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The month’s cover features photographs of Harvey Cushing, MD, FACS, and highlights the many qualities that College President Edward R. Laws, MD, FACS, said Dr. Cushing displayed throughout his influential career. Dr. Laws spoke about Dr. Cushing and the need for unity in surgery during his Presidential Address (see page 8) at this year’s Convocation.

Back cover art courtesy of Melissa Hagan, Magpie Design.
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From my perspective

Of all the changes occurring within our health care system, perhaps the ones that affect surgeons the most are the cultural shifts that seem to be shaking the very foundation of our profession. Examples of some of the cultural transformations that are currently taking place include the corporatization of American medicine, the heightened attention that is focused on serious errors in hospitals with a resultant emphasis on improving patient safety, and the professional liability crisis.

One of the most profound cultural transformations is taking place in our training institutions. Work-hour limits and a new emphasis on the team approach to delivering care will change forever the way in which we practice surgery. This cultural shift affects not only surgery, but all of the medical disciplines as well.

Work hours

Two articles in the October 28, 2004, issue of the New England Journal of Medicine address weekly work hours.* Not surprisingly, the authors note that extended work hours lead to increased failure to provide error-free care. Although critics of the studies discussed in the articles may have a point when they claim that the reports applied faulty methodology, the authors do add to an ever-increasing body of knowledge indicating that house staff should be rested and informed if we are to reduce morbidity and mortality in hospitals.

During recent visits to academic medical centers, I have found that our residency training programs clearly are developing systems to effectively implement the 80-hour work week as mandated in July 2003 by the Accreditation Council on Graduate Medical Education (ACGME). To assist these training institutions in that process, the College has a help page on our Web site, which allows program directors to share their experiences in attempting to implement the mandated changes (see http://www.facs.org/education/rap/index.html).

Although I am confident that training programs are making a smooth transition to the work-hour limits, a more fundamental question remains: What type of surgeons are these redesigned programs producing?

The new culture

The admissions committees of medical schools and residency programs have never been able to effectively determine the motivations of individuals seeking a career in surgery. Furthermore, an individual’s interests and desires may change during the course of the surgical education experience. Some trainees start and remain highly motivated, with a deep and innate commitment to their job and their patients. Others may lose their enthusiasm along the way, while others may have entered training for an entirely different set of reasons. This scope of rationales for embarking on a surgical career has existed from the beginning of formal training.

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Traditionally, residency training has been based on the premise that surgeons and other physicians entered the medical profession because medical practice was almost a calling in life. As a result, one needed to become totally immersed in training and answer to the prevailing comprehensive ideology. Residents were told that they had total responsibility for each patient they treated. This system of complete immersion and absolute responsibility led to long days and sleepless nights. We ran on caffeine and adrenaline.

Today this doctrine has changed and, in some cases, so have surgeons' values. No longer is it "my patient," but it is "our patient." All members of the surgical team share responsibility for providing appropriate care.

And, because all members of the team also are required to work a limited number of hours, new opportunities for immense problems arise. Patient hand-offs are more prevalent, and they can potentially create major lapses in the continuum of care.

What to do

Who knows whether this new way of training residents—with more shared responsibility, limited work hours, and increased concessions regarding lifestyle issues—will work or not? One apparent certainty is that we will never go back to the old etiology that trained generations of surgeons and other medical professionals in the last century.

For a new cultural ethos to evolve, we must make fundamental changes in our approach to resident training. We can start by building a sense of mutual respect for the broad range of individuals involved in the care of our surgical patients, from nurses to allied health care professionals, from anesthesiologists to environmental service workers. As surgeons, we also must improve our communication and leadership skills, so these individuals will view us in a more positive light.

Additionally, we must foster in our residents the true core values of our profession. Professionalism and ethics must be instilled didactically, and not just through casual exposure. Being a surgeon (or any medical professional for that matter) is not a routine job. It incorporates responsibility, service, and a real commitment to the patient.

Guiding ethos

None of us who trained in the “total immersion era” would want to return to that point in our careers. With the development of better systems, technological advances, and the electronic transfer of information, we can craft a more effective way of training rested and informed residents. By accepting and adapting to changes in the culture of resident training, we may very well be able to provide safer, more error-free care of our patients. This mission has been guiding the ethos of our profession. Our commitment to patient safety is a timeless and immovable force within our culture.

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.
HELP HAS ARRIVED

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For more information or to enroll in SESAP 12, call 800.251.3775 or visit our website at www.facs.org
Election brings more physicians to Washington

The 2004 election produced big wins for the Republicans in the Senate and the House of Representatives. Republicans took control of Senate seats previously held by Democrats in Georgia, Florida, North Carolina, South Carolina, South Dakota, and Louisiana, while Democrats won seats held by Republicans in Colorado and Illinois. The Republicans now hold 55 Senate seats, which could lead to an additional four votes for medical liability reform. Tom Coburn, MD (R-OK), won his bid for the Senate, adding a second physician to that chamber. Sen. Harry M. Reid (D-NV) will replace defeated Thomas A. Daschle (D-SD) as the Minority Leader. Republicans increased their majority in the House by two seats, meaning that the party now controls 231 of the chamber’s 435 seats. Two Fellows of the American College of Surgeons were elected to the House, Tom Price, MD, FACS (R-GA), and Joe Schwarz, MD, FACS (R-MI). A third Fellow, Charles Boustany, MD, FACS (R-LA), faces a runoff election December 4.

Dr. Fischer testifies on Medicare coverage

Josef E. Fischer, MD, FACS, Chair of the College’s Health Policy Steering Committee, testified before the Medicare Coverage Advisory Committee November 4 in Baltimore, MD. Dr. Fischer’s testimony supported continued Medicare coverage of bariatric surgery and suggested that long-term data collection and outcome assessments for various procedures were consistent with the College’s mission of promoting quality improvement and patient safety. He also suggested that the surgeon heading an interdisciplinary team experienced in caring for the obese patient be involved in the case on a long-term basis and that the care include both psychiatric and nutritional counselling. During questioning by staff of the Centers for Medicare & Medicaid Services (CMS) with regard to standards for bariatric surgery, Dr. Fischer said that the College would consider working with the agency, the bariatric surgical community, and other stakeholders to develop a verification program for bariatric surgery. To read the text of the statement go to: http://www.facs.org/ahp/testimony/bariatric.html.

Election results mixed on state liability reform

Four states placed medical liability reform initiatives on their November 2 election ballots. Floridians approved a constitutional amendment limiting attorneys’ contingency fees. Two attorney-sponsored amendments passed as well. The first requires release of reports about medical mistakes to patients who request them, and the second strips medical licenses from physicians who are found guilty of three or more incidents of malpractice. Nevada voters “kept their doctors in Nevada” by passing a constitutional amendment to remove exceptions to the state’s cap on noneconomic damages. Two trial attorney-supported amendments that would have diluted existing liability reforms in Nevada statute were defeated.

Wyoming voters split their vote on two constitutional amendments. While they approved a measure that permits the legislature to debate the issue of medical review panels in liability cases, they did not support efforts to allow the state legislature to consider caps on noneconomic damages. And in Oregon, a referendum to reinstitute a cap on noneconomic damages was defeated by 17,000 votes.
Polls show support for reform

The Health Coalition on Liability and Access (HCLA) recently released the results of polls conducted in six states regarding the need for medical liability reform. Consumers were called in North Carolina, South Carolina, Florida, Pennsylvania, Washington, and Alaska, and they indicated strong support for federal medical liability reform. More than three-quarters (76%) of North Carolinians polled support common-sense limits on payments for noneconomic damages, while at the same time ensuring that injured patients receive full payment for lost wages and medical expenses. Staff of the American College of Surgeons chairs the coalition. The complete poll results may be found at www.hcla.org.

