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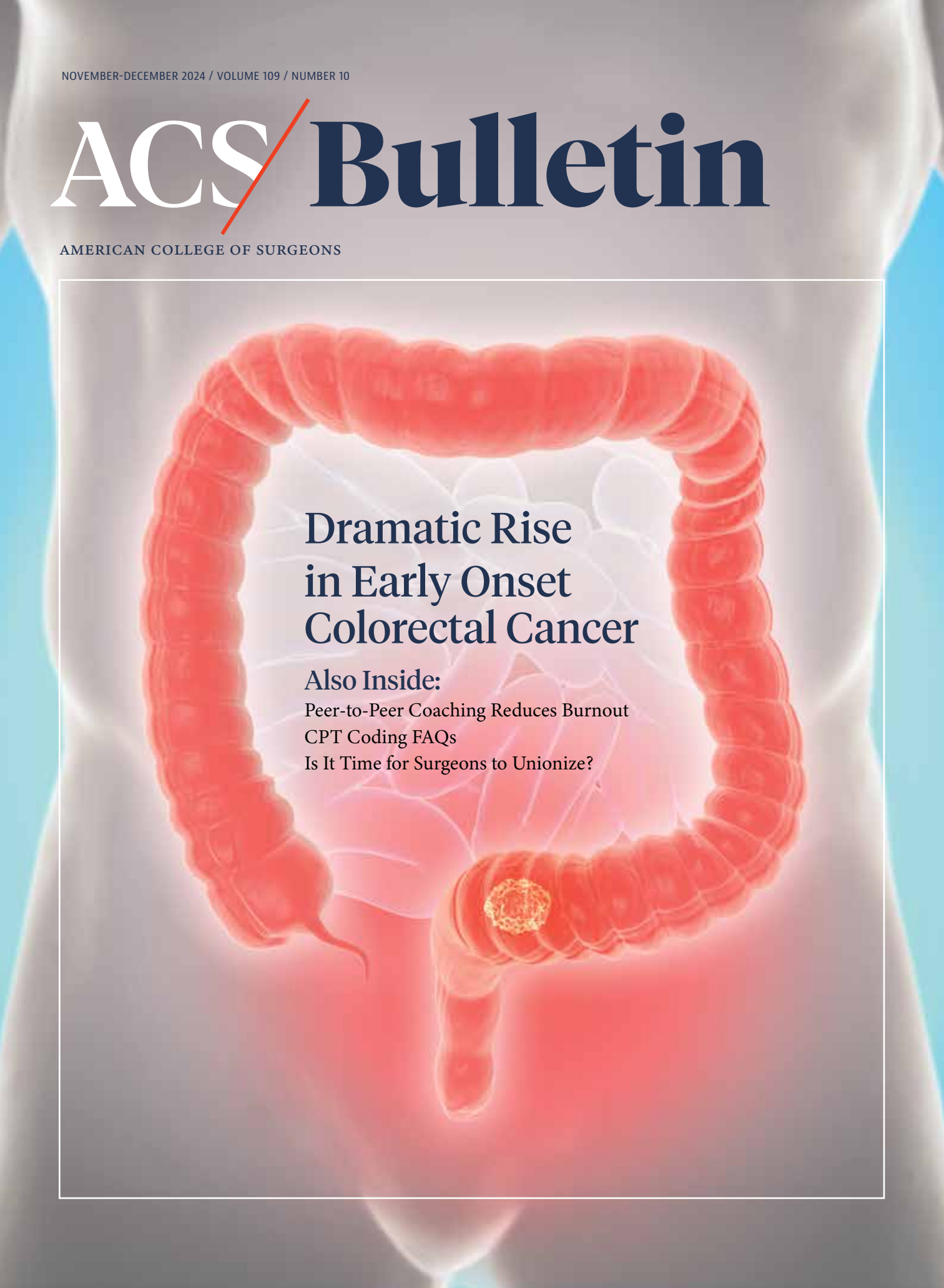
ACS Bulletin

AMERICAN COLLEGE OF SURGEONS



Dramatic Rise in Early Onset Colorectal Cancer

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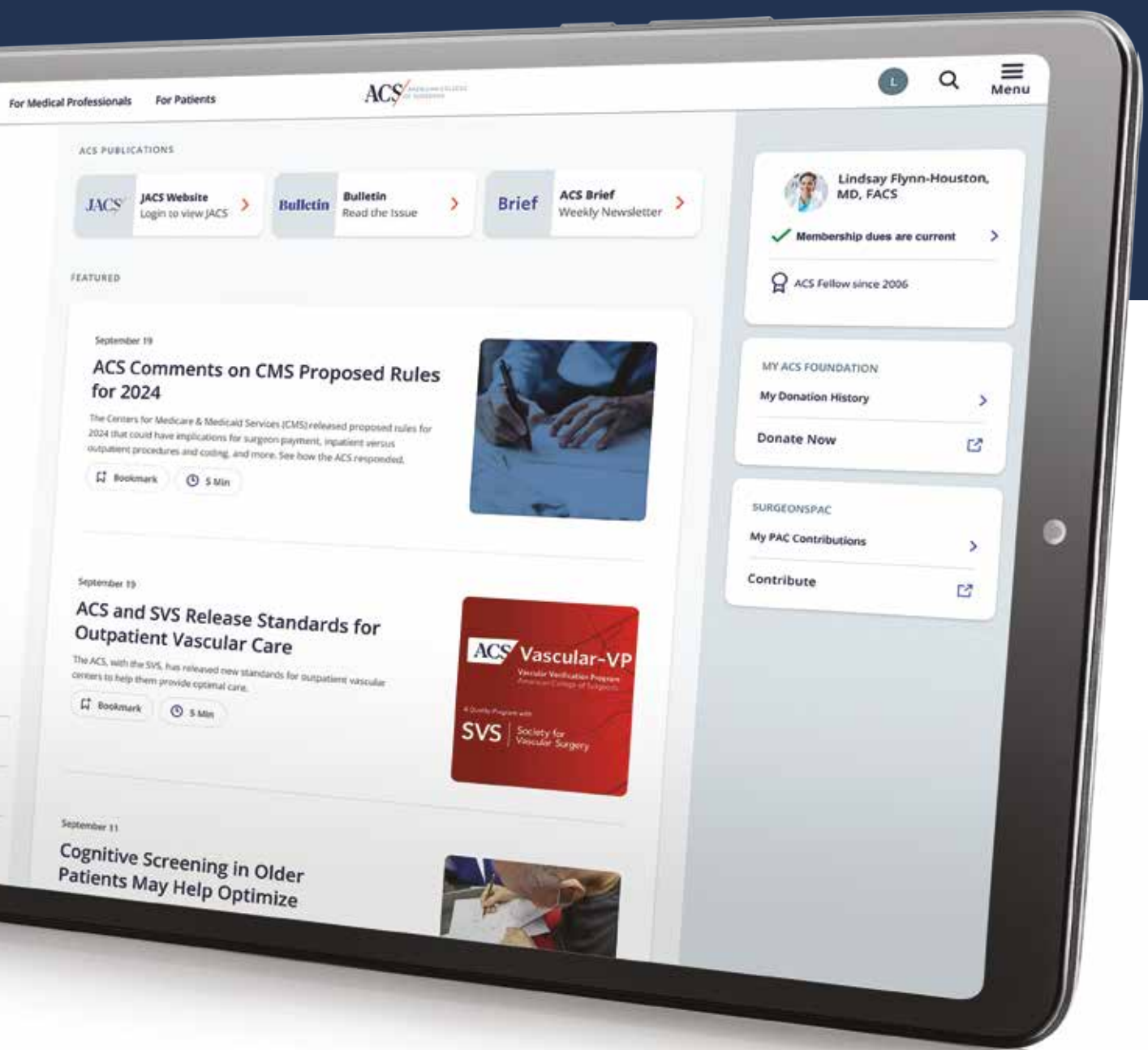

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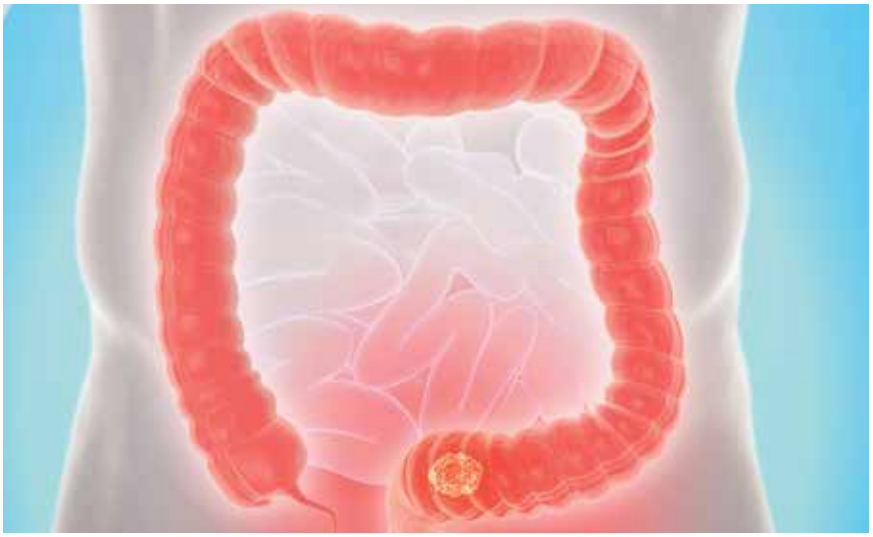
Cover Story



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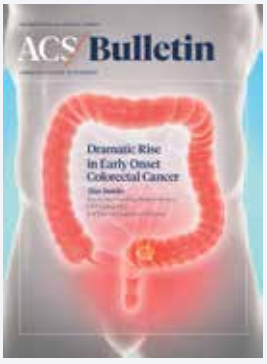

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The ACS's Year in Notable Numbers

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AS 2024 DRAWS to a close, I have been reflecting on the many ways the American College of Surgeons upholds our prestigious traditions.

This October, 114 years after the first Clinical Congress, we, once again, welcomed surgeon colleagues to our annual meeting. To more than 10,000 in-person and virtual participants, 1,807 presenters offered 2,530 presentations. We also inducted 1,894 new Fellows representing 74 countries. Continuing this tradition of engaging surgeons in professional development, education, and camaraderie is incredibly meaningful. (For more details, please see our Clinical Congress recap article on page 44.)

Like Clinical Congress, many ACS accomplishments this year were associated with notable numbers. Here are a few that capture important advancements we made in 2024.

3 This year, we welcomed three new leaders. Our inaugural Chief Health Informatics Officer, **Genevieve Melton-Meaux, MD, PhD, FACMI, FACS, FACSRS,** is a University of Minnesota colorectal surgeon and health informatics specialist who will lead updates to our data systems and AI offerings. Our first Chief Revenue and Chief Operating Officer is **Joe Rytell,** who brings a long history of business excellence in medical technology and biosciences to his role. We have selected accomplished cardiothoracic surgeon **Thomas K. Varghese Jr., MD, MS, MBA, FACS,** as the new Editor-in-Chief of *JACS*.

4 This summer, we launched AJCC Staging Online, a continually updated program for cancer staging. Four to six updated staging protocols are planned for each year; four updates (lung, thymus, and nasopharynx cancer and mesothelioma) were released this year.

20 This year, we also celebrated 20 years since the ACS adopted the National Surgical Quality Improvement Program (NSQIP) from the Veterans Administration. NSQIP now includes 700 participating hospitals, representing a significant portion of our Quality Programs' engagement with 2,200 hospitals worldwide. The Quality Programs we offer now include three launched within the last year: the Vascular Verification Program, Emergency General Surgery Verification Program, and Quality Verification Program, which approaches quality programmatically, across all surgical specialties, at hospital and system levels.

25 Our Trauma Systems Programs recognized their 25th year of service this year, with a broad reach that encompasses 33 US states. In addition, our Trauma area has released *Best Practice Guidelines in Traumatic Brain Injury Management* in conjunction with our neurosurgery colleagues, as well as MyATLS,

an app offering continually updated training in advanced trauma life support. Both are available for download now.

55 This year, 55 volunteer surgeons completed 47 trips to ACS H.O.P.E. Surgical Training Hubs in Ethiopia, Rwanda, and Zambia. On the ground and via teleconferencing, volunteer surgeons in US academic surgical consortia contributed more than 4,000 hours of service via ACS H.O.P.E., our surgical volunteerism initiative. This is the 20th year this group, founded as Operation Giving Back, has provided support to surgeons in resource-constrained environments. We look forward to many more years of engagement and you volunteering with us.

65+ This August, the US Centers for Medicare & Medicaid Services adopted the Age Friendly Hospital Measure, a new standard for improving care for patients over 65. The ACS aggressively advocated for our specialty and enjoyed a significant success in the regulatory realm. This measure is based in part on the ACS Geriatric Surgery Verification (GSV) Program, and your ACS advocacy team was instrumental in ensuring we are not held to unreasonable standards developed for other specialties. Via the GSV, the ACS can help hospitals comply with the new measure, which will take effect on January 1.

80,10 In 2025, the Excelsior Surgical Society will celebrate twin anniversaries. Military surgeons founded the group in 1945 at the Excelsior Hotel in Rome, Italy, and it persisted until its last founding member, **Michael E. DeBakey, MD, FACS,** died in 2008. Ten years ago, in early 2015, the ACS revived the Society as a home for military surgeons within the College. To honor these 80th and 10th anniversaries, the Society will return to Rome for a special conference in February.

100 Advancing surgical quality through innovation is a key part of the ACS mission, and this September, we gathered 100 experts on surgical adhesions, including surgeons, biologists, and biomedical engineers, for our Surgical Adhesions Improvement Project Summit in Washington, DC. Funded by a $1.3 million donation, the summit launched an ongoing effort to find meaningful solutions to vexing adhesive disease, including distribution of three research grants of $100,000 each.

1,000,000 This year, more than 1 million individuals took our Stop the Bleed course, learning first aid for bleeding emergencies. This replicates our numbers from 2023 and brings the lifetime total of the program to 4.1 million people in 167 countries.

There were more achievements at the ACS in 2024—too many to fit into this brief column. For more details on what the College has achieved this year, please read our Annual Report.

While we highlight the high-impact successes that improve surgical care, public health, and surgical workforce conditions here, please know that we also focus on helping ensure surgeons attain professional fulfillment and lifelong camaraderie. On behalf of the ACS, I wish you all the best in your careers, lives, and personal well-being, in this holiday season, in the new year, and always.

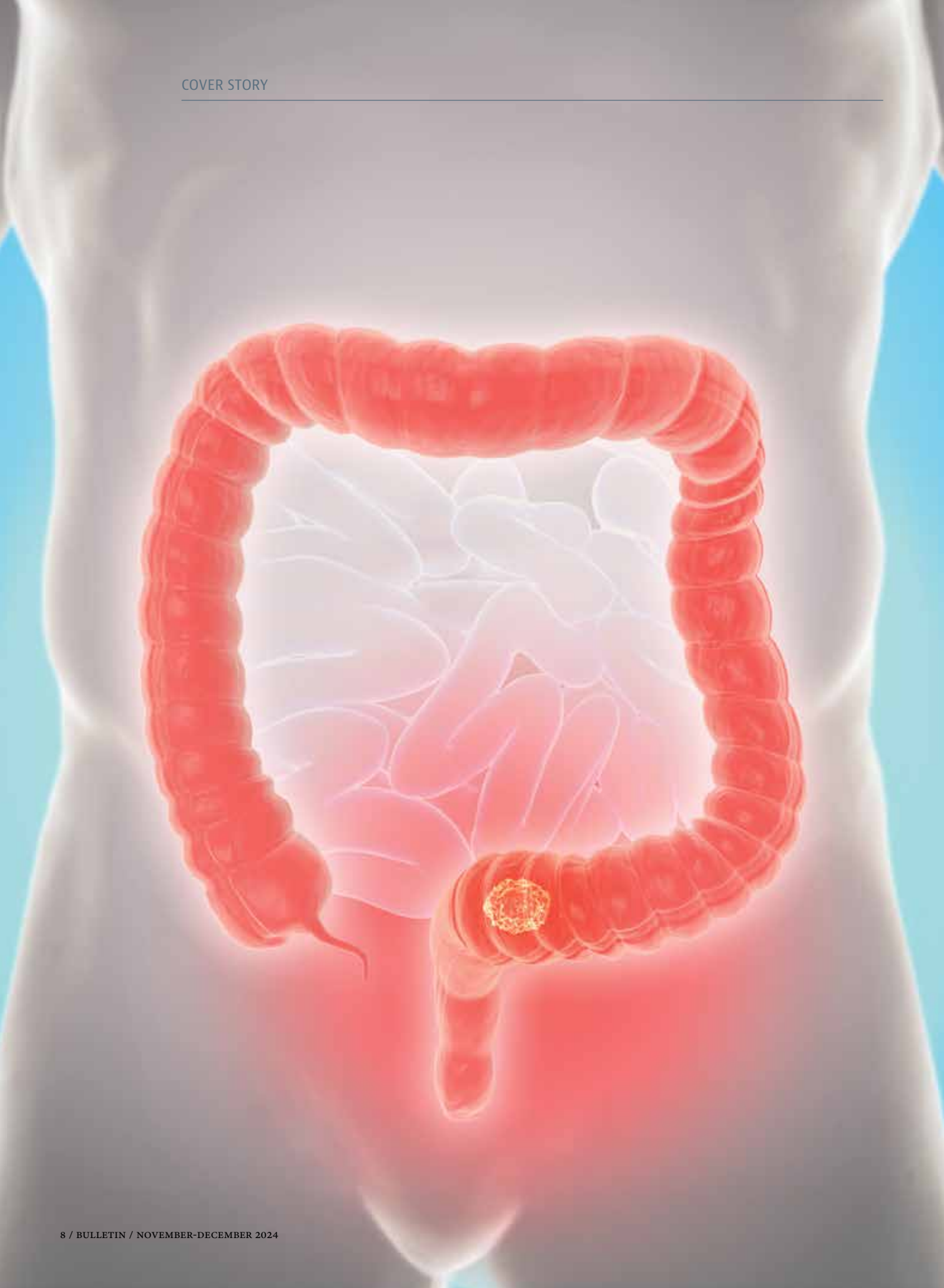
ACS Meetings

- *Clinical Congress On Demand:* If you missed some (or all) of the 2,530 presentations at Clinical Congress this year, you can still access content on demand and claim CME credit online and via the conference app. Videos will remain available until February 24, 2025.
- *TQIP On Demand:* Content from our annual Trauma Quality Improvement Program Annual Conference in November remains available as well. On-demand access to videos is expected to start in early January.
- *2025 Cancer Conference:* If you are part of a surgical oncology team, please join us this March 12–14, in Phoenix, Arizona, for the ACS Cancer Conference for 3 days of discussions on standards, quality, survivorship, and more.
- *Leadership & Advocacy Summit:* If you are interested in learning about leadership and advocacy, join us in Washington, DC, this April for our 4-day Leadership & Advocacy Summit.

