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The 89th annual Clinical Congress took place October 19-23 in the College's hometown of Chicago, IL, and I believe it was one of the most successful meetings we have had in the recent past. I make this statement based on the excitement and positivity many Fellows have expressed with respect to many of the ideas and initiatives emanating from the American College of Surgeons. Our profession is under siege on many fronts, but through constructive attention to and dialogue about the issues, we are responding in a way that will make surgery stronger and more attractive to future generations. All in all, the attendees expressed verbally, as well as in letters to us, that the meeting was extremely well done and was greatly appreciated.

The favorable interest in the meeting also can be measured in part by its attendance statistics. This year, we surpassed the number of health care professionals who attended the 2002 Congress in San Francisco, CA, and the last meeting that took place in Chicago. More than 10,000 physicians and health care professionals participated, along with an increased number of exhibitors. Despite some difficulties with visas, a good number of international Fellows from a multitude of countries were present at the meeting. Additionally, this year, we opened the Congress to medical students, and more than 450 attended. A large cadre of surgical residents from the various disciplines also participated.

**Great beginnings**

We incorporated many tangible differences into this year’s meeting. For example, the Convocation ceremonies took place on Sunday night, and more Initiates were present than has been the case in years past. Also, many more of the Governors participated in the event, which welcomes these young surgeons into our fold.

During the Convocation, the incoming President, Claude H. Organ, Jr., MD, FACS, from Oakland, CA, gave an inspiring talk to the Initiates and announced that his year as President of the American College of Surgeons would be characterized as being the “year of the resident.” (An article that is drawn from the text of his address appears on page 8.) I think this attitude typifies the significant value that the College’s leadership places on young people and residents. We want to create an atmosphere, as well as educational and research opportunities, for these young physicians that excites them and stimulates their interest in the very positive aspects of our profession.

As part of the Convocation, five Honorary Fellows were inducted into the American College of Surgeons, and each brought extremely unique accomplishments to our rank of Honorary Fellows. For instance, E. Catherine Hamlin, MB, BS, DRCOG, made the long journey from Ethiopia, Africa, and received a standing ovation from the audience for her outstanding dedication to treating patients in her adopted country who suffer from vesicovaginal fistulae due to complications during childbirth (see story, p. 29). The entire ceremony was moving and, I believe, meaningful for the new Initiates. Following their initiation, the new Fellows were welcomed by the College’s leadership at a large reception in their honor.

The atmosphere at this year’s Clinical Congress was palpably different than what it has been in the past.
ciation Lecture entitled “Improving American Health Care for the 21st Century.” He outlined the system’s current limitations and efforts to make it more functional. We were most pleased that he could join us this year to offer his vision for the future.

**Unique sessions**

Throughout the meeting, a number of unique sessions were presented. This year, we had a symposium on volunteerism, which, for the first time, actually acknowledged the work of surgeons who give their time in the organized provision of charitable care in the U.S. and abroad.

There was also healthy dialogue throughout the meeting about socioeconomic issues affecting health care. For example, during one session, panelists considered how surgeons can become more effective lobbyists in Washington and how we might create a political climate that will help to correct the professional liability crisis. Interesting talks also were given on choosing a surgical specialty and the various options available to young people, as well as pursuing a career in health policy in order to perhaps help formulate an improved health care system in the future.

The whole area of patient safety and quality improvement was a central focus during various gatherings and symposia. The College intends to make significant contributions to the quality movement by hopefully establishing a center that will address this matter and disseminate information about best practices and evidence-based medicine, so that surgeons may learn from others’ experiences.

The 80-hour workweek for residents was discussed with great enthusiasm, allowing attendees to think about the ways in which we may adequately train surgeons while abiding by the new time constraints. Interesting talks on risk management and professional liability also were presented. Finally, Ben Eiseman, MD, FACS, assembled a knowledgeable group of military physicians from the U.S. and a surgeon from Iraq to talk about the medical response to the conflict in that country.

**Change for the better**

The atmosphere at this year’s Clinical Congress was palpably different than what it has been in the past. We have a wonderful profession, and we are working on the issues that have caused problems in the past. We are trying to create a better environment for surgeons in the present and future.

Many complex issues are before us, which involve not only the health care delivery system, but the training and continued competency of the surgical workforce as well. The College is committed to addressing these concerns. By working with all of you, we will be able to forge a better way of providing surgical care to our patients in the foreseeable future. Your continued help, support, ideas, and suggestions will ensure the College’s viability now and in the years to come.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
The Division of Education of the American College of Surgeons has two sessions currently available online at:

www.facs-ed.org/

Spring Meeting 2003

GS02: A Town Meeting: Changes in Surgical Practice—Getting Ahead of the Game

GS05: New Technology: What’s Proven, What’s Not

GS06: Recognition, Management, and Prevention of Operating Room Catastrophes

GS08: Acquiring Skills to Perform New Procedures: Principles, Challenges, and Opportunities

GS13: Key Issues in Management of Rectal Cancer

GS16: Sentinel Lymph Node Biopsy for Breast Cancer

GS18: Controversies in Inguinal Hernia Surgery

GS21: Patient Safety

GS29: Management of Necrotizing Pancreatitis

GS36: Unexpected Findings of Laparoscopic Cholecystectomy

GS37: American College of Surgeons and the Core Competencies: Innovative Approaches for a New Era

GS47: Operative Techniques for Bad Situations

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Clinical Congress 2002

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Physicians avert 4.5 percent Medicare payment cut

In one of its last acts before adjourning for the winter recess, Congress succeeded in passing H.R. 1, the Prescription Drug and Medicare Modernization Act. In addition to creating a long-sought-after Medicare prescription drug benefit, the legislation reversed the pending 4.5 percent cut in 2004 physician payments, ensuring that fee schedule reimbursements will increase by at least 1.5 percent in both 2004 and 2005. The College lobbied aggressively to avert the payment reduction, which was announced on November 7 by the Centers for Medicare & Medicaid Services (CMS). Due to flaws in the underlying payment formula, CMS attributed the planned reduction to increased volume and intensity of physicians’ services and a lower real gross domestic product (GDP) per capita than previously estimated.

Although H.R. 1 will not correct the formula, it will prevent steep annual fluctuations in payments by permitting CMS to calculate GDP based on a 10-year rolling average. Other changes include a temporary increase in the work component of the geographic price cost index for rural areas, bonuses in areas with physician shortages, and a study of the practice expense component.

In addition to averting the Medicare physician payment cut, the legislation provides important regulatory relief, establishes sensible standards for electronic prescribing, and blocks proposed changes in coding standards. Details follow.

- **Regulatory relief.** To ease the increasing regulatory burden that CMS has imposed on physicians, the bill offers modest reform of audit practices by guaranteeing physicians specific due process rights, including an equitable right of appeal. Specifically, the legislation will better target current Medicare education dollars to provide needed outreach and education to physicians and health care providers on the complexities of Medicare billing. The bill will guarantee regulatory reform in the following areas: extrapolation, consent settlement, evaluation and management service documentation guidelines, Emergency Medical Treatment and Active Labor Act mandates, written advice from contractors, and advance beneficiary notices.

- **Electronic prescribing.** To reduce medical errors, the bill directs the Secretary of Health and Human Services (HHS) to develop and adopt standards for transactions and data elements to enable the electronic transmission of medical information, including prescriptions. On the grounds that this mandate would create unrealistic technological and financial burdens for many surgeons, the College opposed an earlier version of this provision, which would have required that all prescriptions be written and transmitted electronically except in emergencies. The College supports this compromise because it sets a reasonable timetable for HHS to establish sensible standards for physicians who voluntarily use electronic prescribing systems. H.R. 1 also includes grants and incentives to encourage e-prescribing.

- **Coding standards.** The College also successfully lobbied to exclude language that could have replaced the Current Procedural Terminology (CPT) codes used in the Medicare fee schedule with ICD-10 codes. The House version cleared the way for HHS Secretary Tommy Thompson to adopt ICD-10-PCS (a procedure coding system) and ICD-10-CM (a
diagnosis coding system) as a standard within one year of the date of enactment of the bill. Based on the College's strenuous objections and action by the National Committee on Vital Health Statistics, the language was removed.

To find out how your senators and representatives voted on H.R.1, log on to the College's Legislative Action Center at http://capwiz.com/facs/issues/votes/.

The U.S. physician population increased 26 percent between 1991 and 2001, or twice the rate of total population growth during the period, according to a report released by the General Accounting Office this month. The average number of physicians per 100,000 people increased from 214 to 239, while the mix of generalists and specialists (defined as anyone who is not an internist, family practitioner, or pediatrician) remained about one-third general practitioners and two-thirds specialists. The survey does not differentiate between surgical and medical specialties. The survey also indicates that the number of physicians per 100,000 people in nonmetropolitan areas increased 23 percent from 1991 to 2001, while the number of physicians in metropolitan areas increased 10 percent. The report may be found at http://www.gao.gov.

The College is asking Fellows to provide their input regarding the effects of socioeconomic issues on their practices and on patient access to surgical care. This information will assist the organization in telling Congress, state legislators, and regulators about how those factors, coupled with the aging population, are beginning to affect patient access to high-quality care. To provide the College with your views, please take 10 minutes to complete the questionnaire, which can be completed by going to www.facs.org and selecting the “Help Us, Help You” survey.

In honor of National Breast Cancer Awareness Month this past October, many members of Congress highlighted legislation related to breast cancer prevention, research, and treatment. Sen. Olympia Snowe (R-ME) and Sen. Mary Landrieu (D-LA) introduced similar bills, S. 1730 and S. 1684 respectively, requiring health plans to provide coverage for a minimum hospital stay for mastectomies, lumpectomies, and lymph node dissection for the treatment of breast cancer. Rep. Nita Lowey (D-NY) spoke out about the need to research the relationship between breast cancer and the environment. Earlier this spring, Representative Lowey introduced bipartisan legislation, H.R. 1746 and S. 983, with Sen. Lincoln Chafee (R-RI), to increase funding for research on environmental factors related to the etiology of breast cancer, which is conducted by the National Institute of Environmental Health Sciences.

In addition, numerous members of Congress addressed the need to reauthorize and fully fund the National Breast and Cervical Cancer Early Detection Program. This program provides reduced-cost mammograms and follow-up care to thousands of low-income women. The College is actively engaged in federal cancer issues and will continue to work with the broader cancer advocacy community to promote scientifically sound policies to prevent and treat cancer.
PRESIDENTIAL ADDRESS

YOU CAN MAKE A DIFFERENCE

by Claude H. Organ, Jr., MD, FACS, Oakland, CA
Editor’s note: Dr. Organ presented this Presidential Address on October 19 at the Convocation in Chicago, IL.

Fellows of the American College of Surgeons, Regents, Officers, Honorary Fellows, and other interested readers, permit me first to express appreciation to Dr. Sabo for his year as President of the College. Although he assumed this position on short notice, the transition was smooth, and the succession of leadership was uninterrupted, as he performed his presidential responsibilities effectively, admirably, and with dignity. Richard and Melanie Sabo have been true ambassadors for the College, and we thank them. Join me also in expressing appreciation to the many spouses, parents, teachers, and friends for their support of our new Fellows during their long formative years.

I am honored to join the long line of distinguished leaders who preceded me in this position. When I surveyed the highly talented and distinguished men and women in the audience the night of Convocation, I was reminded that when President Kennedy was host to an impressive array of Nobel Prize winners in the White House dining room, he looked at the audience and said, “I think this is the most extraordinary collection of talent, of human knowledge, that has ever been gathered together at the White House, with the possible exception of when Thomas Jefferson dined alone.”

Few of us recall the names of the speaker(s) at our previous graduations or what they might have said. Except for brevity, perhaps this address is no different. In one-and-a-half pages, Ernest Miles described the abdominal-perineal resection for which he was awarded knighthood. Professor Henri Hartman’s description of his pouch consisted of only 12 sentences. And Lincoln’s Gettysburg address of 271 words was brilliantly brief and historically enduring.

