

# Bulletin

**ACS** / AMERICAN COLLEGE  
OF SURGEONS



**Feeling Like  
a Fraud?**

**Recognize the Signs of  
Imposter Syndrome**



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# Contents



7



13



30

## FEATURES

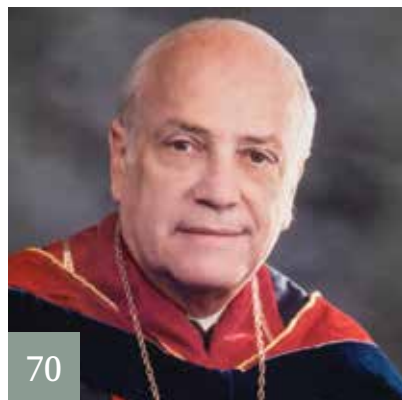
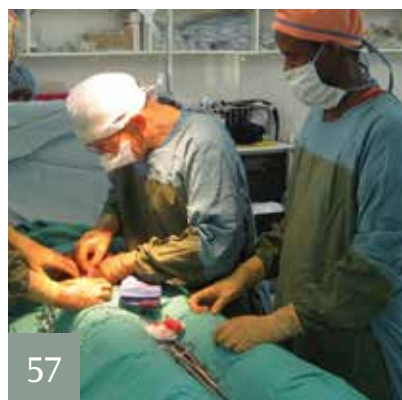
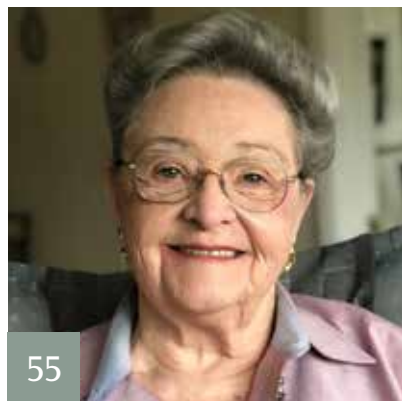
- 7 **COVER STORY:** Feeling Like a Fraud?  
Recognize the Signs of Imposter Syndrome  
Tony Peregrin
- 
- 13 Understanding Intimate Partner Violence:  
How to Break the Cycle  
D'Andrea K. V. Joseph, MD, FACS, FCCM
- 
- 18 The COT at 100: The Critical Role of Trauma Advocacy  
and Injury Prevention  
John W. Scott, MD, MPH, Randi N. Smith, MD, MPH, FACS, John  
H. Armstrong, MD, FACS, Brendan T. Campbell, MD, MPH, FACS,  
Eileen M. Bulger, MD, FACS, and Jeffrey D. Kerby, MD, PhD, FACS
- 
- 27 The Changing Face of Academic Plastic Surgery:  
An Interview with Dr. Kerri Woodberry  
Tony Peregrin
- 
- 30 Profiles in ACS Leadership:  
A Few Questions for Amalia Stefanou, MD, FACS

## DEPARTMENTS

- **COMMENTARY**
- 5 Executive Director's Update:  
*Your Voice Can Be Nearly as  
Important as Your Hands*  
Patricia L. Turner, MD, MBA, FACS
- 
- 52 Letters to the Editor
- **FOR YOUR PATIENTS**
- 33 ACS Quality and Safety  
Case Studies: *New Quality  
Improvement Framework  
Improves How Hospitals  
Perform QI Work*
- 34 ACS Quality and Safety  
Case Studies: *Approach to  
Decreasing CT Utilization for  
Diagnosing Appendicitis*  
Kavita Bhakta, BSN, RN, Theresa  
Viduya, MSN, RN, Kathryn  
Danko, BSN, RN, and Erich  
Grethel, MD, FACS, FAAP

*continued on next page*

# Contents *continued*



## DEPARTMENTS, CONTINUED

- 40 ACS Cancer Research Program: *Genetic and Genomic Testing and Implications in Treatment for Pancreatic Ductal Adenocarcinoma: What All Surgeons Should Know*  
Elizabeth L. Carpenter, MD, Rebecca A. Snyder, MD, MPH, FACS, and Timothy J. Vreeland, MD, FACS

### ■ FOR YOUR PRACTICE

- 44 What Surgeons Should Know: *2023 Changes to Reporting Inpatient and Observation Evaluation and Management Services*  
Jan Nagle, MS, and Teri Romano, BSN, MBA, CPC, CMDP

- 47 A Look at The Joint Commission: *The Joint Commission Releases “Speak Up” to Help Patients Navigate Telehealth*  
Lenworth M. Jacobs Jr., MD, MPH, FACS

### ■ FOR YOUR PROFESSION

- 49 DEI in Action: *Surgeons as Diversity, Equity, and Inclusion Change Agents: Yes, You Can*  
David T. Cooke, MD, FACS

## NEWS

- 55 Dr. Ernestine Hambrick Recognized as Inspiring Surgeon
- 57 Surgeons Honored for Volunteerism and Humanitarian Efforts
- 65 Medical Summit on Firearm Injury Prevention Promotes Collaborative Approach to Address Firearm Violence
- 67 SESAP® 18 Offers Opportunities for Personalized Learning
- 68 Statement of Ownership, Management, and Circulation
- 70 In Memoriam: Dr. W. Gerald Austen, Cardiac Surgery Pioneer
- 72 Apply for 2023–2025 ACS Clinical Scholar in Residence Positions by October 31

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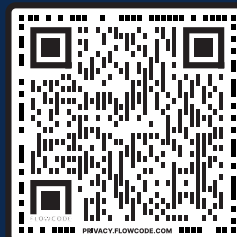
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## Your Voice Can Be Nearly as Important as Your Hands

by Patricia L. Turner, MD, MBA, FACS

**B**orn and raised in Washington, DC, I have been fortunate to have a front-row seat to American democracy and its system of government. While governing bodies around the world function differently, in the US, our government benefits from collaboration, ongoing dialogue, innovative thinking, and immutable facts.

When young surgeons first go to Capitol Hill, they often are skeptical that their contributions will be important, particularly compared to more senior colleagues. It is important for those surgeons to know just how critical their voice is to the conversation.

Many of the influencers—congressional aides and others who have the ears of our representatives and senators—are very interested in what all constituents have to say.

A significant majority of congressional representatives have no backgrounds in healthcare; yet they all vote on health policy issues that impact surgery and our patients. When we visit with our lawmakers, we are giving them the necessary context to make the best decisions for our patients. We are forging relationships with influencers who will seek us out as the trusted voice when they have questions about patient care.

Your voice is an important part of patient care.

### The Power of Advocacy

Thanks to staff in our Washington office and our many members who meet with their lawmakers, taking time to explain issues important to the surgical patient, the ACS has had long and very successful relationships with key contacts at both the state and federal levels, as well as with regulatory and health agencies.

In September, we reached out to two lawmakers with whom we have strong ties to thank them for their introduction of the Supporting Medicare Providers Act of 2022. This legislation provides a critical lifeline to surgeons facing drastic Medicare payment cuts beginning in January 2023.

The lawmakers—Drs. Ami Bera (D-CA), an internal medicine physician, and Larry Bucshon (R-IN), a cardiothoracic surgeon—have worked very closely with us over the years to help ensure patients' access to care, fix the broken Medicare payment system, and create solutions for other issues important to our specialty.

Although more work needs to be done, it is essential that all surgeons in the US show their support for this bipartisan legislation by writing to their Representatives. You can easily do that through SurgeonsVoice at [facs.org/advocacy/surgeonsvoice](https://facs.org/advocacy/surgeonsvoice).

### State-Level Wins

The ACS has had several recent advocacy wins at the state level, as well.

California has become the first state in the nation to require installation of trauma bleeding control kits in new buildings where people will congregate. The legislation is based on the ACS STOP THE BLEED® program.

We, through the ACS Committee on Trauma, members of several California state chapters, and organizations such as the Emergency Nurses Association and American Society of Anesthesiologists, played a significant role in passage of the legislation, which was signed into law September 28.

On the other side of the country, in New York, fellows and residents now qualify for that state's \$1.2 billion healthcare worker bonus program. Initially, the program omitted medical residents from the list of eligible frontline healthcare workers slated to get a bonus for shouldering the brunt of patient care during the height of the COVID-19 pandemic.

After learning about that omission, the ACS and two of our New York chapters immediately weighed in—and lawmakers listened.

Both of these examples prove that when surgeons have a voice in the decision-making process, we can make a difference.

**We likely have one or two degrees of separation from every single person on Capitol Hill through our vast membership. We need to leverage those contacts and have conversations with policymakers.**

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### Firearm Injury Prevention

Another example of how surgeon voices can make a difference relates to efforts to reduce injuries from firearms.

In September, the ACS hosted a Medical Summit on Firearm Injury Prevention, along with the American College of Physicians, American College of Emergency Physicians, American Academy of Pediatrics, and the Council of Medical Specialty Societies. Professionals representing 47 multidisciplinary organizations from across the country took part in the meeting at ACS headquarters in Chicago (see page 65).

We are committed to working together and using our voices to end firearm-related tragedies that occur all too often. We must address the public health crisis of firearm violence; we must make our communities safer, and we must minimize the need for our services as a result of penetrating injuries on children and other victims of firearm violence.

This summit follows a similar meeting that was held in 2019, development of Firearm Safety Team (FAST) recommendations, and subsequent lobbying efforts to educate lawmakers about the importance of these recommendations.

This past June, the Bipartisan Safer Communities Act was signed into law and aligns with three of the FAST workgroup's recommendations.

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### Engaging in the Process

As surgeons, there's nothing more rewarding than saving a patient's life. We do that in the OR every single day. It is also rewarding when our collective voice is used to influence policies that impact our colleagues and our patients.

Without a group of prescient and vocal surgeons, we might not have an emergency medical system or seatbelts in cars. Think about how many lives can be saved if STOP THE BLEED kits were accessible almost anywhere—not only in public buildings but

also in homes and on farms, where several hundred farmers are killed annually, mainly from overturned trailers and other transportation accidents.

We, as a profession, and you, as an individual, are incredibly influential. You don't necessarily have to get on a plane and travel to Washington to make a difference. You can meet with your lawmakers when they are in their home district. You can invite them to your office or hospital for a tour. You can learn more about the ACS Professional Association SurgeonsPAC.

We care for politicians and their families, we operate on their children, and we save the lives of their parents in our facilities. We likely have one or two degrees of separation from every single person on Capitol Hill through our vast membership. We must leverage those contacts and have conversations with policymakers.

We also can use our voice by writing letters, sending emails, and making phone calls. It is essential that each of our voices is heard. Each correspondence is counted, and the higher the number, the more we will move the needle.

The ACS has tools and resources to help you participate in this process. You can access them at [facs.org/advocacy](https://facs.org/advocacy). You can also stop by the Advocacy booth during Clinical Congress and learn more about how you can help.

Advocacy makes a difference, and we can help drive that difference together. ♦

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### Note

The Board of Regents of the American College of Surgeons has approved a change in title for its Executive Director to Executive Director and CEO. This will facilitate the fulfillment of government reports and the execution of documents that reference a CEO.

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If you have comments or suggestions, please send them to Dr. Turner at [executivedirector@facs.org](mailto:executivedirector@facs.org).





**Feeling Like  
a Fraud?**

**Recognize the Signs of  
Imposter Syndrome**

by Tony Peregrin



## HIGHLIGHTS

- Describes the personal experiences of three surgeons who have overcome imposter syndrome
- Identifies potential signs of imposter syndrome, including attributing success to external forces rather than skills/ability
- Highlights strategies for managing these experiences, including seeking out reliable and appropriate feedback

**D**id you sometimes doubt your skills during residency, convinced that you might be exposed as a “fraud”? Have you ever been promoted to a higher position—only to wonder if you possess the talent and experience necessary to effectively lead others?

You are not alone. Imposter syndrome is a psychological experience that occurs when “high-achieving individuals have a pervasive sense of self-doubt combined with a fear of being exposed as a fraud, despite objective measures of success.”<sup>1</sup> This phenomenon—which can affect well-being and lead to burnout—can develop at any stage of a surgical career, although it is especially prevalent among general surgery residents. In a study published in the *Journal of the American College of Surgeons (JACS)*—one of the top five most-downloaded *JACS* articles in 2021—98% of residents reported “moderate,” “significant,” or “severe” imposter syndrome.<sup>1,2</sup>

“People might not want to talk about imposter syndrome—but it looks like they certainly want to read about it,” said Anuradha R. Bhama, MD, FACS, a colon and rectal surgeon from the Cleveland Clinic, OH, and lead investigator of the study. “The prevalence of imposter syndrome in residents is impressive and unexpected,” added Dr. Bhama. “In medicine, especially surgery, there is this expectation to toe the line between humility and hubris. And I think humility sometimes can be viewed as lack of confidence,

and that lack of confidence might be interpreted as a lack of competence. So, there’s a fear that if your imposter syndrome is exposed, there may be unintended consequences regarding colleagues entrusting you with the care of patients or other responsibilities.”

Coauthor Muneera R. Kapadia, MD, FACS, professor of surgery, gastrointestinal surgery at the University of North Carolina at Chapel Hill, reflected on her own experience. “When I think back to residency, especially in my second and third years, as I became more responsible for seeing patients and making initial decisions on whether they needed surgery—I think that’s when there was an incredible amount of self-doubt and certainly feelings of imposter syndrome. Am I good enough? Will I be good enough when I am practicing independently?”

According to the study’s authors, a multivariable analysis of the 141 respondents identified no predictive factors based on demographics or academic achievement. “It’s important then to approach all trainees with empathy. Don’t assume, for example, that simply because a resident is a male that he is tougher and can handle more pressure,” said Dr. Bhama. “One of the reasons I mention this is because when I first started working on this study, my research resident was a white male. Unfortunately, he died from suicide during his research year. You never know what is going on in someone’s mind based on what they show you at the surface level. He did a fantastic job, and I won’t forget that this project all started with his work.”

## Personal Experiences with Imposter Syndrome

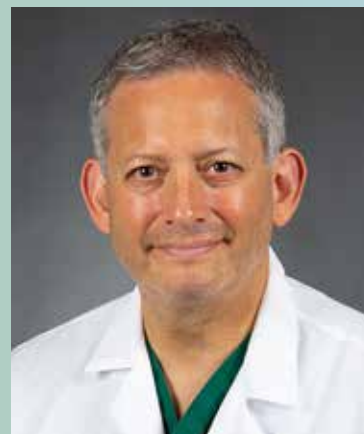
The following personal experiences were courageously shared in an effort to help temper the stigma surrounding imposter syndrome, particularly in the healthcare profession, and provide insights into how three surgeons, at various points in their careers, overcame persistent feelings of self-doubt, anxiety, and a perceived inability to meet expectations.



Dr. Anuradha Bhama



Dr. Muneera Kapadia



Dr. Adam Kopelan

### Residency

“My imposter syndrome started very early in my training, in the late 2000s, when I was told point-blank, women shouldn’t be surgeons, women aren’t as good as male surgeons, or women can’t make difficult clinical decisions because they are too emotional,” said Dr. Bhama. “As a young resident, hearing your program director say that the attendings are ‘infatuated and attracted’ to you, to invalidate positive evaluations of your work, really makes you wonder if you belong. It makes you start to question your academic achievements. I remember thinking, ‘Surely they value my hard work and abilities—but maybe that’s still not good enough?’”

In an effort to find a more inclusive environment, Dr. Bhama transferred to the University of Iowa, Iowa City, in 2011, where she completed her training in general surgery and a research fellowship in surgical oncology at the University of Pittsburgh Medical Center, PA.

“When I was a resident at the University of Iowa, I noticed that my imposter syndrome diminished because I felt that environment was very enriching,” she explained. “They had a group of diverse and successful faculty, especially women, but both men and women. It showed me that being a successful and respected surgeon was not just limited to being a white man. I also felt that the levels of implicit and explicit bias that I experienced were lower in that environment. I felt a strong sense of support from my peers as well.”

### Fellowship

Adam M. Kopelan, MD, FACS—chair of the department of surgery and director of surgical services at Newark Beth Israel Medical Center, NJ, and Chair of the ACS Board of Governors Physician Competency and

Health Workgroup—experienced imposter syndrome at a pivotal point in his surgical training.

“I made the grueling decision to leave my vascular fellowship part way through as I realized that my decision to enter the fellowship was more about my ambition to pursue a successful academic career than what satisfied me on a day-to-day basis, and that ambition was fueled along my pathway through medical school and residency. As I was coming to grips with my decision to leave my vascular fellowship, I felt that I was letting my mentors down in some way, making me feel like an imposter,” Dr. Kopelan shared.

The emotional thoughts connected to feeling like an imposter led Dr. Kopelan to develop clinical depression for which he received help through therapy, counseling, and coaching.

“I learned to use my intellect against any distorted thoughts. I had an ‘aha’ moment when I was challenged with the simple question of, ‘What makes you think that you are not qualified to become a highly successful surgeon?’ because I could not answer that question logically. That realization set me on my way,” he said.

After seeking advice from mentors, Dr. Kopelan found an opportunity that was an ideal fit for his career goals.

“I joined a well-established group of academic-minded surgeons in a growing teaching hospital that needed someone with a minimally invasive surgical skillset. As the hospital system was maturing into a more academically focused system, I saw opportunities to lead, which was a long-standing goal of mine,” Dr. Kopelan explained. “I have been fortunate enough to further develop my skills as a minimally invasive surgeon, an educator, and leader. I have been fortunate to be given the responsibility as both chair of a



department and surgical services director, with responsibilities both in my hospital and within my hospital system.”

### Two years into practice

“When I was a junior faculty, about 2 years into practice, I had a patient have a devastating complication, and she required multiple reoperations,” said Dr. Kapadia. “It was really hard to get up every day and face her and the ongoing surgical issues for the first few weeks. And to make matters worse, that patient was very fond of me. Every time I would see her, she would say, ‘Oh my gosh, you saved my life.’”

Dr. Kapadia said she suffered incredible self-doubt during the time surrounding this case, and that it made it difficult for her to offer surgery to other patients. “Even though I knew that I could do those operations I was thinking about this patient,” she said. “Over time, my self-doubt associated with this patient diminished. As the patient recovered and I was able to re-operate on her and restore her gastrointestinal continuity, I also recovered—but it took several months.”

### Leadership roles

Imposter syndrome can occur at all levels of an organization, including leadership roles that might have some individuals questioning whether or not he or she is equipped to manage a committee or lead the implementation of a newly developed process.<sup>3</sup> The author of a *Harvard Business Review* article identified imposter syndrome in this context as “the flip side of giftedness [that] causes many talented, hardworking, and capable leaders—men and women who have achieved great things—to believe they do not deserve their success.”<sup>4</sup>

“My imposter syndrome kind of shifted from ‘Do I belong in surgery?’ to ‘Can I do this role that I’ve been tasked with?’” admitted Dr. Bhama. “I recently started my current position as the patient experience officer for the Digestive Disease and Surgery Institute at the Cleveland Clinic. Initially, I questioned if I really knew anything about the patient experience. But of course, I know about the patient experience—I’ve been taking

care of patients for almost 20 years now, so this is definitely an area of expertise for me. But my initial gut reaction was, ‘I don’t know how to do this.’”

Dr. Bhama said that strong mentorship, particularly from the department and institute chairs, has been key to her success in this position.

“I recently changed jobs and moved to the University of North Carolina, where I have had the opportunity to take on new roles,” added Dr. Kapadia. “For example, I am now mentoring research residents and I worry whether they will have a good experience. My research mentor when I was a resident was terrific and I want to make sure my mentees have a similar experience. I’m also involved in new areas of research. For example, one of my research mentees has a strong interest in machine learning, which is something I know little about, and there is some imposterism that goes along with that. But with experience and small successes, like completing projects and accomplishing goals, the imposterism diminishes.”

