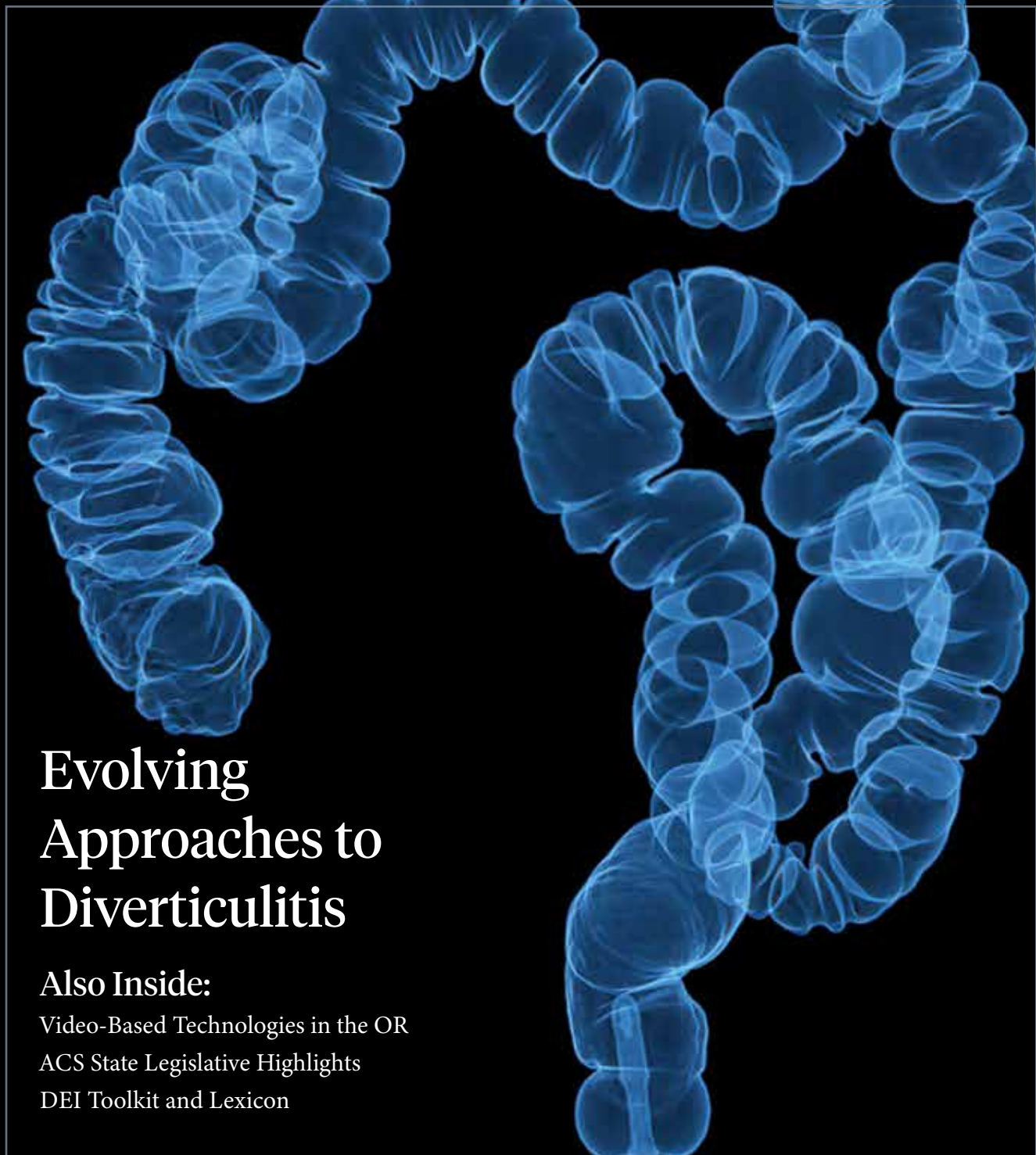


NOVEMBER-DECEMBER 2023 / VOLUME 108 / NUMBER 11

# ACS/Bulletin

AMERICAN COLLEGE OF SURGEONS



## Evolving Approaches to Diverticulitis

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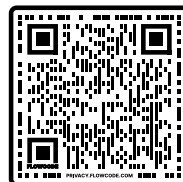
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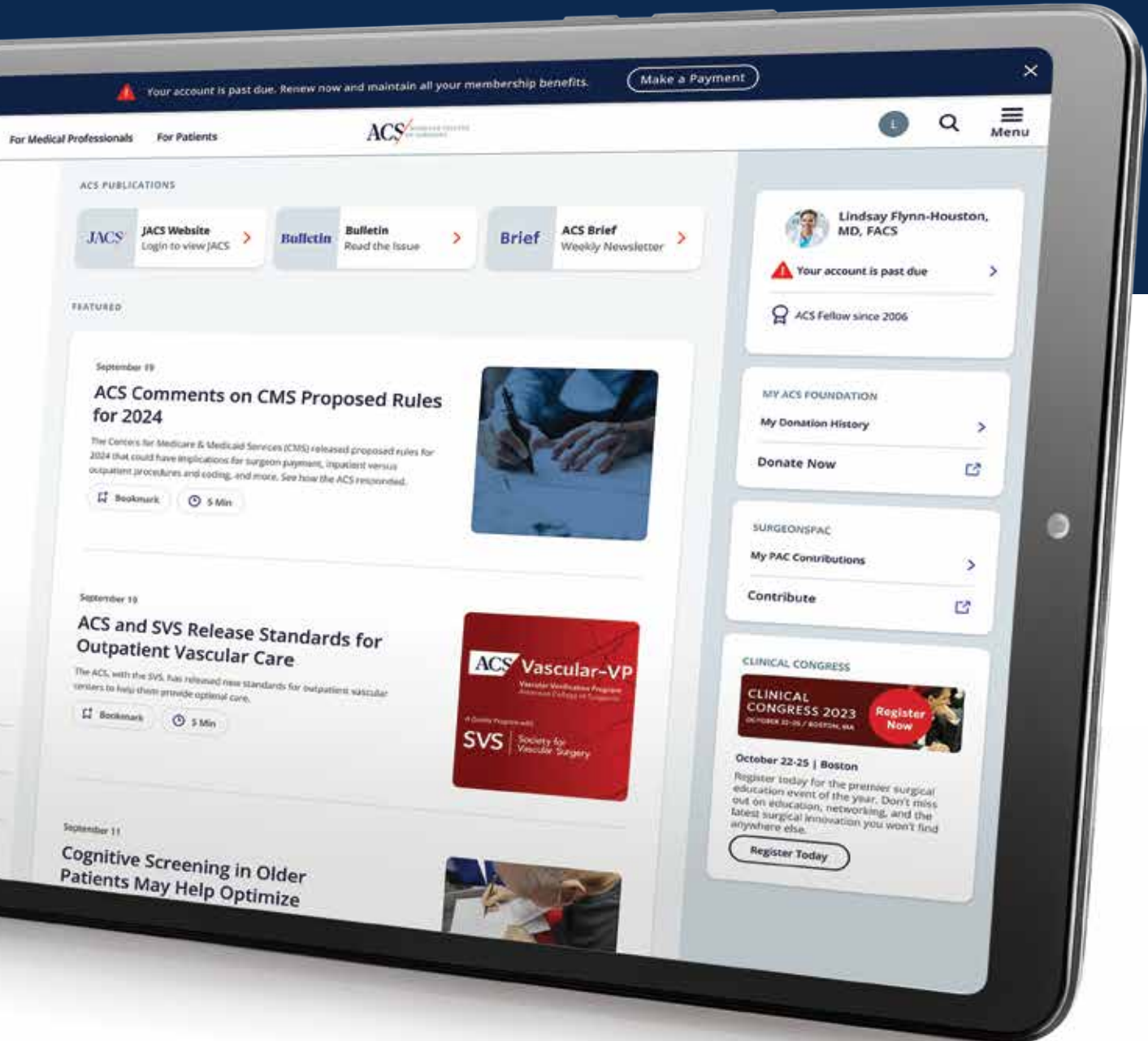
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September 09

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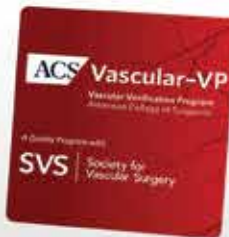


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September 11

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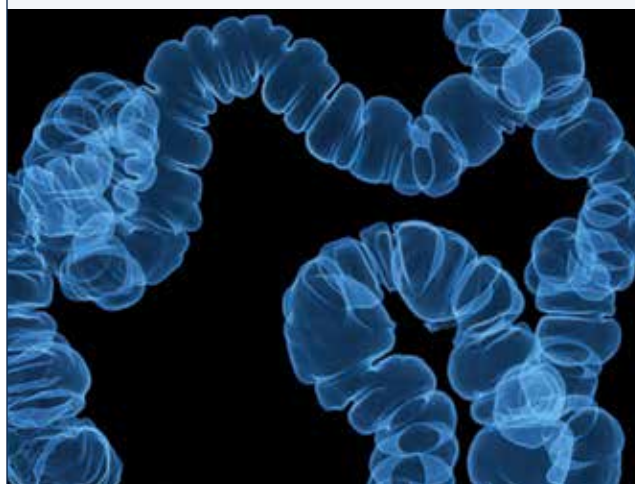
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# Celebrating a Year of Achievement at the ACS

Patricia L. Turner, MD, MBA, FACS

EXECUTIVEDIRECTOR@FACS.ORG



IT IS HARD TO BELIEVE 2024 is almost upon us. 2023 seems to have flown by—perhaps because we have been so incredibly busy with myriad activities to help improve healthcare and serve surgeons.

Among our most successful events in 2023 was Clinical Congress. This year, we gathered in Boston and online. More than 12,000 people attended, including 7,500 surgeons and hundreds of students, surgical residents, and other healthcare professionals. To this broad spectrum of learners, nearly 2,500 faculty offered more than 3,400 presentations, including panel discussions, debates, and Named Lectures.

The conference included

specialized content for surgeons in many surgical disciplines and career stages, including several standing-room-only scientific sessions focused on surgical oncology, medical informatics/artificial intelligence, and trauma surgery. Offerings for students and residents included the always-popular “Spectacular Cases” session, as well as the “So You Think You Can Operate” and “Surgical Jeopardy” competitions.

In addition, the Surgical Ergonomics Clinic and the Surgical Metrics Project returned to our Exhibit Hall, providing unique simulations to help onsite attendees perfect surgical techniques. Both enjoyed robust interest. Read more about these in the October *Bulletin*.

Much of the meeting content, including videos, and nearly 200 Continuing Medical Education credits are still accessible on demand until May 1, 2024, and can be accessed via the online platform and conference app. Forthcoming programming is also planned to help ACS members access Clinical Congress-related content all year.

In addition to Clinical Congress, we have had many other successes in 2023. To better share what the ACS does for healthcare systems, the public, and our members, we have prepared an annual report,

now available at [facs.org](https://facs.org). Here are a few highlights:

**1** In April, we launched The Power of Quality campaign, which strives to bring ACS Quality Programs to the attention of every US surgeon, hospital, payer, and policymaker, for the benefit of all surgical patients. Thus far, we have developed campaign momentum, initiated partnerships, and distributed more than 1,200 Surgical Quality Partner diamonds to participating hospitals.

**2** In May, STOP THE BLEED<sup>®</sup>, our flagship public-facing program, was highlighted at a Chicago Cubs game, where volunteers trained baseball fans to respond to bleeding emergencies. We also prepared 1 million more people worldwide, expanded our Safe Communities program, and advocated successfully for 10 state laws advancing access to STOP THE BLEED training and kits. We will continue to work on making this knowledge as common as CPR.

**3** In June, US Army Colonel (Retired) Brian Eastridge, MD, FACS, became the new Military Health Systems Strategic Partnership-ACS





Dr. Brian Eastridge (left) and Dr. Ronald Weigel

Medical Director. Dr. Eastridge is a professor of surgery, chief of the Division of Trauma and Emergency General Surgery, and Jocelyn and Joe Straus Endowed Chair in Trauma Research at The University of Texas in San Antonio. He will be pivotal to ACS's efforts to advance military-trauma partnerships and be a voice for military surgeons.

**4** In October, a new Medical Director took the helm of our ACS Cancer Programs. Ronald Weigel, MD, PhD, MBA, FACS, is a prolific breast cancer researcher and the E. A. Crowell Jr. Professor and chair of the Department of Surgery at the University of Iowa Health Care in Iowa City. He joins a department focused on restructuring the Cancer Research Program, expanding National Cancer Data Base quality measures, holding the 2024 Cancer Conference, and more.

**5** Also in October, we enhanced the highly personalized Surgeon's Dashboard, where all members can access their most frequently visited webpages, conference registrations, dues payments, and more. Here, you can update your profile to capture your career stage, practice type, surgical discipline, and professional interests, so that we can provide the curated content you want, when you want it. Learn more and update your profile at [profile.facs.org/dashboard](https://profile.facs.org/dashboard).

**6** Throughout the year, ACS Health Outreach Program for Equity in Global Surgery (ACS H.O.P.E.), formerly known as Operation Giving Back, advanced sustainable changes in sub-Saharan African surgical systems by promulgating Advanced Trauma Life Support® training in Ethiopia, working to create a national trauma system in Rwanda, initiating laparoscopic training and research mentorships with surgeons in Zambia, and more. The program is made possible by your donations to the ACS Foundation.

**7** Finally, we have been excited to continue organizing Clinical Congress 2024, which has long been planned for San Francisco, California. While collaborating with the city government and other entities to ensure all attendees' safety and well-being, we have decided to shift the conference dates to Saturday, October 19, to Tuesday, October 22. This is 1 day earlier than the long-used Sunday-Wednesday format, and it will better match many surgeons' availability, limiting time spent away from the hospital.

Lawrence Cohen, PhD, a University of California-Berkeley anthropologist, has written that conferences permit "the care and feeding of professional kinship." It is true that Clinical Congress provides a special

opportunity to connect to peers, mentors, and leaders, refreshing many of us. That said, the ACS seeks to provide professional kinship every day, through programs that improve our work, events that connect surgeons worldwide, and personalized attention to each member. I hope you have benefited this year and will continue to benefit in the year to come.

### **2024 Cancer Conference**

If you are a part of a surgical oncology team, please join us this February 22-24, in Austin, Texas, for the 2024 ACS Cancer Conference. For 2 days, we will share sessions on standards, quality improvement, survivorship, and more. Register here: [facs.org/cancerconference](https://facs.org/cancerconference).

### **2023 TQIP On Demand**

If you are a trauma surgeon who missed the annual Trauma Quality Improvement Program (TQIP®) conference in Louisville, Kentucky, this month, please know the content remains available to you. On-demand access to conference videos will start in early January. Register at [facs.org/tqip](https://facs.org/tqip). **B**

**Dr. Patricia Turner** is the Executive Director & CEO of the American College of Surgeons. Contact her at [executivedirector@facs.org](mailto:executivedirector@facs.org).

# Evolving Approaches to Diverticulitis Give Surgeons a Gut Check in Management Options

Tony Peregrin



**“There is a lot of discussion and controversy around the management of diverticulitis and how it is treated in the US and what is being done in Europe.”**

Alessandro Fichera, MD, FACS, FASCRS

THE PREVALENCE OF DIVERTICULITIS CONTINUES to rise particularly in industrialized countries, with nearly 3 million Americans diagnosed with the condition and 200,000 hospitalized each year.<sup>1,2</sup> Despite the expansive occurrence of this disease, standardized prevention and treatment continue to elude clinicians—although new recommendations for managing these patients are continually explored and debated.

“There is a lot of discussion and controversy around the management of diverticulitis and how it is treated in the US and what is being done in Europe,” said Alessandro Fichera, MD, FACS, FASCRS, division chief of colon and rectal surgery at Baylor University Medical Center in Dallas, Texas. “Both sides of the debate have important data to support what they are doing.”

Once considered a disease predominantly occurring in older patients, the incidence of diverticulitis continues to increase in all age groups, including patients in the third and fourth decades of life around the globe, leading surgeons to consider novel treatment approaches, including selective rather than routine use of antibiotics for uncomplicated cases or the use of laparoscopic surgery when advisable.

In fact, the recently updated guidelines issued by the American Society of Colon and Rectal Surgeons (ASCRS) highlight this changing treatment paradigm with recommendations related to antibiotic use and minimally invasive surgery and guidance for the initial evaluation of acute diverticulitis, such as key physical examination findings and the results of computed tomography scanning.<sup>3,4</sup>

**“It is our job and place to create physician and patient education tools on the subject and to disseminate them widely so that surgeons are equipped with materials to begin implementation.”**

Marylise Boutros, MD, FACS



Access video content at [www.youtube.com/watch?v=13sj\\_HhJo2U](https://www.youtube.com/watch?v=13sj_HhJo2U)

### **Are Antibiotics Necessary?**

The need to administer antibiotics during a case of uncomplicated diverticulitis has been the subject of clinical scrutiny for more than a decade.<sup>5</sup>

“The role of antibiotics is changing,” said Paula Denoya, MD, FACS, FASCRS, program director of the colorectal surgery residency program at Stony Brook Medicine in New York. “I’ve had a few patients tell me that their gastroenterologist has told them they don’t need antibiotics for every attack—but that’s pretty rare. I think most patients call their primary care doctor or the gastroenterologist or even their surgeon and get put on antibiotics. I battle with that myself.”

Based on available Level I evidence, less than 5% of patients fail nonantibiotic therapy and require oral antibiotics for the treatment of their mild diverticulitis, according to Marylise Boutros, MD, FACS, regional research director of the Digestive Disease and Surgery Institute at the Cleveland Clinic Florida in Weston.

“In my own experience with more than 60 patients in a nurse-led pathway for the management of mild diverticulitis with nonantibiotic therapy—the main reason for failure of nonantibiotic therapy was due to the patients being referred by their primary care physician or the emergency room with antibiotics already started,” said Dr. Boutros, who noted other factors that may influence the success of nonantibiotic therapy such as immunosuppression, other severe comorbidities, and underestimating the mild severity of diverticulitis.

A 2019 meta-analysis of nine randomized controlled trials published in *American Family Physician* revealed that patients with this specific disorder who were not treated with antibiotics had shorter hospital stays and showed no differences in complication or readmission rates.<sup>6</sup>

Another article published just last year in the *Annals of Gastroenterology* stated that “there have been

several well-designed randomized controlled trials providing Level I evidence and informing numerous society recommendations on the omission of antibiotics in uncomplicated diverticulitis.”<sup>7,8</sup> Specifically, the Antibiotics in Acute Uncomplicated Diverticulitis (AVOD) trial (published in 2012 and updated in 2019 for long-term follow-up) showed no differences in outcomes for patients treated with or without antibiotics.<sup>7,8</sup> The Dutch Diverticular Disease Study group trial revealed “no significant differences were found at 6 months in days to recovery, recurrence, readmission rates or mortality, among other endpoints.”<sup>7,8</sup>

“The data from Europe are, I wouldn’t say very strong, but for some strong enough that several of my colleagues and friends in Europe are proponents of not using antibiotics in cases of uncomplicated diverticulitis,” said Dr. Fichera. “Anecdotally, from personal experience, I have not been particularly successful in managing diverticulitis without antibiotics. And the reasons could be multifactorial.” He added that the way the disease presents in the US may be different in a more homogeneous population such as Scandinavia and Northern Europe.

The authors of the *Annals of Gastroenterology* article note that the approach for treating uncomplicated diverticulitis without antibiotics has not gained “significant traction in American populations as it has in European populations” where many of these trials were originally evaluated.<sup>5</sup>

A 2018 joint survey of members of the Society of American Gastrointestinal and Endoscopic Surgeons and the European Association of Endoscopic Surgery “found that only 26% of them endorsed a trial of treatment without antibiotics, and half of them still would not practice this society recommendation.”<sup>5,9</sup>

“We clinicians do not like change. The onus falls on us to share this new evidence supporting the treatment of mild diverticulitis without antibiotics with our medical colleagues,” said Dr. Boutros. “Furthermore, one-third of patients presenting with

diverticulitis have had a prior episode of the disease and are primed to expect an antibiotic prescription. It is our job and place to create physician and patient education tools on the subject and to disseminate them widely so that surgeons are equipped with materials to begin implementation in their hospital and communities.”

