” which outlines the criteria for selecting and evaluating institutions that are interested in participating in this program. The Blue Book has been endorsed by both the Defense Health Board and the Defense Health Agency. Members of the COT and the MHSSPACS are providing both consultation and verification trauma site visits for MTFs seeking to participate in their local trauma systems.

**Education**
The military has done a spectacular job of developing a trauma system to provide care to wounded warriors in Iraq and Afghanistan. However, preparation for deployment varied from service to service, and without sustainment, many of the lessons learned soon will be forgotten. To meet the challenge of keeping a
ready military force, the MHSSPACS has developed a method for assessing knowledge points and skills for deploying general surgeons (the Knowledge, Skills and Abilities [KSA] Project). The knowledge exam is administered electronically and has been demonstrated to be capable of distinguishing an experienced surgeon from one with no deployment history. The skills testing is based on the ACS COT Advanced Surgical Skills for Exposure in Trauma (ASSET) course with some additional surgical specialty stations added (ASSET+). This course has been delivered four times to date and is popular with both the students and the faculty. In areas where knowledge gaps are identified, a multimedia curriculum is being developed and housed on the ACS network for easy access.

The Excelsior Surgical Society
After World War II, a group of surgeons met in Rome, Italy, at the Excelsior Hotel to discuss their surgical experiences during the war. This society then met annually until the last members died in the 1980s. In 2015, the Excelsior Surgical Society was reorganized and is now a formal society within the ACS with elected officers, bylaws, and committees. The Society meets by teleconference monthly and formally for an entire day in conjunction with the Clinical Congress for scientific exchange and named lectureships. Membership is open to all surgeons who have served in the U.S. military (active or retired). Excelsior surgeons also participate in the Military Section of the Surgical Forum.

Research
The MHSSPACS works with both the DOD and the newly reorganized Coalition for National Trauma Research to identify and support areas of research relevant to combat casualty care, recognizing that research is an essential component of the readiness mission and for a continuous learning national trauma system.

Appropriate recognition
Three military surgeons were instrumental in forming the MHSSPACS. First is retired U.S. Army Colonel Dr. Rich, who was awarded the inaugural Distinguished Lifetime Military Contribution Award at Clinical Congress 2019 in recognition of his outstand-
ing contributions to military surgery and as a pioneer of modern vascular surgery. Dr. Rich, Dr. Elster, and I worked directly with Jonathan Woodson, MD, MSS, FACS, then Assistant Secretary of Defense for Health Affairs, to create the foundation of this program in 2014.

In addition, Vice Admiral Raquel C. Bono, MD, FACS, former Director of the Defense Health Agency, received the Mary Edwards Walker Inspiring Women in Surgery Award. Vice Admiral Bono has served on the ACS Board of Governors (2014–2016) and has been honored with three Defense Superior Service Medals, four Legion of Merit Medals, two Meritorious Service Medals, and two Navy and Marine Corps Commendation medals for her military service and extensive commitment to the care of injured service members.

Looking forward
The year 2020 is already proving to be a significant year for the MHSSPACS. Multiple military quality site visits are in the planning stages. The KSA Project for military trauma surgeons and the first version of the multimedia curriculum both will be completed this year. A mapping project will highlight MTFs that can serve as trauma centers in areas of the nation that lack access to trauma care, thus expanding the U.S. trauma system to all injured patients. Dr. Knudson and other members of the MHSSPACS will be briefing Congress about the importance of military-civilian partnerships for the readiness mission and the need to fund the Mission Zero Act, and the Blue Book will be published with a formal rollout.

In these unsettled times, the need to continue our partnership with the U.S. military based on the legacy established by my contributors could not be more important.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Surgical residency in Mexico: The future we want to achieve

The Bulletin often publishes articles about surgical training and practice in low- and middle-income countries. In this letter, I offer my perspective as a surgical resident in Mexico.

Every year, the different public and private institutions in Mexico receive applications from hundreds of enterprising physicians who want to train in surgery. Despite the differences in approaches, geography, culture, and economic resources, training hospitals provide trainees with the skills they need to help cure or address their patients’ diseases.

Mexico has a mix of public and private training institutions, so it is inevitable that patients will have access to different types of surgical procedures, such as open versus laparoscopic and, on rare occasions, robotic surgery. Most advances in biomedical technologies in the treatment of different pathologies occur in private institutions, and only some medical units have resources to ensure that surgical patients receive the “gold standard” procedure.

One might assume that the resident or surgeon who is at the best private hospital is the one who is closer to modern medicine, the one with access to high-power resolution imaging, to the boldest approaches, and to the most current literature, whereas surgeons at second-level, public hospitals might only be able to provide life-preserving care to the extent possible with the resources at hand.

It seems surgical residents are exposed to the two alternative worlds of a single country and emerge different surgeons. This assumption proves incorrect when residents meet as part of their rotations and share experiences, compare their acquired skills, and describe what their teachers can do. When the resident of the public institution meets the resident of the private hospital, they exchange the innate wishes of all physicians in training—to be the best surgeons they can be, to innovate, and to go out and look for what it takes to perfect their technique.

When we are performing any operation, we think about what could go wrong and what we learned from reading the articles, watching videos,
To whom it may concern,

Dear sir or madam,

and attending congresses. We turn to all these tools of energy, technology, and new surgical techniques that we have learned from surgeons in high-income countries, but we also recognize the skills we acquire in the continuous care of all those thousands of patients who need to be treated in our own institutions. That same thirst for wanting to be better drives us to publish cases, attend international congresses, join excellent societies such as the American College of Surgeons (ACS), and feel a little emboldened by different societies to carry out refresher courses that lead us to be better surgeons.

Uniformity will continue to be a challenge for Mexico's training institutions. We must promote the integration of knowledge and autonomous learning to produce surgeons with the cognitive abilities and skills needed to provide high-quality surgical care. The pragmatic model of the surgeon is that of a physician who can remove or control disease with any surgical approach by using the tools that are available in the various work environments—in the rural community or in the big city. Humanism is the banner in the decision making of our work, forged for years in our hands. When patient care is our guiding concern, we realize that we are not so far from what we think of as surgery in developed countries, always grateful to societies such as the ACS that allow us to update our skills and have great exposure to problem solving. True success, we realize, is reflected in the health of our patients.

Edwin Maldonado, MD
Mexico City, Mexico

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Edwin Maldonado, MD
Mexico City, Mexico
A tribute to
Robert N. McClelland, MD, FACS,
founder of SRGS

by William W. Turner, Jr., MD, FACS; John A. Weigelt, MD, DVM, FACS;
Patricia Bergen, MD, FACS; Patrice Gabler Blair, MPH;
and Ajit K. Sachdeva, MD, FACS, FRCSC, FSACME
The heart of academic surgery skipped a beat, and the University of Texas (UT) Southwestern, Dallas, lost one of its heroes September 10, 2019, when Robert N. McClelland, MD, FACS, died after an extended illness.

On the national stage, Dr. McClelland may be best known for his participation in the efforts to save the life of President John F. Kennedy November 22, 1963, but it is the multiple generations of students, residents, and faculty members who knew him as “Dr. Mac” on whom he made an even more profound and lasting impact. And his legacy lives on at the American College of Surgeons (ACS) as the visionary educator who created Selected Readings in General Surgery (SRGS®).

This article pays tribute to Dr. McClelland’s impact on his trainees and describes how SRGS went from being one surgeon’s effort to help his residents improve their knowledge base to a globally accessible tool for practicing evidence-based medicine.

Lifelong Texan

Dr. McClelland was born November 20, 1929, in Gilmer, TX, and he spent his early childhood in the east Texas town. His first contact with what would become UT Southwestern was a high school summer job at the historic Old Parkland Hospital at Maple and Oak Lawn Avenues in Dallas, which was the location of the Southwestern Medical College, now known as UT Southwestern. After graduating from the University of Texas, Austin, he matriculated to the University of Texas Medical Branch, Galveston; he graduated from medical school in 1954—the same year that Parkland Hospital moved to Harry Hines Boulevard. After interning for a year at the University of Kansas Medical Center, Kansas City, Dr. McClelland moved to the U.S. Air Force (USAF) as commander of the 7232 USAF Dispensary in Trier, Germany. His military service was followed by two years of training in general surgery at Parkland Memorial Hospital and a one-year hiatus in private practice in Canyon, TX, before returning to Parkland Hospital to complete his surgical residency in 1962. Such interruptions in surgical training for military service and private practice were common at the time.

Under the leadership of G. Thomas Shires, MD, FACS, in 1962 Dr. McClelland joined the faculty of the UT Southwestern Medical Center department of surgery, where he would remain for his entire career. The following year, 1963, was a particularly memorable one for Dr. McClelland. He became certified by the American Board of Surgery, he celebrated his 34th birthday, and two days later he found himself at the head of a stretcher in the Parkland Hospital emergency room during the desperate attempt to save the life of President Kennedy. Along with Malcolm Perry, MD, FACS, and Charles Baxter, MD, FACS, Dr. McClelland performed a tracheostomy on the President. During an interview published in the December 2007 issue of Center Times, UT Southwestern Medical Center’s newspaper, Dr. McClelland said, “Obviously, this was a very unusual occurrence that one would never expect in an ordinary life, and this experience will always be with me.”* Dr. McClelland often described this episode as so vividly etched in his memory that it seemed to have happened yesterday.

Dr. McClelland’s research career at UT Southwestern included investigations into splanchnic hemodynamics, trauma, intravenous alimentation, peptic ulcer disease, gastroesophageal reflux, portal hypertension, and biliary tract disease. He received numerous honors, including the first Alvin Baldwin Jr. Chair in Surgery. He retired in 2007 as an emeritus professor of surgery.