Requirements for informed consents and operative notes revised

The CMS has set new principles for informed consents and operative notes. While most of the Medicare conditions of participation (CoP) and the companion interpretive guidelines apply to the hospital staff, this change directly affects surgeons who practice in hospitals certified by the state survey and certification agency. (The American Osteopathic Association and the Joint Commission on Accreditation of Healthcare Organizations, which also accredit hospitals, have their own standards.) If someone other than the operating surgeon performs important parts of a procedure, even under the surgeon’s supervision, the informed consent and operative report should contain his or her name and describe the important tasks assigned to the individual. Important surgical tasks include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissue. To view the revised guidelines, go to www.cms.hhs.gov/manuals/107_som/som107_appendixtoc.asp and select Appendix A-Hospitals. The surgical conditions of participation and interpretive guidelines are in §482.51-482.51b.

NIH awards new loan repayment contracts

Since fiscal year (FY) 2002, the National Institutes of Health (NIH) has offered more than 3,200 loan repayment grants to health care professionals who commit to research careers. More than 40 percent of the grantees hold medical degrees, while 9 percent hold medical and doctor of philosophy degrees. The program repays up to $35,000 of qualified educational debt for surgeons pursuing careers in clinical, pediatric, contraception and infertility, or health disparities research. The grants may also be used to cover federal and state tax liabilities.

NIH launches new cancer research initiative

The National Cancer Institute of the NIH has announced $14.9 million in funding for a new Integrative Cancer Biology Program, which will use emerging technologies to generate computer and mathematical models for predicting the development and progression of cancer. The program will have nine research centers, including Massachusetts General Hospital and Dana-Farber Cancer Institute in Boston, MA, University Hospital of Cleveland (OH), Stanford (CA) University School of Medicine, and Vanderbilt University Medical Center, Nashville, TN. For more information, go to http://www.nih.gov/news/pr/oct2004/nci-26.htm.
Presidential Address:

Harvey Cushing

and the

unity of surgery

by

Edward R. Laws, MD, FACS,
Charlottesville, VA
Editor's note: Dr. Laws delivered this Presidential Address on October 10 at the Convocation in New Orleans, LA.

It is a pleasure and a privilege to be able to address you today. As young surgeons—superbly educated, armed with the best technical support that has ever existed, and bolstered by the Fellowship of the American College of Surgeons—you represent the future not only of surgery, but of our entire approach to health care for America.

As the fifth neurosurgeon who has been elected President of the American College of Surgeons, it is appropriate for me to speak about the unity of surgery, emphasizing the powerful bonds of collegiality that all surgeons share and the need for us to be united as we try to preserve our principles and the welfare of our patients.

The life and surgical career of Harvey Cushing, MD, FACS, serve as examples of many of the positive and wonderful aspects of surgery as it evolved in the twentieth century. He benefitted enormously from collegial relationships within and outside of American surgery as it gained momentum in the early 1900s.

After a less than superlative undergraduate record at Yale (see foreground photo, above), Dr. Cushing became an excellent student at Harvard Medical School. His initial contributions to surgery began when he and a medical school classmate, Avery Codman, MD, were responsible for giving ether anesthesia to surgical patients. They devised the first anesthesia record (see photo, page 10), and this feat represented the first of a series of revolutionary advances in surgery. Dr. Cushing had some experience with X rays at Harvard, and took a Roentgen tube with him to Johns Hopkins University in 1898 (background photo, this page). He made his own plates and emulsions and published one of the early papers on the use of Roentgen images in surgery (see photo, page 10).
Dr. Cushing’s early contributions to surgery reflected the major influences of the time. Remember that infectious disease was rampant at the turn of the twentieth century, and that a case of cancer was unusual enough to warrant the attention of all the faculty and students. Trauma, of course, was ever-present. Dr. Cushing’s publications of 1898-1900 (early in his residency) focused on a variety of contemporary problems, including: intestinal perforation in typhoid, cholecystitis and cholelithiasis, gunshot wound of the spine, thoracic duct injury, splenectomy for splenic anemia, jejunal fistula, gonococcal peritonitis, anesthesia for hernia and thyroid surgery, amputation, and carotid thrombosis.

These publications reflect the basic principles set forth by William S. Halsted, MD: a keen sense of observation; attention to the details of history and physical diagnosis; and thorough and honest reporting of the outcomes. These principles remain the foundation of our current evidence-based approach to clinical and research problems in all of surgery. These concepts were embraced and perfected by a resident in surgery, and residency education as we know it began at Johns Hopkins. Cushing was one of the first young surgeons to benefit from this revolutionary concept in medical education.

Before returning to Johns Hopkins to complete his residency, Cushing spent the year 1900 abroad, visiting a number of European cities and performing experimental work in the laboratories of Kocher and Kronecker in Berne, Switzerland. There he demonstrated the physiological alterations that accompany increases in intracranial pressure (later known as the Cushing response).

Upon Dr. Cushing’s return to Baltimore, Dr. Halsted asked him to develop and head the Hunterian Research Laboratory (see photo, page 11), where fundamental problems with surgery were to be investigated and where the medical students were given surgical experience in the “dog lab.” The experiments done in the Hunterian lab again reflected the evolving interests of the time and the contributions of the surgical mind-set to solving basic problems in medicine. Many medical students and resident surgeons worked on and elucidated such problems as: cerebrospinal fluid circulation; carbo-
hydrate metabolism, saline irrigations, and infusions; the bacteriology of the upper gastrointestinal tract; pituitary and hypothalamic blood supply and physiology; neuro-ophthalmology; cardiac valvular surgery; neuromuscular physiology; and the transplantation of glands.

Dr. Cushing was a strong and uncompromising taskmaster in the laboratory. At times he became prematurely convinced about the outcomes of certain experiments and was unhappy when results were contradictory. This was one of the sources of controversy between Dr. Cushing and his brilliant pupil, Walter Dandy, MD.

By the time Dr. Cushing joined the faculty at Johns Hopkins in 1908, he had begun to concentrate on neurosurgical problems. He published articles about the treatment of trigeminal neuralgia, peripheral nerve surgery, and pediatric neurosurgery and, in 1912, produced a definitive monograph on the pituitary and its disorders (see figure, this page). The most inspiring aspect of this book, which contains the basic aspects of all we know about pituitary disease, is that it was derived from the careful clinical observation of only 47 patients!

In 1912, after rejecting several other offers, Dr. Cushing became surgeon-in-chief at the Peter Bent Brigham Hospital and professor of surgery at Harvard. There he was responsible for all of surgery and superb progress in many areas of surgery flourished under his leadership. He went to France in 1915 and again in 1917-18 to assist the Allies in the war effort, and there he made many important and lasting contributions to modern military surgery.

The ability to adopt modern techniques and to apply them scientifically continues to characterize American surgery. These characteristics allowed Dr. Cushing and his students to develop the field of neuropathology, to apply the principles of blood transfusion to neurosurgical cases, to study and experiment with hormone replacement therapy and the control of hyper-
tension, and to introduce electrosurgery (the “Bovie”).

The residents and students who worked with Dr. Cushing at Johns Hopkins, at the Brigham, and later at Yale, formed the nucleus of American surgeons who would carry on the traditions that Dr. Cushing exemplified.

And so, in an historical review of one individual we can find many aspects of surgery as we now know it, and note the many roles that we as surgeons may play: the surgeon as humanist; the surgeon as student and lifelong learner; the surgeon as innovator; the surgeon as educator; the surgeon as scientist; the surgeon as philosopher; the surgeon as role model. These facets of a brilliant surgeon reflect the collegial aspects of his evolution as a surgical leader and remain of vital importance to us today.

In closing, I would ask that you enjoy every confidence in your knowledge and skill as surgeons and that you constantly strive to increase these capacities. Use technology and innovation wisely and well. Most of all, cherish your gifts: the gift of technical skill; the gift of cognitive excellence; the gifts of your colleagues; and, most of all, the gift of our surgical patients who depend on us in so many ways.