## Changing Models in the Operative Management of Diverticulitis

Perhaps one of the most significant debates in the surgical management of diverticulitis centers around performing primary anastomosis in cases of acute diverticulitis versus the Hartmann procedure, which involves resection of the rectosigmoid colon with creation of a colostomy. Researchers suggest that resection with primary anastomosis is a viable alternative without increasing morbidity and mortality.<sup>5</sup>

“There have been a lot of data from the past 10 years supporting primary anastomosis, sometimes with diverting loop ileostomy, as opposed to doing a Hartmann procedure or an end colostomy,” Dr. Denoya said. “I think it really depends on the patient’s clinical picture at the time of surgery. How much peritonitis is there? Is it purulent peritonitis or feculent? In a purulent peritonitis patient who is hemodynamically okay during the operation, you can consider doing a primary anastomosis.”

The advantage to this approach is that the patient is more likely to get an ileostomy reversed.

“However, if I have a patient with diffuse peritonitis or hemodynamic instability, or other reasons why they’re very high risk for their anastomosis to fail, I still tend to do a Hartmann at that point. I think it’s the safer choice for these very sick people,” she said.

“There is a lot of talk about primary anastomosis for Hinchey III diverticulitis,” added Dr. Boutros. “However, in practice, I feel that there still are a lot of Hartmann procedures being performed. The Hartmann procedure remains the safe and most efficient option in the emergency setting. Unfortunately, Hartmann reversals are fraught with complications and many patients do not actually get a reversal.”

According to Dr. Fichera, based on the data from European trials, a hemodynamically stable patient without immunosuppression (or any other serious comorbidities) with Hinchey III diverticulitis can be treated with a primary anastomosis with or without proximal diversion rather than the one size fits all of a few decades ago.

“If we go back to the time I was in training, diverticulitis wasn’t as common as it is now,” Dr. Fichera said. “When you saw a patient with perforated diverticulitis and a Hinchey III presentation, or even IV, there was one operation, and that operation was a laparotomy with a sigmoid resection colostomy and a Hartmann pouch. Today, we need to keep in mind that there are patients who do well with a primary anastomosis.”

Another controversial area in the surgical management of diverticulitis is laparoscopic versus the more traditional open surgery, particularly for emergent cases.<sup>5</sup> With minimally invasive surgery, the operation is conducted through small incisions and is generally linked to shorter hospital stays and fewer complications, as well as less pain for the patient.

“In the elective setting, I have usually optimized the patient and almost exclusively use a minimally invasive approach, as the patient outcomes are certainly superior and the operative conditions—although often challenging—include a hemodynamically normal patient able to tolerate a challenging surgery,” Dr. Boutros said. “These days, we offer elective surgery quite selectively such that patients have had multiple episodes of diverticulitis or have abscesses or fistulas, and though these are elective cases, the left lower quadrant is usually fibrotic or inflamed. In the emergency setting, the main priority is getting source control for the sepsis and doing an efficient operation, so that the patient can recover. Thus, though a minimally invasive approach is my preference, not every patient or clinical situation is suitable for this approach.”

Robotic surgery, which also is minimally invasive, provides an enhanced view of the surgical site and can assist the surgeon in terms of flexibility and precision.

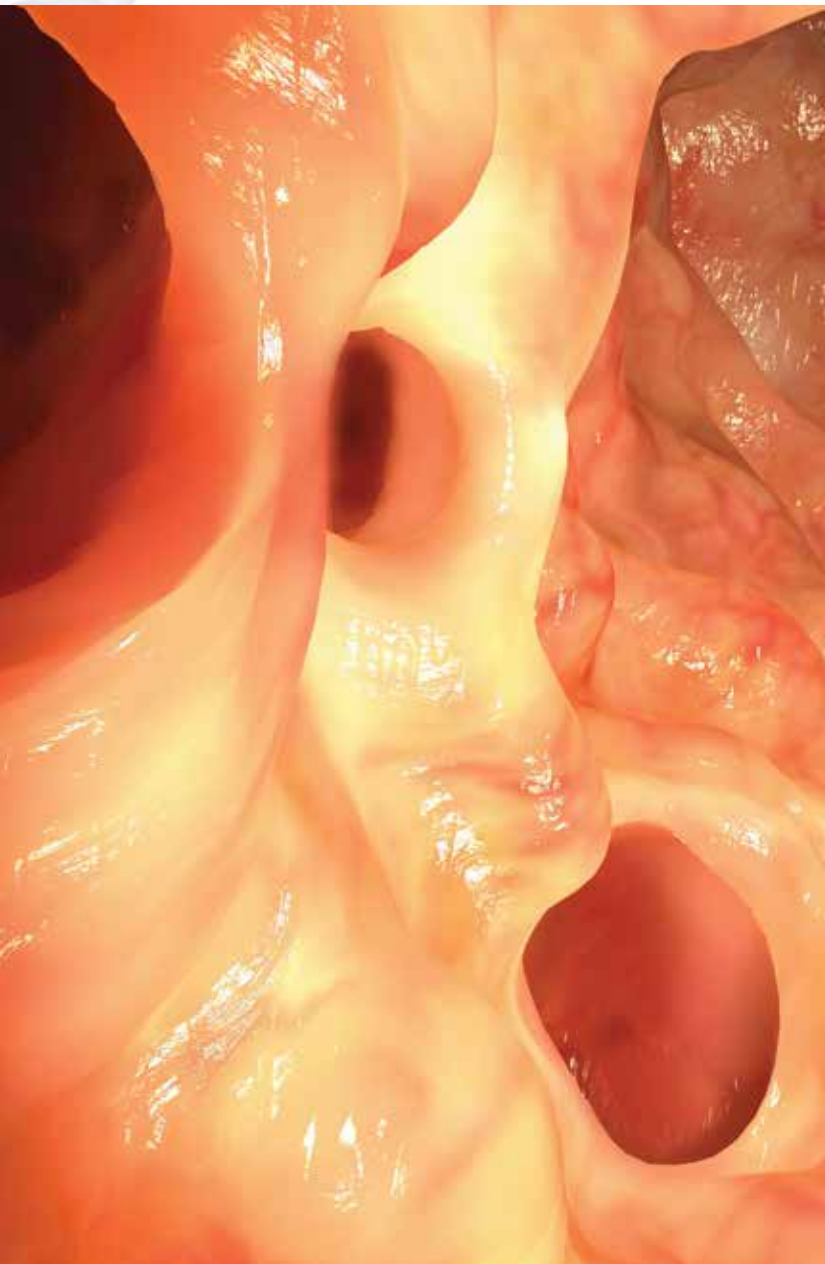
“I think for the chronic patient with other complications like fistulas and abscesses the use of a minimally invasive approach makes a big difference,” Dr. Denoya said, adding that a comfort and skill level with minimally invasive techniques, whether laparoscopic or robotic surgery, is key as is working in a hospital with specialists available, such as urologists, to provide support when necessary.

Whatever approach the surgeon selects, the ASCRS clinical practice guidelines suggest individualizing the decision to operate.<sup>4</sup>

“Use your judgment and individualized treatment, rather than a one-size-fits-all thought process,” Dr. Fichera said. “If you have the right team, equipment, and skills for a patient who has not

**“There is no clear-cut guideline that suggests after a certain number of attacks, you do surgery.”**

Paula Denoya, MD, FACS, FASCRS



had multiple previous abdominal operations, then minimally invasive surgery is totally indicated and definitely has some demonstrated benefits.”

Dr. Denoya shared that when she started her surgical training, the dogma was to operate after two attacks of diverticulitis, but clinical practice has since “moved away from that” and involves much more patient-centered decision-making. “There is no clear-cut guideline that suggests after a certain number of attacks, you do surgery. But I do see in the community that there are still clinicians referring patients after one or two attacks telling them they need an operation,” she said.

It’s challenging to standardize surgical treatment for diverticulitis because there are so many different presentations of the disease—and what’s more, there’s been a notable increase among younger patients. In the US, one study indicated that acute diverticulitis admissions for patients aged 18 to 44 years increased by 82% from 1998 to 2005.<sup>10</sup>

“We went from early surgery for the younger patients with two or three attacks to being more conservative,” explained Dr. Fichera. “But if being conservative means multiple admissions to the hospital and an impact on quality of life and productivity for that patient, we need to balance that.”

He also said it’s important to consider the unique characteristics of the individual you are treating.

“We’re seeing patients in their 20s and 30s with bad disease—perforations, abscess, and the need to undergo resections,” Dr. Denoya added. “I think things are definitely changing as we’re seeing in other diseases, like colon cancer. The incidence of disease is happening in younger people, and we don’t know why.”

A scan shows diverticula within weakened areas in the wall of the colon.

## Genetics and the Gut Microbiome

Diverticulitis is linked to costs totaling more than \$1.6 billion annually in hospitalizations and visits to the emergency room,<sup>3</sup> a reality that is driving clinicians to uncover innovative approaches to treating this condition.

For example, recent research has identified genetic associations to diverticulitis, including some heritable factors uncovered in twin and genetic sequencing studies.<sup>5</sup>

“There is a lot of interest in genetic predisposition in these patients,” Dr. Fichera said. “In fact, the simple approach to familial predisposition has been done—and clearly there is a higher incidence of recurrent severe diverticulitis in relatives of patients who have had diverticulitis. But I’m not certain we know the reason behind that.”

According to Dr. Fichera, clinicians have learned from other diseases, like inflammatory bowel disease, that genetic predisposition typically goes hand in hand with the gut microbiome. “These two areas of study should be advancing together. Clearly, there will be a lot coming out of on these two aspects of diverticulitis in the future.”

Similar to the findings for other gastrointestinal diseases, alterations of the microbiome appear to be related to the occurrence of diverticulitis.<sup>9</sup> Specifically, researchers have shown that changes in the microbiome can be identified when comparing segments of diseased and nondiseased tissue within the same individual, “although

differentiating cause from effect is not feasible without longitudinal studies.”<sup>11</sup>

“If we have supporting evidence, it helps us educate patients as far as what they can do for themselves to change their diet or other risk factors,” Dr. Denoya said. “Certainly, there’s likely microbiome effects and dietary effects that are affecting people from a young age.”

Bridging the gap between research data and practice starts with staying informed on current research, said Dr. Fichera.

“Be aware of the data—and the data to me are pretty clear in showing that patient selection is key in everything we do, but especially for diverticulitis,” he said, adding that factors such as the age of the patient, if they are hemodynamically stable and if they are immunocompromised, are important considerations.

“You still need to use your judgment and engage in individualized treatment,” Dr. Fichera stated.

“Know the literature and know the patient in front of you.” **B**

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### References

1. Hantouli MN, Khor S, Strate LL, et al. What’s in a number? Assessing the burden of diverticular disease. *Ann Surg Open*. 2022;3(4):e202.
2. Strate LL, Morris AM. Epidemiology, pathophysiology, and treatment of diverticulitis. *Gastroenterology*. 2019;156(5):1282-1298.
3. Wolters Kluwer. Treatment for diverticulitis—updated ASCRS guidelines published in *Diseases of the Colon and Rectum*. Press release. May 7, 2020. Available at: <https://www.wolterskluwer.com/en/news/treatment-for-diverticulitis-updated-ascrs-guidelines-published-in-diseases-of-the-colon-and-rectum>. Accessed September 5, 2023.
4. Hall J, Hardiman K, Lee S, et al. The American Society of Colon and Rectal Surgeons clinical practice guidelines for the treatment of left-sided colonic diverticulitis. *Diseases of the Colon & Rectum*. 2020;63(6):728-747.
5. Koprowski MA, Affleck A, Tsikitis VL. Emerging evidence and recent controversies in diverticulitis: A 5-year review. *Ann Gastroenterol*. 2022;35(1):8-16.
6. Bailey J, Dattani S, Jennings A. Diverticulitis disease: Rapid evidence review. *Am Fam Physician*. 2022;106(2):150-156.
7. Chabok A, Pählman L, Hjern F, et al. Randomized clinical trial of antibiotics in acute uncomplicated diverticulitis. *Br J Surg*. 2012;99(4):532-539.
8. Isacson D, Smedh K, Nikberg M, Chabok A. Long-term follow-up of the AVOD randomized trial of antibiotic avoidance in uncomplicated diverticulitis. *Br J Surg*. 2019;106(11):1542-1548.
9. Francis NK, Sylla P, Abou-Khalil M, et al. EAES and SAGES 2018 consensus conference on acute diverticulitis management: Evidence-based recommendations for clinical practice. *Surg Endosc*. 2019;33(9):2726-2741.
10. Al-Saadi H, Abdulrasool H, Murphy E. Complicated diverticulitis: Age distribution, management and burden on health care. *Cureus*. 15(2):e34482.
11. Jeganathan NA, Davenport ER, Yochum GS, Koltun WA. The microbiome of diverticulitis. *Current Opinion in Physiology*. August 2021. Available at: <https://www.sciencedirect.com/science/article/abs/pii/S2468867321000778?via%3Dihub>. Accessed September 5, 2023.





# Video-Based Technologies in the OR Have Potential to Transform Healthcare

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VIDEO-BASED FEEDBACK is an educational and informative learning approach that offers a unique method to assign qualitative and quantitative metrics for surgeons and their teams. These metrics inform the entire operating room (OR), as well as ancillary services that function alongside the OR system.

Surgical teams worldwide are striving to develop algorithms for real-time surgical skill assessment, team performance enhancement, error prevention during surgery, and overall enhancement of patient outcomes. This last aim—improved patient care—is a vital objective, as aligning surgeons' competencies with patient

results is pivotal for ensuring healthcare excellence.

Employing objective quantitative and qualitative parameters alongside outcomes-driven data is poised to offer the most precise and dependable indicators of surgical proficiency and OR efficiency. These metrics have the potential to enhance

training, education, and practice, ultimately elevating the quality of patient care.

Video-based, peer-reviewed education—typically evaluated by human assessors and soon to be supported by artificial intelligence (AI) and augmented reality—represents the forthcoming paradigm in surgical education. Given the ongoing transition to competency-based medical education, a more systematic approach to assessment is imperative to ascertain trainees' proficiency in requisite skills and to provide constructive feedback for competence development.<sup>1</sup>

In 2023, Wong and colleagues introduced a classification system for intraoperative feedback during live surgical procedures.<sup>2</sup> Concurrently, the American Board of Surgery (ABS) conducted an examination of video-based assessment (VBA) as a supplementary tool for appraising technical skills in certification, determining it a promising adjunct to the existing board certification process and warranting further exploration by the ABS.<sup>3</sup>

Given the rapid recognition and inevitable integration of AI and VBA into surgical training, developing more reliable methods of assessing performance in surgical practice and surgical trainees is imperative. Video-based feedback in a nonpunitive approach offers a way to assign qualitative and quantitative metrics that are reproducible and educational.

This article examines 10 current methods for VBA of surgical skills in the OR and

outlines evaluation criteria for intraoperative camera devices.

### Apella.io

Founded in 2019, in San Francisco, California, Apella Technology was established with the primary objective of enhancing hospital operations, elevating surgical quality, augmenting staff training, and advancing overall surgical care.

Apella employs in-OR sensors to gather data and, in conjunction with a diverse range of AI algorithms, generates metrics that specifically target the objectives.

Apella aspires to be integrated into all types of surgical procedures, fostering a unified perspective among healthcare teams, and striving to empower surgeons, OR personnel, and administrative staff. In 2021, the startup initiated the adoption of its technology within ORs, including at institutions like Houston Methodist in Texas.

### Avail Medsystems

Avail Medsystems was founded in 2018, in Santa Clara, California. This technology aims to build a remote network from which every procedure room may have access to, and collaboration with, clinical experts.

The system—which includes both audio/visual hardware and software, with options for set-up of a console or, alternatively, installation of a remote app for iPad or laptop use—is marketed as compatible with all surgery types and allows for live procedures to be streamed, imaging to be shared, and communication between those in the OR and those remotely located.

A member portal is offered from which healthcare providers and industry experts may schedule collaborative procedures. Most recently, a partnership with Medtronic Neurovascular for a remote connectivity program was established.

### Caresyntax

Caresyntax®, as it is known currently, was originally founded in 2013 in Germany, and it expanded to the US in 2017.

This version of Caresyntax resulted from relocation and unification of the former medical technology company S-CAPTE GmbH and is a vendor-neutral platform marketed to gain insight into patient outcomes, operational efficiency, and profitability. The company's High-Fidelity Surgical Record™ works across the preoperative, intraoperative, and postoperative continuum. This includes electronic health records, hospital information systems, supply/implant data, device data, imaging and surgical video, all with anonymization and privacy controls.

Currently, general/visceral, orthopaedic, and cardiovascular surgeries are targeted, though many surgeries are compatible with the technology. The goal is to make surgery smarter and safer.

According to the company, as of 2023, approximately 2,800 ORs and 32,000 surgical teams employ this technology. The University Hospital Virgen del Rocío in Seville, Spain, streams procedures for students with the technology in real time,<sup>4</sup> while Saint Thomas Hospital in Nashville, Tennessee, was able

to mitigate the start times of delayed cases and have a 40% decrease in after-hour cases based on Caresyntax analytics.<sup>5</sup>

Similar collaborations have taken place with the University of California (UC) San Diego Medical Center and the University Hospital Dresden in Germany to improve OR efficiency and patient care. A 2023 publication showed the potential of Caresyntax to reduce costs and improve patient quality of life among colorectal surgeries.<sup>6</sup>

Caresyntax recently developed an app for surgeons, InfluenceOR™, to allow for board-certified review of individual surgeon's procedures, analyzing surgical technique and decision-making through video-based assessments to promote data-driven surgery.

### C-SATS

Crowd-Sourced Assessment of Technical Skills (C-SATS™) is a video capture platform aimed at improving surgical proficiency through performance analytics, self-learning opportunities, and peer-to-peer interactions. C-SATS was founded in 2014, at the University of Washington and was acquired by Johnson & Johnson in 2018.

The technology functions through video capture from any minimally invasive surgery (MIS) platform (agnostic) to a cloud-based HITRUST CSF®-certified private case library. The data are subjected to video-based, AI-driven actionable and objective insight. The platform also includes access to 19,000 procedure videos and an expert case series across 10+ specialties, including bariatric,

gynecology, urology, thoracic, and colorectal surgery.

The surgical library serves as a resource for reviewing diverse surgical approaches, observing procedures conducted by accredited surgeons, accessing insights and strategies for navigating challenging surgical maneuvers, and participating in a surgeon-centric community for inquiries and discourse. The community fosters mentorship opportunities, catering to both experienced surgeons pursuing ongoing refinement and feedback and trainees in remote regions

Department employed C-SATS for assessing incoming residents' surgical technique, achieving favorable inter-rater agreement with expert physician assessors.<sup>8</sup> This technology holds promise for enhancing the efficiency and applicability of expert evaluations across various surgical domains.

### OR Black Box

OR Black Box (ORBB) technology, invented by surgeon Teodor Grantcharov, MD, PhD, FACS, in 2007, aims to enhance patient surgery throughout the

**Video-based feedback in a nonpunitive approach offers a way to assign qualitative and quantitative metrics that are reproducible and educational.**

seeking guidance. Additionally, surgeons who contribute as case reviewers receive compensation for their time.

A 2022 systematic review compared crowd-sourced reviews to traditional expert reviews, revealing that C-SATS consistently delivered accurate evaluations of surgeons' technical proficiency in less time than expert evaluations.<sup>7</sup>

In 2017, UC Irvine's Urology

perioperative process. It has been implemented in various hospitals worldwide; in the US, this technology currently is being used at Stanford University in California, Duke University in Durham, North Carolina, The University of Texas Southwestern in Dallas, and Northwell Health Long Island Jewish Medical Center in New Hyde Park, New York.

ORBB records diverse data during surgery such as OR audio-

video recordings, patient vitals, and surgical instrument usage feedback, fostering transparency and a culture of accountability in the OR.

The collected surgical data are transmitted to computer servers and the ORBB server, where a blend of AI and trained analysts assess the information to identify performance patterns, OR efficiency, safety checklist adherence, and team communication trends. The data then can be used to furnish feedback to individual surgeons and support teams, enabling them to learn from errors and enhance their skills over time.

A 2022 study used ORBB to track checklist compliance, engagement, and quality.<sup>9</sup> The study identified weaknesses in checklist quality, and using the data, the hospital had solid evidence to enforce policy change and track follow-up results that showed improvement in checklist application. A prospective cohort study of laparoscopic surgeries using ORBB at the University of Toronto in Canada revealed frequent disruption and error from various sources, with auditory distractions reported a median 138 times per case.<sup>10</sup> Equipment, such as surgical instruments and laparoscopic consoles, were either absent or malfunctioning in one-third of the cases, and technical error was recorded a median of 20 times per case.<sup>10</sup> These deficiencies led to a median of eight adverse events per case.

## Orpheus Medical

Orpheus Medical, founded in 2010 by Tovi Carmon, was later acquired by Intuitive Surgical in 2020. The technology integrates with the da Vinci robotic surgical system and other video integration systems to capture, stream, and view, surgical video using a touch panel or a remote application.

