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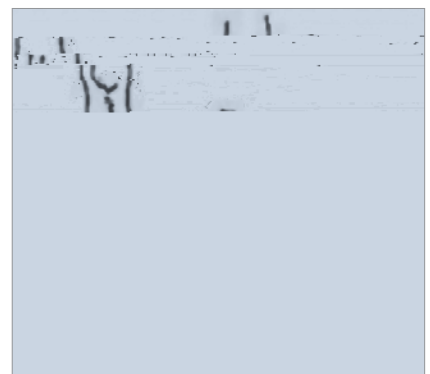
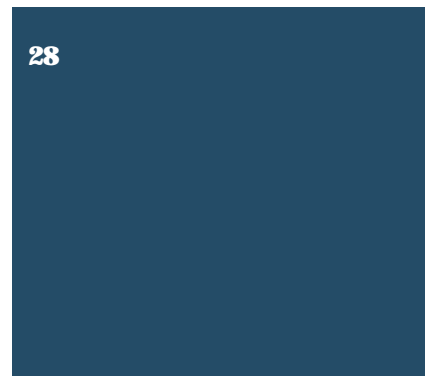
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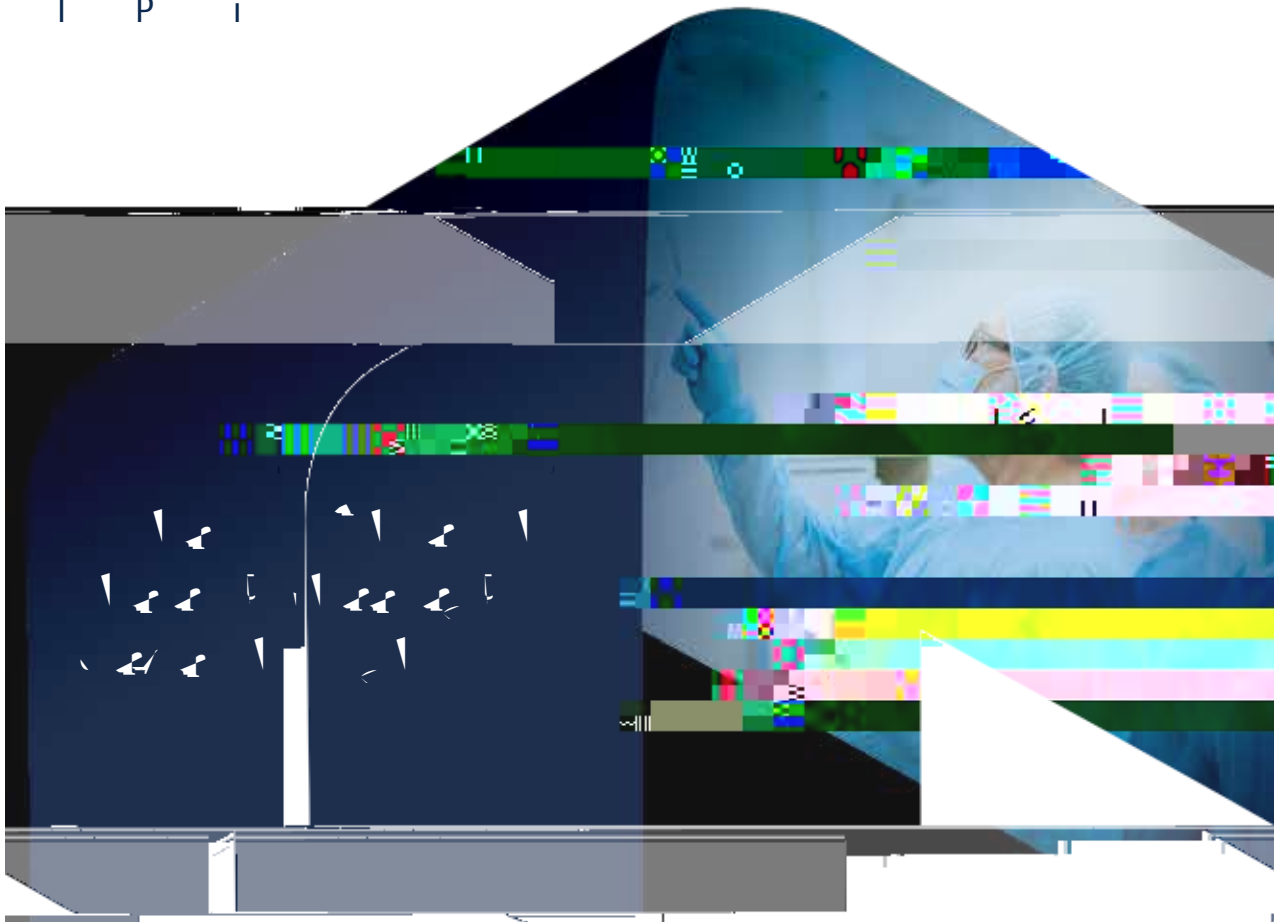
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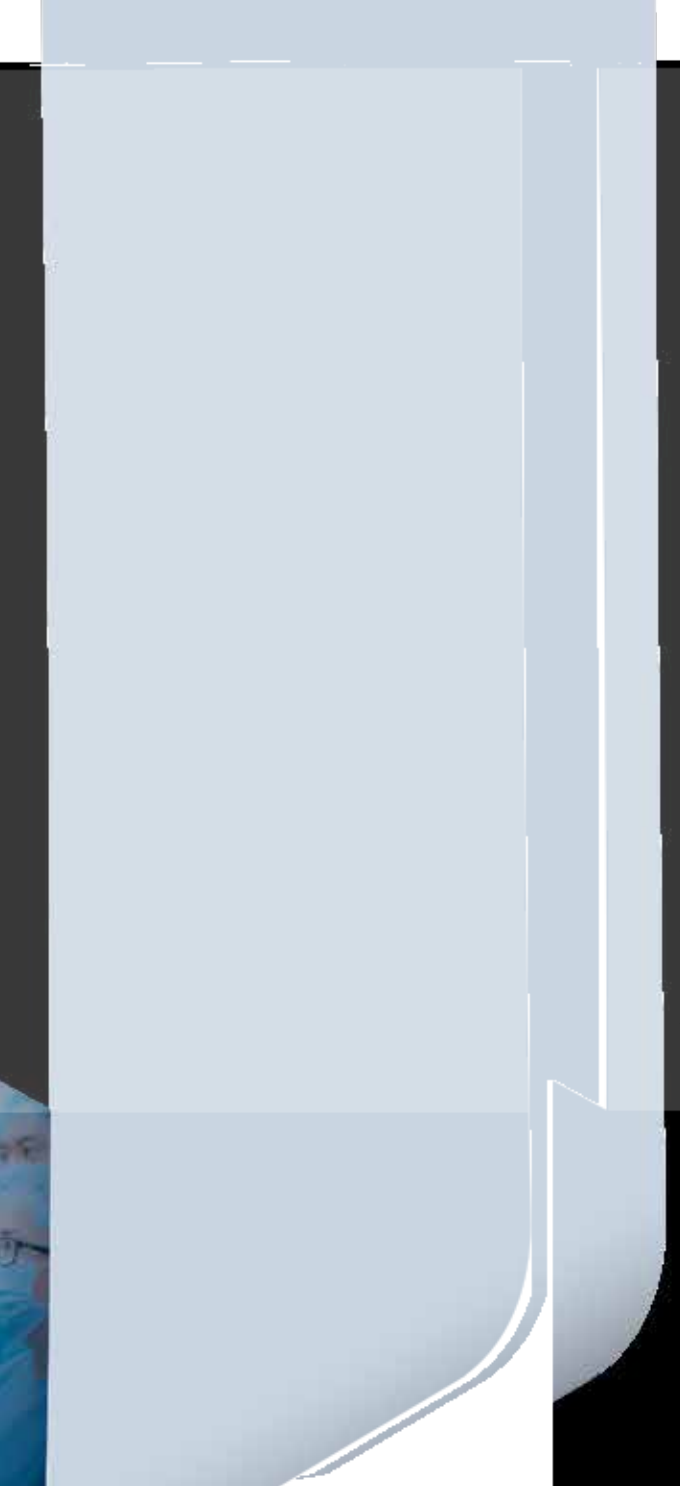


