

commitment is more likely to result in the sort of familiarity with staff and referring physicians that leads to a more normal practice of surgery and larger caseload. A second issue deals with credentialing by the locum tenens agencies and is an area where the surgeon needs to be careful and persistent. Ultimately the client hospital credentials the locum tenens surgeon for work at its facility. However, some of the companies do their own credentialing (beyond their risk-management strategies), which, in the case of one company I have dealt with, was poorly done and without any input whatsoever by any surgeon. The initial result was that this company would “credential” me to deal with a patient’s splenic injury because that was what general surgeons do, but it would not “credential” me to repair the same patient’s facial laceration because I was not a plastic surgeon! But we finally got that absurdity resolved.

Locum tenens physicians I have met have all been sincere in providing excellent patient care under sometimes difficult circumstances. Developing oversight of the locum tenens industry would be helpful.

**Fred V. Schneider MD, FACS
Billings, MT**

Teaching medical students

The article “Teaching surgery to medical students: Perspectives from our mentees” (July 2008, pages 48–53) provides surgeons with important insights that should be considered a challenge. I suspect many of us had similar thoughts years ago when we were in the same position—when we were expected to do as we were told. I have several observations that may be useful for students and others.

When I was trying to decide on a specialty, it seemed to me that people who enjoy working with their hands should enter a surgical field (or a procedurally oriented

medical field). Medical students put off by the demands of a surgical career may not realize that performing surgery is usually fun and rewarding. Simply “confessing” that pleasure, while mentioning that people who dislike working with their hands should enter a medical specialty, may inspire undecided students to look again at surgery.

As an ethicist, I understand Jun Matsui’s moral distress at inflicting unnecessary pain and participating in a system that makes students part of the problem when surgery does not live up to its ideals. Unfortunately, medical ethics rarely deals with organizational issues, especially involving power structures, instead focusing on broader problems such as organ transplantation and end-of-life issues. I would hope that the ACS can address Ms. Matsui’s very appropriate concerns.

**Muriel R. Friedman, MD, FACS
Missoula, MT**

Laparoscopy in third-world countries

It is all very well for Dr. Ross Segan to make a name for himself in being the first to introduce laparoscopic surgery to Afghanistan (“The best and worst week

of my life: A surgeon at war.” *Bull Am Coll Surg.* 2008;93(4):15–21). We all know the advantages of this procedure, but it does need much skill and training and involves expensive equipment. In the 1980s, before laparoscopic cholecystectomy became routine, I used the small-incision open approach to cholecystectomy. A 2” transverse subcostal incision was used (though one registrar used only a 1” incision!).

The advantages are similar to the laparoscopic approach—when an intercostal block is performed at the end of the operation, powerful analgesics are rarely required and the patient is usually able to go home the next day. The time taken is much shorter and, in the event of anatomical, pathological, or surgical difficulties, it is simple to enlarge the wound without so much “loss of face.”

It might be simpler and safer to train local surgeons in third-world countries to use the small-incision open approach to abdominal surgery than risk the complications that bedeviled the laparoscopic operation in its early days.

**K. Bridson Orr, FACS, FRACS,
FRCS
Blakehurst, NSW, Australia**

Trauma meetings calendar

The following continuing medical education courses in trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

- **Advances in Trauma**, December 12–13, Kansas City, MO.
- **Trauma, Critical Care, & Acute Care Surgery–2009**, April 6–8, 2009, Las Vegas, NV.
- **Trauma, Critical Care,**

& Acute Care Surgery 2009–Point/Counterpoint XXVIII, June 8–10, 2009, Atlantic City, NJ.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at <http://www.facs.org/trauma/cme/traumtgs.html>, or contact the Trauma Office at 312/202-5342.