Leading in 2025

If you are already prepared to lead, nominations are open for many ACS leadership positions, including President-Elect, Secretary, First and Second Vice-Presidents-Elect and two Regental roles. See the call for nominations in this issue. B

Dr. Patricia Turner *is the Executive Director & CEO of the American College of Surgeons. Contact her at executivedirector@facs.org.*

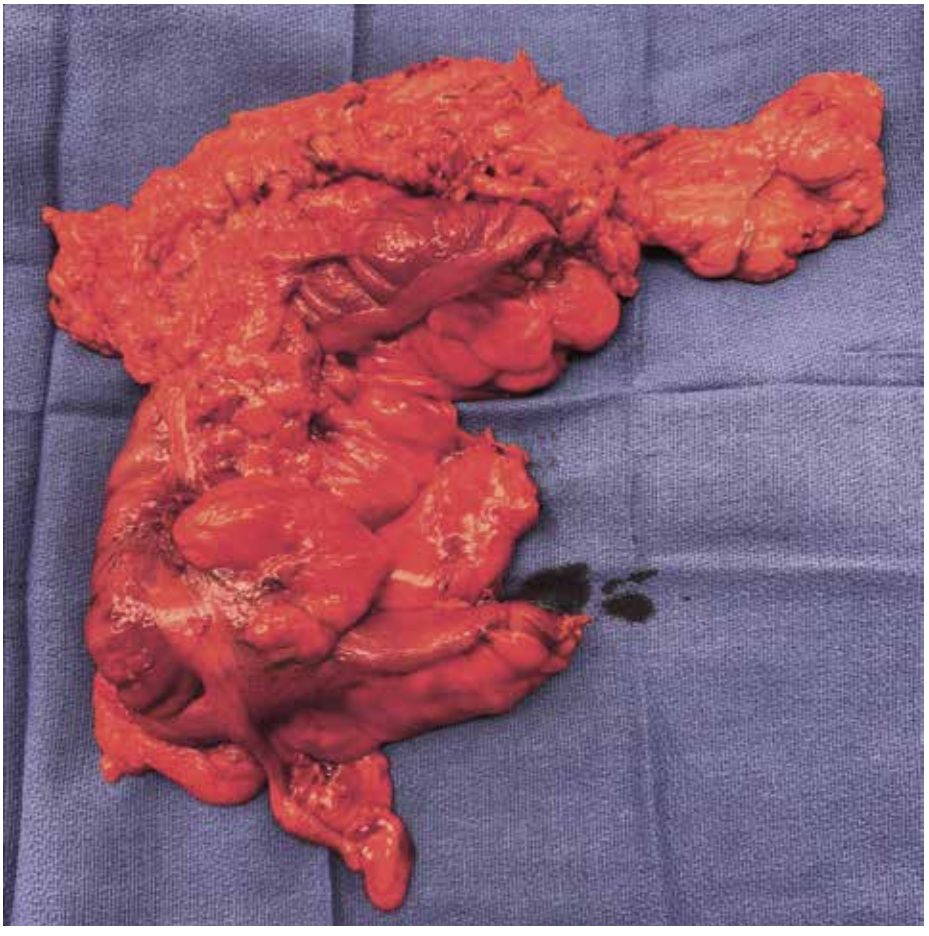


Clinicians Struggle to Understand Dramatic Rise in Early Onset Colorectal Cancer

Tony Peregrin

The number of colorectal cancer cases is increasing at an alarming rate for Generation Z, Millennials, and Generation X—young adults in their mid-20s to late 50s. And while this surge remains a perplexing medical mystery for clinicians, diet and lifestyle are suspected to be driving factors of this disease.[1,2]

Opposite:
A right hemicolectomy specimen recently removed from a patient.



ACCORDING TO a 2023 report released by the American Cancer Society, colorectal cancer cases among adults younger than 55 increased from 11% (1 in 10) in 1995 to 20% (1 in 5) in 2019.[3]

Building on those findings, a 2024 study, also from the American Cancer Society, looked at 23.6 million Americans who were diagnosed with 34 types of cancer from 2000 to 2019.[4] Investigators found the probability of developing 17 types of cancers, including colorectal cancer, increased for individuals during early adulthood and middle age. "Each successive generation born during the second half of the 20th century has had increased incidences of many common cancer types of heterogeneous etiologies compared with preceding generations in the USA," noted the study authors.[4]

For early onset colorectal cancer, a troubling conundrum for clinicians is tethered to the question of "Why?," because some of these young patients present as healthy individuals with no family history of the disease, engaging in regular exercise and consuming a healthy diet. In fact, many of the patients are not obese, which is long considered a primary risk factor for colorectal cancer among adults younger than 55.

High-profile cases of early onset colorectal cancer in individuals who were notably active (and not obese) include Broadway actor Quentin Oliver Lee, who died of stage IV colon cancer at 34 in 2022, and Chadwick Boseman, star of the trailblazing film "Black Panther" who died in 2020 from colon cancer at 43.[5,6] More recently, actor James Van Der Beek, 47, was diagnosed with colorectal cancer.

"In colorectal surgery, we were used to seeing younger people—but there was almost always a reason for it because of underlying conditions such as ulcerative colitis or inherited cancer syndromes," said Steven D. Wexner, MD, FACS, director of the Ellen Leifer Shulman and Steven Shulman Digestive Disease Center at the

Developing an awareness for the red flags that frequently present with early onset colorectal cancer can save lives, especially considering this disease is one of the only cancers that can be prevented with screening.

Cleveland Clinic Florida in Weston, and past-Regent of the ACS. "The shift was in seeing patients who didn't have an underling risk factor, either based on their own disease or their family history and genetic disposition."

Confronting the stark reality of seemingly healthy young people seeking treatment for colorectal cancer continues to be a disconcerting experience for many surgeons.

"I remember seeing the first wave of these patients, if you will, and it just seemed like an anomaly, like one-offs—and it was awful," said Sonia Ramamoorthy, MD, FACS, chief of colorectal surgery at the University of California San Diego and president of the American Society of Colon and Rectal Surgeons. "But this phenomenon started to become more and more commonplace. And I remember saying to our genetics counselor, 'What is going on? We're seeing so many more rectal cancers in young patients—what is happening here?'"

Red Flags for Patients with Early Onset Colorectal Cancer

A scientific review of 81 studies and nearly 25 million colorectal cancer patients under age 50 published in the *Journal of the American Medical Association* in 2024 revealed that the most common warning for the disease in this cohort is passing blood in the stool.[7,8] Abdominal pain, anemia, and altered bowel habits also were identified as common indications of the disease.

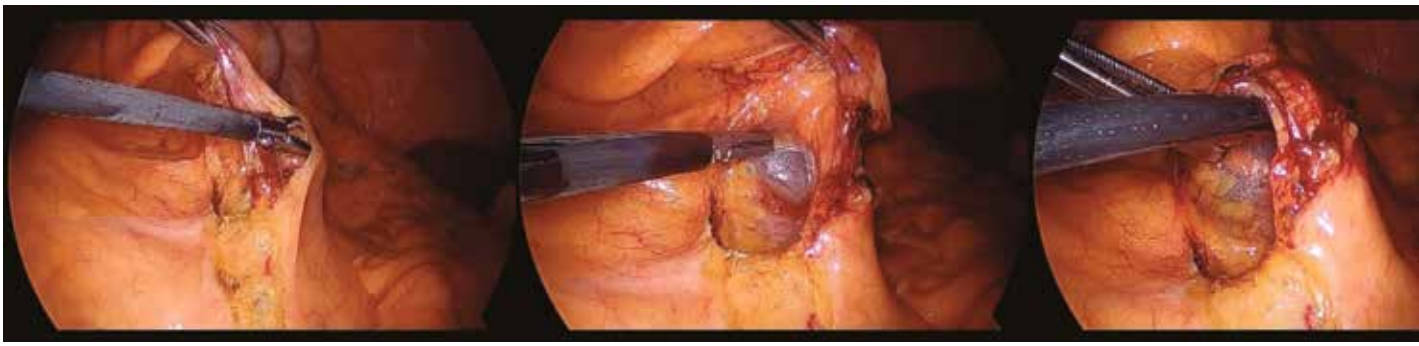
Researchers noted delays in diagnosis were common—up to 6 months from initial presentation of symptoms. Due to these delays, younger adults tend to have more advanced disease, which is typically more challenging to treat.

"The physicians who see these patients before we do—the family practitioners, internists, gynecologist, and gastroenterologist—need to be aware that when a patient presents with rectal bleeding, abdominal pain, diarrhea, unexplained weight loss, or iron deficiency anemia—these symptoms should trigger a colonoscopy," said Dr. Wexner.

Developing an awareness for the red flags that frequently present with early onset colorectal cancer can save lives, especially considering this disease is one of the only cancers that can be prevented with screening.

"If you're 39 and you're having these symptoms, you're not thinking, 'I have colon cancer,'" added Dr. Ramamoorthy. "You're thinking, 'I ate something. I'm working too hard.' If you're tired and you're stressed out, you're thinking, 'It'll go away.' People are presenting later because they're just not attributing their symptoms to something that could be serious. If you're a surgeon or a GI doc and you're getting the referral for this patient—you really need to get the patient in quickly for an evaluation."

In fact, colorectal surgeons are in a unique position to screen select patients presenting with a variety of conditions. "When we see patients coming in for hemorrhoids or diverticular complaints or a hernia repair, we can use these opportunities to suggest a colonoscopy as well



These images are taken from a video depicting a laparoscopic right procedure with colon cancer invading the abdominal wall.

for patients older than 45," Dr. Ramamoorthy said.

Colonoscopy—the Gold Standard—Outshines Other Approaches

While colorectal cancer rates continue to climb among younger adults, rates have declined for adults 60 and older, primarily due to one essential difference between the two cohorts: older adults are much more likely to get a colonoscopy, which is the most accurate way to detect the disease.[9]

The colorectal cancer screening guidelines developed by the American Cancer Society for individuals at average risk recommend regular screening starting at age 45, either through a stool-based test or a visual test (colonoscopy).[10] Unfortunately, less than 60% of eligible candidates have had their recommended screening.

"The colonoscopy is the gold standard of screening because it provides the opportunity to diagnose, treat, and prevent," explained Dr. Wexner. "This screening is exceptionally effective. The problem is people don't always think they have a reason to be screened, particularly younger people who are asymptomatic."

Additional barriers to screening for this age group could include not having a primary care provider or lack of health insurance to cover screening-related costs.

"My personal bias is that we could probably drop the screening age another 5 years—to age 40," said Dr. Ramamoorthy. "I really think we would capture a lot of what we're currently seeing as early onset colorectal cancers. I understand there's a public health price to pay for that—but there's a public health price for not screening this young population for a preventable disease."

Epigenetic Aging

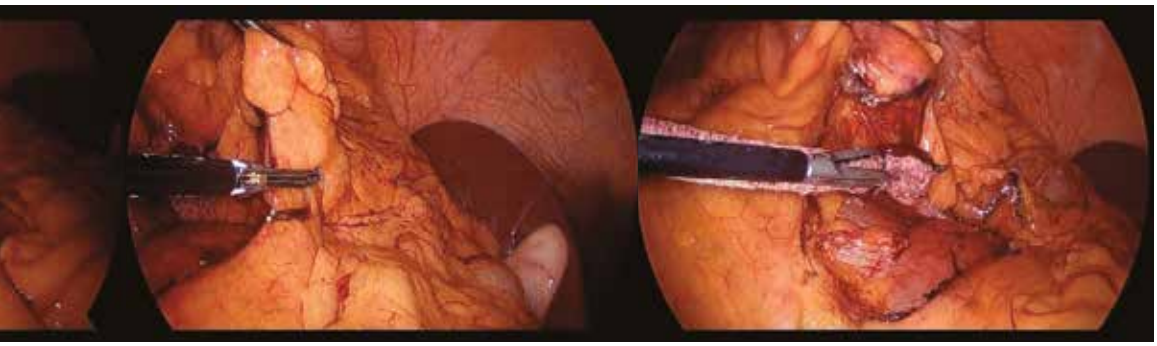
Yin Cao, ScD, MPH, a cancer epidemiologist with the Washington University School of Medicine in St. Louis, Missouri, presented research earlier this year at the American Association for Cancer Research annual meeting suggesting that young adults with cancer are aging faster than their counterparts.

Dr. Cao and colleagues analyzed the association between biological age and cancer risk in 148,724 young adults via data extracted from the UK Biobank database. By examining nine blood biomarkers, including creatinine, C-reactive protein, lymphocyte proportion, and white blood cell count, their findings suggested that bodies with accelerated aging were linked to an increased risk of cancer.[11]

In fact, an expanding body of research suggests that looking beyond calendar age to examine biological or epigenetic aging might help clinicians improve prevention and early detection of cancers in adults younger than 55 years of age.

Cancer has typically been considered an aging-related disease. As the human body ages, it experiences more oxidative stress and DNA damage, which can lead to cell alteration and tumor growth. Research also suggests that during the aging process, the body is less adept at shedding old "senescent" cells, which can be inflammatory and promote tumor growth.

A primary driver of rapidly aging cells is diet, according to researchers from The Ohio State University in Columbus, who presented their findings at the American Society of Clinical Oncology's annual conference in 2024. Specifically, a Western diet consisting of high intakes of prepackaged foods, refined grains, fried foods, and other products can agitate bacteria in the gastrointestinal tract,



resulting in inflammation and accelerated aging of cells.

"The results of this study found that young adults who develop colorectal cancer are, on average, biologically 15 years older than their chronological age, which is fascinating," suggested Dr. Wexner. "It's thought to be related to diet and lifestyle. I like to tell my patients 'What's good for your heart is good for your colon'—for the most part. People need to adopt a healthy lifestyle, which means eliminating or at least limiting red meat intake and consuming a high-fiber diet with lots of raw fruits and vegetables."

He noted that disrupting the gut microbiome with a consistently unhealthy diet is akin to "releasing the brake," thereby providing an opportunity for tumors to grow.

"The risk factors for colorectal cancer have always been there and they haven't changed—diet and exercise—but until recently, we've been more attentive to all the other things like family history and other diseases such as inflammatory bowel disease," said Dr. Ramamoorthy. "As these cancers continue to affect our younger generations, we're focusing on what's being done to our food, how that's affecting our microbiome, and how that is creating a chronic inflammatory state that is manifesting itself potentially in cancer in their gut."

Surgeons' Role in Educating Physicians and Public

The incidence rate of early onset colorectal cancer is expected to double by 2030, which means 10.9% of all colon cancers and 22.9% of all rectal cancers will be diagnosed in young adults—a stark comparison to 2010, when 4.8% and 9.5% respectively were diagnosed in this same cohort. These estimates underscore why this disease, particularly for those under the age of 55, should be a top public health priority, with an emphasis on education and screening similar to breast cancer awareness initiatives.

"I would like to see more surgeons and societies like the College and American Society of Colon and Rectal Surgeons be front and center in a marketing campaign to educate others on the US Preventive Services Task Force screening guidelines," said Dr. Ramamoorthy. "I think when surgeons say something, people listen. They have the power to influence others and make a difference in the public health sector, and with patients and colleagues."

Direct one-on-one conversations with surgeons and other healthcare professionals should underscore the consequences of ignoring the possibility that a young patient could have colorectal cancer.

"These patients are presenting with very obvious symptoms, like rectal bleeding and abdominal pain, and yet they're getting dismissed," Dr. Ramamoorthy added. "Alert the primary care doctors who are in your group or community practice about this phenomenon. Remind them that the screening age has dropped to 45, and encourage them to have anybody who's coming in with some of these symptoms to get an evaluation."

In fact, there are many opportunities to have touchpoint conversations with peers, including before and after hospital lectures, journal clubs, grand rounds, clinical conferences, and more.

"Have a HIPAA-compliant conversation with your colleagues," advised Dr. Wexner. "Tell them, 'I just happened to take care of a 30-year-old with a colon cancer—and

it's really a shame because for 6 months this person had bleeding and abdominal pain, and by the time the colonoscopy was obtained, the lesion had already spread to the liver.' Let people know these real-life stories to help effect change."

Dr. Steven Wexner uses a model of a colon during a patient consult.

Emerging Screening Tools

In July 2024, the US Food and Drug Administration (FDA) approved a blood test, called Shield, to screen for colon cancer. The test, previously available to doctors at an out-of-pocket cost of $895, is now more likely to be covered by Medicare and private insurance companies with FDA approval.

The test, which is the second blood test to screen for colon cancer, is most effective at identifying late-stage cancers and is not intended to replace colonoscopies. According to *The New York Times* and the manufacturer's patient brochure, in a study published in March 2024, Shield found 83% of colorectal cancers but only 13% of polyps, compared with colonoscopies which found 95% of polyps.

"In my opinion, this exciting development will be the first of many such advances in noninvasive detection of colorectal cancers and polyps. However, the very low rate of polyp detection by the recently FDA-approved test is potentially concerning," Dr. Wexner said, adding that several perquisites, such as "impeccable sensitivity and specificity" are necessary prior to universal adoption.

"Moreover, patients with positive tests will require a colonoscopy, and patients with negative tests may not undergo a potentially needed colonoscopy," cautioned Dr. Wexner. "In this latter group of patients, the opportunity to remove precancerous polyps may be missed."

Ideally, the expectation is that this new test, despite its

limitations, could boost the number of people screened for colorectal cancer overall, especially individuals younger than age 45 who are too young for routine colonoscopies.