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ACS Provides Guidance for Senior Surgeons Facing an Age-Old Question

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and recommendations for the implementation of 'whole of career' strategies to ensure the sustained competency of the surgical workforce."¹

The *JACS* article informed some of the key guidelines featured in the newly released ACS Statement, "Sustaining the Lifelong Competency of Surgeons," which is an updated version of "The Aging Surgeon" statement from 2015.

"The 2015 statement was a very conservative dip

sustained at 5 years posttransplant for those patients whose surgeons were older than 48 years.

“Some of these studies show that older surgeons can perform better in terms of outcomes because they've learned through years of experience about how to avoid trouble, how to navigate complex cases or the like,” explained Dr. Rosengart.

Tools for Identifying Declining Capacity

A survey administered to 995 surgeons at ACS Clinical Congress meetings from 2001 to 2006 examined subjective changes in cognitive abilities,

Downloaded from <http://ajph.org/> on September 10, 2014. For more information on this article, please go to the journal website at <http://ajph.org/>.

all surgeons and surgical trainees regardless of age and experience level.” It is suggested that this approach be performed routinely as part of the Ongoing Professional Practice Evaluation (OPPE) that is required of all hospitals subject to third-party credentialing. The ACS Statement and the *JACS* article also support use of neurocognitive assessments tools, which could be considered a potential component of OPPE.

“Importantly, maintaining this responsibility at the local, institutional level with guidance from national entities such as state medical boards, the American College of Surgeons, or the American Board of Surgery could create universal recommendations that could be integrated into local assessments of relevant capabilities,” observed Dr. Rosengart.

The authors of the *JACS* article highlighted specific neurocognitive tests that are available for widespread use, such as the MicroCog test, a computerized neuropsychiatric screening tool that assesses attention and mental control, memory, reasoning, calculation, spatial processing, and reaction time. Other tests described in the article and the ACS Statement include the St. Louis University Mental Status Examination, Montreal Cognitive Assessment, Cambridge Neuropsychological Test Automated Battery, and the Halstead-Reitan Neuropsychological Test Battery.

“Measuring surgeon competency is a multidimensional assessment of the physical and intellectual ability to assess and treat patients who have a variety of diseases,” explained Dr. Kopelan. “There are no singular measures (with exceptions) that we are aware of that can render a surgeon ‘competent’ or ‘incompetent.’ Additionally, competence of a surgeon may vary among a variety

of diseases. Developing a set of tools to trigger when a more formal assessment of competency must be made will be challenging especially given the variability of measurements and the subjective biases of these evaluations.”

However, when a surgeon or hospital system decides to measure surgical performance and potential declining capacity, one factor is consistent across all practice settings—one size does not fit all. Notably, evidence of decline on any of these tests can also signal an opportunity for individualized training, which in at least some cases, has been shown to reverse or at least slow neurocognitive declines and potentially extend a surgeon’s service as an active operator.

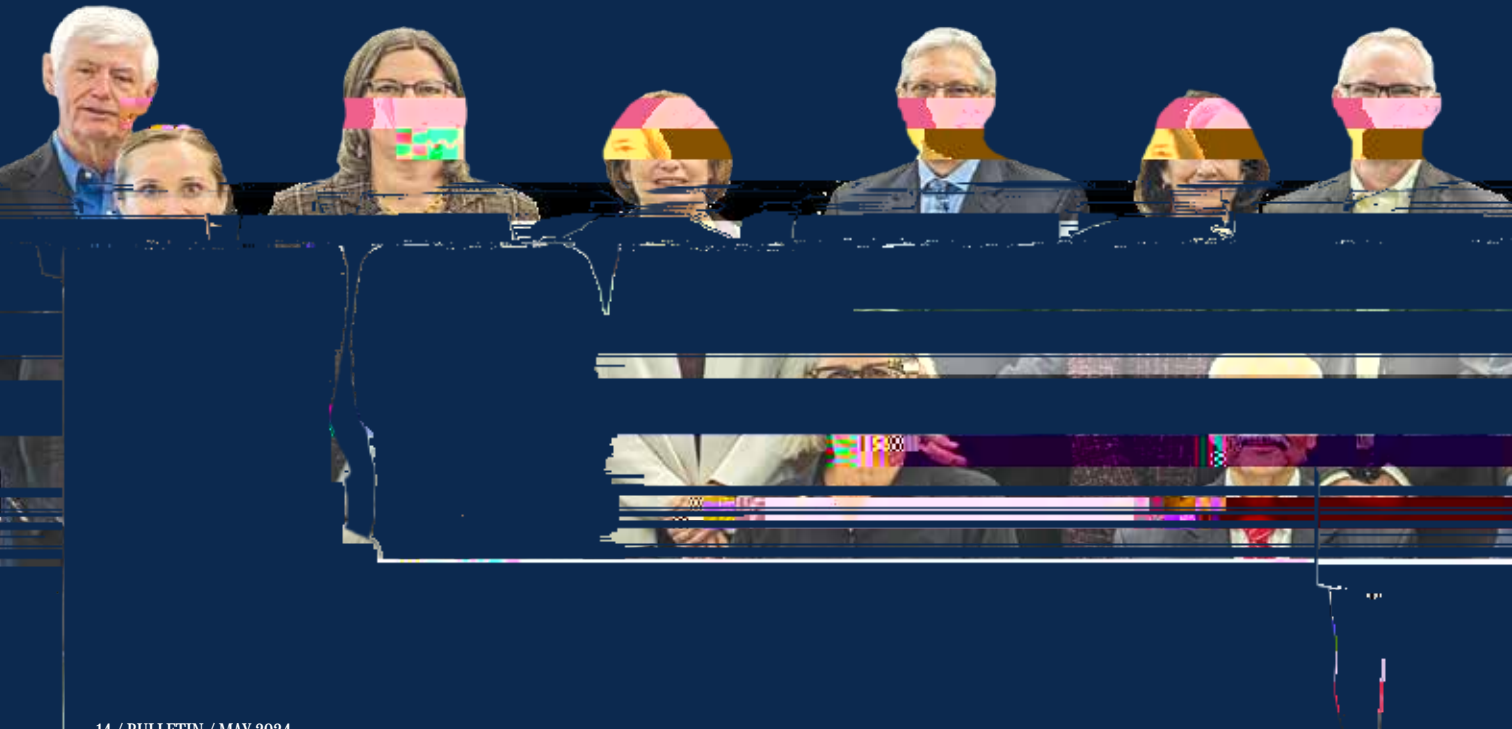
“What we’re proposing is not that a cognitive test would be the one and only standard, the be-all and end-all of approving competency,” Dr. Rosengart said. “These assessments would be part of a mosaic of cognitive testing, including clinical performance, peer review, and so on, that would be potentially different at each institution. And what we’re going to do, hopefully, is create guidelines and a framework for institutions to decide for themselves what that competency testing and approval should look like.”

