



The following comments were received regarding recent articles published in the *Bulletin*.

Letters should be sent with the writer's name, address, e-mail address, and daytime telephone number via e-mail to [sregnier@facs.org](mailto:sregnier@facs.org), or via mail to Stephen Regnier, Editor, *Bulletin*, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.

### **Why supporting UEVHPA is key**

"10 questions and answers about disasters and disaster response" in the March 2010 issue of the *Bulletin* (*Bull Am Coll Surg.* 2010;95(3):6-13) is an excellent overview of what goes into responding to a disaster. The amount of assistance by Americans to the victims of the earthquake in Haiti demonstrates the continued willingness of our country to help those in need. Multiple agencies, including the American College of Surgeons, went from zero to 100 to mobilize relief efforts, in almost unprecedented time frames. The biggest obstacles to this relief effort were not related to the rescuers, but instead to the infrastructure and geography of Haiti itself, as pointed out in the article.

This is in stark contrast to relief efforts for the victims of 9/11 and Hurricane Katrina. In those instances, many relief efforts were shut down as soon as they were conceived, because of licensing and liability issues related to crossing state lines. Physician licensing is a state-by-state decision, with no reciprocity. Many physician rescuers who attempted to help at these homeland tragedies were simply turned away or given jobs that did not take advantage of their skills. It is unacceptable that a surgeon can help out in a neighboring country more easily than he can in a neighboring state. Although this article

was very informative, it did not mention that several states, with the help of the College, are trying to pass the Uniformed Emergency Volunteer Health Practitioner's Act (UEVHPA). This act will allow the creation of a single database to contact health care practitioners (it is not limited to physicians) during a disaster. Signing on to this database is voluntary, and will allow a physician's license and liability insurance to cover him while he helps those affected by the emergency. Because it involves state medical licenses, each state must pass its own version of the act. To date, only 11 states have passed such legislation. Many states considering this legislation are doing so at the direct request of ACS Fellows and Chapters. In Connecticut, we are working closely with our legislators to pass this important act, and several of us have already testified before our state congress. This can only be accomplished with support from politicians and the physician community. Please contact your legislator and support the UEVHPA in your state.

**Philip R. Corvo MD, FACS,  
Stamford, CT  
Past-President, CT Chapter  
of the American College of  
Surgeons**

### **National rural health service**

I certainly agree with "Rural surgeons—We must grow our own" and "Rural surgeons—We must grow our own: A response" published in the April issue of the *Bulletin* (*Bull Am Coll Surg.* 2010;95(4):16-18,19). Mentoring, as well as early and continued exposure [to practicing medicine in rural environments] are important fertilizers to help "grow our own" rural surgeons. However, there is more to solving this shortage, especially as medical students and residents continue to be attracted to surgical subspecialties in increasing numbers. This likely has less to do with

the hope of financial gain than it does the search for a better lifestyle for themselves and their families.

I have practiced full time in academics, in a small private urban partnership, in the Veterans Affairs, a county teaching hospital, and, finally, solo in a 25-bed critical access rural mountain hospital in Northern California during my final four years in practice. Our little hospital needed better coverage and offered an income guarantee to help attract a surgeon.

There may be another, more direct, way to solve the problem of inadequate rural surgery coverage: aside from encouraging rural surgery rotations, we, as a profession, should foster the notion that rural health care can be stimulated through a system of national service—a national rural health service—for young, fully trained physicians and surgeons. It will become readily apparent to many of these young general surgeons that rural America offers a perfect setting and lifestyle to raise a family, and for a successful practice. And many surgeons may find that they will stay in that setting when their period of service is complete. Further, they will discover that modern rural surgery is far more sophisticated and connected than they ever imagined.

My four years practicing rural surgery were, arguably, my happiest years in practice.

**Lawrence A. Danto, MD, FACS  
Northstar-Truckee, CA**

### **Difficult patients**

My first reaction to the May 2010 issue of the *Bulletin*, which featured four articles on the theme of "Dealing with difficult patients" (*Bull Am Coll Surg.* 2010;95(5):10-23), is that, as stated in the American College of Surgeons' Fellowship pledge, the words "dealing with" should be changed to "caring for." This wording gives the concept a different perspective, and foregoes

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blaming the patient. It is often the so-called “difficult patient” who survives, when the submissive and suffering good patient dies of natural causes or medical errors, because these difficult patients tend to have a fighting spirit.

