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ACS Bulletin

AMERICAN COLLEGE OF SURGEONS

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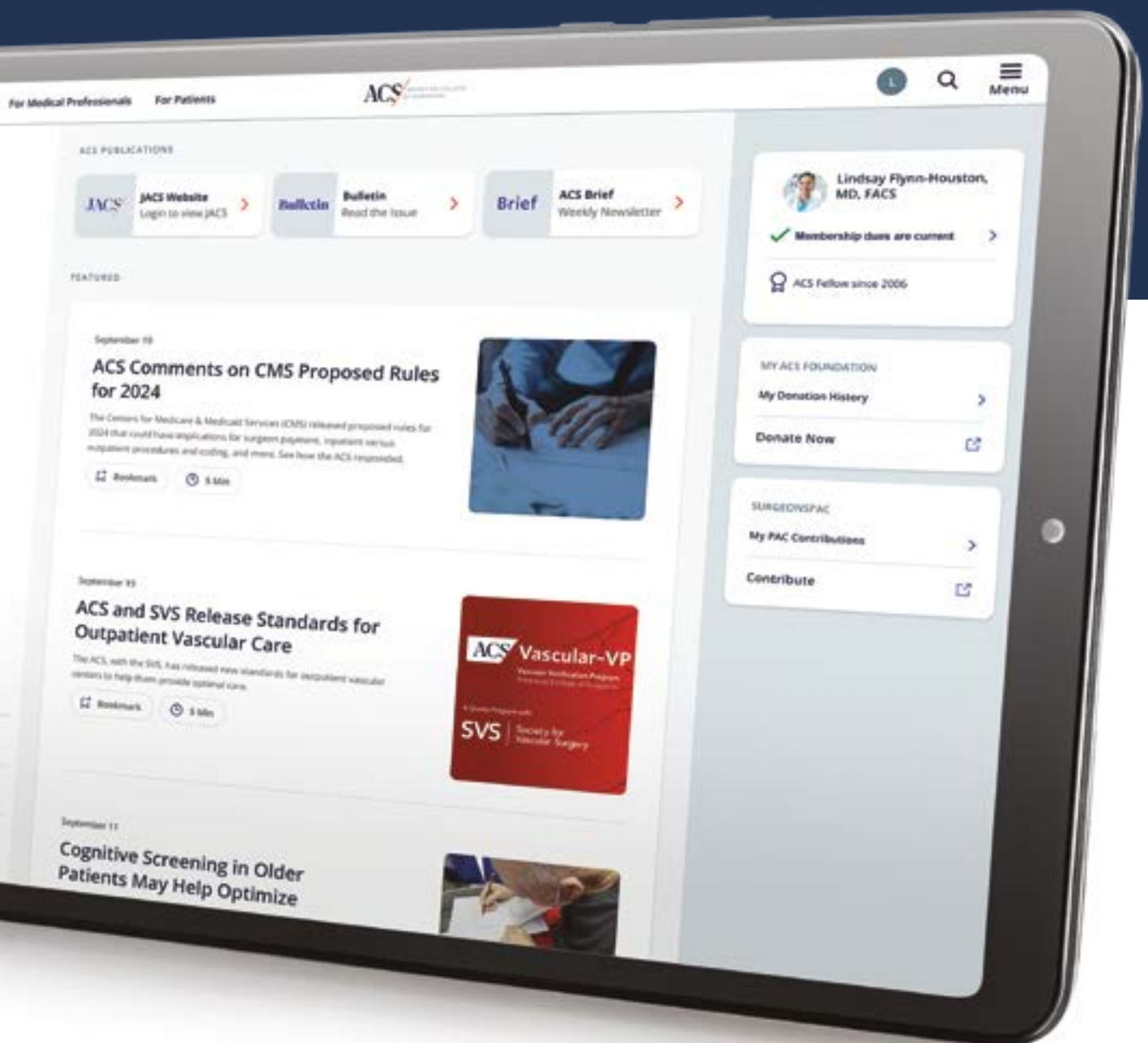

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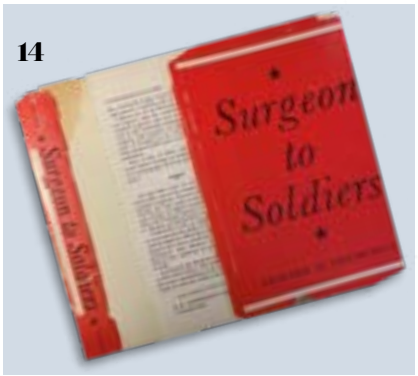

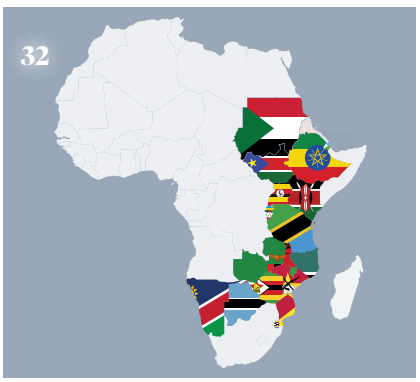

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Excellence in Trauma Surgery via Multidisciplinary Efforts

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WE ARE ALL FAMILIAR WITH THE caduceus, a symbol derived from ancient Greek mythology that depicts two snakes wound around a staff, sometimes topped with wings. The caduceus often appears in medical logos and insignia where another symbol, the rod of Asclepius, depicting one snake wound around a staff, might be seen. The rod of Asclepius is associated with the ancient Greek deity of medicine and has always denoted healing. In contrast, the caduceus is linked to Hermes, Greek god of travelers and commerce, and it is sometimes thought to be used in medicine only in error—although, in third-century London, it was a marker for ophthalmological medicines, in apparent reference to a Homeric poem linking it to the healing of eye disease.

Both symbols, however, connect with the vision of the ACS (although we do not formally use either) as the House of Surgery for all surgical disciplines. Integrating all elements of surgeons and surgery into what's best for our patients and our profession helps us tackle tasks that no single specialty could achieve as effectively alone.

One example of this is in our longstanding work advancing trauma surgery. Surgeons of all kinds are essential to this work, including those in vascular, pediatric, reconstructive surgery, and virtually all other surgical disciplines—more than any one column can describe. In this column, I'll share some examples of how neurologic, ophthalmologic, otolaryngologic, plastic and maxillofacial, and orthopaedic surgery connect with our work in trauma.

Ensuring Trauma Care Is Comprehensive

The ACS engages with multiple surgical disciplines on trauma care in important but straightforward ways. Our Verification, Review, and Consultation program, which began in 1987 and engages approximately 590 participating hospitals today, uses a standards manual, *Resources for Optimal Care of the Injured Patient* (2022), that details program requirements for trauma care. These are, by design, highly multidisciplinary, as effective care of the trauma patient requires engagement across the spectrum of physician specialty and nonphysician care.

For example, among many standards for appropriate trauma care are requirements for access to craniofacial care in Level I adult and pediatric trauma centers and access to ophthalmological, plastic, otolaryngological, and other surgical specialists in Levels I and II adult and pediatric

trauma centers. In addition, the standards require all trauma centers to provide neurological and orthopaedic surgical care.

Similarly, our Advanced Trauma Life Support® (ATLS®) course, which will soon celebrate its 50th anniversary, ensures comprehensive care by including instruction on trauma care across the spectrum of surgical needs. For example, this includes head and neck trauma, ear, nose, and throat trauma, and neurotrauma. ATLS, which was originally the brainchild of orthopaedic surgeon **James K. Styner, MD, FACS,** also includes insights into orthopaedic surgical care.

Building an Ocular Trauma Roadmap

The ACS Committee on Trauma (COT) connects with ophthalmologists on challenges in ocular trauma treatment as well. This past year, the COT created a position paper with recommendations for addressing systems-level gaps in ocular trauma care in the US. Collaborations between the COT and American Society of Ophthalmic Trauma are ongoing.

Improving TBI Care across Surgical Disciplines

Traumatic brain injury (TBI), which has a lifetime prevalence of 18.2% in US adults, is also highly relevant for multidisciplinary efforts.

In October 2024, the COT released a new edition of *Best Practices Guidelines for the Management of Traumatic Brain Injury*. More than 20 neurosurgeons, along with dozens of other healthcare professionals, contributed to the creation of these guidelines. A previous edition, in 2015, has led to improvements in some aspects of TBI care; the aim of this new edition is to continue that success by providing comprehensive best practices.

Similarly, we have created the "Fundamentals in the Management of Traumatic Brain Injury" course as a joint initiative of the Brain Trauma Foundation and the COT, using Brain Trauma Foundation guidelines that have been shown to reduce TBI mortality by 50%.

Uniting Surgical Disciplines at Conferences

ACS conferences, particularly Clinical Congress and the Trauma Quality Improvement Program (TQIP) Annual Conference, include sessions on multidisciplinary trauma care. For example, Clinical Congress 2024 featured neurosurgery-related panels on TBI and domestic violence and guidelines for TBI.

For ophthalmologists, a panel on assessing and managing ocular, orbital, and skull-based injuries was relevant, while a session called "Damage Control Ophthalmology for the Non-Ophthalmologist" addressed ophthalmological trauma surgery. Sessions suited to orthopaedic surgeons included ones on combat trauma and postinjury sports participation.

Leadership and Collaboration

Surgical disciplines also mesh in ACS leadership. Our Board of Regents includes Regents and officers from many surgical disciplines, and our Advisory Councils cover surgical specialties comprehensively, including the neurological, ophthalmic, otolaryngology–head and neck, orthopaedic, oral and maxillofacial, and plastic surgery disciplines I have mentioned in this column.

Succeeding Together

The ACS—The House of Surgery™—strives to include surgeons of all kinds. In many ways, our mission, to heal all with skill and trust, cannot be realized without multidisciplinary efforts—and the ongoing effort to connect across disciplines for the good of all patients is a practice as ancient and as eternal as medicine itself.

Engage with the ACS

The ACS offers many trauma surgery resources to all surgeons. These include the Verification, Review, and Consultation Quality Program, ATLS training (including via the MyATLS mobile app and forthcoming 11th edition), the ACS COT, our TBI guidelines, the "Fundamentals in the Management of Traumatic Brain Injury" course, Clinical Congress 2024 sessions on demand (available until February 24, 2025), and Clinical Congress and TQIP in 2025. B

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How Can AI Revolutionize the Match Day Process?

Rachael Essig, MD
Fedra Fallahian, MD
Camila R. Guetter MD, MPH

Artificial intelligence (AI) has taken the surgical community by storm.

MANY ARTICLES HAVE BEEN published that support the prospect of better patient care and work-life balance with AI at the helm of a new world. AI harnesses the power of computer systems to simulate human intelligence processes.[1,2]

It is important to understand the nuances and key differences regarding the terminology associated with this technology. "Big Data," for example, is a term used when a dataset has reached a size that requires advanced tools to manage it, including acquiring and analyzing the data.[3]

When considering all the data produced and collected by residency and fellowship applicants, program directors, and third-party organizations such as the National Resident Matching Program (NRMP) and the Electronic Residency Application Service, among others, one can only imagine the significant amount of data points acquired during the more than 70 years since the match system has been in place.[4]

While processes continue to evolve regarding the electronic application systems, the changes that have occurred, specifically within the last several years, have been transformative, including the US Medical Licensing Examination converting to a pass/fail system rather than a numbered score (Step 1), and the rise of ChatGPT, which is a generative AI chatbot that can generate human-like conversational responses.

How can applicants, program directors, and the profession strategically and successfully employ these tools to build a better future for surgical care?

Benefits for Programs

The organizational process required every year for the match process is not negligible. A significant amount of time is spent by program directors and program coordinators sending invitation emails and deadline reminders, and scheduling interviews.[5] AI tools could help create and send this messaging, thereby reducing program leadership and administrative workloads.

AI tools also can help gather and summarize information about residency programs (i.e., match statistics, faculty interests, resident experiences, research opportunities, American Board of Surgery In-Training Examination statistics) that can be presented to applicants during their interview day.

AI is capable of analyzing large volumes of data and application packets, so one of the great promises of how this technology can revolutionize the match process is in screening and ranking applicants more efficiently.[6] According to the NRMP, more than 50,000 applicants registered in the 2024 Main Residency Match, an all-time high and 4.7% higher than in 2023.

As the number of residency applications continues to grow,[7,8] it has become increasingly challenging for program leadership to review all the applications and find individuals who would best fit their program. For example, the Internal Medicine Residency Program at Indiana University Health Ball Memorial Hospital in Muncie receives approximately 2,000 applications per year for 10 positions. The program leaders are able to personally interview only 4% of the applicants. Johns Hopkins University in Baltimore, Maryland, receives hundreds of applications each year for its highly competitive surgical residency programs, and the Orthopaedic Surgery Residency Program has received more than 730 applications in recent years.

AI technology can analyze vast amounts of applicant data such as grades, test scores, letters of recommendation, personal statements, and clinical experiences to identify patterns that may not be readily apparent to human reviewers, and AI can complete this process much faster than program leadership.

According to ChatGPT, a detailed evaluation of an application—with a thorough analysis that includes "parsing unstructured data" (e.g., personal statements), would take 1–2 minutes, whereas a human reviewer might be expected to spend 70+ minutes reviewing an application.

In addition, using AI to review applications could help identify strong candidates who might otherwise be overlooked. In fact, by analyzing applicant data against program-specific criteria, AI is able generate a ranked list of applicants based on their potential fit with the program's needs and goals.

AI also can have an important role in reducing the unconscious bias of application reviewers by focusing on objective criteria, reducing the influence of personal biases held by human reviewers and leading to a more equitable matching process.[9-11] AI algorithms can analyze large volumes of applicant data like academic performance, standardized test scores, clinical rotations evaluations, and research experience, focusing solely on relevant metrics rather than subjective interpretations influenced by factors like gender, ethnicity, or alma mater. AI systems also can anonymize applications by removing identifiable information like names and demographics; this helps ensure that reviewers assess qualifications without being influenced by personal characteristics.

Benefits for Applicants

From an applicant's perspective, AI can be an invaluable resource for identifying ideal programs and optimizing a candidate's application. AI tools can help analyze the applicant-program fit by comparing applicants' qualifications and preferences with program requirements and culture.

AI can provide personalized recommendations to both applicants and programs about the likelihood of a good match using historical data about current and previous residents at

a particular residency program.[11] Aside from editing personal statements and suggesting compelling "hobbies," AI can bolster residency applications in meaningful ways. Letters of recommendation play a significant role in resident selection but may be stymied by a program director's implicit bias, specifically for women and underrepresented groups.[12,13] AI models could be used to identify cases of implicit bias in language[10,14,15] and to create more standardized gender-neutral descriptions of candidates.[16,17]

Benefits for the Surgical Profession

AI is helping to synthesize large quantities of data for both the individual applicant and the program. How can this technology be taken a step further to assist the surgical profession overall? What if the trends regarding surgical specialties were ascertained from the data already available and AI used predictive models to understand the specific deficits in the surgeon workforce a decade from now?

This information also can be used by applicants to determine if it is possible to find employment within their chosen specialty and desired geographic location. Program directors also could use AI to help select applicants with interests that align within their geographic location. These capabilities could result in surgeons who are content with their specialty of choice and satisfied that the job market aligns with those interests in their preferred region.

AI-based decision support tools like Career Insights can help applicants make informed decisions by integrating all relevant data, including specialty and location. These software systems leverage AI algorithms to analyze large amounts of data, identify patterns, provide insights to assist humans in making decisions across various fields, like healthcare, and offer recommendations and predictions based on analyzed data. The tools include SWOT analysis, decision matrices, career development assessments, skills gap analysis, job market trend reports, interest inventories, personality assessments, decision trees, and various online career planning platforms that provide data-driven insights to help individuals make informed career choices based on their strengths, preferences, and market demands.

Challenges Associated with AI and the Match Process

There are potential pitfalls of using AI in the residency application process, both from an applicant and reviewer standpoint. While AI can help candidates organize their applications and present themselves in the best light, candidates also run the risk of becoming too reliant on technology to create previously self-generated ideas and narratives.

Research has shown that when presented with ChatGPT-generated personal statements and those written by human applicants, residency application reviewers could not verifiably discern between the two.[1,9,18] Notably, an editorial published in the *Journal of Graduate Medical Education* recommended that applicants clearly disclose if they've used AI and use the technology as "a supplement, not a replacement."[19]

Many of the nuances associated with the traits that make an individual a "good" resident cannot be easily duplicated by

Benefits for Program Directors and Coordinators

- Perform detailed evaluations of applications in minutes
- Organize the screening and ranking of applicants
- Reduce unconscious bias of application reviewers
- Identify strong candidates who best fit the program
- Create and send invitation emails and deadline reminders

Benefits for Applicants

- Identify ideal programs based on academic record, extracurricular activities, and preferences
- Craft and refine impactful personal statements
- Optimize application by highlighting information that aligns with program priorities
- Analyze applicant-program fit
- Provide recommendations about likelihood of a good match

a generative AI model. While AI could help standardize the application screening process, it is imperative that these systems are designed to account for equity and impartiality. AI models have already been shown to create statements that contain unintentional cultural biases.[20,21] Therefore, AI tools must be carefully structured to avoid perpetuating biases that are present in historical data.