Integrity above all else

I am an educational and cultural descendant of Charles Richard Drew, MD. Though his professional life was cut short at the age of 49, he was and continues to be an inspiration for me. As a visionary, educator, surgeon, researcher, and founder of the modern blood banking system, Drew deservedly is the father of African-American surgeons. He believed that excellence of performance would overcome the social and legal restraints then imposed by society. Drew possessed those noble Roman virtues of dignitas, honestas, gravitas, and simplicitas. To our new Fellows, I encourage you to embrace the highest ideals of our profession and avoid the traps of mediocrity and greed.

The world has become smaller, and distant countries are now our neighbors. Improved methods of communication and transportation have brought us closer together. Education, research, and improved patient care are the common bonds that unite us across these boundaries. You represent a rainbow of cultural, ethnic, educational, and geographic diversity, uniquely equipped to assume positions of leadership in the twenty-first century. Patients will be the beneficiaries of your skills and knowledge. Surgery is not a spectator sport, and your involvement in College activities is needed. You can make a difference.

Over dinner recently, a close surgical colleague shared with me that effective July 1, he would no longer receive or treat Medicaid and Medicare patients. Although we have heard these sentiments from our colleagues before, his pronouncement had a ring of disturbing finality. The reimbursement and paper hassle justifications were not new information. Obviously, one cannot financially sustain a practice with a disproportionate number of pro bono patients. However, I trust that the new Fellows will remember where they came from and from whom and on whom they learned the discipline of surgery.

While the serious issue of underfunded health care is being slowly resolved, surgeons must determine their fair share of responsibility for treating the “walking wounded.” The admonition of Hippocrates is as clear today as ever: “Sometimes give your services for nothing and if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such, for where there is love of man, there is also love of the art.”

What’s next?

Now that the new Fellows have been welcomed into this organization, they might wonder, is there more? They undoubtedly will continue to develop their practices and enjoy the spoils of their profes-
sional efforts, which include becoming a specialist on nights, holidays, and weekends. But as they enter into this Fellowship, they should take away something more than this honor and a certificate.

As a Fellow, I admonish all surgeons to refrain from selfish isolation and remain a part of our educational process. Surgery is a lifelong learning experience. In 10 to 15 years, much of one’s current knowledge will not be operative. The best guarantee of maintaining a relevant knowledge base is to remain active in the educational process. Surgeons should also give some of their skills and knowledge back to the system. Remember, you were once a student and a resident. You can make a difference in their lives, and they, in turn, will enrich yours.

Many new Fellows also may be wondering what the College represents and what it holds for its members. Are we a “good ole boys” network dedicated to preserving the status quo? On the contrary, the College is an organization that is in the process of significant transformation to address the needs of our Fellows and our discipline. The College is no longer a sleeping giant.

Our activities are being intelligently blended with those of other professional organizations to more effectively influence issues of mutual concern. Thomas Russell, MD, FACS, Executive Director of the College, is representing our interests and increasing our friendships productively and with distinction. These efforts go beyond just improving the image of the College. Our influence extends into serious policy-making decisions. This objective has been accomplished without losing our identity or sacrificing our principles. The College cannot, and should not, stand alone.

The benefits of College membership are constantly expanding. Consult the Member Benefit Hotline at 800/621-4111. A variety of informational services are available to you, including resources and materials on advocacy and health policy issues, research, optimal patient care, publications, scholarships, education, liaison with multiple organizations, and innovative products.

Historical highlight

Several events highlight our history. In 1905, Franklin Martin, MD, FACS, created Surgery, Gynecology & Obstetrics (SG&O), which later became the Journal of the American College of Surgeons (JACS). In 1910, the Clinical Congress was organized. In 1912, the American College of Surgeons was incorporated. In 1916, the first medical motion picture was presented at a session during the Congress. The efforts of the College, beginning in 1918, to improve the quality of care in hospitals led to the creation of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

In 1920, our colleagues from the United Kingdom presented us with the Great Mace. In 1923, the Junior Candidate Group was established in an effort to bring young surgeons into College fellowship. The Forum on Fundamental Surgical Problems was initiated in 1941, and the Surgical Education and Self-Assessment Program (SESAP), now in its eleventh edition, was established in 1971.

Although we are not living in a completed society, the College is increasingly recognizing the diversity of our membership. I am particularly pleased with the progressive involvement of women and underrepresented minorities in College leadership activities. Our Australian colleagues have provided sterling examples in this area for us: (1) a woman was appointed medical director of the Australian Health Service; (2) the Australian Medical Association elected a woman as president in 2003; and (3) the Royal Australasian College of Surgeons recently elected its first woman president. These honors were hard-earned and well-received.

Research and technology

And now, I’d like to say a word about research. Modern science is preoccupied today with basic mechanisms at the level of the gene, molecule, atom, and fundamental particle. Our current clinical practices are dictated by the research of yesterday. Tomorrow will be no different.

Although the accomplishments of our predecessors in modern surgery have been monumental, we must not rest on our laurels, but continue to develop proactive research initiatives designed to improve quality patient care. You are armed with the skills necessary to intelligently pry into the secrets of nature and may be rewarded with one of its deepest secrets.

Unfortunately, though, the technology that research has created too often has become a substi-
tute for good surgery. This is the fault of the surgeon, not of technology. We have spawned a generation of surgeons who are the high priests and priestesses of laboratory and radiographic triage. This trend has not only been costly, but has served to diminish our profession as a cognitive discipline. While embracing technologic advancements, we need not become technology addicts. Virtual reality, as an example, provides great promise. Simulation will be developed based on patient-specific data, while individualizing each surgical procedure.

A former President of the College, James Thompson, MD, FACS, educator and surgeon-investigator extraordinaire, got it right. He recommended the following rules for the investigator:

• The first challenge in research is being part of the right team and being public.
• Choose important questions and a model that is simple.
• The controls are just as important as the experimental group.
• Statistics help to decide what is real.
• Unpublished research is research undone.
• Master the art of obtaining funding.
• Work hard and with enthusiasm.

Deterrents to caregiving

Osler has reminded us, “...medicine is an art, not a trade; a calling, not a business: a calling in which your heart will be exercised equally with your head.”

So much of our orientation today serves to erode our spirit as caregivers. As surgeons we have experienced and understand the sensitivity and complexity of our relationship with our patients. Too often administrators of our health care delivery systems have neither experienced nor understood that relationship. Our culture as caregivers is being replaced by an overemphasis on process. We are dominated today by a business culture that is eroding our healing relationship with patients. Efficiency and the “bottom line” philosophy must not be ends in and of themselves, but means to an end. The moral code that guides our ethics ultimately lies in our own spirituality. Our challenge is to actively participate in the necessary synthesis of these two discordant cultures.

Surgery is under increased public surveillance. We are consumed by endless paperwork, administrative hassles, bureaucracy, a professional liability crisis, inadequate reimbursement, limited access, impersonalized processes, and burdensome documentation. We are facing additional federal mandates in the Health Insurance Portability and Accountability Act, the Emergency Medical Treatment and Active Labor Act, and the Program for Appropriate Technology in Health audits.

Despite the negative feelings these problems stir, our learning environments must be converted from crucibles of cynicism into cradles of professionalism if we are to close the gap between rhetoric and reality. It is neither wise nor prudent to isolate ourselves in operating rooms, clinics, and research laboratories, all the while disregarding societal needs and trends that negatively impact our discipline.

To preserve the integrity of our profession, we must view with concern and be prepared to deal with those elements in our society who would limit our personal and professional liberties. Activism in support of our discipline is a legitimate expression of professionalism that will not be met with universal acceptance. However, we must join the dialogue, help frame the issues, and refrain from being radical nonparticipants.

The abolitionist Frederick Douglass got it right, too, when he said: “Those who profess to favor freedom and yet depreciate (sic) agitation... want crops without plowing up the ground, they want rain without thunder and lightening. They want the ocean without the awful roar of its many waters.... Power concedes nothing without a demand. It never did and it never will.”

Your involvement can make a difference! One vote gave Oliver Cromwell control of England; caused Charles I of England to be executed; gave America the English language instead of German; changed France from a monarchy to a republic; conferred statehood on California, Oregon, Washington, and Texas; elected Adolf Hitler to leadership of the Nazi party; and won John F. Kennedy the presidency by a margin of less than one vote per precinct.

The Fellowship Pledge you have embraced this evening is the essence of our profession. It involves the surgeon’s relationship with the patient, society, and our professional colleagues. Haile Debas, MD, FACS, surgeon, educator, researcher, and recently retired dean of the University of California,
San Francisco, got it right, too. In an eloquent address to the Pacific Coast Surgical Association in 2003 he stated that our “professional status is not an inherent right but one granted by society... This obligates surgeons to put their patients’ interests above their own.”10

This evening, I urge you to embrace a deeper professional purpose. You too can get it right and be the complete, concerned citizen of society.

This is the last of your springs. In the serenity and quietude of our profession, test the depth of truths, feel the hem of heaven, and as you leave, don’t forget why you came, believing that “every man is my brother,” and “each man’s burden is my own.” Where poverty exists, all are poorer; where hatred flourishes, all are corrupted; and where injustice reigns, all are unequal.

Thank you for this honor, and please join me in welcoming our new Fellows to the halls of learned, caring men and women where you can make a difference.

References

Dr. Organ is emeritus professor, department of surgery, University of California, San Francisco, CA, and is the 84th President of the American College of Surgeons.
Is your state prepared to respond to trauma?

by Adrienne Roberts, Government Affairs Associate, Division of Advocacy and Health Policy, Washington Office

In 2001, with the reestablishment of the Trauma-EMS (emergency medical services) Systems Program, the Health Resources & Services Administration (HRSA) began to assess state trauma systems across the country. In August, HRSA released the results of its report, A 2002 National Assessment of State Trauma System Development, Emergency Medical Services Resources, and Disaster Readiness for Mass Casualty Events. This survey looked at each state’s trauma/EMS program and infrastructure and its ability to respond to injuries.

Background

In 1990, the Trauma Care Systems Planning and Development Act was signed into law. This groundbreaking legislation provided the framework necessary to assist states in developing, implementing, and monitoring statewide trauma care systems. Eighty percent of the funds appropriated for the program are used for trauma care system grants to individual states and U.S. territories. Additional funds are targeted to provide grants to public and not-for-profit entities for conducting research and demonstration projects on methods for improving the availability and quality of EMS and trauma care in rural areas.

An annual amount of $4.8 million was appropriated to the program for fiscal years (FYs) 1992, 1993, and 1994. Ironically, in 1995, the funding was rescinded to pay for disaster relief legislation, and the trauma-EMS program, then called the Division of Trauma and Emergency Medical Services (DTEMS), ceased to exist.

At the urging of the American College of Surgeons, Congress reestablished funding in 2001 at $3 million, and DTEMS, now called the Trauma-EMS Systems Program, was revived. The program continued to secure funding of $3.5 million in FYs 2002 and 2003. Congress is currently debating the FY 2004 Labor, Health & Human Services, and Education Appropriations bill, which has once again set funding for the program at $3.5 million.

To date, every state in the country has received funding under the program for a number of purposes, such as: establishing a state lead agency to administer a trauma system; developing state and regional trauma system plans; drafting state legislation to permit the development of trauma systems and the designation of trauma centers; and training EMS personnel in trauma assessment and triage protocols. In addition, rural grants were awarded to support studies on such subjects as: preventable trauma mortality in rural areas; training and skill maintenance for rural emergency medical services providers; and the impact of triage, documentation, and transport protocols on patient outcomes. Finally, special initiative grants were awarded to address access impediments or to assess emerging issues related to trauma and EMS systems, including the development of 9-1-1 telephone systems in rural areas and enhancement of the ability of EMS personnel to recognize victims of domestic violence for appropriate referral.
Status

When the Trauma-EMS program was reestablished in 2001, the first step was to determine the status of state trauma systems across the country. According to the Senate report that accompanied the FY 2001 appropriations bill, the funds were “...intended to improve the nation’s overall emergency medical system, including the joint efforts between HRSA and the National Highway Traffic Safety Administration (NHTSA) to assess state systems and recommend improvements to the current system.” With the approval of the Office of Management and Budget, and under the guidance of the HRSA Trauma-EMS Systems Program and the Office of Rural Health Policy, a national assessment survey was developed. Additional organizations had input into the development of the survey including NHTSA, the Maryland Institute for Emergency Medical Services Systems, and the Center for Injury Research and Policy at the Johns Hopkins Bloomberg School of Public Health.