The videos can be stored on the data cloud and reviewed from a mobile device or computer by the surgical team with patients postoperatively or for more accurate postoperative documentation. The platform allows for real-time collaboration, consultation, or conferencing, broadening the walls of the OR. Additionally, the video, audio, and images may be edited and annotated, demonstrating practical benefits for quality improvement and education.

## Proximie

Proximie was founded in 2016 by Nadine Hachach-Haram, MD, FACS, a consultant plastic surgeon, as a tool to allow surgeons to connect virtually to any OR, effectively widening access to surgical expertise in areas with low access.

According to Dr. Hachach-Haram, the vision of this platform is to “democratize surgery through better data by connecting every OR and Cath Lab in the world.” The platform is virtually interactive and is currently used for telesurgery and telementoring purposes. Learners can either virtually observe in real time or via

the surgical case library. Surgeons can request intraoperative remote consultations, reducing access barriers in rural settings.

The surgical case library can be used to review personal surgeries, pinpoint weak points, and obtain data-driven feedback. The collective library creates a transparent environment to compare procedures performed by different surgeons in different hospitals to reveal patterns and trends with the overall goal of reducing adverse events and driving productivity. Proximie is currently used within 500 hospitals around the world in more than 50 countries and by 16,000+ users. This technology is for all surgical specialties.

The technology works through a broadcast of four simultaneous live video feeds to multiple users, including from any medical device (imaging, cameras, navigation, fluoro, robotics, scopes, ultrasound, electrocardiogram, and any other device with a video output), as well as regular cameras (webcams, room cameras, overhead cameras, wearables, etc.).

In practical use, the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) used the platform during the COVID-19 pandemic for remote training to teach the Acquisition of Data for Outcomes and Procedure Transfer hernia program. In postcourse surveys, participants reported that the course was effective in meeting their educational goals.<sup>11</sup>

## Sony NUCLeUS

Sony NUCLeUS™ is a digital imaging platform that streamlines the collection, management, and distribution of medical video content across a hospital's network.<sup>12</sup> NUCLeUS came to the US in 2019 after a successful launch in Belgium and Sweden. It is a scalable, vendor-neutral platform that can accommodate virtually any video source, from a wide range of modality manufacturers.

The platform also can capture and record images from endoscopes, robotic-assisted surgical devices, microscopes, angiography systems, C-arms, ultrasound scanners, and more. NUCLeUS is a powerful digital imaging platform that can help hospitals improve the efficiency and effectiveness of their surgical workflows. It also can help improve patient care by providing remote access to medical video content.

NUCLeUS enables real-time surgical live streaming to remote specialists, students, and colleagues, facilitating immediate collaboration, consultation, and educational opportunities. This service enhances healthcare providers' competencies and knowledge, thereby potentially enhancing patient outcomes.

Furthermore, NUCLeUS serves as a valuable tool for the acquisition and analysis of medical video data for clinical research endeavors, contributing to the advancement of disease understanding, treatment

modalities, and the development of improved therapies.<sup>12</sup>

There is a growing body of research on the use of AI to measure OR efficiency. These programs aim to optimize various aspects of OR management, resource allocation, and workflow. However, there is currently no single AI program that can reliably measure all objective quantitative and qualitative metrics in the OR.

## Theator

Theator, an Israeli startup based in Palo Alto, California, was founded by Tamir Wolf, MD, PhD. After experiences with seeing family and coworkers undergo the same procedure—but with drastically different outcomes due to variability in surgery and clinical management—this trauma surgeon wanted to reduce variability in treatment approaches. Thus, he founded Theator, a technology currently implemented in laparoscopic and robotic surgeries.

The software uses machine learning and computer vision to structure and compare surgical video footage, connecting procedural outcomes with specific steps and events to identify successful characteristics as well as deviations from best practices. Real-time analysis generates actionable insights shared with physicians, teams, and institutions to enhance patient care and inform future procedures.

The Theator library contains 30,000+ hours of surgical

data with a billion frames, offering reliable and efficient AI-driven video review and metric analysis for skill improvement among trainees and experienced surgeons.

Theator technology has been incorporated into multiple large-scale settings, including by Tel Aviv Sourasky Medical Center (Ichilov Hospital) in Israel, the Mayo Clinic in Rochester, Minnesota, the Canadian Association of General Surgeons, McGill University in Montreal, Quebec, as well as SAGES as part of its VBA program to measure competency for the relevant procedures.

However, even with an increasing number of centers adopting this kind of technology, an article published in 2020 by researchers from Stanford University found that while AI is a promising quality assurance tool, there is still room for refinement and a need for physician oversight, especially in complex cases.<sup>13</sup>

## Touch Surgery

Touch Surgery, founded in 2013, was designed by four surgeons based in London, UK. These surgeons had the goal of taking surgery education to the next level and began conceptual development in 2010.

The way the surgeons reached their goal is twofold: the Touch Surgery Enterprise and Touch Surgery Simulations. Enterprise is marketed as an AI-powered surgical video and analytics platform to help train

and discover new techniques. Simulations is available as an iPhone and iPad app designed to help trainee surgeons.

This technology allows for AI to automatically segment videos from the OR into key procedural steps, with automatic uploads to secure cloud storage. Surgeons have the option to add annotations to these videos both during and after surgery to facilitate navigation through the library.

Proprietary technology blurs the video recording outside of the body to allow for patient and staff privacy. Actionable information can be obtained by comparing individual cases to a historical database of cases and by examining cross-departmental reports to identify variations in techniques. The repository of cases is designed to promote best practices at both the individual and higher levels, enabling feedback from peers. This technology

is applicable across various specialties and is compatible with numerous laparoscopic and surgical robotic systems.

## Benefits and Challenges of This Technology

General advantages and disadvantages of using AI in VBAs include:

### Advantages

- **Data-driven insights:** AI algorithms can analyze vast amounts of data quickly and identify patterns, trends, and inefficiencies that might not be apparent to human administrators. This data-driven approach allows for more informed decision-making.
- **Real-time monitoring:** AI programs can continuously monitor OR activities, such as surgical start and end times, staff performance, and resource utilization. This real-time

monitoring enables proactive adjustments to improve efficiency during ongoing operations.

- **Predictive analytics:** AI can predict the duration of surgeries, resource requirements, and potential bottlenecks, helping OR managers better plan and allocate resources, leading to improved workflow and reduced waiting times.
- **Automated scheduling:** AI algorithms can optimize surgery schedules, considering surgeon availability, OR utilization, patient needs, and other factors. This optimization can reduce downtime and minimize overbookings.
- **Resource allocation:** AI can assist in allocating resources, such as personnel, equipment, and materials, efficiently, ensuring that the right resources are available at the right time and place.
- **Quality improvement:** By analyzing historical data, AI can identify areas of improvement, allowing for continuous enhancement of OR operations and overall quality of care.

### Disadvantages

- **Data quality and privacy concerns:** AI heavily relies on the quality and quantity of data for accurate analysis. Incomplete or inaccurate data can lead to erroneous conclusions. Additionally, using patient data for AI analysis

AI can predict the duration of surgeries, resource requirements, and potential bottlenecks...leading to improved workflow and reduced waiting times.

raises privacy and security concerns that need to be addressed.

- High implementation costs: Implementing AI programs in an OR setting requires substantial investment in technology, hardware, software, and staff training. Smaller healthcare facilities may find it challenging to afford or integrate these solutions.
- Complex integration: Integrating AI systems into existing OR management systems can be challenging, requiring seamless compatibility and cooperation with other hospital systems.
- Human resistance: Healthcare professionals might be resistant to AI-driven changes in their working practices or be concerned about job displacement. Effective communication and training are necessary to overcome these hurdles.
- Limited AI interpretability: Some AI algorithms, such as deep learning models, can be highly complex and difficult to interpret. Understanding how AI arrives at specific recommendations or decisions can be challenging, raising concerns about transparency and accountability.
- Ethical considerations: AI algorithms need to be carefully designed to avoid biases and ensure fairness in resource allocation, scheduling, and

decision-making, especially in diverse patient populations.

It is important to note that the field of AI is rapidly evolving. Advancements in AI are occurring at a rapid pace and are likely to make AI more accessible and affordable soon. Therefore, we recommend that healthcare organizations consult with experts in the field of AI on a regular basis to stay up to date on the latest AI programs for measuring OR efficiency. **B**

### Disclaimer

The thoughts and opinions expressed in this article are solely those of the authors and do not necessarily reflect those of the ACS.

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### References

1. Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system—rationale and benefits. *N Engl J Med*. 2012;366(11):1051-1056.
2. Wong EY, Chu TN, Ma R, et al. Development of a classification system for live surgical feedback. *JAMA Network Open*. 2023;6(6):e2320702.
3. Pryor AD, Lendvay T, Jones A, et al. An American Board of Surgery pilot of video assessment of surgeon technical performance in surgery. *Ann Surg*. 2023;277(4):591-595.
4. University Hospital Virgen del Rocío-Seville, Spain. Caresyntax®. November 21, 2016. Available at: <https://caresyntax.com/news/spain-seville-university-hospital-virgen-del-rocio/>. Accessed October 3, 2023.
5. Reduce delays ITALC. Caresyntax®. Available at: <https://caresyntax.com/results/saint-thomas-health/>. Accessed October 3, 2023.
6. Moloney E, Mashayekhi A, Javanbakht M, et al. Cost-utility analysis of the Caresyntax platform to identify patients at risk of surgical site infection undergoing colorectal surgery. *Pharmacoecon Open*. 2023;7(2):285-298.
7. Giovanni TA, Alvand SJ, Crystal RD, et al. Value of the Crowd-Sourced Assessment of Technical Skills (C-SATS) platform in surgical procedures: A systematic review of evidence. *Surg Res*. 2022;4(2):1-12.
8. De Simone B, Bartelli M, Coccolini F, et al. Intraoperative surgical site infection control and prevention: A position paper and future addendum to WSES intra-abdominal infections guidelines. *World J Emerg Surg*. 2020;15(1):10.
9. Al Abbas AI, Sankaranarayanan G, Polanco PM, et al. The operating room black box: Understanding adherence to surgical checklists. *Ann Surg*. 2022;276(6):995-1001.
10. Jung JJ, Jüni P, Lebovic G, Grantcharov T. First-year analysis of the Operating Room Black Box Study. *Ann Surg*. 2020;271(1):122-127.
11. Greenberg JA, Schwarz E, Paige J, et al. At-home hands-on surgical training during COVID-19: Proof of concept using a virtual telementoring platform. *Surg Endosc*. 2021;35(5):1963-1969.
12. NUCLeUS. Sony Corporation. Available at: [https://pro.sony/ue\\_US/products/nucleus-platform/nucleus](https://pro.sony/ue_US/products/nucleus-platform/nucleus). Accessed October 3, 2023.
13. Korndorffer JRJ, Hawn MT, Spain DA, et al. Situating artificial intelligence in surgery: A focus on disease severity. *Ann Surg*. 2020;272(3):523-528.







# State Legislatures Help Advance Policies Favoring Surgical Patients

Catherine Hendricks

In 2023, state legislatures convened for the first full sessions since COVID-19. Overall, more than 104,000 state bills were introduced and 14,538 were enacted.

AS THE YEAR comes to a close, all but seven state legislatures have either adjourned or will do so at the end of the year. With a considerable number of healthcare issues under consideration, the ACS continues to lead efforts to advance policies elevating surgical practice while advocating against proposals that undermine it.

State lawmakers have significant power in shaping policies and regulations directly affecting surgeons and their practice. State legislatures often serve as the testing ground for new initiatives that may be considered at the federal level as this environment is typically more accessible and responsive. In 2023, the ACS State Affairs team reviewed 5,823 bills, monitoring and tracking 877.

This article provides a brief overview of that legislation, which includes securing funding for trauma systems, STOP THE BLEED® initiatives, insurance coverage for cancer screening and diagnostic testing, prior authorization, tort reform, and the criminalization of physician care.

### Trauma System Funding and Development

The 2023 state legislative sessions carried forward many of the trauma system legislative priorities from

the previous year, including trauma system funding and advancing STOP THE BLEED initiatives. Notable achievements include Indiana’s SB 4, which established a state trauma care commission comprising 13 members of the Indiana Committee on Trauma (COT), and HB 1001, which allocated significant funding, specifically \$3.3 million in fiscal year (FY) 2023/2024 and \$5.8 million in FY 2024/2025 for the state’s trauma system (see Figure 1, this page).

### STOP THE BLEED

In 2023, progress was made in promoting STOP THE BLEED initiatives across the US. A total of 20 bills were introduced, and five states enacted legislation to ensure the availability of STOP THE BLEED kits and training, with more states considering similar measures (see Figures 2 and 3, page 26–27).

California ran a bill, AB 71, which amends existing law requiring the State Department of Education to make available on its website a list of resources and instructional materials on bleeding control, including training material developed by STOP THE BLEED for school districts. At the time this article was published, this bill was on Governor Gavin Newsom’s desk awaiting his signature.

**Figure 1. Notable Achievements from Indiana**

#### Indiana SB 4—Trauma Systems

- Established a State Trauma Care Commission
- Established commission comprised of 13 members with one member from the IN COT
- Received recommendation from the Governor’s Public Health Care Commission
- Testified in the Senate: Erik Streib, MD, FACS, and David Welsh, MD, FACS
- Appointed Brad Barrett, MD, FACS, as chair of the House Public Health Committee
- Received little opposition in both chambers
- Signed by Governor on May 4, 2023

#### Indiana HB 1001—State Budget

- Will allocate \$3.3M in FY 23/24 and \$5.8M in FY 24/25 for state’s trauma system
- Will provide funding for SB 4
- Passed in the House but failed in the Senate
- Submitted to an ad hoc conference committee to reconcile differences
- Submitted a letter and used SurgeonsVoice to send out action alerts (ACS)
- Had only 9 days to mobilize
- Restored trauma system funding
- Signed by Governor on May 4, 2023

## Efforts to remove barriers to cancer care gained momentum in 2023, with a focus on eliminating cost-sharing for cancer screenings and exploring the role of biomarkers.

Three states passed resolutions memorializing STOP THE BLEED month in May: Delaware, Michigan, and New York. The ACS is developing a toolkit with sample proclamation language and step-by-step instructions on how to request a proclamation from each state's legislature.

### Cancer Prevention, Screening, and Testing

Efforts to remove barriers to cancer care gained momentum in 2023, with a focus on eliminating cost-sharing for cancer screenings and exploring the role of biomarkers. The ACS closely tracked, monitored, and actively advocated for cancer-related bills, resulting in the passage of 12 bills aimed at enhancing cancer prevention and screening.

### Prior Authorization and Utilization Review

Addressing insurance and administrative burdens remains a top priority. According to an American Medical Association (AMA) survey, prior authorization leads to delayed and abandoned care. The average physician practice completes 45 prior authorizations per physician per week, and doctors and their staff spend nearly 2 business days a week completing such authorizations.\*

The ACS is working with the AMA and other national medical organizations to manage issues like prior authorization and utilization review. In the 2023 legislative session, the ACS tracked 95 bills in 30 states. These efforts sought to reform prior authorization processes, ensuring quicker responses and increased transparency. Twelve states

successfully enacted legislation: Arkansas, Arizona, Colorado, Indiana, Maryland, Montana, North Dakota, Rhode Island, Texas, Virginia, Washington, and West Virginia.

The ACS is advocating for prior authorization reforms, including:

- Establishing quick response times (24 hours for urgent, 48 hours for nonurgent care)
- Allowing adverse determinations only by a physician licensed in the state and of the same specialty that typically manages the patient's condition
- Prohibiting retroactive denials if care is preauthorized
- Making authorization valid for at least 1 year, regardless of dose changes; and for those with chronic conditions, the prior authorization should be valid for the length of treatment
- Requiring public release of the insurers' prior authorization data by drug and service as it relates to approvals, denials, appeals, wait times, and more
- Requiring a new health plan to honor the patient's prior authorization for at least 90 days
- Reducing volume through the use of solutions such as prior authorization exemptions or gold-carding programs

### Tort Reform

Tort reform efforts continued in states such as New York, aiming to strike a balance between patient rights and professional liability concerns. The ACS, in collaboration with state chapters and other national medical associations, engaged in advocacy to address concerns related to tort reform legislation.

Earlier this year, New York Governor Kathy Hochul vetoed a bill that would have greatly expanded damages awarded in wrongful death action. Estimates demonstrated a substantial 40% increase in physician's professional liability insurance.

A new version of the bill was introduced during the same session and was passed by the legislature, which unfortunately didn't address any of the concerns raised by the New York ACS Chapter, the ACS, and the Medical Society of the State of New York (MSSNY), and the bill is awaiting action by the governor. The ACS is working with the state chapter and MSSNY to create talking points, fact sheets, and email action alerts asking the governor not to sign the bill.

## Criminalization of Physician Care

The sensitive issue of the criminalization of physician care, which refers to any situation in which physicians can be fined, face licensure discipline or revocation, or in some cases arrested for providing healthcare or referring a patient to healthcare services in the state or out of state continues to be an issue the ACS actively monitors.

During the June 2023 AMA Annual Meeting, delegates discussed a resolution introduced by the American Society of Addiction Medicine (ASAM) calling on the AMA to study the rapidly changing environment in which the practice of medicine has been criminalized.

Stuart Gitlow, MD, MPH, MBA, the ASAM delegate, noted that the Controlled Substances Act requires physicians to prescribe controlled substances for legitimate medical purposes, but that the US Department of Justice views guideline departures—such as off-label prescribing—as not acting in the usual course of professional practice and, therefore, subject to indictment. As a result, he said that several prominent colleagues in several states have been raided, are under indictment, or are in prison.<sup>†</sup>

When US District Judge Robert L. Hinkle blocked a law banning the use of puberty blockers and hormone therapy to treat children diagnosed with gender dysphoria, the Florida Board of Medicine and the Florida Board of Osteopathic Medicine created new informed consent forms for transgender patients seeking gender-affirming care. Adults, children, and parents of kids who receive puberty blockers or hormone therapy must sign the forms. Doctors who violate the law face license revocation and felony charges.

## Supporting State Chapters

ACS chapters are instrumental in shaping state healthcare legislation. In September, the State Affairs Workgroup was established, comprised of four prominent, advocacy-focused surgeons—Arnold Baskies, MD, FACS (NJ), Ali Kasraeian, MD, FACS (FL), Kevin Koo, MD, MPH, MPhil (MN), and Kelly Swords, MD, FACS (CA). This workgroup will play a critical role in identifying advocacy priorities, setting new policy objectives, and evaluating ACS state advocacy grant applications.

These grants can be used to support ACS chapters' annual state advocacy days and other lobbying efforts

## Figure 2. STOP THE BLEED Legislation Passed in 2023

### New Hampshire SB 204

STB kits will be placed in all state-owned buildings, including rest areas, liquor stores, and DMVs.

### Indiana HB 1063

Each school corporation and charter school will develop and implement an STB program.

### Illinois HB 1561

Schools may provide a trauma kit, and all personnel must be trained every 2 years.

### Colorado HB 23-1213

STB kits and training materials will be distributed to schools that opt into the program.

### Florida HB 1537

\$1M (nonrecurring) will be appropriated to the Department of Education to distribute STB kits.

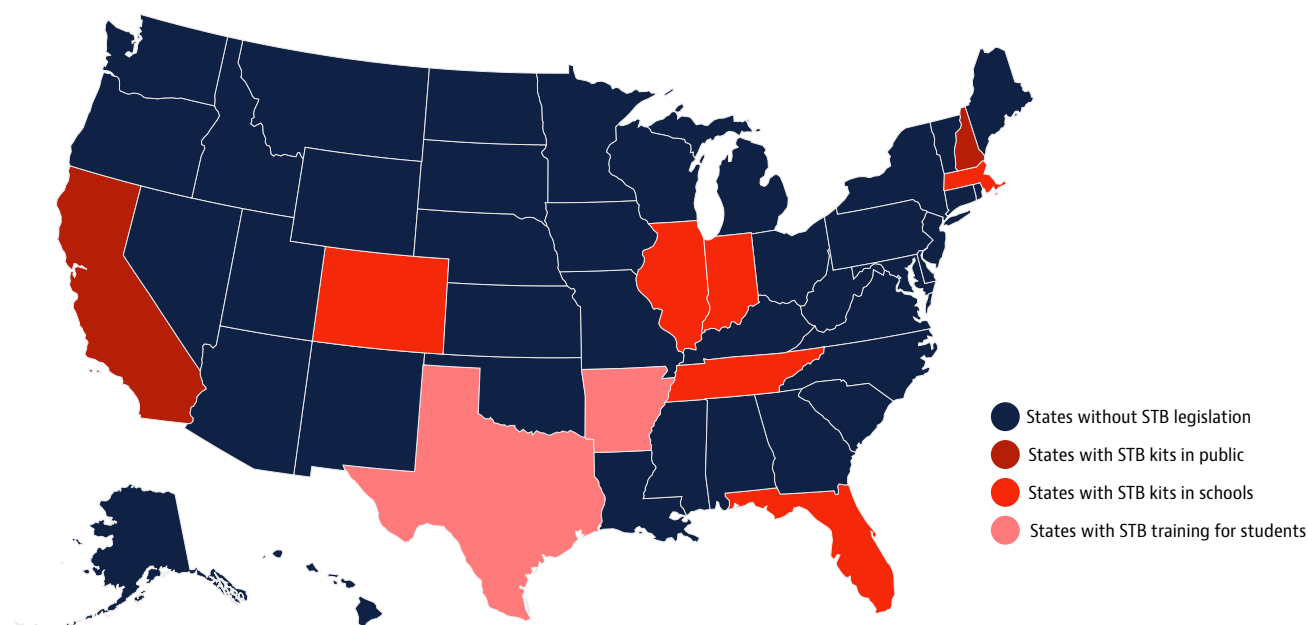
### California AB 70

Trauma kits will be required in certain structures constructed prior to January 1, 2023.