Dr. McClelland became a Fellow of the ACS in 1965 and served on the Committee on Graduate Medical Education (1989–1991). He also was a member of many other prestigious surgical societies, such as the American Surgical Association.

Dr. McClelland established SRGS in 1974 in response to requests from residents for copies of the papers discussed in a journal club that he had started previously.

The Parkland Surgical Society named the Robert N. McClelland Lectureship in his honor. Parkland Hospital moved across Harry Hines Boulevard in 2017, and upon its new opening, alumni and friends established a wall of photos titled “Giants of Surgery.” Those who had the honor and privilege of training under him knew Dr. McClelland as the titan among those giants.

Dedication to lifelong learning

In the operating room (OR), the classroom, the conference room, and social surroundings, Dr. McClelland created a sense of calm. He often did this with earthy humor and a self-deprecating manner. Residents, when pressed to describe Dr. Mac, would often respond, “He knows everything.” But when referred to as an expert, Dr. Mac would recall “the east Texas definition of an ‘expert’ was someone who had just spurted.” Sometimes, when one of the residents gave an incorrect answer to a question, Dr. Mac’s response would be, “Well, that would be correct but in a 180-degree different way.” When we marveled at his expertise in describing some point in surgery, he would respond, “Even a blind hog occasionally finds an acorn.” These “McClellandisms” have endured.

Soft-spoken, rarely cross, humble to a fault, patient as a saint, well-read, and willing to share his knowledge are not always phrases residents use to describe an academic surgeon. Yet Dr. McClelland fit all of these descriptions. He was an inspiration. He taught us that we had embarked on a lifelong learning journey before any committee had coined the term. We were taught that being a surgeon required a mastery of skills and cognitive knowledge as represented in the most up-to-date information.

Those of us who stayed at UT Southwestern and transitioned to junior faculty positions quickly learned that Dr. Mac, along with other, more senior UT Southwestern faculty, set a high mark for us. Saying “no” to a request from a student or trainee was unacceptable. Help was always available, whether it was in the OR, seeing a ward patient, or just reviewing a case. The latter with Dr. Mac was especially rewarding. He gave advice without condescension while providing the appropriate evidence and offering his expertise. These conversations taught us how colleagues relate to each other. Dr. Mac had a way of making you feel that you knew as much as he did, which was never true.

The amazing thing about Dr. Mac was that all of the people he touched had similar experiences. He set the bar high. He helped people reach it. He continued to espouse his educational principles, his humanity, and his professionalism until the day we lost him. His wisdom was widely recognized, and he was invited to comment on surgical problems in conferences, at the bedside, and by telephone nearly any time of day or night. He encouraged us to learn new things, intellectually and in the OR. It seemed he knew everything about all things surgical, and about many other topics, as well.

For many years, Dr. McClelland invited the graduating residents and fellows to his home the weekend before oral boards for a two-day review session. When Dr. Bergen, co-author of this article, took the board exams in 1989, she attended this important session—a rite of passage for Parkland-trained residents. That Sunday evening, Dr. McClelland reviewed an article on colon cancer staging and treatment; Dr. Bergen realized she did not know that area well and
focused intently. Of course, that very question was asked during the exams. With Dr. Mac in her head and gratitude in her heart, she gave an acceptable answer.

Dr. Mac taught thousands of surgeons many lessons about lifelong learning, surgical planning, execution, and professional and personal conduct either through direct contact, SRGS, or the inherited wisdom of those of us who benefited from his tutelage as residents and colleagues. We were so lucky to have him for so long.

**Founding SRGS**

A remarkable feature of Dr. McClelland’s life was his prodigious reading, particularly in surgery. In his later life, he pursued his love of history, often reading several books simultaneously. Many conversations with Dr. McClelland began with, “What are you reading, Dr. Mac?”

Dr. McClelland established SRGS in 1974 in response to requests from residents for copies of the papers discussed in a journal club that he had started previously. The original journal club evolved into the UT Southwestern department of surgery’s Selected Readings Conference, held every Saturday morning and led by Dr. McClelland. He ran these conferences using SRGS as a matrix. His voice was never very loud, and he brought a portable sound system to the conferences to make sure that we heard him—although, it might have been to make sure that we did not fall asleep. On any topic, he could always add material from other sources, which often represented the most up-to-date information. Dr. Mac developed Selected Readings as he saw the need for himself, surgical residents, and eventually practicing surgeons to learn from the surgical literature.

When “evidence-based medicine” became popular, the phrase seemed to have an artificial ring to it. Those of us who trained under Dr. Mac figured out that evidence-based medicine was SRGS and that Dr. McClelland had taught his minions how to practice evidence-based medicine long before someone coined the phrase. Most of us could not imagine our professional lives without SRGS.

SRGS needs some perspective for those surgeons who grew up with the Internet. Picture a very large room filled with bookshelves. On the bookshelves are rows of black file boxes. All had numbers on them that were listed with paper titles in a key book—a filing system that Dr. McClelland devised and that those surgeons who were raised on the paper phase of SRGS duplicated at home. In those boxes were papers from all of the major journals—all and then some. Dr. Mac was essentially the Internet browser. He drew articles from the more than 100 journals to which he subscribed. He reviewed those journals, tore out the papers, and placed file numbers on them based on the topics that they addressed. Every article in Dr. Mac’s library was complete. As the boxes became full, he added more boxes. Throwing away articles was not in the plan.

Many people have used SRGS in their careers, but unless you trained at UT Southwestern or made a special attempt to understand how SRGS was produced, you couldn’t truly appreciate the value and magnitude of Dr. Mac’s library. In fact, residents rarely went to the UT Southwestern library. Instead, they went straight to Dr. Mac’s library when they needed information. It was kind of like an early Internet cafe.

Just as you search the web today, getting articles from Dr. Mac’s library was always diversionary. You would start off looking for an article on a very specific topic. You would find it, but you would also find another 10 articles that you just felt needed to be read. You copied the articles and returned them to their boxes for the next user. It was a resource that was built out of a need at the time and nurtured by the love of learning that Dr. McClelland held dear.
**SRGS goes national**

Ultimately, Dr. McClelland determined that students and residents outside the confines of UT Southwestern might benefit from SRGS. In a December 2007 *Center Times* interview, Dr. McClelland said, “I conceived the basic idea for Selected Readings because it seemed that the available surgery textbooks were too much for medical students and not enough for residents. I borrowed $2,700 from the bank and advertised *Selected Readings* among surgery programs in the United States. I thought if we could obtain 500 subscribers the publication would be practical. Within a month 500 had subscribed. By the beginning of 1975, there were 1,500 subscribers. This number ultimately reached approximately 5,000.”*

When SRGS “went national,” Dr. Mac worried about the cost to subscribers. So, he made reprints of papers on a printing press in his office and drafted residents and their spouses to hand-assemble the papers. Nobody said “no” to Dr. Mac. SRGS subscriptions ultimately extended worldwide. Over the five-year period of a general surgery residency, SRGS covered the entire field of general surgery. At one point, it was estimated that more than 60 percent of the general surgery residents in the U.S. read SRGS.

It is worth noting that Dr. Mac moved into the computer age with remarkable facility, establishing a computer-based reference manager when few of us knew what that was.

*Rian R. McClelland named professor emeritus. UT Southwestern Medical Center *Center Times*; December (holiday) 2007, page 2.

Prior to concerns raised by the Health Insurance Portability and Accountability Act, Dr. Mac bought cameras for all the residents so they could document interesting findings from the OR for use in conferences. Later, they brought the images to him, and he catalogued them, establishing a media library of some significance. Residents and faculty alike raid his media to flavor our presentations. In his later years, after he stopped operating, he was easily found at his roll top desk, with his computer open, reviewing and cataloguing papers. He kept candy at hand to encourage the residents to drop by and chat, which they did often.

**ACS proud to maintain his legacy**

In 2004, the ACS Division of Education learned of Dr. McClelland’s impending retirement and his interest in discussing with the ACS possible strategies to ensure the longevity of SRGS. Then ACS Executive Director, Thomas R. Russell, MD, FACS, brought this opportunity to the attention of Ajit K. Sachdeva, MD, FACS, FRCSC, FSACME, Director, ACS Division of Education.

Subsequently, Drs. McClelland and Sachdeva met several times in Dallas, during which the transfer of *Selected Readings* to the ACS Division of Education was discussed. Issues relating to transfer of copyright and intellectual property to the ACS were specifically addressed. L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), FRCS Glasg(Hon), a Regent
at the time and subsequently ACS President, and Patrice Gabler Blair, MPH, Associate Director, ACS Division of Education, then joined the discussions with Dr. McClelland and Robert V. Rege, MD, FACS, chair, department of surgery, University of Texas Southwestern Medical Center. A Board of Directors for Selected Readings, with Dr. Britt as Chair, was appointed to oversee the transition. The formal gifting of Selected Readings occurred at the ACS Board of Regents Meeting in October 2005, and Dr. McClelland was recognized for his landmark gift.

Following a national search that Drs. Britt and Sachdeva led, Lewis Flint, MD, FACS, was selected as Editor-in-Chief. In July 2007, the editorial office and operations of the Selected Readings were transferred from Dallas to the ACS headquarters in Chicago, IL, under the aegis of the Division of Education. Now in its 14th year as a product of the ACS, Selected Readings continues to thrive, with a stable subscriber base and an international editorial board.