There is an overwhelming lack of transparency among most AI models, and residency applicants, programs, and stakeholders have a right to understand how AI tools manage their data and make decisions that significantly impact their lives and businesses. Programs must ensure that human judgment remains a critical part of the process and resist an over-reliance on machine learning. To be credible, AI models used in the match process should be designed or at least greatly influenced by the dedicated professionals using these tools.

AI is a tool just like the ones we use daily in the OR. Using a tool appropriately allows for ease of operation and a safe surgical setting. Using the tool inappropriately can cause a catastrophic event. Every new tool that is used in the OR must be tested and its background fully investigated prior to use. Additionally, the surgeon must be trained in how to use the tool. AI models—if they are to be used by programs or the surgical profession—need to be created by the surgical profession as all AI is designed to simulate human learning, comprehension, problem-solving, and decision-making.

New tools are being created all the time, and it is important to recognize which are going to be more permanent applications of this technology. AI and big data both seem to be, for the time being, here to stay. In that case, we must harness these tools and use them to help the entire surgical community, including trainees, programs, and patients, and we must stay vigilant of the limitations while appropriately applying the tool.

Dr. Rachael Essig *is a first-year cardiothoracic surgery fellow in the Department of Surgery in the Division of Cardiothoracic Surgery at The University of Utah in Salt Lake City.*

References

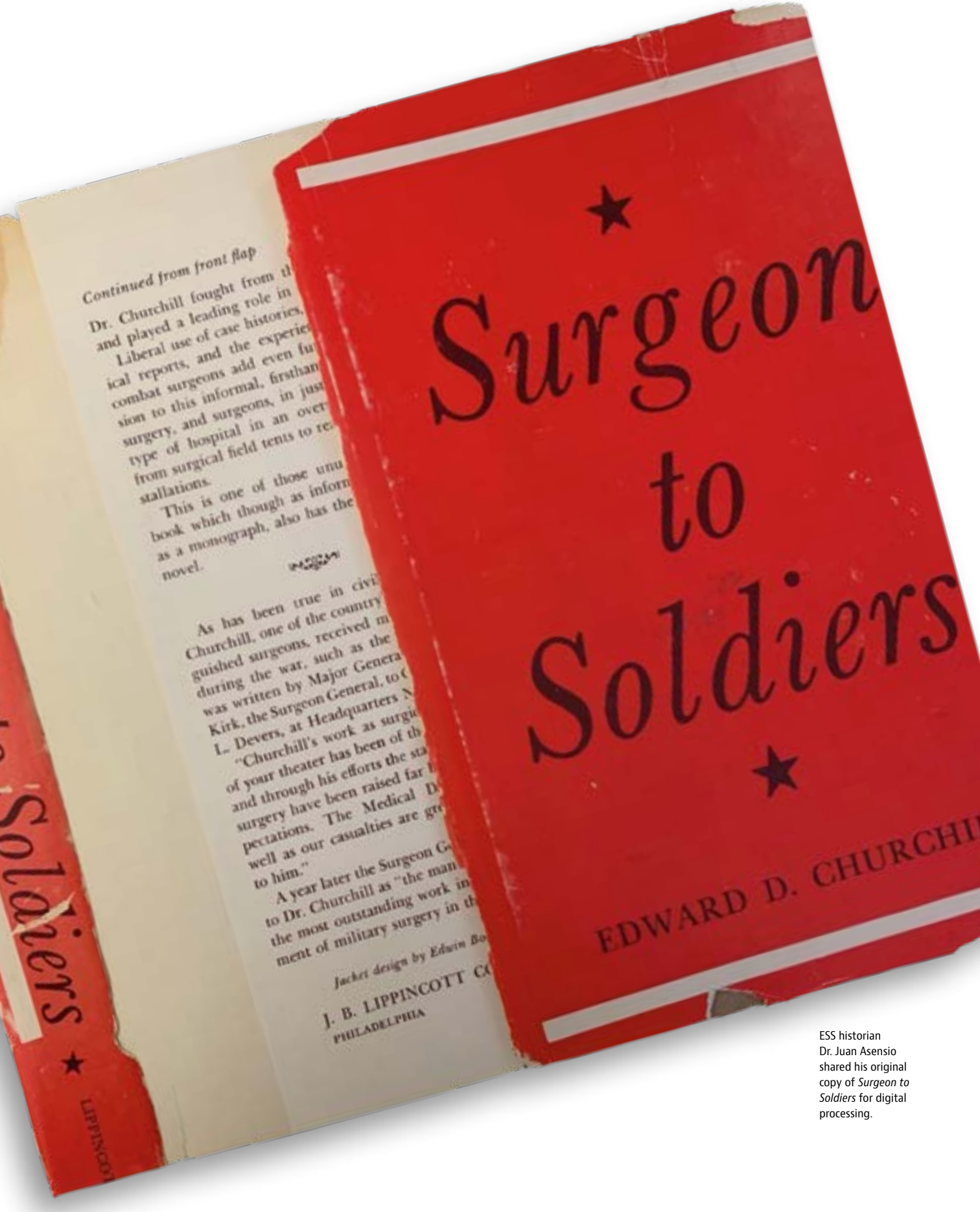
1. Johnstone RE, Neely G, Sizemore DC. Artificial intelligence software can generate residency application personal statements that program directors find acceptable and difficult to distinguish from applicant compositions. *J Clin Anesth*. 2023;89:111185.
2. Mir MM, Mir GM, Raina NT, Mir SM, et al. Application of artificial intelligence in medical education: Current Scenario and Future Perspectives. *J Adv Med Educ Prof*. 2023;11(3):133-140.
3. Pastorino R, De Vito C, Migliara G, Glocker K, et al. Benefits and challenges of Big Data in healthcare: An overview of the European initiatives. *Eur J Public Healt*h. 2019; Oct 1;29(Supplement_3):23-27.
4. Mao R, Williams T, Price A, Colvill K, et al. Predicting general surgery match outcomes using standardized ranking metrics. *J Surg Res*. March 2023; 283:817-823.
5. Strand EA, Sonn TS. The residency interview season: Time for commonsense reform. *Obstet Gynecol*. 2018;132(6):1437-1442.
6. Hassan M, Ayad M, Nembhard C, Hayes-Dixon A, et al. Artificial intelligence compared to manual selection of prospective surgical residents, 2025. *J Surg Educ*. 82(1):103308.
7. Meyer AM, Hart AA, Keith JN. COVID-19 increased residency applications and how virtual interviews impacted applicants. *Cureus*. 2022;14(6):e26096.
8. Singh NP, Boyd CJ. Rapidly increasing number and cost of residency applications in surgery. *Am Surg*. 2023;89(12):5729-5736.

9. Lum ZC, Guntupalli L, Saiz AM, Leshikar H, et al. Can artificial intelligence fool residency selection committees? Analysis of personal statements by real applicants and generative AI, a randomized, single-blind multicenter study. *JB JS Open Access*. 2024 Oct 24;9(4):e24.00028.
10. Sarraf D, Vasiliu V, Imberman B, Lindeman B. Use of artificial intelligence for gender bias analysis in letters of recommendation for general surgery residency candidates. *Am J Surg*. 2021;222(6):1051-1059.
11. John AS, Kavic SM. Leveraging artificial intelligence for resident recruitment: Can the dream of holistic review be realized?. *Art Int Surg*. 2022;2:195-206.
12. Trix F, Psenk AC. Exploring the color of glass: Letters of recommendation for female and male medical faculty. *Discourse Soc*. 2003;14(2):191-220.
13. Madera JM, Hebl MR, Martin RC. Gender and letters of recommendation for academia: Agentic and communal differences. *J Appl Psychol*. 2009;94(6):1591-1599.
14. Catalyst. #BiasCorrect Install. Catalyst. Available at: https://www.catalyst.org/biascorrect-install/. Accessed January 8, 2025.
15. Gender Bias Calculator. Tom Forth. Available at: https://www.tomforth.co.uk/genderbias/. Accessed January 8, 2025.
16. Friedman R, Fang CH, Hasbun J, et al. Use of standardized letters of recommendation for otolaryngology head and neck surgery residency and the impact of gender. *The Laryngoscope*. 2017;127(12):2738-2745.
17. Leung TI, Sagar A, Shroff S, Henry TL. Can AI mitigate bias in writing letters of recommendation? *JMIR Med Educ*. 2023;9(1):e51494.
18. Patel V, Deleonibus A, Wells MW, Bernard SL, et al. Distinguishing authentic voices in the age of ChatGPT: Comparing AI-generated and applicant-written personal statements for plastic surgery residency application. *Ann Plast Surg*. 2023;91(3):324.
19. Mangold S, Ream M. Artificial intelligence in graduate medical education applications. *J Grad Med Educ*. 2024;16(2):115-118.
20. Cao Y, Zhou L, Lee S, Cabello L, et al. Assessing cross-cultural alignment between ChatGPT and human societies: An empirical study. ARXIV Labs. March 31, 2023. Available at: https://arxiv.org/abs/2303.17466#. Accessed January 8, 2025.
21. Ferrara E. Should ChatGPT be biased? Challenges and risks of bias in large language models. First Monday. November 7, 2023. Available at: https://firstmonday.org/ojs/index.php/fm/article/view/13346/11369. Accessed January 8, 2025.

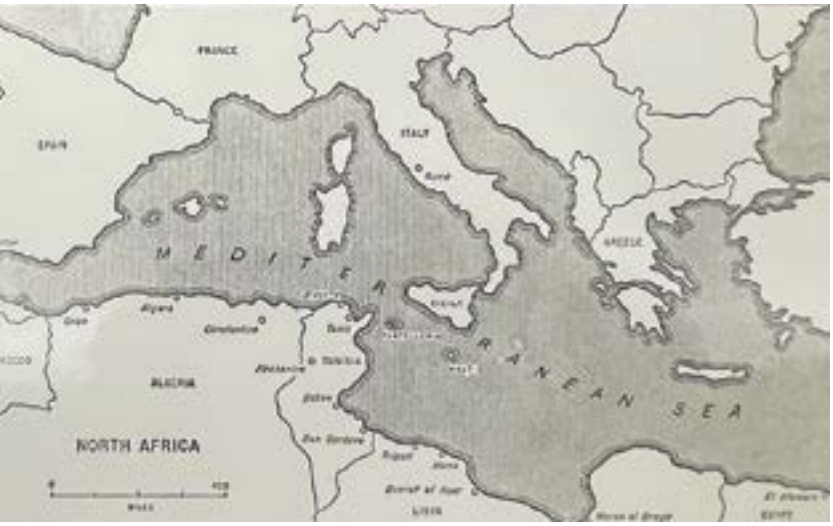
New Edition of *Surgeon to Soldiers* Highlights Innovation, Camaraderie of Military Surgery

Jeremy W. Cannon, MD, SM, FACS

Spring 2025 will mark 80 years since the aggressors of the Third Reich and the Axis powers lost their bid to conquer Europe, North Africa, and Russia. Millions of soldiers, sailors, airmen, marines, and civilians lost their lives in this "great powers" conflict that dramatically reshaped the geopolitical landscape.



ESS historian Dr. Juan Asensio shared his original copy of *Surgeon to Soldiers* for digital processing.



IN THE FACE OF EMERGING THREATS and global aggression from China, Iran, North Korea, and Russia today, it is necessary that all surgeons—both military and civilian—understand the operational and medical aspects of World War II and consider how these experiences might apply to combat casualty care in the present day.[1,2] Thanks to the foresight, discipline, and scholarship of Edward D. Churchill, MD, FACS, we have a guide to help us in this endeavor.

In 1942, Dr. Churchill, a world-renowned thoracic surgeon, volunteered for deployment, and during the subsequent almost 3 years, he meticulously cataloged his journey across North Africa and throughout Europe as the chief surgical consultant for the Allied forces in the Mediterranean Theater of Operations (MTO) (see Figures 1a and 1b, page 16). Some 30 years later, Dr. Churchill published his experiences from World War II, titled *Surgeon to Soldiers: Diary and Records of the Surgical Consultant, Allied Force Headquarters, World War II.*

In the recent US conflicts in Iraq and Afghanistan, this monograph emerged as an inspiration and even a playbook of sorts for deploying surgical leaders like John Holcomb, MD, FACS, and Jay Johannigman, MD, FACS. Because of its limited first printing and significant popularity, copies quickly became hard to find. In fact, one original copy fetched a breathtaking bid of $1,175 at the 2023 American Association for the Surgery of Trauma (AAST) auction supporting military scholarships.

Developing the New Edition

The solution to navigating this supply-demand gridlock started nearly a decade ago. As many of you will appreciate, the path to the finish line in the publishing world is often nonlinear. Like many other pursuits in life, major projects such as this require persistence and a willingness to actively learn along the way.

Thanks to some assistance from LinkedIn, I was fortunate to connect with Keith Donnellan. Donnellan is a senior editor at Wolters Kluwer, the company that acquired Lippincott (the original

publisher) years ago, and he is responsible for their surgical product line, including notable titles like *The ICU Book* and *Mastery of Surgery*. He embraced the vision of this unique project—republishing a wartime memoir with modern commentary for the benefit of military and civilian surgeons and medical planners alike—and became an important advocate for the project's success.

At just about the same time, after lots of digital and archival digging, Donnellan and I found the original copyright for *Surgeon to Soldiers* in the Library of Congress (see Figure 2, on this page).

Interestingly, I also encountered some of Dr. Churchill's correspondence with his editor from Lippincott in my research in the Countway Library in Boston, Massachusetts (see Figure 3, page 18). Now, the challenge was to find any surviving family that might hold claim to this copyright. More internet digging, including a search in Ancestry.com turned up one of Dr. Churchill's grandchildren, Eric Churchill, MD. He works in family practice just outside of Boston and serves as the de facto ambassador for the Churchill family on all aspects related to the Churchill medical legacy.

I will forever cherish my first telephone conversation with Eric who generously took time to share his family's perspective on his late grandfather's contributions to military and civilian surgery. Eric then supplied several digitized historic photographs that greatly enhanced my Excelsior Surgical Society (ESS) presidential address and write-up on expeditionary surgeons published in the *Journal of the American College of Surgeons*. Eric gained the support of his family for publishing a new edition of the book, and he proved to be a great source of encouragement along the way.

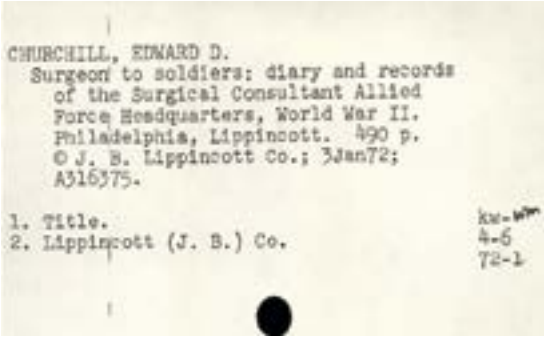
Additional key stakeholders then rallied around this project with very strong support. Michael J. Sutherland, MD, MBA, FACS, Senior Vice President of ACS Member Services, was instrumental in our meetings with the publisher, helping to convince them to back this project. Mary M. (Peggy) Knudson, MD, FACS, and Eric Elster, MD, FACS, also provided key endorsements that led to project approval.

Leading up to the project launch, we realized that the publisher no longer had any copies of this book in its archives, so we had to find a willing donor to contribute a copy of the book for digital processing. Juan A. Asensio, MD, PhD, FACS, FCCM FRCS(Eng), our ad-hoc ESS historian, selflessly kept this project moving along by offering up his copy of *Surgeon to Soldiers*. Of course, this required that the publisher "deconstruct" Dr. Asensio's sacrificial book (see opening spread image). We plan to frame this book in a shadow box and present it to the College as a memento to both the collaborative spirit and the sacrifice required to complete this project.

In 2023, the ACS decided to officially republish *Surgeon to Soldiers* in an effort to make this book accessible to a new generation of surgeons. Through the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS), the ACS enlisted the support of more than 100 surgeons to provide commentaries to accompany most chapters in the book. Available in both e-book and hardcopy formats, *Surgeon to Soldiers, 2024 Edition,* provides a modern context for the service, sacrifice, and innovation that is forged in the crucible of the MTO of World War II (see Figure 4, page 19).

Volunteerism, Leadership, Mentorship

As a civilian surgeon with no prior military experience and no obligation to serve, Dr. Churchill volunteered his expertise for two primary reasons.


CHURCHILL, EDWARD D.
Surgeon to soldiers; diary and records of the Surgical Consultant Allied Force Headquarters, World War II. Philadelphia, Lippincott. 490 p.
© J. B. Lippincott Co.; 3Jan72; A316375.

1. Title.
2. Lippincott (J. B.) Co.

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Opposite page

Figure 1a (top). This map of the MTO shows the area where Colonel Churchill traveled during his 2.5-year mobilization. (Reprinted from the Edward Delos Churchill papers, 1840-1973. HMS c62, with permission from Harvard Medical Library, Countway Library, Boston, MA)

Figure 1b (bottom). In World War II, the MTO had several forward deployed medical facilities, including field hospitals, evacuation hospitals, and convalescent hospitals. (Courtesy of Dr. Eric Churchill, with permission)

Figure 2. The original 1972 copyright for *Surgeon to Soldiers* was found in the Library of Congress.