### Utah HB 61

Schools may purchase trauma kits through a special grant program.

**Figure 3. 10 States Have Passed STOP THE BLEED Legislation**



and can help cover costs such as member travel, catering, venue rentals, and printing. Many states took advantage of this grant program in 2023, boosting interest and attendance at their advocacy day events.

The following 2023 meetings provided opportunities to advocate for meaningful change in healthcare legislation:

- AMA State Advocacy Summit
- Indiana State Advocacy Day
- Texas State Advocacy Day
- Florida STOP THE BLEED Training at the Capitol
- Annual COT Symposium
- Oregon State Advocacy Day
- ACS Leadership and Advocacy Summit
- California State Advocacy Day
- Ohio State Advocacy Day
- Wisconsin State Advocacy Day
- AMA State Advocacy Roundtable
- National Conference of State Legislatures Legislative Summit
- Massachusetts STOP THE BLEED Day at the Capitol

To help increase the impact of state advocacy days, the ACS is working on updating its State Advocacy Day Toolkit, which will be accessible

at [facs.org/AdvocacyToolkit](https://facs.org/AdvocacyToolkit). The Toolkit will include detailed information on working with state legislators, choosing state legislative priority issues, determining the basic structure for the day's schedule, recruiting participants, building educational materials, and preparing for legislative appointments.

Additional state advocacy resources are available at [facs.org/advocacy/state-legislation](https://facs.org/advocacy/state-legislation). In addition, the ACS State Affairs team is available to answer questions and provide background information regarding state issues and policy programs. For more information on how you can get involved in state advocacy efforts, contact Catherine Hendricks at [chendricks@facs.org](mailto:chendricks@facs.org). 

**Catherine Hendricks** is the State Affairs Manager in the ACS Division of Advocacy and Health Policy in Washington, DC.

\*American Medical Association. 2022 AMA prior authorization (PA) physician survey. Available at: <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>. Accessed October 16, 2023.

†Frieden J. States must stop criminalizing medicine, AMA Delegates say. *MedPage Today*. June 11, 2023. Available at: <https://www.medpagetoday.com/meetingcoverage/ama/104948>. Accessed October 16, 2023.

# Ohio Oration Presents Powerful Message about the Value of Chapter Membership

Michael D. Sarap, MD, FACS

The ACS Ohio Chapter has an annual tradition, the Ohio Oration, which is part of its annual meeting. Chapter leaders invite an Ohio Chapter member, or ACS Fellow with Ohio ties, to deliver an address on a topic of his or her choosing. Michael D. Sarap, MD, FACS, presented the Ohio Oration in May with ACS Immediate Past-President E. Christopher Ellison, MD, FACS, in attendance.

Following is an abbreviated version of the presentation, *The Ohio Chapter: Surgical Collegiality in Ohio*, from Dr. Sarap.

I WOULD LIKE to thank Chapter President Amy A. McDonald, MD, FACS, a critical care specialist at MetroHealth in Cleveland, and the members of the Executive Council of the ACS Ohio Chapter for this extraordinary opportunity to present the Ohio Oration.

The invitation invoked a flood of emotions, including disbelief, excitement, and then panic about whether I was in possession of anything important or worthy enough to present to this esteemed group of individuals. Once the initial shock subsided, I felt tremendous gratitude toward my Ohio surgical colleagues. I am, and will forever be, incredibly humbled and honored by this invitation.

I finished my surgical training in 1987 and accepted a position in the small town of Cambridge—happy to be back in my home state of Ohio. In 1989, I was introduced to a concept that I termed “statewide surgical collegiality” in the form of the Ohio Chapter. I had been appointed as the Cancer Liaison Physician for my hospital, dutifully attended the state ACS Commission on Cancer (CoC) meeting, and stayed for the Ohio Chapter meeting. I had not yet met many surgeons outside of my small community and, as a newcomer, honestly felt a little intimidated.

As the first day’s session ended, I was approached by a lively bunch of seasoned Ohio Chapter members and literally “kidnapped” to join them for dinner. They immediately sunk their hooks in deeply, and I have been a committed member ever since.

Over these many years I have experienced and realized the real value of membership, and more importantly, involvement in the Ohio Chapter. More than 10 years ago, I wrote a column for the ACS *Bulletin* about the value of chapter membership. I

have an even greater appreciation for the chapter and its members since I penned that piece.

Individual member surgeons have the opportunity to meet, interact, and become friends with colleagues all over the state and from every type of specialty and practice situation. We share knowledge, experiences, and ideas, while building long-lasting, mutually respectful relationships that break down any perceived differences between community and academic or rural, and urban or general, and specialty surgeons.

One benefit of chapter membership is a statewide personal support system assuring that there is always another surgeon on the other end of a phone call or text, ready and willing to assist a colleague in need. I feel so fortunate to have incredible colleagues in every corner of this state and in every specialty on speed dial willing to listen and lend advice or take a critically ill or clinically challenging patient.

The collegiality of the Ohio Chapter benefits our individual patients as well. I refer several patients every month to my colleagues in academic settings that can offer my patients procedures and expertise not available locally. Often these referrals are expedited by a single phone call or even a text between surgeons. The patients also are comforted by the knowledge that I personally know the surgeon they are going to see in the “big city.”

Frequently, I will present cases to my tertiary colleagues and am reassured that they can be cared



Dr. Michael Sarap



Drs. Christopher Ellison, Amy McDonald, Alisha Reiss, and Michael Sarap attended the ACS Ohio Chapter annual meeting in May 2023.

for locally, avoiding a trip out of town. Patients truly appreciate and understand the value of these types of interactions between colleagues. Academic surgeons also reap the benefits of chapter involvement in the form of additional referrals from community colleagues.

Statewide surgical collegiality also benefits residents and students in the form of opportunities and collaborations for unique rotations and personalized recommendations. Randy J. Woods, MD, chair of the training program at Wright State University in Dayton, Ohio, and I chatted at a chapter meeting years ago about the potential value of sending some of his residents for a rotation at my rural facility to help crystallize their interest in rural surgery. We just published a paper summarizing the benefits of such a collaboration.

A number of years ago my small group found ourselves down a partner, leaving just two of us to cover the community, and we were desperate for help with call coverage. David M. Hasl, MD, FACS, a chapter colleague, stepped up, and his group helped us with call coverage.

The population of the entire state of Ohio unknowingly benefits mightily from the presence of the Ohio Chapter and its members. Through my CoC activities, I have been assisting a group in another Midwestern state working on a project to increase the number of small- and medium-sized

facilities working to become CoC-accredited. Unlike Ohio, a majority of patients in their state with breast, colon, and lung cancers are not treated in accredited cancer facilities. In unaccredited facilities, patients might not benefit from care based on national guidelines.

During a Zoom meeting, I was asked why Ohio has so many CoC-accredited facilities. Ohio has 73 accredited facilities and is third, behind only California and Texas, in the number of accredited cancer programs. I thought about their question and had no answer. I took the question to Dr. Ellison, William C. Sternfeld, MD, FACS, Michael E. Stark, MD, FACS, and others who have been involved in cancer care in Ohio for decades.

Every answer led back to the strong leadership of members of the Ohio Chapter from all the major academic centers that championed the cause for high-quality cancer care in every community in Ohio. Residents trained by these champions then went on to work in smaller Ohio hospitals and became cancer care champions in their own facilities.

The same goes for trauma care and the influence of the Ohio Committee on Trauma (COT). Ohio has 54 verified trauma centers, including 28 Level III centers. The last I checked, that is one of the highest numbers of community trauma centers in the country.



## The Ohio Chapter, because of its inclusiveness and respect for all members...truly facilitated and championed my opportunity to be a national spokesperson on the subject of rural surgery.

In the 1980s and 1990s, Ohio COT Chair Jay Johannigman, MD, FACS, and others were true champions for encouraging smaller facilities in Ohio to raise their level of trauma care and become verified. Dr. Johannigman was instrumental in the process at my own facility. None of this happens without academic and community surgeons building trust and mutual respect while breaking bread or sharing experiences over a cocktail at an Ohio Chapter meeting.

As a young surgeon, during my introduction to the Ohio Chapter, I was impressed and encouraged to see the extensive involvement of women surgeons in the chapter, including women like our current President Dr. McDonald and President-Elect Alisha D. Reiss, MD, FACS.

While many state chapters may have been just an extension of the “old boys’ network” that existed in many surgical organizations, the Ohio Chapter has always had women surgeons at the forefront of our leadership and our activities and initiatives.

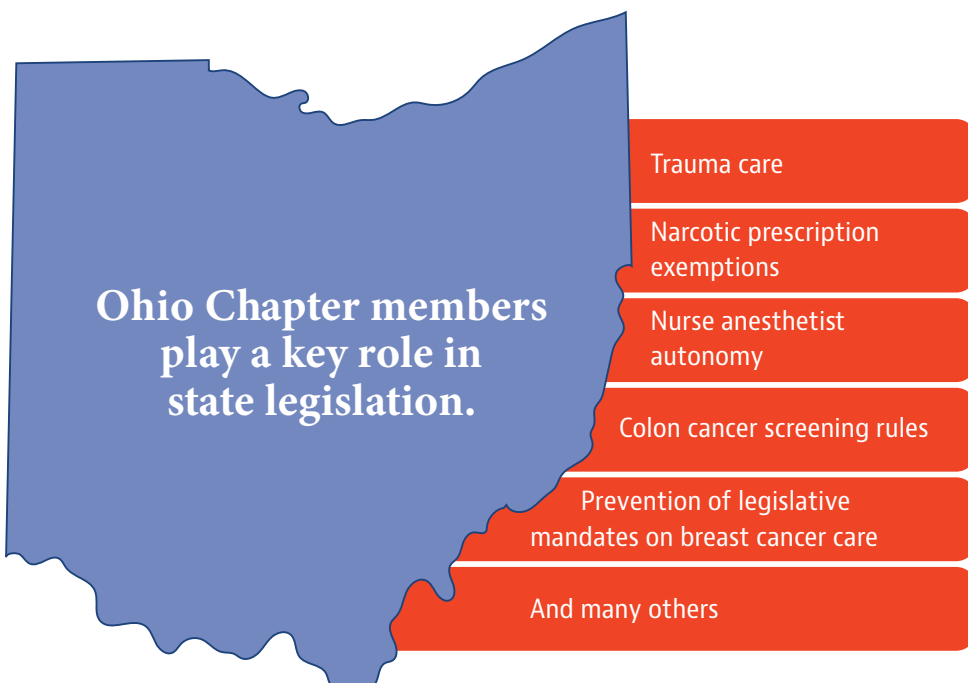
Ohio has a rich heritage of women in surgical leadership positions. Olga Jonasson, MD, FACS, was the first woman chair of an academic department at The Ohio State University in Columbus, and the first female Regent of the College. The Ohio Chapter touts many other female academic and College leaders, including Mary C. McCarthy, MD, FACS, Margaret M. Dunn, MD,

MBA, FACS, and Nancy L. Gantt, MD, FACS.

I was fortunate to have ACS First Vice-President-Elect Carol E. H. Scott-Conner, MD, PhD, MBA, FACS, as a mentor at my training program before she was appointed the chair of the Department of Surgery at the University of Iowa Carver College of Medicine in Iowa City, and I still consider her a close friend. My work on the ACS Advisory Council for Rural Surgery opened doors to close friendships with influential woman leaders like Sharmila Dissanaiké, MD, FACS, Karen Deveney, MD, FACS, Amy L. Halverson, MD, FACS, and current ACS Executive Director and CEO Patricia L. Turner, MD, MBA, FACS.

The Ohio Chapter, because of its inclusiveness and respect for all members—even those with little power or influence from tiny rural communities—truly facilitated and championed my opportunity to be a national spokesperson on the subject of rural surgery.

The Ohio Chapter offers membership status to all Ohio surgeons but the next step for each Fellow is to actually participate. Volunteerism and service make the world a much better place. Ohio Chapter members have played key advocacy roles in legislation on state trauma care, narcotic prescription exemptions for surgical and palliative care patients, prevention of legislative mandates on breast cancer care, colon cancer screening rules, nurse anesthetist autonomy, and many others. Frequently, our chapter



## Ohio Chapter members play a key role in state legislation.

Trauma care

Narcotic prescription exemptions

Nurse anesthetist autonomy

Colon cancer screening rules

Prevention of legislative mandates on breast cancer care

And many others

leaders have had to change their clinical schedules on very short notice to run to the statehouse to testify when important matters arise. These are all examples of service above self.

Accepting even a small role in state chapter leadership as a young surgeon can eventually lead to a position as ACS Governor, which opens doors to opportunities at the College on a national level. The Ohio Chapter serves as an incredible incubator for ACS leadership positions at the highest level, due to the tradition of service of its members. Whenever there are breakout sessions for governors or cancer liaison physicians at national meetings, the Ohio crowd always takes up two tables and is one of the most boisterous and productive of the gathering.

Many of our Ohio Chapter members have been committee chairs, members of the executive council, Advisory Council Chairs, ACS Officers, and ACS Regents. Mark A. Malangoni, MD, FACS, received the 2022 ACS Distinguished Service Award—the highest honor bestowed by the College for his long-term service. Michael J. Sutherland, MD, FACS, is now the ACS Director of Member Services, and we are all very proud of Dr. Ellison, 2022–2023 ACS President. These members are only a small fraction of Ohio Chapter members who have held national positions at the College, and I apologize for the many not included.

The smallest act of service can lead to amazing opportunities. As a new Governor, I volunteered to participate in a medical student career roundtable. This event occurs at the end of the medical student program. They break out beer and wine and set up tables for almost every surgical specialty.

The students engage, speed-date style, every 20 or 30 minutes with gray-haired surgeons who talk about their specialties and answer questions. I happened to be at the rural surgery table with a small-town surgeon from Kansas named Tyler G. Hughes, MD, FACS, who also was volunteering his time.

We struck up a conversation that resulted in a wonderful and enduring friendship, and it led to a membership position on the very first Advisory Council for Rural Surgery. I served two terms as Chair of the Advisory Council for Rural Surgery, and in that role, I was invited to represent rural surgeons at surgical conferences in multiple states, Canada, and Australia. The simplest acts of volunteerism provide a valuable service and can open doors to amazing opportunities.

I will forever be proud and honored to be a part of this organization. Ohio Chapter members epitomize the ACS motto “To Heal All with Skill and Trust.” Thank you all for the opportunity to address the Ohio Chapter of the American College of Surgeons. **B**

**Dr. Michael Sarap** is a senior surgeon with Southeastern Ohio Physicians, Inc., in Cambridge. He is the Co-Chair of the ACS Commission on Cancer Program in Ohio and has previously served as an ACS Governor, Chair of the ACS Advisory Council for Rural Surgery, and President of the ACS Ohio Chapter.

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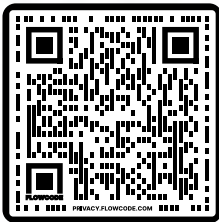
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# ACS DEI Toolkit and Lexicon

Provide Blueprint  
for Implementing  
Equitable Practices

Tony Peregrin

**The ongoing development of the ACS Diversity, Equity, and Inclusion (DEI) Toolkit supports the College’s commitment to uphold the highest standards of inclusion and equity and—when completed—will feature 40+ chapters written by 87 surgeons from 25 aligned committees, workgroups, and stakeholder organizations (see table, page 36).**

“ACS EXECUTIVE DIRECTOR and CEO Patricia L. Turner, MD, MBA, FACS, emphasized that all of these aligned organizations be included in this project,” said Bonnie Simpson Mason, MD, Medical Director of the ACS Office of DEI. “We understand that because of the challenging nature of the content for those who are working in the DEI space, it is important to align messaging and leverage the collective experiences in presenting best practices, such that through shared work, peer mentoring, and collaboration, the House of Surgery could benefit.”


Formally titled the ACS DEI and Antiracism Resource and Implementation Lexicon and Toolkit, this resource is offered in a digital, interactive format with chapters covering key DEI-related topics, including the role of surgical societies in promoting inclusivity, diversifying committee membership, strategies for implementation, and a

Lexicon of language and terms that are relevant to DEI topics in the surgical sphere.<sup>1</sup>

The ACS DEI Toolkit, beta launched in June 2023, features a case-based approach with real-world scenarios that are intended to clarify nuanced aspects of DEI work, with content that is applicable to the individual provider, private practice surgeon, institution, or healthcare system.

The ACS Office of DEI—led by Dr. Mason and Administrative Director Cie Armstead, DBA—partnered with the ACS Board of Governors Diversity Pillar to develop this expanded version of the Toolkit. It will be available to all ACS members, and exploration is underway to offer Continuing Medical Education credits in 2024 to physicians who use Toolkit elements.

“The Toolkit is intended to be a comprehensive resource for our learners, including students and residents in surgery, and for Fellows of the College,



## Organizations that Contributed to the ACS DEI Toolkit

American College of Surgeons

American Association for the Surgery of Trauma

American Board of Surgery

American Surgical Association

Association of Out Surgeons and Allies

Association of Program Directors in Surgery

Association of Surgical Education

Association of Women Surgeons

Eastern Association for the Surgery of Trauma

Latino Surgical Society

Society for Surgical Chairs

Society of Asian Academic Surgeons

Society of Black Academic Surgeons

University of Michigan Health



particularly for leaders in surgery, such as vice-chairs of DEI and other faculty or community surgeons that are primarily responsible for making the decisions to move any equity strategy forward,” explained Dr. Mason.

According to Susan Pories, MD, FACS, and Valentine Nfonsam, MD, FACS, two of the lead editors of the Toolkit, and the authors of its introduction, this resource is intended to “serve as a collection of authoritative and adaptable resources for surgeons to not only learn about DEI, but also to identify practical approaches for addressing issues that arise locally, regionally, and nationally.”<sup>1</sup>

The Toolkit and Lexicon were also developed for use by ACS staff members. “These resources were designed as part of a larger strategy to enhance ACS culture through the work of the ACS DEI Racial Equality, Diversity, and Inclusion program,” said Armstead. “These tools will be used in multiple ways to support all staff in exemplifying ACS values in the workplace.”

A primary aim of this content is to help align staff commitment to the principles of DEI with that of the College’s membership, ultimately fulfilling the ACS’s mission “To Heal All with Skill and Trust.”

The core content of each chapter is organized into four sections: Why (describing the rationale for including a topic); What (outlining research and perspectives); How (identifying strategies and tools for

improvement); and Next Steps (determining future action items toward implementation). Most chapters also feature a list of references or a bibliography of cited sources.

## Lexicon

The ACS Office of DEI started the process of developing the Lexicon by first reviewing associated terminology and usage in healthcare, specifically in surgical settings, but also within association management and other relevant domains.<sup>2</sup>

“We, along with the numerous surgeon volunteers, took an extended amount of time collecting, developing, and reviewing the Lexicon,” Dr. Mason said. “We see the Lexicon as the first step to building a knowledge base and a DEI skillset that will help create safe and equitable clinical, surgical, and learning environments for our surgeons and staff.”

The Lexicon is available to everyone, including surgeon members, staff, and members of the general public, and is intended to help individuals communicate in a manner that recognizes and respects diversity in all of its forms.

“If you think about any given profession, there’s a lexicon of terms that are commonly used that serve as connectors for anyone who’s engaging in that space,” said Armstead. “And when you consider the work of DEI and antiracism, it’s even more important to have an agreed upon terminology and an understanding of what those words mean.”