Under Dr. Flint’s leadership, SRGS remains a critical resource for all general surgeons. SRGS is published eight times a year and focuses on a revolving cycle of the most relevant topics in general surgery, including breast disease, colorectal disease, and biliary tract disease.

SRGS helps maximize surgeons’ time by reviewing 150 of the latest and most valuable articles published in the world’s most prominent medical journals. In addition, subscribers can earn 80 hours of Self-Assessment Credit every year. SRGS also offers different subscription types to best meet the needs of its diverse surgical readership and can be read on any mobile device.

To stay current with surgical literature, improve patient outcomes, and earn Continuing Medical Education Self-Assessment Credit, subscribe to SRGS at facs.org/publications/srgs/subscriptions. ♦
Global Surgical and Medical Support Group helps Kurds develop self-sustaining health care system

by Enrique Ginzburg, MD, FACS, and Aaron Epstein, MD

GSMSG surgical group in front of Yazidi IDP health care center
Our group’s flight, on a Turkish Airlines 737, landed October 7, 2019, in Erbil, Iraq—approximately four years after the Peshmerga Kurdish forces, with the help of U.S. and coalition forces, finally began to turn the tide of the war against ISIS (also known as Islamic State in Iraq and Syria). In its wake, ISIS killed, maimed, raped, and tortured the Yazidi Kurds and other minority groups in Sinjar province, occupying and creating what is arguably one of the most oppressive theocratic regimes in recent history.

Our group was there to aid the Yazidi Kurds, who number approximately 1 million people, of which hundreds of thousands reportedly have been killed by ISIS and persecuted throughout history. They are friendly, peace-loving, devout, and tolerant people.

After clearing customs, we were surprised to be traveling on a newly constructed highway, lined with the glimmering lights of hotels of downtown Erbil. The sight of multiple five-star hotels was a comfort to our anxious thoughts of the area’s conflict and danger that Americans frequently see in the media. In fact, the autonomous region of Kurdistan in northern Iraq appears more westernized than some areas of wealthier nations.

Purpose of the mission
Our protocol drivers from the Kurdish government picked us up at the Erbil airport and whisked us off to Dohuk, the most northwestern city in northern Iraq, sprawled snugly against the mountains north of the Tigris River. We came as members of the Global Surgical and Medical Support Group (GSMSG), an organization founded by Aaron Epstein, MD, a second-year general surgery resident in the department of surgery, University of Buffalo, NY, a Resident Member of the American College of Surgeons (ACS) and co-author of this article. Dr. Epstein’s previous experience in the defense and intelligence arenas motivated him to attend medical school and pursue a career in trauma and critical care surgery.

GSMSG is a 501(c)(3) not-for-profit organization that has arranged for approximately 200 U.S. health care professionals to provide care and training in Iraq/Kurdistan to Syrian Kurdish refugees, internally displaced persons (IDPs), and Iranians. GSMSG surgeons also provide care in Syria and Somalia, as well as other areas within Africa. The GSMSG team as a whole is composed of more than 1,000 U.S. health care providers, more than 200 of whom are physicians and
surgeons across every specialty. The other 800 include nurses, medics, and physician assistants. Most participants in these missions are U.S. military veterans, particularly from the special operations community. GSMSG has been a magnet for the veteran community interested in humanitarian activities overseas.

Dr. Epstein created the organization in 2015 by combining his old networks in global security with his newer networks of medical professionals once he started at Georgetown Medical School, Washington, DC.

The primary objective of the organization is to provide training, as opposed to other aid organizations that usually provide itinerant care. The ultimate goal of GSMSG is to become obsolete within the population it is serving by creating long-lasting, self-sustaining solutions to humanitarian health care crises.

The GSMSG team for this mission was composed of 26 physicians and nurses, as well as one physical therapist and one occupational therapist, Barbara Ginzburg, the wife of co-author Enrique Ginzburg, MD, FACS. Among the physicians were one cardiothoracic surgeon, three obstetricians/gynecologists, five general surgeons, one dermatologist, and one anesthesiologist. The remaining team members were nurses. Most of the nurses and the anesthesiologist were retired U.S. military health care professionals. Another eight members of our GSMSG team were Special Operations veterans who also hold medical credentials.

One of our team members, Asfandiar Shukri, MD, a retired general surgeon in Bloomfield, MI, along with training local medical and surgical professionals, assisted with translation and with patient exams and workups. Dr. Shukri served in Iraq at the height of the Iran-Iraq conflict and is still active in relief missions. He was instrumental in the conviction of Saddam Hussein for the gassing of the Kurds. More specifically, he testified at the trial against Saddam Hussein in Iraq in November 2006, giving an eyewitness account of the horrific effects of weapons of mass destruction used on women, children, and the elderly during Saddam’s regime.

We arrived at the IDP camp the next morning. As we crossed through security gates, we were greeted by Yazidi Kurd children playing in the schoolyard, with the usual smiles and friendliness of all children throughout the world, even when faced with the reality of living in difficult circumstances.

**Treating patients**

We proceeded to the health care center, where we spent the rest of the morning examining patients—primarily children and their mothers. Patients presented with the usual coughs, sore throats, back and neck pain, and pediatric dermatologic issues. We also removed shrapnel from the thigh of a young boy who had been shot by ISIS. We evaluated a woman with a recurrent hydatid cyst, and we attempted to schedule surgery for her at Azadi Medical Center,
the regional tertiary referral hospital in Dohuk. (The operation did not occur on this particular trip, but likely will occur on a future mission.) It became evident to us after discussions with Nezar Ismet Taib, MD, director of the Health Directorate in Dohuk, that hydatid cysts are endemic to the rural areas in northern Iraq.

In accordance with their religious beliefs, young women rarely let male physicians examine them, deferring to women surgeons and internists. One young woman would not even allow us to examine her ankle for inflammation. For this reason, the GSMSG ensures that half of the team who come on the trips are women physicians and health care professionals. On this trip, the GSMSG obstetricians and gynecologists performed the first laparoscopic total hysterectomy in the women’s hospital.

Azadi Medical Center does not provide emergency acute care surgical services. Patients needing this level of care are transferred to Dohuk Emergency Hospital, a more austere two-story complex that houses five intensive care unit beds and five emergency department (ED) triage beds for acute trauma and acutely ill individuals. The ED is divided into two separate sections by a wall, with men on one side and women on the other. Surprisingly, the Dohuk Emergency Hospital had a functioning digital X-ray room and computed tomography scan.

David Epstein, MD, an interventional radiologist in south Florida, and Dr. Aaron Epstein’s father, has participated in multiple missions. Dr. David Epstein is the only interventional radiologist training health care professionals in Kurdistan to perform angiographic embolization techniques.

Establishing a self-sustaining surgical care system

After the second day at the IDP camp, we went to Azadi Medical Center and spent the rest of the mission operating alongside the Kurdish surgeons. The public health system provides free medication and surgical services each day until 1:00 pm. Approximately five operating rooms (ORs) were in use that day. Patients were undergoing pediatric and adult urologic procedures, general surgery operations—including laparoscopic cholecystectomy and hernia repair—as well as otolaryngology procedures. Para-median hernias are common in multiparous women, and umbilical hernias are repaired with only mesh and sutured down circumferentially after primary closing of the fascial defect.

The surgeons claim minimal recurrence and migration, as well as low infection rates. Turnover time is minimal because documentation and all the regulatory processes of ORs in the U.S. are absent. The operations at Azadi Medical Center are performed mainly by the most senior fellows under the supervision of their attendings, who are commonly scrubbed during complex cases in the morning. All private cases are performed in the afternoon, and all cases at the public emergency hospital are staffed...
by senior residents. Laparoscopic equipment for all cases is available for use, but single-case throwaway equipment, such as clip appliers, are unavailable because of cost constraints.

**Focusing on long-term needs**

Although GSMSG teams do clear backlogs in cases both for primary and surgical care, the organization’s main focus is capacity building and establishing training programs for local medical professionals. Too often, groups with good intentions enter an area to provide care, only to leave local populations with little to no follow-up opportunity, or leave behind material donations that cannot be locally replenished or are so technologically advanced that the local health care community is unable to use them.

We also recognize that a lot more goes into reducing morbidity and mortality rates among populations in conflict areas than providing surgical care. For that reason, the GSMSG focuses on providing care and training at the nursing and prehospital medic levels.

To date, in Iraq alone the GSMSG has trained more than 2,000 local health care professionals in prehospital care, trained more than 200 individuals in nursing care, and conducted training sessions for more than 500 local physicians and surgeons. The GSMSG has tended to thousands of primary care patients and completed hundreds of major operations across nearly all major subspecialties, ranging from coronary artery bypass graft, to Ilizarov procedures, to total abdominal hysterectomies. We also maintain follow-up and the ability for local physicians to contact our surgeons stateside for consultation as needed. Fulfillment of this responsibility is usually routed through Dr. Aaron Epstein to the most appropriate provider on the GSMSG roster, and the conversations take place via Skype, FaceTime, or other video-conferencing technology.

**Consider participating**

Expanded participation by U.S. chief residents and fellows on future GSMSG missions would prove beneficial for both the trainees and the local population. For the U.S. trainees, participation in a mission would be a great opportunity to refine techniques such as open procedures, which are rarely done in the U.S., and often only in response to an adverse event caused by medical or operative errors. However, all surgeons should be able to do an open procedure, as it is the ultimate fallback when laparoscopic or robotic equipment fails. Technological advances have the surgical community looking so far forward that we sometimes forget to take the occasional look back, to remember our fundamental roots. After all, the most basic surgical intervention only requires sharp steel, bright lights, and brain power—and maybe some suture.