A primary goal of the Physician Competency and Health Workgroup is to support the College in educating the surgical community about the issues faced by some senior surgeons. “We’re not attempting to take on the role of monitoring the community, but rather, we want to provide support, encourage, and help each other,” said Dr. Rosengart. “We’re certainly not seeking to single out older surgeons. We are simply asking ‘Why wouldn’t you want to focus on a surgeon’s competency throughout their entire career?’”

Career-Long Transition Planning

Blue Ribbon Committee II Advises Sweeping Changes in Surgical Education

M. S. ...ia N ...ma , MPH



1. The following are the names of the members of the Board of Directors of the American College of Surgeons (ACS):

- M. J. Birk
- B. C. C. C. C.
- C. C. C. C.
- S. C. C. C.
- C. C. C. C. ACS
- H. C. C. C.
- N. C. C. C.

Surgical Medical Workforce

Meet the demographic needs of the population served, as well as the sustainability needs of the surgical workforce

Medical Student Education

- Enhance medical school education by programmatically and financially supporting surgical faculty and trainees who work with medical students interested in surgery
- Develop an optimized, holistic residency selection process that evaluates leadership, decision-making, ethics, and technical skills, using standardized competency-based assessments
- Create a nurturing atmosphere for professional development, including role models from diverse backgrounds

Work-Life Integration, Resilience, and Wellness

- Create best practice recommendations for a culture of belonging in surgical trainees
- Convene a multidisciplinary national group for equitable, value-based, sustainable improvement in resident wages
- Develop a national framework defining workplace safety for surgical trainees and create a just pathway for reporting workplace mistreatment

Faculty Development and Educational Support

- Create a national curriculum for faculty training, including the use of entrustable professional activities
- Establish a multidisciplinary surgical task force to develop a faculty teaching performance assessment tool
- Define the economic value of a surgical trainee (i.e., resident, fellow) for the purposes

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training necessary for existing surgeons to develop skills in teaching, evaluation, and education research, and standardizing methods of evaluation for residents.

Impact of the BRC I

In the 19 years since the BRC I report was published, many of those efforts have taken place. Some are reflected in ACS offerings, including courses such as Surgeons as Educators and Successfully Navigating the First Year of Surgical Residency, which is aimed at medical students and PGY-1 residents. The College also has a program, Clinical Scholars in Residence, that grants surgical trainees in mid-residency 2 years of research experience, matching the BRC I's outline of surgeon-scientist development.

“Simulation centers came out of the first BRC,” Dr. Stain added, which aligned with a comment from Dr. Ellison that the ACS has helped surgeons embrace surgical simulation techniques via its annual Surgical Simulation Summit and other resources.

Success of the BRC I report went well beyond the College. While both Drs. Ellison and Stain readily admit that not all the recommendations have come to fruition, they describe the outcome similarly. “The things that were under control of surgeons,” Dr. Ellison said, as opposed to items requiring federal regulation or C-suite participation, “actually got done.”

A prime example lies in the establishment of a national curriculum for training in general surgery and related surgical specialties. After the BRC I published its report, a second group, the Surgical Council on Resident Education (SCORE), con

SIMPLY PUT, AN ENVIRONMENT IN WHICH TEAM members hesitate to speak up or act because they fear criticism or other repercussions from team members higher up in the hierarchy is not conducive to practicing good medicine.

In contrast, a “psychologically safe” work environment is one in which employees share the belief that interpersonal risk-taking is safe.² In the OR, surgical team members feel empowered and enabled to admit errors, ask questions, voice concerns, be creative, and suggest new ideas or raise concerns without fear of humiliation, criticism, or retaliation.³

According to research, a psychologically safe workplace with a culture of trust and open communication among healthcare teams that are providing high-quality patient care is imperative for the high-stress and high-demand space of the OR.⁴

When surgical team members have “radical candor,” mistakes will be avoided, and team members will

feel more engaged in and energized about their OR roles, said Amy C. Edmondson, PhD, professor of leadership and management at Harvard Business School in Cambridge, Massachusetts, who also is a psychological safety expert.

When psychological safety is combined with discipline, shared accountability, and high expectations, it can lead to better outcomes, better problem-solving, a better learning environment, increased adaptability, and better psychological health for all members of the surgical team.

In an environment of psychological safety, “it’s okay to take risks, express your ideas and/or concerns, ask questions, admit mistakes, all without fear of negative consequences,” said Harry T. Papaconstantinou, MD, FACS, a colorectal surgeon and the Glen E. and Rita K. Roney Professor and Chair of the Department of Surgery at Baylor Scott & White Healthcare in Dallas, Texas. “It’s the ability to speak up and not be judged.”

What Psychological Safety Is Not

Psychological safety does not describe a work environment that is comfortable, soft, or permissive. This concept isn't about being nice, and it doesn't mean an OR team should be led to believe their needs should be met at all times, or that they should be in charge, Dr. Edmondson said.