**Dr. Laws** is W. Gayle Crutchfield Professor of Neurosurgery, University of Virginia, Charlottesville, and the 85th President of the American College of Surgeons.
With 2004 coming to a close, it is time to reflect on the actions of the 50 state legislatures. Most of them began their legislative sessions in January or February and adjourned by the end of June. (See table on page 14 for a list of states that either did not meet this year or had full-year sessions.) During that compressed time period, proposed legislation was guided through the twists and turns of the legislative process, not unlike the Monte Carlo Grand Prix (though perhaps not as glamorous or exciting).

Proving once again that they are in the driver’s seat when it comes to managing issues directly affecting their citizens, state legislatures considered tens of thousands of bills relating to various aspects of the daily lives of surgeons and their patients. Regulation of professions, insurance, banking, public health and welfare, education, Medicaid, and, yes, medical liability reform are just some of the many issues in the purview of state legislatures.
Although surgeons may not always be behind the wheel of the legislative process, they can offer strategies to win the race toward improved patient care. The State Affairs staff of the College works with chapters and surgeons on various aspects of grassroots advocacy to help them respond to proposed legislation. Because so many health care bills are considered each year, the State Affairs staff focuses on the ones that are the most important to surgeons as recommended by the Health Policy Steering Committee. For 2004, the three priority issues were medical liability reform, trauma system funding and development, and scope of practice expansion.

To assist the chapters, State Affairs staff attended numerous chapter meetings in 2004 to talk about how surgeons can become active in grassroots advocacy, provide updates on College efforts at the federal and state levels, and serve as “advocacy consultants.”

Through our Surgery State Legislative Action Center (SSLAC), a Web-based advocacy tool (http://www.facs.org/sslac/index.html), surgeons sent more than 3,000 letters and faxes to their state legislators advocating on behalf of medical liability reform, trauma system funding, and scope of practice issues. Additionally, we helped to place print advertisements in a number of newspapers to support ballot initiatives related to medical liability reform, and State Affairs staff were in regular contact with national surgical specialty societies that collaborated on these issues.

Medical liability reform

Not unexpectedly, medical liability reform remains the number one issue at the state level for surgeons. During 2004, at least 23 state legislatures considered a multitude of bills to address this critical issue. Those states passing reforms were: Arizona (expert witness standards); Mississippi (set a $500,000 cap on noneconomic damages, abolished joint and several liability); North Carolina (“I’m Sorry” provision); Oklahoma ($300,000 cap on noneconomic damages); and Ohio (“I’m Sorry” provision, expert witness standards). The governors of two states—Iowa and Missouri—vetoed reform bills containing caps on noneconomic damages.

A few states that were unable to enact medical liability reforms during their legislative sessions did succeed in placing the issue on their general election ballots. Florida, Nevada, Oregon, and Wyoming voters were given the chance to decide on this issue. In addition, Washington State physicians were gathering signatures to force the state’s legislature to adopt a comprehensive reform initiative during next year’s session. If the legislature fails to do so, the initiative will go to the voters in 2006. (See page 6 of this issue for updated information on these ballot initiatives.)

Toward the end of this year, Maryland surgeons learned that their medical liability insurance premiums were going to increase by at least 35 percent, with some experiencing increases of 60 percent or more. Alarmed by these double-digit increases, they joined with other members of the physician community to pressure the General Assembly into holding a special session to enact reforms. Gov. Robert Ehrlich (R) offered strong support for a special session, but legislative leaders were less amenable. The 2005 session will no doubt result in considerable grassroots advocacy activity among Maryland surgeons as they strive to enact much-needed relief.

One interesting development took place in Illinois. Due to the repeated failure of the General Assembly to pass meaningful medical liability reform, two downstate municipalities adopted ordinances incorporating reforms patterned on California’s Medical Injury Compensation Reform Act.
Act. Although the courts ultimately must decide whether the cities have the authority to do this under Illinois’ home rule statute, this bold move reinforces the need for the state legislature to act, and provides an alternative approach to medical liability reform worthy of consideration in other states. (For a more detailed description of state medical liability reform efforts, see page 17 of the November 2004 Bulletin.)

Trauma
Legislation dealing with trauma-related issues surfaced in a number of states. In Indiana, the state Committee on Trauma (COT) successfully won passage of a requirement that automobile passengers under eight years old be seated in a child restraint system. Meanwhile, Oklahoma’s COT convinced legislators to increase funding for the state’s trauma system, including reimbursement for uncompensated care. In addition, a measure was added to the general election ballot in that state to raise the tobacco tax on cigarettes by 80 cents a pack, with some of the additional revenue allocated to the trauma system. Finally, California voters were to vote on Proposition 67, the Emergency Medical Care Initiative. This ballot measure would add a 3 percent surcharge for telephone usage. Funds collected would be used to provide emergency personnel training and equipment, reimbursement for uncompensated emergency physician care, uncompensated community clinic care, emergency telephone system improvements, and hospital emergency services.

Scope of practice
Supporting patient safety and quality of care in state legislatures can be a difficult proposition when battling well-funded and organized allied health professionals who are trying to expand their scopes of practice. Hence, the College joined with other surgical specialty societies in responding to single-degree (DDS) oral surgeons seeking to perform elective cosmetic surgical procedures of the head and neck, and optometrists aggressively seeking to perform eye surgery.

In California, dentists succeeded in gaining passage of legislation to expand their scope, only to see it vetoed by Gov. Arnold Schwarzenegger (R) at the urging of the Coalition for Safe Plastic Surgery (http://www.safeplasticsurgery.org). In his veto message, the governor noted his desire to “fully ensure the safety of California’s consumers,” and called on the Department of Consumer Affairs to conduct an occupational analysis of oral and maxillofacial surgeons to determine whether they should be permitted an expansion of their scope of practice.

While optometric expansion bills were defeated in nine states, Oklahoma’s legislature passed a bill permitting optometrists to use scalpels to perform cataract surgery, plastic surgery, facial reconstruction, and eyeball removal. The American Academy of Ophthalmology’s “Surgery by Surgeons” campaign, with support by the College and the American Medical Association, is educating Oklahoma citizens on the dangers of this scope expansion through a series of radio and newspaper ads and is working with state officials to develop regulations for implementing the legislation.

Other issues
Medical staffs. Conflicts between medical staffs and hospitals occur all too commonly, and physicians in California succeeded in passing the Medical Staff Self-Governance Act to address some significant problems in that state. The law clearly

Medical Staff Self-Governance Act
Incorporates six key principles of medical staff self-governance essential for the professional teamwork of the medical staff:

- Create and amend medical staff bylaws.
- Establish and enforce criteria for medical staff membership and privileges.
- Establish and enforce quality of care and utilization review standards, and oversee other medical staff activities, such as medical records review and meetings of the medical staff and its committees.
- Select and remove medical staff officers.
- Collect and spend medical staff dues.
- Hire independent legal counsel at the expense of the medical staff.
established the independent status of the medical staff and set forth medical staffs’ basic rights and responsibilities. (See boxed item on page 15 for details.)

Surgical taxes. New Jersey surgeons and other physicians strenuously opposed two bills that implemented new taxes on surgical procedures. The first imposed a 6 percent tax on gross receipts generated from cosmetic surgical procedures considered medically unnecessary. The second assessed a 3.5 percent tax on the gross receipts of ambulatory surgical centers not owned by hospitals and was intended to raise funds for uncompensated hospital care. The New Jersey Chapter of the College, the Medical Society of New Jersey, and other surgical organizations have joined together to repeal these taxes.

Advocacy for 2005

Every state legislature will meet in regular session in 2005, providing ample opportunities for surgeons to participate in grassroots advocacy. While no crystal ball is available to predict what issues will have the political momentum for passage, it is a pretty safe bet that the following topics will be on the minds and agendas of legislators:

1. Medical liability reform. Crisis states will remain in that circumstance until their respective state legislatures take action to enact meaningful reforms, including caps on noneconomic damages. Expect municipalities and other local government entities, such as counties, to consider dealing with this issue on their own.