The GSMSG provides a unique opportunity for senior U.S. surgical trainees and fellows to join senior attending-level surgeons overseas in order to
It should be noted that expanded participation by chief residents and fellows in GSMSG will provide greater access for underserved populations in need of surgical care.

experience austere surgical settings and to perform fundamental surgical interventions that are rarely part of training in the U.S. Not only would such an opportunity benefit U.S. trainees, but it would benefit individuals interested in pursuing careers in rural practice or in austere settings. The opportunity to operate under the supervision of leading surgeons from top-tier institutions is rarely available to most U.S. surgical residents.

Obviously, such operative experience is only done to the extent that these procedures provide the maximum benefit to the patient population. It should be noted that expanded participation by chief residents and fellows in GSMSG will provide greater access for underserved populations in need of surgical care. It is clear that this program and others like it create a win-win for both patients and providers. Basic procedures, such as those for acute cholecystitis, appendicitis, or herniated bowel, are lifesaving for the patient, but also give the trainee the chance to refine fundamental skill sets.

Participation in GSMSG is a unique experience that motivated, compassionate, adventurous surgeons will appreciate. GSMSG covers the cost of transportation, room, and board once the senior physician arrives in Erbil. One gets a sense of giving back when participating in the GSMSG mission to Iraq. The experience promotes an appreciation for the geopolitical region of the Middle East and its historical and religious importance. The GSMSG team experience truly is life-changing.

It is important to note that while pockets of ISIS activity have been reported in the most rural areas around the Syrian border, security was never an issue while we were deployed in Dohuk or in Erbil. It was an honor and a privilege to serve the Yazidi people during this mission. One of our local Kurdish/Iraqi partners in the region once told Dr. Aaron Epstein, “For decades, all we have ever known in the region has been the might of the American military. But with GSMSG and your teams, we have truly seen the might of the American heart.” What we who work in medicine have learned is that the human touch and the human presence go a long way toward healing individuals. Often our presence alone provides the needed healing for patients we see in the field. To know that someone is willing to sacrifice time and income to show patients that we care does wonders for those in need.

If you are interested in joining the GSMSG team, visit GSMSG.org. ♦
The American College of Surgeons (ACS) presented the 2019 SurgeonsVoice Advocate of the Year award to Sherry Cavanagh, MD, FACS, at Clinical Congress for her commitment to the College’s advocacy and political efforts, particularly through her involvement with the ACS Health Policy Advisory Council. In this article, Dr. Cavanagh describes why she decided to become a surgeon-advocate and offers advice on getting involved in the advocacy process.

Because of our unique perspectives, expertise, and personal experiences in patient care, surgeons are well positioned to serve as effective advocates at the local, state, and federal levels. Deciding to become involved in surgical advocacy often begins with asking yourself if health care legislation, regulations, and insurance plans are affecting how you practice and care for patients. Do these policies impede your ability to provide quality care? Are insurers providing fair reimbursement or causing unnecessary delays in care with burdensome prior authorization requirements? Have you experienced a disgruntled patient who has received a surprise medical bill? These are merely a few situations where residents, Fellows, and young surgeons can advocate for surgical patients and the profession.

Find your passion
As I entered surgical practice in 2015, the opioid epidemic was emerging as a broader crisis than many policymakers understood it to be. New laws were being implemented with additional requirements and limitations on prescribing, which led me to question who the decision makers were and whether they were receiving physician input. I also experienced the
Knowing about the issues and the College’s position on them is essential to becoming an actively engaged and effective surgeon-advocate.

time-consuming process of obtaining prior authorization from insurers. The need to effect change was apparent, and remaining a bystander was no longer an option.

I began my journey by identifying these two issues of particular interest to my patients and my practice. I learned more about the ACS advocacy programs and activities, and I developed a sense of the various areas where I could make an impact. Knowing about the issues and the College’s position on them is essential to becoming an actively engaged and effective surgeon-advocate.

Locate your legislators and understand policymakers’ positions

The next step on my journey to effect change was to identify the legislators and policymakers best positioned to influence public policy. Several online resources are available to assist you in locating your legislators and learning about their positions on important issues. Additionally, determining if your representative or senators serve on key congressional committees that have jurisdiction over health care policy is helpful. These committees are as follows: the House Committee on Energy and Commerce Health Subcommittee; the House Committee on Ways and Means; the Senate Finance Committee; the Senate Health, Education, Labor and Pensions Committee; and the House and Senate Appropriations Committees.

Before you meet with your U.S. representative or senators, gather some information about them. How have they voted in the past on the issues that matter to you? What kind of work do they do outside of the political arena? You can find some general information on members of the House of Representatives at house.gov/representatives/find-your-representative and on senators at senate.gov/general/contact_information/senators_cfm.cfm.

It’s also important to know whether any bills related to the issues of concern to you have been introduced and how far along they are in the legislative process. You can learn what is on the congressional docket at congress.gov/.

It is helpful to know what the ACS is doing to address the issues. You can learn more about ACS federal legislative priorities at facs.org/advocacy/federal.

The same concepts apply when advocating at the state level. Gather information about your governor and his or her background, past experience with health care issues, and so on. A handy resource is usa.gov/state-governor.

To locate your state legislator, go to openstates.org/find_your_legislator/. To learn more about pending legislation in your state, go to congress.gov/state-legislature-websites. And be sure to contact ACS State Affairs staff and learn more about the College’s state initiatives at facs.org/advocacy/state.

Recognizing staff roles and responsibilities

After requesting a meeting with a state or federal legislator, it can be frustrating to learn that you are meeting with congressional staff.* It is important to note that staff serve as key advisors to their legislators on the issues and provide lawmakers with valuable insights into complex policy issues. Getting to know the health care staff and offering to assist with future health policy priorities is a productive way to build a relationship with members of Congress and state legislators. Working to establish and maintain communication could lead to other opportunities to join “insider” health care advisory committees, physician roundtable events, and more. The following are common congressional staff roles and responsibilities:

Advocacy is a marathon, not a sprint. Continuous active participation is key to seeing results.

ACS SurgeonsVoice Advocate of the Year recognition program

The ACS SurgeonsVoice Advocate of the Year recognition program tracks how engaged surgeon advocates use tools and take action via SurgeonsVoice online. Top advocates establish and maintain relationships with legislators, helping to advance health policy priorities.

The Advocate of the Year is recognized at the annual Clinical Congress, featured in the Bulletin of the American College of Surgeons, and invited to participate in other advocacy-related activities.

To be eligible for recognition, surgeons may demonstrate their engagement through the following activities:

- Attend the annual Advocacy Summit
- Serve on an ACS committee
- Attend in-district meetings
- Host a site visit/facility tour/training
- Present on the value of ACS advocacy efforts
- Join state Chapter Lobby Days
- Contribute to ACS publications
- Participate in press/op-ed opportunities
- Provide advocacy testimonials
- Recruit surgeon-advocates
- Share advocacy-related content via social media
- Become an issue expert

The call for nominations for the 2020 Advocate of the Year will be issued this summer.

Chief of Staff: Oversees the legislator’s office, provides legislative, policy, and political counsel, and assists with Washington, DC, and district office operations.

Legislative Director: Manages the legislative team, prioritizes legislative efforts, and directs the policy agenda.

Legislative Assistant (LA): Serves as the policy expert on an issue or portfolio of issues. Examples include agriculture, budget, education, health, military (typically referred to as “MLA”), taxes, transportation, and so on.

Legislative Aide: While some offices use LA and Legislative Aide interchangeably, aides are typically Senior Legislative Correspondents who work on at least one legislative issue.

Legislative Correspondent: Responsible for monitoring and responding to incoming constituent mail.

Counsel: As the name suggests, this staffer typically assists with drafting legislation, provides detailed analysis on legislative text, and often specializes in a specific legal area of expertise. This position often is staffed at the committee level.

Communications Director or Press Secretary: Serves as the chief spokesperson to the media and external interest groups. This individual organizes press conferences and relays the member’s stance on issues. He or she also drafts newsletters and composes press releases.

Tips to elevate your engagement

The involvement of surgeon-advocates is paramount to establishing an active relationship with federal and state legislators. The key to successful advocacy is an engaged membership, and you can help support this work by engaging in the following activities:
Regularly visit SurgeonsVoice online† and familiarize yourself with the College’s tools and resources that are available to all surgeon-advocates.

Take action on important advocacy priorities that interest you.

Consider joining the Health Policy and Advisory Council—a diverse group of nearly 180 surgeon-advocates who are skilled or have an interest in ACS advocacy priorities and activities, educating their colleagues about making an impact, and ensuring lawmakers hear surgery’s perspective.

Attend the annual ACS Leadership & Advocacy Summit in Washington, DC. During the Advocacy Summit, you will learn about the issues that the College has identified as priorities, have the opportunity to meet with members of Congress and their staff on Capitol Hill, and gain insights into effective grassroots advocacy.

Meet with your member of Congress in-district through the 2020 Advocate at Home Program.

Join your ACS Chapter, advocate with other colleagues at organized state Chapter Lobby Day visits, and consider inviting a legislator to visit your hospital or practice.

Join your local and state medical societies and attend their meetings. There are several advocacy sessions featuring local legislators that members are encouraged to attend.

Learn more about the ACS Professional Association Political Action Committee (ACSPA-SurgeonsPAC) and its role in helping to elect and establish relationships with members of Congress.

In an era when information is communicated in real time and more government offices and officials are communicating via social media, be sure to follow and tag @SurgeonsVoice and your legislators via Twitter. Other ACS handles include: @AmCollSurgeons, @yfaacs, @RASACS, @ACSTrauma, @StopTheBleedACS, and @CoC_ACS. To learn more and create a profile, visit bulletin.facs.org/2016/06/the-surgeon-and-social-media-twitter-as-a-tool-for-practicing-surgeons/.