To complete the survey, states were required to establish trauma-EMS stakeholders panels. These councils included representatives from EMS and hospital administrators, trauma nurses and surgeons, rural health officials, pediatric representatives, public health officials, and citizen advocates. Each state received approximately $40,000 to complete the needs assessment survey and send the results to HRSA.

Survey results

The results of the survey indicate that states continue to make progress toward organizing successful trauma care systems, but, due to significant financial shortfalls, the presence of key trauma care system components continues to vary across the country. “Survey results specific to EMS resources suggest that Americans have some degree of ready access to well-trained prehospital emergency personnel…but 10 to 25 percent of the U.S. population do not have access to basic emergency medical and communications services.”

Because the survey was conducted after September 11, 2001, it provides many details regarding a state’s ability to handle a mass-casualty event. The findings conclude that although most states have developed “disaster readiness plans,” the programs and policies of these plans are incomplete. Although communication systems remain fragmented, it is important to note that the survey questions were asked just a few months after 9/11, and states have successfully improved their systems for a mass-casualty event since then.

Using seven of the original West criteria, the survey posed the following questions to determine states’ trauma system development:

1. Does your organization have the legal authority to formally designate and accredit hospital trauma centers?
2. Does your organization or some other organization designate, verify, accredit, and categorize hospital trauma centers within your service area?
3. What sources or guidelines were used as a basis for the trauma center standards in your service area?
4. Is an on-site hospital visit required to determine a hospital’s initial compliance with trauma center standards?
5. Were (or will) the number of trauma centers identified for your service area (be) limited based on the results of a needs assessment?
6. What type of transport practice occurs in your service area when a field assessment identifies a trauma patient with severe injuries that threaten loss of life or limb?
7. Is a trauma registry present in your service area?
## State assessment of West criteria

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<th>State</th>
<th>Authority</th>
<th>Designation</th>
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</table>

* = Not applicable  * = in process
8. Do you have a designated trauma advisory committee that evaluates the performance of trauma care delivery within your service area?

The table on page 15 provides an overview of the responses to the survey, and the map on this page ranks states’ ability to meet the West criteria. A summary and discussion of the results follows.

- **Legal authority to designate trauma centers.** A total of 38 states now have the legislative authority to designate trauma centers. This is an increase from the 19 states that had this authority in 1988. Four additional states that “identify” hospitals as ACS-designated trauma centers may be added to this list, bringing the total to 42.

- **Formal process for designating trauma centers.** The number of states that have initiated a formal process for trauma center designation has increased dramatically. Since 1988, this number has climbed from 19 to 34.

- **Use of ACS standards for trauma center designation.** The American College of Surgeons has played an important role in developing the trauma center designation process by creating the standards necessary to achieve Level I through IV status. The number of states using some form of ACS criteria has increased from 20 in 1988 to 34 currently. Nine states that do not have legislated trauma systems recognize ACS standards and use them for trauma center designation.
On-site hospital verification of compliance with trauma center standards. These visits are designed to ensure that hospitals that have already been formally designated as trauma centers maintain those high standards. This number has dropped from 37 in 1988 to 36 today.

Number of designated trauma centers limited based on community need. The original 1988 West study concluded that it was important for states to limit the number of designated trauma centers based on community need. The reasoning behind this theory was to keep crucial resources and personnel at key hospitals to treat severe and complex injuries. The number of states that limit the number of designated trauma centers based on community need has grown from five to eight since 1993.

Prehospital triage criteria allowing for the bypass of nondesignated hospitals. It is very important that emergency medical personnel be allowed to bypass nondesignated centers to deliver critically injured patients to the center that can best treat their injuries. In 1993, 18 states had implemented triage bypass protocols. The new survey found that 25 states now have these protocols.

Processes to monitor trauma system outcomes. The establishment of a state trauma registry and committee that monitors patient outcomes is considered an important component of any trauma care system. These elements may provide valuable information in determining a system's strengths and weaknesses. From 1993 to today, this number has increased from 18 to 23, a small but important improvement.

Other survey characteristics
In addition to the information discussed above, the HRSA survey also looked at very detailed and specific characteristics of selected trauma centers as well as trauma systems. These characteristics included the limitations of a hospital's initial designation as a trauma center, hospital standards specific to pediatric care, and burn referral centers. Characteristics discussed for trauma systems were divided into three categories: prehospital categorization and triage, interhospital transfer arrangements, and trauma registry submission information. To order a copy of this survey, go to http://www.ask.hrsa.gov/detail.dmf?id=HRS00327.

What's next?
The findings from this survey confirm that the status of trauma care systems in this country have improved dramatically over the last decade. But great strides still need to be made to protect the lives and limbs of trauma victims. Many of the successes discussed in this article are largely due to the passage and subsequent years of funding of the Trauma Care Systems Planning and Development Act.

When asked to identify the number one weakness of its trauma systems, a lack of funding was the overwhelming response from all states. Just as illuminating is the fact that while the number one weakness listed was financial, the number one strength identified was system planning and operation.

Action needed
Both federal and state policymakers need to recognize the importance of having a fully funded trauma system that responds to both conventional injuries and acts of unconventional terrorism. Please visit the College's Legislative Action Center at http://capwiz.com/facs/home/ to encourage your congressional delegation's support for the trauma care systems legislation.

For copies of A 2002 National Assessment of State Trauma System Development, Emergency Medical Services Resources, and Disaster Readiness for Mass Casualty Events, please contact the HRSA clearinghouse at www.ask.hrsa.gov, or call 1-888/ask-hrsa (275-4772).

References
1. Senate report 106-293 to accompany S. 2553, May 12, 2003, p. 73.
This year’s Clinical Congress featured general sessions, postgraduate courses, and lectures on a diverse assortment of topics of interest to surgeons, including health policy, competence, technological innovations, patient safety, evidence-based care, volunteerism, ethics, and so on. More than 13,400 surgeons, other physicians, exhibitors, guests, and convention personnel participated in the 89th annual clinical meeting of the College, which took place October 19-23 in Chicago, IL.

A few changes were implemented at this year’s Clinical Congress. For example, the Convocation ceremony traditionally has closed the event. This year, for the first time, new Fellows were initiated the night before the official opening of the meeting. This modification necessitated another change: the Annual Meeting of Fellows and Initiates was renamed the Annual Meeting of Fellows and took place on Thursday afternoon. Hence, the meeting ended earlier than in previous years.

A highlight of the meeting was the American Urological Association Lecture, which was delivered by Senate Majority Leader William “Bill” H. Frist, MD, FACS (R-TN) (see photo, top right). In his presentation, Senator Frist laid out an ambitious plan for overcoming the weaknesses in the U.S. health care system. Some specific problems that he said need to be addressed include tort reform, the nursing shortage, uninsured patients, demographic disparities, public health issues, bioterrorism, Medicare reform, and the HIV pandemic.

Other noteworthy moments were reported in the November Bulletin, including the presentation of the Distinguished Service Award to J. Roland Folse, MD, FACS (see photo, bottom right). The November issue also included the citations for the five individuals who were awarded Honorary Fellowship in the College: Attila Csendes, MD, FACS; Sidney Cywes, OSMG, M. Med(Surg), FRCS(Eng, Ed), FRCPS(Glas), FAAP(Hon), FCS(SA-Hon), DSC(UCT-Hon); E. Catherine Hamlin, MB, BS, DRCOG; Henrik Kehlet, MD, PhD; and Marcus J. Killingback, AM, MS(Hon), FRACS, FRCS, FRCS(Ed).

Opposite: Banners announcing the Clinical Congress flew along Michigan Avenue during the convention. (Photo by Chuck Giorno Photography.)
The following is an account of some other significant events that took place during the 2003 Clinical Congress.

**Officers installed**

Claude H. Organ, MD, FACS, FRCSSA, FRACS, FRCS, was installed as the 84th President of the American College of Surgeons during the Convocation ceremonies (see photo, top right). Dr. Organ is emeritus professor, department of surgery, University of California, San Francisco.

In his Presidential Address, Dr. Organ emphasized that young surgeons should address problems with the health care system in a constructive way and should embrace the highest ideals of the profession. He encouraged young surgeons to make a difference and to learn from the legacy of one of his role models, Charles R. Drew, MD, who believed that excellent performance trumped the social and legal restraints imposed by society. Dr. Organ’s address is reprinted on page 8 of this issue.

Other newly installed officers are Anna M. Ledgerwood, MD, FACS, First Vice-President, and Murray F. Brennan, MD, FACS, Second Vice-President (see photos, p. 21).

Dr. Ledgerwood is a general surgeon and professor of surgery, Wayne State University, Detroit, MI. A Fellow since 1975, Dr. Ledgerwood has served on the Committee on Trauma (1980-1990), the Nominating Committee of the Board of Governors (1998-2000), and the Committee on Women’s Issues (2001-present). She presented the 1996 Scudder Oration on Trauma.

Dr. Brennan is a general surgeon and chairman, department of surgery, Memorial Sloan-Kettering Cancer Center, New York, NY. A Fellow since 1977, he has served as a member of the Commission on Cancer since 1989 (Executive Committee, 1990-1995), a member of the Fellows Leadership Society since 1995, and as Vice-Chair of the International Relations Committee since 1997. Dr. Brennan received the ACS Distinguished Service Award in 2000.

**New officials**

Edward R. Laws, MD, FACS (see photo, bottom right), the W. Gayle Crutchfield Professor of Neurosurgery and professor of medicine at the University of Virginia, Charlottesville, was named President-Elect during the Annual Meeting of the Fellows. Since becoming a Fellow in 1974, Dr. Laws has been an active participant in and a leader of numerous College committees. Most recently, he
Dr. Ledgerwood, First Vice-President-Elect.

Dr. Brennan, Second Vice-President-Elect.

Dr. Warshaw, First Vice-President-Elect.

Dr. Laws, Second Vice-President-Elect.

served as Chair of the Board of Regents (2001-2003) and as Chair of the Finance Committee (2002-2003). He also served on the Executive Committee of the Board of Regents from 1998 to 2000. In addition, Dr. Laws served as Chair of the Advisory Council for Neurological Surgery (1986-1992) and as Chair (1991-1992) and Vice-Chair (1989-1991) of the Council of Advisory Council Chairs. He also has been a member of the Nominating Committee of the Board of Regents (1995-1998) and served as its Chair from 2000 to 2001. Dr. Laws has also served on the Central Judiciary Committee (1997-2000), the Honors Committee (1997-present), the Patient Care and Research Committee of the Commission on Cancer (1985-2000), the Board of Governors (1990-1995), the Governors’ Committee on Surgical Practice in Hospitals (1991-1995), and the Committee on Medical Motion Pictures (1988-1997).

Furthermore, Dr. Laws served as the ACS Representative to the American Joint Committee on Cancer (1985-1994) and to the Executive Committee (1992-present) and the Credentials Committee (1992-2000) of the Virginia Chapter of the College. A 1963 graduate of The Johns Hopkins University School of Medicine, Dr. Laws was a surgical intern at The Johns Hopkins Hospital under Alfred Blalock, MD, FACS, and a resident in neurological surgery at that institution under A. Earl Walker, MD. After completing his residency, Dr. Laws was assistant professor of neurological surgery at Johns Hopkins and served as a neurosurgeon there and at The John F. Kennedy Institute in Baltimore until 1972.

From 1972 to 1987, Dr. Laws was a neurosurgeon at the Mayo Clinic and St. Mary’s Hospital, served as Chair of the Board of Regents (2001-2003) and as Chair of the Finance Committee (2002-2003). He also served on the Executive Committee of the Board of Regents from 1998 to 2000.