For Dr. Kopelan, battling his inner voice is a constant challenge. “Anytime I’ve been asked to serve in a leadership role, the first question I ask is, ‘Are you sure that I am the right person?’” he explained. “What do I bring to the table that could be helpful for you and your organization? And that starts from a place of, not insecurity, but uncertainty. Am I sure that I have the credentials or the ability to match what their needs are? And so, I’ll just say, even simply being asked to lead this work group for the ACS and the Board of Governors, I thought that it was out of left field, honestly. But I’ve put a fair amount of energy toward understanding how to make this role successful and how I can give back to the ACS—and I am still learning how to do that.”

### Managing Imposter Syndrome

A commitment to providing the highest standards of surgical care is necessary to avoid serious consequences, but in order to maintain physician mental wellness it is important to recognize the difference between the pursuit of excellence and the pitfalls of perfectionism.

A commitment to providing the highest standards of surgical care is necessary to avoid serious consequences, but in order to maintain physician mental wellness it is important to recognize the difference between the pursuit of excellence and the pitfalls of perfectionism.

“One of the things that has been described in medicine, and specifically in surgery, is a type of failure culture. We have a tendency to overanalyze our failures,” said Dr. Bhama. “For example, look at our morbidity and mortality conferences, which are a longstanding tradition. In most academic centers, we find ways to identify errors and even punish mistakes sometimes, while our successes are often met with silence. We put this moral responsibility on our failures, and we very rarely highlight our successes.”

Executive coaches and mental wellness experts suggest developing an awareness of potential signs of imposter syndrome as a practical first step in managing excessive feelings of self-doubt and a persistent fear of being exposed as inadequate. These indicators vary, but generally include the following:<sup>5-9</sup>

- Inability to accept or internalize accomplishments
- Attributing success to external forces rather than skills/ability
- Frequently comparing yourself to others
- Dwelling on past mistakes without also acknowledging accomplishments
- Resisting new challenges/self-sabotage due to a fear of failure

“Effectively managing imposter syndrome starts with being comfortable discussing these things and the ability to be vulnerable,” added Dr. Kopelan. “Vulnerability is a key component of leadership and, as surgeons, we are all trained to be leaders, whether it’s a leader of our practice or a leader of an organization. Vulnerability, in my mind, leads to more human connections, which leads to more discussions like this.”

Seeking out sources of reliable and appropriate feedback (rather than focusing on internal assessments tainted by self-doubt) also is key in combating imposter syndrome. Mentorship can be a valuable source for







obtaining insights into performance, as is peer support. “My fellowship group—there are five of us who graduated together—often helps me think through a problem, whether it’s about a case or another issue at work that I’ve never experienced before,” Dr. Kapadia said. “Talking about issues helps me to decompress.”

### Diminishing the Stigma

As the study published in *JACS* suggests, nearly all residents experience a degree of imposter syndrome during training. Research indicates that healthcare providers in many specialties, including surgery, also struggle with this phenomenon at various points in their career. Diminishing the stigma surrounding these experiences and normalizing open and collaborative discussions about imposterism and feelings of excessive self-doubt are key for supporting physician well-being and, ultimately, enhancing patient outcomes.

“I think it’s crucial to note that even very minor microaggressions can have a long-lasting impact on the people who are experiencing them,” said Dr. Bhama. “Just one, small offhanded comment to a medical student or an intern today may have a long-lasting result on them, 5, 10, 15 years from now. I think it’s important to be cognizant of that. I know I still think about when I was told that I couldn’t be a surgeon and, well, here I am.” ♦

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**TONY PEREGRIN** is Managing Editor, Special Projects, Division of Integrated Communications, Chicago IL.



# Understanding **Intimate Partner Violence:** How to Break the Cycle

by D'Andrea K. V. Joseph, MD, FACS, FCCM

## HIGHLIGHTS

- Identifies key factors that contributed to high rates of IPV during COVID-19
- Summarizes a brief history of IPV attitudes and policy development
- Outlines factors that make it challenging to identify elder abuse
- Issues a call to action for surgeon participation to help break the cycle of violence

In recognition of National Domestic Violence Awareness month, this article describes Intimate Partner Violence (IPV) behavior and identifies the role of the clinician in incorporating screening tools into healthcare assessment protocols.

### What Is IPV?

IPV, or domestic violence, refers to a pattern of assaultive and coercive behaviors exhibited by a current or former partner or spouse. This behavior can occur among heterosexual or same-sex couples and does not require sexual intimacy. The World Health Organization (WHO) reports that nearly one-third of women worldwide ages 15 to 49 have been victims of physical and/or sexual violence by their intimate partner. Men are reported to be victims of IPV in similar numbers, with 1-in-4 women and 1-in-10 men reporting IPV in their lifetime. However, some researchers suggest that the incidence of IPV in men is underreported due to fear related to potential re-victimization or being misidentified as the perpetrator.

The cost of IPV is also felt on a financial scale and has been reported to exceed \$8.3 billion per year in the US and \$4.4 trillion globally.

IPV is about power and control. It does not discriminate and exists across all ethnic, socioeconomic, and educational backgrounds. Nevertheless, there are certain risk factors that increase the likelihood of IPV. Being female, younger age, and lower socioeconomic status have all been shown to be important risk factors for IPV. Notably, prior exposure to IPV has been described as one of the greatest risks for IPV. In a study by Okuda and colleagues, as many as 66% of male perpetrators reported being victims of abusive behavior themselves, confirming what is often described as the “intergenerational cycle of violence.”

Certain key factors—including increased stress levels and a lack of social support—contributed to the high rates of IPV during the onset of the COVID-19 pandemic. With the onset of the pandemic, there was an amplified amount of stress experienced by all,

including the abuser and the victim. This was further compounded by the sequelae of events as world events evolved. The loss of income and diminished access to social services created a perfect storm where victim and perpetrator were forced together continuously in a high-stress environment.

At the height of the COVID-19 pandemic, several countries instituted lockdowns to help control the spread of disease. An unfortunate but expected side effect of this event was the increase in the number of IPV cases seen globally. The onset of natural or public health-related disasters has been shown to increase the prevalence and severity of IPV. The WHO reported increased reports of IPV from as early as February 2020 in Jingzhou, a city in the Hubei province of China, compared to the same period the year prior. Similar reports have been published around the globe, and in the US, there was a significant rise in domestic violence calls, with Alabama reporting upward of a 25% increase. The increase in IPV directly coincided with the stay-at-home orders, and multiple other studies reported similar trends.

### What Can Surgeons Do?

The need for the surgeon to recognize IPV and intervene has been demonstrated repeatedly. The violent loss of Sherilyn Gordon, MD, FACS, a well-regarded transplant surgeon who was killed by her husband in 2017, is a clear indicator that this public health problem affects us all. The ACS has noted in its Statement on Domestic Violence that it is “the responsibility of the treating surgeon not only to care for the immediate injury and to reassure the patient, but also to identify and report potential threats to his or her safety, and to encourage an ongoing safety strategy.”

Nevertheless, barriers continue to prevent the average clinician from recognizing and addressing IPV, including a lack of IPV awareness and access to appropriate social services resources. One could argue that when there is a better understanding of IPV, the likelihood of social etiquette, where the physician or other

## A Brief History of IPV

It is said that British common law in the 18th century allowed a husband to physically chastise his wife, “provided that the stick used was ‘no thicker than his thumb.’” While this assertion has been largely debunked as myth, there are many supporting documents that confirm that—although this perceived common law may not have been completely factual—it was widely acceptable for a man to discipline his wife as he saw fit. The origins of the phrase have been attributed to the legal commentaries of William Blackstone (1723–1780), although this has never been clearly verified. Nevertheless, a husband or father, as the head of the household, was recognized by early law as having authority to discipline the members of his family. He might administer to his wife “moderate correction” and “restrain” her by “domestic chastisement.” For a long time, violence against women was considered a private issue and the public essentially looked away at signs of domestic abuse.

These actions continued despite advances in the courts. In the Americas, Alabama and Massachusetts made “wife beating” illegal in 1871, and early Puritans openly banned family violence. Violence against women continued to be tolerated until certain significant events in history. In 1978, the New York State Coalition Against Domestic Violence was founded, and marital rape became a crime in 1984, in *People v. Liberta*, a case in which a wife sued her estranged husband for forcibly having sexual intercourse with her. The ruling was against the defendant and marital rape was made a crime by New York’s highest court. The Federal Office of Domestic Violence

was established in 1979 but closed in 1981.

The United Nations considers domestic violence an international human rights issue and adopted the Declaration on the Elimination of Violence Against Women without a vote in 1993. In the US, the Violence Against Women Act (VAWA—Public Law 103-322) was passed by Congress and signed into law by President Clinton on September 13, 1994. The VAWA was reauthorized in 2000, and again in 2005 and in 2013, where provisions were made for services for immigrant, rural, disabled, and elderly women.



Learn more about developing intimate partner violence prevention strategies at this Clinical Congress 2022 Town Hall Session in San Diego, CA:

### INTIMATE PARTNER VIOLENCE PREVENTION STRATEGIES (TH303)

Town Hall Session

Moderator: Tanya L. Zakrison,  
MD, MPH, FACS

Wednesday, October 19, 7:00-7:45 am

Ongoing education of residents and staff should be a mandatory requirement in addressing the knowledge gap. Moreover, by incorporating basic screening tools into patient evaluation and intake, victims and perpetrators would be more easily identified and offered assistance.

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healthcare provider may feel unable to address concerning issues, plays a much lesser role.

In the area of trauma care, Kothari and colleagues found that 5% of trauma patients were admitted due to IPV-related injury. Of female admitted patients, Melnick determined that 18% had screened positive for IPV in the last year. A vast majority of IPV victims, however, go unidentified by their healthcare workers. In one chilling statistic, as many as 66% of women killed by their intimate partner had seen a health professional in the year prior.

Ongoing education of residents and staff should be a mandatory requirement in addressing the knowledge gap. Moreover, by incorporating basic screening tools into patient evaluation and intake, victims and perpetrators would be more easily identified and offered assistance. Despite screening and interventions, some patients may still choose to not report IPV. In a study published by the author of this article and colleagues, researchers found that cisgender men\* were more likely to report with a tablet rather than answer questions when screened by a person.

## The Lost Voices

One of the largely unrecognized groups that experience IPV is the elderly population. Elder abuse is reported as anywhere from 3% to 10% in that population. However, some reports believe this to be much higher due to underreporting and a lack of understanding on the part of the healthcare provider. Moreover, difficulties such as complicating comorbid issues and fear on the part of the individual due to dependency on the abuser, increase the likelihood that the abuse will go unrecognized.

With the number of Americans over the age of 65 expected to double over the next 40 years to reach 80 million by 2040, it is imperative that there be better understanding and more research applied to this

\*Cisgender people have a gender identity that aligns with the sex that a doctor assigned them at birth.



population. Per the latest census data, currently, 16.5% of the US population of 328 million people, or 54 million, are over the age of 65.

It is important to recognize that elderly patients are subject to the same types of IPV with an annual report of approximately 2% experiencing physical abuse, 1% sexual abuse, 5% neglect, 5% financial abuse, and 5% suffering emotional abuse. Factors that make it challenging to diagnose and engage the victim (dementia, dependency, and social isolation) are the same factors that increase the risk for IPV in that population. This does not absolve the clinician of the responsibility of investigating, however.

### Steps Forward

Understanding the impact of IPV and the recognition as a public health emergency is the role of every clinician. The surgeon has a unique opportunity to engage and help break the cycle of violence. In particular, the trauma surgeon may find that the presenting injury is the sentinel event and, therefore, has a responsibility to consider IPV in all patients seen in the trauma bay. At our institution, the division of trauma and acute care surgery has taken the unique step of incorporating IPV screening tools into the trauma tertiary survey in addition to the initial assessment. The hope is that this one small step can help decrease the possibility of overlooking the victim of IPV or the perpetrator. ♦

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## **The COT at 100:** **The Critical Role of Trauma Advocacy and Injury Prevention**

**by John W. Scott, MD, MPH,  
Randi N. Smith, MD, MPH, FACS,  
John H. Armstrong, MD, FACS,  
Brendan T. Campbell, MD, MPH, FACS,  
Eileen M. Bulger, MD, FACS,  
and Jeffrey D. Kerby, MD, PhD, FACS**



## HIGHLIGHTS

- Describes how advocacy and injury prevention have been goals of the COT since its inception
- Identifies the evolution of state, federal, and professional programs and policies that optimize prehospital injury care
- Summarizes the creation and growth of the STOP THE BLEED® program
- Highlights current COT advocacy and injury prevention priorities, including the development of a National Trauma Care System

**A**dvocacy is the action of achieving support for a particular position or policy. Surgeon involvement in advocacy-related healthcare policy is key to safeguarding patient-centered care. Although advocacy is commonly considered an activity that involves engagement with local and federal policymakers to pass specific legislation, this work also involves communicating our healthcare-related priorities with practices, hospitals, and healthcare systems to achieve better care for our patients and communities. Successful advocacy motivates collective attention and action and has an explicit intended outcome, such as a change in actions, policies, rules, laws, or funding.

One of the first standing committees of the ACS, the Committee on Trauma (COT), has been an ardent advocacy organization. Over the last century, the COT has been an effective advocate for policies and programs that prevent injuries, maximize survival of the injured, and optimize the return to a productive and meaningful life after injury. Throughout the 1950s, 1960s, and 1970s, the COT's advocacy efforts focused on the prevention of motor vehicle crashes and creation of a trauma and emergency care system. This eventually led to the creation of the National Highway Traffic Safety Administration (NHTSA). The COT informed and supported historic legislation such as the National Traffic and Motor Vehicle Safety Act (1966), Highway Safety Act (1970), and the Emergency Medical Services Systems Act (1973). Through the 1980s and 1990s—as the structure for trauma systems evolved along with the implementation of the Advanced Trauma Life Support® (ATLS®) Program, the COT Verification, Review, and Consultation Program, and the Trauma System Consultation Program—state and regional advocacy efforts by members of the COT began to advance legislation supporting trauma system development. In the 2000s, the COT's advocacy efforts further advanced the systems of care for the injured and led to publications such as

the 2006 *Guidelines for Field Triage of Injured Patients* and the 2008 systems consultation guide, *Regional Trauma Systems: Optimal Elements, Integration, and Assessment*.

Recognizing the role of advocacy to ensure injury prevention and high-quality trauma care remain a priority at the state and national levels, the COT leadership created the Injury Prevention and Advocacy Pillar in 2010. Today, the COT's advocacy pillar engages with the ACS Division of Advocacy and Health Policy (ACS DAHP), the ACS Professional Association Political Action Committee (ACSPA-SurgeonsPAC), and ACS congressional lobbyists to support legislative priorities that ensure optimal outcomes for injured patients.

### A Tradition of Injury Prevention

Injury prevention has been an integral component of the educational efforts and advocacy priorities of the COT. Over the last century, US life expectancy has increased from 62 to nearly 80 years, mostly due to a decreased incidence of injury-related deaths. This decrease in injury-related deaths is multifactorial and includes the following:

- A general reduction in exposure to dangerous jobs and enhancements to safety improvements in the areas of transportation and housing
- Improvements in the medical care provided to injured patients
- The development of a wide array of evidence-based injury control strategies

Examples of injury prevention successes occurred throughout the history of the COT. Beginning in 1939, Charles Scott Venable, MD, FACS, encouraged surgeons to actively become involved with efforts to reduce morbidity and mortality from motor vehicle

As the concept of trauma centers gained momentum, the need to develop injury prevention research and programs as a regional resource began to take hold.

### ADVOCACY PILLAR CHAIRS

- Edward E. Cornwell, MD, FACS (2010–2013)
- Leonard J. Weireter, MD, FACS (2013–2014)
- Michael Coburn, MD, FACS (2014–2020)
- John H. Armstrong, MD, FACS (2020–present)

### PAST-CHAIRS

#### Trauma Prevention Committee

- John G. West, MD, FACS (1985–1992)
- Ronald V. Maier, MD, FACS (1992–1998)

#### Injury Prevention and Control Committee

- Ronald V. Maier, MD, FACS (1998–1999)
- Sylvia D. Campbell, MD, FACS (1999–2003)
- M. Margaret Knudson, MD, FACS (2003–2007)
- Carol R. Schermer, MD, FACS (2007–2008)
- Michael J. Sise, MD, FACS (2008–2012)
- Deborah A. Kuhls, MD, FACS (2012–2020)
- Brendan T. Campbell, MD, FACS (2020–present)

collisions. In February 1955, the ACS Board of Regents approved a resolution proposed by the COT acknowledging that motor vehicle crash injury prevention was both a civic and professional obligation of the College. That same year, a subcommittee on Traffic Injury Prevention was appointed by COT Chair R. Arnold Griswold, MD, FACS (1952–1957). Additionally, Dr. Griswold testified on behalf of the ACS at a hearing in the US House of Representatives in August 1956, where he offered additional suggestions for effectively managing motor vehicle-related injuries. Another advocate for motor vehicle safety, Horace E. Campbell, MD, FACS, worked collaboratively with the COT to advocate for shatterproof glass and doors that do not open on impact.

The COT was not singularly focused on traffic-related injury. In the 1960s, the ACS, along with partner organizations, identified pediatric burns as an area that could greatly benefit from preventive measures.

As the concept of trauma centers gained momentum, the need to develop injury prevention research and programs as a regional resource began to take hold. Injury prevention was recognized as a foundational component of trauma center resources in the first iteration of the *Optimal Hospital Resources for the Care of the Injured Patient* published in 1976. As injury prevention activity by the COT continued to evolve, Donald D. Trunkey, MD, FACS, COT Chair (1982–1986) established the Trauma Prevention Committee in 1985, naming John G. West, MD, FACS as the first Chair. The 1993 edition of *Resources for the Optimal Care of the Injured Patient* increased visibility for injury prevention with its own dedicated chapter on that topic, eventually requiring Level I and II centers to perform screening for alcohol abuse disorders with that manual's 2014 revision. In 1998, the Trauma Prevention Committee was renamed the Injury Prevention and Control Committee (IPCC) and led the way for the COT to recognize injury as a public health issue and one that needed to

R. Arnold Griswold, MD, FACS, providing testimony on behalf of the ACS at an August 1956 hearing in the US House of Representatives on effectively managing motor vehicle-related injuries



be addressed using scientific methodology and a public health approach. Over the years, the COT has been involved in a wide array of injury prevention efforts including bicycle/motorcycle helmet safety, child safety seat usage, pediatric injury prevention, firearm injury and interpersonal violence, and suicide prevention.

### Current Advocacy and Injury Prevention Priorities of the COT

#### STOP THE BLEED®

Over the past decade, a key advocacy priority of the COT has been to reduce preventable deaths after injury by transforming the public's awareness and skillset to address hemorrhage control in the prehospital setting. Because it is a top cause of preventable death in the injured patient, the control of active hemorrhage has been prioritized in trauma care. Yet, as hemorrhage control at the trauma center was progressively refined by applying ATLS Program "C-Circulation" principles, techniques in prehospital hemorrhage control were variable. Tragically, the nation's attention has been turned to the value of bystander hemorrhage control through numerous mass shooting events such as the 2009 Virginia Tech shooting in Blacksburg, VA, the 2012 Sandy Hook Elementary School shooting in Newton, CT, and the 2018 Stoneman Douglas High School Shooting in Parkland, FL. Within this context, the COT led a massive advocacy movement to transform prehospital hemorrhage control in the US and around the world.