Join the discussion and network with your peers via the ACS Communities.

Practice makes perfect
Advocacy is a marathon, not a sprint. Continuous active participation is key to seeing results. Meeting with your legislators and their staff on a regular basis, serving as a valuable resource, proposing solutions to complex problems, and understanding policymakers’ positions on various issues helps build credibility. Your first meeting might be brief and with health care staff, but your follow-up visit could be a lengthy discussion with your member of Congress. Unlike surgery, which tends to offer a quick fix, effective advocacy takes time. Recognizing that from the outset is critical to your success.

Reduced hospital length of stay (LOS) improves access to hospital beds and decreases cost. For repetitive, high-volume procedures such as bariatric operations, standardization of care can reduce resource use by eliminating unnecessary testing, medications, and interventions in uncomplicated cases and through early identification and treatment of complications. The resulting cost savings ultimately benefit both patients and health care systems. In states with capitated reimbursement rates, such as Maryland, it becomes even more important to ensure that cost-reduction measures have a neutral or positive effect on patient outcomes. Standardized postoperative protocols after surgery have been implemented in bariatric surgery to decrease LOS. In bariatric surgery, postoperative analgesic and antiemetic protocols have yet to be standardized.1-4

The University of Maryland Medical Center, Baltimore, is a 757-bed urban tertiary academic medical center and teaching hospital. The hospital’s bariatrics program is accredited by the Metabolic and Bariatric Surgery Accredited Quality Improvement Program (MBSAQIP) and provides comprehensive weight management for a broad patient demographic.

Approximately two-thirds of patients undergoing laparoscopic gastric bypass surgery were discharged on postoperative day one before the bariatric surgery program instituted analgesic and nausea protocols. Most remaining patients stayed additional days because of inadequate oral intake resulting from persistent nausea. Moreover, the use of narcotic analgesics appeared to be a significant exacerbating factor for nausea.

Context of the QI activity
To address this issue, we developed a narcotic-sparing analgesic protocol and an antiemetic protocol. These protocols have preoperative, intraoperative, postoperative, and postdischarge components. In addition, because these protocols have multiple independent interventions, they are bundled. Typically,
all interventions in patient care bundles are implemented simultaneously, preventing analysis of the efficacy of individual interventions. The downside of this approach is that ineffective (and often expensive) interventions are not identified for potential elimination.5-7 We sought to implement a standardized postoperative analgesia and nausea bundle in sequential stages, allowing us to analyze each intervention as it was added. We hypothesized that our protocols would lead to improved pain and nausea control, which would allow patients to experience decreased hospital LOS.

Putting the QI activity in place
This intervention was a largely physician- and division-driven effort to improve patient symptom control and reduce LOS and cost of care without increasing readmission rates.

Our analgesic and nausea protocols were deployed in stages across four phases of operative care: preoperative, intraoperative, postoperative, and postdischarge. This involved coordination of hospital care teams, including nurses, dieticians, administrators, coordinators, desk staff, residents, operative staff, case managers, pharmacists, and physicians.

Before the protocols were implemented, all patients followed a standardized care pathway, which included routine use of patient-controlled anesthesia, discharge on oral narcotics, and an inpatient order set for nausea that was written with minimal guidance or education for the administering nurses.

From 2015 to 2018, components of the new protocols were introduced sequentially. Implementation required buy-in from the surgeons, as well as the engagement of the nurses led by nursing leadership both in the preoperative and postoperative settings. Intraoperative protocol changes required coordination with anesthesia providers, as well as our surgical technologists.

Development and selection of interventions came from a combination of medical literature as well as provider consensus. We looked at practice patterns among many bariatric surgeons across the country. This analysis yielded a list of interventions that our group discussed, modified, and selectively implemented. Divisional and departmental leadership supported and encouraged enactment of these protocols, and changes were tracked both via internal quality data and coded metrics, as well as MBSAQIP data.
With respect to staffing, these interventions were primarily driven by two surgeon champions and involved the entire staff of our bariatric nursing unit, who received training from our nursing champion.

Description of the quality improvement activity
From 2015 to 2018, key steps were introduced. Throughout implementation in the outpatient preoperative setting, patients were introduced to and taught an educational module with extensive details of their upcoming care (see Figure 1, page 29). This process included providing education on their inpatient medication regimen for pain and nausea such that they would be able to appropriately ask for treatment for their symptoms in a timely and effective manner after their operations.

In the first stage of implementation, on the day of surgery before the operation, each patient is given a scopolamine patch. Intraoperatively, anesthesia administered 1 g intravenous (IV) acetaminophen. Our first postoperative intervention was to eliminate patient-controlled analgesia (PCA), which required the engagement of anesthesia and the pain service, as well as the floor nurses. Nursing was engaged via in-service teaching facilitated by charge nurses, as well as the surgeons.

The next step was implementation of a global reduction in postoperative narcotic use, again by reeducating the nurses on the bariatric patient unit and setting our patients’ outpatient expectations. Along with the intraoperative acetaminophen, patients are given scheduled oral (PO) acetaminophen, as needed (PRN) oxycodone, and rescue PRN morphine based on strict pain score guidelines. Patients were discharged with 10 tabs of 5 mg oxycodone.

Our second stage introduced intraoperative transversus abdominal plane (TAP) and rectus sheath blocks using 60 mL 0.25 percent Marcaine with 1 percent epinephrine expanded to 90 mL, administered by the surgeon intraoperatively via laparoscopic visualization. Our patients were discharged with only five tabs of 5 mg PO oxycodone.

In the third stage, we introduced an aggressive standardized anti-nausea protocol, which required engagement of both preoperative and postoperative nursing staff on the proper sequence and timing of ondansetron, haldol, and diphenhydramine. This step required implementing a nausea score, which would guide the administration of the antiemetic. The house staff was briefed to avoid disrupting the protocol with adjunct antiemetics. We also implemented an inpatient checklist with hourly walking and oral intake goals. Each sequential step required physician-led education of the house officers, as well as changing electronic order sets with help from bariatric office coordinators and the university’s information technology department.

Resources used and skills needed
With respect to staffing, these interventions were primarily driven by two surgeon champions and involved the entire staff of our bariatric nursing unit, who received training from our nursing champion. Office staff within the bariatrics program—particularly our bariatric program manager, who helped implement the information technology changes, and the division’s clinical reviewer—were integral.

Minor additional costs were incurred intraoperatively to administer bupivacaine transversus abdominus plane blocks. MBSAQIP membership was a fixed cost already within the division’s budget.
Despite having no direct measure of pain or nausea during our interventions in this austere data environment, we knew 75 percent of readmissions were pain and/or nausea related, and thus, particularly with respect to early readmissions, the new protocol likely was effective in treating our postoperative patients’ pain and nausea.
The challenges encountered during this quality improvement project has led to improved processes to capture these specific data within our electronic medical record.

electronic health record. Use of multiple sources means that failure of one data source still leaves a usable, albeit more limited, data set.

Nursing engagement and buy-in is the key to implementing new patient care protocols. In addition, if house staff provide some aspects of patient care they must always be abreast of changes and implementations of new portions of the protocol because they are on the front lines for nursing calls and order entry. They also can be used as points of contact to educate nursing and ancillary staff.

Departmental support should follow easily if cost and LOS can be decreased. Demonstrating cost savings and reductions in LOS requires data analysis and review periodically as the intervention is implemented.

Sustaining change requires focused and unwavering pressure. At least one or two primary stakeholders and champions must be involved. Having a passionate, steady, and vocal advocate keeps these projects on track and moving forward. Interventions should be supported with data from the literature, as well as expert provider consensus.

Communication via national meetings with colleagues and with other experts can lead to new ideas. Much of our protocol was pieced together via communal experiences and communication throughout the bariatric surgery community.

REFERENCES

Clinical trials have revolutionized cancer care and remain critical to continuously advancing the care of the surgical patient. From breast conservation, to minimally invasive colorectal surgery, to selective lymphadenectomy in melanoma, large-scale multicenter clinical trials have shaped the way cancer care professionals deliver cancer care. The National Cancer Institute (NCI) supports cutting-edge clinical trials, some of which are conducted via their National Clinical Trial Network (NCTN). The NCTN is a collection of more than 2,200 member institutions, allowing collaboration for large multi-institutional trials.* It is an organization that provides infrastructure to help streamline trial operations, improve accrual through its member organization participants, and reduce administrative burdens.

How is the NCTN organized?
The NCTN is composed of four adult cancer cooperative groups: SWOG (Southwest Oncology Group); the Alliance for Clinical Trials in Oncology (commonly known as the Alliance); ECOG-ACRIN (Eastern Cooperative Oncology Group and American College of Radiology Imaging Network) Cancer Research Group; NRG Oncology (National Surgical Adjuvant Breast and Bowel Project, Radiation Therapy Oncology Group, and Gynecologic Oncology Group); and the Children’s Oncology Group (COG).* The Canadian Cancer Trials Group also partners with these U.S. groups. Each cooperative group has its own operations center, tissue bank, statistical center, and a large group of member institutions. To encourage collaboration among the different NCTN cooperative groups, sites and institutions may become a member of more than one.

From breast conservation, to minimally invasive colorectal surgery, to selective lymphadenectomy in melanoma, large-scale multicenter clinical trials have shaped the way cancer care professionals deliver cancer care.

Participating in the NCTN, and specifically the Alliance and ACS CRP, allows surgeons at all phases of their career—including trainees, academic surgeons, and community practice surgeons—to become more involved with NCI-sponsored clinical trials.