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From 1972 to 1987, Dr. Laws was a neurosurgeon at the Mayo Clinic and St. Mary’s Hospital, Rochester, MN. During that time, he was assistant professor and then professor of neurological surgery at Mayo Medical School. Dr. Laws was named the Joseph I. and Barbara Ashkins Professor of Surgery at Mayo in 1986. He served as professor and chairman of the department of neurological surgery at the George Washington University Medical Center, Washington, DC, from 1987 to 1992. Since then, Dr. Laws has been director of the Pituitary/Neuroendocrine Center at the Uni-
raries of Virginia in Charlottesville and has served on the staff of the Martha Jefferson Hospital.

Dr. Laws has held many leadership positions in organized surgery, including founding member of the American Pituitary Association, the Brain Surgery Society, the International Society of Pituitary Surgeons, and the Society for Neuro-oncology. He has served as president of the American Association of Neurological Surgeons (1997-1998), the Pituitary Society (1997-1998), and the Congress of Neurological Surgeons (1983-1984). Currently, he is president of the World Federation of Neurological Societies.

In addition, Dr. Laws has served as editor of Neurosurgery (1987-1992) and has been a member of the editorial boards of such publications as the Journal of the American College of Surgeons, Cancer, Critical Reviews in Neurosurgery, Journal of Clinical Neuroscience, Minnesota Medicine, Neurologia Medico-Chirurgia, Neuro-oncology, Pan-African Journal of Neurosurgery, and the Journal of Clinical Endocrinology and Metabolism.

In other actions taken during the annual meeting, the Fellows named Andrew L. Warshaw, MD, FACS, Boston, MA, First Vice-President-Elect, and Henry L. Laws, MD, FACS, Clanton, AL, Second Vice-President-Elect (see photos, p. 21).

Dr. Warshaw is surgeon-in-chief, Massachusetts General Hospital, Boston, MA. He is Immediate Past-Chair of the Board of Governors’ Committee on Socioeconomic Activities. A Fellow since 1974, Dr. Warshaw has served on the Surgical Research Committee (1988-1993), the Medical Motion Pictures Committee (1983-1993), and the Board of Governors’ Committee on Surgical Practice in Hospitals (1997-1998). He currently serves on the Committee on Women’s Issues and the Health Policy Steering Committee.

A Fellow since 1965, Dr. Henry Laws served as Vice-Chair of the Board of Governors' Committee on Socioeconomic Activities. More recently, he has been a member of the Medical Motion Pictures Committee (1983-1993) and the Board of Governors’ Committee on Surgical Practice in Hospitals (1997-1998). He currently serves on the Committee on Women’s Issues and the Health Policy Steering Committee.

The Trinity Irish Dancers performed at the Board of Governors Dinner.

Board of Regents
The composition of the Board of Regents changed rather significantly, with a new Chair being elected and five new members named. The Fellows of the College elected Edward M. Copeland III, MD, FACS, Chair of the Board of Regents. Dr. Copeland is The Edward R. Woodward Professor and chairman, department of surgery, University of Florida College of Medicine, Gainesville. He also is the director of the University of Florida Shands Cancer Center.

Dr. Copeland has been a Regent since 1997 and a member of the Executive Committee of the Board of Regents since 1999. He was elected Vice-Chair of the Board of Regents in 2002. As a Regent he has served on the Member Services Committee,
the Honors Committee, the Nominating Committee, and the Finance Committee. He is a Past-Chair of the Program Committee.

Before he was named a Regent, Dr. Copeland was active on the Board of Governors, serving on that body in various capacities from 1990 to 1996. More specifically, he served as Chair of the Executive Committee (1995-1996) and Chair of the Governors’ Committee to Study the Fiscal Affairs of the College (1994-1995). He also has been a member of the Governors’ Committee on Physicians’ Health. Additionally, Dr. Copeland is a Past-Chair of the Medical Motion Pictures Committee (1990-1993) and a former member of the Communications Committee. Additionally, he continues his dedicated service to the Commission on Cancer.

Replacing Dr. Copeland as Vice-Chair of the Board of Regents is Gerald B. Healy, MD, FACS, Boston, MA. Dr. Healy is otolaryngologist-in-chief at Children’s Hospital in Boston. He has been a member of the Board of Regents since 1997. College Committees on which Dr. Healy has been active include the Member Services Committee, the Central Judiciary Committee, and the Nominating Committee. He also served on the Board of Governors and chaired the Advisory Council on Otolaryngology from 1995 to 1997.

The new Regents are as follows: **H. Randolph Bailey, MD, FACS**; **Bruce Douglas Browner, MD, FACS**; **Martin B. Camins, MD, FACS**; **J. David Richardson, MD, FACS**; and **Thomas V. Whalen, MD, FACS**.

ACS Executive Consultant C. Rollins Hanlon (left), and his wife, Peg Hanlon, MD, joined ACS Executive Director Thomas R. Russell, MD, FACS (right), with his wife, Nona Chiampi Russell, MD, at the Board of Governors’ reception.
Dr. Bailey is a colorectal surgeon in private practice in Houston, TX. He is clinical professor of surgery and director, colon and rectal residency training program, at the University of Texas Medical School at Houston. He is also a consultant and adjunct associate professor, division of surgery, University of Texas MD Anderson Cancer Center. Dr. Bailey has been a Fellow since 1976 and served as Chair of the Advisory Council for Colon and Rectal Surgery from 1996 to 2001.

Dr. Browner is an orthopaedic surgeon from Farmington, CT. He has been a Fellow since 1991 and currently serves on the Health Policy Steering Committee and the International Relations Committee. He has served on the Committee on Trauma since 1992 and on the Advisory Council for Orthopaedic Surgery since 1997.

Dr. Camins is clinical professor of neurological surgery at Mount Sinai Hospital and Medical School, New York, NY. He has been a Fellow since 1981 and currently serves on the Committee on Patient Safety and Liability. He served as Chair of the Advisory Council for Neurological Surgery (1997-2001) and as a member of the Executive Committee of the Board of Governors (1992-1996).

Dr. Podratz is the Joseph I. and Barbara Ashkins Professor of Surgery and professor of obstetrics and gynecology at the Mayo Clinic, Rochester, MN. A Fellow since 1984, he served as Chair of the Advisory Council for Gynecology and Obstetrics from 2001 to 2003.
Dr. Richardson is a professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine, KY. He has been a Fellow since 1980 and has served on the Committee on Trauma, the Committee on Medical Motion Pictures, and the Governors’ Committee on Blood-Borne Infection.

Dr. Whalen is a professor of surgery and pediatrics and chief of pediatric surgery, Robert Wood Johnson School of Medicine and Dentistry, New Brunswick, NJ. A Fellow since 1988, he has served as Treasurer of the New Jersey Chapter of the College.


This year’s Medical Student Program attracted more than 400 registered students interested in pursuing careers in surgery. These medical students attended the Clinical Congress and participated in special sessions designed to expose them to the discipline of surgery and provide information on surgical training and careers.
FACS, Calgary, AB, was elected Vice-Chair of the Executive Committee. Julie Ann Freischlag, MD, FACS, Baltimore, MD, was reelected to a one-year term as Secretary.

Also elected to the Board of Governors’ Executive Committee were Donald E. Fry, MD, FACS, Cleveland, OH, and Valerie W. Rusch, MD, FACS, New York, NY.

Awards and honors

In addition to the presentation of Honorary Fellowships and the Distinguished Service Award, other distinctions accorded during the Clinical Congress included the dedication of the 54th volume of the Owen H. Wangensteen Surgical Forum to John T. Grayhack, MD, FACS, Herman L. Kretschmer Professor of Urology at Northwestern University Medical School, Chicago, IL. The Committee for the Forum on Fundamental Surgical Problems dedicates the symposium each year to a preeminent surgical scientist who has made exceptional contributions to research and who is a role model for aspiring academic surgeons. Robert L. Mentzer, Jr., MD, FACS, Chair of the committee, presented the award (see photo, p. 23).

For the first time this year, the Committee for the Forum on Fundamental Surgical Problems also presented Surgical Forum Excellence in Research Awards to surgical residents who submitted outstanding papers. The inaugural recipients of the award were Robert J. Feezor, MD, University of Florida, Gainesville; Emily Winslow, MD, Washington University, St. Louis; and Carlos Murillo, MD, University of Texas, Galveston. Stanley W. Ashley, MD, FACS, a member of the committee, presented the awards (see photo, p. 23).

Meanwhile, the Fellows Leadership Society (FLS) maintained its annual tradition of presenting the Distinguished Philanthropist Award in recognition of extraordinary philanthropic support of the College. This year’s award was presented in absentia to William W. Kridelbaugh, MD, FACS, of Albuquerque, NM. Dr. Kridelbaugh has been a consistent, generous financial supporter of the College. He also is an active member of the Fellows Leadership Society, having established a Charitable Remainder Unitrust that names the College as a beneficiary.

The 2003 National Safety Council Surgeon’s Award for Service to Safety was presented this year to Norman M. Rich, MD, FACS, who, as the citation specifies, “for 35 years has devoted his professional life to the prevention of battlefield injuries and mortality through research, education of students, residents, and surgeons, and through distinguished military and public service as the Founding Chairman of Surgery at the Uniformed Services University of the Health Sciences.” Presenting the award on behalf of the National Safety Council were J. Wayne Meredith, MD, FACS, Chair of the Committee on Trauma, and Michael W. Cathey, Executive Director of Development of the National Safety Council (see photo, p. 24).

Lastly, the International Relations Committee, chaired by Keith A. Kelly, MD, FACS, hosted a luncheon to honor the 2001 International Guests Scholars. Physicians receiving the distinction this year are as follows: Emmanuel A. Ameh, MBBS, Nigeria; Felipe A. Catan, MD, Chile; S.V. Suryanarayana Deo, MBBS, India; Yur-Ren Kuo, MD, Taiwan; M. Carmelita M. Lapitan, MD, FPCS, Philippines; M. Amalia Matamoros, MD, Costa Rica; and Hans Rahr, MD, Denmark. The International Relations Committee’s Selection Subcommittee is chaired by Juan A. Asensio-Gonzalez, MD, FACS (see photo, p. 25).
For nearly three decades, tens of thousands of Ethiopian women shunned by their husbands and families due to the problems associated with vesicovaginal fistulae have received surgical treatment and a renewed sense of self-confidence at Fistula Hospital in Addis Ababa. The founder of the hospital, E. Catherine Hamlin, MB, BS, DRCOG, FACS(Hon), described the important work carried out at the center during a special program that took place during this year’s Clinical Congress in Chicago, IL.

The mission
Dr. Hamlin and her late husband, Reginald Hamlin, MS, BS, MRCOG, established the hospital in 1974, after 15 years of seeing obstetrics-gynecology patients at the Princess Tsahai Hospital in Addis Ababa.

Drs. Hamlin arrived in Ethiopia in 1959 after several years of providing obstetrical and gynecological care in London, England, Hong Kong, and Adelaide, Australia. Originally, they planned to work in the underdeveloped African country for two to three years at the government hospital. Soon after joining the staff at the Princess Tsahai Hospital, however, the couple began seeing their first fistula patients.

Appalled by the condition of the young women, Drs. Hamlin set about teaching themselves how to repair the fissures through correspondence with international experts in the field. Their reputation for restoring the health and dignity of their patients grew, and to meet the increasing demand for the operation, they devoted themselves to
establishing a facility that would specialize in vesicovaginal fistula repair.

Vesicovaginal fistulae, abnormalities in the connection between the bladder and vagina, are all too common in the world’s poorest countries because they occur when women undergo obstructed labor without medical assistance. They generally arise in teenagers who are experiencing their first childbirth and result in incontinence, which prompts rejection from their mates and families.

Given that the hospital’s patients generally are poverty-stricken, Drs. Hamlin wanted to build a center that would provide the corrective medical services at no charge to the patient. Hence, the Hamlins built Fistula Hospital through donations and lived on Ethiopian physician salaries. Many of the nursing staff have been and continue to be former patients.