The development of more precise and reliable noninvasive detection tools, particularly self-administered tests, could be on the horizon; until then, the colonoscopy reigns supreme for identifying colorectal cancer.

"I think someday in our lifetime, we'll hopefully be able to have a home test that identifies the presence of colon cancer and colon polyps—a tool that will be an accurate-enough test that we can say, 'Hey, that's a believable result,'" said Dr. Ramamoorthy.

Future research in the areas of prevention and treatment of early onset colorectal cancer should be multidisciplinary with studies that include diverse populations in order to uncover new mechanisms for identifying young adults who are at high risk for this disease.

To learn more about early onset colorectal cancer from Dr. Wexner and Matthew F. Kalady, MD, FACS, a widely recognized expert in colorectal cancer, listen to episode 44 of *The House of Surgery* podcast, "Colorectal Cancer Is on the Rise in Younger Adults," at *facs.org/houseofsurgery.* B

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Access related video content online.

Access *The House of Surgery* podcast episode on early onset coloretal cancer.

Peer Coaching May Be "Prescription" to Solve Side Effects of Healthcare Corporatization

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As the healthcare landscape in the US becomes increasingly corporatized,[1] bureaucracy is growing, and budgetary control and the locus of healthcare decision-making are moving farther away for the individual clinical practitioner.

FOR MOST OF THE LATTER HALF of the 20th century, healthcare decision-making, specifically decisions about direction, mission, and budget, were all significantly within the control of physicians and surgeons. Physician and surgeon autonomy has shifted radically over the past 30 years. Two noteworthy influences include a shift from private practice to employed physicians (70% of doctors are now employed), and the growth in corporate structures that have shifted the locus of decision-making, marginalizing physicians and limiting their ability to effect change.[1]

Increasing corporatization of healthcare clearly impacts the perceptions of surgeons and physicians. For instance, in a study of emergency medicine physicians, 70% agreed that the corporatization of healthcare has had a negative or strongly negative impact on both their job satisfaction and quality of patient care.[1] A survey of emergency physicians demonstrated that as early as 2013, less than 50% felt "very comfortable" raising quality-of-care issues with hospital administration.[2]

Reduced decision-making authority in high-demand jobs has been shown to increase stress and burnout, which is a growing issue for surgeons. Numerous studies have demonstrated that symptoms of burnout, including emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment approach or exceed 50% among physicians.[3-5] The demand for profit increasingly contributes to settings where physicians feel they cannot consistently meet patient needs and provide quality care, creating a sense of moral injury among providers.[1,4]

The diminished decision-making authority of physicians and surgeons has significant implications for their engagement, performance, and satisfaction. Substantial research also has documented that in high-demand jobs, the degree of control or decision latitude has important implications for both mental and physical health.[6,7]

High-demand and low-control (or decision latitude) jobs are associated with higher depression and death among workers, while high-demand and high-control jobs have a positive association with improved mental and physical health, particularly in high cognitive groups.

Perception of control is important in this context, as measures that either diminish or increase the perception of control, without altering actual control, can either exacerbate or mitigate this association. Thus, diminishing the perceived decision-making authority within the context of physicians' highly demanding jobs directly increases mental stress, impacting overall burnout, well-being, and health.

Importantly, another factor has been shown to influence the association between job control and mental and physical health—the social support at work.[6] Measures that promote internal solidarity and social support have been shown to mitigate the negative effects of low control. These data suggest that efforts to enhance social support among surgeons and physicians may reduce burnout and improve performance.

Therefore, investing in peer-to-peer coaching could reduce the stress and burnout among surgeons and improve surgeons' ability to navigate an increasingly complex bureaucratic structure in order to successfully advocate for their patients.

Using Peer-to-Peer Coaching to Reduce Stress, Burnout

Coaching is effectively used to enhance performance in many high-performing professions such as athletics, business, music, and education.[8] Coaching to improve technical and nontechnical skills in the OR, while a relatively recent development, has gained significant support, with systematic reviews demonstrating improvements in technical surgical performance.[8] In fact, peer coaching can be used to enhance a surgeon's ability to adapt to a changing

healthcare environment, as well as reduce burnout because an essential aspect of effective physician coaching entails assisting practitioners to develop and deploy tactics and strategies that boost their actual and/or perceived sense of control and support when encountering workplace coping challenges.

Systematic reviews and meta-analyses demonstrate that interventions can significantly reduce measured rates of overall burnout, emotional exhaustion, and depersonalization, and that organizationally directed interventions have a larger effect than those that are physician-directed.[9,10] In one cluster randomized trial, physicians in the intervention group had a significant reduction in burnout, and the interventions that improved interpersonal communication among providers and teamwork had an odds ratio of 3.1 (p=0.04) for improved job satisfaction.[11]

Several randomized trials have demonstrated that coaching delivered by either professional coaches or physicians who have received coach training improves burnout and resilience in both residents and practicing physicians and surgeons.[12–14]

In a randomized trial of 80 surgeons in which the intervention group received six monthly coaching sessions from professional coaches, the intervention group had a 5% reduction in burnout relative to controls and significantly improved resilience scores at the conclusion of the trial.[12]

In another setting, after receiving strongly positive feedback from participants of a professional development coaching program for interns,[14] the program's leadership subsequently undertook a randomized trial of coaching for residents. The randomized trial compared the effects on residents' well-being as the result of two interventions. The intervention group received three coaching sessions over a 9-month period. Members of the control group were given electronic wellness resources. Coaching was provided virtually by attending surgeons who had undergone 3 hours of in-person training.

The intervention group showed significant improvement in burnout, work exhaustion, self-valuation, professional fulfillment, and well-being.[15] In a more recently published randomized trial, 138 volunteers from the Massachusetts General Physicians Organization (MGPO) were randomly assigned in a 1:1 allocation to receive either early coaching or delayed coaching (control group) by trained physician peers.[13] Participants underwent six coaching sessions over a 3-month period and self-selected their coaches from a pool of 13 peers who had undergone coach training. After the 3-month coaching period, researchers observed statistically significant improvements in burnout, interpersonal disengagement, professional fulfillment, and work engagement compared to the no-intervention group.

These findings are prompting organizations to implement peer-to-peer initiatives. For example, in response to their high rates of burnout and physician turnover, Envision Healthcare, a national hospital-based physician group, established a peer-coaching program that trained physicians who volunteered their time to learn the peer-coaching process. The trained physician peer coaches provided support to physicians who are at risk of burnout as well as supporting site directors. The program has resulted in increased resources to expand it. Additional referrals of physicians at high risk of burnout have been solicited, and the organization is recruiting additional physicians to provide support.

Another rationale for creating an internal, peer-to-peer coaching network relates to the ever-present need in today's workplace to broaden and deepen a collaborative culture.

Peer-to-peer coaching creates structures and processes for social and professional support within the organization, enhances the listening, leadership, and development skills of those who undergo coach training, and strengthens connectivity across the organization's medical staff structure. Coaching, in this context, is defined by the International Coaching Federation as partnering with a client in a thought-provoking and creative process that inspires them to maximize their personal and professional potential.

Coaching is a collaborative enterprise, in which the coach and client work together as equals to advance action-oriented goals. Coaching is an effective method to foster increased self-awareness and emotional intelligence, enhance psychological safety and trust within collaborative, multidisciplinary teams, and improve resilience and agility to navigate the ever-increasing pace of change. Coaching has been shown to enhance performance and, assuming a successful coaching interaction, may enhance the degree of perceived job control.[16]

The acquisition of coaching skills directly aligns

with the qualities identified in highly effective listeners. In an analysis of data obtained to evaluate the performance of 3,492 managers engaged in a program to improve their coaching skills, characteristics that separated participants from the top 5% of listening skills were identified. The highest-rated listeners exhibited the following:[17]

- Asked questions designed to promote discovery and insight
- Made the conversation a positive experience for the other party by using phrases that offer support and convey confidence in the other person
- Engaged in cooperative conversations
- Provided nonconfrontational feedback that opened alternative paths to consider

Another justification for employing the peer-to-peer coaching model is the fact that physicians and surgeons often prefer support from colleagues more than support from nonphysicians. In a study performed at a Boston teaching hospital, 885 respondents from three different departments indicated they would prefer a colleague as a source of support.[18] For physicians, peer coaching is an opportunity to talk with someone who understands the unique work culture, job responsibilities, opportunities, and trade-offs involved in the lives of medical professionals.[16]

Investing in developing coaching skills within an organization's physician and surgeon groups should provide a strong financial return on investment through reducing burnout and its negative consequences, improving overall productivity, and supporting the development of a coaching culture within the organization.

The negative consequences of burnout are well chronicled. Burnout directly impacts an organization's quality of care. It is associated with a two-fold increase in risk of medical errors and 17% increased odds of malpractice litigation.[5] Burnout also significantly impacts the health of providers increasing the risk of alcohol abuse by 25% and doubling the risk of suicidal ideation.[5]

Burnout also is associated with lower patient satisfaction, reduced physician productivity, and higher physician turnover.[3,19] In a longitudinal study of 2,500 physicians at the Mayo Clinic in

Long-term solutions for the challenges related to physician and surgeon well-being will require a multifaceted approach and an expansion of physician skills regarding self-care.

Rochester, Minnesota, evaluating productivity through billing records, each 1-point increase of burnout on a 7-point scale, or 1-point decrease in professional satisfaction on a 5-point scale, was associated with a 30%–50% increase in likelihood of loss in productivity.[19] The cost of turnover in historical studies is typically 2–3 times the physician's salary, though it may be much higher if the potential loss in revenue is factored into the estimation.[19]

Considering these data, the cost of peer-to-peer coaching seems quite economically sound. The total cost per participant in the Kiser trial, including the training of 13 coaches, was $1,556.73.[13] The ongoing costs for future participants (excluding training) would be $969.23. While creating a peer-to-peer network may have higher upfront costs than using external professional coaches, once physicians are trained, the ongoing cost is less. Comparing the ongoing cost of the MGPO peer-to-peer program to the Mayo program using external professional coaches, the peer-to-peer program cost is $430 less per participant.[13]

Long-term solutions for the challenges related to physician and surgeon well-being will require a multifaceted approach and an expansion of physician skills regarding self-care and promoting and maintaining collaborative teams. A dynamic physician peer-to-peer initiative can add value to such efforts.

At minimum, an organization launching a physician peer-to-peer process will create good will by demonstrating to team members that they are valued by the organization. The improved peer relations, heightened sense of unity and social support, and enhanced professional development in both those who receive coaching training and the clinicians who later are clients of the network will likely be added benefits from this investment.

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Trainees Can Thrive at National Conferences

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THE SCOPE OF RESIDENT EDUCATION and leadership development evolves through graded autonomy obtained during the course of general surgery residency. As a junior resident, priorities include establishing clinical competency and knowledge, while also exploring future career options.

During the latter stages of residency, the focus progresses to leadership development and self-guided surgical education.[1] National conferences offer a wide and impactful platform to develop leadership skills and further surgical education. These conferences afford opportunities to network within a surgical area of interest, explore other styles of surgical practice, and showcase current research.

Research abstracts presented at national conferences have a 68% chance of being accepted for manuscript publication and are more likely to be published in a high-impact journal compared to abstracts not accepted at national conferences.[2]

Despite these benefits, there remains a paucity of published work outlining the potential advantages for residents who attend national conferences. This article provides an outline for residents on how to find established national conferences and become active participants at these meetings, and offers best practices for networking.

In deciding which national conferences to attend, the subspecialty of interest and aim of the society that best reflect the goals of the individual should be prioritized. The ACS recognizes 14 surgical disciplines: cardiothoracic surgery, colon and rectal surgery, general surgery, obstetrics and gynecology, gynecologic oncology, neurological surgery, ophthalmic surgery, oral-maxillofacial surgery, orthopaedic surgery, otolaryngology, pediatric surgery, plastic and reconstructive surgery, urological surgery, and vascular surgery.[3]

On page 26, there is a nonexhaustive list of active surgical societies within each of the various surgical specialties. Generally, the mission of a society will focus on one of the following principles: academic endeavors/accreditation, subspecialty surgery, educational techniques, or a specific pathology. For example, the American Society of Plastic Surgeons is geared toward establishing a standard of care for plastic surgery patients while encouraging competent surgical technique during training and beyond.[4] The American Council of Educators in Plastic Surgery's mission is developing, promoting, and supporting plastic surgery education that meets a predefined set of plastic surgery curriculum standards.[5]

Certain societies focus on a particular pathology, such as the Surgical Infection Society, which aims to provide training and scientifically validated guidelines on the management of surgically related infections. The Crohn's & Colitis Foundation is dedicated to cures for inflammatory bowel disease. Within the realm of surgical education, the Association for Surgical Education is an established society geared toward enhancing the education provided by surgery mentors to their respective mentees.

Conferences also provide education on specific aspects of practice, such as the ACS Leadership & Advocacy Summit, ACS Surgical Simulation Summit, and the ACS Quality and Safety Conference. It is important to identify national conferences that align with the resident's career goals and specialty of interest.

The acquisition of new knowledge is one of the most important benefits of attending conferences. Conferences feature lectures and presentations by various experts in their respective fields discussing current trends and shifts in clinical practice, emerging techniques and treatments, and comprehensive topic reviews that can be informative to participants of all experience levels.

Many exhibitors and sponsors promote their products, and some may offer demonstrations, which can provide opportunities for residents to engage with novel tools that might not be readily available at their home institutions. Additionally, conferences may offer hands-on training courses and examinations; these can sometimes be included with

The acquisition of new knowledge is one of the most important benefits of attending conferences.

conference registration at no additional cost, such as Stop the Bleed training at the ACS Clinical Congress.

Two courses that merit particular mention include the Fundamentals of Endoscopic Surgery and Fundamentals of Laparoscopic Surgery exams offered at the annual meeting of the Society of American Gastrointestinal and Endoscopic Surgeons.[6] Attending this conference enables residents to complete necessary graduate medical education coursework that may otherwise be challenging to obtain at their home program.

Strategies for Reducing Costs

While there are many benefits to attending conferences, they can sometimes be outweighed by the financial costs of attendance. The basic costs include registration fees, travel, food, and lodging. Optional social events and educational activities usually require additional fees and are often necessary to maximize the benefits from conference attendance.

One estimate found that for medical students, who often have comparable registration fees to residents, the total cost of conference attendance was about $800 per conference.[7] While many surgical residency programs offer trainee reimbursement for conference attendance, reimbursement may be capped or limited to a predetermined number of meetings.

It is important for trainees to clarify the reimbursement policies of their programs. If costs are a concern for conference attendance, an alternative option is virtual attendance. Particularly following the global pandemic, many conferences now offer virtual attendance options. These virtual conferences provide an enriching academic experience through participation in lectures and other educational activities without a time commitment and often with a reduced cost.

However, the format of virtual conferences can make networking more challenging, and attendees may be subject to technical difficulties such as disruption of livestreamed content.[8] Many organizations offer previous livestreamed content for review at a later date. For instance, an on-demand library of educational content from Clinical Congress 2024 is now available until February 24, 2025. Both in-person and virtual attendees may access content by visiting *facs.org/clincon2024*.

Another important way to offset costs is through presenting research at conferences, as these activities often will be covered by a resident's department. Certainly, there are multiple challenges for the development and progression of research projects during training, including competing clinical duties, American Board of Surgery In-Training Examination preparation and testing, and scheduling conflicts. Therefore, identifying research mentors and developing projects that lead to presentations require advance planning.

While deadlines vary between individual conferences, abstract submission windows typically open 3-to-6 months prior to the conference date. Other advantages of presenting research—outside of the financial benefit—include engaging a national audience, identifying potential collaborators, and generating ideas for future projects. Trainees should research which conferences are worthwhile for their education and which are most beneficial for presenting and networking. It is expected that these priorities may change throughout the course of training.

Value of Networking and Mentorship

Possibly the most important reason to become engaged in national conferences as a trainee is to embed oneself early in the networking arena.[9] These conferences are places where surgeons of all backgrounds meet to reconnect and establish new relationships.

Effective ways to engage in national conferences include identifying committee meetings to join and projects to become involved with, which can lead to introductions to leaders who are most actively

Surgical Specialty and Associated Organizations

Cardiothoracic Surgery

American Board of Thoracic Surgery
The Society of Thoracic Surgeons

Colon and Rectal Surgery

American Board of Colon and Rectal Surgery
American Society of Colon and Rectal Surgeons

General Surgery

American Board of Surgery
American College of Surgeons
American Surgical Association
Southern Surgical Association
Western Surgical Association

Gynecologic and Obstetrics

American Board of Obstetrics and Gynecology
The American College of Obstetricians and Gynecologists
The Society of Gynecologic Oncology
Society of Surgical Oncology
Surgical Oncology/Gynecologic Oncology

Neurological Surgery

American Academy of Neurological Surgeons
American Association of Neurological Surgeons
The American Board of Neurological Surgery
Congress of Neurological Surgeons

Ophthalmic Surgery

American Academy of Ophthalmology
American Board of Ophthalmology

Oral and Maxillofacial Surgery

American Association of Oral and Maxillofacial Surgeons
American Board of Oral and Maxillofacial Surgery

Orthopaedic Surgery

American Association of Orthopaedic Surgeons
American Board of Orthopaedic Surgery

Otolaryngology

American Academy of Otolaryngology-Head and Neck Surgery
American Board of Otolaryngology

Pediatric Surgery

American Academy of Pediatrics—Section on Surgery
American Pediatric Surgical Association

Plastic and Maxillofacial Surgery

American Association of Plastic Surgeons
Plastic Surgery Research Council
American Board of Plastic Surgery
American Society of Plastic Surgeons

Urology

American Urological Association

Vascular Surgery

Eastern Vascular Society
Midwestern Vascular Surgical Society
New England Society for Vascular Surgery
Pacific Northwest Vascular Society
American Heart Association
Society for Clinical Vascular Surgery
Society for Vascular Medicine
Society for Vascular Surgery
Southern Association for Vascular Surgery
Vascular & Endovascular Surgery Society
Western Vascular Society

Trauma Surgery

The American Association for the Surgery of Trauma
The Eastern Association for the Surgery of Trauma
Society of Critical Care Medicine
Surgical Infection Society
Western Trauma Association

Academic Surgery and Surgical Education

Academic Surgical Congress
American Surgical Association
The Association for Surgical Education
Association of VA Surgeons
Association of Women Surgeons
The Society of Asian Academic Surgeons
The Society of Black Academic Surgeons

Minimally Invasive Bariatric Surgery

American Society for Metabolic and Bariatric Surgery
Society of American Gastrointestinal and Endoscopic Surgeons

Breast Surgery

The American Society of Breast Surgeons

Transplant Surgery

American Transplant Congress

Endocrine Surgery

American Association of Endocrine Surgeons
American Thyroid Association

Note: This list of active surgical societies is not intended to be comprehensive.

advancing the surgical field. Examples of such committees include the ACS Resident and Associate Society (RAS-ACS), which specifically focuses on issues important to trainees and young faculty.