Also, as I have learned, the best doctors are often criticized by patients, nurses, and family and learn from their mistakes, rather than make excuses and blame the patient. I always remember the patient who told me, when I was discharging him, that I was not getting a gift while all his other doctors were. When I asked why, he said, “Because you are always angry.” I said I was sorry, but I didn’t like what had happened to him or what I had to do to him. “Yeah, but you took it out on me.” Again, I said I was sorry, and he said, “Okay, I’ll give you a gift.” He didn’t need to tell me anything, or ever see me again, but he knew I was hurting and helped me become a better doctor.

The opposite of love is indifference, and, worse, rejection and abuse. The difficult patient is often seeking attention because they have never received it in a healthy and loving way from the authority figures in their life. Give them the love they need, and they will not be difficult, because you have let them know that you value them. I have watched difficult, self-destructive patients change over the months when I kept giving them return appointments, despite their behavior. They then realized somebody cared about them, and began to value themselves.

Humor can also break through the aura surrounding the difficult patient. When a frightened patient who didn’t want to enter the operating room met the staff and said, “Thank God all these wonderful people will be taking care of me.” I responded, “I’ve worked with them for years. They are not wonderful people.” Everyone laughed, and we became family.

I touch and hug my patients and ask them for a hug when I am hurting. We heal each other. I also tell them I prefer that they be responsible participants, and not patients, or submissive sufferers.

Yes, life is difficult, but if you truly care for patients, there is no need or reason for them to be difficult. So, learn from your mistakes and your difficult patients rather than blaming them, and your practice will improve and your malpractice suits will likely decrease, too.

**Bernie Siegel, MD, FACS  
Woodbridge, CT**

I say find another physician. I fire these patients as fast as I can. Life is too short to deal with these people. I enjoy my practice and don’t need the hassle of trying to appease these troublemakers. Let someone else play “Marcus Welby.” I don’t need them screaming at my front office staff, or threatening to call the newspaper, or complaining about parking, or why their insurance is not covering their bills, or why my chairs are so hard/soft, or how I should change my practice to fit their schedule, or why I don’t allow cell phones in the exam room, and on and on and on.

**William J. Somers, MD, FACS  
Columbus, OH**

### ***Knowledge of anatomy key for residents***

Dear Dr. Hoyt,

After reading your column in the May issue of the *Bulletin (Bull Am Coll Surg.* 2010;95(5):4-6), I am reminded of the occasion when I first met Robert (Bob) E. Hermann, MD, FACS. We were both residents in Cleveland in different programs, but we both attended the gross anatomy classes at Case Western Reserve University School of Medicine that were given especially for residents in surgery programs in Cleveland. This was an important opportunity to revisit the anatomy lab at a time in our training when

we could better appreciate the need for intimate knowledge of human anatomy.

In the years since I retired from a 40-year career in surgery at the Kaiser Permanente Medical Center in Panorama City, CA, I have volunteered in the gross anatomy lab at UCLA Medical School, helping first-year students in their introduction to the dissection of the human body. The amount of time now devoted to anatomy has significantly diminished during these years, and is of a different order of magnitude from when you and I were in medical school. UCLA Medical School offers more instruction, however, than what is offered at some schools where students do not go to the lab or even have a course in anatomy.

It has become apparent that some residents embarking on training programs in the various surgical fields have a weak understanding of anatomy, which probably is due to inadequate teaching of anatomy during their medical school years. To address this, the anatomy department at UCLA is now providing additional classes in anatomy throughout the four years of medical school, and additional opportunities to surgery residents at the Medical Center.

When you write about the importance of the Association of Program Directors in Surgery, which provides a forum to ensure that “surgery residents acquire the skills and knowledge they will need,” I think that it is paramount to address the possibility that some of the residents may be deficient in knowledge of anatomy, which could significantly impair their skills in their training. Identifying these individuals is important, but an even greater initiative would be to give all residents a chance to revisit the anatomy lab.

**Richard A. Braun, MD, FACS  
Encino, CA**