First, in his own words, “In a professional sense, I played the role of a parent to these young surgeons, and I wanted to join them and help take care of them.”[3] This sentiment harkens back to the days when “residency” and “house officer” were literal terms. A man of his word, Dr. Churchill did indeed “take care of them” for nearly 3 years, and they in turn took care of him as this group of surgeons maintained close professional and personal connections long after the war.

Second, Dr. Churchill feared he would lose professional credibility if he remained stateside. In chapter 3 of *Surgeon to Soldiers*, he further noted that, “Doctors need to learn to be more a part of the world outside of medicine.” Certainly, by heeding this admonition through involvement in organizations like the ACS, our commitment to providing optimal patient care can extend beyond the individual patient in our OR to include the community in which we live.

Dr. Churchill had never worn a uniform, yet he entered the US Army at the senior rank of O-6. He referred to himself tongue-in-cheek as a “chicken colonel,” and his close friends and colleagues dubbed him “Colonel Pete.”[4]

Nevertheless, the hardships of battle quickly transformed him from a bit of an ivory tower dandy to an expeditionary surgeon.[5] He saw action on or near the front lines on a regular basis and met with famous and infamous commanders such as Secretary of War Henry Stimson and General George Patton. Most importantly, he earned the respect of both allies and opponents with his technical facility as a surgeon and his thoughtful and empathetic leadership style.

J. B. Lippincott Company

Figure 3. This document shows correspondence between Dr. Churchill and his editor at Lippincott regarding the original publication.

Lessons from Most Recent “Great Powers” Conflict

Ensuring we fully internalize the surgical lessons learned from World War II could make the difference between winning and losing a future “great powers” conflict. *Surgeon to Soldiers* provides essential insights into such diverse and relevant topics as burn care, resuscitation, wound management, treatment for injury from chemical weapons, and infectious diseases.

Background information on the initial miscue of overreliance on plasma by the US, as described in Dr. Churchill’s memoir, and the process of resetting both the doctrine and supporting logistics offers sobering commentary on how far the medical establishment can stray when conducting thought experiments during peacetime, and the challenges associated with undoing such misguided efforts.

The value of collecting data and reporting results emerges as a central theme. Likewise, medical conferences held in various locations across the MTO throughout the conflict served to disseminate lessons learned and galvanize resolve among the allies while offering a bit of a reprieve from the crushing frontline work of combat casualty care.

Modern-Day Applications

From 2005 to 2012, 192 civilian surgeons representing the ACS, AAST, and the Society for Vascular Surgery served as senior visiting surgeons in Landstuhl, Germany.[6] Ostensibly modeled on the consultant system in which Dr. Churchill served, this platform offered civilian surgeons—many with military backgrounds—an opportunity to mentor younger military colleagues.[7]

The investment by these professional societies and individual surgeons has paid long-lasting dividends for combat casualty care. The individual relationships established in this program positively influenced the careers of many of our current leaders in combat casualty care. Moreover, many involved in this program shaped the long-term military medical strategy and policy both directly and indirectly.[8]

In 2016, the National Academies of Sciences, Engineering, and Medicine convened an expert panel to critically examine military and civilian trauma systems of care.[9] In the shared pursuit of continuously improving outcomes for both military and civilian trauma patients, this report noted, "Military and civilian trauma care and learning will be optimized together, or not at all."

No such opportunity for synergy between military and civilian trauma surgeons and systems existed in Dr. Churchill's day. We now have the unique opportunity to mitigate and even eliminate the age-old "peacetime effect" of allowing our trauma skills to atrophy between conflicts.[10] For more information about this topic, read the January 2025 *Bulletin* article, "Military and Civilian Surgery Partner for Innovation, Effectiveness."

Excelsior Surgical Club

After World War II, "Colonel Pete" became a well-deserved cult of personality. Although he was never promoted beyond "chicken colonel" for his service to the nation, Dr. Churchill was awarded the Distinguished Service Medal, an award typically reserved for general officers.

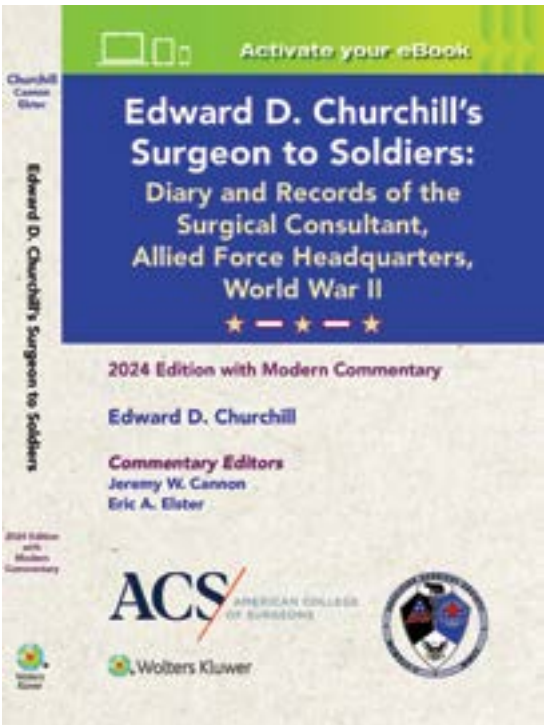


Figure 4.
The 2024 Edition of *Surgeon to Soldiers: Diary and Records of the Surgical Consultant, Allied Force Headquarters, World War II,* with modern commentary, is available in e-book and paperback formats.

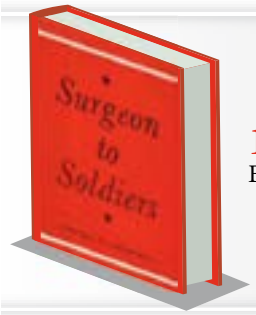
As a member of the Hoover Commission's Committee on Federal Medical Services, Dr. Churchill attempted to help reorganize the Medical Corps of the Department of Defense, but he was met with more than a little resistance despite his affirming and persuasive approach to advocacy. Nevertheless, he continued to support the optimal care of the surgical patient by contributing the introduction to the "Physiologic Effects of Wounds" chapter in the Army Surgeon General's series *Surgery in World War II* and by his continued service as an editor for *Annals of Surgery.*

More than 50 years since his death, Dr. Churchill continues to inspire surgeons of all specialties. The current Edward D. Churchill Professor of Surgery at Harvard Medical School is held by a true pioneer and leader in cardiothoracic surgery, Thoralf M. Sundt III, MD, FACS, son of the late neurosurgeon and Korean War hero, Thoralf M. Sundt Jr., MD, FACS.

The annual Edward D. Churchill Lecture (now hosted in even years by the ESS, which is the ACS Military Chapter, and in odd years at the ACS Clinical Congress) affords an opportunity for civilian and military surgeons alike to reflect on Dr. Churchill's legacy, including his trailblazing efforts to improve the care of his patients, and his work to enhance our profession and our society.

Finally, as detailed in chapter 35 of *Surgeon to Soldiers,* in February 1945, Dr. Churchill gathered in the Excelsior Hotel in Rome, Italy, to debrief with his team of surgical leaders on the lessons they had

By the Numbers: *Surgeon to Soldiers*



1972 Edition

- **37** chapters
- **490** pages
- **1** preface
- **1** epilogue
- **6** appendices
- **1** liminary author

Historic figures encountered include Mark Clark, George Patton, Barbara Stimson, Henry Stimson, and Edith Rogers.

2024 Edition

- **34** commentaries
- **5** new extras, including a foreword by Maj. Gen. Jonathan Woodson, MD, MSS, FACS, a new preface and introduction, a concise map of the MTO, and a timeline
- **2** editors
- **103** commentary authors, including:
  - **90** FACS
  - **1** ID specialist
  - **1** historian

Lessons learned include whole blood saves lives, mobile battle lines require mobile hospitals, and empathic leadership works.

gleaned from combat both directly and from Allied surgeons.

The following year, with the war over and attendees of this inaugural meeting now back in the US, these same surgeons established the Excelsior Surgical Club with Dr. Churchill as the lone "Honor Member." These surgeons sought to "advance their knowledge of the science of medicine and surgery" in the company of friends who had shared the hardships of a grueling deployment (see Figure 5, page 21).[5] These bonds of respect and friendship lasted for decades until the final living member, Michael E. DeBakey, MD, FACS, passed away in 2008.

In 2014, as the Military Health System and the ACS were forming a strategic partnership, Dr. Elster and others were inspired to re-animate the Excelsior Surgical Society as the academic home for military surgeons and their civilian mentors.

In 2015, the first meeting of the new embodiment of the society was held in Chicago, Illinois, during the 101st ACS Clinical Congress. As a result, the year 2025 holds special significance as the 80th anniversary of the end of the war that gave birth to the Excelsior Surgical Club and the 10th anniversary of the "new" Excelsior Surgical Society.

In recognition of this momentous occasion, the ACS and the ESS this month will host an international surgical congress at the Excelsior Hotel in Rome.

This international program will feature military and civilian surgical leaders who, like Dr. Churchill, seek to advance the ESS mission of "preserving the lessons of the past, improving care in the present, and anticipating challenges of the future" for both military and civilian surgery. All ACS members are welcome and encouraged to attend this historic celebration, and connect with and support military surgeons in an effort to optimize combat surgical care. B

Acknowledgment

I would like to extend my deepest gratitude to the extraordinary individuals whose inspiration, contributions, and support made publication of *Surgeon to Soldiers, 2024 Edition* possible. To Col. Jennifer M. Gurney, MD, FACS, Immediate Past-President of the ESS; Capt. Matthew D. Tadlock, MD, FACS, current President; and Col. Matthew J. Bradley, MD, FACS, President-Elect—thank you for your encouragement and partnership in this effort. To Dr. Knudson, inaugural MHSSPACS Medical Director, and Brian J. Eastridge, MD, FACS, current MHSSPACS Medical Director—your pioneering efforts in military-civilian collaboration have been a guiding example for us all. Finally, to Dr. Elster, Past-President of ESS and coeditor of *Surgeon to Soldiers, 2024 Edition*—your scholarship and mentorship have left indelible marks on this project, on me, and on many future military surgeons.

Dr. Jeremy Cannon *is the Immediate Past-President of the ESS and an editor of* Surgeon to Soldiers, 2024 Edition. *He also is a professor of surgery at the Hospital of the University of Pennsylvania and Penn Presbyterian Medical Center of Philadelphia.*

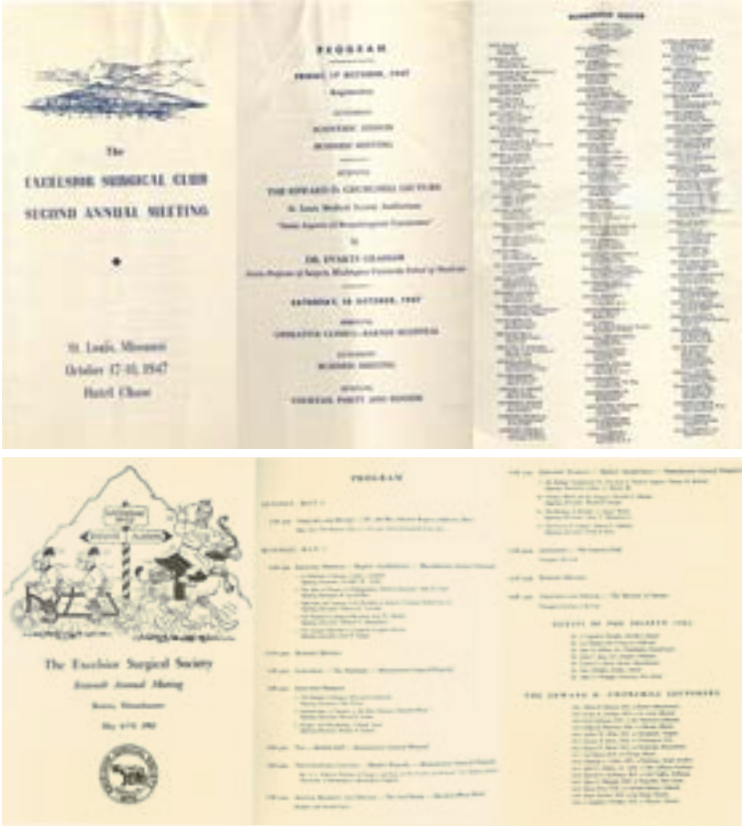


Figure 5.
In 1945, the Excelsior Surgical Club (later to become the Excelsior Surgical Society) was established, with program books created for its annual meetings. (Reprinted from the Edward Delos Churchill papers, 1840-1973. HMS c62, with permission from Harvard Medical Library, Countway Library, Boston, MA.)

References

1. Epstein A, Lim R, Johannigman J, et al. Putting medical boots on the ground: Lessons from the war in Ukraine and applications for future conflict with near-peer adversaries. *J Am Coll Surg*. 2023;237(2):364–373.
2. Cannon JW. Invited commentary: Total war: A succinct surgical overview and why civilian surgeons should care. *J Am Coll Surg*. 2023;237(2):373–375.
3. Churchill ED. *Surgeon to Soldiers*. Philadelphia, PA: JB Lippincott Company; 1972.
4. Cannon JW, Fischer JE. Edward D. Churchill as a combat consultant: Lessons for the senior visiting surgeons and today's military medical corps. *Ann Surg*. 2010;251(3):566–575.
5. Cannon JW. Expeditionary surgeons: Essential to surgical leadership in World War II and today. *J Am Coll Surg*. 2024;238(5):785–793.
6. Knudson MM, Evans TW, Fang R, et al. A concluding after-action report of the senior visiting surgeon program with the United States military at Landstuhl Regional Medical Center, Germany. *J Trauma Acute Care Surg*. 2014;76(3):878–883; discussion 883.
7. Moore EE, Knudson MM, Schwab CW, et al. Military-civilian collaboration in trauma care and the senior visiting surgeon program. *N Engl J Med*. 2007;357(26):2723–2727.
8. Schwab CW. Winds of War: Enhancing Civilian and Military Partnerships to Assure Readiness: White Paper Presented at the American College of Surgeons 100th Annual Clinical Congress, San Francisco, CA, October 2014. *J Am Coll Surg*. 2015;221(2):235–254.
9. National Academies of Science, Engineering, and Medicine. *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury*. Washington, DC: The National Academies Press; 2016.
10. Cannon JW, Gross KR, Rasmussen TE. Combating the peacetime effect in military medicine. *JAMA Surg*. 2020; Epub ahead of print.

GSV Implementation Improves Rate of Patients Discharged Home after Surgery

Samantha Kipley, RN, BSN, and Karen Pollitt, CPHQ

THE AGING POPULATION is reshaping the landscape of healthcare with significant implications related to higher use of services to deliver care for both chronic conditions and complex conditions that require coordination between interdisciplinary teams.

Specifically, healthcare leaders at Rochester Regional Health in New York, which is situated in a rural setting, noted their growing geriatric clientele to be a vulnerable population. Patients often traveled long distances to seek care and had limited access to specialty services.

Rochester Regional Health serves the people surrounding the Finger Lakes region of New York and beyond. This health system is comprised of nine hospitals and employs more than 19,000 people, of which more than 2,000 are medical providers and almost 4,000 are nurses. The hospitals within the health system participate in many programs offered by the ACS, including the Trauma Verification, Review, and Consultation Program, Vascular Verification Program, National Surgical Quality Improvement Program (NSQIP), Quality Verification Program, Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, Commission on Cancer, and the Geriatric Surgery Verification (GSV) Program.

Addressing the Challenge

In an effort to better serve this aging population, Matthew Schiralli, MD, FACS, executive medical director of surgical services, proposed that Unity Hospital of Rochester Regional Health become a beta site for the ACS GSV Program. In December 2020, Unity became the first site to achieve verified status.

Seeing the success at Unity Hospital, the health system made the decision to implement GSV at two

additional hospitals in New York: Newark-Wayne Community Hospital and Clifton Springs Hospital & Clinic. A team, including Julie Giles, AGNP-C (geriatric provider), Jana Cooper-Slifko, FNP-C (geriatric surgery program manager), and Taylor Woodworth, PT, DPT, MBA (system surgical quality project manager), was convened. They focused on a targeted population of patients, 75 years of age and older and having urgent or elective surgery to define the scope of their problem.

The team used an internal data repository and ACS NSQIP data. The data collected from NSQIP were considered the "source of truth," as the information was manually abstracted by nurses, leading to a high degree of accuracy. Data were collected from January through December 2020 (pre-implementation) and January through November 2023 (post-implementation/verification).

Key Findings

Notably, the team discovered that hospitals in the Rochester Regional Health system had begun implementing GSV standards prior to the start of COVID-19. During the pandemic, adherence to the GSV standards was suspended for a period, and as a result, the hospitals' NSQIP data showed worsening outcomes. When the GSV implementation work resumed, outcomes improved. Woodworth noted that "When compliance [with the program] is high, the outcomes are better."