As a trainee, identifying a mentor while attending the meeting can enrich the experience. The value of mentorship in surgery has been well studied and requires an investment from both parties, which can be easier to establish outside of the hospital environment.[10]

The atmosphere at national meetings is generally more collegial with faculty being more accessible and receptive than they might be otherwise during their day-to-day routines. These individuals can help provide valuable introductions, support residents at their presentations, facilitate more socially engaging conversations, and invite residents to important events.

Attending national conferences is beneficial for resident education and surgical leadership development. The benefits include exposure to new and emerging surgical knowledge and techniques, providing a platform to showcase academic endeavors, and plentiful networking opportunities. However, while there are many benefits to attending conferences, time and financial challenges may require that surgical residents identify a select few national conferences that align with their career goals.

Careful consideration of all factors will allow surgical residents to maximize the educational benefits of conference attendance and nurture the beginning of a lifelong engagement within the broader surgical community. B

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Frequently Asked Questions about CPT Coding

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Correct Current Procedural Terminology (CPT®)* coding and documentation are important for seamless billing. This article provides several frequently asked questions and the correct coding responses, along with documentation tips to reduce denials.

Q I just started doing robotic eTEP (extended totally extraperitoneal) hernia repairs. How should this be reported?

A The anterior abdominal hernia repair codes are agnostic of approach. Laparoscopic, robotic, and open procedures are coded similarly. The CPT code to report should be chosen based on hernia size, presence of incarceration, and recurrent nature. If the work required was substantially greater than what is typically required, it may be appropriate to append modifier 22 to the procedure code. Documentation must be submitted that supports the substantial additional work and reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

Q Removal of an abdominal wall tumor resulted in a large defect. Would it be appropriate to report a hernia repair code along with other repair codes such as component separation, adjacent tissue transfer, and/or complex repair?

A It would not be correct to report a hernia repair code for repair of an abdominal wall defect created either iatrogenically (e.g., removal of a tumor) or from trauma (e.g., stab wound). Such a repair is no different than repair for any other anatomic wound (e.g., repair after removal of a tumor from the thigh). The correct code to report would be based on the primary procedure and level of repair documented. For example, soft tissue tumor excision and exploration of a penetrating wound includes simple or intermediate repair. Dissection or elevation of tissue planes to permit resection of the tumor is included in the excision and not separately reported. Extensive undermining or other techniques to close a defect created by skin excision may require a complex repair, which may be reported separately if all the requirements for reporting complex repair are performed. Appreciable vessel exploration and/or neuroplasty also may be reported separately when performed. In addition, adjacent tissue transfer, flaps, and grafts may be reported separately when all the technical aspects of these closure procedures have been performed.

Q Can you please provide clarification on how to measure an anterior abdominal hernia defect in order to select the appropriate hernia repair CPT code? CPT guidelines state that the measurement should be made "prior to opening the defect." What is meant by opening the defect? The defect is already opened. Does this mean prior to repair? Does this mean prior to laparotomy or trocar

placement? We want to ensure we are providing the correct measurement.

A CPT instructions for measuring the total length of anterior abdominal hernia defect(s) states: "Hernia measurements are performed either in the transverse or craniocaudal dimension. The total length of the defect(s) corresponds to the maximum width or height of an oval drawn to encircle the outer perimeter of all repaired defects." CPT also notes that "…the hernia defect size should be measured prior to opening the hernia defect(s) (i.e., during repair the fascia will typically retract creating a falsely elevated measurement)." This sentence was added by the CPT Panel to prevent hernia size inflation after manipulation of the fascia that may enlarge the defect. The goal is to accurately measure the fascial defect that requires repair prior to iatrogenic manipulation that may increase the defect size. In addition, it is important to state the defect size in the operative report For example, "Operation performed: ventral hernia repair of 7 cm hernia defect, measured prior to hernia opening," or in an Addendum to the operative report such as: "Note: hernia size was measured as 7 cm prior to opening of the hernia defect." Inconsistency between measurements without explanation (e.g., preoperative size that is not consistent with intraoperative size), failure to include a specific measurement in centimeters in the operative note, and/or failure to include a description of when and how that measurement was made could all lead to a denial by a payer. Coders and payers are looking for the "correct words." This is not different than measuring and documenting in the operative note the size of a soft tissue tumor to select the correct code (e.g., less than or greater than 5 cm).

Q We always get precertification for planned operations. What is the best advice for selecting an anterior abdominal hernia code for precertification?

A Imaging or a physical exam can estimate the size of the hernia defect and determine if it is reducible or incarcerated/strangulated. However, at operation, it is possible that the size was underestimated. Therefore, it is important to get precertification for the possibilities of a larger size. For example, if the estimated hernia size is 5 cm, include hernia repair CPT codes for both 3–10 cm and greater than 10 cm in your precertification request.

Q What is the appropriate code to report for a robotic-assisted laparoscopic excision of a retrorectal tailgut cyst?

A There is no CPT code for the procedure performed robotically/laparoscopically. Therefore, you should report code 49329, Unlisted laparoscopy procedure, abdomen, peritoneum and omentum, and use the corresponding open procedure code 49215, Excision of presacral or sacrococcygeal tumor, as a proxy for charges.

Q How is a median arcuate ligament release reported?

A There is no specific CPT code for release of the median arcuate ligament. When exploration is performed with division of the diaphragmatic crura and associated compressive ligament, the surgeon may elect to use standard exploratory coding or defer to the unlisted procedure category. Open exploration of the abdomen through a midline or subcostal incision is described by code 49000, *Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure), while open retroperitoneal exploration* is reported with code 49010, *Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)*. Alternatively, a less-invasive laparoscopic exploration of the abdomen is reported with code 49320, *Laparoscopy, abdomen, peritoneum, and omentum, diagnostic,*

with or without collection of specimen(s) by brushing or washing (separate procedure). CPT codes 49329, *Unlisted laparoscopy procedure, abdomen, peritoneum and omentum,* and 49999, *Unlisted procedure, abdomen, peritoneum and omentum,* are alternative reporting options. However, unlisted coding will require submission of medical records and be subject to review by a medical director. For more information, see *www.jvascsurg.org/article/S0741-5214(10)02209-3/fulltext.*

Q How is laparoscopic takedown of a posterior fundoplication reported?

A A laparoscopic takedown of a Toupet fundoplasty is reported with 43289, *Unlisted laparoscopy procedure, esophagus.*

Q When a referring physician sends a patient to see me and sends his office notes, CBC and metabolic panel lab results, and CT imaging with reports, what is counted as a "unique source" or "unique test" when considering how much data are analyzed for selection of a level of evaluation and management (E/M) code?

A For the example above, review of the office notes from a single source would count as one "point" under Category 1 Tests and Documents for E/M code level selection. Review of each lab test and the CT report would each count as review of a unique test under the same category. If, in addition, you separately reviewed and interpreted the CT image (i.e., not just the report), this activity would meet the requirement for Category 2, Independent interpretation of test. Taken together, this work meets the criteria for extensive amount and/or complexity of data to be reviewed and analyzed, which is a high level of MDM.

Q A surgeon performed ureterolysis to identify and protect the ureter during a total colectomy (44150) for extensive fibrosis and scarring due to an inflammatory response following recent bowel perforation. Medicare National Correct Coding Initiative (NCCI) edits indicate code 50715 is a component of code 44150, but this edit can be bypassed using an appropriate modifier. Can code 50715 be reported with modifier 59, *Distinct procedural service*, to bypass this edit?

A Code 50715, *Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis,* may not be reported for the clinical scenario described in the question because the ureterolysis was necessary to identify the ureter which is part of the colectomy procedure. To report 50715 with 44150, the surgeon would have had to document that ureterolysis was performed because the ureters were trapped by the scar tissue, and therefore it was not incidental to the colectomy for identification. For example, obstruction symptoms were noted prior to surgery that is addressed during the same operative session as the colectomy procedure.

Q A patient underwent debridement of a wound on the lower leg measuring 525 sq cm. We billed Medicare 11042 with one unit on one line and 11045 with 26 units on a second line. Medicare covered the claim for 11402 but denied payment for 11045 stating payment was not warranted for 26 units. Is there a different way to report this?

A For this case, you would report 11042, 11045 x 12, 11045-XU x 12, and 11045-XU x 2. However, you will still likely need to do a reconsideration or higher-level appeal with the documentation supporting the number of units being billed. Chapter 1 of the Medicare NCCI General Coding Policy states that code 11045 has a Medically Unlikely Edit (MUE) of 12 units per day. Since each line of a claim is adjudicated separately against the MUE value for the code on that line, the appropriate use of CPT modifiers to report the same code on separate lines of a claim will enable a provider to report medically reasonable and necessary units of service in excess of an MUE value.

Denials due to claim line MUEs or day of service (DOS) MUEs may be appealed to the local claims processing contractor. DOS MUEs are used for CPT codes where it would be extremely unlikely that more units of service than the MUE value would ever be performed on the same date of service for the same patient. If a CPT code has an MUE that is adjudicated as a claim line edit, appropriate use of CPT modifiers (i.e., 59 or -X[EPSU], 76, 77, 91, anatomic) may be used to report the same CPT code on separate lines of a claim. Each line of the claim with that CPT code will be separately adjudicated against the MUE value for that CPT code.

Q A colorectal surgeon and urologist together performed a pelvic exenteration for gynecologic malignancy involving the colorectal system. The descriptor for code 58240 includes many instances of the terms with or without in reference to some subprocedures and the term with for other subprocedures. The surgeons did not perform bladder removal. Does this mean that a reduced services modifier should be appended to the code?

A No, you do not need to append modifier -52 to 58240, *Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof.* In a total exenteration, the provider removes the uterus, tubes, ovaries, parametrial tissue, bladder, rectum, vagina, urethra, and part of the levator ani muscles. In an anterior exenteration, the provider does not remove the rectum. In a posterior exenteration, the provider does not remove the bladder and urethra or may resect a part of the anus, urethra, and part of the vulva. The phrase "or any combination thereof" at the end of code descriptor allows for the variation in work performed for pelvic exenteration.

Learn More

As part of the College's ongoing efforts to help members and their practices submit clean claims and receive proper reimbursement, a coding consultation service—the ACS Coding Hotline—has been established for coding and billing questions. ACS members are offered five free consultation units (CUs) per calendar year. One CU is a period of up to 10 minutes of coding services time. Access the ACS Coding Hotline website at *prsnetwork.com/acshotline.* B

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Jeremy Lewin

Is It Time for Surgeons to Unionize?

Jeremy Lewin, JD

LABOR LAWS HISTORICALLY have made it challenging for many physicians to unionize because they did not meet the statutory definition of "employee" under the National Labor Relations Act (NLRA). The NLRA states that "[t]he term employee shall include any employee...but shall not include any individual having the status of an independent contractor, or any individual employed as a supervisor."[1] This is a two-part test: the physician must work in an employed arrangement, and they must not be a supervisor.

Whether any particular group of physicians can unionize depends upon whether they are considered employees. Until relatively recently, many physicians were ineligible to unionize because they worked as independent contractors. However, with practice consolidation and other changes in the healthcare industry, a growing percentage of physicians are now employed by hospitals and other corporate entities, satisfying the first part of the NLRA's two-part test.

Whether a particular employed physician may participate in a union depends upon that individual's supervisory status. Recent decisions by the National Labor Relations Board (NLRB)—the agency that enforces the NLRA—have clarified that the NLRB does not consider employed physicians with only a limited degree of supervisory authority to be supervisors. For example, a regional office of the NLRB recently found that although a group of hospital physicians had some authority to direct other employees, they were not "supervisors" under the NLRA because their primary purpose was to provide care to patients.

The changing professional landscape for physicians and the NLRB's recent decisions on supervisory status mean that more physicians are eligible to unionize.

Public Support for Labor Unions

If you ask people in the US whether they support unions, 67% say they do, which is up almost 40% from an all-time low of 48% following the Great Recession.[2] Despite this high level of public support, participation in unions is low, at about 10% of wage and salary workers in 2023. That's about half of what it was in 1983.[3] Union representation among physicians appears to be even lower, with estimates generally hovering around 6% to 7%.

However, recent union activity suggests increasing interest in union membership among healthcare workers. In October 2023, more than 500 physicians, nurses, and physician assistants at Allina Health in Minneapolis, Minnesota, voted to unionize by a vote of 325 to 200. The group is represented by Doctors Council Service Employees International Union (SEIU) and is among the largest private sector physician unions in the country. In January 2024, residents, fellows, and interns at Northwestern Medicine in Chicago, Illinois, voted to unionize, citing long hours and low pay. The same month, a group of anesthesiologists in California voted to unionize by a vote of 78 to 25.

Supporters of Physician Unionization

Supporters of physician unionization argue that benefits include the ability to collectively bargain for better working conditions, protection from legal action, and the ability to advocate for improved patient care. However, a recent study of US surgical residents found that, although unionized programs

Notably, many physicians believe striking could run afoul of the Hippocratic Oath's foundational principle of doing no harm.

may offer better benefits, "unions were not associated with improved burnout, suicidality, job satisfaction, duty hour violations, mistreatment, educational environment, or salary."[4]

Other studies have focused on the effects of labor unions on patient outcomes and quality of care. The results have been mixed. A 2020 study of New York nursing homes during the COVID-19 pandemic found that unionized nursing homes had lower mortality rates, better access to personal protective equipment, and stronger infection control measures than their nonunion counterparts.[5]

A separate study focused on nurse unionization in hospitals concluded that hospitals with successful unionization efforts "experience a decline in the incidence of hospital-acquired illnesses" even when accounting for the effects of strikes on mortality.[5] Another study focusing on the general workforce found that unions can result in "increase[d] productivity or product quality through reduced turnover, increased worker effort, and improved worker morale."[5]

Other studies have shown ambiguous or negative impacts. A 2010 study focusing on the effects of nurses' union strikes found that "the average strike increases mortality by more than 18%."[5] Another study "found no impact of unionization on care quality."[5]

Strikes

While physician unionization opens the theoretical possibility of physician strikes, most strikes in the healthcare system have historically involved residents and nurses. This has traditionally been the case because the "union model permitting strikes is not an option in medicine" either legally, morally, or ethically.[6] Notably, many physicians believe striking could run afoul of the Hippocratic Oath's foundational principle of doing no harm.

Some also worry that the public may not be sympathetic to physician strikes because of the perception of high physician compensation, and the concern that physician strikes may jeopardize public health and safety.

Physician Strikes

A rare example of physicians striking occurred in 2015. For the first time in its history, the Union of American Physicians and Dentists (UAPD) staged physician strikes at the University of California (UC) system. Approximately 130 physicians staffing student clinics went on strike to protest citing "lack of control over working conditions, stagnant salaries, and lack of compensation for after-hours work."[6]

Prior to the strike, UC physicians expressed frustration that after joining the UAPD, they had been negotiating their first contract with the UC system for more than a year. Two strikes occurred with prior notice. One involved all 10 student health clinics and lasted only 1 day. The other focused on the two largest clinics and lasted 4 days. Ultimately, UAPD's president reported that the union obtained most of what it had requested.

Resident Physician Strikes

In 2019, resident physicians at the UC San Francisco (UCSF) went on strike to draw attention to continually failing negotiations between their union and the UCSF Medical Center and to express their dissatisfaction with the current grievance procedure. The Committee on Interns and Residents, which represents more than 1,000 UCSF residents, also complained that the medical center underpays and underrepresents residents. To draw attention to these matters, resident

physicians, clinical fellows, and interns participated in a 15-minute walk-out, which they called a "unity break."

In May 2023, more than 150 residents went on strike at Elmhurst Hospital Center in Queens, New York. The strike, which lasted 3 days, was prompted largely by a pay gap between residents at Elmhurst and other affiliated hospitals. The strike ended when the union and the hospital reached a deal that would give Elmhurst residents enhanced pay and benefits, including an 18% pay increase over 3 years.

Challenges and Complexities of Forming a Union

There is a common misconception that only established unions can represent employees, such as the Steelworkers, Teamsters, or SEIU. That is not accurate. In fact, organizations that wish to represent employees, and employees themselves, can form their own "independent" unions that have no formal ties to an established union. That option has recently become increasingly popular, particularly with younger employees who view established unions as out of touch and not aligned with their viewpoints. Some employees also dislike the for-profit, political nature of established unions.

One example of a newly created union that has received considerable media attention is at Amazon, with subsets of Amazon employees having formed their own union called the Amazon Labor Union. Employees at Starbucks have similarly created the Starbucks Workers United union, although it reportedly is "essentially a front for the Service Employees International Union."[7]

Can a Medical Association Form a Union?

As mentioned, organizations other than established unions can form their own independent unions. However, if a medical association were to operate as a union, it would face significant legal and operational challenges. An association's status as a tax-exempt 501(c)(3) or 501(c)(6) organization requires that it focus its primary activities in service of its tax-exempt purpose, which does not include union activities. Devoting significant association resources to activities unrelated to the association's tax-exempt purpose could jeopardize an organization's tax-exempt status.

Forming a New Entity to Perform Union Activities

In light of the risk of losing its tax-exempt status, a medical association would likely need to form a new entity and would apply for tax exemption for that entity under Section 501(c)(5) of the Internal Revenue Code, the section applicable to tax-exempt labor unions. While forming the new entity would help to protect the organization's tax exemption, the complexities of the union formation process would require a significant investment of time and resources.