Meeting patient needs

The Hamlins also dedicated the hospital to the treatment of “the whole patient.” Many of the young women arrive at the Fistula Hospital malnourished, with nerve or muscle damage due to prolonged labor, and emotionally scarred by familial condemnation or abuse. When these “pilgrims” (many of whom walk upwards of 100 miles in hopes of receiving assistance) arrive at the center, they are fed, offered a warm bed, and are given physiotherapy as needed.

Once they are strong enough to undergo the procedure to repair the connection between the bladder and the vagina, the operation is performed using either a labial flap or a gracilis flap. The success rate is approximately 90 percent.

Upon recovery, those patients who can leave knowing that they have a safe place to go are sent home wearing a new dress. Those patients who are at risk of experiencing further ostracism or mistreatment may stay on at the center and enroll in literacy classes or other courses that will provide them with the skills they need to live independently.

Throughout their time at the hospital, the patients are treated with respect and care. “We want them to feel the love,” Dr. Catherine Hamlin has said. “We don’t want them just to become another case.”

Ongoing efforts

Dr. Reginald Hamlin died in 1993, but Dr. Catherine Hamlin, now in her late seventies, continues to raise funds, direct the hospital, and operate on the patients who present with the most difficult conditions. The hospital runs on a comparatively meager annual budget, completing an average of 24 procedures per week at a cost of $450 per case.

To help ensure that all Ethiopian women will have access to this important type of surgical care, all gynecology residents at the country’s medical school rotate through Fistula Hospital, where Dr. Hamlin teaches. Furthermore, she offers ongoing support and supervision to gynecologists in remote parts of Ethiopia, and gynecologists from all over the world have come to train with her.

Dr. Hamlin was born in Sydney, Australia, and is a graduate of the University of Sydney. She trained at the Women’s Hospital Crown Street, also in Sydney, where she met Dr. Reginald Hamlin, a native of New Zealand.

In recognition of her surgical skills, her vision, and her commitment to surgical education and care, Dr. Hamlin was named an Honorary Fellow of the College during the Convocation ceremonies at this year’s Clinical Congress.
Let me start by saying that I hope everyone who attended the 2003 Clinical Congress found it as informative and enjoyable as I did. It went absolutely splendidly, and I want to thank the Program Committee, the staff, and everyone else who worked so hard to make it a great success.

Board of Regents

During the Clinical Congress, the Board of Regents met three times. After two years of having the real pleasure of chairing this group, I can tell you that they are the most dedicated and professional group of physicians with whom one could ever want to be associated. And, I think that we have done good work in that time. We have had lively meetings covering very, very important issues and have moved forward on a number of fronts, largely due to the talent and the exemplary leadership skills of the members of the Board of Regents and our Executive Director, Thomas Russell, MD, FACS.

The Regents are going to be even more responsive in the future. I think you probably sensed some of this spirit at this year’s Clinical Congress. However, the whole concept of the Board of Regents, their representativeness, and their degree of involvement in the actual practice of surgery is undergoing a complete overhaul based on the recommendations offered by a committee that has been studying the Board. This committee has been led by Gerald Austen, MD, FACS, a former Regent and Past-President of the College.

The composition of the Board of Regents changed at the conclusion of this Clinical Congress. We now have three more Regents, who were added in an attempt to broaden the representation of the surgical specialties on the Board and to ensure that this body can help to build the unified house of surgery, which Dr. Russell has envisioned as a primary purpose of the College.

Additionally, the requirements for membership on the Board of Regents have changed. All Regents now will need to be in active practice. We anticipate that this prerequisite will result in a different cast to the Regents’ level of involvement, as well as their level of expertise.

Research and optimal care

As Director of the Division of Research and Optimal Patient Care, R. Scott Jones, MD, FACS, has had a tremendous impact on the College’s growth in this arena. For example, we are embarking on a cooperative effort with the U.S. Department of Veterans Affairs to bring its National Surgical Quality Improvement Program (NSQIP) into the private sector. Ultimately, we anticipate taking this quality initiative into every institution where surgeons work and where we seek to try to improve both the quality and the professionalism with which we complete our tasks.

In addition, we are expanding our efforts in evidence-based surgery, which, after all, is the basis of what we do and the way we can maintain the public’s trust and our commitment to providing proven care to our patients. This en-continued on page 56
It has been my pleasure to have served as Chair of the Board of Governors for the past two years. In this report, I would like to make some general comments regarding the new direction in which the College and the Board of Governors are headed. I also will address the concerns that the Governors raised in 2002 and the College's response. Finally, I will discuss the issues that Governors indicated were of concern as of the middle of October 2003.

New direction

In the past, the Governors sought the establishment of a political action committee (PAC) that would allow surgeons to have more influence on legislative activity in Washington. The College responded vigorously to this proposal in 2002, founding a 501(c)6 organization called the American College of Surgeons Professional Association (ACSPA). The first task that ACSPA accomplished was the establishment of the ACSPA SurgeonsPAC, chaired by Andrew L. Warshaw, MD, FACS.

The College has been addressing the Governors' concerns regarding socioeconomic issues in a number of other ways as well. For example, I think that including a session highlighting all the work that the College is carrying out with regard to health policy issues at this year’s Clinical Congress demonstrated how the organization is using different approaches to resolve our concerns. The program, It Is Not Your Father’s Oldsmobile: It Is Your College, was moderated by Josef E. Fischer, MD, FACS, Chair of the ACS Health Policy Steering Committee. Someone even described the inclusion of this session as an “epiphany.”

Other changes in the Clinical Congress program are noteworthy. For example, I think that moving the Convocation to Sunday night, under the leadership of Edward Copeland III, MD, FACS, incoming Chair of the Board of Regents, and Thomas Russell, MD, FACS, ACS Executive Director, was a substantial move in the right direction.

The Board of Governors also has implemented some structural modifications that I believe will allow this body to function more efficiently and effectively. Specifically, we have consolidated some of the Board’s committees, so now there are six instead of eight. Each of these committees has a reworked mission statement and has identified goals and objectives.

Additionally, I thought it was important that we develop a subcommittee structure that would allow the Board and its committees to receive input from Governors who may not be assigned to a specific committee and from surgeons who are not Governors. This system increases the number of people involved in the actual governance of this organization.

Chapter activities are of particular interest to myself and the other Governors, including the evaluation of what chapters do and how they do it. The Committee on Chapter Activities is chaired by Lester Wayne Johnson, MD, FACS. We are considering the development of report cards for the chapters, and Rhonda Peebles, ACS Manager of Chapter Services, is working on that effort. In other chapter business, the College has established a speakers bureau, which the chapters may tap into when they need guest lecturers for their meetings. Furthermore, I believe that the Committee on Chapter Activities should work to improve grassroots advocacy efforts at the state level, because this is where we can have a major impact.

Concerns and responses

So, how did the College respond to our concerns of last year? I am pleased to say the College did quite well. The issues of greatest concern to the Governors were physician reimbursement, Medicare reform, and funding for trauma systems.

The College actively supported provisions in the House version of the Medicare prescription drug bill, which was passed by Congress in November. This legislation would stop the anticipated 4.4 per-
cent cut in reimbursement for services provided under the Medicare physicians fee schedule and, in fact, result in a 1.6 percent increase in payment.

The College also asked Congress for continued appropriations to finance the trauma care systems and planning initiative.

Additionally, the College actively supported medical liability reform and continues to work in that arena. A member of the College’s Washington Office staff chairs a coalition of 75 organizations gathered together to achieve liability reform. Postgraduate courses on professional liability issues were common at this year’s Clinical Congress, and the College has provided new tools to assist surgeons in their communications with the public and legislators about medical liability reform.

In terms of graduate medical education, the College continued its efforts to help academic medical centers implement the new restrictions on resident work hours and to demonstrate to federal policymakers that we are handling this issue. We do not want the federal government to mandate resident work hours. We need to take care of that issue within the house of surgery.

The College also remains committed to safeguarding funding for graduate medical education programs, achieving health system reform, and working with government agencies on credentialing procedures and processes. In addition, the College also has actively participated in efforts to improve the quality of surgical care.

This year’s report

Another change that the Board of Governors made in the past few years pertains to the submission of the Governors’ reports. We consolidated some of the topics, decreasing the number of subjects considered from about 50 to 17. Additionally, this year the reports were submitted in an electronic format. About 75 percent of the Governors submitted their reports this year, a 7 percent increase from the number of responses we received last year, and it is only the second year that we have used this mode of reporting. The benchmark for the number of Governors is about 88 percent. We are shooting for that same response rate.

This year’s report shows that professional liability is now the Governors’ number one concern. Remember, physician reimbursement was their number one concern last year, but it has moved down the scale. The Governors further report that the liability situation is getting much worse and is an issue of much greater concern.

Tort reform was second on the list of Governors’ concerns, with 92 percent giving it great weight, a significant increase from last year.

Physician reimbursement has dropped to third on the list of the Governors’ primary concerns. Nonetheless, it continued to be of grave concern to the Governors, and 69 percent said it was worse in 2003.

Finishing fourth on the Governors’ rankings was an issue of particular interest to me—graduate medical education. Eighty-four percent of the Governors thought it was a very important issue and that the situation was worsening.

With that comment, I would like to close this report and to thank the American College of Surgeons for the privilege and the honor of having served as Chair of the Board of Governors.
It gives me pleasure to give a brief report on the status of the American College of Surgeons as I finish my fourth year as Executive Director of the organization. I would like to reiterate that this is your College, and we are trying to make it relevant to the needs of surgeons all over the country—for that matter, all over the world—regardless of their practice location or specialty.

Clinical Congress
At this year’s Clinical Congress we instituted a change that, I think, made it possible for more new Fellows to participate in the Convocation without disrupting their practices. We presented the Convocation on Sunday, as opposed to the last night of the Congress. I think that was a good thing to do. We will continue to analyze the effects of time constraints on surgeons’ ability to participate in the Congress and make additional changes as necessary based on your needs.

I would like to point out other significant changes in the actual content of this year’s Clinical Congress, which were instituted under the leadership of Edward Copeland III, MD, FACS. Based on everything I have heard this year, I think it was a very successful enterprise with respect to the subject matter presented and the issues discussed at many of the symposia.

Meeting contemporary needs
As many of you know, the College reorganized in September of 2001 into the four Divisions of Education, Research and Optimal Patient Care, Member Services, and Advocacy and Health Policy. We recruited new people to head the first three of these divisions, and I believe that we are becoming a more productive organization that, hopefully, is meeting the contemporary needs of surgeons with respect to their concerns about practice and political issues.

It is clear to the College’s leadership that many of the problems surgeons face today are political in nature. Senate Majority Leader Bill Frist, MD, FACS (R-TN), during the American Urological Association Lecture, pointed out some of the political problems and the fact that the American College of Surgeons can’t resolve these issues alone. We have to work in concert with other groups. Although one voice may not be speaking for all of American medicine, at least we are talking to the other professional associations about how we can overcome some of the challenges. We anticipate that this dialogue will lead to the development of meaningful policies and that the creation of a political environment promotes professional liability and tort reforms. As J. Patrick O’Leary, MD, FACS, outgoing Chair of the Board of Governors, indicates in his report on page 32, these are the number one and two issues of concern to our Fellows. The professional liability situation has taken on crisis proportions, and, as you know, each year it is getting worse and worse. Something has to happen, and, hopefully, the College will be able to make a difference.

I think we are also becoming much more proactive in our approach to political issues. We used to react to difficulties, trying to fix existing problems. Today, with the Health Policy Steering Committee ably chaired by Josef Fischer, MD, FACS, I think we are trying to handle situations before they become problematic. For example, we have developed a draft of a health system reform proposal, which the College believes addresses concerns about health policies of the future.

So, I see great energy and great enthusiasm among the Fellows, and I see the College taking steps that may have been unwarranted in the past, but that are important to the profession’s political viability today. For instance, I believe the establishment of a political action committee through the American College of Surgeons Professional Association, also mentioned by Dr.
O’Leary, exemplifies how the College is using new strategies to weigh in on issues.