In the pre-implementation phase, data were collected on 264 patients. Of those patients, 79.17% were discharged home after surgery and 19.32% went to rehab. In the post-implementation/verification phase, data were collected on 273 patients. Of those patients, 83.5% were discharged home and 15.4% were discharged to rehab (see Figure 1, on this page).

Overall, there was a 4.3% increase of patients being discharged home after surgery when they were enrolled in the GSV Program. Orthopaedic surgery had a 14% reduction in patients discharged to rehab. General and vascular surgery had a 10% reduction in patients discharged to rehab. Gynecology, ear, nose and throat, and urology maintained a discharge to home at 100% (see Figure 2, page 25).

Outcome measures were reviewed on a quarterly basis with the core team and internal stakeholders.

Lessons Learned

When asked if the GSV Program has been a valuable addition to their healthcare system, the Unity Hospital of Rochester Regional Health team confirmed the benefits of the program.

For example, one of the team members has been known to give her personal mobile number to patients so they have a point of

Figure 1. Impact of GSV Implementation on Postsurgical Discharge Destinations

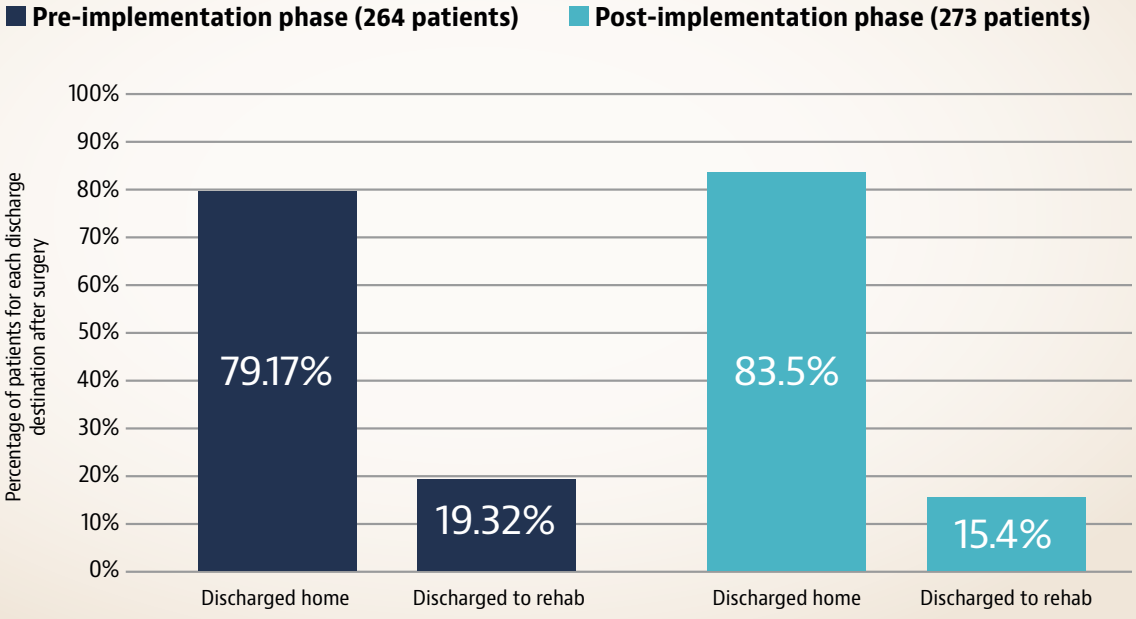
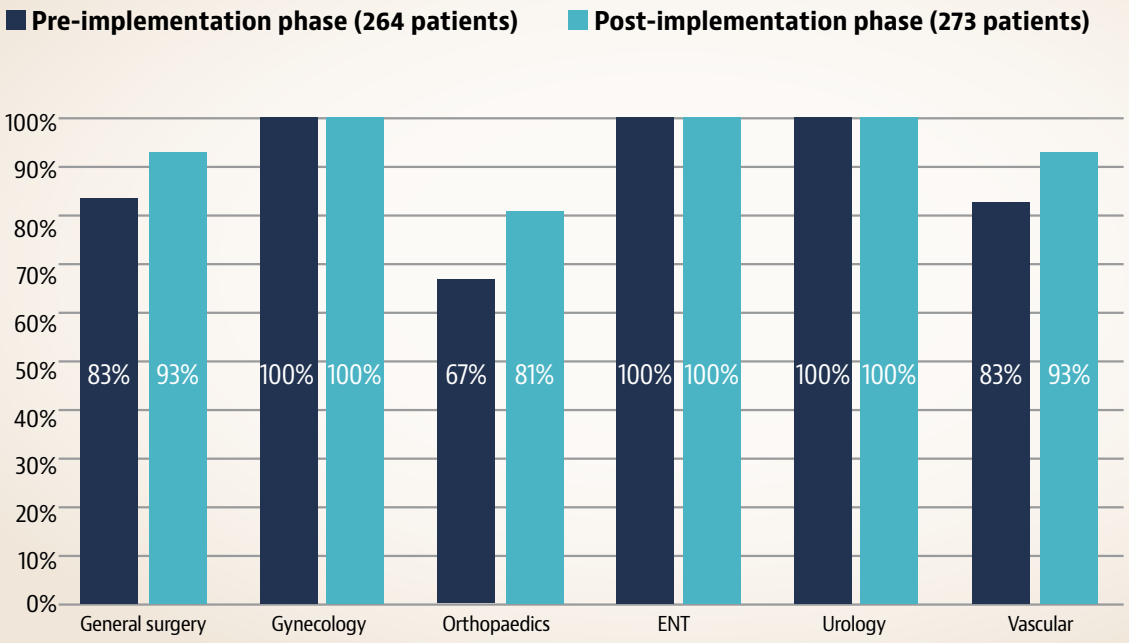


Figure 2. Discharge Home Pre- and Post-Implementation of the GSV Standards by Surgical Specialty



contact through their care. "Patients are very appreciative, especially in the rural areas. Discussing the patient's care with them personally gives them a sense of ease. Many patients are referred by someone else who had a good experience here," Giles said.

Cooper-Slifko noted, "There is communication after multidisciplinary rounds, which lets everyone know what is going to happen before surgery, readdresses educational needs, and gives patients a breakdown of what happens on the day of surgery and after, down to who comes in the room."

Team members agreed that pursuing GSV verification opened their eyes to areas where care can be improved and how healthcare providers treat this population. Specifically, they observed a lack of resources and consultation services such as geriatric, palliative care, and home care in the rural region they serve.

This team's advice to other hospitals pursuing verification is to never understate the importance of the program manager. Having someone who knows the standards inside and out is a crucial piece when setting up for success. And, although the GSV Program has standards, the implementation of the program should be needs-based and relevant to the situation at each hospital.

Rochester Regional continues to replicate these efforts at other hospitals in its healthcare system. These hospitals are now working toward GSV verification. Through this project, the team attributed success to having leadership support, internal stakeholders involved in the preoperative, intraoperative, and postoperative phases of care, and the support of information technology staff.

The GSV Program currently is sustained at Newark-Wayne Community Hospital and Clifton Springs Hospital & Clinic in New York by the GSV nurse champions, geriatrics advanced practice providers, and program manager.

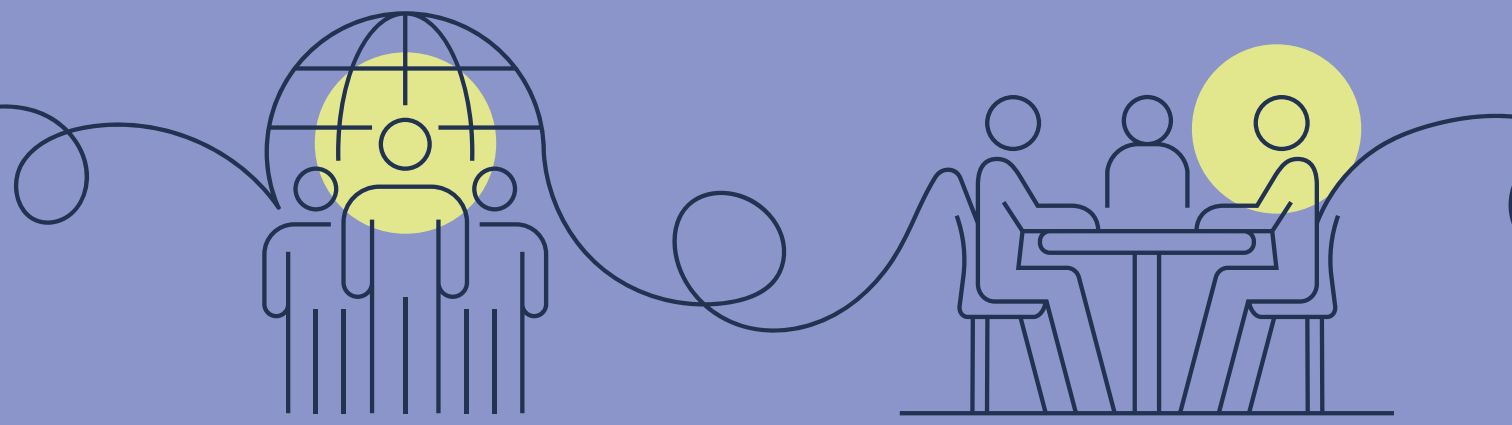
The health system has three verified sites and two more on the path to verification.

Since Unity Hospital became verified for the first time in 2020 and successfully reverified in 2023, many hospitals across the country have reached out to the Rochester Regional Health team for guidance.

The full case study of how Rochester Regional implemented GSV, *Improving Discharge Home Post-Implementation of the Geriatric Surgery Verification Standards*, is available in the ACS Quality Improvement Case Study Repository.

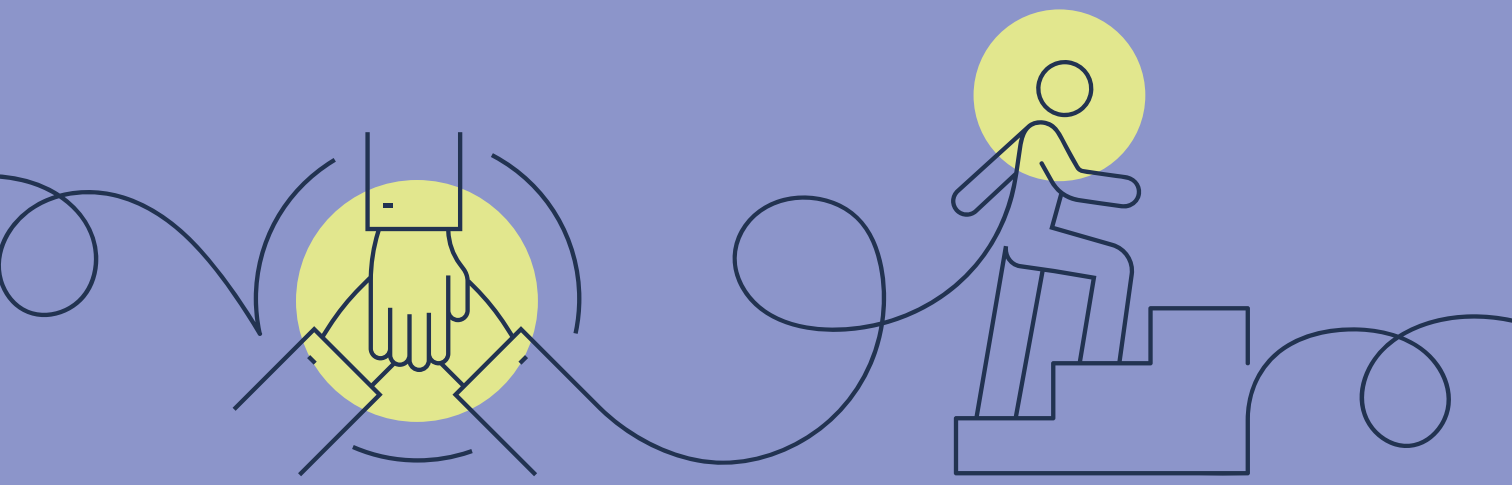
To learn more about the GSV program and how it will benefit your patients, visit *facs.org/gsv*.

Samantha Kipley *is a Quality Resource Specialist in the ACS Division of Research and Optimal Patient Care in Chicago, IL.*



Uncover Engagement Opportunities for Early Career Surgeons at the ACS

Christopher DuCoin, MD, MPH, FACS



The ACS offers an abundance of opportunities for surgeons at every career stage to engage, contribute, and grow professionally. From serving as a Regent or Governor to taking active roles within the Resident and Associate Society (RAS) or the Young Fellows Association (YFA), there is a path for everyone who wants to have an impact within The House of Surgery™.

THIS ARTICLE REVIEWS OPPORTUNITIES for becoming actively involved with the College, including serving on committees, acting as a liaison, or working with governing bodies like the Board of Governors (BoG). By exploring these pathways, I hope to inspire you to find your place within the College and maximize the benefits of active engagement.

As a surgeon who has been engaged with the ACS in various capacities, I can attest to the rewards of involvement. I began my journey at the state and national levels within RAS, which was instrumental in shaping my professional growth and, essentially, my career trajectory.

I later became the YFA Representative for the BoG Survey Workgroup, and I gained invaluable insight into how the College operates. This experience paved the way for my involvement within YFA, as I was nominated and selected into the Governing Council (GC) of YFA and served as Chair of the Communications Workgroup.

Eventually, I was honored to serve as Chair of YFA, a role that allowed me to lead initiatives and engage deeply with the ACS membership, and cultivate a better understanding of the College, specifically around the Regents, their board, and role within the ACS. My journey is just one example of how this organization fosters leadership and engagement among its members.

How Are Regents Selected?

The ACS Board of Regents (BoR) is responsible for the College's overall management and policy development. To me, they represent the elite of American surgery. These individuals are typically senior surgeons who are often well-known names within modern surgery. If you wish to change the course of surgery, this is the group to join.

Regents are selected through a rigorous process that begins with nominations by Fellows of the ACS. Nominees are chosen based on their demonstrated commitment to the College, leadership abilities, and contributions to surgery. The final selection is made by the Nominating Committee of the BoG. Regents are elected to serve 3-year terms and may be re-elected for additional terms, up to a maximum of 9 years.

The Chair and Vice-Chair roles are selected by the BoR Nominating Committee and maintain an effective working relationship with other Regents, Officers, and staff. In total, the BoR comprises 24 members, including the President of the College and elected Regents.

The BoG, YFA, and RAS have representation on many of the BoR standing committees. These committees span all areas of the College, and below is a list of several BoR committees:

- Bylaws Committee
- Central Judiciary Committee
- Communications Committee
- Education Advisory Committee
- Ethics Committee
- Executive Committee
- Finance Committee
- Health Policy & Advocacy Group
- Inclusive Excellence Committee
- Member Services Liaison Committee
- Research & Optimal Care Committee

The BoR also works closely with the BoG, which serves as a liaison between the Regents and ACS Fellows.

Becoming a Regent is a culmination of sustained commitment and leadership within the ACS. If you aspire to this level of engagement, it is essential to build a performance history of service and leadership within the ACS, beginning with roles in committees, advisory councils, and/or the BoG.

Understanding the BoG

The BoG serves as a vital link between the membership and the BoR. Governors represent their respective states, regions, or surgical specialties, providing a voice for the broader ACS membership. In total, there are approximately 300 Governors, each nominated by their respective chapters or specialty societies and appointed to the role as a result of their dedication to advancing the ACS mission and their ability to represent the interests of their constituencies. Governors serve 3-year terms and may be eligible for re-election, for a total of 6 years.

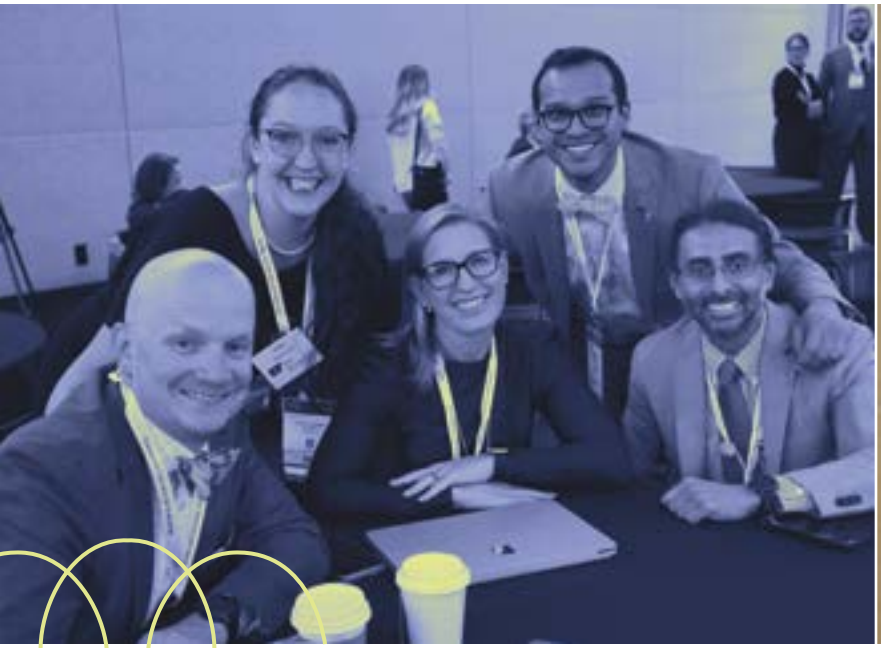
The Executive Committee leads the BoG and ensures the efficient operation of its functions and consists of three key members, including: Chair, who presides over meetings and serves as the primary spokesperson for the BoG; the Vice-Chair who assists the Chair and acts in their absence; and the Secretary who chairs the Fiscal Affairs Committee and serves on the BoR Finance Committee.