In the wake of the Sandy Hook shooting, leaders from the ACS and the COT, led by Lenworth M. Jacobs Jr., MD, MPH, FACS, worked alongside federal agencies, the National Security Council, the US military, and emergency medical response organizations to create a national policy to enhance survivability from active shooter and intentional mass casualty events. These efforts led to the 2013 Hartford Consensus which developed three key recommendations: support early hemorrhage control at the scene; develop an integrated response by law enforcement, emergency medical services, fire, rescue, and public safety officials; and enhance public education to support national resilience. The Hartford Consensus adopted a model of effective grassroots advocacy:

- Define a problem
- Identify a solution
- Build a broad coalition of public and private partners
- Maintain a consistent message
- Leverage multiple channels for communication ("STOP THE BLEED®" [STB] became a rallying cry to gain public attention on the importance of bleeding control)

Early precursors of STOP THE BLEED were developed for professional prehospital personnel and in 2013, the National Association of Emergency Medical Technicians (NAEMT) released the first bleeding



## FIGURE 1. ACS COT STOP THE BLEED®



Dr. Lenworth Jacobs

### Chair of The Hartford Consensus and Founder of ACS COT STOP THE BLEED®

- Lenworth M. Jacobs Jr., MD, MPH, FACS

### Chairs

- Mark L. Gestring, MD, FACS (2016–2022)
- Kenji Inaba, MD, FACS (2022–present)



SAVE A LIFE



Dr. Lenworth Jacobs, second from left, speaks at the White House STOP THE BLEED® event October 6, 2015, in a photo tweeted by the Department of Homeland Security

control course for nonmedical first responders called Law Enforcement and First Response Tactical Casualty Care. However, the need for a course to engage the public in bleeding control was quickly apparent, which led to the development of a course that focused on civilian bystanders similar to how cardiopulmonary resuscitation (CPR) training prepares bystanders for a cardiac emergency. In 2014, the NAEMT Bleeding Control Basic (B-Con) Course was introduced to the public. That course formed the foundation of today's STB Course.

The STB campaign was officially launched at the White House in 2015, and the formal launch of the ACS COT STB program occurred during the 2016 Clinical Congress in Washington, DC (see Figure 1, this page). Since its launch, COT leadership has focused on three key priorities: large-scale training in STB, public access to bleeding control tools, and public policy that supports STB and other trauma priorities. These efforts have resulted in more than 2 million people in 129 countries that are trained as immediate responders. Realizing that defibrillators are ubiquitous, but bleeding control

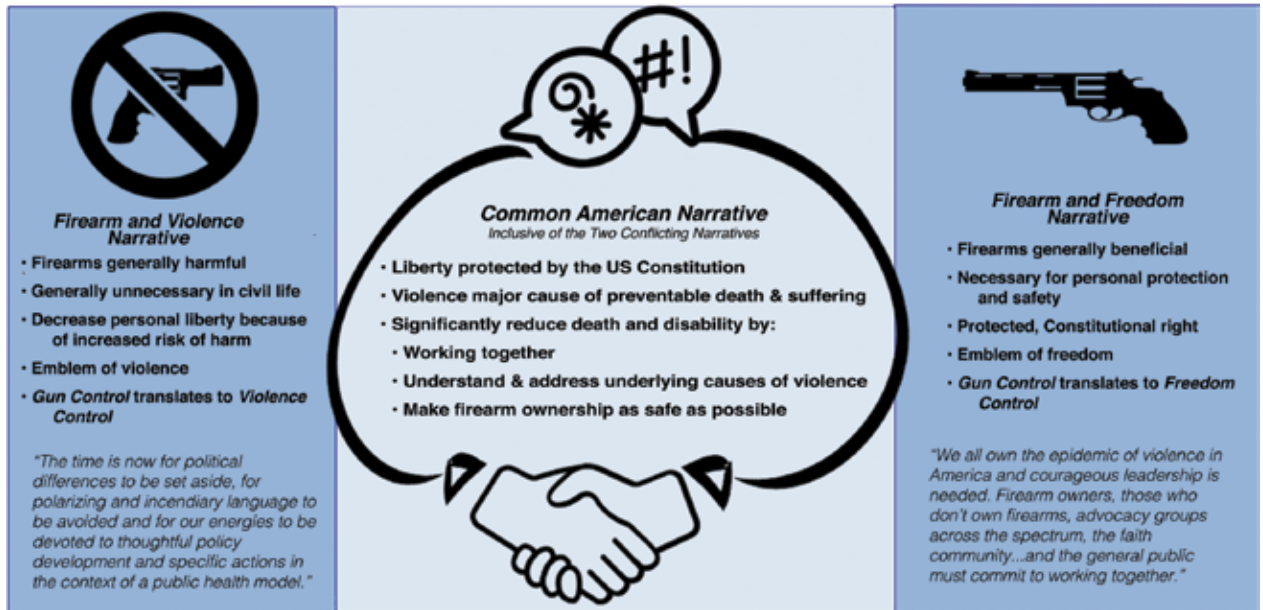
supplies are less commonly available in public places, the Prevent Blood Loss with Emergency Equipment Devices (BLEEDing) Act, shaped by the ACS COT, was introduced in the House in 2019 and the Senate in 2020 to provide grant funding at the state level for bleeding control kits and training. Regarding public policies and public advocacy, multiple state legislatures have passed bills supporting the installation of bleeding control kit stations and STB training in public schools, and multiple corporations have implemented STB training for their employees. Over the last decade, the STB program has demonstrated the rapid impact of comprehensive advocacy through standards, professional education, cross-sector collaboration, citizen training, and public policy.

### Advocating for the Development of a National Trauma Care System

In 2016, the National Academy of Sciences, Engineering, and Medicine (NASEM) published the report, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury*. The ACS was a sponsor of this project, and

FIGURE 2.

## Freedom with Responsibility: A Consensus Strategy for Preventing Injury, Death, and Disability from Firearm Violence



Stewart RM, Kuhls DA, Rotondo MF, Bulger EM. *J Am Coll Surg*. August 2018. Available at: [https://journals.lww.com/journalacs/Fulltext/2018/08000/Freedom\\_with\\_Responsibility\\_\\_A\\_Consensus\\_Strategy.16.aspx](https://journals.lww.com/journalacs/Fulltext/2018/08000/Freedom_with_Responsibility__A_Consensus_Strategy.16.aspx).



the COT, under the leadership of Ronald M. Stewart, MD, FACS, COT Chair (2014–2018), accepted responsibility to advocate for implementation of the recommendations from this report. Dr. Stewart convened a multidisciplinary meeting in Washington, DC, in 2017 to discuss strategies to address these issues.

The COT Advocacy Pillar has supported efforts to advance key recommendations from this report including: The Mission Zero Act, which authorizes funding to support integration of military teams into civilian trauma centers for ongoing training; increases in research funding appropriations to support US Department of Defense-funded trauma research; and increases in funding support for firearm injury prevention research from the Centers for Disease Control and Prevention.

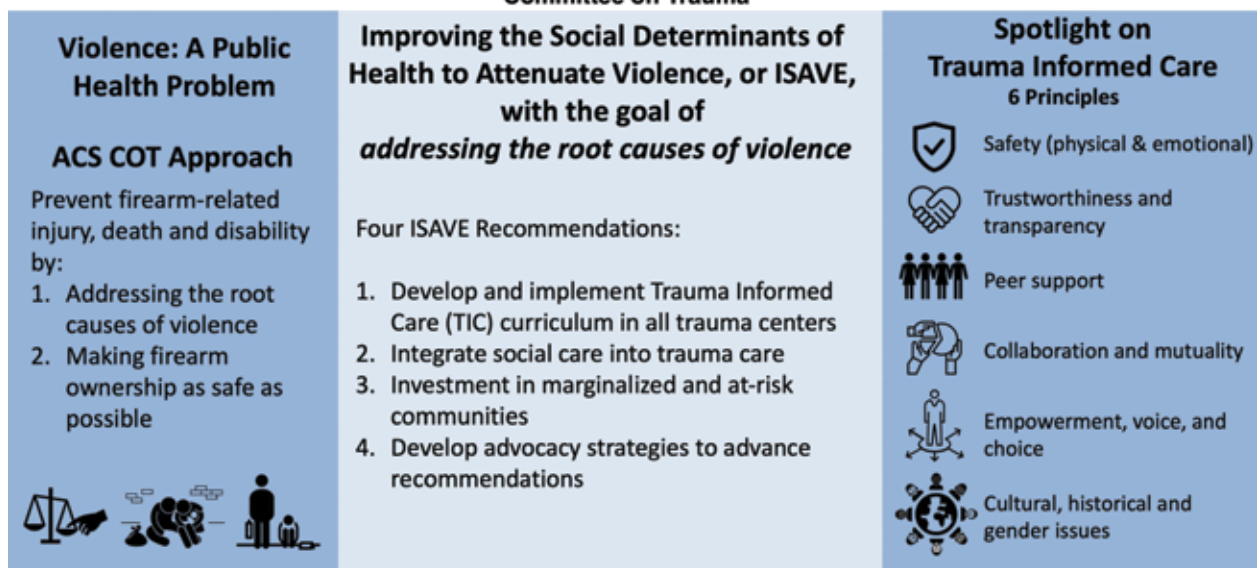
### Regional Medical Operations Centers to Support Disaster Response

COT leaders have been working with the US Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (now

the Administration for Strategic Preparedness and Response) and the Department of Homeland Security for a regionalized approach to disaster management based on the trauma system framework. The COVID-19 pandemic has added focus to the need for infrastructure to support regional coordination of the healthcare system for more effective management of these large-scale events. As a result, the COT has been advocating for the widespread adoption of Regional Medical Operations Centers (RMOCs), also known as Medical Operations Coordination Cells (MOCCs). These centers help rapidly mobilize and coordinate all relevant stakeholders for large-scale response, including public health agencies, emergency management, and all components of the acute healthcare system. Dr. Eileen Bulger, MD, FACS (COT Chair 2018–2022), and Dr. Stewart have participated in several webinars and panel discussions related to this issue, including a session sponsored by the Federal Emergency Management Agency, also known as the Federal Emergency Management Agency Healthcare Resilience Task Force, which has developed a toolkit for MOCC development.

FIGURE 3.

**Strategies for Trauma Centers to Address the Root Causes of Violence: Recommendations from the Improving Social Determinants to Attenuate Violence (ISAVE) Workgroup of the American College of Surgeons Committee on Trauma**



### Firearm Injury Prevention

The Injury Prevention and Control Committee uses a multifaceted approach to address firearm injury prevention. One of the most innovative ideas to come out of IPCC work on firearm injury prevention was the creation of the Firearm Strategy Team (FAST) Workgroup in 2018. Broad representation of surgeons from distinct backgrounds, geographic locations, and with varying firearm experience comprise the FAST Workgroup. In a 2018 article published in the *Journal of the American College of Surgeons* titled, “Freedom with responsibility: A consensus strategy for preventing injury, death, and disability from firearm violence,” the FAST Workgroup described a path forward creating an effective and durable strategy for reducing firearm-related injury, death, and disability in the US (see Figure 2, page 23).

In February 2019, in collaboration with 44 leading US professional organizations, the ACS convened a historic Medical Summit on Firearm Injury Prevention in Chicago, IL. The leadership of these organizations came together to discuss using a public health approach to minimize death and disability related to firearm injuries. The report outlined the current evidence for specific interventions to address suicide, unintentional injury, and intentional interpersonal violence. These interventions include counseling patients and families regarding safe firearm storage; lethal means safety for

suicide prevention; hospital-based violence intervention programs; identifying patients at risk for violence; examining the relationship between mental health and firearm injury; and issues related to public policy. A second Medical Summit on Firearm Injury Prevention, also hosted at the ACS offices in Chicago, IL, took place in September 2022 (see related story, page 65).

To truly understand the impact of injury prevention efforts, research on trends related to injury and violence is essential. To that end, the COT welcomed the inaugural ACS COT Firearm Injury Prevention Clinical Scholar in Residence (a 2-year, fully funded, mentored fellowship) Arielle Thomas, MD, in July 2020. Shelbie Kirkendoll, DO, MS, began her term in this role in July 2022. This fellowship was made possible through a collaboration with the COT’s partner organizations, including the American Foundation for Firearm Injury Reduction in Medicine, the American Association for the Surgery of Trauma, the Eastern Association for the Surgery of Trauma, the Pediatric Trauma Society, and the Western Trauma Association.

### Improving the Social Determinants to Attenuate Violence (ISAVE)

Minority populations have historically had to bear a disproportionate burden of violent injury and death in the US, and they continue to do so. In the last several





COT members in action: Left, Michael Coburn, MD, FACS, COT Advocacy Chair (2014–2020), making visits on the Hill. Right: Joseph V. Sakran, MD, MPH, MPA, FACS, FTL Alum Class of 2016, testifies about the issue of gun violence before a congressional hearing.

years there has been a growing interest and effort among trauma providers to look beyond addressing the physical injury to identify impactful ways to address the risk factors associated with violent injury. One focus of discussion during the Medical Summit on Firearm Injury Prevention involved addressing violence via an upstream approach to understand and mitigate the root causes of violence. In fact, significant attention gravitated toward the social determinants of health (SDOH) as the focal point when addressing upstream factors associated with violence. According to the National Academy of Medicine, SDOH account for 40% of the factors that affect health and wellness. To address these issues, COT leadership established the Improving the Social Determinants to Attenuate Violence (ISAVE) Workgroup under the leadership of Rochelle A. Dicker, MD, FACS (see Figure 3, page 24). ISAVE is a multidisciplinary group with a common goal of creating a more holistic approach to caring for victims of violent injury. The ISAVE group is composed of representatives from community-based organizations, hospital-based violence intervention programs, and law enforcement.

During their first meeting in December 2019, four main ISAVE initiatives were developed with corresponding work groups: Development of a trauma-informed care curriculum, investment in at-risk communities, integrating social care into trauma care, and advocacy.

### Looking to the Future

Despite many remarkable gains in injury prevention, the care of the injured, and optimization of post-injury recovery over the last century, much work remains to be done. Significant gaps in the availability and quality of trauma care across US communities

remain. Thus, one of the COT's advocacy goals for the next decade is to create a National Trauma and Emergency Preparedness System, which will:

- Establish and implement national standards for trauma care, injury prevention, and system readiness
- Support system-wide performance improvement activities
- Ensure readiness through the development of a network of Regional Medical Operations Centers
- Support research to advance the field
- Lessons from the COT's long legacy of effective advocacy will inform the inclusive approach needed to achieve these goals while emphasizing partnerships and stakeholder coalitions

Ultimately, the vision for the future is to ensure that traumatic injury is widely recognized as a worldwide, public health problem and that injury prevention research will be well-supported and identify the best evidence-based interventions to reduce death and disability from injury. The COT IPCC will remain committed to multidisciplinary collaboration in developing strategies to implement these interventions with the support of trauma centers, trauma systems, and like-minded organizations around the world.

Establishing a new norm in trauma care is essential. This new norm will value holistic care and embrace a trauma-informed care model, support investment in our communities, and play a vital role in working with social care practitioners to provide ongoing support after hospital discharge.

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The outcome will be safer communities and a chance for violently injured patients to not only survive, but to thrive.

The concurrent evolution of the science of injury prevention and the advocacy efforts within the COT has culminated in active engagement in structured research, education and training, community prevention, and outreach programs that guide both state and federal policy advocacy initiatives. This work has not only been effective in reducing injuries and deaths in the US, but it also serves as a model for other professional organizations that promote injury prevention using collaborative, community-based, and data-driven programs. ♦

## Acknowledgments

The authors would like to acknowledge the contributions of Rochelle A. Dicker, MD, FACS, Deborah A. Kuhls, MD, FACS, Mark L. Gestring, MD, FACS, Lenworth M. Jacobs Jr., MD, MPH, FACS, Melanie Neal, Holly Michaels, and Jean Clemency to the content of this article.

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## The Changing Face of Academic Plastic Surgery: An Interview with Dr. Kerri Woodberry

by Tony Peregrin

**F**or Kerri M. Woodberry, MD, MBA, FACS—associate professor and chief of the Division of Plastic Surgery at West Virginia University in Morgantown—it all started with a childhood interest in jigsaw puzzles.

“Throughout my life, I’ve always had an interest in putting things back together. And that was probably my attraction to plastic surgery and hand surgery because I thought, ‘You have a broken bone or complex laceration or traumatic injury, and I have the visual acumen to see how those pieces should fit together,’” said Dr. Woodberry, the first Black woman to serve as chief of a division of academic plastic surgery in the US.

Dr. Woodberry attended medical school at The Johns Hopkins University School of Medicine in Baltimore, MD. She stayed in Baltimore to complete her general surgery residency at Union Memorial Hospital, and then completed a plastic surgery residency at The Ohio State University in Columbus and a hand surgery fellowship at the University of Pennsylvania in Philadelphia.

Dr. Woodberry’s clinical and research interests include hand surgery, hand tumors, hand trauma,

breast reduction surgery, breast cancer reconstruction, medical education, and healthcare disparities.

In this Q&A profile, Dr. Woodberry discusses her trailblazing leadership role, Black representation in the House of Surgery, and what trainees should consider in their quest for strong mentorship.

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**You completed your general surgery training at Union Memorial, where you discovered that it had never had a Black graduate from its surgical residency program up to that point.**

When I did my internship year, the chair of surgery offered me a categorical spot to stay at Union Memorial and do general surgery. It was after taking the position that I found this out. In 1990, I did not expect to hear that they had never had a Black graduate from their surgery training program. However, I was not surprised that they had not had a Black woman graduate because, at that time, there were few women in surgery. I thought, “Wow, what if something happens to me, and for whatever reason,



Dr. Woodberry teaching in the OR

I'm not offered to continue in my residency?" Pyramid programs were common at that time, and progression in residency each year was not guaranteed. But I worked hard, and I knew that I was going to do above and beyond what was required to get through the program.

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**Talk about your experience as the first Black woman to serve as chief of a division of academic plastic surgery.**

I try not to focus on the fact that I'm the first Black woman in my role, but instead, I focus on being good at what I do. I think when you are aware of being "the first" it can feel overwhelming, because you think people are watching you more carefully. Even when I was in residency, when people said they'd never had a Black woman go through the program, I didn't want that to be the main focus. I just said, "I'm here to take care of patients. I want to do a great job at that and let my ethics and my quality of work speak for themselves."

**What is it about academic medicine that you find so appealing?**

I think my interest in academic medicine stems from having two parents that taught at Tennessee State University—my dad taught chemistry and my mother taught nutritional sciences. So, I grew up basically on the university campus. I spent a lot of time in the chemistry lab, and I liked the fact that you could answer questions through experimentation. I also liked the impact that my parents had on the lives of so many students. Even when I traveled to other cities, I would run into their students and they would say, "Oh, you're Professor Woodberry's daughter!" I enjoy teaching and consider myself a lifelong learner.

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**What advice do you have for others interested in pursuing an academic surgical career?**

The first thing is to find strong mentorship. Throughout my life, I've had people who have helped guide me. In terms of academics, particularly now, research is extremely important. Get involved with research as

**It's important to remember that sometimes your mentor does not look like you.... Sometimes a person who looks like you may have a better understanding of your situation and what you're going through—but that doesn't mean that you're limited to people who look like you for guidance.**

early as possible in your career so that you can continually develop skills and grow.

I think fellowship training is another thing that's important. I did a hand fellowship and I think going into the academic setting it's great to have an area of focus, particularly in a larger environment where you have so many people.

I love being able to give back, and that is one of the aspects of academics that I like because it's not just about what you can get out of medicine, but what you can give. Giving to patients and giving to medical students and residents is something that I find very fulfilling.

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#### **What should trainees keep in mind when seeking out strong mentorship?**

I do a lot of mentoring. I think students sometimes shy away from asking for help and it's important for them to recognize that people want to help. It's okay to email someone just out of the blue and say, "I read your biography or your research article, or I heard about you and I'd like to get some advice."

It's also important to remember that sometimes your mentor does not look like you. I've had many mentors who have given me advice and have helped me along the way. Sometimes a person who looks like you may have a better understanding of your situation and what you're going through—but that doesn't mean that you're limited to people who look like you for guidance.