**Fiscal affairs**

I would be remiss if I didn’t say something about the fiscal affairs of the American College of Surgeons. I can tell you that financially the College is in great shape. We have a sizable endowment, which we use effectively to fund scholarships and other investments in the future.

We have great real estate here in Chicago, and one of our historically significant buildings, the Nickerson Mansion, has been transferred in a partnership arrangement to another principle—Richard H. Driehaus, founder and chief executive officer of Driehaus Capital Management, Inc. As part of this agreement, Mr. Driehaus has agreed to invest somewhere between $15 and $20 million to refurbish the mansion and the Murphy Auditorium. No College money will be spent on this effort. While Mr. Driehaus will have ownership rights to the Nickerson Mansion, the College will be able to use the building for any of our functions. We will retain ownership of the Murphy Auditorium. By this time next year, the restoration project should be well under way.

**Long-term vision**

One thing that I remind myself of on a daily basis in this job is that we have short-term goals, and we have long-term goals. The short-term goals are to help ease the burdens surgeons shoulder because of day-to-day worries, such as reimbursement cuts and the liability crisis. While these issues ultimately need to be resolved with long-term solutions, right now, surgeons really need short-term fixes to make practice more appealing.

But it is the way the College handles enduring issues that will define our legacy as a professional organization. Richard Cruess, MD, this year’s Martin Memorial Lecturer, mentioned some of these perennial concerns—professionalism, ethics, oaths, and so on. These are the matters to which the College must devote a significant amount of energy.

The connection between patient safety and quality improvement is, of course, another important area. We are working diligently in this high-stakes arena. The fact of the matter is that we have reached a point where errors or mistakes in hospitals are unacceptable and can have significant consequences, not only for the institution where the mistakes occur, but for the individual provider as well. During the Clinical Congress, we had a very good discussion about what our safety center will perhaps look like in the future and how we will need to develop it with input from organizations that represent other parts of the surgical team, such as operating room nurses, anesthesiologists and anesthetists, pharmacists, and other health care professionals.

In conclusion, I would like to thank all the Fellows of the American College of Surgeons. Our greatest asset is our Fellows who volunteer their time and expertise to the organization. I also want to say that we are blessed at the American College of Surgeons with a fantastic and very dedicated staff, many of whom have worked for 30 or 40 years at the College, and I think we have an environment today where they can flourish and carry out the work that needs to be done to assist the Fellows.
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This fall, ACS Surgery: Principles and Practice unveiled a new organizational structure online at www.acssurgery.com. The table of contents now features an intuitive “body system approach” plus a new section, Elements of Contemporary Practice, which covers such key topics as patient safety, patient risk assessment, and malpractice. The following is an overview from the newest additions to ACS Surgery, the practicing surgeon’s first and only Web-based and continually updated surgical reference.

Elements of contemporary practice

6. Minimizing the risk of malpractice claims. Grant Fleming, Esq., and Wiley W. Souba, MD, ScD, FACS. The authors discuss the genesis of malpractice claims, personal issues for the defendant physician, methods for preventing malpractice claims, and ways in which surgeons may assist in their defense in the event of a lawsuit. Points featured in this chapter include: (1) professional negligence has little bearing on whether patients sue; (2) the physician-patient relationship is key; and (3) rapport may develop through discussion about informed consent. This chapter is available to ACS Surgery subscribers or for individual purchase at www.acssurgery.com.

Elements of contemporary practice

7. Elements of cost-effective nonemergency surgical care. Robert S. Rhodes, MD, FACS, and Charles L. Rice, MD, FACS. The authors discuss general issues regarding the control of health care costs and the improvement of health care outcomes, and describe the particular suitability of surgery for cost-effective analysis. In addition, they address recent changes in the concept of quality of care, examine the relation of quality to cost, and specify the particular skills and attributes that can help surgeons become cost-effective. The authors also look at waste in the health care system, lead-time bias in assessing evidence, and the effect of disease prevalence on the value of diagnostic tests.

This item is available to ACS Surgery subscribers or for individual purchase at www.acssurgery.com.
I. Basic surgical and perioperative considerations

2. Prevention of postoperative infection. Jonathan L. Meakins, MD, DSc, FACS, and Byron J. Masterson, MD, FACS. The authors discuss in depth the epidemiology of surgical site infection (SSI), including risk stratification for SSI, control of bacteria sources, the probability of contamination, the role of local factors in the development of SSIs, host defense mechanisms, antibiotic prophylaxis, and skin preparation. The prevention of infection in bowel surgery is also described. This chapter also examines administration of a second dose of prophylactic antibiotics, delayed closure for heavily contaminated wounds, the necessity of using routine techniques for reducing patient flora, the proper use of electrocautery, and the effects of diet. This item is available to ACS Surgery subscribers or for individual purchase at www.acssurgery.com.

III. Alimentary tract and abdomen

21. Open hernia repair. Robert J. Fitzgibbons, Jr., MD, FACS; Alan T. Richards, MD, FACS; and Thomas H. Quinn, PhD. The authors describe the epidemiology of hernia; the classification of hernia types; and abdominal wall anatomy. They also chronicle a variety of approaches to inguinal herniorrhaphy, including choice of procedure: conventional anterior nonprosthetic repairs; conventional anterior prosthetic repairs; preperitoneal nonprosthetic repairs; and preperitoneal prosthetic repairs. The chapter concludes with a discussion of incisional herniorrhaphy and repair of other abdominal wall hernias. This chapter also discusses the tailoring of a procedure to the patient’s particular hernia and postherniorrhaphy pain. It is available to ACS Surgery subscribers or for individual purchase at www.acssurgery.com.

IV. Vascular system

9. Repair of infrarenal abdominal aortic aneurysms. Frank R. Arko, MD, and Christopher K. Zarins, MD, FACS. In their chapter, Drs. Arko and Zarins discuss preoperative evaluation, operative planning, operative technique, and outcome evaluation of abdominal aortic aneurysms (AAAs). In addition, they describe endovascular repair, including preoperative preparation, technique, and outcome evaluation. Topics featured in this chapter include the advantages of endovascular repair and spiral CT angiography, proper patient selection, and endoleaks. This chapter is available to ACS Surgery subscribers or for individual purchase at www.acssurgery.com.

V. Trauma and thermal injury

15. Miscellaneous burns and cold injuries. David Heimbach, MD, FACS, and Nicole Gibran, MD, FACS. Drs. Heimbach and Gibran discuss the management of patients with wounds resulting from low-voltage and high-voltage electrical currents, and describe nonsurgical problems related to electrical injury. Resuscitation and surgical considerations also are presented. In addition, they describe the general emergency care of patients with chemical burns and discuss the treatment of injuries resulting from exposure to alkalis, anhydrous am-
monia, and various acids. Treatments for a variety of cold injuries as well as injuries resulting from exposure to ionizing radiation are described. The management of patients with toxic epidermal necrolysis is also presented.

Featured in this chapter is an overview of the following topics: resistance to high-voltage current and heat, cardiac arrest as a common cause of death in electrical injury, the incidence of cata
dracts after electrical injury, and conservative care for frostbite and recovery from that condition. This chapter is available to ACS Surgery subscribers or for individual purchase at www.acssurgery.com.

VI. Critical Care

13. Multiple organ dysfunction syndrome. John C. Marshall, MD, FACS, FRCS(C). The author describes the approach to the multiple organ dysfunction syndrome. Presented are the clinical definitions of organ dysfunction, quantification of organ dysfunction, prevention of organ dysfunction in critically ill patients, evaluation, and support of patients with established organ dysfunction. Pathogenesis is discussed in depth, and complexity theory is described. This chapter includes information on the occult intraabdominal focus of infection, the benefits of invasive monitoring, and the cautious use of empirical therapy. This item is available to ACS Surgery subscribers or for individual purchase at www.acssurgery.com.

Looking ahead

New and revised chapters scheduled to appear as online updates to ACS Surgery: Principles and Practice in the coming months include the following:

- “Fast-track surgery,” by Henrik Kehlet, MD, and Douglas W. Wilmore, MD, FACS.
- “Infringuinal arterial procedures,” by William D. Suggs, MD, FACS, and Frank J. Veith, MD, FACS.
- “Intraabdominal infection,” by Robert G. Sawyer, MD, FACS; Jeffrey S. Barkun, MD, FACS; Robert Smith, MD; Tae Chong, MD; and George Tzimas, MD.
- “Lower-extremity amputation for ischemia,” by William C. Pevec, MD, FACS.
- “Metabolic response to critical illness,” by Palmer Q. Bessey, MD, FACS.
- “Rehabilitation of the burn patient,” by Lee D. Faucher, MD.
- “Upper gastrointestinal bleeding,” by Kristi L. Harold, MD, and Richard T. Schlinkert, MD, FACS.

Mr. Kelly is editor, What's New in ACS Surgery: Principles and Practice, WebMD Reference, New York, NY.
The white coats are coming

A revolutionary approach to achieving tort reform

by Arthur Ellenberger, Verona, NJ

New Jersey surgeons donned white coats this fall, making house calls to patients in key areas of the state to discuss the medical liability crisis. The campaign was organized by the Medical Society of New Jersey and the New Jersey Chapter of the ACS in response to the state legislature's failure to pass meaningful tort reform this summer.

Background

New Jersey surgeons and other physicians have been mobilizing and carrying out enthusiastic grassroots advocacy programs throughout the year. Until 8,000 physicians marched on Trenton on February 4, state senators said caps on pain and suffering were not on the negotiating table. After that rally—the largest this state has seen—and two others, physicians hammered out a compromise bill with the senate for a $300,000 cap on non-economic damage awards, with some exceptions. The bill had other perks, which we were assured would stem the flood of doubling professional liability premiums. Eight Democratic members of the assembly, who noted that physicians, not lawyers, were leaving our state, said they would vote for the senate compromise bill.

Nonetheless, on July 1, assembly Democrats called for a party block vote against the bill. We lost 41-38 with one abstention. Herb Conaway, MD (D-Dist 7), voted for the bill, but the opposition had a winning number of votes and didn’t need his support to stop the bill. They effectively pulled both caps and teeth from the legislation.

Backlash

New Jersey surgeons believe that assembly Democrats ignored their needs and threw
down the gauntlet, voting as a block against the medical community. The eight members who told us they were with us later lined up along the party line, defeating our compromise by three votes. Surgeons and other physicians believe assembly Democrats stonewalled them and clearly are disinterested in the needs of patients and physicians.

My personal voting record and many years of advice to physicians has been to support good candidates in both parties. However, this situation has forced us to discard a bipartisan approach until we win the most important political battle New Jersey physicians have ever faced.

Marching on Trenton again would have been pointless. Physicians needed a grassroots advocacy strategy that would defeat Democratic assembly candidates on November 4. Our focus went from changing legislation to changing assembly faces. Local grassroots action assigned to winnable, swing districts (1, 3, 4, 14, 36, and 38) became the best new battlefield tactic.

Pounding the pavement

We chose to use a structured, politically savvy approach, speaking directly with the public about the problems we believed Democratic assembly members were perpetuating. Physicians were asked to see patients until 2:00 pm, Tuesday, October 7, then leave their offices wearing their white coats, and meet in groups at 3:00 pm in the selected districts.

We got the hang of voter canvassing in Rutherford, NJ (District 36). By the time we knocked on three doors and talked with the residents we were on a roll. The key is telling your story briefly and asking for support in a friendly way.

Surgeons didn’t need a script. A greater force springs from what you live with—the fear that one lawsuit could leave you uninsurable and destroy a hard-earned career. Physicians told the public about “jackpot justice” and the need for reforms in order to sustain a well-trained, competent medical and surgical workforce in their state.

We started as a group of four, but split in two to cover more homes and hand out more flyers. One house looked overgrown and issued unfriendly barking noises, so we skipped it. All the people we spoke with said they are registered voters and promised to get out to the polls on election day.