The BoG operates under a pillar structure to organize its work into functional areas. These include:

- **Advocacy and Health Policy Pillar:** Focuses on legislative and regulatory issues affecting surgeons and patients
- **Communications Pillar:** Increases communication between Governors and their chapters and specialty societies through presentations, reports, summaries, *Bulletin* articles, and surveys
- **Education Pillar:** Addresses surgical education, training, and lifelong learning initiatives
- **Inclusive Excellence Pillar:** Ensures alignment with the strategic vision of the College
- **Member Services Pillar:** Advocates, provides resources, helps strengthen chapters, and reviews and recommends recipients of the Surgical Volunteerism and Humanitarian Awards
- **Research and Optimal Patient Care Pillar:** Oversees initiatives to improve surgical outcomes and patient care, and supports clinical research and guidelines for optimal surgical practice

Within each pillar, there are workgroups tasked with specific objectives. Examples of these workgroups include the Integrated Communications Workgroup, which works to enhance communication between the BoG and Fellows.

While the BoG is a sizable entity—representing Fellows domestically and internationally—it does provide ample opportunity to become an engaged member of the College. Serving as a Governor allows you to contribute to the governance of the ACS, while also networking with surgical leaders from across the world.



Exploring YFA and RAS

YFA

YFA is designed for ACS members who are under the age of 46 and are within 10 years of completing their surgical training. The association provides a platform for young surgeons to connect, collaborate, and influence the future of the profession.

YFA has a GC that oversees its activities, including workgroups focused on advocacy, communications, education, member engagement, inclusive excellence, and quality. The GC consists of 15 nominated and selected individuals. Key members of the GC include the Chair who oversees the association's activities and represents YFA within the ACS to the BoG and Regents.

The Vice-Chair assists the Chair and may assume their duties if necessary, while learning the Chair role, and the responsibilities associated with the six workgroup Chairs. The GC also consists of seven members-at-large—individuals who contribute to the council's initiatives and represent the broader young fellow community.

Members can serve two 3-year terms for a total of 6 years, as long as they continue to meet the age requirement for YFA membership. GC members are eligible for the Vice-Chair role, for which there is a national election and vote.

YFA has representation within nearly every aspect of the College; for example, there are YFA liaison roles within ACS chapters and on ACS BoG Workgroups. Getting involved in YFA is an incredible opportunity. For more information, email Brad DeFabo Akin at bakin@facs.org.

The YFA workgroups have similar goals to those in the BoG and RAS. These workgroups are:

- Advocacy & Issues
- Communications
- Inclusive Excellence
- Education
- Member Services
- Quality

Each of these workgroups have members that hold liaison positions within other areas of the College, specifically the BoG, ensuring that if you are in YFA, there is likely an area of meaningful engagement available for you.

My tenure as Chair of the YFA GC was one of the most rewarding experiences of my career. It allowed me to work alongside passionate peers, develop leadership skills, and contribute to projects that benefited ACS members nationwide.

Active engagement with the ACS not only enhances your career but also allows you to contribute to the advancement of surgery and the betterment of patient care.

RAS

RAS is the gateway to ACS engagement for residents and Associate Fellows of the College. Like YFA, RAS has a GC and several committees that focus on areas such as education, advocacy, and global surgery. Membership in RAS offers trainees the chance to build their professional network, gain leadership experience, and influence the future of surgery.

If you are a surgical resident, you are eligible for involvement within RAS. Of note, if an individual is past their resident-level training and is in fellowship training or their first few years as an attendant, they would remain an ACS Resident Member and involved in RAS.

Similar to YFA, RAS has a GC that includes a Chair, which leads RAS initiatives and serves as the primary representative for RAS at the ACS level. The Vice-Chair assists the Chair and serves as a deputy leader for RAS. The Secretary position manages communications and documentation for RAS. The RAS GC also includes workgroup chairs who oversee the key functional areas of RAS through workgroups.

Leveraging the ACS Surgeon's Dashboard

In short, the ACS provides countless opportunities to get involved, whether you aspire to serve as a Regent, Governor, or an active member of YFA or RAS. Each pathway offers unique benefits and opportunities for personal and professional growth. To explore these opportunities, I encourage you to use the new ACS Surgeon's Dashboard. This innovative platform provides easy access to information about the College, upcoming events, and ways to engage with committees, associations, and other ACS initiatives.

Active engagement with the ACS not only enhances your career but also allows you to contribute to the advancement of surgery and the betterment of patient care. No matter where you are in your career, there is a place for you within the College. By taking the first step and getting involved, you can find your spot within the ACS and make a lasting impact on our surgical community.

Dr. Christopher DuCoin *is a professor of surgery, vice-chair of surgery, and chief of the Division of Gastrointestinal and General Surgery at the University of South Florida in Tampa. He also is a former Chair of the YFA Governing Council.*

Global Collaborations Help Expand Surgical Workforce Opportunities for Women

Melanie Sion, MD, FACS
Mumba Chalwe, MD, MMed
Ainhoa Costas-Chavarri, MD, MPH, FACS
Hilary Sanfey, MBBCh, MHPE, FACS
Nancy L. Gantt, MD, FACS
Agneta Odera, MBChB
Jane Fualal, MBChB, MMEd

The landscape for women in surgery in much of the world historically has been one of challenges and barriers. Globally, surgery remains a heavily male-dominated profession.

IN LATIN AMERICA, WOMEN represent approximately 15% of surgeons, in China, women are 6% of the total number of surgeons, and in England, women comprise approximately 17% of practicing surgeons, depending on specialty.[1-3]

In the US, there has been a dynamic evolution over the past 50 years as gender balance in the field has shifted from less than 2% women to approximately 25% of all practicing surgeons.[4]

Similarly in Eastern, Central, and Southern Africa, women surgeons a decade ago represented 9%, while today, that number has risen to 27%.[5]

There also has been a seismic shift in gender balance in the cadre of medical students entering medical school in the US (approximately 50% are women),[6] and surgical trainees in various specialties are showing similar patterns. While true gender parity has yet to be attained, progress is exemplified by metrics such as these, and it is likely that these trends may continue in the future. This growth is a result of the multidecade, multifaceted effort by individual women surgeon pioneers and surgical leadership, as well as society as a whole.

Founded in 1913, the ACS has focused on building a surgical workforce based on inclusive excellence. The Association of Women Surgeons (AWS) was created in 1981 to champion gender-related challenges for women surgeons. The AWS Foundation also was created for the advancement of equity for women in the surgical profession. These organizations are making an impact on the profession by recognizing, supporting, and fostering collaboration on a global scale.

COSECSA

College of Surgeons of
East, Central and Southern Africa

Surgeon Workforce Shortage in Sub-Saharan Africa

In low- and middle-income countries, and particularly on the African continent, the global surgeon workforce shortage is a major issue. The need to recruit and train surgeons is imperative in sub-Saharan Africa, where the surgeon-to-population ratio is approximately 1 per 100,000—well below the requisite minimum of 20 per 100,000 to adequately serve a population.[7,8]

Central to the solution for this crisis has been the establishment of the College of Surgeons of East, Central, and Southern Africa (COSECSA). A primary goal of COSECSA is to grow the number of practicing surgeons on the African continent, while ensuring quality training standards. COSECSA has also been a champion for growth and innovation, as its members are considered to be thought leaders for the region, as well as ambassadors for international collaboration.

Officially inaugurated in 1999, COSECSA represents 14 member sub-Saharan countries and eight partner countries, unifying a diversity of nationalities under a single professional umbrella and providing a central accreditation body.[9] The visibility and validation of the newer surgical society supported by established societies was an important component to building international credibility.

In 2008, the Royal College of Surgeons in Ireland (RCSI)/COSECSA Collaboration Programme began, which is a pivotal partnership that continues to this day. The ACS and AWS Foundation (AWSF) built a supportive and reciprocal collaboration with COSECSA to help the organization expand its own global presence and impact on surgeons and surgical practice in Africa. The Pan-African Academy of Christian Surgeons also provided mentorship and sponsorship for, and endorsement of, COSECSA.

Professional Societies, Gender Equity Initiatives

Investing in the education and empowerment of women surgeons has been a focal point for sub-Saharan Africa. Women in Surgery Africa (WiSA) was formed in 2015 to provide peer-to-peer mentorship and support for women surgeons, surgeons in training, and medical students in the COSECSA region.[10] Historically, traditional gender roles in Africa have had priority, which can lead to significant barriers for women pursuing careers in medicine and surgery. This history reflects a complex interplay of cultural, social, and economic factors that have shaped the landscape for women surgeons.

With data-based tracking of gender-based metrics within COSECSA, the organization developed an initiative to increase the enrollment of women in surgical training programs and increase the number of women successfully completing those programs in the region. Figure 1 on the next page shows the growth of women surgical trainees entering COSECSA training programs during the last 20 years, and Figure 2 shows the number of women surgeon graduates.

The ACS-COSECSA Women Scholars Program, which began in 2017, provides funding toward the women trainees' examination and travel fees to enter into an accredited COSECSA surgical training program and then to become certified surgeons as fellows of COSECSA (FCS). In 2018, the ACS Foundation and AWSF joined together to financially support this program.

Figure 3 on the next page shows the number of women graduates of COSECSA supported by the scholarship as compared to the gender ratio and total number of graduates 2019 to 2023.

Figure 1.

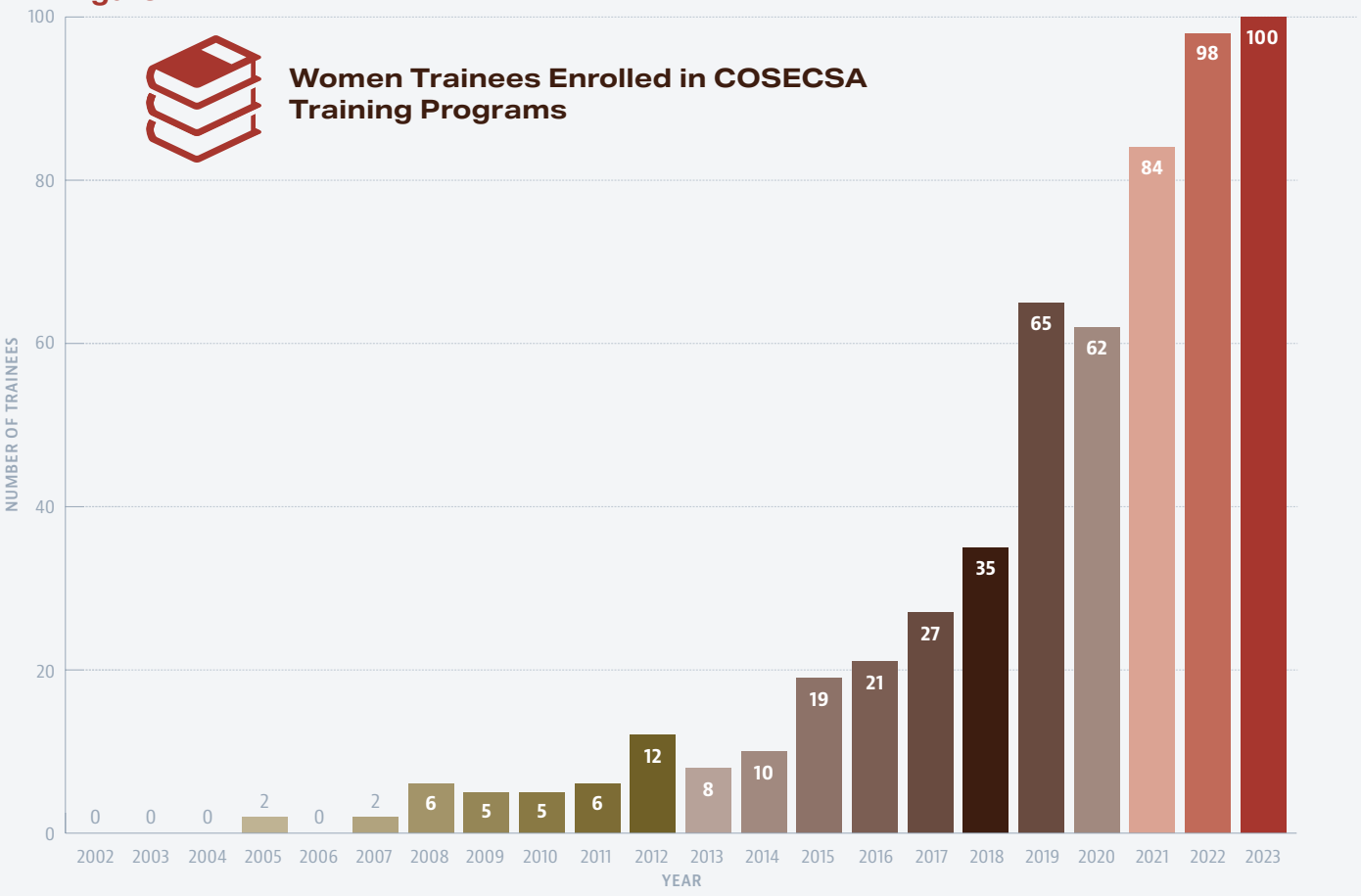


Figure 2.

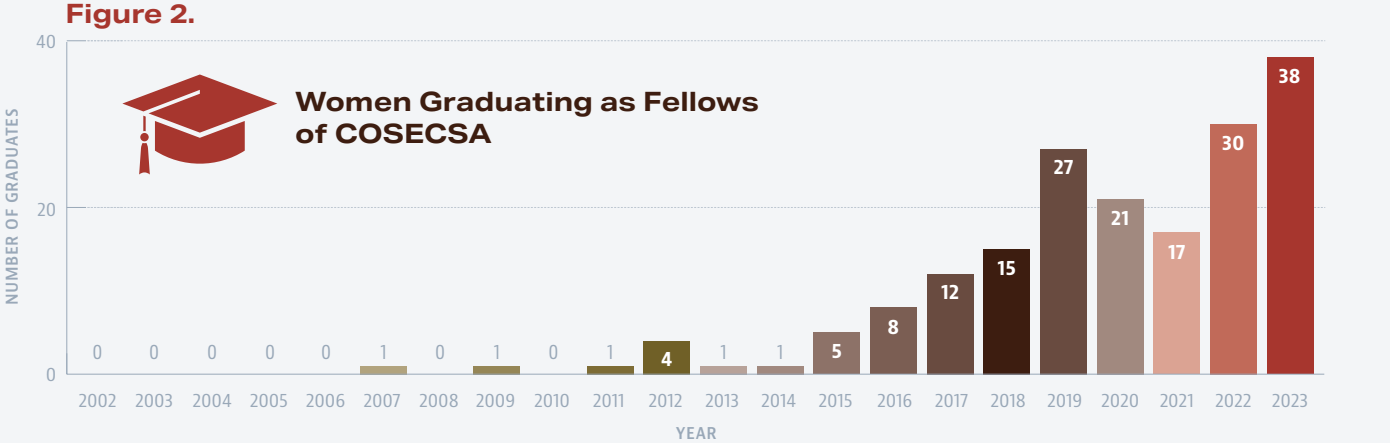
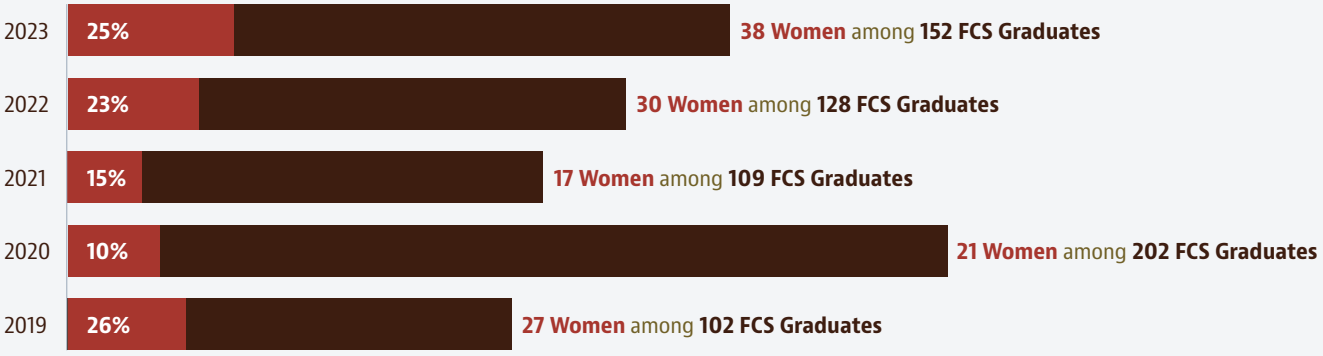


Figure 3.