Cooperative group, and membership in any cooperative group allows the institution to participate in any NCTN trial (see Figure 1, this page).

Committee involvement
Each cooperative group has various committees, ranging from disease site-specific committees to health services research committees. The Alliance also has some disease site-specific surgical working groups.

Within the Alliance, the Alliance/American College of Surgeons Clinical Research Program (ACS CRP), an ACS Cancer Program, includes the following committees: Education, Dissemination and Implementation, Cancer Care Standards Development, and Cancer Care Delivery Research.†

How does one get involved?
The first step to participating in clinical trials is to become credentialed by the NCI as an investigator. Requirements include the Good Clinical Practice (GCP) training at least every three years. A popular provider of GCP course content and certificates of completion is the Collaborative Institutional Training Initiative (CITI). More information about CITI can be found at https://about.citiprogram.org/en/courses/.

The three options for participating in NCTN clinical trials are as follows:

- Participate in the NCI Community Oncology Research Program (NCORP), either through receiving a grant as a main member or through...
NCTN COOPERATIVE MEMBERSHIP AND PARTICIPATION INFORMATION

Alliance for Clinical Trials in Oncology: www.allianceforclinicaltrialsinoncology.org/main/

NRG Oncology: www.nrgoncology.org/About-Us/Membership/Membership-Requirements

SWOG: www.swog.org/about/join-swog-cancer-research-network

ECOG-ACRIN: https://ecog-acrin.org/about-us/membership/membership-classifications

affiliate membership status. For community hospital cancer programs, affiliation with an NCORP site is the most common approach. A total of 46 community sites are spread across more than 900 locations (both community hospitals and private practices). Individuals, organizations, group practices, and other cancer care providers that are interested in becoming affiliate members can contact the principal investigator or administrator of a community NCORP site or minority/underserved NCORP site. The listing of sites and more information can be found at http://ncorp.cancer.gov.

• Access trials through the NCI’s Cancer Trials Support Unit website at www.ctsu.org.

• Become a member through one of the cooperative groups. Membership and participation information can be found on the websites available in the sidebar, this page.

Cooperative group meetings are open to anyone at a cancer care center that is affiliated with that particular NCTN group; for instance, if your institution is an Alliance member, attendance is free to any of the Alliance or ACS CRP committee meetings. It is a forum to learn the latest updates on enrolling clinical trials and to interact with national leaders regarding upcoming clinical trials, as audience feedback is actively sought when new study concepts are presented. In addition, the ACS CRP committees regularly work with programs that directly affect surgeons, such as by collaborating with the Commission on Cancer on operative standards for cancer surgery, developing cancer clinical trial-related content for the ACS Clinical Congress, and implementing programs to disseminate the latest trial data to practicing surgeons.

To register for an upcoming Alliance Group Meeting, which takes place in Chicago, IL, in May and November each year, you must create a Cancer Therapy Evaluation Program (CTEP) ID. Use the CTEP-Identity and Access Management application (available at https://ctepcore.nci.nih.gov/iam/ApplicationLoginPage.do) to obtain a user account, then complete the NCI registration through the NCI Registration and Credential Repository (available at https://ctepcore.nci.nih.gov/rcr). If you cannot attend the biannual meetings, you can participate in monthly conference calls.

Conclusion
Participating in the NCTN, and specifically the Alliance and ACS CRP, allows surgeons at all phases of their career—including trainees, academic surgeons, and community practice surgeons—to become more involved with NCI-sponsored clinical trials. For more information, contact ACS CRP at clinicalresearchprogram@facs.org.

The news has been full of workplace violence incidents over the last decade, and the health care field is not immune to those tragic events. In 2015, a family member of a patient who died while receiving care from a cardiovascular surgeon shot and killed the surgeon at a hospital in Boston, MA. In 2017, a physician shot seven people—killing one—at a hospital in New York, NY, where he once was employed.

Defining workplace violence
Workplace violence is defined as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty,” according to the Centers for Disease Control and Prevention (CDC) National Institute for Occupational Safety and Health (NIOSH).1 Violence toward health care workers can take many forms, such as biting, kicking, punching, pushing, pinching, shoving, scratching, spitting, name calling, intimidation, threats, yelling, harassing, stalking, beating, choking, stabbing, and killing.2

The Occupational Safety and Health Administration (OSHA) released a report in 2015, The Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, indicated that from 2011 to 2013, the annual number of workplace assaults was between 23,540 and 25,630. Of those assaults, between 70 and 74 percent happened in the health care or social service settings. The report also stated that assaults to health care workers comprised 10–11 percent of workplace injuries leading to time away from work, versus just 3 percent of injuries among all other private-sector employees.3

Workplace violence occurs in all health care settings, but most incidents happen in the emergency department (ED) and inpatient psychiatric settings.4

Resources available
To help stem the tide of workplace violence, The Joint Commission made available several tools on its Workplace Violence Prevention Resources web page. These resources include the following:

- Sentinel Event Alert Issue 59: Physical and verbal violence against health care workers
- Quick Safety Issue 47: De-escalation in health care
- Blog posts on the topic
- Research on improvement methods
- Presentations
- Federal and state resources

The Sentinel Event Alert includes an infographic that lists ways to identify factors associated with perpetrators of violence, which are as follows:

- Altered mental status or mental illness
- Patients in police custody
- Long wait lines or crowding
- Recipients of bad news about a diagnosis
- Gang activity
- Domestic disputes among patients or visitors
- Presence of firearms or other weapons

The infographic also suggests that when violence occurs, staff should report it immediately to hospital leadership, security, and—if necessary—law enforcement.

Of perhaps greater importance to the practicing surgeon is the Quick Safety report on de-escalation, which lists several techniques to use as a first-line response to potential violence or aggression. These recommendations are as follows:5
FOR YOUR PRACTICE

Workplace violence occurs in all health care settings, but most incidents happen in the ED and inpatient psychiatric settings.

• Recognize aggressive patients or behaviors using assessment tools, such as the following:
  – STAMP (staring, tone and volume of voice, anxiety, mumbling, and pacing), a tool used to observe and document behaviors that could potentially lead to violence
  – OAS (overt aggression scale), which measures aggressive behaviors
  – BVC (Brøset violence checklist), which can be used to predict imminent violent behaviors
  – BRACHA (brief rating of aggression by children and adolescents), an instrument that scores 14 areas to assess risk of aggression

• Intervene using the following tactics:
  – Use verbal communication techniques that are clear and calm. Staff should project a nonconfrontational attitude and avoid using abbreviations or health care terms.
  – Use nonthreatening body language when approaching the patient.
  – Approach the patient with respect and be supportive of their issues and problems.
  – Use risk assessment tools for early detection and intervention.
  – Provide staff training regarding the use of de-escalation techniques.
  – Respond to the patient’s expressed problems or conditions to help create a sense of trust with the health care professional.
  – Implement environmental controls, such as minimizing lighting, noise, and loud conversations.

Surgeons face critical and emergency situations daily, including encounters with victims of trauma or with family members who have received sad news about their loved ones, aggressive coworkers in stressful situations, and so on. We need to maximize our efforts to keep these men and women safe from the threat of workplace violence. For more resources, visit the Workplace Violence Prevention Resources webpage at https://jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/.

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.

REFERENCES
The year 2020 marks the 75th anniversary of the atomic bombings of Hiroshima and Nagasaki, Japan. It also marks the 65th anniversary of an early example of international outreach and cooperation through surgery.

An American-educated pastor, Rev. Kiyoshi Tanimoto, was one of six survivors profiled in John Hersey’s classic Hiroshima, first published as an article in The New Yorker in 1946. His Hiroshima Methodist Church would later provide a rudimentary support group for a number of local technical high school students who were burned and disfigured by the blast.

Although an American entity in postwar Hiroshima, the Atomic Bomb Casualty Commission, was studying late effects of the new weapon, its mandate was diagnostic, not therapeutic. In fact, only one visiting plastic surgeon—Truman Blocker, MD, FACS, Galveston, TX—operated on a single patient.

Wheels set in motion
In May 1955, after a number of visits to Japan to meet with Reverend Tanimoto, Norman Cousins—the influential editor of the Saturday Review, a peace activist, and an advocate for nuclear disarmament—helped spearhead the visit of 25 young women Hiroshima survivors to the U.S. It was not an easy task. The project was fraught with political and financial pitfalls; the State Department had concerns that these visits would be viewed as some sort of apology for dropping the bombs that many felt hastened the end of World War II. There also was concern that the public’s sympathy for these young women would fuel communist propaganda and anti-government sentiment. Meanwhile, the Japanese were suspicious that the women were to be further exploited or used for experimental surgery. Alternatively, there was the implied affront that health care in Japan was not up to Western standards.

Ultimately, almost a decade after injury, these Hibakusha (the Japanese term for people affected by the bomb) were brought to the U.S. for treatment of their scars and deformities. The chief of plastic surgery at Mount Sinai Hospital, New York, NY, Arthur J. Barsky, Jr., MD, and internist William N. Hitzig, MD, accompanied Mr. Cousins to Japan to examine potential patients. Stateside, Dr. Barsky’s plastic surgery colleagues—Sidney Kahn, MD, FACS, and Bernard E. Simon, MD, FACS—also would volunteer their services. Mount Sinai donated their facilities, including four inpatient beds. Several Japanese physicians came to New York to chaperone, as well as to observe the techniques and treatments being used.