Unions employ staff to perform specialized activities that are generally outside the scope of an association's expertise, including:

- Engaging with potential union members
- Campaigning to obtain signatures in support of unionization
- Filing petitions and other documents with the NLRB
- Defining geographic territories for union representation
- Negotiating election agreements
- Participating in hearings regarding election procedures
- Negotiating collective bargaining agreements with employers
- Handling grievances
- Coordinating strikes

The typical geography associated with establishing and operating a union would present further challenges. Because of the legal standards that govern unionization, unions typically represent workers at a single location or multiple locations of a single employer if they are located in close proximity to one another. Very rarely would it be appropriate or permissible for a union to represent employees across a broader geography or employees who work for different employers as a single bargaining unit.

This aspect of unionization

would mean the new entity would have to create local offices with their own staff throughout the country. This challenge has contributed to the limited success of independent unions as compared to established unions with a nationwide presence through affiliated "locals" that are responsible for specific geographies.

American Medical Association Union Activity

Notably, in 1999, the American Medical Association (AMA) helped form a national labor organization under the NLRA called Physicians for Responsible Negotiation (PRN). The PRN was designed to support the "development and operation of local negotiating units as an option for employed physicians and for resident and fellow physicians."[8] Just 5 years later, "after spending a substantial amount of money on the venture that signed up few physicians, the AMA discontinued financial support for the project."[8]

Given the operational challenges outlined earlier, it is not surprising that the AMA ceased funding its union effort after just a few years.

Partnering with an Established Union

Taking into account the significant resources necessary to support the formation and operation of a union, especially on a nationwide basis, associations may consider partnering with an established union with an existing infrastructure and the experience necessary to manage the complex and cumbersome procedural and operational aspects outlined in this article.

Internal Revenue Service (IRS)-related issues and antitrust risks would present potential challenges. The IRS might object, for example, if it learned that the association gave resources to the union free of charge or at a discount, since the activities these funds would support would not be related to the association's tax-exempt purpose. These resources would not be limited to cash payments or staff support for the union's services, and would include assets such as member lists, which the union would surely want in order to access the association's members.

Partnering with a labor union also may present risk of antitrust violations. Before labor union law was firmly established in the US, many union activities were considered unlawful. Section 1 of the Sherman Act declares that any "contract, combination…or conspiracy in restraint of trade or commerce among the several states" is illegal. The Sherman Act was used effectively in actions against early trade unions.

The US Supreme Court later held that two other Federal acts, the Clayton Act and the Norris-LaGuardia Act, provide a statutory exemption from antitrust laws for certain union activities. More recent statutes, along with favorable judicial interpretation of labor statutes, have resulted in further

Whether to form or join a union is a complicated question.

protections for union activities.

These protections are not absolute, and they do not automatically apply simply because a union is involved. To the contrary, where a union acts with a nonlabor group to restrain competition in a business market, the activities would constitute an antitrust violation.

Tax-exempt medical associations are highly scrutinized for antitrust violations and authorities would be quick to cite any coordinated efforts between an association and a union that may appear to have an anticompetitive effect. This could be especially problematic if the activities appeared to target certain employers. An example of such activity would be targeted boycotts of practices owned by private equity-backed firms or insurance companies.

Should Doctors Unionize?

There are many misconceptions about what unions can and cannot do. For example, physicians sometimes tell me they believe a union would negotiate better Medicare reimbursement rates. However, union negotiations are focused on the employment relationship, not reimbursement rates.

In fact, to the extent I have seen union attention to Medicare, it has typically been in support of Medicare for all initiatives.

Union contracts, called "collective bargaining agreements," cover features like wages, benefits, working conditions, job protections, and time off.

Whether to form or join a union is a complicated question. Some people argue that unions help employees negotiate more effectively with employers and promote better working conditions. Others argue that unions impose rigid policies, prevent merit-based promotions, add costs, and cause conflicts with management.

There is no right or wrong answer, but as the professional landscape for physicians and surgeons evolves and more of these healthcare professionals are considering unions, it is important to gather as much information as possible to help make an informed decision.

Disclaimer

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

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Dr. Gregory Evans

Dr. Ntirenganya Faustin

Collaborative Effort Helps Bridge Global Surgery Workforce Gaps

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Lieutenant Colonel Charles Furaha, MD
Andrea Pusic, MD, MHS, FACS, FRCSC

Dr. Michelle Coriddi and Rwandan resident Moses Mtonga work together at the microscope during surgery.

The lack of access to surgical care worldwide is a significant concern. The ACS Health Outreach Program for Equity in Global Surgery (ACS H.O.P.E.) was established to assist low- and middle-income countries (LMICs) in capacity building, patient care, and training the next generation of surgeons.

GLOBAL SURGICAL NEEDS consist of both material and human resources. Fulfilling the gap in human resources necessitates a collective understanding that while most global surgeons are general surgeons, there is more need than for specialist care such as plastic surgery. Plastic surgery has traditionally been limited to global burn care, cleft lip, and palate care among other clinical conditions.

In the past decade, ongoing demands from LMICs have encouraged us to provide even more complex plastic surgery education and patient care. This viewpoint article describes a current experience developing a comprehensive plastic surgery program in Rwanda.

Recently, the ACS Oral and Maxillofacial Surgery Advisory Council started working to support Rwanda plastic and reconstructive surgery training in partnership with the Surgeons in Humanitarian Alliance for Reconstruction, Research, and Education (SHARE) program.

The Rwanda plastic surgery capacity building initiative started 5 years ago through a collaboration between the Rwanda Ministry of Health, University of Rwanda, Operation Smile, and College of Surgeons of East, Central, and Southern Africa. Notably, this partnership has shown sustained growth and development during the last 3 years. After a new and improved curriculum, approved by the University of Rwanda,

Above:
Dr. Steven Roser and Dr. Gregory Evans join the participants of the Craniofacial Plating Workshop at King Faisal Hospital.

Right:
Dr. Gregory Evans leads a hands-on training session on craniofacial plating techniques at King Faisal Hospital.

was implemented both at the university medical center and affiliated hospitals, the number of trainees increased from three to 13.

Working in silos negatively impacts progress, particularly in global health. When different organizations join hands to combine resources and avoid duplication, a lot can be achieved. One of the most important resources that was combined in this partnership was teaching faculty. With the help of ACS H.O.P.E., there was a significant increase in the number of educators and other volunteer surgeons from the US to support the expansion of the Rwanda plastic surgery training program.

The implementation of the program was harmonized with the new curriculum and featured six modules: general plastic surgery, burns, maxillofacial surgery, microsurgery, aesthetic surgery, and hand surgery. Each module consists of simulation exercises, didactics, and hands-on patient care delivered by a team of three-to-four surgeons. Some of the modules required additional partnership with industry that provided training materials to be used in the simulation laboratory.

The contributions of the US faculty have enhanced the growth of our training program with a potential to expand to other central African countries. In addition, we hope to contribute to the Committee on Certification in plastic surgery by adopting our structured curriculum for training and academics.

This collaboration with ACS H.O.P.E. is producing committed and competent plastic surgeons

Dr. Andrea Pusic and Dr. Michelle Coriddi collaborate with Rwandan residents in a microsurgery case.

for Rwanda and the region. We are very excited to see our graduates excel as educators and contributors to the training of the next generation of plastic surgeons. It is notable to see that two of the most recent graduates already have obtained additional training in craniofacial surgery at the Hospital for Sick Children in Toronto, Canada, and in microsurgery at Chang Gung Hospital in Taiwan.

We are enthusiastic about continuing to grow the ACS H.O.P.E. and SHARE collaboration as we move forward and expand sites beyond Kigali, Rwanda. B

Disclaimer

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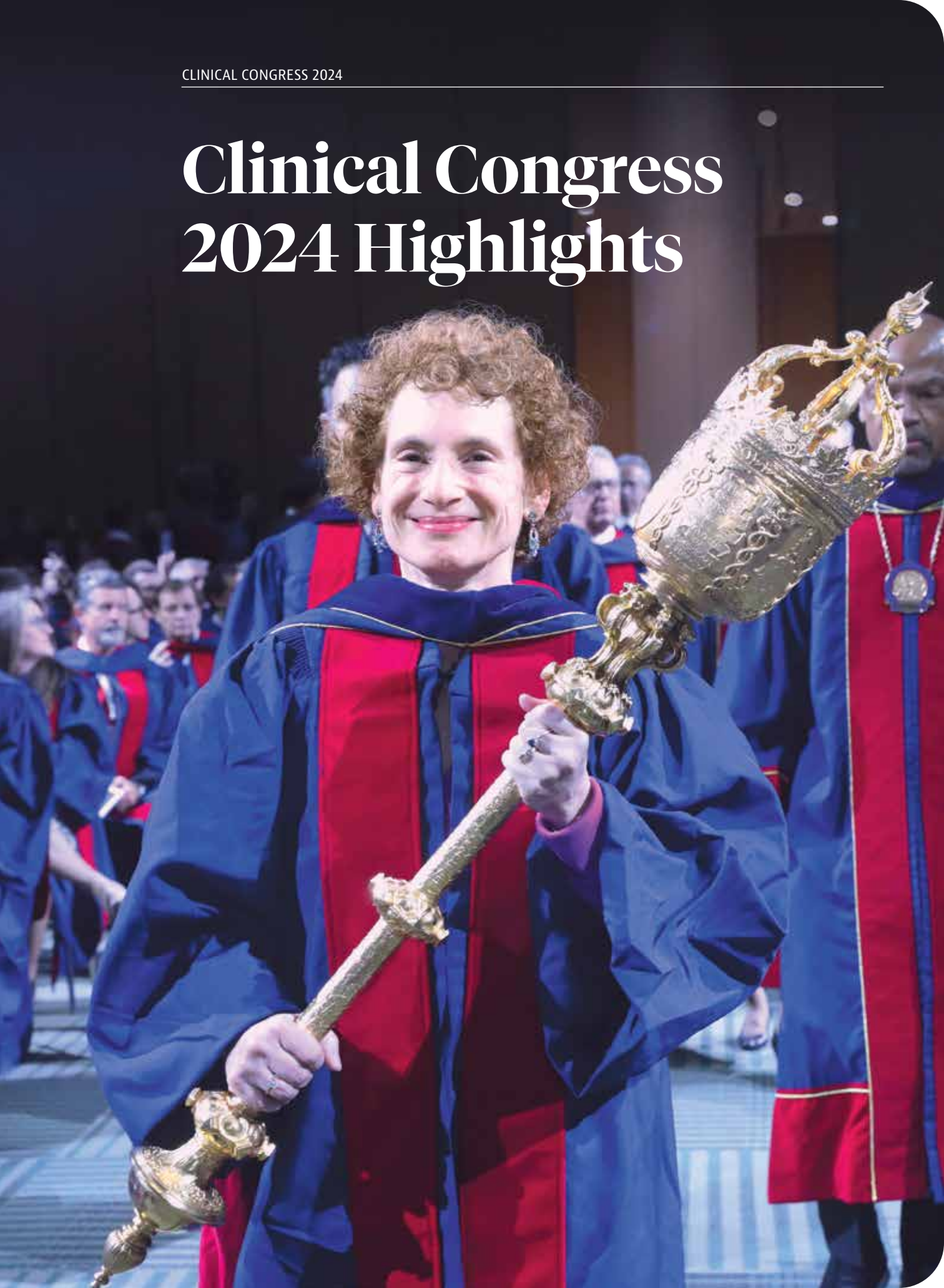
Clinical Congress 2024 Highlights



The ACS Clinical Congress 2024 in San Francisco, California, offered surgeons, residents, medical students, and other healthcare professionals, both domestic and international, opportunities to advance their surgical skills and knowledge and interact with their peers, ACS leaders, and staff.

APPROXIMATELY 11,000 individuals participated in the event, with nearly 10,000 attending in-person and more than 1,000 engaging virtually and accessing the conference's content on demand. All registrants can view on-demand content and claim continuing medical education credits through February 24, 2025; registration remains open for new participants.

This article summarizes some of the meeting highlights.

Convocation

This year, 1,894 surgeons from 74 countries 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, eight international surgeons were conferred Honorary Fellowship, and the ACS Distinguished Service Award, Lifetime Achievement Award, and several other prestigious awards were presented. 2023–2024 ACS President Henri R. Ford, MD, MHA, FACS, led the installation of new officers, including Beth H. Sutton, MD, FACS, as President, Nancy L. Gantt, MD, FACS, as First Vice-President, and Dennis H. Kraus, MD, FACS, as Second Vice-President. (See pages 52–55.)

The 2024 Honorary Fellows are:

- Emmanuel Adoyi Ameh, MBBS, FACS, FWACS, FRCSI, Abuja, Nigeria
- Yuichiro Doki, MD, PhD, Osaka, Japan
- Christine Gaarder, MD, PhD, FACS, FEBS EmSurg, FEBS AWR, Oslo, Norway
- Andrew Graham Hill, MBChB, MD, EdD, FACS, FISS, FRACS, FRSNZ, Aukland, New Zealand
- Jamal Hoballah, MD, MBA, FACS, Beirut, Lebanon
- P. Ronan O'Connell, MB, MD, FRCSI, Dublin, Ireland
- Shailesh Vinayak Shrikhande, MBBS, MS, MD, Mumbai, India
- Catherine S. C. Teh, MD, FPCS, FRCSEd, Manila, Philippines

(See pages 60–63 for career summaries.)

Layton F. Rikkers, MD, FACS, received the 2024 Distinguished Service Award for his years of dedication to the ACS through holding various leadership roles, including as First Vice-President. Among many other contributions, Dr. Rikkers helped create the popular ACS Surgeons as Leaders Course, which provides aspiring surgeon leaders with skills needed in the OR and board room.

The sixth ACS Lifetime Achievement Award was presented to David B. Hoyt, MD, FACS, past-ACS Executive Director (2010–2022). During Dr. Hoyt's tenure as the leader of the ACS, he was instrumental in overseeing the development of guidelines for quality and safety, as well as surgical education and training. He also oversaw the initiation of the Stop the Bleed program and development of the Military Health System Strategic Partnership-ACS.

The 2024 Owen H. Wangensteen Scientific Forum Award was presented to Mary T. Hawn, MD, FACS, for her nearly 4 decades as a researcher of minimally invasive foregut surgery and a driver for improving surgical quality. Dr. Hawn also has extensively researched surgical quality measurement and national policy affecting surgical populations, which has informed policy about national surgical quality measurement.

Barbara J. Pettitt, MD, MHPE, FACS, received the Dr. Mary Edwards Walker Inspiring Women in Surgery Award for a career that has combined clinical care with surgical education while also contributing to research on surgical pedagogy. She has been recognized as being a highly regarded surgeon educator and is a longtime member of multiple organizations focused on advancing women in surgery.

USN Commander (Retired) C. William Schwab, MD, FACS, was honored with the fifth ACS Distinguished Lifetime Military Contribution Award for his many and ongoing contributions to trauma surgery and research, including on firearm injury prevention, contributions to military-civilian partnership in trauma care, and various leadership roles in trauma societies.

More in-depth articles about these award recipients are available in the October *Bulletin.*

A recording of Convocation, which includes the awards presentations and the ACS Presidential Address, is available at *facs.org/convocation*.

Named Lectures

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

Cardiothoracic surgeon Jessica S. Donington, MD, MSCR, FACS, delivered the John H. Gibbon Jr. Lecture, "Lung Cancer Revolution." In her talk, Dr. Donington discussed changes in lung cancer care that have occurred in the last decade, including expanded screening efforts, more effective treatment, and a personalized therapeutic approach—all of which have had a notable impact on lung cancer mortality.

In addition to talking about the intersection of lung cancer, smoking cessation, and stigma, she detailed many of the evolving treatment techniques and noted that surgeons are playing a more important role than ever in curing the disease.

"We're seeing dramatic changes in treatment strategies for all stages of disease, and in the last 3 years, it has all been centered in our world—resectable lung cancer," Dr. Donington said.

In the Herand Abcarian Lecture, "We Have Come a Long Way…Where Do We Go from Here?," colorectal surgeon Ann C. Lowry, MD, FACS, spoke on the generation of surgeons that she has observed in her 40-year career and made observations on the past, present, and future of surgery.

She described the positive changes in gender and racial demographics of surgeons, but also looked at the ongoing challenges with attrition and burnout for modern practitioners. Recruitment, wellness, and mentoring programs are being implemented, but even still, "we need to do better," Dr. Lowry said, especially in changing surgical culture.

"Organizations can establish well-meaning policies, but if the culture is not consistent with those policies, then change doesn't happen," she said.

Otolaryngologist—head and neck surgeon Mark C. Weissler, MD, FACS, delivered the John J. Conley Ethics and Philosophy Lecture, "Surgical Professionalism and Autonomy in the 21st Century." In his talk, he discussed the longstanding moral contract that surgeons enter into when joining the profession, which in the 20th century was focused on trust between surgeons and patients, which implied autonomy and self-regulation for surgeons.

However, Dr. Weissler noted, the 21st century has seen external stressors begin to erode those two cornerstones of modern surgery, including the corporatization of medicine, burdensome or ill-advised policy, and ever-growing expectations for successful treatment of surgical disease.

Addressing these stressors will take a comprehensive effort from physicians and health leaders, he said and suggested that professional organizations also have a role to play.

"Large organizations such as the ACS can and should focus on moral advocacy that is truly directed at what is best for patients. Adopting an attitude of professional altruism can have a beneficial impact that carries over into regulatory power and surgeon well-being," Dr. Weissler said.

Noteworthy Academic Programming

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

New in 2024 were Opening Day Thematic Sessions that focused on specialty content such as artificial intelligence, cardiothoracic surgery, education, neurosurgery, quality, and vascular surgery, as well as multidisciplinary content that spanned the duration of the conference.

In addition to Didactic and Skills Postgraduate Courses, Clinical Congress 2024 provided attendees with access to 108 expert-led Panel Sessions, including:

- The popular "10 Hot Topics in General Surgery" session, hosted by ACS Past-President E. Christopher Ellison, MD, FACS, and ACS Regent Kenneth W. Sharp, MD, FACS, which this year covered ultrasound in inguinal hernia, clinical approaches to transgender patients with breast mass, and more
- Interesting Great Debates, expanded this year to include two sessions where experts on opposing

More than 1,800 surgeons were initiated into ACS Fellowship.