Gender Ratio and Total Number of Graduates

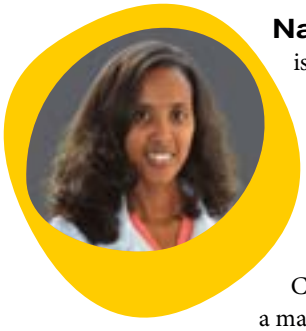


Past Recipients

Past recipients of the ACS-COSECSA Women Scholars Program have recognized it as deeply meaningful, validating, and hugely impactful for them early on in their careers. Some African women who have trained to be surgeons find the final hurdle to become a certified COSECSA fellow insurmountable as they balance their career, motherhood, and finances in emerging and fragile economies. The award provides financial benefits to offset these challenges, and it raises the visibility of the trainees into a cohort of individuals who remain connected to the ACS, AWS, and COSECSA.

Past recipients have gone on to have highly successful careers and have grown into leaders of their specialties in their countries. The following profiles highlight an inspiring award recipient from each year.

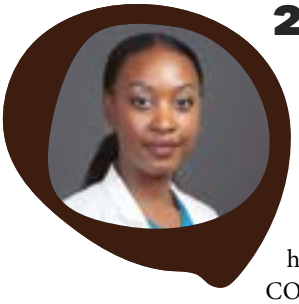
2017



Nardos Worku, MD, is one of the few pediatric orthopaedic surgeons in Ethiopia. She has both specialty (orthopaedics) and subspeciality (pediatric orthopaedics) certifications from COSECSA and has received a master's degree in public health from Jimma University. Her outstanding performance led to being recognized by the Women Scholars Program and attending the qualifying exams in Maputo, Mozambique.

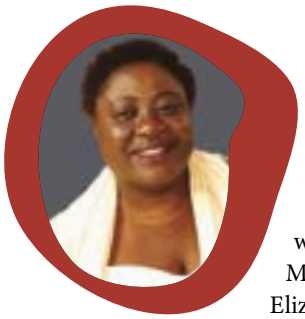
After becoming a fellow of COSECSA, she was able to complete her pediatric orthopaedic fellowship at CURE Children's Hospital of Ethiopia in Addis Ababa and help many children with deformities and fractures since that time. Dr. Worku also held leadership roles as an executive member for the Ethiopian Society of Orthopedics & Traumatology. She currently works at Lancet General Hospital in Addis Ababa, Ethiopia, as a pediatric orthopaedic surgeon, leading the pediatric orthopaedic unit.

2018



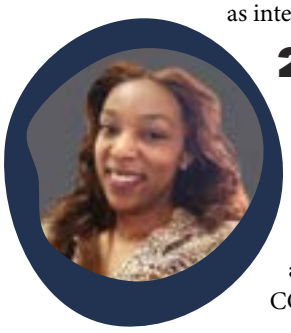
Mumba Chalwe, MD, was selected for the ACS/AWSF COSECSA Women Scholars Program Award in 2018, which facilitated her accreditation by COSECSA. As Zambia's first woman urologist, she has actively mentored and trained emerging female surgeons in her field. In her capacity as chairperson of WiSA, Dr. Chalwe has led various research grant initiatives and surgical leadership programs aimed at supporting women surgeons across the COSECSA region. Currently serving as the head of urology at Ndola Teaching Hospital, an academic institution in Zambia's Copperbelt region, Dr. Chalwe is at the forefront of enhancing prostate cancer care. She also is engaged in cancer research within the same facility. Her commitment to advocating for the surgical profession extends both locally and regionally, actively contributing to national surgical society efforts in formulating perioperative care policies. Dr. Chalwe's career trajectory is a testament to the significant impact women surgeons can have in their communities when provided with the necessary support and resources. Through her leadership and advocacy, she continues to inspire and empower future generations of women in surgery.

Past recipients have gone on to have highly successful careers and have grown into leaders of their specialties in their countries.



2019

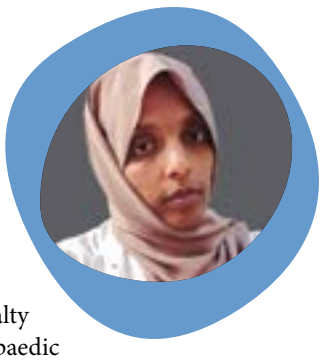
Lieutenant Colonel Takondwa Itaye-Kamangira, MBBS, MMed, worked for the Malawi Ministry of Health at Queen Elizabeth Central Hospital in Blantyre, Malawi, following training. In the subsequent months after she became a COSECSA fellow, Dr. Itaye-Kamangira was employed as a surgeon for the Malawi Defense Force (MDF) and has risen to the rank of lieutenant colonel. Since working at the MDF, Dr. Itaye-Kamangira has been deployed twice on United Nations (UN) missions to the Democratic Republic of Congo (DRC). On her second deployment with MDF, she was the commanding officer for her team tasked with setting up and running a surgical unit (Light Mobile Surgical Module) in the DRC to support the troops and other UN employees. She also volunteers her time in the district hospital near her home when she is available. Her commitment to these roles has led to her appointment as the medical advisor to the Southern African Development Community Mission in the DRC. Receiving the Women Scholars Program Award provided the opportunity for Dr. Itaye-Kamangira to progress professionally. Today, as a fully accredited surgeon, she is able to serve her community in Malawi as well as internationally.



2020

Tracern Mugodo, MD, was selected for the ACS/AWSF COSECSA Women Scholars Program Award in 2020 and became an orthopaedic fellow of COSECSA. She stated that "the scholarship enabled me to register for my exams, covered my travel expenses to write exams and many opportunities as an Associate Fellow of the ACS to advance my career in various ways from reading materials, leadership skills programs to scholarship opportunities. Gratitude fills my heart as I reflect on the outcomes of this scholarship opportunity." In 2021, The Royal College of Surgeons of Edinburgh granted Dr. Mugodo the Faculty of Remote, Rural and Humanitarian Healthcare Fellowship Fund. She has become the clinical manager for Zimbabwe's clubfoot program, an opportunity that she says has empowered her as a leader due to the role's impact on the many lives of children born with this condition. Dr. Mugodo currently is a consultant orthopaedic surgeon at Parirenyatwa Hospital in Harare, Zimbabwe, and is pursuing new directions as an orthopaedic spine surgeon following an AO Spine Fellowship in Cape Town, South Africa.

2021

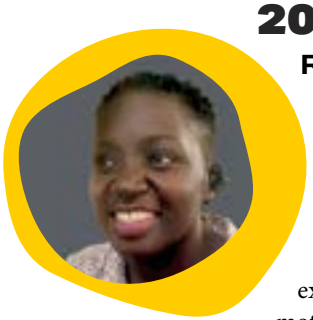


Shikuria Lemma, MD, attributes her ability to become a COSECSA fellow and taking the necessary exams to the opportunities provided by the Women Scholars Program Award. Since passing the COSECSA exams, her certification has led to more job opportunities in her region as well as attaining subspecialty fellowship training. She is an orthopaedic and trauma surgeon in the Black Lion Specialized Hospital, in Addis Ababa, Ethiopia, and was able to pursue subspecialty training in foot and ankle surgery beginning in January 2025 in Egypt.

"I just want to say thank you for your support. Being selected as one of the recipients of the ACS scholarship award was a great moment for me. I felt recognized by something bigger," said Dr. Lemma, who plans to return to Ethiopia to practice after training in Egypt.

Mentorship is a crucial component of professional development, and these professional organizations aim to initiate a program that connects aspiring female surgeons with experienced mentors.

2022



Rovine Naluyimbazi, MBBS, MMed, said: "I received life-changing news. I had been awarded a scholarship from the American College of Surgeons. This timely support arrived just before my final exams, providing the much-needed motivation to succeed. The scholarship covered all examination expenses, including registration, travel, and accommodations, which would have been insurmountable following the recent loss of my father."

Dr. Naluyimbazi then qualified as a pediatric surgeon, and she has gone on to acquire minimally invasive surgical skills, with the goal to further refine these techniques. Her clinical interests include neonatal, urological, and oncological conditions. She currently is a pediatric surgeon at Mulago National Referral Hospital in Kampala, Uganda.

2023

Tinotenda Masenda, MD, is currently practicing as an orthopaedic and trauma surgeon in her home country of Zimbabwe, where women surgeons are a minority. Estimates suggest that she is one of four practicing women orthopaedic surgeons in the region.

"Receiving the ACS award was very beneficial because it went a long way toward helping me get through my COSECSA orthopaedic exams," said Dr. Masenda. "The financial support enabled me to achieve my dream of becoming a surgeon. This goal would not have been possible without the support from the ACS Women Scholars Program Award. There are many doors that have been opened, which I hope to use for my professional development."

Dr. Masenda is currently working toward completing subspecialty training in foot and ankle surgery as well as limb reconstruction. She has established a network of colleagues through the ACS, and as a result, has been able to find supportive mentorship opportunities.

2024

Nakavizya Janet Nshinka, MD, is currently a urology registrar at Ndola Teaching Hospital in Zambia. The scholarship enabled her to pursue the fellowship in urology under COSECSA, where she received the honor of best-performing student in urologic surgery. The ACS scholarship has affected her career and professional aspirations. Her mentor, Dr. Chalwe, a 2018 awardee profiled earlier in this article, was one of the earliest recipients of the scholarship and was her inspiration. She shared her commitment to continuing the legacy of mentoring young women doctors and encouraging them to pursue careers in surgery. Dr. Nshinka has contributed to Zambia's urology workforce where access to specialized care is extremely limited. She is passionate about prostate cancer research and management as well as the field of andrology, especially since male reproductive health is not well-studied in her country. She said she looks forward to future opportunities for advanced training and research to improve urologic care and outcomes in Zambia and beyond.

Future Directions

The AWSF is working to grow the Women Scholars Program and provide ongoing support to past recipients as well as to future grant awardees. Mentorship is a crucial component of professional development, and these professional organizations aim to initiate a program that connects aspiring female surgeons with experienced mentors.

Surgeon role models not only demonstrate the possibilities within the field but also provide practical insights and advice on overcoming barriers. Supporting African women surgeons so they can attain successful practices and visible leadership roles promotes the value of women in surgery and will make positive inroads into the severe surgeon workforce shortages in the region. B

Dr. Melanie Sion *is a surgeon for Yale Medicine General Surgery, Trauma & Surgical Critical Care in New Haven, CT. She also is the leader for global surgery at Yale with special interests in developing surgical services in Southern and Eastern Africa and educating the medical community on health disparities in surgical care due to global inequity.*

References

1. Bueno Motter S, Brandão GR, Oliveira Trindade B. The current state of women surgeons in Latin America. *Am J Surg*.2023; 226(1):133–134.
2. Zhang H, Yuan Y, Yuan Y. Surgical gender disparity in China: Unveiling challenges and charting a course for equality. *Int J Surg*. 2024;110(4):2494-2495.
3. Dosis A, Husnoo N, Roney S, Hendry C, et al. A census of general surgery consultants in England and Wales: Implications for the current and future surgical workforce. *Ann R Coll Surg Engl*. 2024;106(2):150-159.
4. Association of American Medical Colleges. US Physician Workforce Data Dashboard. Available at: https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard. Accessed January 8, 2025.
5. O'Flynn E, Andrew J, Hutch A, Kelly C, et al. The specialist surgeon workforce in East, Central and Southern Africa: A situation analysis. *World J Surg*. 2016;40(11):2620-2627.
6. Association of American Medical Colleges. Majority of US medical students are women, new data show. Press release. December 9, 2019. Available at: https://www.aamc.org/news/press-releases/majority-us-medical-students-are-women-new-data-show. Accessed January 8, 2025.
7. World Bank. Health nutrition and population statistics. Available at: https://databank.worldbank.org/source/health-nutrition-and-population-statistics/Type/TABLE/preview/on. Accessed January 8, 2025.
8. Meara JG, Greenberg SL. *The Lancet Commission on Global Surgery Global Surgery 2030: Evidence and Solutions for Achieving Health, Welfare and Economic Development.* Surgery. 2015;157(5):834-835.
9. College of Surgeons of East, Central, and Southern Africa. Our history. Available at: https://www.cosecsa.org/our-history/. Accessed January 8, 2025.
10. Women in Surgery Africa. Overview. Available at: http://www.womeninsurgeryafrica.org/overview/. Accessed January 8, 2025.

Dr. James Elsey

US Healthcare System Is in Crisis

James K. Elsey, MD, FACS

During my 44 years of active surgical practice, I have witnessed numerous, significant, and onerous progressive changes that threaten the quality, safety, accessibility, and affordability of medical care in this country.

sadly, it has evolved into a highly corporatized system controlled by a decreasing number of increasingly powerful conglomerates where profit is often the main metric of performance and success. The stark realities of this dark devolution create daily difficulties for patients trapped in this harsh and inequitable system.

A frequent, disturbing type of patient encounter during my practice highlights the essence of this decay. Often when suggesting the need for a particular surgery to a patient they would rarely ask the most obvious and important questions such as: "Will I have significant pain? Is it dangerous? Can I die?"

Instead, they more commonly asked: "How can I pay for this? Will I lose my house or my job? How fast can I get back to work?," followed, all too frequently, by comments like: "There is no way I can afford this. I don't have access to that level of deductible. This will bankrupt me." And, periodically, they would come to this decision: "I just can't proceed, doctor. This will put my family in the street. I'll just tough it out and take my chances."

There is something deeply and fundamentally wrong with this increasingly common situation where the accessibility of healthcare, which I believe should be a basic human right, is determined by one's financial station in life. For this to be occurring in the most affluent country in the world is not just wrong, but in my opinion, abjectly amoral.

It is as true today as it was 50 years ago when Martin Luther King Jr., so rightly said: "…of all forms of inequality, injustice in health is the most shocking and inhumane."[1] Unfortunately, these inequities in access to care are a demonstrable result of our current broken and failed healthcare system.

Unsustainable and irresponsible political promises, unrealistic patient expectations, as well as corporate and individual greed have created this flawed system—one that is too expensive and costs twice that per capita compared to the rest of Western world.[2]

This system leaves too many people out resulting in 26 million uninsured and 43 million underinsured.[3] In fact, recent World Health Organization metrics suggest that the US does an incredibly poor job with healthcare delivery, with the US ranked 37th overall to comparable Western country metrics and last among the 11 highest-income countries.[4] These rankings are not surprising when you consider the fact that the US healthcare delivery system consumes 17% of our current gross domestic product and is the leading cause of personal bankruptcy accounting for 66.5% of total US individual monetary defaults.[5,6]

Placing Profits over Patient Care

The US healthcare system handicaps business competitiveness with a crippling 160% increase in employer healthcare costs in the last 20 years, which averages about $14,000 per employee.[7] This system also causes downward pressure on employee wages resulting in a 8.9% inflation adjusted decrease in employee household income.[8] In addition, it requires many Americans and their families to line up in fields for humanitarian healthcare events mirroring the activities of many third-world countries as well as requiring increasing numbers of citizens to use the ER as their default medical care.

This default is fragmented, costly, inefficient, and a generally poor method of providing care with a total lack of continuity. This healthcare model also drives significant racial disparities in the availability and quality of care, and in the outcomes for these patient populations.

Currently the US, compared to similar Western countries, has the lowest life expectancy at birth, highest reported maternal and infant mortality, highest hospitalization rate from preventable causes, highest death rate for avoidable and treatable conditions, highest suicide rate, and highest chronic disease burden rate in the world.[9]

In essence, we are spending more than any other civilized country in the world and getting markedly worse results. No other known industry in a competitive or many noncompetitive societies could survive by being twice as expensive while producing markedly inferior products, services, and results.

Over the past several decades, many inadequate policies, negative influencers, and societal and demographic changes have come together to create our current failing healthcare system.

Our system lacks an emphasis on primary and preventive care. We strain under a dysfunctional payment system. It is plagued by a costly and onerous liability industry, and it has fallen prey to the detrimental policies of the medical industrial complex and corporatized care.

Our system struggles to care for an exploding aging demographic. It is threatened by a significant impending shortage and maldistribution of providers. Our politicians and citizens refuse to maturely engage on a solution to the looming financially threatening entitlement crisis. We have irresponsibly significantly underfunded our public and mental health systems.

Finally, we have tolerated a general lack of accountability for much of our population as it pertains to medical compliance and irresponsible behaviors such as overeating and sedentary lifestyles, as well as cigarette, alcohol, and drug abuse.

These and many other events, policies, and forces have created the broken dysfunctional system of American healthcare. A system that is so badly flawed that most experts believe it will likely implode, creating devastating effects on our country's health and economy. As a nation, we cannot and should not continue to support or tolerate a system that threatens the quality, safety, accessibility, and affordability of its citizens' healthcare.

To successfully meet the many requirements and challenges to achieve inclusive and affordable national wellness, we are going to have to radically reform the current failing system.

Access should not be rationed, excluded, or penalized by a system that places the "god of profit" over the general welfare of our citizens.