2. Hospital/physician conflicts. States experiencing construction of specialty hospitals with physicians as owners will see an increase in legislation supported by hospital associations to greatly restrict these facilities, including attempts to go after ambulatory surgery centers and other outpatient facilities not owned by hospitals.

3. Scope of practice. The usual allied health professionals will continue efforts to expand their practice into areas legitimately reserved for trained physicians.

4. State budget shortfalls. As legislators work to pare costs and increase revenues, Medicaid reimbursement rates may be cut, and new taxes may be assessed on health care services to meet budget needs.

Regardless of the issue, surgeons and ACS chapters need to be advocates for their patients and their profession. Regular interaction with legislators through letters sent via the SSLAC, personal telephone calls to elected officials, participation in coalitions with other state specialty and medical societies, visits to the state capital to meet with legislators, and contributions to political action committees are all essential components of successful grassroots advocacy. The State Affairs staff of the College is available to help with all of these activities and are an excellent resource to speak at chapter meetings, set up action alerts and letters on the SSLAC, and so on. As state legislative issues arise, chapters are encouraged to contact Jon Sutton, Manager, State Affairs, at jsutton@facs.org, or by calling him at 312/202-5358.
Highlights of the 90th annual Clinical Congress
The 90th Annual Clinical Congress of the American College of Surgeons featured a diverse assortment of general sessions on a variety of issues from the clinical to the political and a total of 41 postgraduate courses, some spanning several days and presenting opportunities to learn the most advanced procedures. Some of the topics frequently discussed during these sessions, as well as the named lectures, multidisciplinary courses, and programs in the surgical specialties, were patient safety and quality of care and surgical volunteerism.

A total of 13,404 individuals attended the meeting October 10-14 in New Orleans, LA. Of the attendees, 7,553 were physicians, and the rest were exhibitors, guests, spouses, or convention personnel.

**Highlights**

The American Urological Association lecture, which immediately followed the Opening Ceremony, set the tone for this year’s emphasis on patient safety and quality of care. The guest speaker was Harvey V. Fineberg, MD, PhD, president of the Institute of Medicine (IOM), who reiterated the findings from the IOM’s recent studies and reports on medical errors and quality. Other sessions centered on safety and quality themes included those on practice-based learning and improvement, the National Surgical Quality Improvement Program, surgical teamwork, lessons from aviation, and other related issues.

A key component of quality is the study and dissemination of outcomes data. Several sessions focused on outcomes, and this year’s Ethics and Philosophy Lecture centered on surgeons’ obligation to share information about their outcomes with patients. Bernard Lo, MD, professor of medicine and director of the program in medical ethics at the University of California, San Francisco, explained that patients need access to this information to make sound and informed decisions.

With respect to volunteerism, Theodore J. Dubuque, Jr., MD, FACS, a general surgeon from St. Louis, MO, received the 2004 Surgical Volunteerism Award of the American College of Surgeons during the Board of Governors’ dinner (see photo, above). Dr. Dubuque was recognized for his longstanding humanitarian efforts and leadership in providing much-needed surgical services to patients who live in and near Milot, Haiti.

As further evidence of the College’s commitment to charitable care, the Board of Governors’ Committee on Socioeconomic Issues, chaired by Robert V. Stephens, MD, FACS, a general surgeon in Phoenix, AZ, presented a panel discussion on the topic. Additionally, a general session moderated by Richard W. Furman, MD, FACS, a thoracic surgeon in Boone, NC, explored the many ways Fellows give of their time to help people in...
need of surgical care here and abroad. During both of these sessions, Kathleen Casey, MD, FACS, a general surgeon in Newport, RI, reported on the College’s Operation Giving Back program.

Other highlights were reported in the November Bulletin, including the presentation of the Distinguished Service Award to Richard B. Reiling, MD, FACS, of Charlotte, NC (see photo, right). The November issue also included the citations for the three individuals who were awarded Honorary Fellowship in the College: Angelita Habr-Gama, MD; Mohamed A. Ghoneim, MD; and Shu You Peng, MD.

The following is an account of some other significant events that occurred during the 2004 Clinical Congress.

**Officers installed**

Edward R. Laws, MD, FACS, was installed as the 85th President of the American College of Surgeons during the Convocation ceremony. Dr. Laws is the W. Gayle Crutchfield Professor of Neurosurgery at the University of Virginia, Charlottesville. A Fellow of the College since 1974, Dr. Laws has been an active participant in and a leader of numerous College activities. He became President-Elect in 2003 and served as Chair of the Board of Regents from 2001 to 2003. As a Regent from 1994 to 2003, Dr. Laws served on the Board’s Executive Committee (1998-2000), as Chair of the Finance Committee (2002-2003), and as Chair of the Nominating Committee of the Board of Regents (2000).

In his Presidential Address (see page 8), Dr. Laws told the Initiates that they represent the future of surgery and encouraged them to follow the example of Harvey Cushing, MD, FACS, during their surgical careers. Dr. Cushing, President of the ACS from 1922 to 1923, is highly respected for his contributions to surgical research, science, and education. Dr. Laws also declared that the theme of his Presidential year will be the unity of surgery.

Other newly installed Officers are Andrew L. Warshaw, MD, FACS, Boston, MA, as First Vice-President, and Henry L. Laws, MD, FACS, as Second Vice-President (see photos, page 21).

Dr. Warshaw is surgeon-in-chief and chairman, department of surgery, Massachusetts General Hospital, Boston, MA. He also is the W. Gerald Austen Professor of Surgery at Harvard University. A Fellow since 1974, Dr. Warshaw chaired the Board of Governors’ Committee on Socioeconomic Issues from 1999 to 2003. He also 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 and on its Executive Committee from 1996 to 1998. He also has been a liaison to the Governors’ Committee on Ambulatory Surgery (1995-1998), the Committee on Allied Health (1975-1985, Chair 1978-1981), and the Medical Motion Pictures Committee (1995-2003).

**New officers-elect**

Kathryn D. Anderson, MD, FACS, FRCS(Eng), professor emeritus, Keck School of Medicine, University of Southern California, San Diego, was named President-Elect during the Annual Meeting of the Fellows. Dr. Anderson is the first woman to hold this position in the history of the College (see photo, page 20).
Since she became a Fellow in 1974, Dr. Anderson has held many important positions within the organization. She was the College's Secretary from 1992 to 2001 and First Vice-President from 2001 to 2002. In these capacities, she also was an ex officio member of the Board of Regents. Additionally, Dr. Anderson served as a member of the Board of Governors (1986-1992), the Advisory Council for Pediatric Surgery (1991-1992), the Finance Committee (1992-1995), the Honors Committee (1992-2002), and the Communications Committee (1995-2002). She chaired the Organization Committee from 1998 to 2002.

She also has been active at the chapter level, having served as Vice-President of the Metropolitan Washington, DC, Chapter (1987-1988) and on the Executive Council of the Southern California Chapter (1993-2001).

Born in Ashton-under-Lyne, Lancashire, England, Dr. Anderson earned her bachelor and master of arts degrees from Cambridge University, graduating with honors in both instances. She then came to the U.S. and graduated with her medical degree from Harvard Medical School, Boston, MA, in 1964. She completed her internship in pediatric medicine at Boston Children’s Hospital, her residencies at Georgetown University Hospital, and a fellowship in pediatric surgery at Children’s National Medical Center, Washington, DC.


In 1992, Dr. Anderson left the east coast for the west and accepted the position of professor of surgery at the University of California, Los Angeles. She left that post earlier this year and was named professor emeritus, surgery. From 1992 to 1994, Dr. Anderson was on staff at Children’s Hospital of Los Angeles as director of the operating room, head of the division of pediatric surgery, vice-president of surgery, and surgeon-in-chief.

Aside from the College, Dr. Anderson has held leadership posts at other surgical organizations. From 1985 to 1986, she chaired the surgical section of the American Academy of Pediatrics. Additionally, she served as president of the American Pediatric Surgical Association (1999-2000) and currently is the second vice-president of the American Surgical Association.