We watched an opposition party worker drive up and be refused a request to put lawn signs in front of houses we had just visited. He saw more white coats coming down the street and got into his car and left the neighborhood.

One noticeably pregnant woman came to the door and said she was due the following day. She chatted amiably with obstetrician-gynecologist Anthony Caggiano, MD, FACS, who told her he had delivered

<table>
<thead>
<tr>
<th>Advantages of “battlefield deployment”</th>
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<tbody>
<tr>
<td>1. Physicians didn’t miss a day of practice.</td>
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<td>2. Physicians, and the hospitals supporting them, didn’t lose income.</td>
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<tr>
<td>3. Physicians maintained public good will.</td>
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<tr>
<td>4. It was not likely to draw adverse editorials. What could the media or the Federal Trade Commission say was anti-patient?</td>
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<tr>
<td>5. Surgeons exercised their constitutional right to influence legislators through a day of structured, appropriate grassroots activism.</td>
</tr>
<tr>
<td>6. By making grassroots noise, we did something physicians have never done before: create a block of squeaking wheels. This outcome alone is likely to cause some legislators indigestion and situational reassessment.</td>
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<tr>
<td>7. We built future good will for scope-of-practice and other important patient and physician legislative issues.</td>
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<tr>
<td>8. Physicians proved they would get behind a cause and participate in pre-election activities, just like union members.</td>
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<tr>
<td>9. It taught legislators that physicians are politically savvy and active.</td>
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<tr>
<td>10. Physicians learned how to relate to political realities and step up to the plate so that other people, who know less about delivering health care, won’t prevail.</td>
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more than 6,400 babies and wanted to stay and continue caring for patients in this state. A neonatal nurse who worked in New York came to the door and promised to vote for candidates who supported our cause. She wanted our bumper sticker, and I promised to display a bumper sticker saying, “Kiss A Nurse PRN.” A warm welcome was noted at all homes displaying signs of Halloween and children. We left the area when it was getting late and we had run out of candidate circulars.

I believe this “battlefield deployment” approach succeeded in raising the public’s awareness of the damaging effects of the current tort system and has a number of advantages, which are highlighted in the sidebar on page 44.

Given the success of this first effort and with the election drawing near, we again deployed physicians to key districts on Saturday, November 1. This second effort went as well as the first.

**Landslide of apathy**

Unfortunately, very few voters made it to the polls on November 4, and the Democrats took total control of the state legislature. The fact of the matter is that New Jersey has more registered Democrats, and this party spent more on its campaigns, thanks largely in part to the governor’s fundraising. Redistricting two years ago also played a role.

Although we have yet to win the war, I believe that we have made progress on some rather significant fronts. Until physicians became more involved in the political process, we had no hope of achieving tort reform. Caps were not on the assembly table.

A former Democratic governor of our state once said, “Doctors don’t vote or donate to campaigns, and no two of you can agree on anything, so why should I listen to you?” It was worth the effort to amaze him and his party with the spirited activism surgeons and other physicians demonstrated.

In addition to canvassing the districts, we asked physicians to urge their families, friends, and employees to go to the polls. The heightened enthusiasm for participating in the political process was a win in itself. Furthermore, the state medical society’s political action committee raised more funds than ever. There was still some physician apathy, but it was a start in terms of getting physicians involved politically.

This program made physicians more aware of how legislators affect them and how to participate in local politics. We are now recognized players in the political arena and will be consulted in the future if we continue to take an active interest in the political process.

The College gave us wonderful support. Thomas Russell, MD, FACS, Executive Director of the ACS, was in contact with us and sent letters and reception area educational brochures on the lawsuit crisis to key district Fellows. Additionally, the American College of Surgeons Professional Association ran advertisements in local newspapers, which our members liked. ACS State Affairs staff Chris Gallagher and Jon Sutton came to New Jersey and participated in our rallies and house calls. Heather Bennett, Executive Director and lobbyist for the New York Chapter, climbed porches with us.

Mr. Gallagher, Ms. Bennett, and I were in northern and central New Jersey, with John K. Donahue, MD, FACS, ACS Governor, Robert C. Davies, MD, FACS, Chapter President, organized surgeons in south New Jersey.

We participated in the program with the Medical Society of New Jersey (MSNJ), and the president of that organization, Mark T. Olesnicky, MD, proved to be an able TV spokesman. MSNJ flyers, bumpers stickers, and campaign prescription pads were useful props.

We had blue skies, puffy white clouds, and wine-red mums. October 7 and November 1 were ideal fall afternoons filled with serious campaigning by a few hundred physicians and enough television coverage to frighten our opposition. Indeed, legislators whom we targeted phoned to ask us to “call off the dogs.” We asked them, “What did you expect with a party vote against us—for doctors to lie down and creep away?” I doubt they will vote as a block against us again.

Thank you for your warm concern. I’ll get off your porch.

Mr. Ellenberger is the Executive Director of the New Jersey Chapter of the American College of Surgeons.
2004 International Guest Scholars selected

The Board of Regents awarded 10 International Guest Scholarships for 2004 at the 89th annual Clinical Congress. This program enables talented young academic surgeons from countries other than the U.S. or Canada to attend and participate in the activities of the Clinical Congress, and to tour surgical institutions of their choice in North America.

The program is administered by the College’s International Relations Committee. The requirements for applicants for the 2005 International Guest Scholarships will appear in the January 2004 edition of the Bulletin. They also appear on the College’s Web site at www.facs.org/member/services/igs.html.

The 2004 International Guest Scholars are: Kasonde Bowa, MBChB, Lusaka, Zambia; Dan David Hershko, MD, Zikhron Yaaqov, Israel; Sophie Marie Jaillard, MD, Lille, France (Abdol Islami Scholar); Jonathan Barnes Koea, MBChB, Auckland, New Zealand; Chung-Yau Lo, MBBS, FACS, Hong Kong, China; Carlos Guillermo Ocampo, MD, Buenos Aires, Argentina; Juan Pablo Pantoja, MD, Mexico City, Mexico; Emil Florentin Popa, MD, Bucharest, Romania; Hassan Saidi, MBChB, Nairobi, Kenya; and Saurabh Varshney, MBBS, Doiwala, India.

NE Mexico Chapter to host Eighth Latin American Congress

Roman Gonzalez, MD, FACS, President of the Northeast Mexico Chapter, has announced that the Eighth Latin American Congress will take place May 5-8, 2004, in Monterrey, Mexico.

The four-day education program will include postgraduate courses, panel discussions, and surgical videos that will highlight the following types of surgery: thoracic, colorectal, vascular, head/neck and breast cancer, bariatric, and trauma.

Faculty members will include Fellows from the U.S. as well as Latin America. For more information about the Eighth Latin American Congress and to register, visit http://www.congresolatinoamericanoaacs.com.
CALL FOR SUBMISSIONS

The Committee for the Forum on Fundamental Surgical Problems
The American College of Surgeons

For the 2004 Owen H Wangensteen 59th annual Surgical Forum
Journal of the American College of Surgeons

Accepted abstracts* will be presented at:

American College of Surgeons
Clinical Congress

October 10-14, 2004
New Orleans, LA

Who
• Young surgical investigators (principal investigator is first named author).
• Up to ten (10) co-authors allowed.

What
• 250 maximum word abstract that presents a concise summary of research done and in progress, but not presented or published previously. Title must be brief; body of abstract must include Introduction, Methods, Results, Conclusions. One-page table may be submitted separately (see Author Instructions on Web site) if absolutely necessary; table does not count toward the 250 maximum word count.

When
• Abstracts accepted from November 1, 2003, through March 1, 2004.

Where
• Online submissions ONLY: http://www.facs.org/sfabstracts/.
• Final Decision: May 2004 (principal author will be contacted).
• Format: Follow Author Instructions, Online Submission.
• Questions: kkoenig@facs.org or: 312.202.5336.

The Excellence in Research Awards Program has been established by the Surgical Forum Committee to recognize excellence in research performed by surgical residents and Fellows, further increase the visibility of the Surgical Forum as a venue for resident research presentation, facilitate and encourage attendance of residents and Fellows at the Forum sessions, encourage residents and Fellows to participate in research during their training period, and contribute to the overall quality of the Annual Meeting of the American College of Surgeons. The committee will consider all accepted abstracts for the award and will present awards during a special session at the Clinical Congress.

Contributions sought for 2004 Clinical Congress

Paper sessions
The ACS Program Committee, Division of Education, would like to invite surgeons and surgical residents to submit abstracts for clinical paper sessions at the 90th Annual Clinical Congress, to be held October 10-14, 2004, in New Orleans, LA. These paper presentations may include clinical work that has not been previously presented or published elsewhere. The Program Committee will consider only those abstracts where the principal author or a coauthor is a Fellow of the College. The following instructions should be strictly adhered to:

1. The abstract should provide adequate information and objective data to evaluate the abstract properly.
2. The abstract must be limited to one 8-1/2" x 11" page, with 1" top and bottom margins and a left margin of 1-1/2". (It is permissible to single-space the abstract.)
3. At the top of the page, please include the full title of the abstract and complete names and academic degrees of all authors, and indicate a surgical category based on the list below that best represents the overall topic of the paper.
   • Adrenal Surgery
   • Bariatric Surgery
   • Breast Surgery
   • Cardiac Surgery
   • Colorectal Surgery
   • Esophageal Surgery
   • Gastric and Duodenal Surgery
   • Liver, Biliary Tract, Pancreas Surgery
   • Minimal Access Surgery
   • Neurological Surgery
   • Noncardiac Thoracic Surgery
   • OB/GYN Surgery
   • Perioperative and Critical Care Surgery
   • Skin, Plastic and Reconstructive Surgery
   • Small Intestinal Surgery
   • Surgical Education
   • Surgical Oncology
   • Thyroid and Parathyroid Surgery
   • Transplantation
   • Trauma Surgery
   • Vascular Surgery
   • Other
4. At the bottom of the page, include a footnote providing the principal author’s mailing address, telephone number, e-mail, fax number, and, where pertinent, medical school affiliation and other institutions from which the work originates.
5. The original and one copy of the abstract should be submitted.
6. Photographs should not accompany the abstract.
7. The deadline for the receipt of abstracts is Monday, March 1, 2004. They should be mailed to: Camille Kidd Moses, Program Committee, Division of Education, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Quality of the paper and a balanced program remain the committee’s principal criteria for evaluating the abstracts received. Because of the competitiveness of the scientific program, it is unlikely that an author would be selected to present his or her work in two successive years. Questions regarding the submission process should be directed to Ms. Moses at 312/202-5325.

Scientific exhibits
The Program Committee is calling for the submission of abstracts for the scientific exhibit/poster session at the 90th Annual Clinical Congress in New Orleans.

The abstracts will be peer-reviewed by the Program Committee, and the most competitive abstracts will be accepted based on top scores and available space. There is no charge for the scientific exhibit display space; however, exhibitors must pay for shipping and the cost of any additional rental items in the exhibit space. The abstract submission deadline is Monday, April 5, 2004. Beginning in January 2004, printed submission forms may be obtained by contacting Lisa Richards at 312/202-5385 or lrichards@facs.org. The online submission form will be available on our Web site at www.facs.org/clincon2004/sciexhibit.html/.
**Video-based education programs**

The College’s Committee on Video-Based Education, Division of Education, invites videotape submissions for the 2004 Clinical Congress, to be held October 10-14, 2004, in New Orleans, LA. Authors of videos should submit the video with a narrative soundtrack explaining the procedure along with the Video Information Form by March 1, 2004. Please submit information in one of the following formats: Mini-DV [NTSC], DVCPRO [NTSC], DVCAM [NTSC], BetacamSP [NTSC], or SVHS [NTSC]. If you can not produce one of these formats, please send a DVD or a Standard VHS tape. Please do not send a CD.

A Video Information Form may be obtained by contacting Gay Lynn Dykman by phone at 312/202-5262 or by e-mail at gdykman@facs.org.

If you have further technical questions regarding video production, please contact Ciné-Med, Inc., at 800/633-0004, Video Production Department, or videohelp@cine-med.com.