The Lexicon’s composition is intended to facilitate efficient use of its content. Related terms are grouped together; for example, the term “bias” includes references to “implicit bias” and “unconscious bias.” According to the Lexicon’s introduction, this resource is “not designed as an exhaustive encyclopedia of all DEI-related terms. Only terms that are the most germane to DEI in the College and the House of Surgery are included.”<sup>2</sup>

Historical, social, or cultural context for select terms is provided to offer insights that extend beyond the standard definition and to enhance appropriate use of words or phrases.

Both Dr. Mason and Armstead described the Lexicon as a dynamic resource that will be updated as needed, and they encourage participants to avoid

## The ACS has a long-established commitment to the principles of DEI, particularly in the past couple of decades.

using it as a definitive guide for determining correct (or incorrect) wording.

“It is critically important, for those of us in the DEI space, both on the staff side and member side, to have an understanding of how the College is using certain terms and phrases,” explained Armstead. “Because, quite honestly, in society right now, there’s a lot of misinformation and conflicting interpretation regarding DEI terminology. Hopefully, the Lexicon provides a level of clarification that provides a common ground for us to move this work forward.”

### The College’s Role in Supporting DEI

The ACS has a long-established commitment to the principles of DEI, particularly in the past couple of decades. In 2001, the ACS Board of Regents published its first Statement on Diversity, which was updated in 2018.<sup>3</sup>

On June 9, 2020, the ACS Committee on Ethics and the Board of Regents issued a call to action describing racism as a “public health crisis resulting in healthcare inequities” and requesting that “all members of the organization to treat all patients, regardless of race, ethnicity, religion, or sexual preference with compassion, skill, and fidelity.”<sup>4</sup>

Later that same year, the ACS Board of Regents appointed a Task Force on Racial Issues, which issued its recommendations in November 2020—including the formation of the Office of Diversity, Equity, and Inclusion, which was launched in August 2021.

In June 2021, the idea to develop what would eventually become the ACS DEI and Antiracism Resource and Implementation Toolkit was conceived as a result of the Promoting DEI and Antiracism: Professional Surgical Society Retreat. Members from 54 organizations, 13 ACS Advisory Council Chairs, and 17 surgical board leaders, Regents, Officers, and ACS executive leadership participated in the virtual meeting.<sup>5</sup>

Today, the College’s role in supporting DEI initiatives continues with the ongoing development of the ACS Toolkit, and with the establishment of the innovative grant program, which awarded \$325,000 in grants in December 2021, and \$50,000 in sustainability grants in 2023. Additionally, the new ACS Equity in Quality Initiative will work in tandem with the ACS Office of DEI and the Division of Research and Optimal Patient Care to determine how equity can be integrated into the ACS Quality Programs.

“We are building all of our DEI-related efforts on a foundation of education and evidence such that our surgeons can more confidently communicate their efforts in DEI for the benefit of all surgery patients,” Dr. Mason said. **B**

**Tony Peregrin** is the Managing Editor of *Special Projects in the ACS Division of Integrated Communications in Chicago, IL.*

### References

1. Pories S, Nfonsam V. Introduction to ACS DEI Resource and Implementation Toolkit. American College of Surgeons. ACS Office of DEI. 2023. Available at: <https://learning.facs.org/content/introduction-acs-dei-resource-and-implementation-toolkit>. Accessed August 4, 2023.
2. American College of Surgeons. ACS Office of DEI. Introduction to the ACS DEI and Antiracism Lexicon. 2023. Available at: <https://learning.facs.org/content/introduction-acs-dei-and-antiracism-lexicon>. Accessed August 4, 2023.
3. American College of Surgeons Commitment to Diversity, Equity, and Inclusion. Available at: <https://www.facs.org/about-acs/diversity-equity-and-inclusion/commitment-to-diversity-equity-and-inclusion>. Accessed August 4, 2023.
4. Hoyt DB. Looking forward. July 2020. *Bull Am Coll Surg*. Available at: <https://bulletin.facs.org/2020/07/looking-forward-july-2020>. Accessed August 4, 2023.
5. American College of Surgeons. ACS hosts the Promoting DEI & Anti-Racism Professional Surgical Society Retreat. August 2021. *Bull Am Coll Surg*. Available at: <https://bulletin.facs.org/2021/08/acs-hosts-the-promoting-dei-anti-racism-professional-surgical-society-retreat>. Accessed August 4, 2023.



Drs. Shankar Raman (left) and Tracy Hull

# Surgeons Can Champion Participation in ACS CoC Initiatives

Shankar Raman, MD, MBA, FACS, FASCRS

Tracy Hull, MD, FACS, FASCRS



## The ACS is dedicated to improving patient care and supports numerous programs that promote quality care.

MANY OF THESE programs have standards for accreditation along with guidelines that must be met for a center to be designated by the ACS. Given the vast experience accrued by the ACS over multiple decades of setting standards and verifying individual hospital programs across the country, as well as the continued changes to managing disease processes, the standards are edited and streamlined as needed.

The standards follow a similar theme across the spectrum, starting with institutional administrative commitment, program scope, and governance, and then moving onto resources (i.e., facilities, equipment, personnel, services), followed by patient care standards and data surveillance. Standards pertaining to quality improvement (QI), education, and research complete the spectrum.

While there may be variations depending on the individual

verification programs, the approach is similar—to make it easy for hospitals, administrators, physicians, quality personnel, site reviewers, ACS staff, and others to be on the same proverbial page in terms of how this information is developed and presented.

Such homogeneity within the standards eliminates confusion and elucidates what is expected of these programs when a site review is conducted. It is duly important to point out that institutional administrative commitment is at the beginning of each of the standards manuals. Without support from the leaders at the top of the institution, it is widely recognized that none of the Quality Programs will succeed.

### **QI Project Promotes Smoking Assessment in Cancer Treatment**

Among the most recent initiatives from the ACS Cancer Programs are Just ASK and

Beyond ASK. The Just ASK initiative was an elective QI project open to all Commission on Cancer (CoC)- and National Accreditation Program for Breast Centers (NAPBC)-accredited programs, using existing resources to address smoking in newly diagnosed cancer patients.<sup>1</sup>

Essentially, the project focused on asking all newly diagnosed cancer patients about their smoking status, with the aim of integrating smoking assessment as part of treatment for cancer patients. For the purpose of the Just ASK QI initiative, use of combustible cigarettes and other smoked tobacco products, such as cigars and pipes, were included whereas e-cigarettes and smokeless tobacco were excluded. Participation in the Just ASK initiative and completion of the clinical research study fulfilled CoC or NAPBC standards. Programs that had applied for CoC or NAPBC accreditation also were able to participate in this initiative.<sup>2</sup>

The Beyond ASK program is a year-long QI initiative that is focused on advising and assisting newly diagnosed cancer patients on smoking cessation.<sup>3</sup> The project aims to offer cessation assistance to newly diagnosed patients who report combustible tobacco use.

Through this project, surgeons advise patients on the harmful effects of smoking and how that impacts cancer treatment as well as how smoking cessation can improve survival. Other components of the initiative are assisting patients with quitting smoking by counseling and medication and referring and/or connecting patients with institutional or community-based resources and smoking cessation quit lines.<sup>3</sup> Participation in this initiative also helps programs meet CoC or NAPBC standards.

### **Benefits of Participating in CoC Accreditation Programs**

The following are the reasons why institutions should consider participating in CoC accreditation programs and quality initiatives:

- Accreditation ensures that programs have the resources, structure, and processes in place to deliver high-quality, patient-centered cancer care.
- Participation in accreditation programs promotes best practices for delivering evidence-based, high-quality care.
- The accreditation standards decrease variation in care by streamlining and standardizing the patient care pathway, which also is likely to decrease

inequities in cancer care delivery.

- Participation in accreditation programs requires use of the cancer registry whereby programs can track their own outcomes and identify opportunities for improvement.
- Accreditation also provides programs working on QI initiatives with the framework and resources needed for driving these improvements.
- Accredited institutions have achieved the public seal of trust, having demonstrated their commitment to quality.

While not a reality yet, a goal of accreditation is to help secure reimbursement from regulators, funders, and payers.

**Surgeons have a powerful voice in achieving buy-in and support from administrators and other leaders for accreditation and quality initiatives related to cancer care.**



Ultimately, accreditation programs aim to provide value to patients and healthcare institutions.

Surgeons have a powerful voice in achieving buy-in and support from administrators and other leaders for accreditation and other quality initiatives related to cancer care. The following may help initiate the conversation:

**Share powerful stories.**

A negative experience in a patient's cancer journey can be a strong motivator for changing the status quo and starting the process for accreditation. For programs that have achieved accreditation, sharing patient testimonies that attest to a positive experience and

outcomes helps with garnering ongoing support.

**Focus on how achieving accreditation could provide a competitive business advantage in heavily competitive markets.**

Institutions should focus on high-quality cancer care as a differentiator. We recommend working with business analysts to forecast an increase in volume that could justify upfront investment.

**Present institutional cancer data periodically to the medical staff executive council, quality and safety committee, as well as to the governing board.**

These data will help identify

opportunities for improvement and obtain institutional support and commitment for resources to improve outcomes.

**Explore how other opportunities might be available to engage in QI efforts.**

For example, the Just ASK and Beyond ASK initiatives were focused on smoking. In most matrixed environments, such QI efforts might gain traction with institutional areas that are focused on population health. Ultimately, these QI efforts are aimed at improving the health of the population, as the transition to value-based care and capitation models become stronger. Such population health

# Surgeons have always been at the forefront of innovation and quality in healthcare.

services organizations might be willing to invest in resources that support cancer center QI initiatives.

**Recognize that collaboration is vital for success and that administrative support and commitment toward QI initiatives may not happen after a few meetings.**

In reality, it takes multiple attempts for such initiatives to become a priority. Ensuring that the goals and priorities of the cancer clinicians are aligned prevents conflict among competing priorities.

**Celebrate every win with your team, including administrative leaders.**

With the current healthcare environment, there has been a significant turnover in the C-suite. Recognizing every win for cancer care staff mitigates the possibility of burnout among clinicians and nonclinicians.

Participating in CoC accreditation programs shows a commitment by the centers to delivering high-quality care. Achieving CoC accreditation is a strong and independent predictor of high hospital performance for quality measures relevant to breast and colon cancer. Studies have demonstrated improved performance in CoC-accredited

hospitals when compared to nonaccredited hospitals.<sup>4,5</sup> As the standards and initiatives are evidence based, accreditation ensures that programs have implemented processes that are aligned with clinical research.

Surgeons have always been at the forefront of innovation and quality in healthcare. In addition, surgeons are strong patient advocates, ensuring that healthcare is patient-centered. These clinicians bring a strong leadership presence and are uniquely positioned to effect change in the institutions and communities they are fortunate to serve. Therefore, it is only natural that surgeons lead their institutions to participate in CoC initiatives, including new accreditation programs

and QI efforts. Our “why” for participation in such efforts has never been stronger. **B**

## Disclaimer

The thoughts and opinions expressed in this viewpoint article are solely those of the authors and do not necessarily reflect those of the ACS.

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## References

1. American College of Surgeons. Cancer Programs. Just ASK Quality Improvement Project and Clinical Study. Available at: <https://www.facs.org/quality-programs/cancer-programs/pdsa-just-ask>. Accessed September 27, 2023.
2. American College of Surgeons. Cancer Programs. Just ASK frequently asked questions. Available at: <https://accreditation.facs.org/accreditationdocuments/cancer/JustASKFAQs.pdf>. Accessed September 27, 2023.
3. American College of Surgeons. Beyond ASK Quality Improvement Project. Available at: <https://www.facs.org/quality-programs/cancer-programs/beyond-ask-quality-improvement-project>. Accessed September 27, 2023.
4. Schroeder MC, Gao X, Lizarraga I, et al. The impact of Commission on Cancer accreditation status, hospital rurality and hospital size on quality measure performance rates. *Ann Surg Oncol*. 2022;29(4):2527-2536.
5. Shulman LN, Browner AE, Palis BE, et al. Compliance with cancer quality measures over time and their association with survival outcomes: The Commission on Cancer’s experience with the quality measure requiring at least 12 regional lymph nodes to be removed and analyzed with colon cancer resections. *Ann Surg Oncol*. 2019;26(6):1613-1621.

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# Clinical Congress 2023 Highlights



# The ACS Clinical Congress 2023 in Boston, Massachusetts, provided opportunities for surgeons, residents, medical students, and other healthcare professionals, both domestic and international, to hone their surgical skills and knowledge and interact with their peers, ACS leaders, and staff.

MORE THAN 12,000 INDIVIDUALS participated in the event, with nearly 11,000 traveling to Boston and more than 1,300 thousand engaging virtually and accessing the conference's content on demand, marking a strong return to prepandemic attendance figures. All registrants can view on-demand content through May 1, 2024, and registration remains open for new participants.

This article summarizes some of the highlights.

## Convocation

This year, 1,674 surgeons were initiated into ACS Fellowship following an inspiring procession of ACS leaders and invited guests. Secretary Sherry M. Wren, MD, FACS, FCS(ECSA), presented the Great Mace.

During the hour-long program, seven international surgeons were conferred Honorary Fellowship, several of the College's most prestigious annual awards were presented, and 2022–2023 ACS President E. Christopher Ellison, MD, FACS, led the installation of new officers, including Henri R. Ford, MD, MHA, FACS, as President, Tyler G. Hughes, MD, FACS, as First Vice-President, and Deborah A. Kuhls, MD, FACS, as Second Vice-President.

The 2023 Honorary Fellows are:

- Luigi Bonavina, MD, FACS, *Milan, Italy*
- Christopher R. Chapple, BSc, MBBS, MD, FRCS(Urol), FEBU, *Fulwood, Sheffield, UK*
- Nicola Fearnhead, BM BCh, FRCS, DM, FASCRS, *Cambridge, UK*
- Anna Martling, MD, PhD, *Stockholm, Sweden*
- Deborah McNamara, MB(Hons), FRCSI, MD, FRCSI(Gen), *Dublin, Ireland*
- Masaki Mori, MD, PhD, FACS, *Isehara, Japan*
- Richard David Rosin, MS, MB BS, FRCS(Eng), FRCS(Ed), FICS, FCCS, DHMSA, *Cave Hill, St. Michael, Barbados*

The 2023 Owen H. Wangensteen Scientific Forum Award was presented to Monica M. Bertagnolli, MD, FACS, a world-renowned surgical oncologist and cancer researcher, for her impactful research in tumor immunology, including more than 25 years of National Institutes of Health (NIH) and other funding, and her history of high-level leadership in federal research agencies. She recently was confirmed as Director of the NIH, after previously serving as Director of the National Cancer Institute.

Ronald M. Stewart, MD, FACS, received the 2023 Distinguished Service Award for his many leadership roles in ACS trauma efforts, including as Chair of the Committee on Trauma (COT) and the Medical Director of ACS Trauma Programs. Among many other contributions, Dr. Stewart has been instrumental in advancing the College's firearm violence reduction efforts (see October *Bulletin*).

Sujana S. Chandrasekhar, MD, FACS, a highly regarded otologist-neurotologist, received the Dr. Mary Edwards Walker Inspiring Women in Surgery Award for her career-long commitment to advancing women surgeons in multiple professional associations and other avenues (see October *Bulletin*).

USAR Major General (Retired) Jonathan Woodson, MD, MSS, FACS, MG, MC, renowned for his significant contributions to both military and civilian surgical care, was honored with the fourth ACS Distinguished Lifetime Military Contribution Award (see page 60).

## Named Lectures

Clinical Congress featured 11 Named Lectures, which provided attendees with opportunities to hear internationally renowned surgeons and healthcare experts share their insights on medicine and surgery.

Transplant surgeon Bartley P. Griffith, MD, FACS, FRCS, delivered the John H. Gibbon Jr. Lecture, What's New May Be Old: Xenotransplantation. In his talk, Dr. Griffith discussed the historic, in-human xenotransplants of genetically modified pig hearts that his team from the University of Maryland Medical Center in Baltimore performed in January 2022 and September 2023. He was quick to note that for all the recent advances in xenotransplantation, the field is already here—and that there are other possible futures for heart transplantation.

“We have challenges ahead, much to be done in xenotransplantation, but the field of cardiac replacement for surgeons is wide open, it's alive, and it's exciting to talk about,” Dr. Griffith said.

In the Olga M. Jonasson Lecture, Phoenix Rising: The Culture of Surgery—A Paradigm Shift, plastic and reconstructive surgeon Susan E. Mackinnon, MD, FACS, discussed how “energy leadership,” a seven-level strategy, can transform how an individual interacts with, and ultimately, leads teams. Contemporary surgical culture often leaves surgeons struggling in the lower levels, defined by conflict, coping, and other difficult emotions that can lead to burnout and moral distress. But, at higher levels, surgeons can develop their resilience skills and learn to collaborate, show compassion, and reclaim

their passion for the field and impart it to others, Dr. Mackinnon said.

Trauma surgeon M. Margaret Knudson, MD, FACS, past-Medical Director of the Military Health Service Strategic Partnership American College of Surgeons, delivered the Excelsior Surgical Society/Edward D. Churchill Lecture: Service, Synergy, and Surgical Mythology. Dr. Knudson said that Dr. Churchill referred to military surgery as a “discontinuous specialty,” with gaps between conflicts.

“Let's see if we can think synergistically, working between the military and civilian world, in making military surgery a continuous specialty,” she said, describing several ways surgeons can be a part of a continuous military specialty, including ACS-initiated or support programs.

As part of the lecture, television journalist Bob Woodruff took the podium as a special guest to speak of his interaction with military surgeons after suffering a severe injury from an improvised explosive device during a reporting trip to Iraq in 2006.

## Noteworthy Academic Programming

Clinical Congress was anchored by expansive academic, scientific, and educational programming.

In addition to Didactic and Skills Postgraduate Courses, Clinical Congress 2023 provided attendees access to 97 expert-led Panel Sessions. These included noteworthy sessions such as the always-popular 10 Hot Topics in General Surgery, hosted by Dr. Ellison and ACS Regent Kenneth W. Sharp, MD, FACS; the inaugural Great Debates: Biliary and Hernia, which saw surgeons debating treatment of the two most-common general surgery diseases; the thought-provoking Next Generation Predictive Tools and Artificial Intelligence (AI) for Anticipating Postoperative Outcomes, which explored how AI is shaping all phases of surgery, and much more.

Three Special Sessions once again were offered at Clinical Congress, which provided attendees with an in-depth look at important topics in surgery.

The ACS Academy of Master Surgeon Educators Special Session: Acquisition of New Surgical Skills by Practicing Surgeons provided details on how surgeons can and must seek out effective education and training programs to acquire the new skills.

Surgeons as Leaders: An Update on Firearm Injury Prevention had ACS trauma leaders reviewing and providing new developments in the College's

Dr. Ronald Stewart received the 2023 Distinguished Service Award for his many leadership roles in ACS trauma efforts.







ongoing firearm injury reduction initiatives. The Power of Quality Special Session provided surgeons with essential information about how they can start or grow quality programs in their hospitals, how they can become more effective champions of surgical quality, and how the ACS will assist hospitals in promoting their participation in quality programs.

The Named Lectures, Panel Sessions, and Special Sessions are available to view via the on-demand platform.

## Hands-On Events

Returning this year were two hands-on, simulation-based learning stations in the Exhibit Hall—the Surgical Ergonomics Clinic and Surgical Metrics Project.

The second ACS Surgical Ergonomics Hands-On Clinic for practicing surgeons and surgery residents generated significant interest and had more than 550 participants, which emphasized the importance of health and well-being in the physically demanding field.

In a space four times larger than at last year's clinic, ergonomic coaches helped participating surgeons learn about the ACS Surgical Ergonomics Recommendations, while applying them in a simulated environment at three stations with open, laparoscopic, and robotic surgery equipment.

This year's iteration of the Surgical Metrics Project, the third since it was initiated in 2019, offered an opportunity for individual surgeons to learn more about the future of digital healthcare and optimizing their practice. In 15- to 20-minute blocks at each of three simulation stations, nearly 500 conference

attendees had the opportunity to become research participants themselves by completing short but challenging operative tasks. New this year was the addition of expert surgical coaches, global surgery collaborators, new institutional partnerships, and more technology.

Read more about each station in the October *Bulletin*. Results from the Surgical Metrics Project will be described in a *Bulletin* article to be published in 2024.

## Awards and Honors

Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery, domestic and international volunteerism, leadership in residency, and much more at Clinical Congress. Visit *Clinical Congress News* on the ACS website for a complete listing of the awards, honors, and dedications provided at this year's conference.