---

#### **Do feelings of isolation increase as you advance in your career due to a lack of diversity?**

Absolutely. I thought about that long and hard when I was in medical school because I knew that surgery, at that time, was a male-dominated field. I thought about whether or not I wanted to be in an environment for the rest of my life where I probably wouldn't

see women or people who look like me. I think my passion for what I was doing outweighed the thought that I would be in an isolating environment, and I was willing to make that sacrifice.

When I came here to West Virginia University as division chief, one of my concerns was whether I would feel isolated in this environment. And so, I helped to start a group called People of Color Forum, which brings together people across the university who may feel isolated to share their experiences. Sometimes you have to go out of your way to create a safe space in which you can talk about your experiences.

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#### **How do you define yourself as a leader?**

I would say that I am more of a democratic and servant leader. I look for everyone's strengths and place them in roles to maximize their potential. Communication, collaboration, and equity also are important in my role as a leader. I try to look at things from the perspective of all team members to make decisions with the best interests of all involved. We have an amazing group of physicians, residents, and staff and I could not have asked for a better opportunity as a division chief. ♦

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PROFILES IN ACS LEADERSHIP:

**A Few Questions for  
Amalia Stefanou, MD, FACS**



**Editor's note:** The *Bulletin* of the ACS publishes a series of articles profiling leaders of the College. The series is intended to give readers a look at the person behind the surgical mask and inspire members to consider taking on leadership positions within the organization and the institutions where they practice.

**T**his month's profile features Amalia Stefanou, MD, FACS, Chair of the Governing Council of the Young Fellows Association (YFA) of the ACS. She is a colon-rectal surgeon at Moffitt Cancer Center in Tampa, FL.

**Why did you decide to pursue a career in surgery?**

I really loved working with the surgeons when I was in medical school. The combination of problem solving, pace of the work, and complexity of the actual operations drew me in; I was hooked. I completed residency at Henry Ford Hospital in Detroit, MI, and then a colon-rectal surgery residency at John H. Stroger Hospital of Cook County in Chicago, IL. As a colon-rectal surgeon, I take care of patients with benign anorectal problems to complex inflammatory

bowel disease or cancer. It's important to make connections with patients quickly to gain trust and have a treatment plan for them. I like being able to offer them some assurance and say, "Here's what I think is wrong, and this is how we're going to help you." Being able to help them overcome their fears and seeing the look in their eyes when you have helped them get through a difficult situation is extremely rewarding.

**What role has mentorship played in your journey to becoming YFA Chair?**

I think mentorship is important to career development, but if you don't think you have found the right mentor yet, you can still seek out others. Personally, I have connected with some impactful mentors by reaching out either in person or over email. I have

**My goal is to be approachable, available, and supportive. Surgical training is a challenge and being there for my mentees is a way to give back to the surgical community.**

met a lot of great leaders of the College and in surgery by emailing them and asking them a couple of questions about something I heard them say at a conference or I read in a paper they had published. This has led to several meaningful relationships for me that have shaped the trajectory of my career. Email and social media should not be underestimated as ways to build these relationships.

I work with residents and fellows, and it is always important and gratifying to mentor them as well. My goal is to be approachable, available, and supportive. Surgical training is a challenge and being there for my mentees is a way to give back to the surgical community. Professional development is really important, and we do not learn enough in training about topics like managing teams effectively and being an effective leader.

---

### **In what ways has membership in the ACS benefited you?**

Membership in the ACS has benefited me in many ways. It allows me to get involved and serve on different committees. I have learned a lot about not only the College, but also about surgery on a broader scale in terms of advocacy, leadership, career development, and making contacts with colleagues across the country. That has been a wonderful experience for me because otherwise I never would have met these people with whom I can share common struggles and successes. These discussions with my colleagues in YFA and the ACS help me work through the challenges we face as surgeons. Serving on the YFA Governing Council and its committees has given me a lot of professional fulfillment that otherwise I think I'd be missing.

---

### **How did you get involved in YFA?**

Knowing after I started my first job after training that I wanted to be more involved in the ACS, I applied after receiving an email with an open call

for applications for the YFA Governing Council (GC). There was a formal process, including an interview. This showed me that ACS really is an organization that represents its surgeons. While a lot of my peers in YFA were involved in the Resident and Associate Society (RAS) prior to becoming Fellows, this is certainly not necessary, and anyone with interest should apply for positions within the College.

During my time on the GC, I have been on the Advocacy Committee, chaired the Communications Committee and wrote the quarterly newsletter, and have served as Vice-Chair and now Chair. These opportunities have been invaluable for developing leadership skills, networking, and feeling like I am contributing to the College.

The YFA has evolved over the past several years to increase participation and transparency in our appointment process, and this is important to include as many young Fellows as possible on the ACS committees and Advisory Councils. This gives young Fellows opportunities to make connections with the College's leadership and each other. We have term limits for the Governing Council to ensure that young surgeons can continue to get involved and participate.

---

### **Young surgeons often are busy building their careers and balancing that with a personal life. How does YFA help them stay grounded and still be involved in the College and other societies?**

That is important because I've noticed that's the big difference between the membership of RAS and YFA. Residents often are looking to build their curriculum vitae through volunteer activities to apply for fellowships or secure positions in a practice or institution after they graduate from training. Young Fellows are already working in clinical practice, often with teaching, leadership, or research commitments as well. This is not even to mention family



Right now, the YFA is trying to focus on what we can do to support both early and mid-career surgeons. As surgeons, we all are goal driven, and Fellows in this time frame may be thinking about a change in the next couple years.... I think the YFA should constantly be considering what our surgeon peers may need in terms of support from the College.

responsibilities. It's a busy time in one's career and our time, consequently, may be more limited.

Right now, the YFA is trying to focus on what we can do to support both early and mid-career surgeons. As surgeons, we all are goal driven, and Fellows in this time frame may be thinking about a change in the next couple years. Maybe they aspire to be a division head or department chair or some other leadership role and are wondering, "How do I get there from here?" I think the YFA should constantly be considering what our surgeon peers may need in terms of support from the College.

---

**What advice do you offer to residents and young surgeons who are interested in ACS leadership positions?**

I believe there is a place for everybody in the ACS. The first step is to decide what you are interested in and how you want to contribute. There are so many different committees, work groups, and advisory councils, and the YFA has liaisons to many of them. If an interested surgeon goes to the ACS website and spends some time researching opportunities, a wealth of information, including contact information, is available. People always are happy to have volunteers, so I would recommend you show interest, attend the meetings, and volunteer for something. Then be sure to complete the task. There are plenty of ways to get involved and so many opportunities for enthusiastic surgeons.

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**How do you maintain work-life equilibrium and your well-being?**

It really is about planning and prioritizing. One week you may need to be at work more and the next week you're home more. We have managed by prioritizing

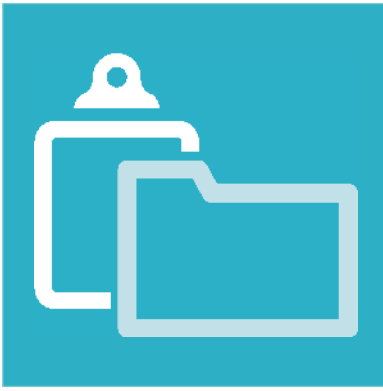
things by the week—thinking and talking about what we need to get done this week, what's important, what's not important. I think one should eliminate tasks or chores that are not enjoyable or necessary. For example, my husband and I order delivery dinner a few regular nights per week so that we can focus on what is important to us as a family and to our jobs.

When I am not in the hospital, I like to run and spend time with my family to maintain my well-being.

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**As your term as YFA Chair comes to a close this month, what's next on your leadership agenda?**

It has been a lot of fun to meet dynamic leaders within the College, a privilege to be part of program development, and collaborate with other young Fellows of the ACS. A few years ago, it never occurred to me that I would become the Chair of YFA, so this has definitely been a great experience. I really hope to stay engaged in the ACS in some capacity because I truly believe it is the largest support we have as surgeons on so many levels. ♦



## ACS Quality and Safety Case Studies: New Quality Improvement Framework Improves How Hospitals Perform QI Work

In early 2021, a work group comprising representatives from the ACS Quality Programs was formed to understand the limitations and barriers affecting the performance of quality improvement (QI) projects in hospitals and develop a framework to help hospitals improve how they perform their QI work.

The work group consisted of representatives from the following ACS Quality Programs:

- Children's Surgery Verification QI Program
- Commission on Cancer
- Metabolic and Bariatric Surgery Accreditation and QI Program
- National Accreditation Program for Breast Centers
- Trauma Verification, Review, and Consultation Program

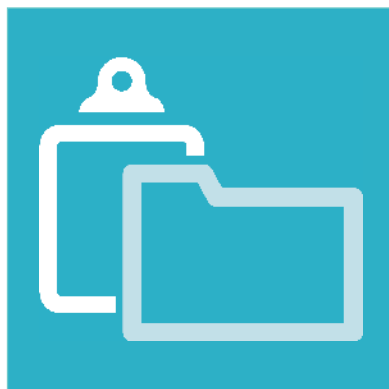
The QI Framework will facilitate execution of more comprehensive and effective projects as well as offer support for the planning, execution, evaluation, and reporting of these efforts. It can be used across all surgical specialties.

The QI Framework includes eight components and 40 specific criteria that will guide a project team through the execution and documentation of quality improvement projects, including problem detailing, aim specification, strategic planning, process evaluation, outcome evaluation, cost evaluation, and knowledge acquisition.

### End-of-Project Decision-Making

To help hospitals become familiar with the components and criteria of the QI Framework, it has been retroactively applied to the 2022 Best Practices Case Studies featured in the following case study. While this example does not include all 40 criteria of the QI Framework, it demonstrates how the eight components compose a successful QI project. For more information on the ACS Quality Framework, contact [ACSQualityFramework@facs.org](mailto:ACSQualityFramework@facs.org). ♦

In early 2021, a work group comprising representatives from the ACS Quality Programs was formed to understand the limitations and barriers affecting the performance of QI projects in hospitals and develop a framework to help hospitals improve how they perform their QI work.



## ACS Quality and Safety Case Studies: Approach to Decreasing CT Utilization for Diagnosing Appendicitis

by Kavita Bhakta, BSN, RN, Theresa Viduya, MSN, RN,  
Kathryn Danko, BSN, RN, and Erich Grethel, MD, FACS, FAAP

**R**educing radiation exposure in the pediatric population has long been a quality initiative nationwide. Dell Children's Medical Center (DCMC) joined the Pediatric Surgery Quality Collaborative (PSQC) in 2020 and one of the first projects initiated in the collaborative focused on decreasing computed tomography (CT) use to diagnose appendicitis. A review of the literature by the collaborative found a study specific to CT use for diagnosing appendicitis in the pediatric population that showed a correlation between radiation exposure and increased cancer risk in later adult life.\* After interviewing participating hospitals that were either high or low outliers, the collaborative created an implementation guideline to assist members in decreasing their CT rates.

DCMC's National Surgical Quality Improvement Program Pediatric (NSQIP-P) 2020 Semi-

Annual Report (SAR) showed an increased CT rate to diagnose appendicitis compared with the previous report. After further historical review, the institution found the CT rate of 30.3% in 2020 was the highest since data collection for the appendectomy variable in NSQIP-P started in 2015.

DCMC is a free-standing pediatric hospital located in Austin, TX. This 240-bed institution has 50 subspecialties and is a designated magnet hospital with a Level I Pediatric Trauma Center, Level I Children's Surgery Center, and a Level IV Neonatal Intensive Care Unit. In fiscal year 2021 alone, DCMC had an average daily census of 121 patients, more than 39,800 Emergency Department (ED) visits, and 7,121 surgeries.

DCMC is affiliated with The University of Texas at Austin Dell Medical School and is part of the Ascension Healthcare Company, a faith-based nonprofit healthcare system that includes more than 150,000 associates, 40,000 aligned partners, and operates more than 2,600 sites of care in 19 states and the District of Columbia.

Beginning in May 2021, a project team consisting of two RN coordinators, a nurse manager, project manager, and surgeon champion met to develop a plan to decrease DCMC's CT rate.

The implementation guideline provided by the PSQC encouraged the use of a pediatric appendicitis scoring tool, appendicitis guideline, ultrasound (US) protocol and training, US report in electronic health records (EHR), and US strategies for patients with BMI  $\geq 30$ . The team noticed that besides magnetic resonance imaging (MRI) use, DCMC already had most implementations advised by the collaborative in place but compliance with some of these factors had decreased over time. The project team organized a larger interdepartmental CT reduction team and included the addition of 14 representatives:

- Administration: Director of trauma services (1), interim surgical services director (1)
- Surgery: General surgeons (2), surgery advanced practice providers (2)

\*Lee KH, Lee S, Park JH, et al. Risk of hematologic malignant neoplasms from abdominopelvic computed tomographic radiation in patients who underwent appendectomy. *JAMA Surg.* 2021;156(4):343-351.

Beginning in May 2021, a project team consisting of two RN coordinators, nurse manager, project manager, and a surgeon champion met to develop a plan to decrease DCMC's CT rate.

- ED: Emergency medicine physicians (2), RN (1)
- Radiology Department: Radiologist (1), radiology manager (1)
- Imaging Leads: US technician (1), CT technician (1), MRI technician(1)

### Goal Specification

#### SMART Goals:

*Specific:* Using the implementation guideline provided by the PSQC, DCMC aimed to decrease its CT use rate to  $\leq 15\%$  while maintaining a negative appendicitis rate of  $\leq 1.75\%$ .

*Measurable:* NSQIP-P and institutional data (Centricity and EHR)

*Achievable:* PSQC set a goal to have the CT use rate decrease to  $\leq 15\%$  by the end of 2021. The team discussed this goal and determined it was not attainable as the project started mid-year (July 2021); therefore, DCMC decided to increase the timeline to 1 year (June 2022).

*Relevant:* Historically, DCMC's CT rates for diagnosing

appendicitis have been lower, as low as 12.8% in 2015. DCMC needed to address the changes that have occurred since this time and also determine any new implementations that could be added to the Acute Appendicitis Guideline to decrease the CT rate.

*Timeline:* July 2021–June 2022.

### Strategic Planning

Monthly meetings were scheduled starting in May in which each department was introduced to the project and end goal. Historical NSQIP-P data were reviewed and showed a decrease in compliance with Pediatric Appendicitis Score (PAS) documentation by the ED and surgery. The group found that it would be beneficial also to collect data on all patients who were evaluated for appendicitis and received imaging at DCMC. This larger pool of data allowed the team to monitor the success rates of appendix visualization via US and CT in patients who did not have appendicitis, as both data points are not collected in NSQIP-P. The additional data were collected via Centricity and hand-pulling from EHR.

Since MRI use would be a new amendment to the current institutional Acute Appendicitis Guideline, the team also conducted a literature review to investigate the effectiveness and cost difference between MRI and CT for diagnosing appendicitis. As the actual cost of these procedures is institution based, DCMC connected with its Billing Department for the internal costs. The team determined that the fast-sequence MRI would be just as effective as CT for diagnosing appendicitis and the long-term benefits of decreased radiation exposure outweighed the cost difference.

A CT-utilization dashboard was created for easy data visualization and ad lib monitoring by the team. Data points on the dashboards included monthly CT rate, PAS completion, US visualization rates, ED duration, admissions for observation, and lab counts (see Figure 1, page 36).

Many of the implementations involved in DCMC's project were already in place; for example, the institution had an established Acute Appendicitis Guideline, the physicians were using an appendicitis scoring tool, and

FIGURE 1. CT UTILIZATION DASHBOARD

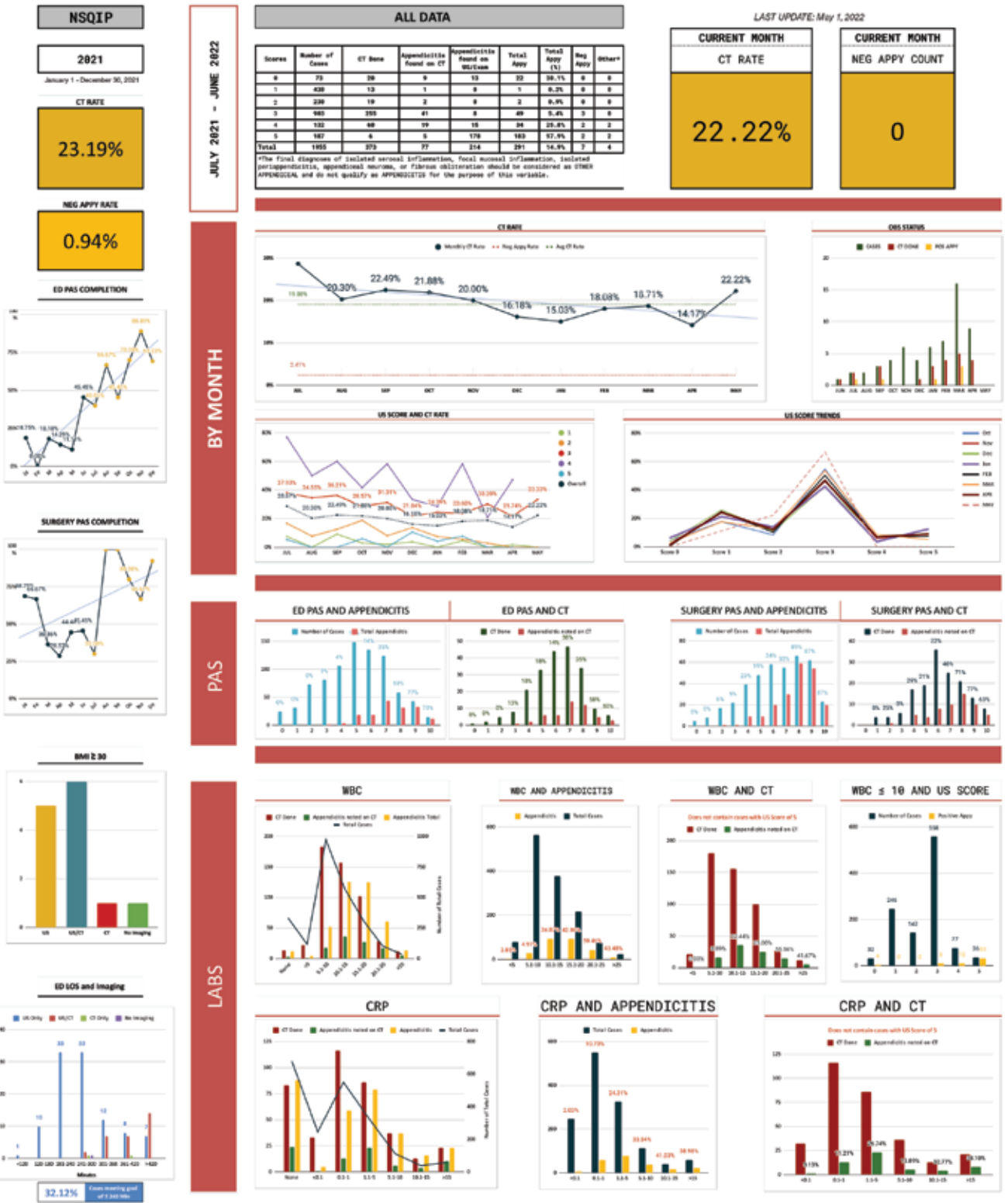
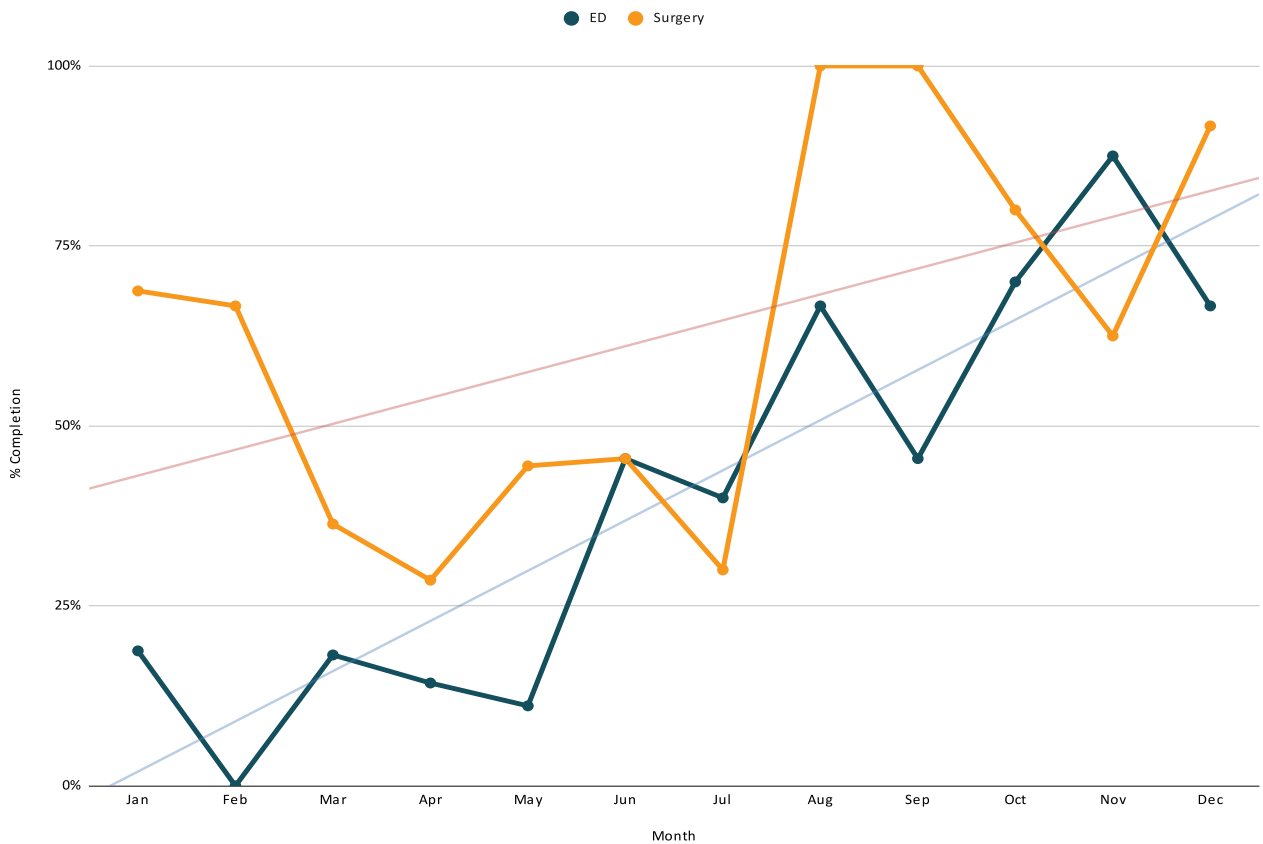