The 2023–2024 Officers, Officers-Elect, and Board of Regents gather for a photo during Clinical Congress.

sides discussed the use of whole blood in pediatric patients and angioembolization, as well as rib fracture fixation and whether general surgeons should cover bariatric and colorectal emergencies
- An update on artificial intelligence (AI) in "Generative AI Tools for Surgery: Will AI Change My Practice?," which examined the surgical risk assessment calculator, how effective use of AI requires high-quality data, and regulatory concerns

Three Special Sessions were offered, providing attendees with an in-depth look at important topics in surgery:

- The ACS Academy of Master Surgeon Educators Special Session: "Value of the ACS Academy of Master Surgeon Educators across the Surgical Specialties" highlighted the importance of the Academy in recognizing surgeon educators and engaging them in advancing surgical education in all discipline
- "Behind the Curtain of Trauma Activation Fees—Impact, Potential, and Peril for Modern Trauma" explored the nature of trauma activation fees, their place in the trauma system, best practices for appropriate utilization of trauma activation fees, and how surgeons can engage to shape the issue
- "Complying with New CMS Age Friendly Measure" detailed how the ACS Geriatric Surgery Verification Program can help hospitals meet the regulatory requirements of the eponymous and mandatory measure while also improving patient outcomes, reducing costs, and increasing surgical capacity

The Named Lectures, Panel Sessions, and Special Sessions are available for registered attendees via the on-demand platform.

Hands-On Events

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

The third ACS Surgical Ergonomics Hands-On Clinic for practicing surgeons and surgery residents generated significant interest and had approximately 100 participants, emphasizing the importance of health and well-being in the physically demanding field.

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. In addition, a certified physical therapist will share different stretching exercise protocols that can be implemented in the OR, between cases, or at home.

This year's iteration of the Surgical Metrics Project, the fourth 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. Participants had the opportunity to become research participants themselves by completing short but challenging operative tasks while wearing motion sensors on their fingers and EEG sensors on their foreheads to record motions and thought processes.

Awards and Honors

Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery, domestic and

Access related video content online.

international volunteerism, leadership in residency, and much more. Visit *Clinical Congress News* at *facs.org/ccnews* 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 22, with Dr. Sutton 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 2024–2025. (See pages 56–57.)

The President-Elect is Anton N. Sidawy, MD, FACS, a renowned vascular surgeon who is the Lewis B. Saltz Chair of Surgery and professor of surgery at The George Washington University School of Medicine and Health Sciences in Washington, DC.

Dr. Sidawy said the appointment "fills me with pride and the satisfaction that others see me as a passionate servant leader and consensus builder."

The First Vice-President-Elect is trauma surgeon Anne C. Mosenthal, MD, FACS, the chief academic officer at Beth Israel Lahey Health—Lahey Hospital & Medical Center in Burlington, Massachusetts. The Second Vice-President-Elect is pediatric surgeon Edward M. Barksdale Jr., MD, FACS, the chief surgical officer at the Chicagoland Children's Health Alliance and a professor of surgery at The University of Chicago, both in Chicago, Illinois.

The new Chair of the BoR is renowned gastrointestinal surgeon Fabrizio Michelassi, MD, FACS, the Lewis Atterbury Stimson Professor and chair of the Department of Surgery at Weill Cornell Medicine, and surgeon-in-chief of NewYork-Presbyterian/Weill Cornell Medicine, both in New York. The Vice-Chair is trauma and critical care surgeon Lena M. Napolitano, MD, FACS, professor of surgery and associate chair for the Department of Surgery at the University of Michigan School of Medicine in Ann Arbor.

Four surgeons were elected to initial terms on the BoR:

- Audra A. Duncan, MD, FACS, professor of surgery and chair/chief of vascular surgery at Western University in London, Ontario (3-year term)
- Arun K. Gosain, MD, FACS, division head of plastic surgery at Ann & Robert H. Lurie Children's Hospital of Chicago, Illinois (3-year term)
- Sanjay R. Parikh, MD, FACS, division chief of otolaryngology—head and neck surgery at Seattle Children's Hospital, Washington (3-year term)
- Daniel L. Dent, MD, FACS, professor of surgery in the Division of Trauma and Emergency Surgery at The University of Texas Health Science Center at San Antonio (2-year term)

In addition, seven surgeons were reappointed to the BoR: James W. Fleshman, MD, FACS, FASCRS, Shelly D. Timmons, MD, FACS, Carol L. Brown, MD, FACS, Andrea A. Hayes Dixon, MD, FACS, FAAP, Dr. Napolitano, Kenneth W. Sharp, MD, FACS, and Philip R. Wolinsky, MD, FACS.

The following Officers of the BoG Executive Committee were elected:

- **Chair:** Marion Henry, MD, FACS, professor of surgery at UChicago Medicine in Illinois
- **Vice-Chair:** Cherisse D. Berry, MD, FACS, division chief of acute care surgery at NYU Langone Health in New York (also serves as Education Pillar Lead)
- **Secretary:** Robert D. Winfield, MD, FACS, division chief of acute care surgery at The University of Kansas Medical Center in Kansas City

The following surgeons were elected to the BoG Executive Committee for a 1-year term:

- **Member Services Pillar Lead:** Rohan A. Joseph, MD, FACS, a general and bariatric surgeon at HCA Florida Capital Surgical Specialists in Tallahassee
- **Advocacy Pillar:** Alisha D. Reiss, MD, FACS, a general surgeon at Wayne HealthCare in Greenville, Ohio

In addition, three Pillar Leaders were reappointed for 1-year terms: Wendy Ricketts Greene, MD, FACS, Diversity Pillar Lead; Sundeep G. Keswani, MD, FACS, Quality, Research, and Optimal Patient Care Pillar Lead; and Joseph V. Sakran, MD, MPH, MPA, FACS, Communications Pillar Lead.

Member Engagement Activities

Clinical Congress 2024 provided attendees and their guests with opportunities to participate in social and wellness activities, including 5K guided running tours through San Francisco, 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 San Francisco's unique dining and cultural scene.

Clinical Congress 2025

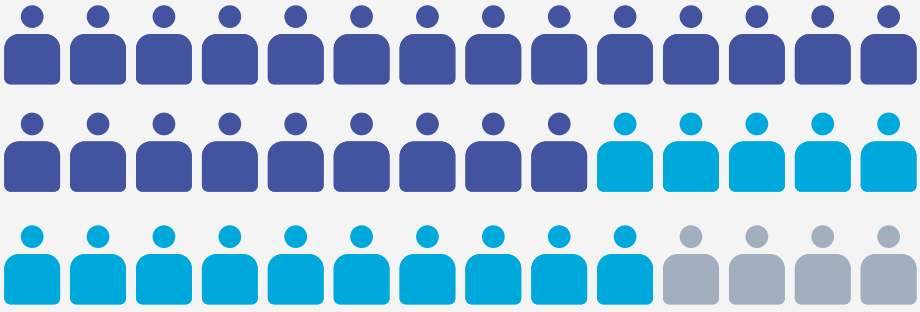
The next Clinical Congress will take place October 4–7, 2025, in Chicago, Illinois. Abstract submission begins mid-December, and housing reservations are underway.

CLINICAL CONGRESS 2024

BY THE NUMBERS

10,896 Registrants — **9,884** In-Person | **1,012** Virtual

1,894
INITIATES
From 74 Countries



35% First-Time Attendees

6,895
App Downloads

117
Registrant Countries

38M
Impressions for #ACSCC24
[July-Oct]

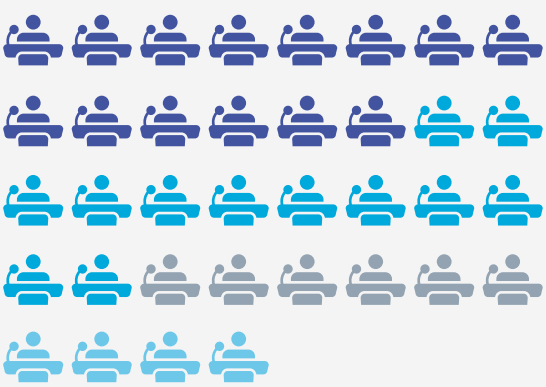
9,100
Total Mentions for #ACSCC24

2,223 Total Speakers

729 Scientific Forum Abstracts Presented

442 Scientific Forum ePosters Presented

169 Videos Presented



210.5
CME Credits Available
for In-Person Attendees

Dr. Beth Sutton Is Installed as ACS President

BETH H. SUTTON, MD, FACS, who has spent much of her career balancing private practice with ACS leadership, was installed as the 105th President of the ACS during the Clinical Congress 2024 Convocation in San Francisco, California.

Dr. Sutton is a general surgeon from Wichita Falls, Texas, where she maintained a private surgical practice for many years.

For her presidential year, Dr. Sutton has chosen the theme of "Excelling Together." In addition to highlighting the special ability of the College to unite surgeons across disciplines, practice types, and career stages, Dr. Sutton explained her vision of excellence, "I would like to encourage all our Fellows and our other members in all surgical disciplines to keep the personal connection between one surgeon and one patient."

Background and Career Highlights

Dr. Sutton's interest in medicine began early in childhood, with the gift of a book on the human body she received from a great-aunt. After years of interest, she entered Baylor College of Medicine in Houston, Texas, in 1972.

She had her first exposure to surgery at Baylor, an experience that made her certain surgery was the path for her. "The first time I saw an operation, I had done the physical examination for a patient who was about to have a coronary artery bypass the following day, and the cardiologist told me that I needed to attend the surgery. So I went, and the surgeon was very welcoming, and the anesthesiologist allowed me to stand next to him behind the ether screen so that I could look over. For the first time, I saw a live beating heart. Then I was able to watch the surgeon take the vein grafts and sew them into place, thereby bringing blood to the muscle of the ventricle. At that moment, I thought it would be wonderful to be a surgeon and fix things."

After medical school, she completed an internship at the St. Paul Hospital at The University of Texas Southwestern Medical Center in Dallas, followed by a residency in general surgery at Scott & White Memorial Hospital in Temple, Texas.

ACS Service

An ACS Fellow since 1984, she has held many leadership roles within the College. She is a Past-President of the North Texas ACS Chapter, a past Governor-at-Large representing North Texas (2004–2010), and a past member of the Board of Governors

(BoG) Executive Committee (2008–2010). Her ACS leadership also includes nearly a decade on the Board of Regents (2012–2021), including a year as Chair (2019–2020).

Dr. Sutton is a past member of the ACS Advisory Council for General Surgery and many ACS committees, including the Committee on Healthcare Disparities, Committee on Professional Opportunities for Senior Members, Committee on Transition to Practice (Mastery in General Surgery), and Committee on Preceptorship for Practicing Surgeons. She also has been a member of the ACS Women in Surgery Committee and ACS Committee on Optimal Access/Healthcare Disparities. Finally, she has served as a faculty member of the Surgeons as Leaders course.

Beyond her roles with the College, she has held leadership positions within many surgical organizations for much of her career. Dr. Sutton is a past president of the Texas Surgical Society, a past local president of the American Cancer Society, and a current member of the Board of Directors of the American Board of Surgery. In addition, she previously has served as a president of the Association of Women Surgeons (AWS).

Honors and Awards

Recognition of Dr. Sutton's contributions to surgical leadership include a Distinguished Alumna in General Surgery Award from her former residency program at Baylor Scott & White Health. She also is a four-time winner of the United Regional Health Care System Department of Surgery Quality Champion Award, and for her contributions to advancing women in surgery, she has been a recipient of the AWS Foundation's Nina Starr Braunwald Award.

Leadership Vision

However far she has moved into leadership positions, Dr. Sutton has never lost her focus on the quality of care and the level of trust between surgeons and their patients. "Surgical care remains a critical initiative that we must maintain," she said. "The skills are commonly available through programs from the College, but the technical skills are only part of the process. We need professional skills and the ability to relate to patients. And most importantly, we need to relate to them and communicate with them in a way that lets them know we care so that they feel free to trust us."

The introductory video about Dr. Sutton that was played at Convocation is available to view at *facs.org/bethsutton*.

Vice-Presidents

First Vice-President Nancy L. Gantt, MD, FACS, and Second Vice-President Dennis H. Kraus, MD, FACS, also were installed during Convocation.

Dr. Gantt, a well-respected general surgeon and educator, is a professor of surgery at Northeast Ohio Medical University in Rootstown, as well as co-medical director of the Joanie Abdu Comprehensive Breast Care Center at Mercy Health–St. Elizabeth Youngstown Hospital in Ohio. A Fellow of the College since 1992, she also is a past Vice-Chair of the ACS BoG Executive Committee and Diversity Pillar Lead.

Dr. Kraus is a renowned head-and-neck oncologic surgeon and executive medical director of oncology and enterprise at Centura Health in Denver, Colorado. Dr. Kraus—an ACS Fellow since 1994—has served the College on the BoG, American Joint Committee on Cancer, Commission on Cancer, and Patient Education Committee.

Access introductory video about ACS President Dr. Beth Sutton.

ACS President Encourages Surgeons to Excel Together

IN A SPEECH FILLED with compassion and focused on practicality given during Convocation at the ACS Clinical Congress in San Francisco, newly installed ACS President Beth H. Sutton, MD, FACS, shared her vision for her presidential year.

"Our healthcare system has many aspects in need of improvement, and surgeons of all specialties, working together, can make it better for our patients and ourselves," Dr. Sutton said.

Her speech described many logistical and administrative challenges to delivering high-quality surgical care, ranging from prior authorization denials and strict productivity limits to "the loss of autonomy, lack of adequate staff support, endless administrative tasks, and financial pressures that can erode the joy we take from our relationships with our patients and with each other."

Raising the history of the ACS, Dr. Sutton compared this year's cohort of Fellows, inducted at Convocation, with the first Fellows of the ACS. Remarkably, both groups had approximately the same percentage of general surgeons (57%) versus surgeons in other disciplines (43%). However, Dr. Sutton noted, in contrast to the environment a century ago, general and specialist surgeons now faced sub-specialization that splinters surgeons into many healthcare associations.

She then expressed her view that an emphasis among surgeons to unite across all specialties may ameliorate the challenges surgeons face today: "Why should you join me in feeling an intense connection with and responsibility to surgical colleagues in disciplines other than our own? Because we and our patients need each other. We surgeons need each other to care for individual patients."

Indeed, Dr. Sutton said, "the essential elements required for us as surgeons to do our duty to the patient are common to all surgical specialties," including prompt access to care, coordination between specialties, quality improvement initiatives, and adequate communication between rural and tertiary centers.

"Only if all surgeons ally together to be advocates for each other and our patients will these critical requirements be preserved," she said.

Since its founding in 1913, the ACS has worked to enhance surgeons' careers and patient outcomes in all surgical disciplines, practice types, career stages, and geographic locations. Dr. Sutton described this history and noted the ongoing work at the ACS to

educate, advocate for, and uplift surgeons.

The point of all these efforts, she explained, is not merely to enhance the power or well-being of practicing surgeons. Rather, she pressed for compassionate, emotionally responsive care for all patients, advising surgeons to consider how they wish to be treated, saying, "We must be the patient's teacher and guide, and keep always in mind that really, we work for no one else."

The full Convocation ceremony is available online at *facs.org/convocation*. The address also is available as episode 45 on *The House of Surgery* podcast at *facs.org/houseofsurgery*.

Dr. Sutton maintained a long-standing private practice in general surgery in Wichita Falls, Texas. She earned a medical degree from the Baylor College of Medicine in Houston, Texas, and completed a surgical internship at St. Paul Hospital at The University of Texas Southwestern Medical Center in Dallas and a general surgery residency at Scott & White Memorial Hospital in Temple, Texas.

She has been a steadfast leader within the ACS for many years. After serving as a president of the North Texas ACS Chapter, a past Governor-at-Large representing North Texas, and a past member of the Board of Governors Executive Committee, she was a member of the Board of Regents (BoR) for a decade, as well as BoR Chair for 1 year.

Dr. Sutton also has held leadership positions for numerous other organizations. As a result of her leadership and support of others, she has received the Distinguished Alumna in General Surgery Award from her former residency program at Scott and White Memorial Hospital, the Association of Women Surgeons Foundation Nina Starr Braunwald Award, among other prestigious recognitions. B

Dr. Anton Sidawy Is ACS President-Elect

RENOWNED VASCULAR SURGEON Anton N. Sidawy, MD, MPH, FACS, was elected President-Elect of the ACS during the Annual Business Meeting of Members at Clinical Congress 2024 in San Francisco, California. The First Vice-President-Elect and Second Vice-President-Elect also were announced.

Dr. Sidawy, who is the Lewis B. Saltz Chair of Surgery and professor of surgery at The George Washington University (GW) School of Medicine and Health Sciences in Washington, DC, said the appointment, "fills me with pride and the satisfaction that others see me as a passionate servant leader and consensus builder."

A native of Syria, Dr. Sidawy immigrated to the US at age 25 after earning his medical degree at the Aleppo University School of Medicine in Syria. He completed his general surgery residency, including a year as administrative chief resident at the Washington Hospital Center in Washington, DC, as well as a fellowship in vascular surgery at Boston University Hospital in Massachusetts. He later earned a masters degree in public health from GW.

An ACS Fellow since 1987, Dr. Sidawy has served as a member of the ACS Board of Governors (2001–2007) and Board of Regents (2015–2024). The latter role included a year as Chair of the Board of Regents (2021–2022). He also led a joint effort by the ACS and the Society for Vascular Surgery (SVS) to create the Vascular Verification Program, an ACS Quality Program that provides hospitals with critical oversight of their vascular surgery programs.

For his longstanding excellence in surgery and surgical leadership, Dr. Sidawy was awarded a 2020 Presidential Citation Award from SVS and the 2006 LaSalle D. Leffall Jr., Award from the Metropolitan Washington DC Chapter of the ACS. He also is the namesake of the Anton N. Sidawy Lectureship of that chapter, which was established in 2008.

A firm proponent of the ACS motto "To Heal All with Skill and Trust," Dr. Sidawy said that he expects his year as ACS President to be focused on "working to the benefit of our Fellows and surgical patients and improving the practice environment and the quality of surgical care for all in the community at large."