## Annual Business Meeting

The Annual Business Meeting of Members convened on October 25, with Dr. Ford presiding. Following a series of reports from the Board of Regents (BoR), Board of Governors (BoG), ACS Foundation, and the ACS Professional Association Political Action Committee, new ACS Officers and other officials were elected for 2023–2024.

The President-Elect is Beth H. Sutton, MD, FACS, a private practice surgeon in Wichita Falls, Texas, who was chosen for her dedication to the ACS and her leadership experience.

“I am deeply honored to serve as President-Elect of the ACS, an organization that has been pivotal in

The 2022-2023 President, President-Elect, and Board of Regents gather for a photo following the fall Board meeting held prior to Clinical Congress.

shaping surgical practice and education,” Dr. Sutton said. “I look forward to contributing to our ongoing efforts to advance surgical care and enhance our professional community.”

The First Vice-President-Elect is general and breast surgeon Nancy L. Gantt, MD, FACS, a professor of surgery at Northeast Ohio Medical University in Rootstown and co-medical director of the Joanie Abdu Comprehensive Breast Care Center at Mercy Health–St. Elizabeth Youngstown Hospital. Otolaryngologist Dennis H. Kraus, MD, FACS, executive medical director of oncology and enterprise at Centura Health in Denver, Colorado, is the Second Vice-President-Elect.

The new Chair of the BoR is Anthony Atala, MD, FACS, the George Link Jr. Professor and director of the Wake Forest Institute for Regenerative Medicine and the W. H. Boyce Professor and Chair of Urology at the Wake Forest University School of Medicine in Winston-Salem, North Carolina. The Vice-Chair is Fabrizio Michelassi, MD, FACS, the Lewis Atterbury Stimson Professor and Chair of Weill Cornell Medicine, and surgeon-in-chief at NewYork-Presbyterian/Weill Cornell Medicine in New York City.

One surgeon was elected to fill a vacancy on the BoR: Liane S. Feldman, MD, FACS, the Edward W. Archibald Professor and chair of the Department of Surgery at McGill University in Montreal, Quebec.

In addition, five surgeons were reappointed to the BoR: Francoise P. Chagnon, MS, FACS, FRSCS; Annesley W. Copeland, MD, FACS; Gary L. Timmerman, MD, FACS; David J. Welsh, MD, FACS; and Douglas E. Wood, MD, FACS, FRCSEd.

The following Officers of the BoG Executive Committee were elected:

- **Chair:** Lillian S. Kao, MD, FACS, professor in the Department of Surgery and chief of the Division of Acute Care Surgery at the McGovern Medical School at The University of Texas Health Science Center in Houston
- **Vice-Chair and Member Services Pillar Lead:** Marion C. W. Henry, MD, MPH, FACS, professor of surgery at UChicago Medicine in Illinois
- **Secretary:** Cherisse D. Berry, MD, FACS, chief of the Division of Acute Care Surgery at New York University Langone Health

The following surgeons were elected to the BoG Executive Committee:

- **Diversity Pillar Lead:** Wendy Ricketts Greene, MD, FACS, director of the Acute and Critical Care Surgery Service of Emory University Hospital in Atlanta, Georgia
- **Quality, Research, and Optimal Patient Care Pillar Lead:** Sundeep G. Keswani, MD, FACS, chief of pediatric surgery at Texas Children’s Hospital in Houston
- **Communications Pillar Lead:** Joseph V. Sakran, MD, MPH, MPA, FACS, vice-chair and director of clinical operations at Johns Hopkins Medicine in Baltimore, Maryland

In addition, two Pillar Leaders were reappointed:

- **Advocacy Pillar Lead:** Don J. Selzer, MD, FACS, Willis D. Gatch Professor of Surgery, program director of the fellowship for advanced gastrointestinal and bariatric surgery, and chief of the Division of General Surgery at Indiana University Health in Indianapolis
- **Education Pillar Lead:** Amit R. Joshi, MD, FACS, professor of surgery and associate dean for graduate medical education at Cooper Medical School of Rowan University in Camden, New Jersey

## Member Engagement Activities

Clinical Congress 2023 provided attendees and their guests with opportunities to participate in wellness activities, including 5K guided running tours through Boston, yoga, a steps challenge, and a scavenger hunt. The annual Taste of the City on the last night of the conference offered an informal venue for attendees, their families, and guests to experience Boston’s unique dining and cultural scene.

## Clinical Congress 2024

In response to feedback from attendees, the next Clinical Congress will take place October 19–22, 2024, in San Francisco, California, on a new Saturday-through-Tuesday schedule to bring less disruption to attendees’ practices. Abstract submission begins mid-December, and housing reservations are underway. **B**

# CLINICAL CONGRESS 2023 By the Numbers

**SURGEONS  
UNITED**

**1,674**  
Initiates

**12,401** Registrants

**11,088** In-Person **1,313** Virtual



**36%** First-Time Attendees

**201.5**  
CME Credits  
Available  
For In-Person Attendees

**2,013**  
Surgeon's Dashboard  
Profile Updates

**91M**  
Impressions for  
#ACSCC23  
[July-Oct]

**7,888**  
App Downloads

**110**  
Registrant  
Countries

**212**  
Participants in  
Steps Challenge

**7,502,259**  
Steps Taken

**2,435** Total Speakers

**808** Scientific Forum  
abstracts presented

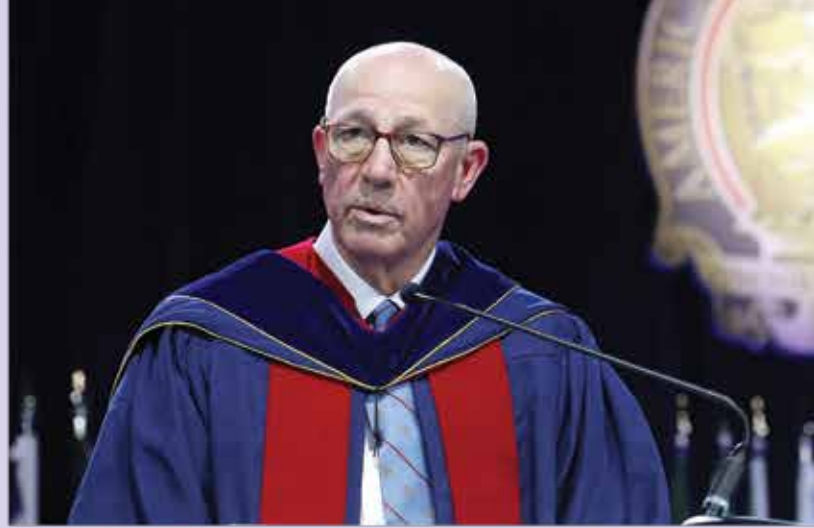
**428** Scientific Forum  
ePosters presented

**214** videos presented



**13,850** Hours of  
on-demand sessions  
watched from  
10/22 to 11/22





# Dr. Henri Ford Is Installed as ACS President



Henri R. Ford, MD, MHA, FACS, a world-renowned pediatric surgeon and prolific physician-scientist, was installed for a 1-year term as the 104th President of the ACS during the Clinical Congress 2023 Convocation in Boston, Massachusetts.

Dr. Ford is the dean and chief academic officer of the University of Miami Miller School of Medicine in Florida, where he has focused on developing the next generation of surgeon leaders, increased research funding, and worked to make Miller School one of the most diverse medical schools in the US.

For his presidential year, Dr. Ford has chosen the theme “Achieving Our Best Together: #Inclusive Excellence.”

“The past 3 decades have not only reinforced the concept that we achieve our best together but have

also demonstrated convincingly and unequivocally that inclusive excellence is essential to accelerate progress and heal all patients with skill and trust,” Dr. Ford said. “It is our pledge to carry the mantle in the struggle for health equity and to never waver from our core values as surgeons. This is our duty, this is our purpose, this is our calling.” (See the Presidential Address recap on pages 54–55.)

## Background and Career Highlights

Born in Port-au-Prince, Haiti, Dr. Ford moved with his family to Brooklyn, New York, when he was 13 years old. He excelled in high school and received a full scholarship to Princeton University in New Jersey. He graduated cum laude from Princeton in 1980 with a bachelor of arts degree in public and international affairs, then earned his medical degree from Harvard Medical School in Boston, Massachusetts.

Dr. Ford completed his surgical internship and residency at NewYork-Presbyterian/Weill Cornell Medical College in New York, and he also completed a research fellowship in immunology at the University of Pittsburgh School of Medicine and a clinical fellowship in pediatric surgery at the Children’s Hospital of Pittsburgh, both in Pennsylvania.

Following this training, Dr. Ford became the Benjamin R. Fisher Chair in Pediatric Surgery at the University of Pittsburgh and surgeon-in-chief at Children’s Hospital of Pittsburgh. In 2005, he was appointed vice president and chief of surgery at Children’s Hospital Los Angeles in California and professor of surgery at the University of Southern California (USC) Keck School of Medicine. He was

later promoted to vice dean of medical education at Keck. During this time, Dr. Ford also received a master of health administration degree from USC.

Dr. Ford is an internationally recognized authority on necrotizing enterocolitis. He is the author of more than 300 peer-reviewed articles, book chapters, invited articles, abstracts, and presentations. He has a strong reputation for mentoring physicians and physician-scientists, and he regularly returns to Haiti to teach, lead operating teams, and assist in developing surgical systems. In 2015, he performed the first successful separation of conjoined twins in Haiti alongside surgeons he helped train.

## ACS Service

Dr. Ford has been an ACS Fellow since 1996 and has a long history of service to the organization. He served on the ACS Board of Regents from 2012 to 2021, participating on the Antiracism Committee, Honors Committee, and Research and Optimal Patient Care Committee, among others. He has served as a liaison for the ACS Advisory Council for Pediatric Surgery, was a member and Chair of the ACS Ethics Committee, and is a Past-Chair of the Nominating Committee and Past-Vice-Chair of the ACS Board of Governors. He also chaired the Program Committee, which is tasked with creating the Clinical Congress educational program each year.

In addition, Dr. Ford was the 2022 recipient of the ACS Owen H. Wangenstein Scientific Forum Award. He currently serves as Vice-Chair of the ACS Health Outreach Program for Equity in Global Surgery (formerly Operation Giving Back), the College's surgical volunteerism initiative that serves the US as well as countries in sub-Saharan Africa.

## Honors and Awards

In 2022, Dr. Ford was elected to the prestigious National Academy of Medicine. In addition, he chairs the Council of Deans of the Association of American Medical Colleges (AAMC), leading 157 medical school deans in North America. He also is a recipient of the AAMC's Arnold P. Gold Foundation Humanism in Medicine Award. In 2021, Dr. Ford received the Arnold Salzberg Mentorship Award from the American Academy of Pediatrics and the Excellence in Education Award from the National Medical Fellowship.

His other notable positions include serving on the Board of Trustees of Princeton University and the Board of Directors of the AAMC. In addition, he is past president of the Society of Black Academic Surgeons, and the first Black president of the Surgical Infection Society, the American Pediatric Surgical Association, and the Association for Academic Surgery, which established the Henri Ford Junior Faculty Research Award in his honor.




Dr. Ford's introductory video that was played during Convocation is available to view at [facs.org/henriford](https://facs.org/henriford).


## Vice-Presidents

The First Vice-President, Tyler G. Hughes, MD, FACS, and Second Vice-President, Deborah A. Kuhls, MD, FACS, also were installed.

Dr. Hughes is dean of University of Kansas School of Medicine-Salina, where he previously served as clinical professor of surgery and director of medical education. A Fellow of the College since 1986, he has served in several ACS leadership positions, including as ACS Secretary from 2019 to 2022. He presently is Editor of the ACS Communities. Dr. Hughes was instrumental in establishing the Advisory Council for Rural Surgery, which he also chaired.

Dr. Kuhls is assistant dean for research and professor of surgery at the Kirk Kerkorian School of Medicine at the University of Nevada, Las Vegas. Dr. Kuhls is a trauma surgeon who is board-certified in general surgery and critical care. For the ACS, she has served as the President of the Nevada Chapter and Chair of the Committee on Trauma Injury Prevention and Control Committee. In recent years, Dr. Kuhls has played an important role in developing the ACS's recommendations for responding to firearm violence. **B**

 Scan to watch Dr. Ford's introductory video.



# ACS President Exhorts Inclusive Excellence in Surgery



In an emotional address to thousands of people at the Boston Convention & Exhibition Center, as well as those watching virtually around the world, newly inducted ACS President Henri R. Ford, MD, MHA, FACS, urged colleagues to rededicate themselves to the 112-year-old ACS motto—To Heal All with Skill and Trust.

For more than a century, this premise has allowed the College to set the highest standards for training and surgical practice to help ensure the best possible

outcomes for all patients.

“All’ is an inclusive term that precludes discrimination on the basis of race, ethnicity, sex, gender, religion, geography, class, or sexual orientation,” Dr. Ford proclaimed. “The overarching goal of healing all with skill and trust or achieving health equity for all surgical patients creates an imperative not only for inclusive excellence, but also for global engagement.”

Dr. Ford described several decades where the ACS struggled to become an umbrella

organization for all surgical specialties and diversify the makeup of its members. He also highlighted the key role that the Board of Regents played in creating the infrastructure for training in surgery by establishing a Committee on Graduate Training for Surgery and the Surgical Specialties in 1932, with representation from OB-GYN, thoracic surgery, ophthalmology, otolaryngology, orthopedic surgery, and neurosurgery.

“Together, these disciplines epitomize the notion that we achieve our best together,” he said, adding that the changing physiognomy of the ACS has coincided with the “most extensive proliferation of initiatives to support the Fellows.”

Dr. Ford described the expansion of educational programs, introduction of numerous quality initiatives and verification programs, and the growing influence that the ACS has in shaping health policy at the state and national levels. He outlined the increasing number of ACS chapters outside of the US and Canada, as well as the



“I believe that we are stronger and more vibrant today because of our intentional efforts to promote inclusive excellence.”

—Dr. Henri Ford

growing impact of the ACS Health Outreach Program for Equity in Global Surgery (ACS H.O.P.E., formerly Operating Giving Back).

“I believe that we are stronger and more vibrant today because of our intentional efforts to promote inclusive excellence,” Dr. Ford said. “Despite what some critics and skeptics may argue, the ACS’s bold and courageous embrace of inclusive excellence that began post-World War II and accelerated in the 1990s has allowed it to not only blossom, but also to deliver on the promise of its motto to promote health equity for all surgical patients, with unprecedented success.”

As he concluded his address, Dr. Ford urged his colleagues to “carry the mantle” in the struggle for health equity and never waver from the ACS mission.

The full Convocation ceremony, which includes Dr. Ford’s Presidential Address, is available online at [facs.org/convocation](https://facs.org/convocation). The address also is available as an episode on The House of Surgery podcast at [facs.org/houseofsurgery](https://facs.org/houseofsurgery).

Dr. Ford is the dean and chief

academic officer of the University of Miami Miller School of Medicine in Florida.

Born in Port-au-Prince, Haiti, Dr. Ford moved with his family to Brooklyn, New York, when he was 13 years old. He received a full scholarship to Princeton University in New Jersey, where he graduated cum laude. He then earned his medical degree from Harvard Medical School in Boston, Massachusetts.

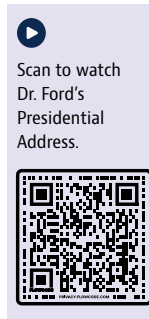
Following his surgical internship and residency at NewYork-Presbyterian/Weill Cornell Medical College in New York, he also completed a research fellowship in immunology at the University of Pittsburgh School of Medicine and a clinical fellowship in pediatric surgery at the Children’s Hospital of Pittsburgh, both in Pennsylvania.

Dr. Ford is a prolific researcher and an internationally recognized authority on necrotizing enterocolitis. He has authored more than 300 peer-reviewed articles, book chapters, invited articles, abstracts, and presentations. In 2015, he performed the first successful

separation of conjoined twins in Haiti alongside surgeons he helped train.

His long list of accomplishments include election to the National Academy of Medicine in 2022, the same year he received the ACS Owen H. Wangenstein Scientific Forum Award.

Learn more about Dr. Ford’s career and his presidential platform, Achieving Our Best Together: #InclusiveExcellence, in a video that was featured during the Opening Ceremony of Clinical Congress 2023, at [facs.org/henriford](https://facs.org/henriford). **B**



# Dr. Beth Sutton Is ACS President-Elect



An esteemed general surgeon in private practice, Beth H. Sutton, MD, FACS, is the 2023–2024 President-Elect of the ACS. Her election was announced at Clinical Congress 2023 during the Annual Business Meeting of Members, where the First Vice-President-Elect and Second Vice-President-Elect also were announced.

“I want to thank everyone who considered me worthy of becoming your President-Elect,” said Dr. Sutton. “I arrive to this moment having been buoyed up and inspired by the hard work and dedication of scores of surgeon colleagues and ACS staff members whose accomplishments greatly exceed mine. With your continued support, I will do my best to continue to advance the goals of the College.”

When Dr. Sutton was a young girl, her great-aunt gifted her a book about how the human body worked, which included detailed pictures and descriptions. After that, she sought out books about nurses and doctors, especially biographies. With her interest growing, Dr. Sutton suspected that she would pursue a career in medicine, but it wasn’t until after she viewed a case in the operating room as a medical student that she knew she was going to be a surgeon.

Dr. Sutton, who practices in Wichita Falls, Texas, earned her medical degree from Baylor College of Medicine in Houston, Texas, and completed her residency at Baylor Scott & White Medical Center in Temple, Texas.

An ACS Fellow since 1984, Dr. Sutton has held several leadership roles within the College. She was a member of the Board of Regents (BoR) from 2012–2021 and is a Past-Chair. She also was a member of the Board of Governors (BoG) Executive Committee from 2008 to 2010, and a Governor-at-Large for the North Texas Chapter from 2004 to 2010.

Dr. Sutton is currently serving or has served on several ACS committees, including the Committee on Healthcare Disparities, Committee on Professional Opportunities for Senior Members, Advisory Council for General Surgery, Committee on Transition to Practice (Mastery in General Surgery), and Committee on Preceptorship for Practicing Surgeons. In addition, she is a faculty member for the ACS Surgeons as Leaders course.

Beyond her roles with the College, Dr. Sutton is an American Board of Surgery Director, a past-president of the Texas Surgical Society, and a past-president of the Association of Women Surgeons, as well as a member of several other healthcare organizations.

“I arrive to this moment having been buoyed up and inspired by the hard work and dedication of scores of surgeon colleagues and ACS staff members whose accomplishments greatly exceed mine.”

—Dr. Beth Sutton

### Vice-Presidents-Elect

Nancy L. Gantt, MD, FACS, a general surgeon who is co-medical director of the Mercy Health Joanie Abdu Comprehensive Breast Care Center in Youngstown, Ohio, and professor of surgery at Northeast Ohio Medical University in Rootstown, is the is First Vice-President-Elect. A Fellow of the College since 1992, Dr. Gantt has served in several ACS leadership positions, including Vice-Chair of the BoG Executive Committee and Diversity Pillar Lead. She also currently is part of the ACS Aspiring Leaders Program and a member of several ACS committees, including the BoR Antiracism Committee, Patient Education Committee, and Advanced Curriculum in General Surgery Steering Committee. For the ACS Ohio Chapter, Dr. Gantt is a member of the Medical Education Committee, Annual Program Committee, and Advocacy Committee.



Dennis H. Kraus, MD, FACS, executive medical director of oncology and enterprise within the Centura Health in Centennial, Colorado, is the Second Vice-President-Elect. A head-and-neck oncologic surgeon, Dr. Kraus has been an ACS Fellow since 1994. He is a member of the ACS Program Committee and has served the College on the BoG, American Joint Committee on Cancer, Commission on Cancer, and Patient Education Committee. He also was Chair and Vice-Chair of the Advisory Council for Otolaryngology–Head and Neck Surgery and Vice-Chair of the BoG Patient Education Pillar. A long-standing innovator and leader in the field of head-and-neck oncologic care, Dr. Kraus has provided several innovations in the field of head-and-neck oncologic malignancy that have been associated with decreased morbidity and improved cosmetic and functional outcomes for patients. **B**







# Dr. Jonathan Woodson Becomes Fourth Recipient of ACS Lifetime Military Award



US Army Reserve Major General (Retired) Jonathan Woodson, MD, MSS, FACS, MG, MC, who has spent a lifetime advancing both military and civilian surgical care, was bestowed the ACS Distinguished Lifetime Military Contribution Award during Clinical Congress in Boston, Massachusetts.