Dr. Anderson has been honored by the following: the Association of Women Surgeons with the Nina Starr Braunwald Award (1995); the Royal College of Surgeons of England, which named her a Fellow by election; and the National Library of Medicine, which features her in an exhibit called “Changing the Face of Medicine: Celebrating America’s Women Physicians.”

In other actions during the Annual Meeting of Fellows, J. Patrick O’Leary, MD, FACS, New Orleans, LA, was elected First Vice-President-Elect, and William F. Sasser, MD, FACS, St. Louis, MO, was named Second Vice-President-Elect (see photos, right).

Dr. O’Leary is chair, department of surgery, Louisiana State University Health Sciences Center, New Orleans, LA. A Fellow since 1975, Dr. O’Leary served as Chair (2001-2003) and Vice-Chair (1999-2001) of the Executive Committee of the Board of Governors. He served on the Governors’ Committee on Chapter Activities (1997-1998, liaison member, 1998-2002), and was President of the Louisiana Chapter of the ACS (2000-2001). Dr. O’Leary currently serves on the Advisory Council for General Surgery and as a member of the Advisory Committee on Surgical Education and Self-Assessment Program.

Dr. Sasser is associate clinical professor of surgery, St. Louis, MO. A Fellow since 1971, Dr. Sasser served as Secretary of the Executive Committee of the Board of Governors (1998-2001), as Chair of the Governors’ Committee to Study the Fiscal Affairs of the College (1998-2001), and as a liaison member of the Governors’ Committee on Socioeconomic Issues (1997-1998) and the Governors’ Committee on Chapter Activities (1996-1998). He served as a member of the Finance Committee of the Board of Regents from 1998 to 2001.
Surgical Forum dedicatee Dr. Brennan (right) with Dr. Mentzer.

National Safety Council awardee Dr. Lucas (right) with Dr. Meredith.

Surgical Forum Excellence in Research Awards: Front row, left to right: Dr. Dharmarajan, Dr. Moore, and Dr. Woodrum. Back row: Dr. Ashley, Dr. Danzer, Dr. Kumar, Dr. Glasgow, Dr. Walsh, Dr. Heider, and Dr. Vasudevan. Not pictured: Dr. Koh.
Board of Regents

Only one new Regent was elected this year—Barrett George Haik, MD, FACS, Memphis, TN. Dr. Haik is chair, department of ophthalmology, University of Tennessee Health Science Center, College of Medicine, Memphis.

A Fellow since 1984, Dr. Haik has served as the American Ophthalmological Association’s representative to the Board of Governors since 2000. He served as Chair of the Advisory Council for Ophthalmic Surgery (2002-2004) and as a member of the Forum on Fundamental Surgical Problems (1999-2004). Dr. Haik will serve an initial three-year term as a Regent.

Reelected to additional three-year terms on the Board of Regents were Barbara L. Bass, MD, FACS, Baltimore, MD; A. Brent Eastman, MD, FACS, San Diego, CA; Richard J. Finley, MD, FACS, Vancouver, BC; and Jack W. McAninch, MD, FACS, San Francisco, CA. Edward M. Copeland III, MD, FACS, Gainesville, FL, continues to serve as Chair of the Board of Regents, and Gerald B. Healy, MD, FACS, Boston, MA, continues to serve as Vice-Chair.

Board of Governors

The Board of Governors reelected Courtney M. Townsend, Jr., MD, FACS, Galveston, TX, to an additional one-year term as Chair of the Board of Governors. Mary Margaret Kemeny, MD, FACS, Jamaica, NY, was elected to a one-year term as Vice-Chair of the Board of Governors, and Julie Ann Freischlag, MD, FACS, Baltimore, MD, was reelected to an additional one-year term as Secretary. Also elected to the Board of Governors’ Executive Committee were Kirby I. Bland, MD, FACS, Birmingham, AL, and Michael J. Zinner, MD, FACS, Boston, MA.

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 55th volume of the Surgical Forum to Murray F. Brennan, MD,


FACS, Memorial Sloan-Kettering Cancer Center, New York, NY. The Committee for the Forum on Fundamental Surgical Problems dedicates the symposium annually to a recognized 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, page 22).

For the second year in a row, 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 categories for the award and the respective 2004 recipients were as follows: alimentary tract, T. Ryan Heider, MD, University of North Carolina at Chapel Hill; cardiothoracic surgery, Sekhar Dharmarajan, MD, Washington University School of Medicine, St. Louis, MO; critical care, Mark D. Walsh, MD, University of Colorado Health Systems, Denver; neurosurgery, Enrico Danzer, MD, The Children’s Hospital of Philadelphia, PA; pediatric surgery, Sanjeev A. Vasudevan, MD, Texas Children’s Hospital, Houston; plastic surgery, Sanjay Kumar, MD, University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School, Camden; quality, outcomes, and costs, Derek E. Moore, MD, Vanderbilt University Medical Center, Nashville, TN; surgical oncology, Sean C. Glasgow, MD, Washington University, St. Louis, MO; urology and reproductive surgery, Chester Koh, MD, Wake Forest University, Winston-Salem, NC; and vascular surgery, Derek T. Woodrum, MD, University of Michigan, Ann Arbor. Stanley W. Ashley, MD, FACS, a member of the committee, presented the awards (see photo, page 22).

The second annual ACS Resident Award for Exemplary Teaching was presented to Glenn Ault, MD, a PGY-6 in the University of Southern California Colorectal Surgery Program (see photo, page 23). The award is sponsored by the Division of Education to recognize excellence in teaching by a resident and to highlight the importance of teaching in the daily lives of residents. Dr. Ault was selected by an independent review panel of the Subcommittee on Resident Education based on evidence of teaching excellence.
The Fellows Leadership Society (FLS) continued its annual tradition of honoring extraordinary philanthropic support of the College through the Distinguished Philanthropist Award. This year’s award was presented to C. Rollins Hanlon, MD, FACS, and his wife Margaret H. Hanlon, MD, of Chicago, IL (see photo, page 23). The Hanlons consistently have given generously both of their time and finances in support of medical and social organizations. Indeed, they currently rank within the very top tier of donors to the College.

The 2004 National Safety Council Surgeon’s Award for Service to Safety was presented to Charles E. Lucas, MD, FACS, Detroit, MI. The award citation specifies that Dr. Lucas has demonstrated “continuous and indefatigable commitment to the care of injured patients, the development of trauma care standards, the prevention of injuries, and the training of future trauma surgeons over the last 35 years.” J. Wayne Meredith, MD, FACS, Chair of the ACS Committee on Trauma, presented the award on behalf of the National Safety Council (see photo, page 22).

The Commission on Cancer hosted the presentation of two awards offered through The National Cancer Fighters Awards Trust. The Cancer Fighter of the Year Award was presented to Philip J. DiSaia, MD, University of California, Irvine, for exemplary leadership in cancer research, treatment, education, and patient care. The award is sponsored through The Awards Trust, which also presented its Lifetime Achievement Award to Oliver H. Beahrs, MD, FACS, Rochester, MN, for national leadership in cancer surgery, research, treatment, education, and patient care. Dr. Beahrs is a Past-President of the College.

Finally, the International Relations Committee, chaired by Dr. Brennan, honored the 2004 International Guest Scholars: Kasone Bowa, MD, ChB, Lusaka, Zambia; Dan D. Hershko, MD, Haifa, Israel; Sophie M. Jaillard, MD, CHRU, de Lille, France; Jonathan B. Koea, MD, ChB, Auckland, New Zealand; Chung-Yau Lo, MBBS, FACS, Pokfulam, Hong Kong, China; Carlos G. Ocampo, MD, Buenos Aires, Argentina; Juan Pablo Pantoja, MD, Mexico, DF, Mexico; Emil F. Popa, MD, Bucharest, Romania; Hassan S. Saidi, MD, ChB, Nairobi, Kenya; and Saurabh Varshney, MBBS, MS(ENT), Doiwala, Dehradun, India (see photo, page 25).
Report of the Chair of the Board of Regents

by Edward M. Copeland III, MD, FACS, Gainesville, FL

Patient safety, quality improvement, communication with the Fellows, and appropriate use of new technology are some of the issues that the College is addressing this year.