Hiroshima Maidens receive care and comfort
The “Hiroshima Maidens,” as they became known, stayed in private homes in the New York City vicinity as they prepared for or recuperated from numerous operations. The living arrangements had been worked out through the generosity of the Quaker community and their Friends’ meetinghouses. Real and lasting familial bonds eventually transcended considerable cultural and socioeconomic differences, including the language barrier. In all, the
Dr. Hitzig (left) and Dr. Barsky (second from right) examining one of the Hiroshima Maidens
(United Press telephoto, copyright unknown, collection of the author)

Ready to return to Japan again after a lengthy series of plastic surgery treatments to heal scars of atom bomb burns,
this group of Hiroshima Maidens wave before departing New York’s Idlewild Airport for California on June 12, 1956.
Dr. Sadamu Takahashi, right, carries an urn enclosing the ashes of one of the girls, Tomako Nakabayashi, who died
of a heart attack while undergoing an operation in May. From left are: Sayoko Komatsu; Atsuko Yamamoto; Mitsuko
Kuramoto; Keiko Kawasaki; Motoko Yamashita; Tazuko Shibata; Masako Wada; Hideko Sumimura; Terue Takeda
and Yoshie Harada. (AP Photo/Jacob Harris, used with permission; print also in the collection of the author.)
plastic surgery team performed approximately 140 separate operations on these young women over a one-and-a-half-year period. The physicians and patients became popular symbols of goodwill and understanding between the two countries that had previously been enemies.

War often yields advances in surgery and medicine. Perhaps in the case of the Hiroshima Maidens, the terrible injuries, both physical and psychological, did put a more public and personal spotlight on the devastation of the new nuclear weapons. The U.S. surgeons and physicians who treated the Maidens had no political agenda; all had served ably in the U.S. Armed Forces during wartime. Their goal was simply to be of help and comfort, one patient at a time.

As a result of his efforts, Dr. Barsky became the first honorary member of the Japanese Plastic Surgical Society. In the 1960s, Dr. Barsky cofounded Children’s Medical Relief International and set up a pediatric plastic surgery unit in Saigon, Vietnam. Sadly, Saigon was in a new war zone, but Dr. Barsky was driven by the same noble mission to care for and train anyone in need of his talents and compassion.

Acknowledgment
The author would like to express his gratitude to Arthur J. Barsky III, MD.

BIBLIOGRAPHY
Cori McKeever Ashford has been appointed Director of the American College of Surgeons Division of Integrated Communications. Ms. McKeever Ashford has more than 20 years experience in health care communications and integrated marketing.

A career in communications
Ms. McKeever Ashford joins the College from Weber Shandwick, an integrated marketing agency. At Weber Shandwick, she served as executive vice-president, overseeing its health care practice in the central region, including Chicago, IL; Minneapolis, MN; and St. Louis, MO. She also oversaw one of the firm’s largest client engagements, leading a multidisciplinary team of 70 people across 14 geographies in the U.S., Europe, and Asia.

Prior to Weber Shandwick, Ms. McKeever Ashford spent more than a decade working at the Chandler Chicco Agency in its New York, NY; London, U.K.; Washington, DC; and Chicago offices. While at Weber Shandwick and Chandler Chicco, she had a strong record of developing and implementing integrated communications campaigns that improved business performance, including for blue-chip and startup biopharma companies, diagnostics businesses, hospitals, and professional associations.

Accomplishments in the field
Ms. McKeever Ashford routinely interacts with health care practitioners, translating complex clinical data into clear, straightforward messages to generate widespread awareness. Recently, she counseled Physician-Scientist Support Foundation board members, including two Nobel laureates, on strategy to create awareness of the lack of physician-scientists and the need for increased funding to drive more people into this field.

As a member of the Health Care Council of Chicago, she is actively involved in building a foundational initiative for the organization that supports community health and well-being programs for Chicago area populations at risk for violence.

Ms. McKeever Ashford received her bachelor’s degree in journalism and a minor in political science from Ohio University, Athens. In 2019, she received the Healthcare Businesswomen’s Association Rising Star Award. She participated as a judge in the 2020 ShareCare Awards, a National Academy of Television Arts & Sciences Award program for best-in-class communications campaigns that promote well-being. She has been a panelist at an American Board of Medical Specialties Annual Meeting and Health Care Council of Chicago events, and she served as a moderator for an ExL Drug Pricing and Reimbursement Strategies Summit.

The communications and health care landscapes are changing rapidly and navigating this terrain requires up-to-the-minute knowledge of the latest platforms; an understanding of the convergence of different forms of media; and, critically, how to harness insights about key audiences to drive programs that will make an impact.

Ms. McKeever Ashford looks forward to implementing such initiatives for the College. ♦
Stanley J. Dudrick, MD, FACS, whose research into intravenous feedings was recognized as a critical step forward in surgery, died peacefully January 18 at his home in Eaton Center, NH, at 84 years old. His commitment to developing parenteral nutrition changed the face of care for acutely ill patients and is credited with saving millions of lives.

Dedication to improving nutrition for surgical patients
Dr. Dudrick was a lifelong proponent of nutrition science. He led a groundbreaking research study in 1968 that established the fundamentals of the field. Subsequently, Dr. Dudrick and his team demonstrated the technique of safe, long-term central venous catheterization, which until then was thought to be too dangerous to be practical. They demonstrated that total parenteral nutrition (TPN) using essential amino acids was a therapeutic option for renal failure; small bowel fistulas could close spontaneously if nutrition was restored and maintained; immune incompetence could be reversed by TPN if secondary to protein-calorie malnutrition, even in patients with significant tumor burden; and other seminal discoveries.

In 1975, he collaborated with 35 health care professionals to form the American Society for Parenteral and Enteral Nutrition (ASPEN) and became its first president. ASPEN has since grown to more than 6,500 members and is one of the world’s largest organizations dedicated to improving the research and application of clinical nutrition therapies.

Dr. Dudrick had a distinguished career in academic surgery for more than 40 years. He served as the first professor and founding chair of the University of Texas Medical School at Houston and also chaired the departments of surgery at University of Pennsylvania, Philadelphia; Saint Mary’s Hospital, Yale University, New Haven, CT; and Bridgeport Hospital/Yale New Haven Health System. In 2007, Dr. Dudrick was named chairman emeritus, department of surgery, and director emeritus, program of surgery, at Saint Mary’s Hospital and Yale.

Recognition from the ACS and other organizations
Dr. Dudrick became an American College of Surgeons (ACS) Fellow in 1970 and served as a Governor from 1979 to 1985. He also was a member of the Committee on Medical Motion Pictures and the Pre- and Postoperative Care Committee; Co-Chair of the Surgical Education and Self-Assessment Program; and a member of the Editorial Subcommittee for the Manual of Surgical Nutrition.

In 2005, the College recognized Dr. Dudrick with the Jacobson Innovation Award in honor of his major contributions to science, medicine, and education through his initial research and ongoing contributions to the field of nutritional support for surgical patients. Dr. Dudrick also was recognized as an ACS Icon in Surgery at Clinical Congress 2014 in San Francisco, CA. View the video presentation at bit.ly/2SigOow.

Dr. Dudrick’s accomplishments in research, education, and clinical practice have been recognized by many...
other medical organizations, including the following honors: the first American Surgical Association Flance/Karl Award in 1997; the American Medical Association (AMA) Joseph B. Goldberger Award in Clinical Nutrition; the AMA Brookdale Award in Medicine; and the William E. Ladd Medal of the American Academy of Pediatrics. In 2017, Dr. Dudrick was awarded ASPEN’s first Lifetime Achievement Award. “ASPEN’s interdisciplinary membership and approach reflects one of the principles that guided Dr. Dudrick’s life and marked his brilliant and life-changing career,” said Ezra Steiger, MD, FACS, FASPEN, AGAF. “Dr. Dudrick will be remembered as a healer and visionary, whose kindness has deeply touched many people, and whose achievements have changed the lives of many,” added ASPEN president Lingtak-Neander Chan, PharmD, BCNSP. Read more about Dr. Dudrick’s life and career at bit.ly/2H7Gm10.

Separating truth from alternative facts: 37 years of guns, murder, and violence across the U.S.

Nathan R. Manley, MD, MPH, MS; Peter E. Fischer, MD, MS, FACS; John P. Sharpe, MD, MS; and colleagues in the April Journal of the American College of Surgeons (JACS) found that gun violence represents an ongoing public health concern, with the proportion of firearm homicides steadily and significantly increasing over the past 37 years. Federal Bureau of Investigation homicide data can serve to supplement trauma registry data by helping to define gun violence patterns. However, stronger partnerships between local law enforcement agencies and trauma centers are necessary to better characterize firearm type and resultant injury patterns, direct prevention efforts and firearm policy, and reduce gun-related deaths. This article and all other JACS content is available at journalacs.org.
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“I can say without hesitation that my participation in the FTL—and the opportunities it has provided—has been the single most pivotal, educational, and gratifying experience of my career, in more ways than I could have ever imagined. I do not know of any other opportunity for junior faculty that allows them to contribute so significantly to trauma care as far as the arms of the COT reach, which, as we all know, is around the world.”
— MEGAN BRENNER, MD, FACS (FTL GRADUATE, OCTOBER 2016)

“We can support the COT in its vision to eliminate preventable deaths and disabilities across the globe by engaging the next generation of trauma surgeon leaders early and fostering their growth to ensure the COT remains the leading organization in revolutionizing the future of care to the injured patient. The program that does that is the FTL. Winston Churchill said, ‘We make a living by what we get. We make a life by what we give.’”
— PETER E. FISCHER, MD, FACS (FTL GRADUATE, OCTOBER 2016)

Ensure the work in trauma goes on.