The Distinguished Lifetime Military Contribution Award, created by the Board of Regents in 2018, is not granted annually but rather on the basis of merit. Dr. Woodson, the fourth winner, is a quadruple board-certified surgeon whose career intertwines military service, surgical practice, and leadership in education.

Following earning his medical degree from New York University School of Medicine in New York City, Dr. Woodson completed residency training in

internal medicine and general and vascular surgery at Massachusetts General Hospital and Harvard Medical School in Boston, Massachusetts. He also completed fellowships in general, vascular, and critical care surgery at Waltham Weston Hospital & Medical Center in Massachusetts, and Massachusetts General Hospital.

Via this training, Dr. Woodson attained board certification in internal medicine, general surgery, surgical critical care, and vascular surgery. In addition, he completed a fellowship at the Health Services Research Institute of the Association of American Medical Colleges in Washington, DC, and later, a master's degree in strategic studies from the US Army War College in Carlisle, Pennsylvania.

His career achievements also include several years as the Lars Anderson Professor in Management and Professor of the Practice at Boston University Questrom School of Business, with joint appointments as professor of surgery at the School of Medicine and professor of health law, policy, and management at the School of Public Health. At Boston University, he also established and led the Institute for Health System Innovation and Policy.

At present, Dr. Woodson is the president of the Uniformed Services University (USU) of the Health Sciences in Bethesda, Maryland, where he leads the F. Edward Hébert School of Medicine and its associated graduate programs in biomedical sciences, public health, nursing, dentistry, and allied health. Prior to assuming this role in 2022, Dr. Woodson was appointed as a member of the USU Board of Regents in 2016, and served as its chair from 2019 to 2021.



Dr. Woodson's military achievements span several countries. He joined the military in 1986 as a Captain and served for 36 years, retiring as a Major General of the US Army Reserve and Commander of the US Army Reserve Medical Command of Pinellas Park, Florida, in 2022.

During his military career, Dr. Woodson was deployed to Saudi Arabia for Operation Desert Storm, to Afghanistan during Operation Enduring Freedom, and to Iraq during Operation Iraqi Freedom, as well as to Kosovo. Additionally, in 2010, President Barack Obama appointed Dr. Woodson the Assistant Secretary of Defense for Health Affairs and Director of the Tricare Management Activity in the US Department of Defense, a role he held until 2016.

Notably, Dr. Woodson is the second winner of the Distinguished Lifetime Military Contribution Award who responded to the terrorist attacks on September 11, 2001. The 2021 winner, Lieutenant General (Retired) Paul K. Carlton, MD, FACS, was present in the Pentagon in Washington, DC, at the time of the airplane crash and helped rescue three colleagues from the burning building immediately afterward. Dr. Woodson's contribution to the rescue operation was at the World Trade Center in New York, New York, where he responded as a senior

medical officer with the US National Disaster Medical System.

In nomination materials for the Distinguished Lifetime Military Contribution Award, Board of Regents member Anton N. Sidawy, MD, MPH, FACS, wrote, "Jonathan is the ultimate officer, gentleman, and scholar. He is highly respected, transparent, and extremely thoughtful."

When asked about the award, Dr. Woodson responded with a modesty that seemed to reflect Dr. Sidawy's description. He said, "To think that the College would honor me with a lifetime achievement award is unexpected, and I'm very humbled by it and very honored." **B**

Dr. Christopher Ellison presents Dr. Jonathan Woodson with the ACS Distinguished Lifetime Military Contribution Award during Clinical Congress.

# Seven Eminent Surgeons Are Awarded Honorary ACS Fellowship

Honorary Fellowship in the ACS was awarded to seven prominent surgeons from around the world at the October 22 Convocation during Clinical Congress 2023 in Boston, Massachusetts. The granting of Honorary Fellowships is one of the highest honors bestowed during Clinical Congress.

Following are summaries of the careers of this year's Honorary Fellows.

View the full citations and sponsors for the Honorary Fellows—as well as all new Fellows inducted during Clinical Congress—in the 2023 Convocation program at [facs.org/convocation](https://facs.org/convocation).

## Luigi Bonavina, MD, FACS Milan, Italy



Dr. Luigi Bonavina is a full professor of surgery at the University of Milan and director of the Department of General and Foregut Surgery at IRCCS Policlinico San Donato in Milan, Italy, where

he also is the director of the Foregut Research Center and the Institutional Multidisciplinary Surgical Oncology Board.

Dr. Bonavina's practice in general surgery and surgical oncology is focused on advancing the surgical treatment of diseases of the esophagus. In his career, he has performed more than 2,000 major surgical procedures on the esophagus via minimally invasive thoracoscopic and laparoscopic surgery and transoral surgery, including esophagectomies for cancer and caustic ingestion, funduplications and magnetic sphincter augmentations for reflux disease, Heller myotomies for motility disorders, and septum divisions for Zenker diverticulum. Dr. Bonavina has authored more than 450 peer-reviewed research articles and more than 50 book chapters.

An ACS Fellow since 1995, he also is a member of many other scientific societies, including the Académie National de Chirurgie, American Foregut Society, and European Surgical Association.



**Christopher R. Chapple, BSc, MBBS,  
MD, FRCS(Urol), FEBU**

**Fulwood, Sheffield, UK**



Prof. Christopher Chapple is a reconstructive urologist in the Royal Hallamshire Hospital at the Sheffield National Trust Hospital in the UK.

Following his training, Prof. Chapple established a reconstructive urological practice at Sheffield National Trust Hospital, where he has focused on functional reconstruction of the urinary tract and urogynecological care for patients referred locally, regionally, and nationally. He also has completed investigations into the effects of neurological disease on the lower urinary tract, as well as the importance of novel receptors and mechanisms of action (the purinergic system, for example). In the course of this work, he has authored more than 750 peer-reviewed articles.

Prof. Chapple is the secretary general of the European Association of Urology, an honorary professor of surgery at the University of Sheffield, a visiting professor of urology at Sheffield Hallam University, and a fellow of several medical organizations. In 2015, he received a lifetime achievement award from the Society for Urodynamics, Female Urology, and Urogenital Reconstruction. In addition, in 2020, he was the first person to be inducted into the International Continence Society Hall of Fame.

**Nicola Fearnhead, BM BCh, FRCS, DM,  
FASCRS**  
**Cambridge, UK**



Dr. Nicola Fearnhead is a consultant colorectal surgeon at Cambridge University Hospitals Foundation National Health Services Trust and an associate lecturer at the University of

Cambridge in the UK. She has had continuous funding for research activities since 2009.

She is a leader in patient-reported outcomes using Delphi analyses and was awarded the 2017 Patient Champion Award for this work. Dr. Fearnhead's efforts to secure optimal outcomes for patients also

is reflected in her research, which has focused in part on the integration of patients into clinical research, including through seeking a broad spectrum of patient views, showing others how to access patient voices, and emphasizing the need to act on patients' input.

In her research group, she has established eight new principal investigators and five associate principal investigators in the past 5 years. Throughout her career, she has published 158 peer-reviewed articles and numerous book chapters and guidelines, delivered more than 150 national lectures and 25 international lectures, and trained more than 30 fellows in colorectal surgery. Dr. Fearnhead is a past-president of the Association of Coloproctology of Great Britain and Ireland and a member of several medical organizations.

**Anna Martling, MD, PhD**  
**Stockholm, Sweden**



Dr. Anna Martling, of Stockholm, Sweden, is a senior consultant surgeon on the cancer team in the Division of Coloproctology at Karolinska University Hospital, professor of surgery at Karolinska

Institutet, and dean of Karolinska Institutet North.

In addition to continuous clinical practice treating colorectal cancer, she has headed a research group since 2008 with a special focus on clinical, translational, and epidemiological studies on colorectal cancer. Through this group, Dr. Martling has served as a principal investigator for six randomized controlled trials and led many studies of large cohorts of patients with colorectal malignant conditions. Her work has generated insights into predictive and prognostic biomarkers, aspirin use, radiotherapy, the timing of surgery, and the development of new surgical techniques in colorectal cancer surgery, and she has authored 133 peer-reviewed articles on these topics and more.

**Deborah McNamara, MB(Hons), FRCSI,  
MD, FRCSI(Gen)  
Dublin, Ireland**



Prof. Deborah McNamara is a consultant general and colorectal surgeon at Beaumont Hospital in Dublin, Ireland, co-lead of the National Clinical Program for Surgery, and clinical professor in

surgery at the Royal College of Surgeons of Ireland (RCSI) in Dublin, where she also currently serves as vice-president.

Following her appointment as a consultant general and colorectal surgeon at Beaumont Hospital in 2003, she was chosen as clinical director for surgery at Beaumont Hospital, where she has led the development of Beaumont's colorectal cancer biobank and contributed to research collaborations between Beaumont clinicians and RCSI-affiliated scientists.

Prof. McNamara is the first woman to be appointed a consultant colorectal surgeon in Ireland and has participated in efforts to advance gender equity in the surgical profession, including as chair of the RCSI Short-Life Working Group on Gender Diversity in Surgery, which generated a groundbreaking report that inspired changes in Ireland's surgical environment.

**Masaki Mori, MD, PhD, FACS  
Isehara, Japan**



Prof. Masaki Mori is vice-president of Tokai University and dean of Tokai University School of Medicine in Tokyo, Japan, and an internationally recognized leader in cancer stem-cell

research in gastrointestinal cancers.

Prof. Mori's research interests include gastrointestinal surgery, cancer surgery, and translational research. His many achievements include authorship on more than 1,400 peer-reviewed articles. His published insights include identification of CD13 as the world's first cancer stem-cell marker for liver cancer and the creation

of a drug delivery system for inhibitors of CD13. In addition, his accomplishments include the discovery of the antitumor effects of microRNAs, the potential application of microRNA to inhibit tumor growth, and the quantitative analysis of microRNA methylation by mass spectroscopy as a means of cancer diagnosis.

Prof. Mori became an ACS Fellow in 1995, and he has been the recipient of numerous prestigious awards in Japan. For his contributions to academic development, he was awarded the Medal of Honor by the Emperor of Japan in 2020.

**Richard David Rosin, MS, MB BS,  
FRCS(Eng), FRCS(Ed), FICS, FCCS, DHMSA  
Cave Hill, St. Michael, Barbados**

Dr. Richard Rosin is a professor of surgery and honor senior lecturer at the University of the West Indies



in Cave Hill, Barbados, where he leads the Department of Surgery.

Dr. Rosin became a senior consultant surgeon at St. Mary's Hospital and the Imperial School of Medicine in London,

specializing in upper gastrointestinal and minimal access surgery and surgical oncology. His innovations as a clinician include the development of the first totally implantable infusion pumps for chemotherapy of the liver and the introduction of laparoscopic surgery, including performing the first laparoscopic cholecystectomy in England. In addition to his work in the UK and Barbados, Dr. Rosin periodically returns to his native country, Zimbabwe, to provide care to hernia patients.

In recognition of his career success, he was made a fellow of both the Royal College of Surgeons of England and the Royal College of Surgeons of Edinburgh; he also was named a Hunterian Professor of the Royal College of Surgeons of England, which is the most prestigious award in surgery in the UK. **B**

# ACS/Clinical Congress 2024

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Videos are peer-reviewed and may be recommended for inclusion in the ACS Video Library following presentation.

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### SUBMISSION INFORMATION

- Online submissions only
- Deadline: 11:59 pm CT on March 1, 2024
- Abstract and video specifications and guidelines available at [facs.org/clincon2024](https://facs.org/clincon2024)



**ACS** AMERICAN COLLEGE  
OF SURGEONS



# New Sustainable Healthcare Certification Will Help Reduce Greenhouse Gas Emissions

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

A 2022 study by the Harvard T. H. Chan School of Public Health found that in a 3-year period, 81% of primary care clinic staff said their organization experienced some type of disruption due to extreme weather events later attributed to climate change.

FURTHERMORE, a study from 2012 by The Commonwealth Fund projected that if all US hospitals reduced energy consumption and waste—and implemented efficiencies in operating room practices—these actions could lead to more than \$5.4 billion in savings.

The data show that healthcare as an industry disproportionately contributes to climate change, with nearly 9% of total greenhouse gas (GHG) emissions coming directly from healthcare, according to an article published in *The New England Journal of Medicine* in 2021.

A study published in *Health Affairs* in 2020 also described the healthcare industry as an unusually high contributor of GHG emissions, stating that “the US healthcare system is responsible for about a quarter of all global healthcare greenhouse gas emissions, which is more than the healthcare system of any other nation.”

If we, as surgeons, were to champion efforts at our organizations to correctly manage and control this issue, it has the potential to not only reduce our industry’s carbon footprint but also curb excess expenses and create financial savings.

The Joint Commission has heard from healthcare organizations across the country that need guidance on how to accelerate their sustainable practices and reduce GHG emissions.

Answering that call, a new Sustainable Healthcare Certification program, set to launch January 1, 2024, will provide a framework to help organizations begin, continue, or expand their decarbonization efforts, and to receive public recognition for their commitment and achievements in contributing to environmental sustainability.

The voluntary Sustainable Healthcare Certification program is available to Joint Commission-accredited and non-Joint Commission-accredited hospitals and critical access hospitals. To achieve the certification, healthcare centers must have the following:

- Baseline emissions data for three GHG emission sources and an action plan to reduce them at the time of review
- 24 months of data and the ability to demonstrate a reduction of those three GHG emission sources at the time of recertification

“We want to work with the momentum of healthcare organizations leading the way in sustainability excellence—inspiring and guiding others that want to prioritize greener practices,” said Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI, president and chief executive officer of The Joint Commission Enterprise, in a news release announcing the new certification. “Healthcare is one of the largest sectors in the US and one dedicated to improving people’s health and well-being. Now is the time for The Joint Commission to take its place among other leading healthcare organizations to help accelerate environmental sustainability.”

The standards for the new program specifically outline measuring (and later reducing) anesthetic gas use, including volatile agents and nitrous oxide. Other benefits of the certification include:

- Improved health outcomes for patients
- Environmental impact reduction
- Cost savings, such as qualifying for tax incentives for climate resiliency and renewable energy infrastructure projects
- Enhanced reputation and community engagement
- Regulatory compliance and risk mitigation

The Joint Commission has launched a Sustainable Healthcare Resource Center to provide tools, literature, videos, and more to help organizations get started on implementing sustainability efforts. **B**

#### **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.

**Dr. Lenworth Jacobs** is a professor of surgery and professor of traumatology and emergency medicine at the University of Connecticut in Farmington and director of the Trauma Institute at Hartford Hospital, CT. He is Medical Director of the ACS STOP THE BLEED program.

# Cancer QI Initiative Helps Increase Treatment Compliance

Laurie J. Kirstein, MD, FACS

Anthony D. Yang, MD, MS, FACS

Eileen Reilly

Rebecca A. Snyder, MD, MPH, FACS

**The best outcomes are achieved when patients complete guideline-recommended cancer treatment. For some cancer patients, missing radiation therapy (RT) sessions during active treatment may increase the risk of local recurrence.<sup>1,2</sup>**

STUDIES ESTIMATE THAT patients miss more than 20% of RT treatments. Incomplete or missing RT appointments may serve as a warning sign of additional risk factors that negatively affect outcomes, including psychosocial concerns, lack of social support, and transportation and accessibility issues.<sup>3,4</sup>

The ACS Commission on Cancer (CoC) accreditation program includes a “Barriers to Care” standard in which programs must “identify one patient-, system-, or provider-based barrier to accessing health and/or psychosocial care and develop and implement a plan to address the barrier.” However, program staff members have

traditionally had difficulty in identifying meaningful and sustainable ways to address these barriers and have expressed interest in receiving help in meeting the standard.

In order to better support programs in addressing barriers to care, the Breaking Barriers national quality improvement (QI) initiative was launched in January 2023, by the CoC and the National Accreditation Program for Breast Centers (NAPBC), with support from the ACS Cancer Programs. This QI project seeks to reduce the rate of patient RT “no-shows” by 20%.

The focus on RT appointments in the Breaking Barriers project was chosen as the initial target for

identifying actionable barriers to treatment because there are data to support that three or more missed RT treatments can be detrimental to patient outcomes.

Concentrating the project on RT treatments also is advantageous for QI in that they occur in a set number of treatments during a defined time period, which makes them particularly amenable to collecting data on missed treatments and the reasons for these no-show appointments.

While some breaks in treatment are unmodifiable (toxicity), others—specifically those related to social and/or psychosocial barriers to care—can be identified, addressed, and mitigated with the creation of

standardized processes.

There are 354 CoC- and NAPBC-accredited programs in the US that participate in the Breaking Barriers QI project. The ACS Cancer Programs is helping develop local processes to track patient attendance at RT treatment appointments and classify the specific reasons for missed appointments.

In addition to understanding the no-show rate and identifying and prioritizing common barriers to care leading to missed RT appointments, programs also are instructed to develop a community asset map or a listing of community resources that address patient drivers of health outside of the walls of the clinic.

These resources may include ride-share services, food banks, mental health services, community support groups, and more. Programs are encouraged to consider their patient population's sociodemographic characteristics, including education, language, and spiritual and religious affiliations when seeking out community partners. The community asset map can be used to help identify solutions to reduce the major social and psychosocial drivers of missed RT treatment appointments at their institution.

At the initiation of the project, programs were required to submit a letter of support from their radiation oncology clinic leadership and identify the members of their local Breaking Barriers multidisciplinary QI team. Programs currently are submitting bimonthly data on patients missing three or more treatments, reported by disease site. In addition, programs also submit survey

data on organizational readiness, current systems, and workflows for addressing no-shows and feasibility and effectiveness of implementation strategies.

The ACS Cancer Programs is supporting this QI project by providing participating programs with guidance, resources, and consultation throughout the project life cycle. Specific forms of support include data collection resources, education in quality and process improvement methods, assistance with approaches to identify local barriers to care and specific ways to address the barriers, project assistance "office hours," and educational webinars. The webinars also include presentations by participating hospitals that address best practices, experiences, and challenges.

Preliminary data have revealed that 91% of Breaking Barriers project programs had patients missing three or more RT treatments. The most common reasons for patient no-shows to RT appointments are illness not related to treatment toxicity, transportation challenges, psychosocial issues, and healthcare-related system inefficiencies.

Data will continue to be collected and analyzed for the remainder of the 2023 calendar year. Programs will then have the opportunity to continue participation in 2024.

The first year of the project has focused on data collection, instituting processes for identifying no-show patients, and distinguishing the specific reason why the patient missed the appointment.

In 2024, programs will identify

one barrier and participate in cohort learning with other programs that also self-selected that barrier. Together, with support from the ACS Cancer Programs, they will share strategies, resources, and best practices and, ultimately, reduce barriers to care and achieve improved outcomes for all their cancer patients. **B**

**Dr. Anthony Yang** is the vice chair of quality, the H. H. Gregg Professor of Cancer Research in the Division of Surgical Oncology, and associate director of the Surgical Outcomes and Quality Improvement Center within the Department of Surgery at the Indiana University (IU) School of Medicine in Indianapolis. He also is the CoC cancer liaison physician at IU Health West Hospital in Avon.

**Dr. Laurie Kirstein** is a breast surgical oncologist at Memorial Sloan Kettering Cancer Center and an associate professor of surgery at the Weill Cornell Medical College, both in New York City. She also is the current Chair of the CoC Education Committee and Education Liaison for ACS Cancer Programs.

#### References

1. Morris BB, Hughes R, Fields EC, et al. Sociodemographic and clinical factors associated with radiation treatment nonadherence and survival among rural and nonrural patients with cancer. *Int J Radiat Oncol Biol Phys.* 2023;116(1):28-38.
2. Ohri N, Rapkin BD, Guha C, et al. Radiation therapy noncompliance and clinical outcomes in an urban academic cancer center. *Int J Radiat Oncol Biol Phys.* 2016;95(2):563-570.
3. Chiang YY, Chou YC, Chang KP, et al. Missed radiation therapy sessions in first three weeks predict distant metastasis and less favorable outcomes in surgically treated patients with oral cavity squamous cell carcinoma. *Radiat Oncol.* 2020;15(1):194.
4. Chow R, Hasan S, Choi JI, et al. Effect of treatment interruptions on overall survival in patients with triple negative breast cancer. *J Natl Cancer Inst.* 2023;115(9):1029-1035.

# First World War Catalyzes Forward Surgical Care

Thomas S. Helling, MD, FACS

During the Great War, the French revolutionized forward surgical care through the introduction of Antoine Gosset's modification of the mobile surgical unit, the ambulance chirurgicale automobile, informally referred to as "auto-chirs."



Originally envisioned by a young French medical officer, Maurice Marcille, Gosset's version resulted in a highly effective portable surgical platform with expanded resources to not only tend to surgical injuries, but also provide a means of short-term recovery.