FIGURE 2. ED AND SURGERY PAS COMPLETION RATE (2021)



the ultrasound technicians were trained on visualizing the appendix. Ultimately, it came down to focusing on bringing these processes back to light and increasing compliance.

### Process Evaluation

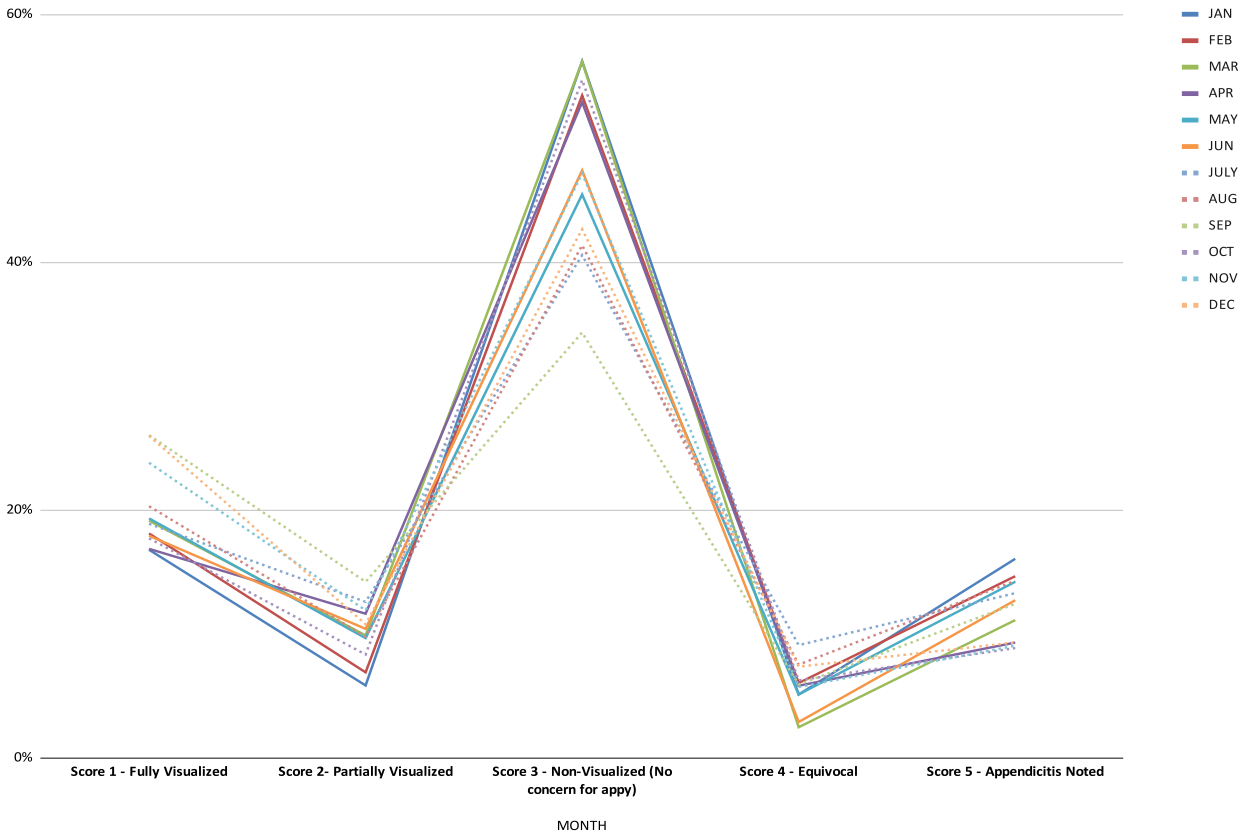
The representatives took the information from the monthly meetings back to their respective departments and returned with follow-up interventions and goals. The ED stated it would reach 100% compliance with PAS documentation by conducting inservices with attendings and residents, posting reminder

flyers at workstations with instructions on simple EHR documentation, and counseling individuals who remained noncompliant at each data review. The radiology department made it mandatory to scan patients for a minimum of 15 minutes to visualize the appendix and, when available, ask another technician to scan the patient if the appendix was not visualized. The surgery department encouraged colleagues to give families the option to admit patients with equivocal exams for observation and next-day repeat US in lieu of a CT, held an inservice with its group to

complete PAS documentation, and initiated the institutional process to incorporate MRI use for diagnosis of appendicitis.

The institutional Acute Appendicitis Guideline is in the process of being amended to incorporate MRI use for diagnosing appendicitis and is under review for approval by the evidence-based outcomes center committee. At present, the MRI implementation is in the logistics phase, which includes developing an MRI protocol and navigating how to incorporate the stat MRI orders from the emergency department into the daily MRI schedule.

FIGURE 3. ULTRASOUND SCORE TRENDS (2021)



**Outcome Evaluation**

The 2020 NSQIP-P data showed DCMC to have a CT rate of 30.3% with a negative appendicitis rate of 0.7%. According to the 2021 NSQIP-P data, the CT rate decreased to 23.2% with a negative appendicitis rate of 0.9%. PAS completion in both emergency and surgical departments and US visualization had an increasing trend over the year (see Figure 2, page 37, and Figure 3, this page). DCMC also

<sup>†</sup>Kim J, Kim K, Kim J, et al. The learning curve in diagnosing acute appendicitis with emergency sonography among novice emergency medicine residents. *Wiley*. 2017;46(5):305-310.

has shown an increase in hospital admissions for observation since the project began.

**Setbacks**

Visualization of the appendix is highly dependent on the experience of the technician.<sup>†</sup> Staff turnover increased during the coronavirus pandemic, leading to a loss of experienced technicians. The data do show improvement, but the numbers may have been better if staff turnover did not occur.

There was a setback related to visualization of the appendix in patients with a high body mass index; the radiology

department is troubleshooting to determine if anything can be done differently in these patients other than changing patient position and emptying bladder prior to US scan.

As expected, operationalizing MRI imaging instead of CT brought up some reservations in each involved department. DCMC addressed some of these reservations, such as MRI technician availability and interpretation of results, by seeking advice from other institutions involved in the PSQC who already were utilizing MRI for diagnosing appendicitis. The institutions shared their available

## No additional costs or funding beyond normal hospital operations were needed to implement or maintain the project at the time this case study was written.

resources, some of which included literature supporting MRI use, MRI protocol information, and coding. With the knowledge gained from these resources, the team is working through its concerns with hospital administration while emphasizing the importance of reducing radiation exposure to young children.

### Cost Evaluation

No additional costs or funding beyond normal hospital operations were needed to implement or maintain the project at the time this case study was written. However, the MRI implementation pilot may reveal future additional costs.

Cost considerations were not the focus of this project; however, with the unadjusted base cost for an abdomen/pelvis CT with contrast at DCMC being \$7,586, and the goal being to reduce the number of CT scans significantly, a cost savings may or may not be balanced out with resources committed to other aspects of the abdominal pain work-up.

### Knowledge Acquisition

There were several lessons learned from this quality improvement project, including:

- Leadership is very important for change; having an involved leadership group increases buy-in from other stakeholders and provides the support and encouragement for the team to move forward toward project goals.
- Access to data is vital and presentation matters. Information Systems Department involvement was necessary to pull the required non-NSQIP-P data. Additionally, the creation of a dashboard to visualize the data allowed stakeholders to review data any time, so meetings were more efficient and the project team received more feedback.
- Not having a dedicated data analyst meant the project team took on this extra role.
- PSQC has been an excellent networking resource, which has been very helpful as this institution proceeds with MRI use for diagnosing appendicitis.

### End of Project Decision-Making

Upon project completion, the dashboard will be available to the entire hospital in Tableau allowing for sustainability

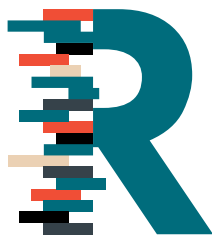
of data dissemination and continuous monitoring.

The Acute Appendicitis Guideline is under review to incorporate MRI use. Once implemented and if CT rate continues to decline, DCMC does not foresee additional changes until the 3-year guideline review mark. DCMC plans to share the guideline and project results with other Ascension hospitals in the surrounding area. ♦

### Acknowledgments

Special thanks to Terry Fisher and Kevin Lally, MD, FACS, from the PSQC for help with this project. The team also would like to thank Afif Kulaylat, MD, and Michael Moore, MD, from Penn State, Loren Berman, MD, FACS, from Nemours, and KuoJen Tsao, MD, from Children's Memorial Hermann for MRI resources and guidance. Lastly, thank you to the CT reduction team, for the time and hard work dedicated to this effort.

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## ACS Cancer Research Program: Genetic and Genomic Testing and Implications in Treatment for Pancreatic Ductal Adenocarcinoma: What All Surgeons Should Know

by Elizabeth L. Carpenter, MD, Rebecca A. Snyder, MD, MPH, FACS,  
and Timothy J. Vreeland, MD, FACS

**P**ancreatic ductal adenocarcinoma (PDAC) is a particularly lethal malignancy, with a 5-year survival of less than 10%.<sup>1-3</sup> Despite recent diagnostic and therapeutic advances, overall survival has only marginally improved.<sup>3-6</sup> Known risk factors for PDAC include cigarette smoking, obesity, environmental and chemical exposures, and alcohol.<sup>1</sup> The role of genetic abnormalities, however, has become increasingly important as genetic testing platforms, and our knowledge of genetic risk factors, have improved.

### Genetic Testing in PDAC

Pathogenic germline variants for pancreatic cancer are identified in more than 10% of patients with PDAC.<sup>7,8</sup> Both the National Comprehensive Cancer Network (NCCN) and American Society of Clinical Oncology (ASCO) recently updated recommendations to include genetic testing for all patients with newly diagnosed pancreatic cancer.<sup>1,9,10</sup> Given the lack of any single

driver mutation in PDAC, but rather numerous tumorigenic pathways, patients require broad genetic testing.

The most common genetic drivers of pancreatic cancer are genes that play a role in DNA damage repair. These include mutations in BRCA1 and BRCA2 (Breast Cancer gene 1 and 2), but also less well-known genes such as ATM, PALB2, and CDKN2A, among others.<sup>11,12</sup> Specifically, these gene mutations (whether germline or somatic) lead to homologous recombination deficiency (HDR) and hindrance of double-stranded DNA break repair.<sup>12-16</sup> Such mutations leave these tumors susceptible to specific therapies, including platinum-based chemotherapy and poly (ADP-ribose) polymerase inhibitors (PARP).<sup>17,18</sup> Platinum agents work by binding and cross-linking DNA, causing DNA damage and cell death, while PARP are theorized to inhibit the repair of single-strand DNA breaks, although the exact mechanism remains unclear. When PARP are combined with preexisting mutations

affecting double-stranded DNA break repair, tumor cell death occurs via a process known as synthetic lethality.<sup>19,20</sup>

These effects translate to meaningful improvements in patient outcomes.<sup>17,18</sup> In one study conducted by Park and colleagues, patients with somatic or germline HDR stage III/IV PDAC had a significantly prolonged progression-free survival (PFS) when treated with first-line platinum chemotherapy (HR 0.44,  $p < 0.01$ ) compared with patients without an HRD mutation; this effect was not observed among patients treated with a non-platinum regimen.<sup>21</sup>

Importantly for surgeons, these findings may have implications in the neoadjuvant setting. As neoadjuvant therapy is increasingly used in treatment of nonmetastatic PDAC, mutation status should be defined at the time of diagnosis to ensure that patients with germline or somatic HRD mutations are considered for upfront platinum therapy.<sup>22</sup> This is specifically relevant when a gemcitabine-based regimen is chosen over

As neoadjuvant therapy is increasingly used in treatment of non-metastatic PDAC, mutation status should be defined at the time of diagnosis to ensure that patients with germline or somatic HRD mutations are considered for upfront platinum therapy.

FOLFIRINOX (fluorouracil, leucovorin calcium [folinic acid], irinotecan hydrochloride, and oxaliplatin). In this situation, combination with cisplatin rather than the more common gemcitabine-nab-paclitaxel should be considered, particularly for patients with BRCA/PALB2 mutations.<sup>1</sup>

These patients also may be candidates for PARP therapy.<sup>18</sup> In the Pancreas Cancer Olaparib Ongoing (POLO) trial, a phase-3 randomized controlled trial comparing PFS in patients with BRCA1/2 germline mutations and metastatic disease without progression on platinum therapy, patients receiving the PARP olaparib had significantly longer PFS compared with placebo (7.4 versus 3.8 months,  $p = 0.004$ ).<sup>23</sup> Combination strategies and use of PARP in the adjuvant setting are being actively investigated.<sup>18,20,24</sup> For example, the phase 2-APOLLO\* trial—which aims to investigate the benefits of adjuvant olaparib

versus placebo on relapse-free survival in patients with resected pancreatic cancer with BRCA1/2 or PALB2 pathologic mutations after platinum-based chemotherapy—is currently recruiting and projected to conclude in 2024 (NCT04858334). The role of PARP in the neoadjuvant setting is not yet defined but also is being studied.<sup>18</sup>

### Genomic Testing

In addition to germline testing, tumor molecular profiling is recommended to identify actionable somatic mutations in patients with locally advanced or metastatic disease who are candidates for anti-cancer therapy.<sup>1</sup> While relatively rare in PDAC, patients with mismatch repair-deficient (dMMR) and microsatellite instability-high (MSI-H) mutations may be responsive to PD-1 blockade with the immune checkpoint inhibitor pembrolizumab, which now is recommended as a second-line option in dMMR/MSI-H positive tumors.<sup>18,25-28</sup> There is potential for targeting

KRAS mutations, which may be found in approximately 90% of pancreatic cancers.<sup>29</sup> Preliminary results investigating the efficacy of KRAS inhibitors in solid tumors including pancreatic cancer, such as sotorasib in the CodeBreak 100 trial, are highly promising.<sup>30-32</sup> Variants such as neurotrophic tyrosine receptor kinase (NTRK) fusions, though found in an extremely small subset of patients, also are important to recognize and target.<sup>18</sup>

### What All Surgeons Should Know

Increasing attention is directed to genetic and genomic drivers of PDAC. With potentially actionable mutations being found in up to 25% of patients, genomic sequencing is recommended for locally advanced or metastatic disease, and genetic testing for newly diagnosed PDAC or when suspicion exists for inherited risk.<sup>1,8,18</sup> Long-term survival of patients with PDAC remains poor, but there is reason for optimism following the discovery of HDR mutations

\*A Randomized Phase II Double-Blind Study of Olaparib Versus Placebo Following Curative Intent Therapy in Patients With Resected Pancreatic Cancer and a Pathogenic BRCA1, BRCA2 or PALB2 Mutation.



In addition to germline testing, tumor molecular profiling is recommended to identify actionable somatic mutations in patients with locally advanced or metastatic disease who are candidates for anti-cancer therapy.

and the potential for more targeted treatment regimens.<sup>18</sup> Because surgeons often are the first clinicians to see a patient after a diagnosis of pancreatic cancer, it is critical for surgeons to be aware of the recommendation for genetic testing and to understand the implications of identifying targetable alterations. ♦

### Disclosures

The views expressed herein are those of the authors and do not reflect the official policy or position of Brooke Army Medical Center, the US Army Medical Department, the Department of the Army, Department of the Air Force, Department of Defense, or the US government.

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## Long-term survival of patients with PDAC remains poor, but there is reason for optimism following the discovery of HDR mutations and the potential for more targeted treatment regimens.

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## What Surgeons Should Know: 2023 Changes to Reporting Inpatient and Observation Evaluation and Management Services

by Jan Nagle, MS, and Teri Romano, BSN, MBA, CPC, CMDP

In 2021, the Current Procedural Terminology (CPT\*) Editorial Panel revised the office/outpatient evaluation and management (E/M) codes (99202–99205, 99211–99215). For CPT 2023, the panel has revised additional families of E/M codes to be consistent with the changes to the office/outpatient E/M codes. This column focuses on the changes to the hospital inpatient and hospital observation E/M codes that surgeons routinely use.

### Will there continue to be separate E/M codes for inpatient and observation care in 2023?

No, for 2023, the codes for reporting observation care services (99217–99220) will be deleted and observation care services will be merged into the codes previously used to report only inpatient care services (99221–99233, 99238–99239). See Table 1, page 45, for the

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revised 2023 code descriptors. Although the same code will be used to report either inpatient or observation care services, you will still need to know the facility status of the patient to accurately report the place of service code as either hospital inpatient (21) or hospital outpatient (22).

### Will there continue to be separate codes for initial and subsequent hospital visits?

Yes, codes 99221–99223 will continue to be reported for new patients and codes 99231–99233 will continue to be reported for established patients.

### In addition to merging inpatient and observation care services into single codes, how else has this family of codes changed?