Vice-Presidents-Elect

Anne Mosenthal, MD, FACS, a trauma surgeon who is the chief academic officer at Beth Israel Lahey Health—Lahey Hospital & Medical Center in Burlington, Massachusetts, is the First Vice-President-Elect. Dr. Mosenthal has pioneered work to advance palliative care into surgical practice and is a founding member, past Vice-Chair, and current Chair of the ACS Committee on Surgical Palliative Care. She also has held leadership roles in the ACS Trauma Quality Improvement Program, through which she has developed best practice guidelines for palliative care in trauma settings.

Edward M. Barksdale Jr., MD, FACS, chief surgical officer at the Chicagoland Children's Health Alliance and a professor of surgery at The University of Chicago, both in Chicago, Illinois, is the Second Vice-President-Elect. He has contributed to many ACS committees for more than 2 decades, including most recently as a consultant to the Committee on Interprofessional Education and Practice. An expert in childhood cancer and chronic intestinal disease, Dr. Barksdale also worked closely with the mayor, chief of police, and other officials in Cleveland and throughout Ohio on successful antiviolence initiatives while serving as surgeon-in-chief at Rainbow Babies and Children's Hospital/University Hospitals in Cleveland, Ohio.

Both Drs. Mosenthal and Barksdale will serve alongside Dr. Sidawy as officers-elect until October 2025, when they will assume roles as First Vice-President and Second Vice-President and Dr. Sidawy becomes ACS President. B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Eight Renowned Surgeons Receive Honorary ACS Fellowship

Emmanuel Adoyi Ameh, MBBS, FACS, FWACS, FRCSI
Abuja, Nigeria

Dr. Emmanuel Adoyi Ameh is a professor and chief consultant pediatric surgeon in the Department of Surgery at National Hospital in Abuja, Nigeria. A specialist in pediatric surgery and former chief of pediatric surgery at Ahmadu Bello University in Zaria, Nigeria, he also has focused his career on advancing surgical training and practice in sub-Saharan Africa.

Dr. Ameh has served in multiple leadership positions in global surgery, including as a past -chair for the Global Initiative for Children's Surgery. He also has led the development of surgical textbooks and training resources in pediatric surgery for use in sub-Saharan Africa and helped oversee regional postgraduate surgical education and specialization via the West African College of Surgeons.

Widely sought as an international visiting professor, Dr. Ameh has received numerous travel and guest scholar awards. He is the first Board of Governors member representing the ACS Nigeria Chapter and has played a crucial role in the success and expansion of this chapter.

Professor Yuichiro Doki, MD, PhD
Osaka, Japan

Dr. Yuichiro Doki is a groundbreaking esophageal cancer surgeon from Osaka, Japan. As the current director of Osaka University Hospital, Dr. Doki has helped build a preeminent academic department of gastroenterological surgery that includes 500 surgeons.

In his own practice, Dr. Doki has operated on more than 1,500 patients, pioneered preoperative chemoradiation therapy, perfected an induction chemotherapy regimen that has become standard in Japan for esophageal squamous cell carcinomas, and led many randomized clinical trials on the use of synthetic ghrelin to induce appetite in patients. His 1,237 peer-reviewed articles have been cited more than 31,000 times.

Dr. Doki's leadership includes membership on the executive board of the Japanese Surgical Society, current presidencies of the Japan Esophageal Society and Japan Society of Clinical Oncology, and seats on several Japanese government councils on cancer patient care, which has extended his influence throughout his entire nation.

Honorary Fellowship in the ACS was awarded to eight prominent surgeons from around the world at the October 19 Convocation during Clinical Congress 2024 in San Francisco, California.

The granting of Honorary Fellowships is one of the highest honors bestowed during Clinical Congress. Summaries of their careers follow.

Christine Gaarder, MD, PhD, FACS, FEBS EmSurg, FEBS AWR
Oslo, Norway

Dr. Christine Gaarder is a leader in the development of trauma care and trauma systems in Europe and worldwide. She is the chief of the Department of Traumatology and a professor of trauma and simulation at Oslo University Hospital and an attending surgeon in the Department of Gastrointestinal Surgery at Oslo University Hospital Ullevål, both in Norway.

Dr. Gaarder has lectured and trained surgeons and teams in more than 20 European countries as well as South Africa, Australia, and the Middle East, including as instructor at the annual War Surgery Courses of the Norwegian Armed Forces and ACS Advanced Trauma Life Support® and Advanced Surgical Skills for Exposure in Trauma courses. She has edited several editions of the International Society of Surgery's Definitive Surgical Trauma Course.

Dr. Gaarder has held many positions of trust within surgical organizations. She is the current president of the European Society for Trauma and Emergency Surgery, past-president of the International Association for Trauma Surgery and Intensive Care, and a cofounder of the Norwegian Hernia Society.

Andrew Graham Hill, MBChB, MD, EdD, FACS, FISS, FRACS, FRSNZ
Auckland, New Zealand

Dr. Andrew Graham Hill is a renowned colorectal surgeon in New Zealand. He is a professor of surgery, head of South Auckland Clinical Campus, and assistant dean in the Faculty of Medical and Health Sciences at the University of Auckland, as well as consultant general and colorectal surgeon to the Counties Manukau District Health Board, all in New Zealand.

Dr. Hill has established an internationally recognized research group in perioperative care and has focused his research on randomized clinical trials addressing fundamental questions in surgical care, particularly metabolic responses to surgery. As a result of his influence, he has been awarded the John Mitchell Crouch Fellowship—the Royal Australasian College of Surgeons' highest research award.

A past-president of the International Society of Surgery, Dr. Hill also is the President of the Australia and New Zealand Chapter of the ACS and a member of the ACS Board of Governors.

Jamal Hoballah, MD, MBA, FACS
Beirut, Lebanon

Dr. Jamal Hoballah, a vascular surgeon, is the chairperson and professor of surgery at the Faculty of Medicine and Medical Center of the American University of Beirut, in Beirut, Lebanon.

Dr. Hoballah has published 142 peer-reviewed articles and 92 book chapters and edited 16 books on a range of surgical topics. He also developed and administered the ACS Comprehensive General Surgery Review Course in Beirut, later expanding it to Jordan, Greece, and Latin America. Dr. Hoballah has been instrumental in expanding access to the ACS National Surgical Quality Improvement Program across the Middle East.

He is a founder and leader of multiple Middle Eastern surgical associations. He is a past-President of the ACS Lebanon Chapter, past-ACS Governor, and past-Vice-Chair of the ACS International Relations Committee. He remains on the Executive Board of the International Relations Committee.

Dr. Hoballah also has received an honorary fellowship of the American Surgical Association and numerous other awards.

P. Ronan O'Connell, MB, MD, FRCSI
Dublin, Ireland

Dr. P. Ronan O'Connell is an internationally recognized colorectal surgeon and emeritus professor of surgery at the University College Dublin in Ireland, and a past-president of the Royal College of Surgeons in Ireland.

Dr. O'Connell has contributed to many advancements in colorectal surgery, including guidelines for the diagnosis and treatment of functional colorectal disease, technology for treatment of colorectal cancer, and centers of excellence for rectal cancer care in Ireland. His publication record, which includes more than 230 peer-reviewed articles and 28 book chapters, has focused on inflammatory bowel disease, pelvic floor physiology, colorectal cancer, and more.

Dr. O'Connell has served on the editorial board of the *Journal of the American College of Surgeons* and the *Annals of Surgery*, associate editor and editor of the *British Journal of Surgery*, associate editor of *Diseases of the Colon & Rectum,* past-editor-in-chief for the European Surgical Association, and joint editor on several surgical textbooks. His contributions have been recognized by numerous awards, notably the Patey Prize of the Surgical Research Society.

View the full citations and sponsors for the Honorary Fellows, plus the full list of all Fellows inducted during Clinical Congress, in the 2024 Convocation program at *facs.org/convocation.*

Shailesh Vinayak Shrikhande, MBBS, MS, MD
Mumbai, India

Dr. Shailesh Vinayak Shrikhande is a renowned hepatobiliary surgeon. He is a professor and the head of the Division of Cancer Surgery, chief of the gastrointestinal and hepato-pancreato-biliary service, and deputy director of the Tata Memorial Hospital in Mumbai, India.

His clinical practice has included performing more than 1,200 pancreatoduodenectomies. He also has given more than 600 invited lectures, served as a visiting professor to renowned institutions globally, and has repeatedly been listed in Stanford University's list of the world's highest contributing researchers. Dr. Shrikhande has been a leader in ensuring access to care for patients, accomplishing this goal in part by teaching surgeons through India and ensuring the creation of housing for impoverished patients at his institution in Mumbai.

He has received three awards from the Governor of Maharashtra, India, as well as numerous other recognitions. He holds honorary fellowships from the American Surgical Association and the Royal College of Surgeons of England.

Catherine S. C. Teh, MD, FPCS, FRCSEd
Manila, Philippines

Dr. Catherine Teh is a renowned hepatopancreatobiliary (HPB) surgeon from Manila, Philippines. She serves as chief of HPB Surgery at the Makati Medical Centre in Manila and Tarlac Provincial Hospital in Tarlac City; director of the Great Valley Medical Center in Quezon City; and medical director of the Global Cancer Care Institute in Bay, Laguna, all located in the Philippines.

Dr. Teh has led transformative change in HPB surgery and transplantation nationally. She has pioneered the use of laparoscopic liver resection and associated liver partition with portal ligation staged surgery in the Philippines, created and led the Liver Centre of the National Kidney and Transplant Institute and the Centre for Liver Care in the Makati Medical Centre, and increased multidisciplinary care to patients needing hepatobiliary oncologic care and transplant. She also has established a foundation to support indigent HPB surgical patients, created an HPB training program for surgeons in the Asia Pacific region, and worked to reduce liver transplant cost in the Philippines.

Dr. Teh was the first female chair of surgery at her institution and is the first woman from the Philippines to become a Fellow of Royal College of Surgeons (Edinburgh). She has taken special care to mentor and support women in surgery as she breaks new ground herself. B

Dr. Raghuvir Gelot Is Honored as Distinguished Philanthropist

The ACS Foundation recognized Raghuvir Gelot, MD, FACS, with this year's Distinguished Philanthropist Award at ACS Clinical Congress 2024 in San Francisco, California. The award is the ACS Foundation's highest and most significant honor.

Since 1989, the ACS Foundation has honored individuals with this award for their exemplary investment in the mission of the College to advance surgical practice, research, and patient care. Distinguished Philanthropist Award recipients, along with other philanthropic Fellows and friends of the ACS, have contributed more than $23 million to support ACS programs, including scholarships, research awards, and initiatives that promote lifelong learning for surgeons.

"Dr. Gelot's generosity and commitment to the College inspire others to give, and his philanthropic spirit has left a lasting impact," said H. Randolph Bailey, MD, FACS, Chair of the ACS Foundation. "We are honored to recognize him as this year's Distinguished Philanthropist. His contributions have significantly furthered the College's goals and initiatives."

Dr. Gelot is an otolaryngologist and head-and-neck surgeon who dedicated his career to serving patients at East Carolina University Health Roanoke-Chowan Hospital in Ahoskie, North Carolina. An ACS Fellow since 1996, his philanthropy has had a significant impact on the surgical community and global healthcare.

In 2008, Dr. Gelot established the Baxiram S. and Kankuben B. Gelot Community Surgeons Travel Award, which provides funding for international physicians to attend ACS Clinical Congress. In 2013, he also created the Kankuben B. Gelot Scholarship. This award offers stipends for nurses or residents to participate in the joint annual meeting of the North and South Carolina ACS Chapters. Additionally, Dr. Gelot funds an annual award to support the resident poster/paper competition at the event.

Dr. Gelot's commitment to advance surgical education through these scholarships has provided the opportunity for 15 international and 12 domestic scholars to attend Clinical Congress or ACS chapter meetings, and it has provided awards for 72 residents who have participated in the clinical poster/paper competitions at the combined chapter meetings.

"I have never thought or dreamed of receiving this prestigious award, and to be named alongside the giants of the American College of Surgeons for someone as obscure as I am is a great honor," said Dr. Gelot.

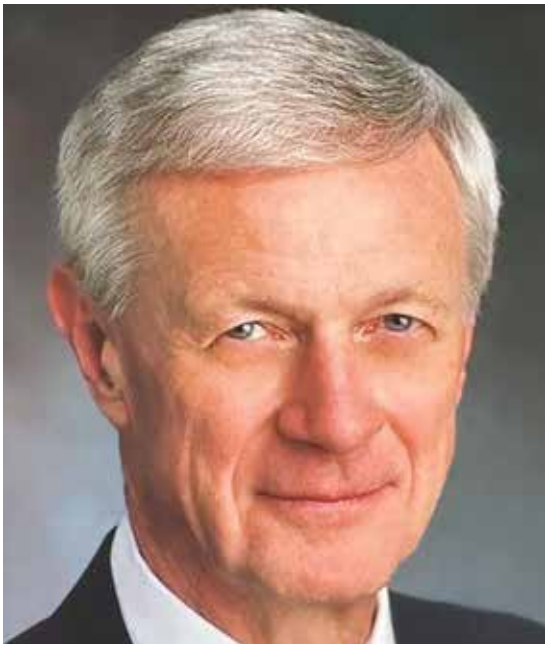
"His words are a reflection of his modesty," said Kenneth Sharp, MD, FACS, a member of the ACS Board of Regents and Liaison to the ACS Foundation Board. "Dr. Gelot is anything but obscure and deserves this recognition."

The Impact Award, which acknowledges a commitment to advancing surgical education, also was presented at Clinical Congress 2024.

Christina Hewes Corson received the award for establishing the John Duncan Corson Guest Scholarship in 2021, in honor of her husband John Corson, MD, a vascular and cardiothoracic surgeon. The award—organized by the ACS International Relations Committee—provides early career surgeons from the UK or the Republic of Ireland the opportunity to attend Clinical Congress and travel to academic medical institutions in the US to share and learn best practices regarding current surgical research.

For more information about the ACS Foundation and these awards, visit *facs.org/foundation.*

Dr. Raghuvir Gelot receives the Distinguished Philanthropist Award from Dr. Ken Sharp, who serves as Liaison to the ACS Foundation Board.



Dr. David Murray, ACS Past-President

"When you were with David Murray, you just knew you were in the presence of a great man." That's how ACS Past-President Patricia J. Numann, MD, FACS, describes David G. Murray, MD, FACS, who passed away October 1 at the age of 94.

A RENOWNED ORTHOPAEDIC SURGEON AND distinguished surgeon-scientist, Dr. Murray was an ACS Fellow for 58 years and a Regent and Officer for more than 10 years, culminating with his service as the 77th ACS President (1996-1997). He retired from clinical service at The State University of New York (SUNY) Health Science Center in Syracuse in 2001.

"He was one of my favorite people," Dr. Numann said. "I will miss his wisdom and even-tempered demeanor. He was always very thoughtful when facing challenging situations and led by having the respect of others and valuing their input. In all ways, David was honorable."

Born in Ames, Iowa, Dr. Murray—as a young boy—loved building things with his hands, working on his family farm, and tagging along with his grandfather, who was the local physician. He eventually decided to follow in his grandfather's footsteps.

After earning his medical degree from Washington University School of Medicine in St. Louis, Missouri, in 1955, Dr. Murray completed a surgical internship at Vancouver General Hospital. He went on to serve as a lieutenant in the US Navy, participating in Operation Deep Freeze II in the Antarctic. Dr. Murray resumed general

surgery training at SUNY Upstate, followed by an orthopaedic residency at The University of Iowa in Iowa City.

In 1962, he returned to SUNY Upstate, and just 4 years later, he was named chair of the Department of Orthopaedic Surgery—a position he held for 30+ years before retiring. When he became chair, he was one of the youngest orthopaedic chairs in the country, and he went on to train more than 120 orthopaedic surgeons, as well as many other physicians and support staff during his tenure.

Considered an "enlightened" man, Dr. Murray was one of the first surgeon leaders to accept women into his training program and onto his faculty.

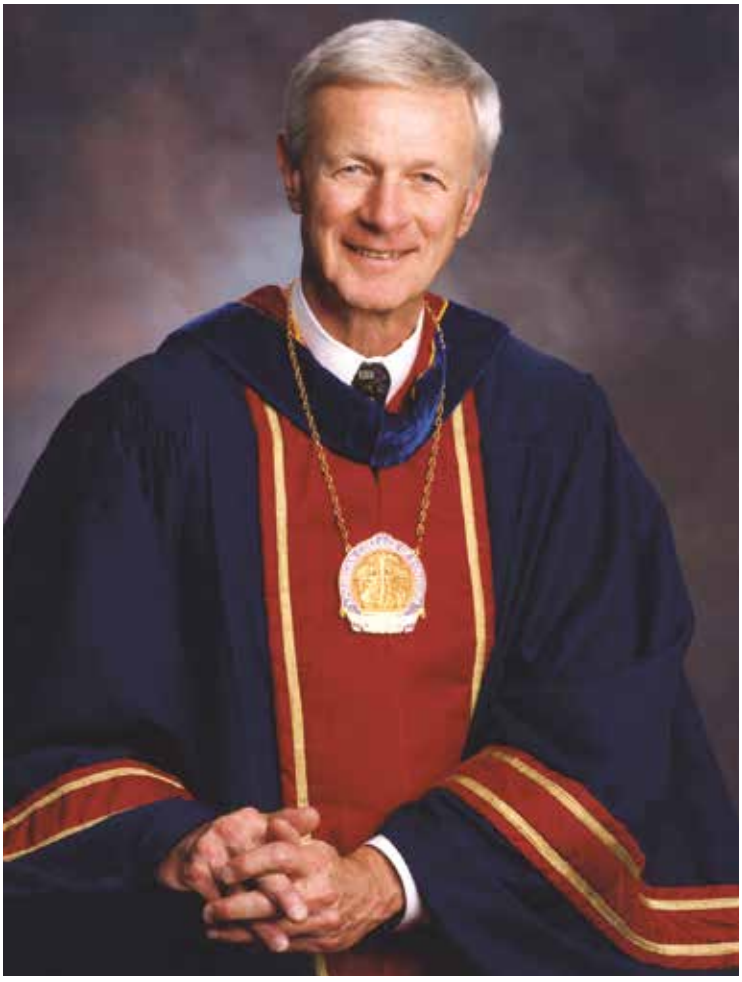
"I met David Murray in 1963 when I was a third-year medical student. The division had just become a department, and he offered me an orthopaedic residency," said Dr. Numann. "At that time, women had their applications for surgery returned. Dr. Murray was an enlightened man who defended the equality of women and advocated for us before that was even thought of."