Like the rearranging of the deck chairs on the sinking Titanic, piecemeal realignments will not be enough. They are failing now and will fail in the future. As President Abraham Lincoln so aptly said when faced with a similar existential crisis decades ago, "The dogmas of the quiet past are inadequate to the stormy present. We think anew and act anew."[10]

In consideration of this concept and our current predicament, I am reminded of an observation said to be made by Winston Churchill that describes our country's often tortuous and convoluted method of confronting public and policy issues: "Americans will always do the right thing, only after they have tried everything else."[11]

In essence, this is where we find ourselves today with our failing healthcare system. We have tried everything else, and now it is time to do the right thing.

As stated, our current system is so badly broken and dysfunctional that a complete overhaul is needed. Healthcare scholars, when asked if they were to design a new system from scratch, all seemingly agree that it would look nothing like our current model.

Significant and necessary reform will pose a complex rubric that will no doubt be hamstrung by the forces of traditional, societal, governmental, financial, and professional habits and interests. As we approach this formidable but essential task, we must be guided by the wisdom of H. L. Mencken who warned: "For every complex human problem there is a solution that is clear, simple, and wrong."[12] With this insight in mind, the efficacy of our proposed reforms will be completely dependent on the intensity of our engagement, quality of our debates, and courageousness of our actions.

As someone who has dedicated my entire life to the practice of the noble art of medicine and has served in healthcare leadership at the highest levels, I firmly believe that healthcare is a fundamental human right and not a luxury for the privileged few. I do not believe that the provision of healthcare should be a profit-centric-driven system.

This model may be permissible to produce inanimate commodities; however, the provision of medical care is different. It is an intimate human

need that we all depend on. Access should not be rationed, excluded, or penalized by a system that places the "god of profit" over the general welfare of our citizens. As a country of manifest bounty based on the principles of the general welfare and common good of its citizens, we should not have a situation where anyone goes without adequate medical care or is one illness away from financial catastrophe.

In contemplating this sad situation, one of my previous partners—a man who had selflessly dedicated his entire life to the surgical care of his community much to the sacrifice of everything else—told me on his death bed that he was leaving this world with a heavy heart. He said, "My friend, I am leaving at a time when the practice of medicine—the profession to which I have given my all—is no longer one that I recognize or respect." These words haunt me to this day.

However, it does not have to be this way. Furthermore, I believe it can't stay this way. The US healthcare system can and must be reformed. Acting with courage, conviction, intellect, and sacrifice guided by the concept of the greater good, we can return medicine to its original high Hippocratic principles of servitude that made it once a part of the "shining city on a hill" motif of the great American experiment.

We can return medicine once again to its rightfully noble place in the affairs of mankind. A place once described by Robert Louis Stevenson as one that: "When that stage of man is done with and only remembered to be marveled at in history, as to have contributed little to the defects of the period, and most notably exhibited the virtues of the race."[13]

This is my hope!

Disclaimer

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

Dr. James Elsey *is a professor of surgery at the Medical University of South Carolina in Charleston, and Past Vice-Chair of the ACS Board of Regents.*

References

1. University of Michigan School of Public Health. Reflecting on Dr. King's legacy and the field of public health. January 18, 2021. Available at: https://sph.umich.edu/pursuit/2021posts/neblett_mlk.html. Accessed November 25, 2024.
2. Centers for Medicare and Medicaid Services. National medical expenditures 2022. Available at: https://www.cms.gov/newsroom/fact-sheets/national-health-expenditures-2022-highlights. Accessed November 25, 2024.
3. Peter G. Peterson Foundation. The share of Americans without healthcare insurance in 2023 remained low. Available at: https://www.pgpf.org/article/the-share-of-americans-without-health-insurance-in-2023-remained-low/. Accessed November 25, 2024.
4. The Commonwealth Fund. Mirror, Mirror 2021: Reflecting Poorly Health Care in the U.S. Compared to Other High-Income Countries. August 4, 2021. Available at: https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly. Accessed November 25, 2024.
5. Centers for Medicare & Medicaid Services. National health expenditure data. September 10, 2024. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data. Accessed November 25, 2024.
6. Bedayn J. States confront medical debt that is bankrupting millions. April 12, 2023. Available at: https://apnews.com/article/medical-debt-legislation-2a4f2fab7e2c58a68ac4541b8309c7aa. Accessed November 25, 2024.
7. La Roche J. Buffett: Medical costs are the tapeworm of American economic competitiveness. Yahoo Finance. May 6, 2017. Available at: https://finance.yahoo.com/news/buffett-medical-costs-tapeworm-american-economic-competitiveness-220647855.html. Accessed November 25, 2024.
8. Miller BJ, Nyce S. The big paycheck squeeze: The impacts of rising healthcare costs. WTW. July 27, 2023. Available at: https://www.wtwco.com/en-us/insights/2023/07/the-big-paycheck-squeeze-the-impacts-of-rising-healthcare-costs. Accessed November 25, 2024.
9. Gunja MZ, Gumas ED, Williams II RD, US health care from a global perspective, 2022: Accelerating spending, worsening outcomes. The Commonwealth Fund. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022. Accessed November 25, 2024.
10. US National Archives. The Center for Legislative Archives. President Abraham Lincoln's Second Annual Message to Congress, December 1, 1862. Available at: https://www.archives.gov/legislative/features/sotu/lincoln.html. Accessed November 25, 2024.
11. Langworth R, ed. *Churchill by Himself: The Definitive Collection of Quotations.* New York, NY: PublicAffairs; 2008:573.
12. Mencken, H. L. *Prejudices: Second Series.* New York, NY: A. A. Knopf, 1920.
13. Stevenson RL. Eulogy of the Doctor. 1800. Available at: https://loc.getarchive.net/media/eulogy-of-the-doctor-by-robert-louis-stevenson-compliments-of-the-haley-m-o. Accessed November 25, 2024.

Pioneers Advance Surgical Management of Lung Cancer

Alex G. Little, MD, FACS

Strong individuals, in and out of the OR, pioneered thoracic surgery to treat lung disease, overcoming cultural, religious, and technical challenges. Specifically, surgical advances with accurate knowledge of anatomy were difficult due to religious proscriptions against the dissection of cadavers.

HIPPOCRATES ENCOURAGED surgeons wanting to gain hands-on experience to "go to war," and Ambroise Páre in the 16th century proclaimed war to be the greatest school of surgery.[1] However, without an understanding of pulmonary dynamics, surgeons struggled with chest injuries, uncertain whether to close or leave open full-thickness wounds and, thus, were limited to pulling spears and arrows and suturing lacerations.

A move in the right direction finally came when Dominique-Jean Larrey (1766–1842), a French military surgeon and chief surgeon to Napoleon Bonaparte, closed an open chest wound, which improved the soldier's breathing.

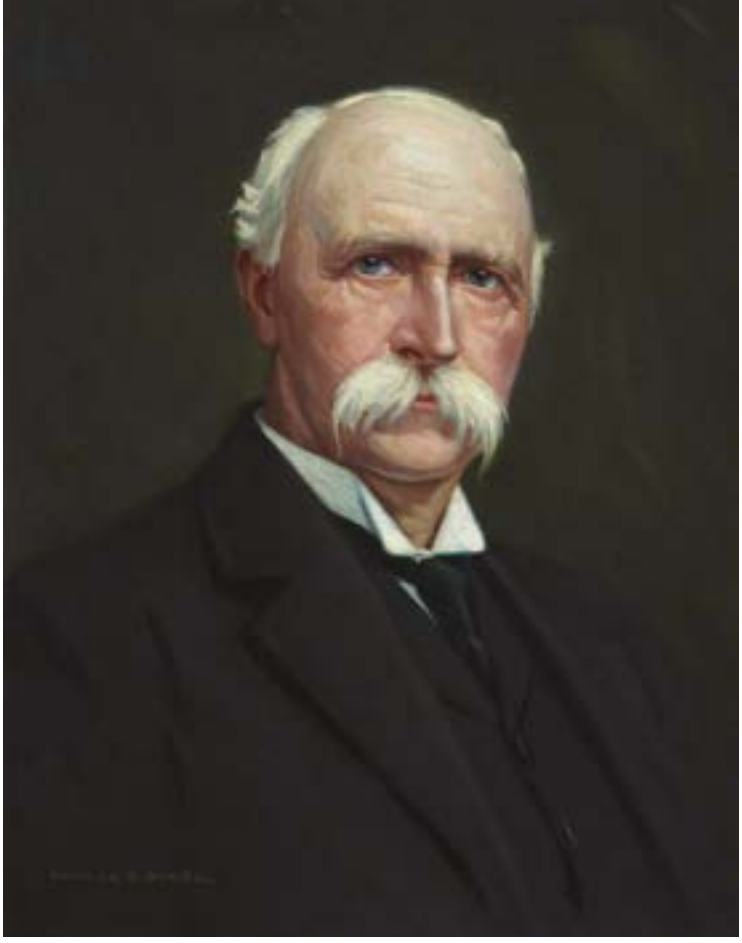
Traumatic lung herniation presented an early opportunity for a limited lung operation as an example from 1499 illustrates. A hesitant Italian physician named Rolandus described his experience: "Called to a citizen of Bologna on the 6th day after his wound I found a portion of the lung issued between two ribs…and it was not possible to reduce it. This compression exercised by the ribs, retained its nutrient from it, and it was so mortified that worms had developed in it…I, yielding to his prayers…made an incision through the skin…Then with a cutting instrument I removed all the portion of the lung, level with my incision."[2]

Procedures, such as the one described by Rolandus, which showed a patient could not only survive but also function after the loss of lung tissue, were supplemented in 1861 when Jules-Émile Péan, a renowned French surgeon of the 19th century, found a chest wall tumor invading his patient's lung and simply excised the involved lung with the tumor, providing more confidence that patients could tolerate some amount of lung loss.

These procedures nudged the process forward, but each failed to be an intrathoracic operation, which Block, a Polish surgeon, attempted in 1841. After practicing with rabbits, he resected the lung apex of his cousin for tuberculosis. As observed by author R. H. Meade, "…unfortunately his cousin was not as hearty as the rabbits and died."[1]

Apparently devastated, Block committed suicide soon thereafter. Nonetheless, interest in treating lung infections persisted, especially for tuberculosis and bronchiectasis. These were difficult and typically unsuccessful operations.

In 1923, Evarts A. Graham, MD, FACS, former ACS President (1940–1941), found 48 reports of lung resection for bronchiectasis with a 52% mortality rate, and enthusiasm for these procedures waned.



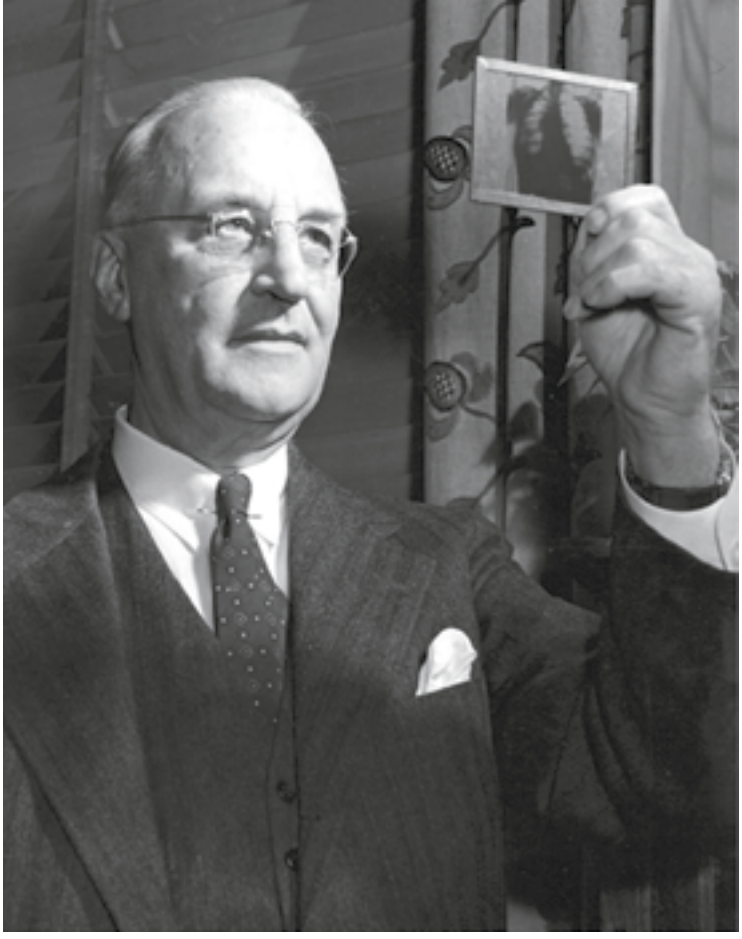
Scottish surgeon Dr. William Macewen is credited with performing the first pneumonectomy in 1895 on a patient with a lung destroyed by infection. (Courtesy of the Royal College of Surgeons of Edinburgh)

First Successful Pneumonectomy

In 1895, the Scottish surgeon William Macewen, CB, FRS, FRCS, removed a patient's lung, which was riddled with both tuberculosis and bacterial infection, by essentially shelling it out. There was no attempt to control hilar structures that were presumably buried in an inflammatory mass. The patient survived and, even though it was an inelegant undertaking, Dr. Macewen is credited with performing the first successful pneumonectomy.

Dr. Macewen was a formidable individual and had little tolerance for ignorant behavior. He once found himself in a railway carriage with an offensive drunk and "he placed his two thumbs inside the mouth of the drunken fool and dislocated the man's lower jaw so that he sat absolutely dumbfounded…for the rest of the journey. Then…the jaw was liberated."[3] By declining the chair of surgery position at Johns Hopkins, he opened the door for William S. Halsted, MD, FACS(Hon), to make his seminal contributions.

Two other surgeons advanced lung surgery with a focus on infections. Rudolf Nissen, whose eponym is featured in antireflux surgery, reported the first successful "true" pneumonectomy in 1931, when he removed the lung of a 12-year-old girl with chronic



In 1933, Dr. Evarts Graham successfully performed a left pneumonectomy, establishing the ability of a patient to function with one lung and an operation to help cure lung cancer. (Courtesy of the Bernard Becker Medical Library)

bronchiectasis following a chest injury. He suture ligated the hilum but left the lung in situ allowing it, deprived of its blood supply, to eventually slough off.

Cameron Haight, MD, FACS, from the University of Michigan in Ann Arbor, repeated this feat a year later in a 13-year-old girl, although he ligated the two left lobes separately.

The patients were so hemodynamically unstable that the surgeons had to abort first attempts, necessitating a second and successful operation. Both patients survived, and lung surgery began inching forward.[4]

Lung cancer is now the most frequent reason for lung resection. This all-too-common malignancy received little attention until early in the 20th century following the introduction of x-ray technology in 1895. Dr. Graham, leader of the Empyema Commission during World War I, famously performed the first successful operation for lung cancer with his pneumonectomy in 1933 in St. Louis, Missouri.

He was prepared for the challenge. As chair of surgery at Washington University in St. Louis, he was an experienced surgeon, had performed lung resections in animals, and had considerable experience with thoracic procedures such as the infamous operation for bronchiectasis.

Dr. Graham chose pneumonectomy for this patient because the tumor was at the orifice of the left upper lobe. He performed a left thoracotomy and occluded the pulmonary artery to assess the patient's response.

Satisfied the patient could tolerate the operation, Dr. Graham ligated the hilum and "mass transfixion (sic) ligatures were placed in the hilum, and the lung was removed." He implanted radon seeds in the hilar tissues to address possible remaining cancer.[5] The patient endured postoperative infections, survived, and though several subsequent patients did not, this precedent established surgery for lung cancer.

Over time, surgeons have established lobectomy as the operation of choice for localized disease, balancing preservation of lung function and cure. Removal of even less lung by segmentectomy or wedge resection—also known as precision surgery—is now performed for very localized disease.

Following Dr. Macewen's precedent, Dr. Graham also declined the offer of chair of surgery at Johns Hopkins, in this case opening the door for Alfred Blalock, MD, FACS, former ACS President, and his accomplishments.

Strong and bold surgeons developed and advanced chest surgery in general and lung surgery in particular. Thoracic surgery has come a considerable way from primitive and hesitant undertakings during a relatively short time.

Fewer than 100 years have passed since Dr. Graham's milestone operation. But evolution and innovation have not ceased. We will see new techniques that are as revolutionary as the advent of minimally invasive surgery and revised surgical strategies that leverage the power of new chemotherapy and immunotherapy agents.

Dr. Alex Little *is a clinical professor at The University of Arizona in Tucson.*

References

1. Meade RH. *A History of Thoracic Surgery*. Springfield, Illinois: Charles C Thomas, 1961.
2. Paget S. *The Surgery of the Chest*. London, United Kingdom: John Wright & Co.,1896:43-45.
3. Little AG. *Cracking Chests: How Thoracic Surgery Got From Rocks to Sticks*. Boston, Massachusetts: SDP Publishing,2022:148-149.
4. Nissen R. Total pneumonectomy. *Ann Thor Surg*. 1980: 29(4):390-394.
5. Mueller CB. *Evarts A. Graham: The Life, Lives, and Times of the Surgical Spirit of St. Louis*. Memphis, Tennessee: Decker Inc.,2002:117-140.