Similar to the changes made to the office/outpatient E/M codes, only a “medically appropriate” history and/or examination will be required for reporting inpatient/observation care services. The extent of history and physical

This column focuses on the changes to the hospital inpatient and hospital observation E/M codes that surgeons routinely use.

TABLE 1. REVISED CPT E/M CODES FOR 2023\*

Initial Hospital Inpatient or Observation Care	
99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low-level medical decision-making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99222	Initial hospital inpatient or observation care, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99223	Initial hospital inpatient or observation care, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and high level of medical decision-making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
Subsequent Hospital Inpatient or Observation Care	
99231	Subsequent hospital inpatient or observation care, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision-making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99232	Subsequent hospital inpatient or observation care, per day, for the E/M of a patient, which requires a medically appropriate history and/or examination and high level of medical decision-making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
Hospital Inpatient or Observation Discharge Services	
99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter.
99239	More than 30 minutes on the date of the encounter.

\*IMPORTANT: These revised CPT codes will not be effective until **January 1, 2023**. Continue to use the current 2022 codes for inpatient and observation E/M services for reporting these visits through December 31, 2022.

examination is not an element in selecting the level of these E/M codes. In addition, references to a “focused, detailed, or comprehensive” history and/or examination have been removed from the code descriptors.

**How do I select the correct code?**

Code selection will be based on either the level of medical decision-making (MDM) as defined for each service or the total time on the date of the encounter. These elements will be

used for selecting all hospital E/M visit codes with the exception of emergency department visit codes (which only use MDM) and critical care services codes (which only use time).

**How is MDM used to select the level of code?**

For codes 99221–99223 and 99231–99233, the level (straightforward, low, moderate, high) of MDM selected is based on two of the three elements of MDM: (1) number and complexity of problems addressed at the

encounter, (2) amount and/or complexity of data to be reviewed and analyzed, and/or (3) risk of complications and/or morbidity or mortality of patient management. These are exactly the same elements used to select a level of office/outpatient E/M services code.

**How do I use total time to select a level of code?**

When time is used for reporting inpatient/observation care E/M services codes, the time defined in the code descriptors is used

## Look for an update after the final rule for the 2023 physician fee schedule is released in November.

for selecting the appropriate level of services. The time includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified healthcare professional (QHP) on the date of the encounter. It includes time regardless of the location of the physician/QHP (for example, whether on or off the inpatient/observation unit). It does not include any time spent in the performance of other separately reported procedures or service(s). For coding purposes, time for these services is the total time on the date of the encounter.

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### How is time reported if both the physician and QHP provide face-to-face and non-face-to-face services on the day of encounter?

A visit in which a physician and QHP both provide services related to the visit is defined as a split or shared visit. When time is being used to select the appropriate level of services for which time-based reporting of split/shared visits is allowed, the time personally spent by the physician and QHP assessing and managing

the patient and/or counseling, educating, communicating results to the patient/family/caregiver on the date of the encounter is summed to define total time. However, remember that only distinct time should be summed for split/shared visits (for example, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

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### I have heard there are new restrictions for reporting split/shared visits—is this true?

For Medicare patients in 2022, the Centers for Medicare & Medicaid Services finalized that the treating provider who performs the “substantive portion” of the visit will bill the service. For more information on 2022 reporting, see the April 2022 issue of the *Bulletin*. For 2023, based on negative comments about the plan that CMS created for 2022, along with changes to the code descriptors, the reporting requirements for a split/shared visit are under review. Look for an update after the final rule for the 2023 physician fee schedule is released in November.

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### What resources does the ACS offer to improve my coding skills?

The ACS collaborates with KarenZupko & Associates (KZA) to offer coding courses that provide the tools necessary to increase revenue and decrease compliance risk. These courses are an opportunity to sharpen your coding skills. You also will be provided online access to the KZA alumni site, where you will find additional resources and frequently asked questions about correct coding. Additional information about the courses and registration can be accessed at [karenzupko.com/general-surgery](https://karenzupko.com/general-surgery).♦

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## A Look at The Joint Commission: The Joint Commission Releases “Speak Up” to Help Patients Navigate Telehealth

by Lenworth M. Jacobs Jr., MD, MPH, FACS

**T**elehealth has grown in popularity during the COVID-19 pandemic. It has many benefits, such as saving the patient travel time or transportation costs, increasing access to specialists and second opinions, and it can take place almost anywhere a patient can have a private conversation.

Some healthcare services that may be conducted via telehealth include:

- Follow-ups with surgical care team after a procedure or another type of in-person visit
- Therapy or counseling sessions
- Monitoring chronic conditions with a hybrid approach—that is, alternating in-person visits with telehealth evaluations
- Prenatal care
- Genetic counseling
- Observation for acute respiratory viral illnesses

To help patients better understand telehealth, The Joint Commission released

Speak Up™ At Your Telehealth Visit—a new patient safety campaign designed to educate healthcare consumers on how to navigate virtual healthcare as it changes the way patients and providers can interact.

These educational resources include:

- An infographic poster/flyer in three sizes (8.5"×11", 11"×17", and 24"×36")
- An animated video, available in both English and Spanish
- A distribution guide with recommendations on how healthcare organizations can share these materials for patients and their families, caregivers, and advocates

“The appropriate use of telehealth has the power to make healthcare more accessible for patients with diverse health needs and for underserved communities,” said Ana Pujols McKee, MD, FACP, executive vice-president, chief medical officer, and chief diversity, equity and inclusion officer for The Joint Commission. “However, as

To help patients better understand telehealth, The Joint Commission released Speak Up™ At Your Telehealth Visit—a new patient safety campaign designed to educate healthcare consumers on how to navigate virtual healthcare as it changes the way patients and providers can interact.

Launched in 2002, the award-winning Speak Up program has been used in more than 70 countries.

**SpeakUp**<sup>™</sup>  
AT YOUR TELEHEALTH VISIT



with any healthcare experience, there is room for human error and miscommunication. Patients can have a better telehealth experience by becoming aware of the benefits and risks of telehealth and speaking up when they have questions or concerns.”

The campaign also notes some areas in which patients may troubleshoot challenges during a telehealth visit, such as:

- Reading instructions sent by the care team
- Checking with the insurance provider to ensure telehealth is covered
- Writing down questions that arise before, during, or after the visit
- Keeping a list of current medications or symptoms
- Finding a comfortable, quiet, and private place with a lot of light

Speak Up At Your Telehealth Visit can be viewed at [jointcommission.org/resources/for-consumers/speak-up-campaigns/at-your-telehealth-visit](http://jointcommission.org/resources/for-consumers/speak-up-campaigns/at-your-telehealth-visit).

### History of Speak Up

Launched in 2002, the award-winning Speak Up<sup>™</sup> program has been used in more than 70 countries. It encourages patients to be their own advocates and to:

- Speak up
- Pay attention
- Educate yourself
- Advocates (family members and friends) can help
- Know about your new medicine
- Use a quality healthcare organization
- Participate in all decisions about your care

Organizations are free to reproduce and disseminate Speak Up At Your Telehealth Visit materials if they credit The Joint Commission.

For updates on new Speak Up campaigns as they become available, sign up for email alerts at [jointcommission.org/ealerts](http://jointcommission.org/ealerts). ♦

### Disclaimer

The thoughts and opinions expressed in this column are solely those of Dr. Jacobs and do not necessarily reflect those of The Joint Commission or the American College of Surgeons.

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## DEI in Action:

# Surgeons as Diversity, Equity, and Inclusion Change Agents: Yes, You Can

by David T. Cooke, MD, FACS

**T**he healthcare workforce lacks diversity. When we look at diversity in cardiothoracic surgery, my specialty, we find that only 17% of faculty are women and 12% are defined as underrepresented in medicine (URiM). Looking at trainees, 24% identified as women and 16% identified as URiM.<sup>1</sup>

### But why does this matter?

There are two truths: first, workforce diversity is simply the right thing to do to achieve a society that is more integrated and just; and second, diversity also improves the bottom line of businesses and other organizations facing complex challenges in the knowledge economy.

University of Michigan mathematics professor Scott Page, PhD, identifies the quantitative value of diversity. He defines the “diversity bonus,” when teams think differently and bring different heuristics, as the collective performance that includes a bonus of production that is quantifiable.<sup>2</sup> This bonus, plus the cultural competency of

care providers, optimizes the implementation of healthcare.

Marcella Aslan, MD, PhD, MPH, and her research team in a study of primary care in Oakland, CA, found that Black men seen by Black physicians agreed to more preventative services than those patients seen by non-Black doctors; these effects seem to be driven by better communication and more trust.<sup>3</sup>

Greenwood and others studied patient physician-gender concordance and its effects on mortality among female heart attack patients. The group found that mortality rates decreased when male physicians practiced with more female colleagues or have treated more female patients in the past.<sup>4</sup>

Seeing voluminous compelling data, the University of California made a bold move and updated its academic personnel policy for faculty appointment and promotion. Its new policy dictated that to achieve appointment and promotion, a candidate must document contributions to diversity in one or more of the traditional activities of academic excellence.

[The University of California’s new policy dictated that to achieve appointment and promotion, a candidate must document contributions to diversity in one or more of the traditional activities of academic excellence.]



There are numerous examples of how an individual surgeon can contribute to diversity in healthcare. For example, being involved with the training program at one's own institution can assist with the recruitment, retention, and successful graduation of diverse trainees.

In defense of the new policy, the University of California at Davis chancellor Gary S. May, PhD, MS, and Renetta Garrison Tull, PhD, vice chancellor of diversity, equity and inclusion, stated that a "true commitment to diversity, equity and inclusion is active and not passive... and actively seeks solutions to remove barriers that would facilitate inclusion.... Attention to the needs of our evolving and diverse student body necessitates assessment of faculty contributions to diversity in support of the broader mission of higher education."

Contributing to diversity is part of the stated mission of many institutions, and it is logical for those institutions to have their faculty and/or staff be in line with that mission.

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#### **You may ask yourself, "What can I do?"**

There are numerous examples of how an individual surgeon can contribute to diversity in healthcare. For example, being involved with the training program at one's own institution can assist with the recruitment, retention, and successful graduation of diverse trainees. In the role of an assigned mentor, an assistant, associate or

program director, member of the program evaluation committee, clinical competence committee, or applicant interviewer, one can foster a welcoming and supportive environment of inclusion for diverse candidates and trainees. Most medical schools have a diversity in medicine visiting elective program or clerkship, which facilitates diverse candidates to visit your residency program.

These programs often are underutilized. Martin and others looked at cardiothoracic surgery training program director awareness of available visiting medical student clerkships for URiM students. This survey of program directors found that 61% were aware of these URiM visiting clerkships at their institutions, but only 44% had participated in the past 3 years.<sup>5</sup>

Within our surgical societies there are many opportunities to contribute to diversity. The ACS, The Society of Thoracic Surgeons (STS), and other surgical societies have avenues to volunteer as a mentor. The Young Fellows Association of the ACS hosts a speed mentoring event at Clinical Congress every year. The STS performed a climate survey of its members, asking them the question "What are some of the barriers to diversity and/or inclusion within cardiothoracic

## An individual does not need to look like the colleague they are helping, but must endeavor to understand and acknowledge that colleague's professional needs.

surgery?” For respondents who self-identified as women, Black, and/or Asian, the number one response was “few URiM and/or women CT surgery mentors and role models,” stressing the importance of mentorship.<sup>6</sup>

### Can you mentor someone who does not look like you?

The answer is a resounding yes. Becoming a successful mentor requires engaging in cross-demographic mentorship. An individual does not need to look like the colleague they are helping, but must endeavor to understand and acknowledge that colleague's professional needs. Those needs may include:

- Professional development training
- Access to opportunities and networks
- Emotional support to manage the stressors of academic advancement
- Institutional sponsorship
- Serving as a role model whose success they want to emulate
- Providing a safe space to discuss experiences
- Providing honest, direct, and constructive feedback<sup>7</sup>

If an individual cannot directly mentor an early career colleague, then that individual's professional expertise can still be of value by directing the mentee to other faculty members and staff as part of a mentoring team that can fill the mentee's needs. An individual also can be a “connector” by introducing a diverse colleague to their professional network, providing productive and career-enhancing interactions across an organization or specialty.

Many of my mentors do not look like me and are from vastly different backgrounds than I. But the common denominator is that they care about me and my professional success.

In summary, diversifying our workforce is now a mission of our industry. Contributing to diversity is not difficult and it can be accomplished as part of your routine career. Women and URiM trainees, junior faculty, and staff require mentorship, yet you do not need to look like your mentee to be an effective mentor. At a minimum, be a connector providing mentees access to your extensive network. ♦

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**Editor's note:** Letters should be sent with the writer's name, address, email address, and daytime telephone number via email to Natalie Boden, MBA, Director, Division of Integrated Communications, at [nboden@facs.org](mailto:nboden@facs.org). Letters may be edited for length or clarity. Permission to publish letter is assumed unless the author indicates otherwise.

### **In a Subset of de Novo Stage IV Patients, There Will Be a Survival Benefit: Listen to the Other Side of the Story**

We read the article, titled "To Operate or Not in De Novo Stage IV Breast Cancer: Is That Still a Question?" by Preeti D. Subhedar, MS, MD, FACS, Sarah Blair, MD, FACS, and Judy C. Boughey, MD, FACS, published in the June 2022 issue of the *ACS Bulletin*, and we'd like to express our thoughts on this subject. We think that their comments and conclusions seem biased and reductive, particularly for a topic complicated by widely disparate presentations of the extent of metastatic disease, phenotypes, and responsiveness to metastatic therapy.

The paradigms of breast cancer treatment have drastically evolved from standard care to individualized treatment. Therefore, it is crucial to assess the patient by considering his or her age, the clinical and pathological characteristics of the tumor, the organ where the metastasis is located, and the extent of the metastasis in de novo stage IV breast cancer (BC).

We believe that the question is not whether primary surgery is beneficial in de novo stage IV BC,

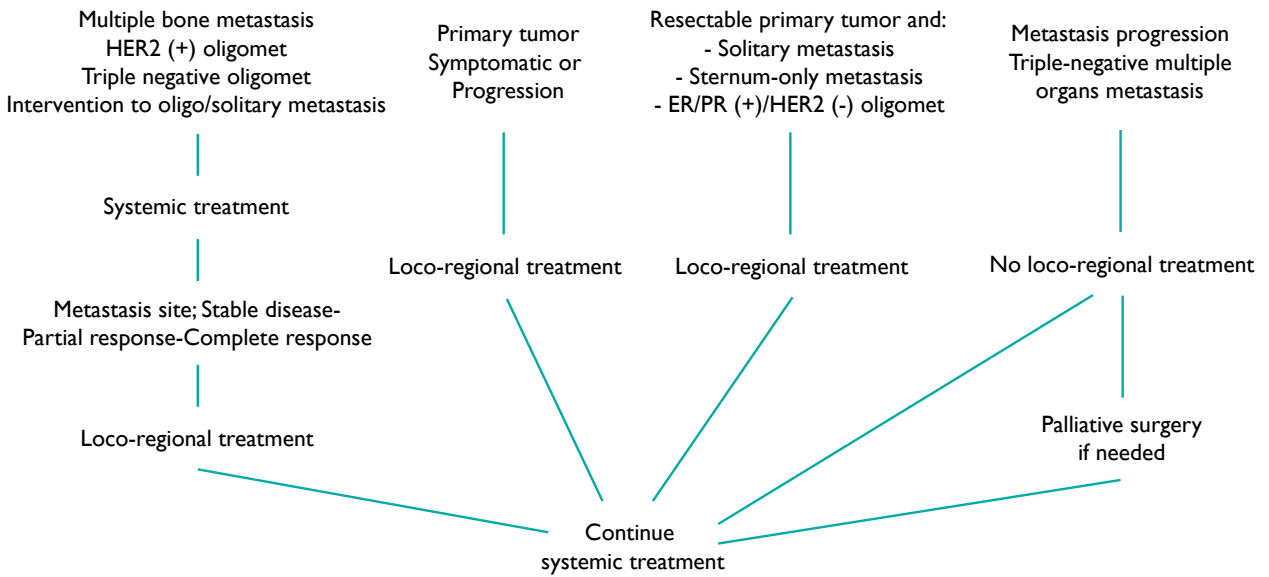
but who is a good candidate for it (see Figure 1, page 53). A patient who may have overall (OS) and loco-regional progression free (LRP) survival benefits from loco-regional treatment (LRT) include:

- Patients who receive systemic therapy for a while and images revealed that no evidence of distant metastasis
- Systemic therapy (ST) controls distant metastasis (no progression or regression)
- Progression of the primary breast tumor
- Solitary (oligo) distant organ metastasis such as bone, liver, and lung
- Patients who underwent an intervention for oligo/solitary metastasis followed ST and no new metastasis
- Patients with only sternum metastasis

Evidence of survival benefits include:

- Study shows the OS rates of 98% (95% CI: 94.6%–100%) at both 5 and 10 years in patients with

FIGURE 1. PROPOSED LRT IN DE NOVO IV BREAST CANCER



human epidermal growth factor receptor (HER2) (+) de novo stage IV BC when they reach no evidence of disease (NED). The progression-free survival was 100% at 5 and 10 years, indicating no progression events for any of the patients. A strategy involving ST and resecting or radiating residual disease and continuing maintenance therapy with an HER2-targeted agent and endocrine therapy, if appropriate, is recommended.<sup>1</sup>

- The long-term results of the MF 07-01 study<sup>2</sup> showed that local control provides a significant survival advantage in all subgroups except for the patients with triple-negative BC in both 5-year and 10-year OS (5-year OS: 42% for LRT vs. 24% for ST, HR: 0.66,  $p = 0.005$  and 10-year OS: 19% for LRT vs. 5% for ST, HR: 0.71,  $p = 0.0003$ ). Hazard of death decreased 29% in the primary surgery group in 10 years. The BOMET study, which is a

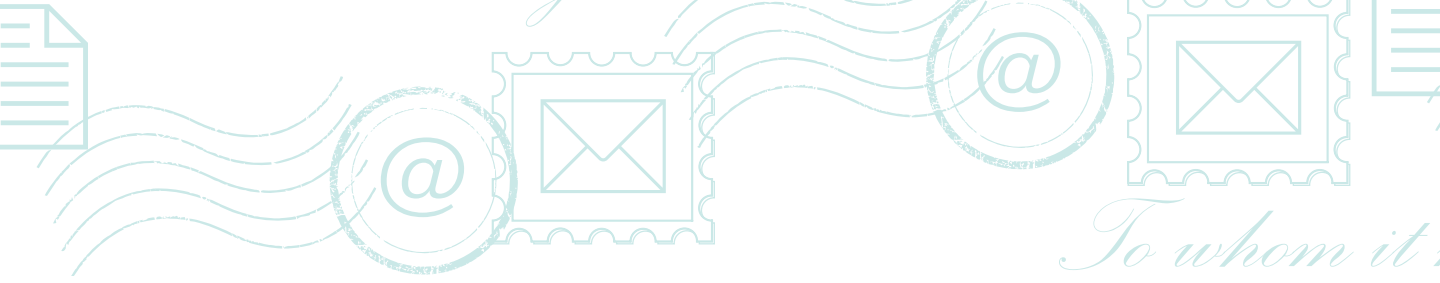
prospective multicenter registry study, compared ST-only with LRT with ST and showed that receiving adjuvant locoregional treatment for bone-only metastasis stage IV breast cancer reduces the risk of death 60% in 3 years follow-up.