NSQIP

Whether or not we like the concept of payment for performance, the health care marketplace seems to be moving in this direction. Rather than blocking this hurting force, the College, under the direction of our Past-President R. Scott Jones, MD, FACS, has elected to put quality measures in the hands of individual institutions and surgeons by working to apply the National Surgical Quality Improvement Program (NSQIP) in the private sector. NSQIP was developed and validated in the U.S. Department of Veterans Affairs (VA) health care system. It is the only prospective, risk-adjusted, peer-controlled database that quantifies 30-day surgical outcomes. As Harvey V. Fineberg, MD, PhD, president of the Institute of Medicine, said during this year’s American Urological Association Lecture at the Clinical Congress, the 30-day mortality and morbidity in VA hospitals have decreased 27 and 45 percent, respectively, since NSQIP was instituted in 1992. Now under the direction of the College, NSQIP is ready to be applied in the private sector.

ACSPA

The American College of Surgeons Professional Association (ACSPA) and its political action committee (ACSPA-SurgeonsPAC) are a reality and functioning with an expected positive influence in Washington. As an example, the College’s Division of Advocacy and Health Policy, led by Ms. Cynthia Brown, helped win a three-year reprieve from negative adjustments to physician payments under Medicare. Clearly, we need to reverse the downward slide of reimbursement and then elevate payment to the proper level for the work done.

Additionally, the ACSPA holds membership on the steering committee of Doctors for Medical Liability Reform, a national coalition of medical and surgical specialties working to educate the public about the negative effects of the medical liability crisis on access to care.

Andrew Warshaw, Jr., MD, FACS, chairs the Board of the ACSPA-SurgeonsPAC. The PAC is financed by contributions made by U.S. Fellows of the College; however, no ACS dues dollars are used to make contributions to any political campaign.

Practice management

Under the direction of ACS Regent Charles Mabry, MD, FACS, and Frank Opelka, MD, FACS, practice management courses will soon be offered to surgeons throughout the nation and will be available on CD-ROM. Additionally, at the Spring Meeting, a popular course was presented for surgical house officers.

Young surgeons

ACS Immediate Past-President, Claude H. Organ, Jr., MD, FACS, instructed all of us at the beginning of his term that this would be the year of the resident. Likewise, a potential decrease in the number of medical students applying to surgical residency programs has piqued our focus on exposing young minds to the joys of a surgical career. Under the supervision of Paul E. Collicott, MD, FACS, Director of the ACS Division of Member Services, the Resident and Associate Society (RAS) was created to meet the needs of young surgeons. The RAS and the longstanding Committee on Young Surgeons have combined forces to ensure that residents and Associate Fellows play a more active role in the direction of the College now and in the future.
Reaching out

A new College membership category called Affiliate Member is now available to nonsurgeon professionals, including anesthesiologists, emergency medical physicians, critical care physicians, and radiologists. It also is open to surgical scientists, doctors of philosophy and of education, and to allied health professionals, such as nurse practitioners, physician assistants, and registered nurses. Office and business managers, certified surgical technologists, and first assistants also are eligible for membership in this category.

More than 1,800 Affiliate Members attended the 2003 Clinical Congress, and the College intends to continue to reach out to all of the professionals on the surgical patient care team to ensure the highest level of cooperation and communication. In this regard, the leadership of the College has initiated a summit meeting on a semiannual basis with the leadership of the American Society of Anesthesiology and the Association of Operating Room Nurses.

JACS

The roots of the American College of Surgeons were planted in 1905 when Franklin H. Martin, MD, FACS, a Chicago, IL, gynecologist, began publishing the journal Surgery, Gynecology & Obstetrics (SG&O). Within 18 months, SG&O had 1,800 subscribers, and by 1910, it had 3,500 subscribers. The subscribers met in Chicago in 1910 and eventually became the nucleus of the American College of Surgeons. The name SG&O was changed in 2001 to the Journal of the American College of Surgeons (JACS) under the skillful guidance of ACS Past-President, Seymour I. Schwartz, MD, FACS, who recently elected to step down as Editor.

I am happy to announce that Timothy Eberlein, MD, FACS, Digby Professor and chairman of the department of surgery at Washington University School of Medicine, St. Louis, MO, is the new Editor. The publisher will continue to be Elsevier, and conversion to an electronic format is under way to improve timeliness of publication and ease of continuing medical education.

Association management

The College’s recent efforts in association management have been successful, and we are now managing the administration activities of four associations. We look forward to working in this capacity with the College chapters, regional surgical societies, and other national organizations in the future.

Thanks

Lastly in my report to you, but foremost in my mind, I want to thank Thomas R. Russell, MD, FACS, ACS Executive Director, and the College staff for the excellent job they have done in these past five years and to announce that Dr. Russell has signed up for at least another five years. Thank you, Tom.

Dr. Copeland is Edward R. Woodward Professor, department of surgery, University of Florida College of Medicine Gainesville, FL.
The primary responsibility of the Board of Governors is to serve as a communication link between the Fellows of the College and the leadership of the College. The members of the Board of Governors are allocated by state, province, or country to represent the Fellows within. Governors are surveyed annually so that the leadership can better gauge the climate of the surgical environment in which the Fellows practice.

At its annual meeting, the Board reviewed the results of this year’s survey and found that the highest ranking issues of concern to our Fellows are professional liability, malpractice, tort reform, physician reimbursement, and changes in Medicare and Medicaid. The Governors likewise reviewed the College’s activities in response to the survey from the previous year. Overall, the Fellows are pleased with the College’s efforts to address the concerns raised by the Fellows through the Governors.

Committee reports

The Board also heard reports from six of its committees and approved the action items that came from those reports. Following is a summary of some of the recommendations in those reports.

The Governors’ Committee to Study the Fiscal Affairs of the College developed a dues modification strategy, which would impose any changes in dues on a small, annual, incremental basis rather than rely on large, infrequent adjustments. Dues would be adjusted periodically after demonstrable needs have been evaluated.

The Governors’ Committee on Socioeconomic Issues had three action items. One requested that the residency review committees develop guidelines for volunteer experiences to occur in the fourth or fifth year of residency. In a related item, the committee recommended that the College establish resident volunteerism travel awards to help defray expenses associated with participating in medical missions. Thirdly, the committee called upon the Board of Regents to instruct the Convention and Meetings support area to consider local, state, and national political environments in the criteria used to select meeting sites.

The Governors’ Committee on Surgical Practice in Hospitals and Ambulatory Settings reported that it is in the process of revising the guidelines for optimal ambulatory surgical care and office-based surgery.

It’s important to note that three of the Governors’ committees sponsored general sessions at this year’s Clinical Congress. In addition, the Governors’ Committee on Physician Competency and Health sponsored free blood pressure screening during the Congress, which were provided by American Vascular.

Operation Giving Back

Finally, the program of which we are most proud, Operation Giving Back (OGB), now has a Web site and a full-time Director, Kathleen Casey, MD, FACS. OGB was initiated by the Governors’ Committee on Socioeconomic Issues and was approved by the Board of Governors and subsequently the Board of Regents. It provides resources for Fellows to find surgical volunteer opportunities in this nation or abroad that best fit their talents, interests, beliefs, and lifestyles. Once the College’s Web portal is fully functional, the OGB site will be featured prominently there, as well.
As I come to the end of my fifth year as the Executive Director, I am really looking forward to continuing in this capacity for the next five years, so you are going to have to put up with me for a little bit longer. This job is pleasurable because of two major components. First of all, the volunteers and other members of the College have offered me incredible support as I have traveled around the country. I have been to more than 50 chapter meetings and to the meetings of other medical organizations, many of which I never before even knew existed. I have been warmly received by most other organizations, but not all. For example, when you go to the Society of Dermatological Surgeons and you question their abilities or their right to call themselves surgeons, you are not always welcome. However, I have done the best I can in sometimes politically charged environments.

