



**Presidential
Address:**

second **Challenges for the**
Century

by J. David Richardson, MD, FACS

Editor's note: The following is an edited version of the Presidential Address that Dr. Richardson wrote for presentation at the Convocation on October 4 at the American College of Surgeons (ACS) Clinical Congress 2015 in Chicago, IL. Dr. Richardson was unable to attend the event. In his absence, ACS Executive Director David B. Hoyt, MD, FACS, read the speech. The presentation has been modified slightly to conform with *Bulletin* style.

In 2013, the ACS celebrated its 100th anniversary, and we have devoted considerable time to reflecting on the organization's glorious past. The challenge as we move into the second century is to cherish the traditions and values of the past while embracing our future with enthusiasm.

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Our challenge

The etymologic derivation of the word "challenge" is 13th-century French, at which time it suggested "an accusation of wrongdoing." That is certainly not the current intent. By the late 14th century, the word came to mean "a call to fight," and, in a figurative sense, that is part of my meaning. We often use the word "challenge" to mean "arouse or stimulate," and hopefully, the younger Fellows will embrace that definition.

This class of ACS Initiates is reportedly the largest in the College's history, with 1,679 new Fellows. It is much more diverse than in our remote past, with 354 women and 451 from outside the U.S. A total of 981 Initiates are in general surgery-related specialties [such as breast, endocrine, vascular, and trauma surgery], whereas 698 are in defined specialties outside of general surgery [such as neurological, cardiothoracic, and orthopaedic surgery].

Pillars of the College

The Board of Governors, which represents the many broad constituencies of the College, uses the term "pillars" to define certain core activities of the ACS. Although these areas of focus will likely change going

forward, I would like to offer some brief thoughts regarding the current pillars and possible future challenges in each area.

Communications

"Communications" might seem like the most straightforward area of College activities, but in my tenure of leadership, it may have been the most difficult to accomplish. The College leadership is very sensitive to the concerns and desires of Fellows, and while responsive to those issues, it often has been difficult to communicate the activities of College Officers and staff to rank-and-file members. As a consequence, there often is a disconnect between our busy Fellows and equally hardworking leadership because of poor communication.

The future of communications is rapidly changing and younger generations of Fellows should be able to communicate better than mine. Young Fellows of the ACS should begin to communicate with the organization's leaders now. We have a large number of online "Communities" for myriad surgical interests at present. Embrace the Young Fellows Community; become enmeshed in conversations about advocacy, rural surgery, international surgery, or wherever your interests and passions may lie.

Member Services

The mission of the Division of Member Services is to serve the many diverse interests of ACS members. As with Communications, the great challenge is, how do our Fellows engage with the ACS as an organization and vice versa?

At the April 2015 ACS Leadership & Advocacy Summit, retired U.S. Army General Stanley McChrystal offered his perspective on leadership, conveying what he learned from his command experience in the Middle Eastern theater. These lessons have been collected in his widely acclaimed book, *Team of Teams: New Rules of Engagement for a Complex World*. Stated simplistically, one theme he articulated is the need to have leadership that is not top-down but that is actively engaged

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with those rank-and-file troops who have “boots on the ground.”

I would opine that a truly successful surgical group must be bottom-up with active engagement of our surgeons in the field. Several decades ago, the Board of Regents had a reputation for rigidity—whether deserved or not. I can assure all ACS Fellows that the current members of the Board of Regents and ACS Officers are actively engaged and fully committed to serving our patients and our Fellows in a flexible and timely manner. However, a top-down organizational structure from Chicago or Washington, DC, will never allow us to be the organization we desire to be.

The Advanced Trauma Life Support® program is one of the most successful programs in ACS history, and its reach is worldwide. However, establishing this program wasn't a dream of a Regent sitting in Chicago, but rather it was a mission generated by surgeons in Nebraska who saw a need and acted on it. Similarly, our current initiatives in rural surgery were instigated by the women and men in rural areas who developed an Advisory Council for Rural Surgery and the online Rural Surgery Community, and these individuals continue to advocate for change in this important area.

Countless other efforts have similarly arisen, and the ACS leadership has responded accordingly. For young Fellows, local involvement may be an ideal starting point. Many ACS chapters are floundering and need the energy and creativity young Fellows can bring to the table. When local issues are identified, become involved and use the chapters, Members Services staff, or specialty society Governors as a conduit to ACS leadership. Good actions—those that are patient-centric rather than surgeon-centric—often are successful.

Quality: The founding pillar

Improvement in the quality of surgical care was the core principle behind the founding of the College, and quality improvement remains one of the ACS' primary missions today. Surgeons undoubtedly want to provide high-quality patient care, but the majority of these health care professionals are unlikely to directly

participate in quality efforts in their practices or at their hospitals. I would submit simply working in a hospital that has a surgical quality officer, chief medical officer overseeing quality efforts, a “quality” nurse, or the like will not suffice.

Quality, which will be increasingly data- and outcomes-driven, is the benchmark by which future surgeons will be judged. Surgeons must own quality. Its measurement must be local, personal, accurate, and risk-adjusted. If surgeons don't become involved in quality improvement and take ownership of this space, someone else will. The ACS has invested millions of dollars in the development of quality programs, but surgeons and their institutions must put them to use to have a meaningful impact on patient care.

We have recently seen Internet rating services that rank the quality of care that surgeons provide. Some of these rankings use administrative data as a source for these evaluations. Surgeons must take a leadership role in providing the transparency of our quality improvement effort as well.

The College has the ACS National Surgical Quality Improvement Program (ACS NSQIP®) and “QIPs” for trauma, cancer, and other areas of surgery. If your hospital can't afford to participate in ACS NSQIP, find a partner, build a consortium or cooperative, or create your own quality improvement measurement tool. Specialty societies have registries that you can tap. Tomorrow's surgeons will need a record of all cases and outcomes and a means to critically evaluate their work. Undoubtedly, the tools will change, but the core value of quality care for our patients must not. My admonition is that you “own” quality, or the system may own you.