In a surgical context, psychological safety means absolutely no hesitation if a team member has even the remotest suspicion that the surgeon is about to do something wrong, she said, adding that a psychologically safe environment promotes candor, and candor requires strength, courage, and honesty.

Although such an environment may occasionally divert or distract the team from the task at hand, it is a risk worth taking, Dr. Edmondson said. "While it may be distracting to have someone say something irrelevant or not helpful at the moment, compare that to what might happen if the team member noted a significant error was about to be made but was afraid to speak up."

In a psychologically safe OR, the surgeon is still in charge. Team members who constantly interrupt an operation with inaccurate, irrelevant, or unhelpful comments should later be taken aside and given feedback to help make them more effective—but in a way that does not discourage them from speaking up in the future, she explained.

How Psychological Safety Affects Surgical Settings

Psychological safety has been shown to improve performance in a variety of areas, including aviation and healthcare.

"Everybody's prone to error, but better teams are better able to catch and correct each other's errors," Dr. Edmondson said.

Research supports that psychological safety benefits patient safety by improving the delivery of clinical care.⁵ For example, in intensive care units, psychological safety is associated with better health outcomes, lower morbidity, and lower mortality, according to Dr. Edmondson. That's largely due to the fact that staff, such as respiratory therapists or nurses, feel able to speak up about what they see and what they know.

In a study of the impact of psychological safety in radiation oncology, researchers found

that psychological safety was associated with more reported near misses because healthcare workers were more willing to point them out. Near-miss reporting is important to quality improvement efforts because it can uncover underlying causes of potential patient harm that could lead to adverse events.⁶

"We think big failures come out of the blue, but they're actually on top of a pile of often underreported near misses," Dr. Edmondson said. "The more we hear about what's really going on, the higher the reliability of our processes and the better we are able to prevent the big, bad ones."

At this point, however, data related to the influence of psychological safety on surgical outcomes are limited. That said, Dr. Papaconstantinou maintained that there is intuitive logic to the idea that if everyone in the OR feels empowered to point out a potential error, the result would be fewer errors because they would have been prevented or corrected. In addition, pointing out a potential error creates the opportunity for the surgical team to learn how to avoid that same error in the future.

Improved Team Performance

A psychologically safe OR is an environment safe for learning, with mutual professional respect, open communication, and suspended judgment.⁴ The result often is that clinicians are more engaged and better able to learn and creatively solve problems. OR teams demonstrating higher levels of psychological safety also are better able to successfully implement new technologies.⁷

"Work is more engaging and meaningful if you believe you matter and if you believe your voice is expected and welcome," Dr. Edmondson said.

Psychological safety supports three other conditions that help make work significant and attractive:

- Purpose and meaning
- Culture and community
- Growth and development

Dr. Edmondson described how it's difficult for people to feel purpose and find meaning in their jobs if their input is not welcome. Likewise, it's tough to feel part of a community in which you are not encouraged to participate. Finally, opportunities to gain experience and develop new skills require an environment

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surgical team points out a potential issue, (c) - 17 i 5 s t 1 6 t o l l e T h a d 1 0 4 5 s p o n T o p L e O f f i n a s i f y 1 0 1 0 f a k e 9 t 1 6 t

modesty. Admit that you're a fallible human being, and the last thing you want is for something to go wrong that could have been prevented.

Seek feedback. Be approachable.

Ask good questions during the procedure, such as: I'm about to close up, have we missed anything? Do you see anything? Is everything accounted for?

Respond appropriately.

When someone speaks up, monitor yourself. Whether the comment is right or wrong, helpful or unhelpful, don't look annoyed or angry. Just thank them for their input in a positive manner.

In addition, surgeons need to learn to respect and trust their team members.

"Too many people think trust is something that must be earned, when in fact, trust means a willingness to act despite uncertainty," said Dr. Edmondson.

To trust a team member is to believe they are willing and capable of doing the assigned task. To build trust, start by assigning small tasks and graduate to more important, high-stakes tasks.

Dr. Papaconstantinou agreed that trust helps create an environment of mutual professional respect that is essential to psychological safety. Trust makes it possible to manage conflict in a productive and healthy way, allowing questions to be raised about important issues such as patient safety or operational efficiency.⁸

“If you avoid conflict, then you have a lack of commitment and a lack of accountability because the team is not engaged in decision-making, and that negatively impacts results,” he said.

Consistent Teams Are More Likely to Be Psychologically Safe

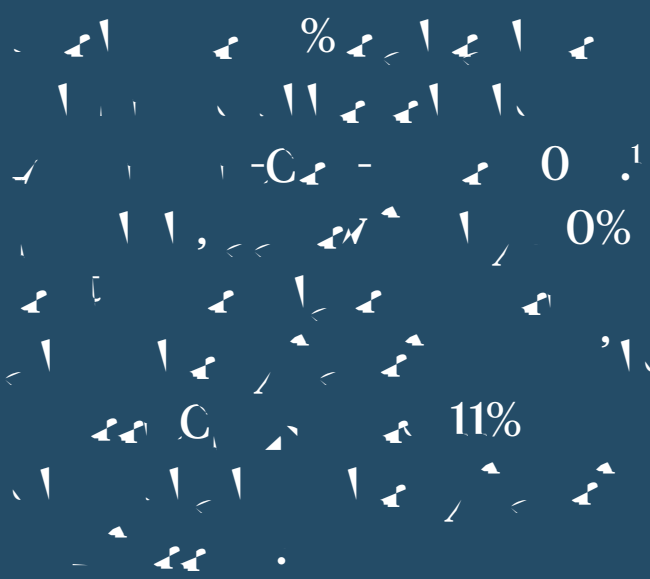
Surgical teams that have worked together before are more conducive to psychological safety and higher performance than surgical teams that haven't.⁴ In contrast, most team members who rotate on to ad hoc teams reported decreased psychological safety due to communication problems worsened by a lack of team identity, familiarity, and trust that haven't.⁴



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LONG-TERM
IMPACT ON
SURGERY

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PATIENTS FREQUENTLY complain of brain fog, cognitive difficulties, and other neurologic sequelae as the primary drivers of decreased quality of life. These patients also perform worse in cognitive measures of working memory, attention, and processing speed compared to controls.⁴

A recent study that gave cognitive assessments to more than 100,000 people with and without long COVID confirmed that complaints of brain fog in long COVID patients were correlated with lower cognitive performance in memory, reasoning, and executive function tasks.⁵ Although mRNA vaccines against SARS-CoV-2 have been extremely effective in preventing severe acute disease, the incidence of long COVID

Neurocognitive Disorder	Definition
Perioperative Neurocognitive Disorder (PAND)	Cognitive dysfunction during or within 48 hours after surgery
Postoperative Delirium (POD)	Disorientation, inattention, and fluctuating consciousness
Neurocognitive Disorder (NCD) - Residual	Cognitive dysfunction persisting beyond 48 hours
Postoperative Neurocognitive Disorder (PNCND)	Cognitive dysfunction during or within 48 hours after surgery

In 2015, the American Society of Anesthesiologists launched the Brain Health Summit, with participation from the ACS, to discuss the state of the science of perioperative cognition.¹⁰ Subsequently, a working group proposed new nomenclature to better align perioperative terminology to diagnoses already used in medical fields.¹¹

For example, the term “postoperative cognitive dysfunction” had no consensus definition and was primarily used in research, disconnected from patients’ real-world experiences. The currently recommended term for cognitive impairment identified during the overarching perioperative period is “perioperative neurocognitive disorder,” with specific subclassifications defined by timing (see Table, this page).

