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Santry H, Pringle PL, Emhoff TA, Velmahos GC, Britt LD, Hargraves L, Kiefe CI. (2012). Acute Care Surgery Patterns in the Current Era: Results of a Qualitative Study. UMass Center for Clinical and Translational Science Research Retreat. Retrieved from https://escholarship.umassmed.edu/cts_retreat/2012/posters/56

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ACUTE CARE SURGERY PATTERNS IN THE CURRENT ERA: RESULTS OF A QUALITATIVE STUDY

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Introduction: Since Acute Care Surgery (ACS) was first conceptualized as a specialty a decade ago, ACS teams have been widely adopted. Little is known about the structure and function of these teams.

Methods: We conducted 18 open-ended interviews with ACS leaders (1 interview/center representing geographic [New England, Northeast, Mid-Atlantic, South, West, Midwest] and practice [Public/Charity, Community, University] variations). Two independent reviewers analyzed transcribed interviews using an inductive approach to determine major themes in practice variation (NVivo qualitative analysis software).

Results: All respondents described ACS as a specialty treating "time sensitive surgical disease" including trauma, emergency general surgery (EGS), and surgical critical care (SCC). 11/18 combined trauma and EGS into a single clinical team; 6/18 included elective general surgery. Emergency orthopedics, neurosurgery, and triage for all surgical services were rare (1/18 each). 11/18 had blocked OR time. All had a core group of trauma and SCC surgeons; 8/18 shared EGS due to volume, manpower, or competition for EGS call. Many (12/18) had formal morning signout rounds; few (2/18) had prospective EGS data registries. Streamlined access to EGS, evidence-based EGS protocols, and improved communication were considered strengths of ACS. ACS was described as the "last great surgical service" reinvigorated to provide "timely," cost-effective EGS by experts in "resuscitation and critical care" and to attract "young, talented, eager surgeons" to trauma and SCC; however, there was concern that it might become the "waste basket for everything that happens at inconvenient times."

Conclusion: Despite rapid adoption of ACS, its implementation varies widely. Standardization of scope of practice, continuity of care, and registry development may improve EGS outcomes and allow the specialty to thrive.