In addition to all of you, the College staff have proven invaluable to me. You can only imagine the myriad of details that have to be carried out in an efficient way just to present the Clinical Congress. I am in awe of their professionalism and their interest in making certain that the College is well served so that we can better serve our patients.

I think a lot has come out of the reorganization that we did in 2001. We had another planning session this past June, which centered on what we need to do in order to make certain that the College remains relevant and that we stay ahead of this changing health care environment.

So much is happening in Washington, DC, and I think many changes will occur in the future. We have an active Health Policy Steering Committee that is looking to the future and is trying to arrive at a system that the College could endorse. Rather than just working on the current problems, we’re trying to be more visionary and come up with a plan that will meet the needs of patients in the coming years. We also intend to get the support of other groups for this plan so that when Congress entertains the issue of health care reform at some time in the future, we will be unified as a profession. Crafting a plan that other groups will advocate is, I believe, a real challenge for the Health Policy Steering Committee and for the Division of Health Policy and Advocacy.

We are also doing many things politically today that we never would have done a few years ago. For example, forming the American College of Surgeons Professional Association (ACSPA) and its political action committee (PAC) under the leadership of Andrew L. Warshaw, MD, FACS, absolutely were steps we needed to take. I think we are going to reap more and more benefits from these activities.

The formation of the ACSPA and its PAC were based on recommendations from the Socioeconomic Committee of the Board of Governors. This committee also made recommendations regarding the idea of volunteerism and giving back. It is important to me to make certain that Fellows have a positive feeling about and continue to enjoy this wonderful profession. The most negative Fellow whom I have met out of our 65,000 members, and I have met a lot of them, says that the one thing he really enjoyed is volunteerism. A smile comes to his face when he talks about his trips to the Far East to volunteer his time and services. So I think the spirit of the College's Operation Giving Back program is going to be so important, because there is nothing worse than depressed surgeons. How can we possibly serve our patients if we’re depressed?

The other issue that I think has been a significant advance for the College this past year is developing the concept of the Web portal, which will be a means eventually of really communicating in an individualized and customized way with our Fellows. This idea emanated from the Resident and Associate Society—from the young surgeons—who brought this concept forward as a
key vehicle for advancing their future. I am pleased to say that we have an active editorial board that will be working hard to bring this project to fruition.

During his Presidential year, Immediate Past-President Claude H. Organ, Jr., MD, FACS, promoted the Year of the Resident, and I think we have successfully achieved his objectives. We are paying much more attention to the young surgeons and residents than perhaps we used to, and we are going to do more and more of that as we actively reach out and make certain that medical students, as they make the transition to a surgical career, know exactly what the College is, what we stand for, and what we are trying to do for them.

ACS President Edward R. Laws, MD, FACS, has announced that he would like to have his Presidency remembered for promoting unity in the surgical profession. Dr. Laws has pledged that the staff will work completely behind the Fellows as we unify not only the house of surgery, but also the house of medicine. We will work with the American Medical Association; we will work with the Association of Operating Room Nurses; we are going to work with the anesthesiologists, the nurse anesthetists, the surgical technologists, and the physician assistants—because these health care professionals are going to be delivering much of the care provided in this country.

I want to thank Courtney M. Townsend, Jr., MD, FACS, for his leadership of the Board of Governors, because it is a critically important component of the College which, as this report illustrates, generates many of the ideas for our initiatives.

Obviously, it is important that we think about short-term issues. All of the issues that Dr. Townsend mentions in his report (see page 29) that come from the Board of Governors are relatively short-term issues. Reimbursement, professional liability, regulatory overburden, and so on, are very important short-term issues that we deal with as a College through advocacy efforts and almost as a trade association looking out for our Fellows.

However, the College also must continue to address the long-term issues. These issues are matters on which we as a professional association need to step to the forefront and stand for ethics and professionalism and safety and quality initiatives. These are long-term issues, and they are what the College will be remembered for in the future.

Finally, I would be remiss if I didn’t say something about the fiscal affairs of the College. I can assure you that under the astute direction of our Treasurer John L. Cameron, MD, FACS, the College’s monies are well protected and invested. We have not needed to use any of the 5 percent of the endowment reserved for operations in the years since 2000. Instead, we have a wonderful endowment through which we can support scholarships and other programs that are of real benefit to our members. The College is in good fiscal condition.
ACS Officers and Regents

Officers/Officers-Elect

Edward R. Laws
President
Neurosurgery
W. Gayle Crutchfield Professor of Neurosurgery and professor of medicine, University of Virginia
Charlottesville, VA

Andrew L. Warshaw
First Vice-President
General surgery
Surgeon-in-chief, Massachusetts General Hospital
Boston, MA

John L. Cameron
Treasurer
General surgery
Professor and chair, department of surgery, The Johns Hopkins University School of Medicine
Baltimore, MD

Henry L. Laws
Second Vice-President
General surgery
Birmingham, AL

John O. Gage
Secretary
General surgery
Private practice
Pensacola, FL

J. Patrick O’Leary
First Vice-President-Elect
General surgery
Chair, department of surgery, Louisiana State University Health Sciences Center
New Orleans, LA

Kathryn D. Anderson
President-Elect
Pediatric surgery
Professor emeritus, Keck School of Medicine, University of Southern California
San Diego, CA

William F. Sasser
Second Vice-President-Elect
Thoracic surgery
Associate clinical professor of surgery, St. Louis University
St. Louis, MO
Board of Regents

Edward M. Copeland III
Chair
General surgery
Edward R. Woodward Professor, department of surgery, University of Florida College of Medicine, Gainesville, FL

Gerald B. Healy
Vice-Chair
Otolaryngology
Otolaryngologist-in-chief, Children's Hospital, Boston, MA

H. Randolph Bailey
Colon and rectal surgery
Clinical professor and chief, division of colon and rectal surgery, University of Texas Health Science Center, Houston, TX

Barbara L. Bass
General surgery
Professor of surgery and vice-chair, academic affairs and research, University of Maryland School of Medicine, Baltimore, MD

L. D. Britt
General surgery
Brickhouse Professor and chair, department of surgery, Eastern Virginia Medical School, Norfolk, VA

Bruce Douglas Browner
Orthopaedic surgery
Gray-Gossling Professor and chairman, department of orthopaedic surgery, University of Connecticut Health Center, Farmington, CT, and director of orthopaedics, Hartford (CT) Hospital

Martin B. Camins
Neurological surgery
Clinical professor of neurological surgery, Mount Sinai Hospital and Medical School, New York, NY

A. Brent Eastman
General surgery
Chief medical officer, Scripps Health, and N. Paul Whittier Chair of Trauma, Scripps Memorial Hospital, La Jolla, CA, and clinical professor of surgery, University of California, San Diego, San Diego, CA
Richard J. Finley
General surgery
C. N. Woodward Chair in Surgery and professor and head, division of thoracic surgery, University of British Columbia Faculty of Medicine Vancouver, BC

Josef E. Fischer
General surgery
Professor of surgery, Harvard Medical School, and chairman of surgery, Beth Israel Deaconess Medical Center Boston, MA

Barret G. Haik
Ophthalmic surgery
Chair, department of ophthalmology, University of Tennessee Health Science Center, College of Medicine Memphis, TN

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Professor and chairman, department of surgery, University of California-San Francisco, East Bay Oakland, CA

Charles D. Mabry
General surgery
Private practice Pine Bluff, AR, and assistant professor of surgery, practice management advisor to the chairman, department of surgery, University of Arkansas for Medical Sciences Little Rock, AR

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Urology
Professor of urology, University of California-San Francisco, and chief of urology, San Francisco General Hospital San Francisco, CA

Mary H. McGrath
Plastic surgery
Professor of surgery, division of plastic surgery, University of California San Francisco, CA

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Colon and rectal surgery
Professor of surgery and health policy, management and evaluation, University of Toronto, and head, division of general surgery, Mt. Sinai Hospital Toronto, ON
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Pediatric surgery  
Professor of surgery and pediatrics, and chief of pediatric surgery, Robert Wood Johnson School of Medicine  
New Brunswick, NJ
Transanal endoscopic microsurgery.