Postoperative delirium deserves special attention, as it may occur as a common complication distinct from other perioperative neurocognitive disorders. It is characterized by an acute onset of waxing and waning confusion, with changes in the levels of consciousness, attention, orientation, and disorganized thinking. The clinical presentation differs according to psychomotor subtype, ranging from hypoactive (e.g., slowed movements, quiet affect—symptoms that are easy to miss) to hyperactive delirium (e.g., restlessness and agitation), as well as mixed subtypes.

The rate of postoperative delirium across the literature is highly variable from 5% to 52%¹² and dependent on the detection method (from prospective screening using validated tools to retrospective chart reviews using keywords). However, there is some evidence that rates vary by specialty and operative stress load.^{13,14}

Across multiple studies, the prevalence of postoperative delirium ranges from 5% to 52%.





COVID-19: A Review of the Literature

may be important to test for viral RNA or protein present in stool samples from long COVID patients before elective surgery, as the gut may be a cryptic viral reservoir.

One possible intervention for patients suspected of having a persistent infection may be to administer nirmatrelvir/ritonavir (Paxlovid) as preoperative prophylaxis to help clear infection. There is some evidence that nirmatrelvir/ritonavir may help alleviate long COVID symptoms as well,²⁶ and it is currently being tested as a treatment for long COVID in clinical trials.³²

Another option for surgeons when confronted

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four years ago, the Regents of the American Surgeons defined four evils in surgical practice. unjustified surgery, ghost surgery, fee-splitting, and exorbitant fees. The Regents submitted these definitions to the members of the American Medical Association who gave their approval to them.

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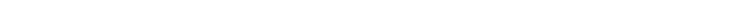
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MAY WE ASK SURGERY A QUESTION?

"The Board consider it to be a patient who has made an agreement of the patient. However, the Board

It is doubtless the blackest sort of heresy to ask questions of the profession of surgery, but so be it. My experience with surgery leads me to ask questions. Nor is this experience here. I have seen three cases of three cousins, each widowed by surgery. There must be many similar cases, and I am lead to wonder whether the profession of surgery, at present, is to save life or promote surgery.

The first death occurred twelve years ago. The patient



These two cases were just the first of two personal examples Climenko used to illustrate the human cost of unjustified surgery and to urgently plead for reform.

The ACS addressed these ethical challenges through massive undertakings, such as

in a way that would protect patients' rights while still allowing for practical surgical training.

Sensationalized articles in newspapers like *The New York Times*, with headlines such as "Patients Unaware Surgeon May Be a Beginner" from 1978, stoked fears and raised questions about the identity of the person wielding the scalpel. These articles oversimplified the issue, causing widespread concern among the public and putting pressure on the medical community to address the problem.

The BoR was divided on how to respond to the public pressure. The BoR fielded questions from constituents, discussed the issue at multiple conferences, and sent a survey out to program directors across the country. While some Board members took a more rigid stance, stating that any involvement of assistants was a violation of the patient's trust and the principle of informed consent, others took a more nuanced stance, arguing that the definition should not be so rigid as to be impractical.

ACS defined fee-splitting as "the refunding of any portion of the total fee for the care of a patient to either the surgeon or the referring physician."

The primary ethical concern with fee-splitting is that it can create financial incentives that prioritize profits over patient care. When physicians receive compensation for referring patients to a specific specialist or facility,

dialogue demonstrates the commitment of both surgeons and the ACS to navigating the complexities of evolving surgical practice while upholding the highest ethical standards. The ACS's responsiveness to these inquiries and its efforts to provide guidance on a case-by-case basis highlight the important role the organization played in shaping the ethical landscape of surgical practice during this period.

This concept is defined as “a fee [that] is excessive when it is greater than the patient is reasonably able to pay

or higher than justified by the service rendered.”

At the time that the ACS was founded, the responsibility to charge fair fees was conceptualized as a responsibility of the surgeon. In fact, the original ACS Fellowship Pledge in 1916 included a direct commitment to “make fees commensurate with the service rendered and with the patient’s rights.” However, the pledge was written at a time when surgeries were procedures that could be done primarily by a single surgeon and financial arrangements could be more directly negotiated between the two parties.

Since then, the scope of surgery changed, so too had the site of practice and the size of the care teams. Because procedures involving the abdomen and chest required better lighting and more involved postoperative care, the primary location of surgeries shifted from homes to hospitals, where teams of nurses and other physicians were involved.

While the BoR said it was content that the majority of fees were reasonable, the Regents also recognized that “scarcely a day passes that I do not hear of one or more outrageous fees.” As an example, it mentioned the case of a patient making \$40 per week



being charged \$1,500 for a cast. Part of the motivation to address the issue was also to help preserve the public's trust in the surgical profession. The issue of exorbitant fees was an issue that received significant public attention, with magazines like *Better Homes & Gardens* publishing articles about how to negotiate fees with your surgeon (see photo, page 40).

The BoR established a committee to investigate the

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THROUGH RESOURCES such as the annual Leadership & Advocacy Summit (see a recap of the 2024 Summit on pages 58–65), SurgeonsVoice Advocacy Center, and ACS Professional Association-SurgeonsPAC, the ACS introduces resident and associate surgeons to the practice of advocacy and various methods with which advocacy can be accomplished.

While comprehensive, advocacy in this context exists within a surgical society. Aside from surgical societies, exposure to advocacy occurs in state medical societies and, more rarely, student interest groups. Some may question whether exposure to advocacy should be more



David A. Eick, MD, FACS

Chief Surgical Officers Are Needed in Hospitals with Complex OR Environments

David A. Eick, MD, FACS, FAHA

THE CARE OF SURGICAL patients constitutes a significant portion of the overall enterprise of healthcare delivery. Data from the Centers for Medicare & Medicaid Services suggest that payments for surgical care represent more than 50% of federal

degree of strategic and operational oversight.