- Visit [facs.org/ftl100](http://facs.org/ftl100) to donate. You can also text FTL100 to 41444.

The FTL100 Campaign supports mentorship activities that further the identification and development of surgeons with an interest in the practice of trauma surgery through the Trauma Mentoring Fund. Opportunities for a named mentoring scholarship also exist through the Future Trauma Leaders Named Mentorship Fund.
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.

Apply or nominate a colleague for ACS Academy of Master Surgeons Educators 2020 class

Applications for Membership, Associate Membership, and Affiliate Membership are now being accepted for this third application cycle of the American College of Surgeons (ACS) Academy of Master Surgeon Educators. Nominations will be accepted until March 20, 2020. Applications will be accepted until April 3, 2020.

Developed by the ACS Division of Education, the mission of the Academy is to play a leadership role in advancing the science and practice of education across all surgical specialties, promoting the highest achievements in the lifetimes of surgeons.

The Academy’s goals include the following:

- Defining megatrends in surgical education and training
- Providing mentorship
- Steering advances in the field
- Underscoring the critical importance of surgical education in the changing milieu of health care
- Fostering innovation and collaboration

Induction into the Academy is a high honor, and membership carries with it the responsibility to “give back” by supporting the mission and goals of the Academy and participating in Academy-sponsored programs and activities.

Additional information about the Academy, as well as the online application, can be found on the website at facs.org/acsacademy. Navigate to “Apply for Membership” or “Nominate,” which can be found on the left-hand navigation tabs and under the introductory paragraphs.
A surgical champion since 2008 for Project Access, Sandra L. Freiwald, MD, FACS (middle), leads hundreds of volunteers to provide surgical care to low-income and uninsured San Diego County residents during local half-day Saturday Surgery Days. Along with her colleagues, Dr. Freiwald created a program that has empowered the surgical community and benefits individuals who otherwise would not have access to elective operations.

Making a difference in your community starts with you.
One personal challenge. One decision to give back.

facs.org/ogb
The American College of Surgeons (ACS) is offering two positions for Associate Fellow surgeons to participate in a two-year, fully funded fellowship with the ACS Geriatric Surgery Verification (GSV) Quality Improvement Program. The goal of the fellowship is to foster the development of surgical experts in the implementation of such a population-based quality program, as well as to support the implementation of the ACS GSV at the fellows’ home institution or an institution within their ACS chapter’s catchment area.

The College will provide scholars with mentorship, education, support, and first-hand experience and skills they need to address issues of safety and health care quality in the older adult population. Ideally, at the completion of the two years, the scholar will have the tools and support to apply for grant funding in geriatric surgical care delivery or outcomes improvement. Each fellowship position is fully funded by the ACS, which will provide $25,000 each year (for a total of $50,000 for the two-year program) to cover travel, administrative, and meetings costs for each of the participating scholars.

**Scholar expectations**

At a minimum, scholars are expected to participate in the following events and activities in the course of their fellowship:

- Activities of the ACS GSV program Steering Committee, including attendance at meetings and completion of assignments that advance the work

- The ACS Geriatric Surgery Task Force meeting at the annual ACS Clinical Congress each year, including promoting new educational sessions related to the surgical care of older adults and reporting on the progress of ongoing implementation activities

- The annual ACS Quality and Safety Conference each year, including the development of sessions to assist current and potential applicants to the ACS GSV program to navigate the challenges of implementation

- Site visits for the GSV program to increase personal and programmatic understanding of implementation challenges and solutions

- Leading talks, as requested, pertaining to the ACS GSV program and the care of older adult surgical patients

- Scholarly activities such as writing about the experience or the program

- Advocacy as it pertains to policies affecting the geriatric population

**Application requirements**

Applicants must be Associate Fellows of the ACS and have graduated from an accredited allopathic or osteopathic medical school in the U.S. or Canada, completed residency and/or fellowship training in the U.S. or Canada, and been in practice less than six years. The applicant must work in a hospital that has applied for the ACS GSV program at least at the commitment level, or must have identified a hospital within their respective chapter that has applied for the ACS GSV at the commitment level or higher. If the applicant’s hospital has not applied for or enrolled in the ACS GSV program, enrollment or a letter expressing an intent to enroll at least at the commitment level within the first six months of the fellowship program will be required. Additionally, the applicants must have the
The goal of the fellowship is to foster the development of surgical experts in the implementation of such a population-based quality program, as well as to support the implementation of the ACS GSV at the fellows’ home institution or an institution within their ACS chapter’s catchment area.

Support of their department chair, who must be willing to champion the applicant’s efforts and participation in the ACS GSV program and to provide the time necessary for the scholar to be successful in the fellowship.

The deadline for application for this fellowship is April 1, 2020. The timeline of the application process follows (all in 2020):

- Interview notification: April 30
- Interview: Early May
- Notification of appointment: May 31
- Starting date: July 1

For more information and a full breakdown of requirements, visit the ACS Associate Fellow Scholar in Geriatric Surgery web page at facs.org/quality-programs/about/clinical-scholars-program/geriatric-surgery. Contact the ACS Clinical Scholars in Residence Program at clinicalscholars@facs.org with any questions.

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facs.org/join
The American College of Surgeons (ACS) is accepting applications for the Gerald B. Healy, MD, FACS, Traveling Mentorship Fellowship. Colleagues and friends of Dr. Healy, Past-President of the ACS, Past-Chair of the Board of Regents, and an Honorary Fellow of the Royal College of Surgeons and the Royal College of Surgeons in Ireland have established funding for the annual mentoring fellowship program in his honor.

Mentorship is one of the hallmarks of academic and professional success. This program is intended to help young surgeons develop new ideas, innovative approaches, and well-informed attitudes about safety, quality, and professionalism via visits to successful mentors.

The Gerald B. Healy, MD, FACS, Traveling Mentorship Fellowship will be used to visit and engage with one or more successful mentor(s). The award, in the amount of $5,000, will cover the recipient’s travel and per diem costs and subsidize revenue lost from days away from clinical duties.

**Application requirements**

Applicant requirements are as follows:

- Applicants must be U.S./Canadian Fellows or Associate Fellows of the ACS and hold an academic rank no higher than associate professor.

- Mentors must be U.S./Canadian Fellows of the ACS or, if in a nonsurgical (microbiology, anatomy, and so on) or nonmedical (business, law, and so on) field, be appropriate for the research and education needs of the applicant.

- Applications must consist of the following items, to be e-mailed to the Scholarships Administrator at scholarships@facs.org as a single PDF document:
  - A one- to two-page essay describing the applicant’s interest in and qualifications for this program
  - A joint statement from the mentor and mentee about their commitment to the relationship, including a description of the anticipated plan for the mentorship and expenditure of funds
  - A brief curriculum vitae (10 or fewer pages) of the applicant and biosketch of the mentor

**Awardee responsibilities**

The recipient will submit reports for submission to the *Bulletin of the American College of Surgeons*, detailing their experience and lessons learned, and preserving such thoughts about the week for the edification of future generations of surgeons.

A financial report also will be provided at the end of the award period; the traveling fellow may use the funds to subsidize travel and per diem for mentor visits, or to replace lost revenue from clinical duties. The latter purpose is taxable.

The deadline for applications is May 15, 2020. A single traveling fellow will be selected, and all applicants will be notified of the outcome of the selection process by June 30.

Visit the Gerald B. Healy, MD, FACS, Traveling Mentorship Fellowship web page at facs.org/healy for more information. Questions also may be submitted to scholarships@facs.org. ♦
Developed by international disease site expert panels, the eighth edition of the AJCC Cancer Staging Manual brings together all currently available knowledge on cancer staging. In this significantly expanded edition, you’ll find:

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# Calendar of events

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

## MARCH

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

## APRIL

**Turkey Chapter—Turkish National Surgery Congress**  
April 1–5  
Antalya, Turkey  
Contact: Prof. Mahir Ozmen, uck2020@flaptour.com.tr

**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@sdsm.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, PR  
Contact: Aixa Velez-Silva, acspuertoricochapter@gmail.com, acspuertoricochapter.org

## 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

**Northern California Chapter**  
May 8–9  
Berkeley, CA  
Contact: Christina McDevitt, nccacs@att.net, northerncalifornia45011.wildapricot.org

## FUTURE CLINICAL CONGRESSES

**2020**  
October 4–8  
Chicago, IL

**2021**  
October 24–28  
Washington, DC

**2022**  
October 16–20  
San Diego, CA
NATIONAL DOCTORS’ DAY
MARCH 30, 2020

“Dr. Farnell taught technical skill and the humility to yield it wisely. When I am challenged, I remember the calm, effective approach that could overcome the most difficult situations safely. Thank you.”

— Shannon M. Foster, MD, FACS, in honor of Michael B. Farnell, MD, FACS

“Dr. Dissanaike is an amazing leader who leads by example, striving to achieve optimal work-life integration for her team. I have learned how to be a servant leader from her. A true role model. I will always be grateful for her generosity.”

— Shankar Raman, MD, FACS, in honor of Sharmila Dissanaike, MD, FACS

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#NationalDoctorsDay

• Donations made in honor of someone are a thoughtful way to say thank you.
• Give a gift to honor surgeons and other physicians, family members, colleagues, and friends.
• All donors and their honorees will be featured in a special recognition listing in the Bulletin of the American College of Surgeons and on the ACS website.
Eduardo Kobra, a Brazilian street artist, created this nine-story mural of Chicago blues legend Muddy Waters.

facs.org/clincon2020

Join us in Chicago!

McCormick Place | Chicago, IL

Save the Date
October 4–8