- The BOMET study<sup>3</sup> showed that 5-year OS was 75%, 72%, and 69% in patients who underwent LRT with solitary metastasis, oligometastases, and multiple metastases, respectively, but these rates were 45%, 42%, and 31%, respectively, in the ST group ( $p < 0.05$ ). 5-year OS rates were 76% in solitary and 70% in oligometastatic patients in the ST+LRT group, while it was 74% and 76% in the LRT+ST group, respectively. There was no OS benefit for starting with ST in solitary and oligometastatic disease. However, the study showed a statistically significant difference in the 5-year OS rate in patients with multiple bone

metastasis, especially with more than five metastases; these were 83% and 67% in the ST+LRT group, respectively. In contrast, 5-year OS rates were 55% for those with multiple metastases and 31% in patients with more than five bone metastases in the LRT+ST group. Starting with ST followed by LRT in patients with a higher metastatic disease burden seems to be a more rational approach.

- Several meta-analyses, prospective observational studies, and retrospective studies showed similar result as approximately 30%–40% reduction in death with LRT compared with ST only.
- All randomized clinical trials and retrospective studies on this topic showed the benefit of LRP-free survival interval with primary breast surgery in this cohort of patients; E2108 trial<sup>4</sup> LRP is 39.8% in the ST-only group and 16.3% in the LRT group. In MF07-01 Study LRP is 1% in the LRT

*To whom it may concern,*



group and 14% in the ST group. In the Indian Study<sup>5</sup> LRT resulted in a significant improvement in LRP-free survival compared with that in the ST-only group (median not attained vs. 18.2 months [95% CI 15.1–21.3]; HR 0.16, 95% CI 0.10–0.26;  $p < 0.0001$ ).

- The MF07-01Q study demonstrates that patients who had LRT had similar physical and mental health outcomes compared with those who had ST only in a cohort of patients who lived longer than 3 years, and de novo stage IV BC patients had mental health scores comparable to those with early stage BC.<sup>6</sup>

Attendees at one of the world's most prestigious meetings, the St. Gallen International Breast Cancer Consensus Conference in 2021, stated that the panel continues to endorse first-time curative intention for oligometastatic BC, for example, with isolated metastasis in the sternum (85%), isolated metastasis to bone, or single nodule (82%). Some were even following curative intent after multiple metastases had responded well to primary ST (29%).<sup>7</sup>

We believe that concluding that LRT has no place in de novo stage IV BC treatment eliminates the possibility of long-term NED or even a cure. LRT as a

treatment option for intact primary tumor for de novo stage IV BC needs to be considered case-by-case (individualize treatment) with input and discussion from all stakeholders. The fact that many patients, most of whom are oligometastatic (low tumor burden), have been shown to benefit more from ST and/or LRT in many studies and in daily practice, perhaps, necessitates a new staging system where these patients would be included in a group other than stage IV. Surgeons should be aware that the subset of de novo stage IV BC patients have a survival benefit from LRT, and that timing the intervention allows us to take advantage of the window of time before the disease progresses.

In conclusion, the goal should be to identify any subset of de novo stage IV patients that might potentially benefit in terms of OS, recognize who they are, and when definitive LRT should be delivered rather than issuing a blanket statement to all surgeons in the American College of Surgeons that they are obligated to tell every patient considering local treatment that there is no survival benefit. ♦

Atilla Soran, MD, MPH, FNCBC, FACS  
Serdar Ozbas, MD, FEBS  
Vahit Ozmen MD, FACS

On behalf of Breast Health  
Working Group International

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## Dr. Ernestine Hambrick Recognized as Inspiring Surgeon

Esteemed colon-rectal surgeon Ernestine Hambrick, MD, FACS, will receive the Dr. Mary Edwards Walker Inspiring Women in Surgery Award at Convocation during Clinical Congress 2022 in San Diego, CA.

Throughout her long, distinguished career, Dr. Hambrick achieved many firsts, among them being the first woman Diplomate of the American Board of Colon and Rectal Surgery, the first woman on the American Society of Colon & Rectal Surgeons (ASCRS) executive council, and the first woman vice-president of the ASCRS and its research foundation.

Dr. Hambrick also is the first colon-rectal surgeon and the first Chicago-based surgeon to receive the Dr. Mary Edwards Walker Inspiring Women in Surgery Award.

She always has been an active supporter of women

in surgery, especially in colon-rectal surgery, and her leadership, mentorship, and commitment to advancing women surgeons continues to thrive. The women's group within ASCRS that she helped to create now has an annual networking luncheon with more than 200 attendees.

Many of the women surgeons on whom Dr. Hambrick has had an impact—directly and indirectly—have ascended to leadership positions within surgery and continue to make significant contributions to the surgical community.

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### **STOP Colon/Rectal Cancer Foundation**

In addition, Dr. Hambrick embodied the spirit of Dr. Mary Edwards Walker in her creation of the STOP Colon/Rectal Cancer Foundation. During her career and from the personal

Many of the women surgeons on whom Dr. Hambrick has had an impact—directly and indirectly—have ascended to leadership positions within surgery and continue to make significant contributions to the surgical community.



Dr. Hambrick introduces the Dr. Ernestine Hambrick Lectureship at the 2022 ASCRS annual meeting

experience of losing her only brother to colon cancer, Dr. Hambrick recognized that most colon-rectal cancers could be prevented with screenings.

“It became clear to me that nobody needed to lose a brother like that. Nobody needed to lose a father or mother,” Dr. Hambrick recalled. “We knew how to prevent colon cancer. But that knowledge was new knowledge, and it needed to be disseminated not only through the medical profession, but also in the public domain.”

Dr. Hambrick left her practice after 25 years as a colon-rectal surgeon to lead STOP Colon/Rectal Cancer Foundation, advocating tirelessly for the eradication of colon and rectal cancer and helping to get March designated as National Colorectal Cancer Awareness Month. The STOP Colon/Rectal Cancer Foundation closed after 10 years of work because it had achieved

much of its mission to promote public awareness, preventative screening, early detection, and healthy lifestyle choices.

#### A Career of Service

Born in the small town of Griffin, GA, Dr. Hambrick knew at an early age that she wanted to be a physician. When she was 4 years old, she fell and cut her eyelid; a short encounter with a local physician left a lasting impression.

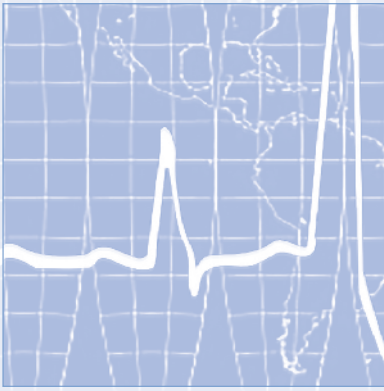
She completed her MD degree at the University of Illinois College of Medicine and her general surgery residency and colon and rectal surgery fellowship at Cook County Hospital. Afterward, she joined the staff at Cook County Hospital in Chicago, IL, and established a private practice at Michael Reese Hospital and Medical Center, also in Chicago.

Dr. Hambrick served the last 8 years of her career as a

hospice physician, providing care to patients and families in their greatest time of need. She now is retired and resides in Stanley, VA, near childhood friends.

The Inspiring Women in Surgery Award is named in honor of Mary Edwards Walker, MD, the first female surgeon employed by the US Army, the only female recipient of the Congressional Medal of Honor, and a tireless crusader for women’s rights. ♦





## Surgeons Honored for Volunteerism and Humanitarian Efforts

The ACS Board of Governors (B/G) Surgical Volunteerism and Humanitarian Awards Workgroup has announced the recipients of the 2022 ACS/Pfizer Surgical Volunteerism and Humanitarian Awards. The workgroup received exceptional nominations, reflecting the remarkable commitment of ACS Fellows to provide care to underserved populations.

The contributions of the five award recipients are briefly summarized in this article and will be formally recognized at Clinical Congress 2022 in San Diego, CA, during the annual B/G reception and dinner Tuesday, October 18. Clinical Congress attendees are invited to hear the honorees speak at a Panel Session, Humanitarian Surgical Outreach at Home and Abroad: Reports of the 2022 Surgical Volunteerism and Humanitarian Award Winners, Monday, October 17.

### Academic Global Surgeon Award

This award honors those surgeons committed to giving back to society by making significant contributions to surgical care through organized educational activities. This award is intended for ACS Fellows in active academic global surgical

practice who are committed to applying research, training, and evidence-based advocacy to make significant contributions to surgical education and care in regions of inequities, or retired Fellows who have been involved in academic global surgery during their active practice and into retirement.

This year, the Academic Global Surgeon Award will be presented to **James Allen Brown, MD, FACS**, a general surgeon in Johns Island, SC, for his nearly 2 decades of work providing surgical education and training to physicians in Cameroon.

During his time as a US Navy surgeon and as a private practitioner, Dr. Brown joined several medical mission trips to Latin America, Asia, and Africa. In 2003, he traveled to Northern Cameroon for 2½ weeks, where he witnessed an overwhelming lack of surgical services and determined that surgical training could assist in addressing these gaps. In 2008, Dr. Brown and his wife moved to Cameroon full time, partnering with the Pan-African Academy of Christian Surgeons (PAACS), a not-for-profit dedicated to high-quality surgical training in Africa.

Dr. Brown's contributions to academic surgery in Cameroon, through his work

at Mbingo Baptist Hospital, have been comprehensive and transformative. Among his achievements, he initiated a Residency Review Committee (RRC) composed of all the PAACS training program directors, the chief hospital administrator, senior nursing supervisor, the head chaplain, and the chief residents from each program.

The RCC served as oversight for planning and policy decisions for the training programs. He opened a seven-bed intensive care unit (ICU) and a four-bed postanaesthesia care unit, where 12 ICU nurses completed their training and began working. In addition, Dr. Brown invited two US perioperative nursing educators to teach a 6-month perioperative nursing course. Before this point, none of the operating room (OR) nurses or surgical technicians had any formal training. Instructors used an OR nurses textbook from the US to teach 3 months of classroom didactics and 3 months of hands-on operating room procedures for 20 nurses and techs. This course revolutionized the OR, and safety, efficiency, and professionalism improved.

Fifty African surgical residents across the continent have received training from Mbingo in Dr. Brown's tenure, and 20 fully



Mbingo Baptist Hospital: Dr. James Allen Brown (left) assists the chief resident—the hospital's first woman resident—in the OR. She now serves as faculty general surgeon and assistant program director in the Mbingo surgical training program.



Mbingo Baptist Hospital: Dr. James Allen Brown (far left) with residents from Cameroon, Nigeria, and the Democratic Republic of Congo. These residents now serve as fully trained general surgeons throughout Africa.

trained surgical graduates from the Mbingo program now work in nine African countries.

In terms of infrastructure and practice, Dr. Brown supervised the construction of a new surgery clinic at Mbingo, which transformed the clinic from a single room with a curtain between two stretchers to seven private exam rooms with a sink, desk, and laptop in each room. He also oversaw an OR expansion, renovating six rooms and adding four more, as well as adding specialized equipment for laparoscopy, ophthalmology, orthopaedics, and pediatric surgery.

This renovation included dramatically expanding storage for OR supplies. Dr. Brown implemented a peritoneal dialysis program for acute renal injury, raising the survival of those patients from zero to 70%, and the program is now taught throughout the region.

Throughout his time in Cameroon, Dr. Brown has advocated for improving surgical resident education. He has partnered with numerous international university programs

to establish partnerships to receive residents and faculty for global surgery rotations and research; worked to get hospital accreditation from regional surgical societies such as the College of Surgeons for East, Central, and Southern Africa; and established collaborative relationships with national surgeons, hospitals, and medical schools to share resources, enhance consultations, and provide training.

Even in the face of the ongoing Cameroonian civil war, which has brought active conflict to his immediate area and threats of violence against himself, his wife, and his staff and students, Dr. Brown's work to train residents and treat patients has continued. Though training has often been interrupted and the surgery volume has dropped, thousands of patients who would not have had access to care have received the care they needed.

### International Surgical Volunteerism Award

The International ACS/Pfizer Surgical Volunteerism Award

is given in recognition of those surgeons who are committed to giving back to society by making significant contributions to surgical care through organized volunteer activities abroad.

This year, the award will be given to **Eid B. Mustafa, MD, FACS**, for his more than 30 years of volunteer surgical and medical services to the people of the Palestinian West Bank, in addition to other underserved areas of the Middle East.

Dr. Mustafa was born in the West Bank, received his medical education in Egypt, and then moved to the US to perform his residency and fellowship training in plastic and reconstructive surgery. After his training, he relocated to the medically underserved city of Wichita Falls, TX, where he was the only practicing plastic and reconstructive surgeon for many years. His international volunteerism began in earnest in 1987, when he met Charles Horton, MD, the founder of Physicians for Peace, who worked with Dr. Mustafa to initiate medical missions to the West Bank the following year.



Hebron, 1994: Dr. Eid Mustafa (center, speaking) at a clinic, explains treatment options for a facial burn scar to a pediatric surgeon



West Bank's Ramallah Hospital, 1996: Dr. Eid Mustafa (center, seated) shows the markings for a cleft lip procedure and explains surgical technique

For many years, Dr. Mustafa traveled to the West Bank for between 10 and 21 days. His initial efforts focused on congenital defects, burn care, and reconstruction from injury. As his missionary work evolved, he recruited a multidisciplinary team aimed at the needs of each individual community, including specialists in urology, orthopaedics, peripheral vascular surgery, off-pump cardiothoracic surgery, cardiology, and physical therapy. With the advent of minimally invasive surgery during this period, he arranged for equipment and education to be provided in the West Bank to accommodate the growing interest.

His trips provided preoperative care, intraoperative teaching, and postoperative care for the patients.

The teams developed by Dr. Mustafa have provided more than 2,000 procedures to date. Dr. Mustafa has been responsible for all logistics, including planning with the host country, setting up patient visits, acquiring visas, and

making travel and lodging arrangements for his team and educational venues. He has conscientiously provided for the safety of his volunteers in areas with significant personal security concerns.

Dr. Mustafa's efforts have now expanded beyond surgical services. Recognizing the burgeoning need for care of the increasing diabetic population in the West Bank, Dr. Mustafa founded centers in Al-Bireh, Nablus, and Hebron to deliver dietary information, preventative foot care, smoking cessation, neuropathy education, and medication management. These centers also offer education about the long-term sequelae of diabetes, including cardiovascular disease, kidney failure, and ophthalmologic complications. In addition, burn centers were established in Nablus and in Hebron due to the war-time thermal injuries seen in these areas. These centers were not only equipped to take care of the burn injuries but provided education and training to the surgical staff, nurses, and therapists.

In addition to educating US medical students on the need for and realities of international surgical volunteerism, medical education is included in each of Dr. Mustafa's mission trips, which are open and free to all who wish to attend. These missionary conferences are coordinated with the Ministry of Health and often one of the local medical schools. Subjects are chosen based on the needs of the medical communities and include topics such as trauma care, patient safety in the operating room, and complication assessment. Dr. Mustafa also has been a diligent advocate and fundraiser for his medical services, gathering funds and resources from countries including the US, Germany, Kuwait, and beyond.

Dr. Mustafa has been an international ambassador for the ACS, taking pride in his fellowship and advancing the ideals of the College. He began teaching the principals of the Advanced Trauma Life Support® curriculum on the West Bank years ago, at a





Port-Au-Prince: Dr. Alexis Bowder (far right) in her capacity as Program in Global Surgery and Social Change Research Fellow, meets with Haitian surgeons to discuss moving forward clinical research in the country



Hôpital Universitaire de Mirebalais: Dr. Alexis Bowder (far left), then a surgical sub-intern, in daily morning rounds

time when political divisions prevented formal recognition and certification of the course.

### Resident Surgical Volunteerism Award

The ACS/Pfizer Resident Surgical Volunteerism Award is given in recognition of those surgeons who have been involved in significant surgical volunteer activities during their postgraduate surgical training. This award honors surgeons committed to giving back to society by making significant contributions to surgical care through organized volunteer activities. This year, the award will be given to two surgeons: Alexis Bowder, MD, and Matthew Goldshore, MD, MPH, PhD.

The first Resident Surgical Volunteerism Award recipient is **Alexis Bowder, MD**, a general surgery resident in Milwaukee, WI, who receives this award for her 10 years of volunteer work in practice, education, and research, primarily in Haiti.

Dr. Bowder has been involved in global volunteer work since

2012, when she spent 6 weeks as an interpreter at a primary care clinic in Honduras between her first and second years of medical school. Between her third and fourth years of medical school, she worked for 1 year at Hôpital Universitaire de Mirebalais in Haiti, working as a research associate with Harvard Medical School's Program in Global Surgery and Social Change. As a sub-intern, Dr. Bowder recorded vitals for surgical patients and removed dressings before rounds. In the OR, she filled roles ranging from circulating to first assisting surgeon. Patients seen in the surgical clinic or around the hospital were given her phone number and could contact her for perioperative issues. In addition to working with the Haitian team, she was the liaison for any visiting surgical teams from the US or internationally. She helped visitors reach the hospital, locate patients to evaluate, and schedule procedures.

As a resident, even with ongoing political strife primarily in the capital of Port-au-Prince, she continued regular trips

to Haiti, where she shifted the focus of her clinical and education efforts to include St. Boniface Hospital in Fond-des-Blancs. While continuing to participate in daily rounds and postoperative care of patients, Dr. Bowder dedicated more time to developing the surgical research skills of the Haitian medical students, residents, and faculty, and supported their clinical research.

Her work supporting surgical research at St. Boniface Hospital led to the development of a sustainable database of surgical cases and their postoperative outcomes, including the design of an electronic database to be implemented in the coming years. In collaboration with Haitian colleagues, she established a not-for-profit organization, the Haiti Surgical Research Consortium, which seeks to strengthen the Haitian surgical system by promoting Haitian-led surgical research training and capacity building to better inform efforts and provide universal access to timely and affordable surgical care. Dr. Bowder has been



CSH: Dr. Matthew Goldshore (far left in first photo, far right in second) leading personal patient navigator training

integral in collaborating with several Haitian organizations and *Info-CHIR*, Haiti's only peer-reviewed journal of surgery and anesthesiology, to implement an annual surgical research curriculum to teach Haitian clinicians the skillsets to design, conduct, and disseminate their own clinical research.

Even early in her career, Dr. Bowder has been a strong advocate on the global stage for improving care in Haiti. In the last 2 years, she attended the United Nations General Assembly to advocate for surgical care and attended grassroots meetings on the importance of developing a National Surgical, Anesthesia, and Obstetric Plan (NSOAP) in the country. Additionally, she worked with the Global Surgery Foundation and the United Nations Institute for Training and Research to perform a situational analysis of obstetric and cervical cancer care in Rwanda and Zambia to inform future interventions for decreasing maternal mortality by improving access to cesarean sections and surgical care for cervical cancer.

In addition, Dr. Bowder personally has raised more than \$5,000 to support Haitian faculty and trainees in their research efforts—assisting with publication and international presentation of their work and developing a Haitian research education platform.

The second Resident Surgical Volunteerism Award recipient is [Matthew Goldshore, MD, MPH, PhD](#), a general surgery resident in Philadelphia, PA, for his work toward establishing the Center for Surgical Health (CSH), which serves as an access point into high-value surgical care for patients who typically rely on the emergency room for treatment.

Dr. Goldshore's educational background in public health helped him develop the skills to become a key part of the development of CSH, which opened in 2021. CSH has developed a sustainable surgical access model for uninsured Philadelphians that relies on partnerships with community organizations, with several partners throughout the city aiding in expansion of clinical services.

Recognizing that changing the landscape of surgical care for vulnerable populations requires a multipronged approach that includes improving access to surgical consultation and operative intervention, interdisciplinary public health and clinical outcomes research, and beyond, Dr. Goldshore implemented a one-to-one, patient-centered system in which CSH collocates at health centers for assessment of surgical disease. Patients immediately are paired with an interdisciplinary Personal Patient Navigator (PPN) team composed of medical, nursing, legal, and social work trainees. The team walks the patient through their perioperative trajectory, registering them within the Penn Medicine system and submitting medical assistance applications to the state.