Strong leadership in the OR is necessary not only for efficient care but also to improve patient outcomes. The inherently multidisciplinary care within the OR depends on effective communication for high-quality care; attention to best practices has the potential to improve communication and reduce incidents of potential harm.

The culture within an OR environment has an important impact on patient outcomes as well, and effective leadership has a profound but inestimable impact on maintaining a culture that is appropriately patient-focused.⁴

With this concept in mind, I propose a chief surgical officer position or title within every hospital that has a multifaceted OR environment.

What Are the Responsibilities of a Chief Surgical Officer?

The OR is a limited resource with significant associated costs, and therefore, access (allocated starts) needs to be managed wisely, including setting block allocations and managing flexibility for emergent cases. Polarities arise and must be managed by a leader who listens and carries the respect of the OR community. Ensuring that the structure and processes within the OR support optimal practice and quality of care is clearly an important domain of leadership.

Acute shocks to normal operations will occur; for example, the COVID-19 pandemic had an impact on standard operating procedures specifically concerning issues related to capacity and safety. These situations need thoughtful leadership and clear communication.

Additional responsibilities may be less obvious, but also are within the scope of a chief surgical officer. Plans to grow OR capacity need to

in with the overall strategic plan of a hospital campus. Growth in surgical capacity requires more than implementing adjustments in the OR, as accompanying increased capacity in preoperative/recovery spaces, central sterile processing, waiting areas, staff touchdown areas, and sterile cores also should be considered. The chief surgical officer is integral to representing all these concerns.

Who Is Qualified to Be a Chief Surgical Officer?

It should be noted that a chief surgical officer does not need to be a surgeon. The main requisite for the role is that the individual be a respected leader within the community of physicians and allied health staff who work within the OR. Other important attributes of a chief surgical officer include a passion for improving the function of the OR and a willingness to interface collaboratively with other disciplines to identify and achieve shared goals.

This new title is necessary because no other title fits this purpose. Many hospitals already have leaders in the surgical space—such as the surgeon-in-chief or chief medical officer—who have responsibilities along the lines described in this viewpoint article. However, as noted earlier, a chief surgical officer does not need to be a surgeon. Therefore, the title of surgeon-in-chief may not be appropriate. The title of chief medical officer also does not fit, as the experience/expertise, decision-making, and relationships that a leader needs to exert to be effective as a chief surgical officer are distinct from those of a chief medical officer. Other intra-institutional roles (e.g., chief operations officer) do not specifically pertain to the complex clinical considerations that are inherent to effective surgical care.

The chief surgical officer role also is important

because it is essential to effectively defining and developing leaders who seek to elevate their profiles and have a lasting impact in this important sphere. Resources to support a chief surgical officer do exist, and I list several of them here. The ACS published a handbook—*Optimal Resources for Surgical Quality and Safety*—that focuses on quality with many practical and real-world concepts. The second edition of the textbook *Operating Room Leadership and Perioperative Practice Management* was published in 2019, and this is an excellent resource.⁵

In addition, academic programs focusing on surgical leadership are certainly useful for surgeons who seek to expand their leadership skills. Programs that are formally designed to train chief medical officers abound, but none that are specifically focused on the complex multidisciplinary leadership that is necessary for an effective chief surgical officer.

In each hospital with a busy OR, there currently is a person functioning (formally or informally) as a chief surgical officer, and this person may be struggling to define their role in the OR within a vacuum.

In addition to formally proposing and defending the title of chief surgical officer, the secondary goal of this viewpoint is to highlight the need for organized forums where the skills of a chief surgical officer can grow within a community of other leaders facing similar challenges. The conferences, educational programs, and other venues where surgical leaders convene need to formally include content that focuses on the needs of the chief surgical officer. Our leaders, hospitals, and patients will surely benefit. **B**

Disclaimer

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

Dr. David Etzioni is chair of the Department of Surgery and chief surgical officer at the Mayo Clinic in Phoenix, Arizona.

References

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IT'S IMPORTA

As a result of this success, the Surgical Pause has been implemented at more than 50 medical centers across the VHA and the private sector; this tool also has been adopted as a national practice by the VHA's National Surgery Office and by a growing number of private sector institutions.

The US Department of Veterans Affairs (VA) also developed a national CPRS (computerized patient record system) template to facilitate frailty assessment with the RAI.²

Surgical teams can implement the Surgical Pause by dedicating 5–10 hours a week for the first 3 months to establish the program. Afterward, only a few hours a week are required to review frail cases and generate

The History of Breast Reconstruction Is a Journey of Resilience

Sami M. A.,
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S. sa P. i s, , A



WILLIAM S. HALSTED, MD, FACS,
performed the first radical

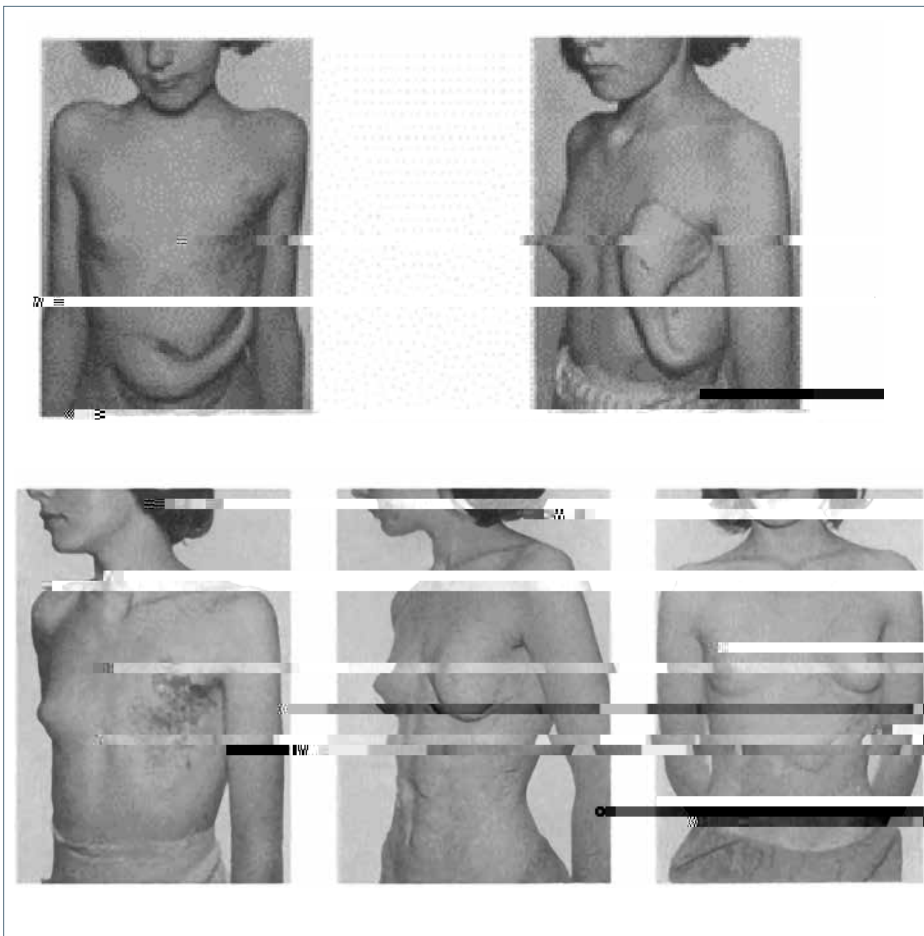
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FACS, from Atlanta, Georgia, made a quantum leap in autologous breast reconstruction with the development of the transverse rectus abdominis myocutaneous (TRAM) flap.³ Other local and regional flaps for breast reconstruction such as