Dr. Murray also was a distinguished surgeon-scientist, recognized for his research on general bone physiology, the use of electrical current to promote bone remodeling and healing, respiratory insufficiencies resulting from fat embolism during surgery, and total joint replacement procedures. In fact, Dr. Murray—revered as a talented technical orthopaedic surgeon and one of the first joint replacement surgeons—designed, developed, and patented the variable-axis knee prosthesis. It often is referred to as the "Syracuse knee" and laid the groundwork for replacement knee designs in use today.

At SUNY Upstate, the David G. Murray, MD, Endowed Professorship in Orthopedic Surgery was established to ensure continued research related to musculoskeletal cancer. Dr. Murray also worked tirelessly with local officials and hospital leaders to design, build, and finance the SUNY Upstate Institute for Human Performance.

Following his retirement, Dr. Murray ran a small clock repair business—Doc's Clocks—out of a workshop adjacent to his home in Syracuse. He repaired approximately 50 to 70 clocks each year, providing his services to the owners of all types of clocks—mantel, anniversary, cuckoo, and grandfather clocks. He also returned to his farming roots when his son, Bruce, purchased land on Seneca Lake in New York, and together they created the vineyard, Boundary Breaks Wine in Lodi, New York.

Dr. Murray is survived by his wife Judith Sayles, three sons, Christopher, Bruce, and James, six grandchildren, and three great-grandchildren. B



Report on ACSPA/ACS Activities, October 2024

Lillian S. Kao, MD, MS, FACS

The Board of Directors of the ACS Professional Association (ACSPA) and the ACS Board of Regents (BoR) met October 18 at the Hilton San Francisco Union Square in California.

THE FOLLOWING IS A SUMMARY of key activities discussed and 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 benefits surgeons and patients, including expanded legislative advocacy and political programming, such as the ACSPA-Political Action Committee (SurgeonsPAC).

ACS

The BoR accepted resignations from 19 Fellows and changed the status from Active or Senior to Retired for 110 Fellows. The Regents also approved the following items:

- Statement on Automatic Crash Notifications
- Statement on Workplace Violence
- Best Practices Guidelines: Management of Traumatic Brain Injury (revision)
- Statement on the Physician Acting as an Expert Witness (revision)
- Statement on Surgeon Well-Being (revision)

These statements are available at *facs.org/statements*; additional details from these statements will be available in the *Bulletin* and weekly *ACS Brief* email.

In addition, Regents approved the formation of the Sweden Chapter and integration of the Jacksonville Chapter into the Florida Chapter of the ACS.

Advocacy and Health Policy

The results of a Division of Advocacy and Health Policy strategic review of programs and products were presented, identifying internal and external challenges, defining future vision, and establishing priorities for moving forward.

Topics included:

- ACSPA-SurgeonsPAC
- Coalitions
- Elections
- Future advocacy and health policy agenda

Recommendations included:

- Continuing to focus on top advocacy priorities and efforts by furthering Congressional and Federal relationships after the election results
- Convening focus groups with Fellows to better understand how the College should prioritize advocacy efforts
- Developing additional resources on surgeon expectations to better integrate ACS statements
- Exploring opportunities with other coalitions
- Implementing strategies to increase contributions to the ACSPA-SurgeonsPAC and its value to the membership
- Using ACS programs and leadership groups to expand dissemination of advocacy efforts and priorities

Education

Clinical Congress 2025

The proposed program for Clinical Congress 2025 was presented for the Regents' comment and review. The final program was approved at the BoR Adjourned Meeting on October 22, 2024.

Fellowship in Surgical Ethics

Offered for the first time in 2015, the Fellowship in Surgical Ethics is sponsored by the ACS Division of Education and The MacLean Center for Clinical Medical Ethics at The University of Chicago. The program is intended to prepare surgeons for careers that combine clinical surgery with scholarly studies in surgical ethics and to provide specialized

knowledge, skills, and training to develop leaders in the field of surgical ethics. Applications will be accepted for the 2025–2026 academic year until January 2025.

Research and Optimal Patient Care

The Division of Research and Optimal Patient Care (DROPC) provided a status update on the recommendations from an October 2022 strategic analysis of Trauma programs.

Reviewed programs:

- Trauma Quality Programs
- Verification, Review, and Consultation: 590 centers
- Trauma Quality Improvement Program (TQIP): 912 centers
- Performance Improvement and Patient Safety Program
- Trauma Systems Consultation Program

Recommendations:

- Strengthening core trauma quality programs to increase impact and expand reach
- Phase 1 included identifying improvements in content, format, and delivery of the TQIP benchmarking reports

ACS Foundation

The mission of the ACS Foundation, a separate 501(c)(3) organization, is to secure financial support for the College's charitable, educational, and patient-focused initiatives. The Foundation offers a wide spectrum of funding opportunities for ACS Fellows and supporters to ensure the highest level of surgical care and education.

As of July 1, 2024, more than $217,000 in philanthropic gifts, including eight new gifts or pledges of at least $10,000, had been secured. Highlights of this work are the successful completion of the Excelsior Surgical Society Campaign and Skills Course funding. Chapter Funds continue to grow and more than $25,000 was raised from the Georgia Society of the ACS, North Carolina Chapter, and the South Carolina Chapter. The Missouri Chapter has committed to creating a new Chapter Fund.

Clinical Congress 2024 featured a planned giving presentation to help surgeons better understand the importance and tax implications of estate planning. A revamped and improved Planned Giving website is underway.

The inaugural Surgical Adhesions Summit, funded by Peter and Marshia Carlino, was held in September in Washington, DC. Surgeons from around the globe participated and shared new perspectives and proposed solutions. Due to the success of the Summit, the Carlinos who have already given $1 million for this project, committed to investing an additional $300,000 to support three new research grants.

Dr. Lillian Kao *is the Immediate Past Chair of the ACS Board of Governors, as well as division director of acute care surgery, the Jack H. Mayfield, MD, chair of surgery (endowed), and vice-chair for quality of care in the Department of Surgery at the McGovern Medical School at The University of Texas Health Science Center at Houston.*

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GSV
Geriatric Surgery Verification

Is your hospital ready for the new CMS Age Friendly Measure?

Beginning in January, hospitals participating in the Centers for Medicare & Medicaid Services (CMS) Hospital Inpatient Quality Reporting Program will have to comply with this new regulatory requirement.

The ACS Geriatric Surgery Verification Program (GSV) gives hospitals the tools to fulfill the requirements of the new measure while improving surgical care for older adult patients. GSV includes evidence-based practices that enable hospital teams to deliver optimal care and help patients achieve their care goals.

Learn more at *facs.org/gsv*

ACS AMERICAN COLLEGE OF SURGEONS

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

THE ACS 2025 NOMINATING Committee of the Fellows (NCF) and Nominating Committee of the Board of Governors (NCBG) will accept nominations through February 14, 2025, for leadership positions in the College.

Officers-Elect

The 2025 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.*

Board of Regents

The 2025 NCBG will select nominees for three vacancies on the Board of Regents to be filled at Clinical Congress 2025.

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) Diana L. Farmer, Sarwat Salim, and Steven C. Stain.

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 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:

- Acute care surgery (trauma surgery and emergency general surgery)
- Burn and critical care surgery
- Gastrointestinal surgery
- General surgery
- Surgical oncology
- Transplant surgery
- Urology

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-acs/governance/get-involved/regent.*

The deadline for submitting nominations is **Friday, February 14, 2025.** Nominations must be submitted to officerandbrnominations@facs.org. For more information, contact Emily Kalata at 312-202-5360 or ekalata@facs.org.

Call for Nominations for ACS Treasurer

THE ACS 2025 Nominating Committee of the Board of Regents (BoR) will accept nominations for the position of ACS Treasurer through **March 31, 2025.**

Responsibilities

The responsibilities of the position include:

- The Treasurer shall oversee, in conjunction with the Chief Financial Officer, the funds of the College under the supervision of the Finance Committee and shall make such reports to the Finance Committee, the BoR Executive Committee, and the BoR as may be required.
- The Treasurer will attend the meetings of the BoR and will have a reporting relationship with the Finance Committee and ACS Executive Director.
- The College shall purchase a bond or insurance coverage to ensure the faithful performance of the duties of the office of Treasurer. In the absence or inability to act as the Treasurer, the duties of the Treasurer shall be performed by such person and in such manner as the Finance Committee may direct.
- The Treasurer shall serve as the Chair of the Investment Subcommittee.
- The Treasurer shall serve an initial 3-year term and may serve a maximum of two 3-year terms.

Criteria for Consideration

The Nominating Committee of the Board of Regents (NCBR) will use the following guidelines when considering potential candidates:

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship, along with impeccable adherence to the highest principles of surgical practice.
- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.
- Nominees must have prior experience serving on a financial committee, preferably of a nonprofit organization; additional experience serving on an investment committee is desirable.
- Nominees must be able to read and understand financial statements and exhibit astute business acumen.
- Members of the NCBR recognize the importance of achieving representation of all who practice surgery.
- The ACS encourages consideration of women and other underrepresented minorities for all leadership positions.

Nomination Process

All nominations must include:

- A letter of nomination
- A current curriculum vitae
- A personal statement from the candidate detailing ACS service
- Name of one individual who can serve as a reference

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

Nominations must be submitted by **March 31, 2025** via the online form at *www.surveymonkey.com/r/Treasurer25.* For more information, contact Ken Puttbach at kputtbach@facs.org.

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Member News

Rogers Is Elected to National Academy of Medicine

Selwyn O. Rogers Jr., MD, MPH, FACS, has been elected to the prestigious National Academy of Medicine. 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. At The University of Chicago in Illinois, Dr. Rogers—a trauma surgeon—is the James E. Bowman Jr. Professor of Surgery, executive vice president of community health engagement, founding director of the Trauma Center, and chief of the Section of Trauma and Acute Care Surgery.

Plevnia Joins AAOMS Board of Trustees

Julia R. Plevnia, DDS, FACS, is serving a 2-year term as a member of the board of trustees at the American Association of Oral and Maxillofacial Surgeons (AAOMS). Dr. Plevnia served in the US Army, where she taught in oral and maxillofacial surgery programs at military hospitals, and is owner, partner, and practicing oral and maxillofacial surgeon at Dry Creek Oral Surgery in Parker, Colorado.

Farber Is Promoted to Surgeon-in-Chief in Boston

Alik Farber, MD, MBA, FACS, is surgeon-in-chief at Boston Medical Center and the James Utley Professor and Chair of Surgery at the Boston University Chobanian & Avedisian School of Medicine in Massachusetts, after having served in interim roles since January 2024. A vascular surgeon, Dr. Farber has been with Boston Medical Center since 2005.

Goldberg Is Chief of Perioperative Services

Ross F. Goldberg, MD, FACS, is chief of perioperative services for the Jackson Health System in Miami, Florida. Dr. Goldberg also will continue in his roles as medical director of perioperative services for Jackson Memorial Hospital in Miami and affiliate professor in the Department of Surgery at the University of Miami Miller School of Medicine, both in Florida.

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. Submissions will be printed based on content type and available space.

Additional Member News items are available on *facs.org*.

Waljee Leads Plastic Surgery in Indiana

Jennifer Waljee, MD, MPH, MS, FACS, is chief of the Division of Plastic Surgery in the Department of Surgery at Indiana University School of Medicine in Indianapolis. She previously served as director of the Center for Healthcare Outcomes & Policy and the George D. Zuidema Professor at the University of Michigan in Ann Arbor.

Tadlock Is Specialty Leader at BUMED

Matthew D. Tadlock, MD, FACS, is the general surgery specialty leader for the Surgeon General of the US Navy Bureau of Medicine and Surgery (BUMED)—an agency of the US Department of the Navy that manages healthcare activities for the US Navy and US Marine Corps. US Navy Captain Tadlock is a trauma/critical care surgeon currently assigned to Expeditionary Strike Group 3, officer in charge of Surface Medical Group Pacific, and an associate professor of surgery at the Uniformed Services University of the Health Sciences in Bethesda, Maryland.

Gosain Heads Up UVA Pediatric Surgery

Ankush Gosain, MD, PhD, MBA, FACS, is chief of the Division of Pediatric Surgery and surgeon-in-chief at the University of Virginia (UVA) Health Children's. Dr. Gosain previously served as the Dr. David R. and Kiku Akers Endowed Chair of the Department of Pediatric Surgery at Children's Hospital Colorado (CHC) in Aurora. He also was associate vice chair of pediatric surgical research in the Department of Surgery at CHC.

Costantini Is Division Chief at University of Minnesota

Todd Costantini, MD, FACS, is chief of the Division of Critical and Acute Care Surgery and vice chair for clinical quality in the Department of Surgery at the University of Minnesota in Minneapolis. Previously, Dr. Costantini held the position of trauma medical director at the University of California San Diego Health and developed a national reputation for efforts in trauma research and protocol development.

JACS JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS

Highlights

The following articles appear in the November and December 2024 issues of the *Journal of the American College of Surgeons*. A complimentary online subscription to *JACS* is a benefit of ACS membership. See more articles on the *JACS* website.

Understanding and Assisting the Recovery of Non-English-Speaking Trauma Survivors: Assessment of the NESTS Pathway

Alexis G. Antunez, MD, Juan P. Herrera-Escobar, MD, MPH, Saba Ilkhani, MD, MPH, and colleagues

Spanish-speaking patients who suffer traumatic injury have gaps in their postdischarge care. A multi-institutional pathway was designed to aid them in accessing social and healthcare support. Patients often needed and obtained assistance with food, housing, and utilities, and access to mental healthcare within the pathway notably improved.

Evidence Review for the ACS Quality Verification Part III: Standardization, Protocols, and Achieving Better Outcomes for Patient Care

Chelsea F. Cardell, MD, MS, Xane D. Peters, MD, MS, Q Lina Hu, MD, MS, and colleagues

The ACS Quality Verification Program reflects essential resources and infrastructure for surgical quality improvement across all specialties and patient populations. This study reported evidence in support of disease-based management, team-based multiphasic surgical care, and external regulatory review to promote surgical quality.

Contemporary Evaluation of Work-Life Integration and Wellbeing in US Surgical Residents: A National Mixed-Methods Study

Lauren M. Janczewski, MD, MS, Joanna T. Buchheit, MD, MS, Kimberly B. Golisch, MD, MS, and colleagues

This study found that parents and female residents were more likely to report work-life conflict, which was associated with career dissatisfaction, burnout, thoughts of attrition, and suicidality. Qualitative data revealed work-life integration interventions, including protecting health maintenance time, supporting life outside of work, and allowing meaningful autonomy in scheduling.

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IMPORTANT RISK INFORMATION

Do not inject or place **PerClot** Absorbable Hemostatic Powder into blood vessels such as artery or vein as potential for embolization and death may exist.

Do not use **PerClot** Absorbable Hemostatic Powder for treatment of severe or extreme bleeding.

Do not inject into bladder or ureteral lumen.

Single use only. Do not re-use. Do not re-sterilize. Re-use or reprocessing of a single use device may lead to contamination and compromised device function or structural integrity.

Safety and efficacy of **PerClot** Absorbable Hemostatic Powder have not been clinically evaluated in children (less than 21 years old) and pregnant or lactating women.

PerClot Absorbable Hemostatic Powder should be used with caution in the presence of infection or in contaminated areas of the body. If signs of infection or abscess develop where **PerClot** Absorbable Hemostatic Powder has been applied, re-operation may be necessary in order to allow drainage.

Safety and efficacy of **PerClot** Absorbable Hemostatic Powder in neurological and ophthalmic procedures have not been established.

Safety and efficacy of **PerClot** Absorbable Hemostatic Powder have not been clinically evaluated for use in controlling post-partum bleeding or menorrhagia.

Once hemostasis is achieved, excess **PerClot** Absorbable Hemostatic Powder should be removed from the site of application by irrigation and aspiration particularly when used in the pericardial cavity and around foramina of bone, areas of bony confine, the spinal cord, and/or the optic nerve and chiasm. **PerClot** Absorbable Hemostatic Powder achieves its maximum swelling within 10 minutes when exposed to blood or other fluids. Dry, white **PerClot** Absorbable Hemostatic Powder should be removed. The possibility of the product interfering with normal function and/or causing compression of surrounding tissues due to swelling is reduced by removal of excess dry material.

The effect of this product on patients with known sensitivity to starch or starch-derived materials has not been studied.

The efficacy of **PerClot** Absorbable Hemostatic Powder in achieving hemostasis in cortical bone and spinal bleeding has not been studied in randomized clinical trials.

Blood vessels, suture line gaps, and large needle holes with a diameter of ≥2mm must be ligated prior to **PerClot** Absorbable Hemostatic Powder application.

Do not apply more than 50g of **PerClot** Absorbable Hemostatic Powder in diabetic patients as it has been calculated that amounts in excess of 50g could affect the glucose load.

As with other hemostatic agents, do not apply **PerClot** Absorbable Hemostatic Powder to sites where there is negative peripheral venous pressure as material may be drawn into the vascular system potentially resulting in life-threatening thromboembolic events.

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TAP HERE TO GET MORE INFORMATION ON PERCLOT

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References: 1. Water Mass Absorbance: **PerClot** versus **Arista**. August 2014. Baxter Data on File. REF-32407, Assessment of the hemostatic efficacy of **PerClot**, **Surgicel** Powder, and **Arista** in a Porcine Liver Abrasion Model. December 2021. Baxter Data on File. REF-36820. **2.** Evaluation of the Adhesive Properties of **PerClot** and **Arista**. September 2022. Baxter Data on File. REF-37550. **3.** Assessment of the hemostatic efficacy of **PerClot**, **Surgicel** Powder, and **Arista** in a Porcine Liver Abrasion Model. December 2021. Baxter Data on File. REF-36820.

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