Education is our foundation—not a pillar

Since the first Clinical Congress more than 100 years ago, education has been at the heart of all College efforts. The ACS now engages in myriad educational activities at all levels, from “boot camps” for incoming residents to residency teaching tools. However, our primary focus has been primarily on post-residency

educational activities, whereas resident education has been organized and managed by other groups.

I believe it is time to examine whether the oversight of residency training is properly structured. In my opinion, the greatest threat to the provision of quality surgical care in the future lies not with adherence to quality metrics, but with inadequacies in core surgical training. Surgical training in the U.S. has, for the past century, been among the best, if not the best, in the world. However, a variety of forces are, in my opinion, eroding the quality of our training

Be assured, I am not railing on about duty hours; that ship has sailed. I would, however, submit that surgical training is different than in other nontechnical specialties. Six competencies are common to all surgical training—patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice—but patients are most concerned about the seventh competency: Can my surgeon diagnose my problem and render surgical treatment that is safe and effective?

Completion of a computerized checklist verified by a site visitor, who may be a retired pediatric neurologist, will not suffice to ensure quality training in the procedural aspects inherent to surgery. Pilots teach other pilots to fly aircraft, and those individuals who understand airplanes and aviation verify that training. Although surgeons teach surgeons how to operate, those individuals who verify that training and establish the standards for it often know little, if anything, about surgery.

Understand I am not an “outsider” railing about the system. I have spent 18 years as a general surgery residency program director; seven years on the American Board of Surgery, including one as chair; and seven years on the Residency Review Committee for Surgery, including one year as vice-chair. With that history, one could conclude that I am part of the problem. But the years that I have spent engaged in these endeavors have convinced me that future leaders of the College

should demand radical changes in training paradigms for surgeons.

I would further suggest that the ACS should play an integral part in creating those changes. This issue affects not simply general surgery, but rather all surgical specialties. We should partner with our surgical boards to improve core training; the College has extensive experience in skills verification, and we must ensure our future surgeons have an adequate skills set.

Undoubtedly, any attempt to fundamentally change training will be met with heavy resistance from entrenched organizations currently in control. If my views are mine alone or represent the views of only a minority of surgeons, these views on training will fade away rapidly; however, if you in your practices come to believe surgical training requires substantial improvement, become part of the drumbeat for action.

We should engage existing organizations in a cooperative spirit. However, real solutions may require a surgical approach; that is, create a thoughtful, calculated plan that can be executed decisively. If leading that charge requires direct ACS engagement, we should stay true to our duty to our patients.

The Advocacy Pillar

Advocacy within the ACS is centered primarily on issues that affect U.S. Fellows, largely because most other developed nations have rigidly defined national health care systems. The College entered this arena somewhat late but has become an active force for representing the interests of our patients and their surgeons by advocating in the halls of Congress and state governments, at meetings of policymaking think tanks, with payors, and in discussions with other stakeholders in health care. We have a Washington, DC, office near Capitol Hill and a great staff who represent all of us.

The challenges of advocacy are ever-evolving and changing daily. To paraphrase a line said by Jack Nicholson when referring to the U.S. Marines in the 1992 movie *A Few Good Men*, “You want us on that wall. You need us on that wall.” The ACS and its Division

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of Advocacy and Health Policy stand on the wall daily for surgeons and, most of all, for our patients. Most surgeons have no concept of how our advocacy efforts affect their daily practices.

All surgeons should be involved in advocacy. Be an advocate for your profession with your patients and your health care institutions. If you are a U.S. citizen, give of your talents and your treasure—that is, consider contributing to the ACS Professional Association, a branch of the ACS focused largely on supporting congressional candidates who have demonstrated an understanding of how health policy affects surgical patient care. For those surgeons who believe too much money is spent trying to influence policy, I would remind you that Americans spend billions annually on Halloween candy. I cannot overstate the need for a vibrant advocacy effort.

Changes in health care may require a different form of advocacy in the future. Approximately 80 percent of surgeons are now employees of health care networks or institutions rather than in traditional private practice, and the number of surgeon employees will likely reach 100 percent soon. Problems have already surfaced for surgeons with contracts, terminations without cause, and other issues. Bundled care payments may come, which will mean that one lump-sum payment will be made to a hospital or large group to share for all aspects of care, including all physicians' services. Who will represent the interests of surgeons and their patients? An organization with the College's cachet may need to continually reaffirm the benefit of surgical therapy for our patients.

As corporate medicine continues to grow and consolidate, a new form of representation may be needed to protect the interests of surgeons and their patients. The College would be the ideal group to lead such an effort.

Whereas the ACS is the logical organization to protect the interests of general surgeons, those surgeons who practice in the surgical specialties should support the College as well. The collaboration between the ACS and your specialty group or academies can represent an enormous voice for surgical care.

The constancy of change

U.S. Founding Father Benjamin Franklin expressed his concern about the permanence of the U.S. Constitution when he opined, "Nothing can be said to be certain except death and taxes." I posit that the third certain feature of our lives is change itself. Although this presentation has suggested challenges young College Fellows may encounter in the future, in truth, I have no earthly idea what obstacles you may face in your careers. However, I am confident there will always be a hill to climb and that there will always be another peak to scale.

When the seas get rough, and at times they likely will, be certain of your anchors: your family, your friends, your faith in whatever belief system you embrace, and your profession. The American College of Surgeons can be that professional anchor with the support of you and your fellow Initiates. Embrace the College and build your own pillars; you and your patients will be well served by your efforts. ♦