the latissimus myocutaneous flap were popularized and refined during this period. Further advancements in microvascular surgery allowed the development of the free TRAM flap, which involves harvesting less muscle. Muscle-sparing methods were

further explored to reduce patient morbidity, leading to the creation of the deep inferior epigastric flap in 1989, by Isao Koshima, MD, and Shugo Soeda, MD, from the University of Tsukuba in Japan.⁴

Alongside the autologous tissue breast reconstruction development, others pioneered implant-based reconstruction. In the 1950s, surgeons initially tried injecting liquid silicone into breasts, which led to significant



since the 1960s. Modern approaches such as skin and nipple-sparing mastectomies, when oncologically sound, preserve the natural appearance of the breast, areola, and nipple skin, which are difficult to reconstruct. Oncoplastic breast reductions have improved the shape of some lumpectomy defects. Fat grafting has grown in popularity to correct smaller deformities and asymmetries and allowed for refinement of breast reconstruction results.

It is important to emphasize that breast reconstruction goes well beyond physical restoration and plays a pivotal role in the psychological and emotional well-being of many women who undergo surgery for breast cancer. The BREAST-Q was developed by plastic surgeon Andrea Pusic, MD, FACS, as a way of analyzing patient-reported outcomes (PRO) after breast surgery.⁵

BREAST-Q measures PROs quantitatively and qualitatively with validated questionnaires that address quality of life domains and satisfaction after surgery. Studies using the BREAST-Q have demonstrated that reconstruction helps improve patients' quality of life and physical functioning, satisfaction with their appearance, psychosocial, and sexual outcomes.

Unfortunately, not all women have access to breast

Observations from Breast

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Leadership & Advocacy Summit Unites Surgeons, Inspires Change

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Dr. Sunil Geevarghese shares a strong message about moral injury within the surgical profession.

Surgeons from the state of Texas discuss their plans for the in-person visits on Capitol Hill.

THIS POWERFUL EVENT, held at The Westin Washington, DC Downtown Hotel, April 13–16, underscored the vital intersection of leadership and advocacy in shaping the future of surgical practice. “The 2024 Leadership & Advocacy Summit was another example of the leadership strength in the ACS,” said Michael J. Sutherland, MD, MBA, FACS, Director of the ACS

Division of Member Services. “We brought together a slate of amazing individuals who all share one common trait: they are all Fellows of the American College of Surgeons. These formidable surgeons shared insights and expertise from their personal journeys to help us all become better leaders.” Also worth noting, this year, leadership presentations were interspersed with advocacy

topics to help provide the important throughline between learning about leadership to taking action for the profession and surgical patients.

How Do You Control the Risk?

Just before the official start of the leadership portion of the summit, three special preconference seminars were offered, including “Controlling Risk:

The Techniques of Operating Excellence,” presented by Jim Wetherbee, a retired US Navy officer and aviator, aerospace engineer, and astronaut. A veteran of six Space Shuttle missions, the only American astronaut to command five missions in space, and the only person to land the Space Shuttle five times, he holds more than 3 decades of experience in high-hazard operational environments.

Wetherbee shared with a sold-out audience his thoughts on effective leadership

- Following procedures (and rules) thoughtfully
- Identifying trigger steps
- Being assertive (to authority) when necessary
- Balancing confidence with humility

Additional techniques are examined at length in Wetherbee’s book: *Controlling Risk: Thirty Techniques for Operating Excellence*.

Mitigating Moral Injury

The Leadership Summit officially kicked off on Sunday morning, with compelling messages from Sunil K. Geevarghese, MD, MSCI, FACS, from Vanderbilt University Medical Center in Nashville, Tennessee.

In the session, “Moving Forward after Moral Injury: A Leader’s Perspective,” Dr. Geevarghese explored the dynamics of moral injury that surgeons may experience as a result of major surgical complications and the potential progression to second victim syndrome and burnout. He stressed that moral injury, second victim syndrome, and burnout are not “synonyms,” adding that moral injury happens much earlier.

“Moral injury is going to happen as we operate and care for patients. But second victim syndrome and burnout don’t have to,” Dr. Geevarghese said.

The term “moral injury” was first used to describe soldiers’ responses to their actions in war. It represents “perpetrating,



failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations,” according to Dr. Geevarghese. In the context of healthcare, moral injury is being unable to provide high-quality care and healing.

Sustainability in Healthcare

In the session, “Sustainability in Healthcare: Where We Are



with the people who are actually doing the work,” he said.

The ability and willingness to take risks is another quality that surgeons bring to the senior executive offices. Dr. O’Malley explained that surgeons are reputable risk-takers. “We put a knife to patients, and every patient is a life-or-death risk, no matter what you’re doing. As a leader and CEO, taking risks is a big part of what you have to do if you want to change the culture or build the future.”

It can be lonely at the top, though, Dr. Higgins shared. He explained that a coach (he has two of them) can help examine and enhance leadership skills, identify short- and long-term goals, improve communication, foster strategic thinking, and perhaps most importantly, provide psychological safety (see article on page 22).

“A coach will give you the feedback you need to be better as a leader. I recommend that anyone who I hire at the senior management level have a coach.”



Dr. Don Selzer reminds the audience to be patient with “the long game of Congress.”