When their Emergency Medicaid or Medicaid application is approved, the patient receives care at University of Pennsylvania (UPenn) surgery from residents and faculty, who support them from preoperative diagnosis to postoperative primary care handoff. When an application





A Somaliland government hospital: Dr. Ted Sugimoto (center) training a surgeon (left), now an OB-GYN. The nurse on Dr. Sugimoto's right is now a certified registered nurse anesthetist.

is denied, it is sent to a partner at Community Legal Services, who support the appeal. Most referrals to CSH come from community organizations or from emergency department encounters.

Dr. Goldshore and his colleagues at CSH understand the need to address a patient's social determinants of health. CSH provides a direct connection to the UPenn Social Needs Response Team, with the ability to offer a range of services to match specific patient needs. For example, patients without reliable transportation to in-person office visits or appointments are given parking passes or are scheduled for transportation services, and patients whose primary language is Spanish are connected with a translator and often assigned a PPN fluent in Spanish.

Dr. Goldshore meets with CSH staff weekly to discuss their approximately 80 patients from nine clinical divisions, including general surgery, women's health, pediatrics, and so on. Each individual patient's status and next steps of care are reviewed,

which provides a teaching opportunity for medical students and lays the groundwork for patients to receive the best standard of care. The clinics actively support patients through the perioperative continuum.

Education and advocacy are critical elements of successfully running a practice like CSH, and Dr. Goldshore is intimately involved in supporting each of these areas. He is a leader in courses at CSH, UPenn Perelman School of Medicine, and the Measey Surgical Education program funded by a grant he submitted. As an advocate, Dr. Goldshore played an integral role in securing funding for CSH and for key staff through the University of Pennsylvania Health System and the Perelman department of surgery.

### **Surgical Humanitarian Award**

The ACS/Pfizer Surgical Humanitarian Award recognizes Fellows who have dedicated a substantial portion of their career to ensuring the provision of surgical care to underserved populations

without expectation of commensurate reimbursement.

This award is intended to honor an ACS Fellow who has dedicated a significant portion of his or her surgical career to full-time or near full-time humanitarian efforts rather than routine surgical practice. This effort may reflect a career dedicated to "missionary surgery," the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach.

This year, the Surgical Humanitarian Award will be given to **Ted Sugimoto, MD, FACS**, for his more than 3 decades of work providing surgical care to disadvantaged patients in several African countries.

Dr. Sugimoto first became involved in volunteerism while he was a medical student traveling to the Dominican Republic. He and his wife, a registered nurse, chose to pursue full-time work overseas following his general surgical training. In 1989, he began his



Dr. Ted Sugimoto (left) and a patient who suffered a severe head injury, who he treated, from initial visit to follow-up to full recovery



full-time career in surgical volunteerism in the Zaire, now the Democratic Republic of Congo (DRC), and has since split his time between DRC, Kenya, Senegal, and Somalia.

Much of Dr. Sugimoto's surgical career was spent in the DRC and Somalia, both volatile areas, and sometimes conflicts put him and his family in personal peril. For example, in 2002, he was working in eastern DRC when tribal conflicts escalated to war, which led to the massacre of at least 3,000 people from both tribes involved in the conflict. Many patients, hospital workers, and others were killed. Much of the hospital, built in the 1950s, and the surrounding homes and structures were destroyed, including the home where the Sugimoto family first lived when they moved to the DRC. Throughout these dire situations, Dr. Sugimoto continued to deliver care for locals and those who suffered casualties from the conflict.

Despite the relative stability of Kenya and Senegal, Dr. Sugimoto worked with underserved populations in

these areas, often providing care to patients who were unable to cover the costs for care at government hospitals.

Though trained as a general surgeon, Dr. Sugimoto often was required to provide care outside of the standard scope of practice for US-based general surgeons. He gained this additional knowledge over the years from specialists in other fields, but often relied on books and internet resources to provide the necessary care. As the only surgeon for a large area and without specialist referral options, he became an orthopaedist, urologist, gynecologist, and plastic surgeon. He learned reconstructive techniques, including cleft lip and palate repairs.

Aside from providing surgical care, he accumulated equipment and medication while stateside to supplement what the hospitals were able to find locally. He collected equipment from donors, purchased equipment from organizations, and arranged transport overseas, sacrificing personal space and

funds to bring the equipment directly to the hospital. While working in Senegal, he was an integral part of transitioning the physical structure of the hospital to a working facility, particularly regarding surgical care needs.

Dr. Sugimoto also has been heavily involved in training the next generation of care providers, often local physicians who had limited exposure to surgery during medical school. He taught at both the nursing and medical schools, training DRC postgraduate general medicine students in surgery. He has served as an instructor and principal at a nursing school; an intern instructor in Kenya; and both an academic and hands-on surgery education leader in Somalia—where the program is now largely run by locals—demonstrating the long-term impact of his work. ♦



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# Medical Summit on Firearm Injury Prevention Promotes Collaborative Approach to Address Firearm Violence



Representatives from the in-person attendees at the Medical Summit on Firearm Injury Prevention

In response to the public health crisis of firearm violence, professionals from 47 multidisciplinary medical societies and health organizations from across the country participated in a Medical Summit on Firearm Injury Prevention at ACS headquarters in Chicago September 10–11.

“This critical public health crisis requires that we all come together to find solutions to save lives and support our communities,” said ACS Executive Director and Chief Executive Officer Patricia L. Turner, MD, MBA, FACS. “With 47 medical and community organizations at the table, I know that we can develop a consensus-based approach that will lead to improved policies and

robust engagement strategies that can positively impact communities across the nation.”

Summit organizer Eileen M. Bulger, MD, FACS, Medical Director of ACS Trauma Programs, concurred. “Now that we’ve concluded the second summit, it’s becoming even more clear that there are many things we can all agree on in terms of immediate, actionable items that can address firearm violence,” she said.

Cohosted by the ACS, American College of Physicians, American College of Emergency Physicians, American Academy of Pediatrics, and the Council of Medical Specialty Societies, this hybrid in-person and virtual meeting was the second such meeting aimed at developing firearm violence prevention recommendations. It built upon

the first Medical Summit’s work from 2019, the results of which can be viewed in a *Journal of the American College of Surgeons* article at [bit.ly/3LmOZVD](https://bit.ly/3LmOZVD).

The meeting provided an opportunity for an inclusive and collegial dialogue on identifying opportunities for the medical community to reach a consensus-based approach to firearm injury prevention, with a focus on understanding and addressing the root causes of firearm violence while advocating for bipartisan policy solutions to address the issue.

Broadly, topics discussed included:

- The public health approach to firearm violence in the US
- Recent and potential legislative approaches related to prevention



Summit co-organizer Dr. Eileen Bulger



Speakers Gita Pullapilly (left) and Joseph Sakran, MD, MPA, MPH, FACS

- Addressing violence through community engagement
- Using healthcare resources to influence the social determinants that contribute to violence
- How effective communication on firearm violence from the healthcare sector can influence policy work and community building

Some of the most significant work at the summit came from breakout discussions during each session, where participants worked together to educate one another on their areas of expertise and develop a set of initial recommendations that will drive the coalition's future action.

"The summit has once again provided an excellent format for addressing firearm violence. The key remains approaching firearm

injury and death as a medical and public health problem, not a political debate. It also provides a way for professional organizations to move beyond published statements to taking constructive actions as part of a coalition," said Jeffrey Kerby, MD, FACS, Chair of the ACS Committee on Trauma. "The public health approach has been very effective in significantly reducing traffic injuries and deaths through the years. We know this approach can work with firearm violence too."

The planning committee will compile and disseminate the recommendations and proceedings for participating organizations to further consider. Leaders at the summit also committed to a long-term working relationship (or coalition) and agreed to create an infrastructure for continued longitudinal

collaboration so that effective firearm violence prevention education, resources, and policy solutions can be pursued.

Proceedings from the second Medical Summit on Firearm Injury Prevention will be released in the coming months.

The ACS leadership role in coordinating the summit is an extension of recent work to create practical, apolitical recommendations for reducing firearm violence in the US. This work includes development of Firearm Safety Team (FAST) recommendations based on public safety principles. The Bipartisan Safer Communities Act, the most significant new federal legislation addressing firearm violence in 30 years, was signed in June and aligns with three of the FAST workgroup's recommendations on red flag laws, obtaining ownership, and firearm registration. ♦



# ACS SESAP 18

Surgical Education and  
Self-Assessment Program  
American College of Surgeons

## SESAP® 18 Offers Opportunities for Personalized Learning

The newest edition of *Surgical Education and Self-Assessment Program (SESAP®)*, which officially will be launched at this month's Clinical Congress 2022, is a premier educational resource for practicing surgeons and surgery residents. The 18th edition continues the legacy of providing the highest-quality, peer-reviewed content.

With *SESAP 18*, the ACS promotes surgical excellence through an innovative educational model to reinforce learning and foster mastery of content.

"*SESAP 18* continues the tradition of introducing novel educational features in each new edition, based on the latest educational underpinnings and evolving needs of practicing surgeons and surgery residents," according to Ajit K. Sachdeva, MD, FACS, FRCSC, FSACME, MAMSE, Director of the ACS Division of Education. "Several new features have been added to *SESAP 18* to enhance personalized education and promote expertise."

### New Personalized Assessments and Returning Features

For individuals who wish to incorporate *SESAP 18* into their regular routines, the *SESAP* Small

Bites feature allows subscribers to receive links to *SESAP 18* questions via email by selecting the frequency and desired topic areas. For the first time, *SESAP* subscribers will be able to create personalized assessments that randomly select questions from across one or more specified categories. Participants will be able specify the number of questions, the category or categories to be used, and whether to select only questions that were answered incorrectly.

These new custom assessments will allow each surgeon to create unique assessments targeted to individual study. *SESAP 18* also allows participants to easily create personalized flashcards and save them by category for future reference. Finally, new progress reports for residents can easily be shared with program directors and will include comparisons of scores with resident peers completing *SESAP*.

These new features build on others introduced with *SESAP 17*, which was the first edition to offer packages that may be purchased by category. Likewise, the program offers the ability to highlight and save text, bookmark and notate

content in custom library folders, target searches quickly across categories, and compare scores and answer selections with peers. As *SESAP 18* Program Director John A. Weigelt, MD, DVM, FACS, MAMSE, said, "*SESAP 18* continues the evolution of making the program more user-friendly and valuable as an educational activity. We believe *SESAP 18* is continuing a terrific heritage as a CME [continuing medical education] activity for general surgeons."

*SESAP 18* contains more questions than the previous edition, with a total of 665 multiple-choice questions in nine major areas of general surgery: abdomen, alimentary tract, breast, emergency general surgery, endocrine, legal/ethics, perioperative care, surgical critical care, and trauma. A total of 38 surgeon authors contributed to the program using a rigorous peer-review process to provide expanded critiques that offer evidence-based explanations of all the answer choices, as well as supporting references from the literature.

Participants in *SESAP 18* can earn up to 168 *AMA PRA Category 1 Credits™*. In addition, Education Credits

*SESAP 18* contains more questions than the previous edition, with a total of 665 multiple-choice questions in nine major areas of general surgery.

of Excellence are again being offered for those surgeons who wish to pursue a higher level of achievement, and *SESAP 18* content is available by category to accommodate their goals.

#### ***SESAP 18 Advanced***

Because of the success and popularity of *SESAP 17 Advanced*, the *Advanced* series will continue

with *SESAP 18 Advanced*, which will be released in summer 2023. *SESAP 18 Advanced* will feature additional in-depth content for surgeons seeking greater knowledge in specific areas. Modules will address clinical problems in areas of greater complexity or that may be still evolving, including:

- Abdomen

- Alimentary tract
- Breast
- Emergency general surgery/trauma
- Endocrine
- Melanoma, sarcoma, and soft tissue/skin malignancies
- Surgical critical care

More information is available on the ACS website at [facs.org/sesap](https://facs.org/sesap). ♦

# Bulletin



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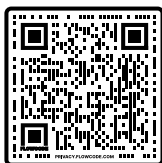
# The Operative Word



## New from the *Journal of the American College of Surgeons*

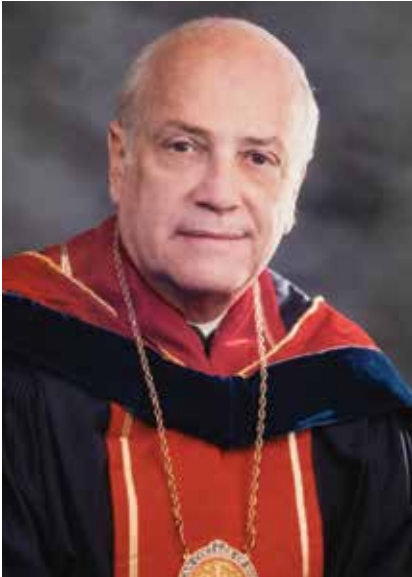
*The Operative Word* is a new podcast during which, hosts Jamie Coleman, MD, FACS, and Dante Yeh, MD, FACS, speak with recently published authors about the motivation behind their latest research and the clinical implications it has for the practicing surgeon.

Listen and subscribe on Apple Podcasts, Spotify, or wherever you get your podcasts. You also can listen on the ACS website at [facs.org/podcast](https://facs.org/podcast) or by scanning the QR code.



#JACSOperativeWord





## In Memoriam: Dr. W. Gerald Austen, Cardiac Surgery Pioneer

**W. Gerald Austen, MD, FACS**, ACS Past-President and a giant in cardiac surgery, died September 11 at the age of 92. Dr. Austen passed away surrounded by family at Massachusetts General Hospital (MGH) in Boston, where he played a key role in growing the institution to a world-class medical establishment and revolutionizing cardiac care.

Born in Akron, OH, Dr. Austen graduated from the Massachusetts Institute of Technology in Boston with a degree in mechanical engineering in 1951 and received his medical degree from Harvard Medical School (HMS) in 1955. He completed residencies in general surgery and cardiothoracic surgery at MGH and returned there after spending 2 years conducting research at the National Institutes of Health.

Dr. Austen was appointed professor of surgery at HMS at the age of 36 and served as the hospital's first chief of cardiovascular surgical research. As a professor, he was regarded

as a kind, engaged mentor. He went on to be appointed as the MGH chief of surgical services at only 39 years of age, which was a notable achievement for a young surgeon, and he would hold the position for 29 years. After his retirement from clinical practice in 1998, he was honored with the creation of the W. Gerald Austen Chair in Surgery at HMS and MGH. In 2020, MGH renamed part of the hospital to the W. Gerald Austen, MD, Building to honor his decades of service to the hospital.

Among Dr. Austen's many contributions to patient care and surgical science, he was instrumental in the design and creation of a cardiopulmonary bypass machine and the intra-aortic balloon pump. Because of his engineering background and knowledge in fluid mechanics, he was able to provide a unique mechanical perspective to solving serious cardiac issues. Dr. Austen and MGH colleague Robert Shaw, MD, worked together on the bypass machine after their practice hours, and it was put into clinical use in 1956.

Several of the "test patients," who had end-stage cardiac disease and were expected to die within 30 days without treatment, were able to have heart surgery, recover, and lead full lives. In the 1960s, Dr. Austen worked with Mortimer Buckley, MD, FACS, and others to develop and successfully implement the intra-aortic balloon to patients experiencing cardiogenic shock.

These remarkable innovations would invigorate cardiac care at MGH and change the face of heart health around the world.

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### More than a Decade of ACS Leadership

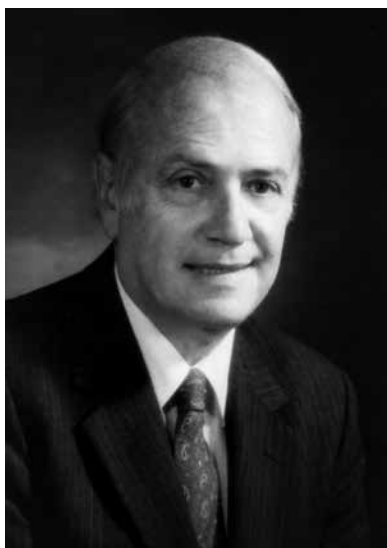
Dr. Austen's dedication to surgery and innovation carried through to his more than 20 years of service as a leader in numerous roles with the ACS. He served as ACS President from 1992 to 1993, leading the College in a transformative time for organization as it sought to increase its presence in Washington, DC, and be a part of conversations involving physician



Dr. Austen in 1983



Dr. Austen at Clinical Congress (undated)



Dr. Austen (undated)



Dr. Austen testifying in 1988 at a hearing conducted by the House Ways and Means Subcommittee on Health on the subject of physician payment under the Medicare program

reimbursement. His term as President was a capstone to his years serving on the ACS Board of Regents (B/R) (1982–1991) in various capacities, including as B/R Chair (1989–1991), and Chair of the Health Policy and Reimbursement Committee and the Finance Committee. Dr. Austen's commitment to the ACS and its principles extended beyond his years as a leader and active practice into philanthropy; in 2014, he and his wife Patricia were honored with the ACS Distinguished Philanthropist Award.

During his time at the College, Dr. Austen worked closely with other significant figures in the ACS and surgical history, including C. Rollin Hanlon, MD, FACS, ACS Past-Director and Past-President; Oliver Beahrs, MD, FACS; David Sabiston, MD, FACS; LaSalle Leffall, MD, FACS; and Frank Spencer, MD, FACS, among many others.

Beyond the ACS, Dr. Austen was a respected and valued leader in many other organizations, serving as president of the Association

for Academic Surgery, Society of University Surgeons, American Surgical Association, American Heart Association, and American Association for Thoracic Surgery.

Dr. Austen is survived by his wife, four children, and 10 grandchildren. His legacy includes inspiring medical students and staff, as well as improving the lives of thousands of patients. Read more about Dr. Austen's remarkable life and career at [bit.ly/3SAuzuR](http://bit.ly/3SAuzuR). ♦



## Apply for 2023–2025 ACS Clinical Scholar in Residence Positions by October 31

The American College of Surgeons (ACS) is now accepting applications for the 2023–2025 Clinical Scholar in Residence positions. Applications are due **Monday, October 31, 2022**.

This 2-year, onsite fellowship affords the selected ACS Clinical Scholars the opportunity to get involved in surgical outcomes research, health services research, healthcare policy, diversity, equity and inclusion, and quality improvement. The scholar will work in multiple areas within the ACS Division of Research and Optimal Patient Care (DROPC) to advance the quality improvement initiatives of the ACS and to perform research relevant to projects within the College.

Five fellowship spots are available for July 1, 2023–June 30, 2025, with a focus in cancer, trauma, and other areas of surgery. The spots include one position with the ACS Cancer

Programs, one position with the ACS Committee on Trauma, and three positions with ACS general surgery programs.

### Continuing Your Education

The goal of the ACS Clinical Scholar in Residence program is to help prepare a surgical resident for a career in academic surgery through a unique, practical research and health policy experience at the ACS. The program includes the opportunity to earn a masters of science in Clinical Investigation (MSCI), Health Services and Outcomes Research, or Healthcare Quality and Patient Safety through Northwestern University's Schools of Medicine, Public Health, and the Institute for Healthcare Studies.

In addition, the scholar will be able to participate in resident educational activities through the Northwestern University

department of surgery.

The ACS offers a variety of educational programs, such as the Outcomes Research and Clinical Trials Courses that the scholar will be able to complete. The scholar also will interact and be mentored by various surgeons affiliated with the ACS and DROPC from across the country and be supported by ACS staff statisticians and project analysts.

Applicants must have completed 2 years of clinical training, be a US citizen, and obtain approval from their home institution to be considered. Interviews will be scheduled via video conference in October.

Visit the Clinical Scholars in Residence web page at [bit.ly/3AP2auY](https://bit.ly/3AP2auY) for more information on specific positions, application requirements, and to see mentors and other scholars. For more information, contact [csholars@facs.org](mailto:csholars@facs.org). ♦

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