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**Clowes research award given**

The George H.A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award for 2004 was granted to Herbert Chen, MD, FACS, assistant professor of surgery, University of Wisconsin, for his research project titled “Inhibition of Gastrointestinal Neuroendocrine Tumor Progression by Signal Transduction Pathways.”

The purpose of the Clowes Award is to provide support for promising young surgical investigators. The award is sponsored by The Clowes Fund, Inc., of Indianapolis, IN, in the amount of $40,000 for each of five years, beginning July 1, 2004.

Information regarding the Clowes Award and the other scholarships, fellowships, and awards offered by the College appears on the College’s Web site, www.facs.org/memberservices/clowes.html. The requirements for the year 2005 will appear in the January Bulletin.

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**2004 ACS Japan Traveling Fellow selected**

George K. Gittes, MD, FACS, associate professor of surgery and Ashcraft Chair for Pediatric Surgical Research at the Children’s Mercy Hospital/University of Missouri, Kansas City, has been selected as the 2004 ACS Japan Traveling Fellow.

As the Japan Traveling Fellow, Doctor Gittes will participate in the annual meeting of the Japan Surgical Society in Osaka, Japan, April 7-9, 2004. He will attend the Japan Chapter meeting during that event and will then travel to several surgical centers in Japan.

Trauma and critical care course slated for March 2004

Trauma and Critical Care 2004 will present Practice Guidelines: The Next Level, March 22-24, 2004, at Caesars Palace, Las Vegas, NV. Kenneth L. Mattox, MD, FACS, will serve as program director. The program committee consists of Demetrios Demetriades, MD, PhD, FACS; M. Margaret Knudson, MD, FACS; Norman E. McSwain, Jr., MD, FACS; Michael J. Sise, MD, FACS; Daivd H. Wisner, MD, FACS; and Mary K. Allen, Program Coordinator.

The program objectives are to:

1. Describe new and innovative guidelines and management strategies for the injured patient in the EC, ICU, and OR settings.
2. Discuss practical techniques and guidelines for the management of difficult traumatic injuries at various anatomical locations, such as the heart, liver, abdomen, and esophageal gastric junction.
3. Identify challenges facing the trauma practitioner with a mass casualty disaster in both urban and rural areas.
4. Discuss and establish guidelines for trauma issues, including transfer agreements and the effects of the new Emergency Medical Treatment and Active Labor Act regulations.
5. Describe issues and guidelines in traumatic critical care, including appropriate use of ventilators, antibiotics, and nutrition, as well as monitoring and managing DVT and pulmonary embolus.
6. Describe and compare evaluation and management of adults and children for fluid resuscitation, operative versus nonoperative management, endpoints of resuscitation, and pain control.
7. Describe new concepts in hemorrhage control, imaging, drugs, and monitoring cerebral cortical oxygenation.
8. Describe guidelines for state-of-the-art management of a diverse set of trauma-related issues including burns, damage control laparotomy, removable IVC filters, fluid resuscitation, colon and rectal injuries, thoracic aortic injuries, and clearing the cervical spine.
9. Debate the value of air ambulance and in-flight care on outcomes for trauma patients.
10. Analyze the current changes in trauma and critical care training and practice.
11. Describe guidelines for difficult management problems, including wound dehiscence, enteric fistula, and the patient presenting with anticoagulants on board.
12. Evaluate the benefit of knowledge gained and lessons learned in providing quality trauma care in the practice setting.

Faculty include: Felix D. Battistella, MD, FACS, Sacramento, CA; Henry C. Cleveland, MD, FACS, Denver, CO; Edward E. Cornwell III, MD, FACS, Baltimore, MD; H. Gill Cryer, MD, FACS, Los Angeles, CA; Gerald B. Demarest, MD, FACS, Albuquerque, NM; Demetrios Demetriades, MD, PhD, FACS, Los Angeles, CA; John J. Filipides, MD, FACS, Las Vegas, NV; David B. Hoyt, MD, FACS, San Diego, CA; Jay A. Johannigman, MD, FACS, Cincinnati, OH; M. Margaret Knudson, MD, FACS, San Francisco, CA; Kathleen R. Liscum, MD, FACS, Houston, TX; Robert C. Mackersie, MD, FACS, San Francisco, CA; Kenneth L. Mattox, MD, FACS, Houston, TX; Norman E. McSwain, Jr., MD, FACS, New Orleans, LA; Frank L. Mitchell III, MD, FACS, Tulsa, OK; Scott H. Norwood, MD, FACS, Tyler, TX; John T. Owings, MD, FACS, Sacramento, CA; Scott R. Petersen, MD, FACS, Phoenix, AZ; Peter Rhee, MD, FACS, Los Angeles, CA; G. Tom Shires, MD, FACS, Las Vegas, NV; Michael J. Sise, MD, FACS, San Diego, CA; David W. Tuggle, MD, FACS, Oklahoma City, OK; Alex B. Valadka, MD, FACS, Houston, TX; George Velmahos, MD, FACS, Los Angeles, CA; Matthew J. Wall, Jr., MD, FACS, Houston, TX; and David H. Wisner, MD, FACS, Sacramento, CA.

Complete course information can be viewed online through the American College of Surgeons Web site (www.facs.org/trauma/cme/traumtgts.html). For further information, contact the ACS Trauma Office at 312/202-5342.
In the last few months, this column has focused on motor vehicle driver-related injury. But just how safe is it to ride in a car? When looking at the motor vehicle passenger-related deaths contained in the second annual report of The National Trauma Data Bank (NTDB), we see a familiar trend. Readily visible in the figure accompanying this column is a bimodal distribution of passenger deaths. This information may be directly related to what we have previously reported.

New teenage drivers often have passengers of similar age. One of the contributing factors to motor vehicle crashes is distraction within the vehicle. This distraction is a major reason for the graduated driver’s license restriction on the number of passengers that may ride with a new driver. A newly acquired skill is hard enough to perform without someone next to you taking your mind off of the task at hand. It is not difficult to see how this negative interaction would result in the first peak on our graph at right.

In order to make headway in reducing this peak, we need to focus education and prevention strategies at this population of drivers and passengers. One cannot stress enough the importance of wearing seat belts. Society is in the early phase of embracing seat belt use as well as condemning drinking and driving. But we still have a long road ahead of us. Time will tell whether we have been successful in reducing these deaths. The NTDB continues to accrue trauma records every year and this will allow us to track this trend and hopefully witness a downturn.

The second peak appears at the same age range as it does for driver deaths. This peak correlates with an increase in the comorbid factors that are seen in the elderly. This is directly related to a reduced physiologic reserve. Major injuries may be fatal as with passengers of any age, but crashes that produce less physical injury may still result in death in this age group. Better engineering of motor vehicles along with expanded trauma system coverage and improved access to trauma care will be necessary to reduce this peak.

Throughout the year we will be highlighting these data through brief reports that will be found monthly in the Bulletin. For a complete copy of the National Trauma Data Bank Annual Report 2002, visit us at http://www.facs.org/trauma/ntdbannualreport2002.pdf. If you are interested in submitting your trauma center’s data, please contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.
How Good Is
Your Cancer Program?

Display This
And Everyone Will Know.

Does our facility offer high-quality, multidisciplinary, and comprehensive cancer care?

Find out. Take The Next Step.

Participate in the Approvals Program sponsored by the Commission on Cancer (CoC) of the American College of Surgeons and receive notable benefits that will enhance your cancer program and the quality of your patient care.

For more information, call 312/202-5085 or visit our Web site at: http://www.facs.org/cancer/index.html.

Take The Next Step

• Get recognition from other national health care organizations, including the JCAHO, as having established performance measures for high-quality cancer care.
• Receive a model for organizing and managing your cancer program to ensure multidisciplinary, integrated, and comprehensive oncology services.
• Participate in a network of quality cancer programs that provide care to 80 percent of newly diagnosed cancer patients.
• Get FREE marketing by partnering with the CoC and American Cancer Society (ACS) in the Facility Information Profile System (FIPS)—an information sharing effort of resources and services and cancer experience for the ACS National Call Center and Web site.
• Participate in the National Cancer Data Base (NCDB)—a nationwide oncology outcomes database for 1,500 hospitals in 50 states—and get benchmark reports containing national aggregate data and individual facility data to assess patterns of care and outcomes relative to national norms.

Programs already participating in the Approvals Program have made the investment to benefit their patients, community, institution, and health care providers. If your facility is committed to providing high-quality cancer care, then Take The Next Step and become one of the more than 1,500 CoC-approved programs in the United States and Puerto Rico that can display the CoC stamp of Approval.
Chapter
news

by Rhonda Peebles, Chapter Services Manager, Division of Member Services

To report your chapter's news, contact Rhonda Peebles toll-free, at 888/857-7545, or via e-mail at rpeebles@facs.org.

Hawaii hosts OR safety program

The Hawaii Chapter held its Annual Summer Travel Meeting August 1-2 in Oahu. The operating room safety theme of the program attracted a "standing room only" audience of surgeons and operating room nurses. The operating room safety presentations were followed by a special presentation on evidence-based surgery. In addition, the 2003 ACS Hawaii Resident Research Competition winners were announced. They were drawn from 16 submissions and are as follows: first place, Matthew Mayfield, MC, USA; second place: Daniel Judd, MC, USA; and third place, a tie between Alessandra Puggioni, MD,* and Gary Blum, MD.

Philippine Chapter addresses leadership transitions

The Philippine Chapter held a general meeting last July to address issues related to chapter management and administration. The event was well attended by former officers, Governors, and members. The agenda focused on how to improve the performance of the Philippine Chapter to make it more relevant to the needs of the local Fellows. After much study and discussion, the chapter agreed to amend its bylaws so that the Philippine Governor also will serve as President throughout a period of time that is consistent with the Governor's term. A photo from this important meeting for the Philippine Chapter appears below.

New York announces PAC and program directors group

The New York Chapter recently announced that it has formed a political action committee

*Denotes Associate Fellow or participant in the Candidate Group.

The Philippine Chapter officers and members at their meeting in July.
(PAC) that will be managed by Heather Bennett, JD, the chapter’s Executive Director. In addition, the New York Chapter has established a Resident Program Directors Committee in an effort to accomplish the following objectives: (1) organize a unified position for the surgical response to the resident work-hour restriction; (2) advance programs for residents sponsored by the College; and (3) coordinate the efforts of and provide representation for medical education institutions in New York State. The New York Chapter intends to convene the initial meeting for the program directors in the near future.

For more information about these activities, contact Heather Bennett at 518/432-7471 or nysacs@nysurgeon.org.

New Jersey members educate public about tort reform

In response to inaction by the members of the New Jersey State legislature, on October 7, members of the New Jersey Chapter went “door-to-door” to talk with voters about the need for tort reform (see photo, this page). In their visits with voters, New Jersey Chapter members discussed the need for a cap on noneconomic damages to prevent surgeons from closing their practices and moving out of state. For more information, see the article on page 43.

New hotline for all ACS members

All College members—Fellows, Associate Fellows, Candidates, and medical students—may use a new toll-free number to contact the College. It is 1-800/621-4111. Chapters are encouraged to alert their members to this new service.

Chapter anniversaries

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Smile.
The lowest rates ever on ACS 10-Year Term Life!
deavor is going to be enhanced enormously by a number of related programs. The American College of Surgeons Oncology Group was our first step in that direction, and the College is now undertaking other prospective trials in areas outside of cancer. As a result of these programs, evidence-based practice guidelines and information are becoming available for all of the Fellows of the College who are hoping to achieve the goal of providing better—optimal, if you will—patient care.

This concludes my remarks, other than to note that many more activities are going on, and you may read more about them in the reports from my colleagues, Dr. Russell and J. Patrick O’Leary, MD, FACS, outgoing Chair of the Board of Governors (see pages 32 and 34 of this issue).

Next month in JACS

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• TA90 Response and Prognosis in Melanoma
• Verification of Pelvic Nerve Function

Collective Review

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