Terry Wilcox, from Patients

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detailed the “asks” and provided background information in preparation for the visits to the Congressional offices. The attendees broke into groups by state and discussed how to:

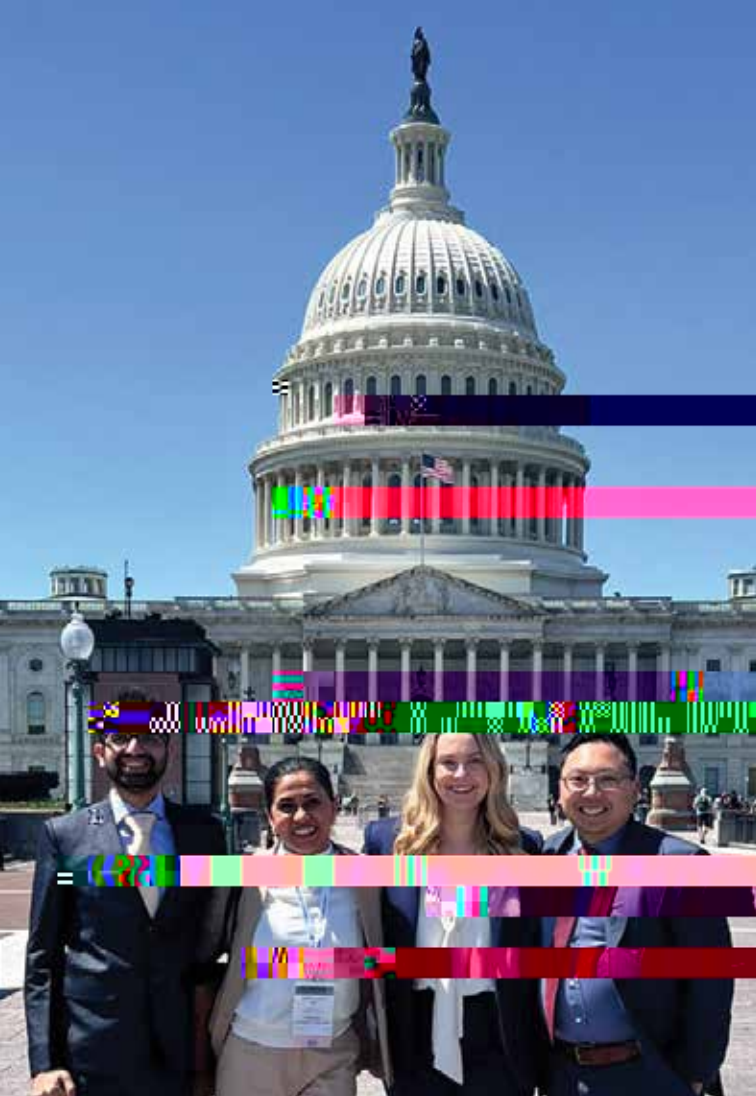
- Stabilize the Medicare physician payment system (Strengthen in



#ACSLAS24 Hill Visits

On Hill Day, 215 Advocacy Summit attendees representing 39 states participated in 212 meetings.





Thank You National Doctors' Day Contributors



Nicole Baril, MD, FACS, *in honor of*
Sherry Wren, MD, FACS

Jeremy Cannon, MD, SM, FACS, *in honor of*
Chip Baker, MD

Jeannette Capella, MD, FACS, *in honor of*
Stephen ReMine, MD, FACS

Alice Dachowski, MD, FACS, *in honor of*
Jessie Thernberg, MD, FACS, and Josef Fischer,
MD, FACS

Robert Fanelli, MD, MHA, FASGE, FACS, *in honor*
of Richard E. Dean, MD, FACS

Ryan Fields, MD, FACS, *in honor of*
Timothy Eberlein, MD, FACS

Arun Gosain, MD, FACS, *in honor of*
Joseph G. McCarthy, MD

Danielle Katz, MD, FACS, *in honor of*
Thomas Russell, MD, FACS

Stanley Konefal, MD, FACS

Evaluating Outcomes of Non-Accidental Trauma in Military Children

Joseph A. Twrdh, D. Florence, D. Douglas

Military-associated children diagnosed with non-accidental trauma were younger and experienced a higher mortality rate, longer length of hospital stay, and more complications than civilians. This paper identified a high-risk, vulnerable population in need of additional support and research.

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Member News



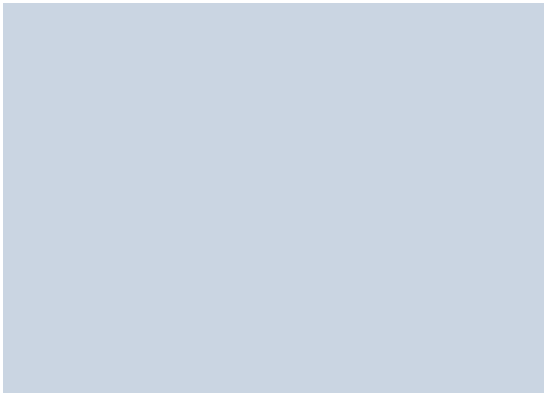
D. T. Gilliland

Terry Gilliland, MD, FACS, a general surgeon in Steamboat, Colorado, has been named president of Geisinger Health in Danville, Pennsylvania. He also will assume the role of chief executive officer (CEO) at Geisinger once the current CEO transitions to a new position. Previously, Dr. Gilliland was chief medical officer at the artificial intelligence precision health company Cogitativo in Berkeley, California.



D. Russell Woo

Pediatric surgeon Russell K. Woo, MD, FACS, is the first associate dean for clinical programs at Hawaii Pacific Health (HPH) and chief academic officer for the HPH Medical Group, both in Honolulu. Before these new roles, Dr. Woo was a professor and associate chair for research in the Department of Surgery at the University of Hawaii John A. Burns School of Medicine (JABSOM) in Honolulu. He also served as the JABSOM Department of Surgery's director of surgical education at the Kapi'olani Medical Center for Women and Children in Honolulu. Dr. Woo is a Governor-at-Large on the ACS Board of Governors and holds other ACS roles.





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D. Ria Hass

Rian M. Hasson, MD, MPH, FACS, has taken on a first-of-its-kind role in the Department of Surgery at Brigham Women's Hospital in Boston, Massachusetts—vice chair for diversity, equity, and inclusion. A cardiothoracic surgeon, she also will serve as an associate surgeon in the Division of Thoracic Surgery. Before joining the Brigham, Dr. Hasson was an assistant professor of surgery at the Dartmouth-Hitchcock Medical Center and the Dartmouth Institute for Health Policy and Clinical Practice, both in Lebanon, New Hampshire, and at the Geisel School of Medicine at Dartmouth in Hanover, New Hampshire. She also was the director of the Lung Cancer Screening Program and the founding co-director of the Lung Health and Pulmonary Nodule Clinic at the Dartmouth-Hitchcock Medical Center.



Sharmila Dissanaik, MD, FACS, FCCM, will take over as chair of the Department of Surgery at The University of New Mexico School of Medicine in Albuquerque. She will assume the new role in August. Dr. Dissanaik currently is the Peter C. Canizaro Chair and University Distinguished Professor at Texas Tech University Health Sciences Center in Lubbock. For the ACS, she is a member of the Board of Governors Physician Comoun-23y)2f (. F)12 4@ic3o-1.26d0(H)29e)-W(6c)-13(e A

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