Skilled surgeons and technicians with radiological capabilities could rapidly redeploy a limited number of vehicles near the front lines to care for "non-transportable" (critically injured) casualties (see photo, this page).

The mobile equipment was distributed among several trucks



## While evacuation of casualties from the battlefield was chaotic and prolonged at times, the function of the surgical teams in AEF forward field hospitals was considered exceptional and established the modern foundation of early forward surgical care for the seriously injured.

for transportation to the front lines, including a separate truck for each of the following: operating tables and surgical instruments, radiology, sterilization, tentage and bedding, and basic supplies of sustenance. Of necessity, its bed capacity required “elasticity” to accommodate flow of critically wounded casualties, which proved remarkably effective in the prolonged Battle of Verdun (1916–1917).

With the US entry into the war in April 1917, there was an immediate concern regarding the treatment of the wounded among the American Expeditionary Forces (AEF). In August 1917, medical officer Captain Percy R. Turnure sent a letter to the Surgeon General of the Army, stating that:

[T]here be provided a mobile operating unit mounted on automobile trucks and provided with a well-lighted and heated operating room, electric lighting, steam and sterilizing plants, these to be fully equipped in such a manner as to insure the best hospital conditions and at the same time capable of being erected and in action in less than an hour.<sup>1</sup>

The Surgeon General agreed to this request. A mobile unit, designated “mobile operating unit,” was assembled, and it consisted of five sections that were fully independent and easily transportable. Each section could care for up to 40 casualties. However, by the time these units reached France and were properly outfitted, the armistice was signed, and they never saw service.

Nevertheless, the principle of early treatment of war wounded, as demonstrated by the French, prompted the organization of mobile field hospitals capable of surgical procedures (essentially

prototypes of the “mobile operating unit” suggested by Turnure) staffed by personnel from base or evacuation hospitals.

AEF General Order No. 70, issued May 6, 1918, provided two types of these mobile surgical capabilities. First was a mobile hospital consisting of necessary surgical and radiographic equipment, fashioned much like the French auto-chirs and able to house up to 120 patients. “The operating features are designed to provide all modern facilities for six surgical teams. Mobile hospitals may function independently, or they may be attached to other advanced sanitary formations.”<sup>2</sup>

Second, to augment surgical resources in times of heavy casualties, General Order No. 70 provided for a mobile surgical unit (modeled after the French groupes complémentaires to augment divisional hospitals) that consisted of portable sterilizing, x-ray and electric lighting plants, a light-frame operating room, and surgical material mounted on two motor trucks.<sup>2</sup>

These units specifically could not operate independently and therefore, must be attached to existing forward field hospitals, which housed more than 100 beds—usually located in the divisional rear area. They were specifically designed for “immediate surgical aid to the non-transportable [critically] wounded.”<sup>2</sup>

During the all-American Meuse-Argonne offensive in September and October 1918 by the newly formed First Army, five mobile hospitals—with their surgical units (as provided by General Order No. 70 and similar to auto-chirs)—were employed, leapfrogging forward as this now rapid war of maneuvering saw sudden shifts in battlefield tactics (see photo, page 72).

Each mobile hospital was designed to promote

**Opposite Page**  
The Gosset-Marcille auto-chir—assembled in 3 hours, making it possible to establish up to 14 operating rooms in Verdun—allowed surgeons to operate on the wounded as close as possible to the battlefield. (Credit: Archives of Dr. E. Chassaing)



The operating room at AEF Mobile Hospital No. 39 at Aulnois-sur-Vertuzy, France, awaits patients. (Credit: National Library of Medicine)

forward flow of patients from admissions to undressing stations to bathing and cleansing areas to the operating area itself. Shock victims were first diverted to special areas for warming and resuscitation.

For the most part, nontransportable casualties arrived, many of whom needed surgery immediately. “The condition of the wounded received at this point was deplorable. Some wounds had not been dressed...some were exposed on the field for two or three days before arrival.”<sup>3</sup> Delays were attributed to a quagmire of traffic on congested roads.

Two additional mobile hospitals were used for neurosurgical trauma. Seriousness of injuries was exemplified by reports from Mobile Hospital No. 5 which, during the month of October 1918, admitted 839 patients, 119 of whom died (14% mortality).<sup>1</sup>

Treated casualties were then transported by truck back to evacuation hospitals located much farther in the rear. Comparable figures for the French *Hôpitaux d’Origine d’Étapes* (evacuation hospitals) with their attached auto-chairs around Verdun demonstrated a hospital mortality of 8.6%, but this was at an evacuation hospital where the injured already had been stabilized in forward field hospitals.<sup>3</sup>

All things considered, while evacuation of casualties from the battlefield was chaotic and prolonged at times, the function of the surgical teams in AEF forward field hospitals was considered exceptional

and established the modern foundation of early forward surgical care for the seriously injured.

“The Army Commander has observed the efficient manner in which your department has handled the numerous duties in connection with our recent operation,” [Meuse-Argonne], so wrote General H. A. Drum, First Army chief of staff. These practices would carry forward in future wars in the 20th and 21st centuries.<sup>4</sup> **B**

**Dr. Thomas Helling** is professor of surgery and a member of the Division of General Surgery at the University of Mississippi (UM) School of Medicine and UM Medical Center in Jackson.

#### References

1. Lynch C, Ford JH, Weed FW. *The Medical Department of the United States in the World War Volume III: Field Operations*. Washington, DC: Office of the US Surgeon General, 1925.
2. Center of Military History. *United States Army in the World War 1917–1919: General Orders, GHQ, AEF Volume 16*. Washington, DC: Center of Military History, United States Army, 1997.
3. Mignon AHA. *Le Service de Santé Pendant la Guerre 1914–1918, Vol II: La Bataille de Verdun*. Paris: Masson & Cie, 1926.
4. Lyle HHM. The principles of the surgery, hospitalization and the evacuation of the wounded in the Meuse-Argonne offensive. *Military Surgeon*. 1939;84(6):580-591.

# Full mCurriculum Course—Bridging Military and Civilian Trauma Surgery—Is Now Available

TO HELP SURGEONS ACHIEVE and maintain their clinical readiness, the ACS, in coordination with the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS) and the Uniformed Services University Health Sciences in Bethesda, Maryland, has developed a free video-based resource—the Military Clinical Readiness Curriculum, also known as the “mCurriculum.”

The full slate of 42 mCurriculum modules is now available.

Several modules of the mCurriculum were first released in late 2022; recently, additional modules were published, representing the complete course of easily navigable “just-in-time” educational elements for surgeons to access whenever they need to hone their surgical skills.


While the course is designed to improve the trauma surgery skills of deployed military surgeons, it also can be valuable for trauma surgeons and general surgeons operating in civilian settings, particularly rural ones.



The mCurriculum is organized into seven domains of knowledge, with multiple modules in each section:

- Airway and Breathing (four modules)
- Critical Care and Prevention (six modules)
- Expeditionary Unique (10 modules)
- Head and Spine Injury (five modules)
- Torso Trauma (five modules)
- Transfusion and Resuscitation (six modules)
- Wounds, Amputations, and Fractures (six modules)

The modules detail critical topics such as burn care, trauma airway management, thoracic trauma, damage control surgery, urologic and gynecologic trauma, fresh whole blood transfusion, infection control, pain and delirium, management of severe head trauma, and many more.

The mCurriculum course is available at [facs.org/mcurriculum](https://facs.org/mcurriculum). 

# Report on ACSPA/ACS Activities, October 2023

Ross F. Goldberg, MD, FACS

The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the ACS Board of Regents (BoR) met October 21, 2023, at the Omni Seaport Hotel in Boston, Massachusetts.

THE FOLLOWING IS A SUMMARY of key activities discussed. The information provided was current as of the date of the meeting.

## ACSPA

The ACSPA, a 501(c)(6), allows for a broader range of activities and services that benefit surgeons and patients, including expanded legislative advocacy and political programming, such as the ACSPA Political Action Committee (ACSPA-SurgeonsPAC).

From January 1 to September 15, 2023, the ACSPA-SurgeonsPAC raised more than \$195,000 from 472 ACS members and eligible contributors and disbursed nearly \$232,000 to 96 candidates seeking federal office, political campaigns, and other PACs. Fund distribution focuses on health professionals, key congressional leaders, and members who serve on US House and Senate committees with jurisdiction over various healthcare policies and issues, including ACS-supported legislative priorities.

## ACS

The BoR accepted resignations from 18 Fellows and changed the status from Active or Senior to Retired

for 112 Fellows. The Regents also approved the following items:

- Formation of the Ethiopia Chapter
- Formation of the Kenya Chapter
- Best Practice Guidelines for Geriatric Trauma Management from the Committee on Trauma
- Trauma protocol for Post-Discharge Venous Thromboembolism Prophylaxis developed by the ACS Committee on Trauma and the American Association for the Surgery of Trauma

## Division of Education

The Division of Education reported on the following key activities.

### Clinical Congress 2024

The proposed program for Clinical Congress 2024 was presented for the Regents' comment and review. The footprint of Clinical Congress 2024 in San Francisco, California, will be moved into the weekend, starting on Saturday, October 19, and ending Tuesday, October 22. No program content will be lost by the move. The Program Committee

continues to identify transformational changes to the program to be implemented over the next several years.

### Committee on Ethics

The Committee on Ethics sponsored several sessions at Clinical Congress 2023, including the John J. Conley Ethics and Philosophy Lecture with Travis N. Rieder, PhD, titled America's Opioid Dilemma: Ethical Prescribing During an Overdose Epidemic. Plans are underway for activities at Clinical Congress 2024.

### Fellowship in Surgical Ethics

Applications are being accepted for the 2024–2025 academic year until January 2024. Offered for the first time in 2015, the Fellowship in Surgical Ethics is sponsored by the ACS and The MacLean Center for Clinical Medical Ethics at The University of Chicago. The program's goals are to prepare surgeons for careers that combine clinical surgery with scholarly studies in surgical ethics and provide specialized knowledge, skills, and training to develop leaders in the field of surgical ethics.

### Division of Research and Optimal Patient Care

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

A follow-up discussion to the strategic analysis that was conducted in February focused on:

- Advancing ACS programs and mission through partnerships
- Increasing Quality Program participation—a payer strategy
- Public reporting from the ACS

### Office of Diversity, Equity, and Inclusion

The Office of Diversity, Equity, and Inclusion (DEI) continues to implement the 3–5-year strategic priorities approved by the BoR at the June meeting. External and internal strategies support the ACS's commitment to achieving surgical excellence.

At the 2023 Quality and Safety Conference, the Office of DEI and DROPC launched the Equity in Quality Initiative. By codifying equity

into quality and safety standards, the ACS will develop a system of review and verification of DEI programs for hospitals, departments of surgery, and professional organizations.

A collaborative Didactic Course—DEI and Antiracism Fundamentals, Skills Building, and Implementation Principles for Surgeons—was developed for Clinical Congress 2023. Work is underway to expand the course into a 2-year longitudinal certification program to be released in 2024.

A beta version of the ACS DEI and Antiracism Resource and Implementation Toolkit was launched in June and an official version is now available to ACS members and staff. More than 90 surgeon authors submitted content, and 22 aligned groups collaborated on the project. The interactive Toolkit provides complimentary access to a collection of authoritative and adaptable tools including:

- Content addressing more than 40 DEI and antiracism topics
- DEI and Antiracism Lexicon and Resource Library with more than 100 entries

### ACS Foundation

The ACS Foundation remains focused on securing and growing financial support for the College's charitable, educational, and patient-focused initiatives. For fiscal year 2023, the Foundation raised \$1,640,832 in contributions. Individual donations totaling \$606,455 supported the Greatest Needs Fund with \$200,000 of those monies directed toward scholarships.

Programs, projects, and initiatives received \$264,938. Corporate support reached \$645,062, focusing on the support of the Resident Surgical Skills Competition, surgical skills courses at Clinical Congress, and patient education resources.

The Fall Appeal and National Doctors' Day generated \$204,031. There were 1,124 contributors, and the average individual gift was \$439. **B**

**Dr. Ross Goldberg** is the Immediate Past-Chair of the ACS Board of Governors, as well as chief of the Perioperative Division at Jackson Memorial Hospital in Miami, Florida, and an affiliate professor in the Department of Surgery at the University of Miami Miller School of Medicine in Florida.

# Call for Nominations for ACS Officers-Elect and Board of Regents

THE ACS 2024 NOMINATING Committee of the Fellows (NCF) and the Nominating Committee of the Board of Governors (NCBG) will accept nominations through February 16, 2024, for leadership positions in the College.

## ACS Officers-Elect

The 2024 NCF will select nominees for three Officer-Elect positions of the ACS:

- President-Elect
- First Vice-President-Elect
- Second Vice-President-Elect

### Criteria for Consideration

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

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

The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

All nominations must include:

- A letter of nomination
- A current curriculum vitae
- One personal letter of support is required; a maximum of three is allowed

In addition, nominations for President-Elect must include a personal statement from the candidate detailing their ACS service, interest in the position, and vision for the College's future.

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

Any attempt to contact or influence members of the NCF by a candidate or on behalf of a candidate will be viewed in a negative manner and may possibly result in disqualification. Applications submitted without

the requested information will not be considered.

Learn more about the roles, duties, and time commitment involved for these Officer positions at [facs.org/about-acs/governance/get-involved/officers](https://facs.org/about-acs/governance/get-involved/officers).

## ACS Board of Regents

The 2024 NCBG will select nominees for four vacancies on the Board of Regents to be filled at Clinical Congress 2024.

For information only, the current members of the Board of Regents who will be considered for reelection to their second or third terms are (all MD, FACS) Carol L. Brown, Andrea A. Hayes Dixon, James W. Fleshman Jr., Lena M. Napolitano, Mark T. Savarise, Kenneth W. Sharp, Shelly D. Timmons, and Philip R. Wolinsky.

### Criteria for Consideration

The following guidelines are used by the NCBG when reviewing candidates for potential nomination to the Board of Regents.

- Loyal members of the College who have demonstrated

## The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

outstanding integrity and an unquestioned devotion to the highest principles of surgical practice

- Demonstrated leadership qualities such as service and active participation on ACS committees or in other areas of the College

The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

Only individuals who are currently, and are expected to remain, in active surgical practice for their entire term (up to three 3-year terms) may be nominated for election or reelection to the Board of Regents.

The NCBG recognizes the importance of the Board of Regents representing all who practice surgery in both academic and community practice, regardless of practice location or configuration. Consideration will be given in this nomination cycle to the following disciplines:

- Burn and critical care surgery
- Gastrointestinal surgery
- General surgery

- Otolaryngology–head and neck surgery
- Plastic and reconstructive surgery
- Surgical oncology
- Transplant surgery
- Trauma surgery
- Vascular surgery

Nominations not meeting these criteria will be accepted for review by the NCBG in the event of an unexpected vacancy.

All nominations must include:


- A letter of nomination
- A personal statement from the candidate detailing their ACS service and interest in the position
- A current curriculum vitae
- One personal letter of support is required; a maximum of three is allowed

Entities such as surgical specialty societies, ACS Advisory Councils, ACS Committees, and ACS Chapters that wish to provide a letter of nomination must provide at least two nominees, and a description of their selection process, along with the total

list of applicants reviewed.

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

Learn more about the roles, duties, and time commitment involved for Regent positions at [facs.org/about-acsgovernance/get-involved/regent](https://facs.org/about-acsgovernance/get-involved/regent).

The deadline for submitting nominations is **Friday, February 16, 2024**. Nominations must be submitted to [officerandbrnominations@facs.org](mailto:officerandbrnominations@facs.org). For more information, contact Emily Kalata at 312-202-5360 or [ekalata@facs.org](mailto:ekalata@facs.org). 

# Member News

## Three ACS Fellows Are Elected to NAM



Dr. Robert Montgomery



Dr. Lisa Newman



Dr. Joseph Sakran

Robert A. Montgomery, MD, DPhil, FACS, Lisa A. Newman, MD, MPH, FACS, and Joseph V. Sakran, MD, MPA, MPH, FACS, were elected to the National Academy of Medicine (NAM). Election to the Academy is considered one of the highest honors in the fields of health and medicine and recognizes individuals who have demonstrated outstanding professional achievement and commitment to service. The newly elected members bring NAM's total membership to more than 2,400.

Dr. Montgomery, chair of the Department of Surgery at NYU Langone Health and director of the NYU Langone Transplant Institute in New York, New York, was recognized for "significant contributions to the field of transplantation." He led the team that performed the first successful genetically edited pig-to-human kidney xenotransplant and invented the type of "kidney swap" that is responsible for more than 1,000 kidney transplants a year.

Dr. Newman, chief of the Section of Breast Surgery at NewYork-Presbyterian/Weill Cornell Medical

Center and Weill Cornell Medicine in New York, and executive director and founder of the International Center for the Study of Breast Cancer Subtypes at NewYork-Presbyterian/Weill Cornell Medicine, was recognized for her efforts to address and eliminate breast cancer disparities across the world, and whose research on characterizing hereditary susceptibility for triple-negative breast cancer associated with African ancestry have earned worldwide acclaim.

Dr. Sakran, executive vice-chair of surgery, director of clinical operations, and associate professor of surgery and nursing at Johns Hopkins Medicine in Baltimore, Maryland, was recognized for his innovative work and exceptional leadership in firearm injury prevention that has been instrumental in establishing the urgency and intellectual foundation to drive research and evidence-based policy change at the local, state, and federal levels.



## Bertagnolli Is Confirmed as New Head of the NIH



Dr. Monica Bertagnolli

World-renowned oncologic surgeon and cancer researcher Monica Bertagnolli, MD, FACS, has been confirmed to lead the US National Institutes of Health (NIH)—the largest biomedical research agency in the world. Dr. Bertagnolli is the first surgeon and the second woman to serve in this role. Since October 2022, she has been director of the National Cancer Institute, the lead agency for cancer research and part of the NIH.

Previously, Dr. Bertagnolli was the Richard E. Wilson Professor of Surgery in surgical oncology at Harvard Medical School, a surgeon at Brigham and Women's Hospital, and a member of the Gastrointestinal Cancer Treatment and Sarcoma Centers at Dana-Farber Cancer Institute, all in Boston, Massachusetts. She also has decades of experience in clinical research and executive leadership in oncology and cancer policy.

Dr. Bertagnolli was the recipient of the 2023 Owen H. Wangensteen Scientific Forum Award at Clinical Congress 2023 in Boston, Massachusetts.

## Turner Becomes President-Elect of CMSS



Dr. Patricia Turner

Patricia L. Turner, MD, MBA, FACS, has been elected 2024 president-elect of the Council of Medical Specialty Societies (CMSS). She will transition to a 1-year term as president in November 2025. Dr. Turner—a general surgeon—is the ACS Executive Director and Chief Executive Officer. CMSS is a coalition of 50+ organizations representing more than 800,000 physicians that works to advance the expertise and collective voice of specialty societies in support of physicians and the patients they serve.



Have you or an ACS member you know achieved a notable career highlight recently? If so, send potential contributions to Jennifer Bagley, MA, *Bulletin* Editor-in-Chief, at [jbagley@facs.org](mailto:jbagley@facs.org). Submissions will be printed based on content type and available space.

## Desai Is Division Chief in North Carolina



Dr. Chirag Desai

Chirag Desai, MD, FACS, is the new division chief of abdominal transplant surgery and executive medical director of the University of North Carolina (UNC) Healthcare Center for Transplant Care in Chapel Hill. Since 2016, Dr. Desai has been with UNC at Chapel Hill, previously serving as surgical director of liver transplantation and director of the Chronic Pancreatitis and Autologous Islet Cell Transplant Program.

## Rizzari Joins Vanderbilt



Dr. Michael Rizzari

Michael D. Rizzari, MD, FACS, is now the surgical director of living donor liver transplantation at the Vanderbilt Transplant Center in Nashville, Tennessee, and staff surgeon in pediatric abdominal transplant surgery at Monroe Carell Jr. Children's Hospital at Vanderbilt. Specializing in liver transplantation and hepatobiliary surgery, he also is associate professor of surgery in the Division of Hepatobiliary Surgery and Liver Transplantation within the Department of Surgery at Vanderbilt University Medical Center. Previously, Dr. Rizzari was in Detroit, Michigan, serving as surgical director of living donor liver transplantation at Henry Ford Hospital, a pediatric liver transplant surgery faculty member at Children's Hospital of Michigan, and clinical assistant professor of surgery at Wayne State University School of Medicine. **B**



Disaster Management and Emergency Preparedness  
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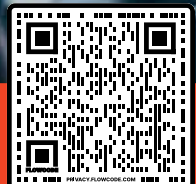
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# ACS Cancer Conference 2024

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