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New 2025 NAPRC Standards Highlight Advances in Rectal Cancer Care

Steven D. Wexner, MD, FACS
Tracy L. Hull, MD, FACS
Judy C. Boughey, MD, FACS

THE ACS RELEASED NEW National Accreditation Program for Rectal Cancer (NAPRC) standards in 2025 that address recent advancements in rectal cancer care.

The current standards, published in *Optimal Resources for Rectal Cancer Care* and originally released in July 2020, serve as a comprehensive guide that details the requirements for NAPRC accreditation.

Since the original standards were published, many advancements and changes have occurred in rectal cancer treatment. Among the most paradigm shifting of these advances has been the tremendous growth in the "watch and wait" approach, wherein treatment with neoadjuvant chemoradiotherapy becomes the definitive treatment, rather than the originally intended neoadjuvant treatment followed by planned surgical resection.

Because of the large increase in the number of patients assigned to "watch and wait" protocols, a new standard was introduced to establish definitions, documentation requirements, and compliance measures for the management of patients who are using this protocol. Previously, many patients in a "watch and wait" protocol were not discussed at a Rectal Cancer Multidisciplinary Team (RC-MDT) meeting, which now will be a requirement.

Another patient group that the previous standards did not include were those who undergo transanal excision of lesions thought to be benign adenomas in whom invasive cancer is identified. This scenario is addressed by the new standard "Local Excision of Rectal Cancer," and patients presenting or referred to an NAPRC-accredited program will have their details discussed at a RC-MDT.

The third new standard relates to RC-MDT review following neoadjuvant therapy. Many patients receive neoadjuvant therapy. The NAPRC deems it mandatory to have each of these patients undergo RC-MDT review following neoadjuvant therapy to help develop a consensus on whether they should

be offered "watch and wait" or proceed to surgery.

In conjunction with the release of the revised standards, the NAPRC developed four templates that NAPRC-accredited programs (and those seeking accreditation) will have the option to use when documenting the review of patients by the RC-MDT. These templates are included in *Optimal Resources for Rectal Cancer Care*.

The fourth major change in the NAPRC standards involves lowering the minimum compliance percentage required to meet a standard to 90%.

Algorithms are included in *Optimal Resources for Rectal Cancer Care* in order to assist programs in understanding where each standard fits into the patient care journey for individuals diagnosed with rectal cancer.

The program also is retiring some standards. As mentioned, nearly all patients undergo neoadjuvant therapy. Because of this extensive change in care, the standard Adjuvant Therapy after Surgical Resection was retired in 2023.

These many changes join the core NAPRC standards that address administrative commitment, rectal cancer multidisciplinary care, the need for a rectal cancer program director and rectal cancer program coordinator, as well as rectal cancer multidisciplinary team meetings with rectal cancer multidisciplinary team attendance.

Standards also involve ACS Commission on Cancer accreditation, routine review of diagnostic pathology, guidance on the use of systemic staging with computerized tomography, local staging and standardized reporting with magnetic resonance imaging, carcinoembryonic antigen level, as well as treatment planning discussion and recommendation summary, definitive treatment timing, surgical resection and standardized operative reporting, specimen photographs, and treatment outcome discussion and outcome summary. Furthermore, the quality measures, quality improvement initiative, and rectal cancer program education remain as standards.

The field of rectal cancer care is rapidly evolving. We can envision that in the not-too-distant future we may introduce additional new standards related to other evolving topics such as immunotherapy. We also hope to develop standards relating to value that describe pathways for delivering the best possible care at the least possible cost.

Cost has many forms, including financial expenditures, patient morbidity and mortality, and quality of life. The NAPRC looks forward to continuing to improve the care of rectal cancer patients, specifically through these standards, which define how we achieve this mission.

Dr. Steven Wexner *is director of the Ellen Leifer Shulman and Steven Shulman Digestive Disease Center and emeritus chair of the Department of Colorectal Surgery at the Cleveland Clinic Florida in Weston. He is Chair of the ACS Commission on Cancer (CoC) National Accreditation Program for Rectal Cancer and a member of the CoC Executive Committee.*

ACS Communities Has New Editor-in-Chief

THE ACS COMMUNITIES—the networking tool exclusive to members of the College—has a new Editor-in-Chief.

Sean J. Langenfeld, MD, FACS, the chief of the Division of Colon and Rectal Surgery and the Jon S. Thompson Endowed Professor of Surgery at University of Nebraska Medical Center (UNMC) in Omaha, has started his role as the platform's second leader. He also is vice-chair for quality and compliance in the UNMC Department of Surgery.

He succeeds Tyler H. Hughes, MD, FACS, who served as the inaugural Editor-in-Chief of the Communities since its launch in August 2014.

Dr. Langenfeld began his term on February 1 after shadowing Dr. Hughes in January.

The Communities platform offers ACS members a private online forum where they can pose clinical questions, offer guidance, exchange resources, and connect with colleagues in any surgical specialty, career stage, and/or local chapter.

In his new position, Dr. Langenfeld will be responsible for overseeing and reviewing new postings and making sure they adhere to the Communities Code of Conduct. He also will help start conversations and promote ACS content, such as articles in the *Bulletin*, the *ACS Brief*, and other publications, in their relevant communities.

Looking Forward

"I'm very excited about the opportunity to build on the amazing foundation created by Dr. Hughes and the ACS team," Dr. Langenfeld said.

He noted that his priorities include protecting existing networks and resources, which is particularly

important for rural and community surgeons who can benefit from a "virtual surgeon's lounge." Dr. Langenfeld also plans to explore new ways to engage surgeons who are early in their practice, connecting them with more senior contributors so that all benefit from diverse perspectives.

"The ACS Communities platform is an invaluable tool that supports practicing surgeons and allows us to provide the best possible care for our patients, and so I greatly value the trust that has been placed with me to captain the ship," he said.

Background and Social Media Expertise

Dr. Langenfeld has a history of service to professional organizations, including the ACS, where he has been a Fellow since 2014. Within the College, Dr. Langenfeld has served as President of the Nebraska Chapter, on the Executive Committee for the Committee on Video-Based Education, and a member of the Advisory Committee on the Surgical Education and Self-Assessment Program.

Most germane to his new position leading the ACS Communities, Dr. Langenfeld has proven to be a leading voice in how medical professionals, including surgeons, should interact with social media.

In addition to serving on the ACS Young Fellows Association Social Media Subcommittee, as chair of the American Society of Colon and Rectal Surgeons (ASCRS) social media committee for almost 10 years, and as creator and moderator of the 1,000+ member ASCRS closed Facebook group, Dr. Langenfeld has provided talks, led courses, written commentaries, given podium and poster presentations, held visiting professorships, led grand rounds, and authored peer-reviewed articles and book chapters on the dangers and impact of social media in the healthcare space.

Dr. Hughes has given a firm vote of confidence, reinforcing that Dr. Langenfeld is uniquely qualified to take the reins.

"I am pleased that Dr. Langenfeld will be assuming that role. We first met when he was in the early stages of his career, and I have seen him continually grow into an ever better and more thoughtful surgeon," Dr. Hughes said. "He has extensive experience in social communications, and I feel he will lead the ACS Communities to a new era introducing younger surgeons to this platform while strengthening its most vital components."

Learn more about the ACS Communities at *facs.org/communities*.

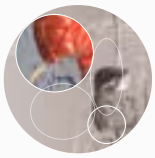
Top 10 Most-Read *Bulletin* Articles Published in 2024

1 New 2024 CPT Coding Changes Affect General Surgery, Related Specialties

January

2 Electric Bikes Are Emerging as Public Health Hazard

July/August

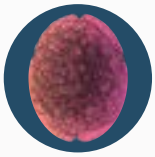


3 Are Antibiotics the Answer to Treating Appendicitis?

April

4 Clinicians Struggle to Understand Dramatic Rise in Early Onset Colorectal Cancer

November/December



5 Long COVID May Have Long-Term Impact on Surgery

May

6 Conversations in Acute Cholecystitis Management Include Treatment Timing, Robotics

September

7 Physician Workforce Data Suggest Epochal Change

April

8 In Memoriam: Dr. Mark Savarise, ACS Regent

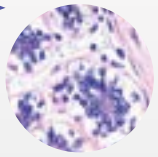
July/August

9 ACS Provides Guidance for Senior Surgeons Facing Age-Old Question

May

10 Multidisciplinary Approach to Treatment, Emerging Techniques Optimize Survival and Quality of Life for Breast Cancer Patients

October



CALL FOR ABSTRACTS

Submissions close 11:59 pm CT, March 3

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ACS AMERICAN COLLEGE OF SURGEONS

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.

Does your hospital want to improve the care of older adult surgical patients?

The ACS Geriatric Surgery Verification Program (GSV) gives hospitals the tools to improve the care of older adult surgical patients, reduce costs, and create more efficiencies. GSV includes proven, evidence-based practices enabling hospital teams to deliver optimal care while helping patients achieve their care goals.

In addition, GSV helps hospitals participating in the Centers for Medicare & Medicaid Services (CMS) Hospital Inpatient Quality Reporting Program comply with the new CMS Age Friendly Hospital Measure—a new regulatory requirement that became effective January 1, 2025.

Book a call with our GSV Team today!

ACS AMERICAN COLLEGE OF SURGEONS

Standout 2024 *JACS* Articles Offer Snapshot of Innovation and Impact

IN THE EVER-EVOLVING FIELD of surgery, staying informed about influential research is essential for advancing clinical practice and improving patient outcomes. This compilation of the most read articles from the *Journal of the American College of Surgeons* (*JACS*) in 2024 showcases groundbreaking studies that span diverse topics in surgery, public health, and medical innovation.

Among the most-cited works are investigations into long-term diabetes remission, the role of robotics in gastrointestinal surgery, and strategies to optimize care for patients with exsanguinating injuries.

The most-read and top altmetric articles in *JACS* reflect the diverse interests of the Journal's audience—from surgical outcomes and mental health screening tools to societal concerns like firearm-related violence and scooter injuries. Other highlights include gas-bloat syndrome, opioid-prescribing variations, and innovative approaches to transplant candidacy for obese patients. Together, these lists capture the intersection of clinical innovation, patient well-being, and public health, offering valuable insights into the challenges and opportunities shaping modern medicine.

"The *Journal of the American College of Surgeons* publishes articles that will have the highest impact for the practicing surgeon—regardless of specialty. We have accepted a number of excellent articles that represent this goal," said Timothy J. Eberlein, MD, FACS, *JACS* Editor-in-Chief. "I would like to thank each of the authors who submitted to the *Journal* in my final year as Editor-in-Chief, and I am especially appreciative to all our editors and reviewers who maintain the highest standards and perform thorough reviews that make our *Journal* better. Finally, it has been my honor and privilege to serve as the Editor-in-Chief over these past 21 years. The *Journal* will be in exceptional hands with Dr. Tom Varghese."

JACS JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS

Most Cited

Continued Diabetes Remission Despite Weight Recurrence: Gastric Bypass Long-Term Metabolic Benefit

Analysis of Conflicts of Interest in Studies Related to Robotics in Gastrointestinal and Abdominal Wall Surgery

Prioritizing Circulation to Improve Outcomes for Patients with Exsanguinating Injury: A Literature Review and Techniques to Help Clinicians Achieve Bleeding Control

Validity of Entrustable Professional Activities in a National Sample of General Surgery Residency Programs

Scheduled Follow-Up and Association with Emergency Department Use and Readmission after Trauma

Most Read on *journalacs.org*

Gas-Bloat Syndrome after Magnetic Sphincter Augmentation: Incidence, Natural History, Risk Factors, and Impact on Surgical Outcomes Over Time

Development and Initial Performance of the Hospital Mental Health Risk Screen

Baseline Characteristics and Use of Pretherapeutic 18F-Fluorodeoxyglucose-PET for Pancreatic Cancer

Home Is Not Always Where the Sleep Is: Effect of Home Call on Sleep, Burnout, and Surgeon Well-Being

Drivers of Variation in Opioid Prescribing after Common Surgical Procedures in a Large Multihospital Healthcare System

Top Altmetrics*

Child Firearm-Related Homicide and Suicide by State Legislation in the US (2009 to 2020)

National Trends and Clinical Outcomes after Scooter Injury in the US: 2016 to 2020

Defining the Problem: 53 Years of Firearm Violence Afflicting America's Schools

Collaborative Approach Toward Transplant Candidacy for Obese Patients with End-Stage Renal Disease

Cost-Effectiveness of Nonoperative Management vs Upfront Laparoscopic Appendectomy for Pediatric Uncomplicated Appendicitis Over 1 Year

A subscription to *JACS* is a membership benefit for all active ACS Fellows, Associate Fellows, and Resident Members. Visit *JACS* online at *journalacs.org*.

*Altmetrics, or alternative metrics, are measures that take into account online reader behavior, network interactions with content, and social media.

Member News

Rosen Leads GI Surgery at Northwestern

Michael J. Rosen, MD, FACS, is chief of the Division of Gastrointestinal Surgery in the Department of Surgery at Northwestern Medicine in Chicago, Illinois. A general surgeon, Dr. Rosen previously was a professor of surgery, section head of the abdominal wall reconstruction team, and surgical operations vice chair in the Department of General Surgery of the Digestive Disease & Surgery Institute, all at the Cleveland Clinic in Ohio.

Ford Joins Group to Govern The Joint Commission

Henri L. Ford, MD, MHA, FACS, was appointed to the Board of Commissioners of The Joint Commission. The board's 21 voting members provide policy leadership and oversight for The Joint Commission, which accredits and certifies more than 23,000 healthcare organizations and programs in the US. The ACS nominated Dr. Ford—the College's Immediate Past-President—to serve as one of its representatives on The Joint Commission board. His 3-year term began on January 1. Dr. Ford is the dean and chief academic officer at the University of Miami Miller School of Medicine in Florida.

Ferzandi Is President of Urogynecologic Society

Tanaz R. Ferzandi, MD, MBA, MA, FACS, has taken over as president of the American Urogynecologic Society, which supports professionals who treat female pelvic floor disorders; her term will run through the end of 2025. Dr. Ferzandi is director of the Division of Urogynecology and Pelvic Reconstructive Surgery at the Keck School of Medicine of the University of Southern California (USC) in Los Angeles, as well as associate fellowship program director for urogynecology and service line chief of obstetrics and gynecology at Keck Hospital of USC. For the ACS, she serves on the Advisory Council for Gynecology and Obstetrics and the Board of Governors Infertility & Pregnancy Complications Task Force.

Mouawad Chairs Surgery in Michigan

Nicolas J. Mouawad, MD, MPH, MBA, FACS, is chair of the Department of Surgery at McLaren Bay Region Hospital in Bay City, Michigan. He also will continue in his role as chief of vascular and endovascular surgery. Dr. Mouawad serves on the ACS Advisory Council for Vascular Surgery and Legislative Committee, as well as Vice-Chair of the ACS Foundation Board of Directors.

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.

McLellan Is EPH Chief of Staff

Jennifer A. McLellan, MD, FACS, is the new medical chief of staff at Estes Park Health (EPH) in Colorado. A general surgeon, Dr. McLellan has worked at Estes Park Health since 2019.

Menezes Steps into Interim Surgery Chair Role

Nelson Menezes, MD, FACS, has been appointed interim chair of surgery at The Brooklyn Hospital Center (TBHC) in New York. He has been chief of vascular surgery since 1998. Board certified in both general and vascular surgery, Dr. Menezes also serves as the medical director of TBHC's Vascular Lab and is involved in resident education and research.

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JACS JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS

Highlights

The following articles appear in the February 2025 issue of the *Journal of the American College of Surgeons*. A complimentary online subscription to *JACS* is a benefit of ACS membership. See more articles at ***facs.org/jacs***.

Analysis of Surgeon and Program Characteristics Associated with Success on American Board of Surgery Exam Outcomes

Carol L. Barry, PhD, Andrew T. Jones, PhD, Jonathan D. Rubright, PhD, and colleagues

This study examined resident and program characteristics that predict success on American Board of Surgery (ABS) exams. The researchers found a strong relationship between US Medical Licensing Examination scores and outcomes of the ABS exam. After controlling for prior exam performance, small correlations also were observed between board-certification success and sex, international medical graduate (IMG) status, and percentage of IMGs in a program.

Early Experience of the Peer Advocate Program: Using Quality Improvement to Optimize Behavioral and Communication Disconnects in the Operating Room

Shaina R. Eckhouse, MD, FACS, Margaret Huston, MD, Eileen R. Smith, MD, and colleagues

To help optimize team function and potentially enhance patient outcomes, a multidisciplinary task force developed a novel reporting system that separated mechanical and procedural safety events in the OR from communication and behavior-related events. Early experience with the system was positive. It addressed the latter disconnects in an efficient and supportive manner, while restoring conversation and communication.

Impact of Multi-Institutional Enhanced Recovery after Surgery Protocol Implementation on Elective Colorectal Surgery Outcomes

Marta Antoniv, MD, Andrei Nikiforchin, MD, Naomi M. Sell, MD, MHS, and colleagues

A standardized enhanced recovery after surgery (ERAS) protocol, used across multiple institutions, significantly improved elective colorectal surgery outcomes, reducing complications, length of hospital stay, and readmissions. These findings support the broader implementation of ERAS to enhance patient care and reduce healthcare costs.

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