Theodore J. Sadarides, MD, Rush University Medical Center, Chicago, IL.

For transanal removal of rectal adenomas, the chief limiting factor is access and exposure. Can the lesion be seen in its entirety using such conventional instruments as handheld or self-retaining retractors? These instruments usually restrict the surgeon to the distal 7 or 8 cm of rectum, and if transanal excision is not possible, the surgeon must resort to either a transabdominal approach or to the more rarely used transsacral approach. Removing cancers through the anus is restricted by the same factors, and a strict selection process must be used to achieve acceptable recurrence and survival rates. These selection criteria mandate that the cancer be well differentiated, that it lack venous or lymphatic invasion, and that it not penetrate beyond the submucosa. If these criteria are satisfied, the likelihood of lymph node metastases being present and beyond the reach of surgical excision is low.

Transanal endoscopic microsurgery (TEM), pioneered by Prof. Gerhard Buess, has extended the boundaries of transanal surgery by virtue of its longer reach and enhanced visibility. The device facilitating TEM is an endosurgical unit that regulates four different functions simultaneously, namely, carbon dioxide insufflation, water irrigation, suction, and monitoring of intrarectal pressure. The TEM scope itself is closed and airtight. When carbon dioxide is insufflated, the rectum distends and maintains itself in an “open” state as long as there is no leak within the system. This rectal distention greatly facilitates visualization, excision of the lesion, and precise closure of the wound. Water irrigation is used to cleanse the lens periodically, while suction removes blood, smoke, and particulate matter. The rectal pressure is set at approximately 15 cm H₂O; the unit automatically adjusts the suction and rate of insufflation to maintain this level.

The rigid operating scopes are available in lengths of either 12 or 25 cm and have a diameter of 4 cm. The distal end of the scope is beveled and should face down at the lesion. This determines patient position. For a posterior lesion, the patient is positioned in the lithotomy position; and for an anterior lesion, the patient is positioned in the prone position. Colonoscopy should be performed before the procedure to ensure no synchronous lesions are present. If TEM will be used to remove a cancer, endorectal ultrasound is performed to determine the depth of penetration and, hence, the suitability for TEM. Patients undergo bowel preparation. The operation may be performed under either regional or general anesthesia. Most patients are treated as outpatients unless urinary retention
or medication-related nausea requires admission.

The scope is inserted under direct vision up to
the lesion and is then secured to the operating room
table. The lesion is positioned in the center of the
visual field and the margin of excision mapped
around the tumor with the cautery. A 5 mm mar-
gin is used for small adenomas, whereas a 1 cm
margin is used for larger adenomas and all can-
cers. Dissection is undertaken in the submucosal
plane when removing a small adenoma. However,
when removing larger adenomas and cancers, one
should excise down to the extrarectal fat to pro-
perly stage the tumor. Caution should be exercised
when excising anterior lesions, especially in women
in whom transmural dissection risks entry into the
peritoneal cavity. Laparotomy and anterior resec-
tion may be preferable for such lesions. After the
lesion is excised, the wound is closed transversely
with a monofilament suture. Follow-up consists of
serial proctoscopic exams and endorectal ultra-
sound. (Indeed, in some published series, ultra-
sound has been the only diagnostic modality that
detected recurrent disease.)

Compared to low anterior resection, TEM may
achieve comparable recurrence and survival rates
for pathologic T1 (pT1) cancers, with lower mor-
bidity and surgical mortality. TEM excision of pT1
lesions alone is considered sufficient oncologic
treatment, provided the margins of excision are
clear and no ominous pathologic features, such as
poor differentiation or lymphovascular invasion,
are evident. If the tumor removed by TEM is found
to be pT2, further therapy with either radiation
and chemotherapy or radical surgery is indicated
because local failure rates of up to 40 percent have
been reported. Local recurrence after TEM exci-
sion of pT1 tumors is about 13 percent. In the Rush
University Medical Center experience, the local
recurrence rate was 7.5 percent following TEM
excision of 53 pT1 cancers. All recurrences have
been salvaged with radical surgery except in one
case involving a nonagenarian patient who was
unfit for radical surgery.

Costs are substantially less for TEM than for lap-
arotomy. Complications include fecal soilage (noted
in up to 2%), perforation into the peritoneal cavity
(reported in up to 5% in some series), conversion
to laparotomy (5%), urinary dysfunction (3%), pe-
rianal fistulae (1.5%), and bleeding.

TEM has therefore emerged as a safe method to
resect selected rectal neoplasms transanally. It pro-
vides better access and exposure to lesions in the
midrectum and proximal rectum than conventional
approaches.

For more information, contact whatsnsw@webmd.net.

This month at
ACS Surgery Online

New and revised chapters are published each
month online at www.acssurgery.com. ACS Sur-
gery Online recently featured these chapters:
• Injuries to the great vessels of the abdomen,
  by David V. Feliciano, MD, FACS
• Laparoscopic colectomy, by Babak N. Rad,
  MD, and Robert W. Beart, Jr., MD, FACS.
• The elderly surgical patient, by James M.
  Watters, MD, FACS, Jacqueline C. McClaran,
  MD, and Malcolm Man-Son-Hing, MD, FRCPC.

DECEMBER 2004 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
Socioeconomic tips

Surgeons express new optimism at Clinical Congress

by the Division of Advocacy and Health Policy

Each year at the Clinical Congress, the Division of Advocacy and Health Policy sponsors complimentary practice management consultations. Tom Loughrey of Economedix was the consultant again this year, and he reports that the surgeons who participated in these meetings displayed a somewhat more optimistic and upbeat attitude than in the past. Following are some questions we had for Mr. Loughrey and his responses.

What were the main topics of interest this year?

Residents and surgical fellows asked about career opportunities, including what to look for in proposed employment contracts and practice equity buy-ins. Young surgeons also expressed surprising interest in starting solo surgical practices, which may indicate renewed confidence in the ability of the marketplace to support a solo practice.

Mid-career surgeons generally asked about operational issues, such as group expansion, compensation, personnel management, technology integration, and compliance, particularly regarding coding documentation.

Surgeons looking at the last years of their careers were primarily interested in practice succession, recruiting, practice valuation, partnership issues, and checklists for closing a practice. Some questions covered all stages of a surgeon’s career such as personal financial planning.

Is it really possible for someone just starting out to go solo?

It depends on how much risk the surgeon is willing to accept. Starting a solo practice is much like investing in the stock market. Unfortunately, most young surgeons are unprepared for all the issues they will face in starting their careers. Entering a good group practice is an opportunity to learn. While there is a cost to pay, it is generally beneficial to join a group and take advantage of what other surgeons have discovered through experience.

Spending a few years in a group may prepare surgeons for solo practice. And, other surgeons may find that they would prefer to remain in a group so that they can share call and expenses and consult with and enjoy the collegiality of other surgeons. In the end, though, if someone is truly committed to going into solo practice he or she probably only wants advice about what to do.

So what kind of advice do you give a surgeon who wants to enter solo practice?

If I cannot talk them out of it, then they clearly have the traits they need to practice independently: resolute passion and an admirable level of self-confidence. Basic advice includes checking out the opportunity completely. Is it in a good location? Is the market sufficient relative to the number of surgeons already in the community? Will the professional community welcome the practice? After thinking about these basics, it is necessary to draft a business plan. A good business plan is pragmatic and conservative. It addresses such key issues as practice location, services that will be offered, and means of promoting those services.

The best plans have at least a three-year pro forma financial statement showing cash flow and cash needs. Most surgeons leave training programs with no concept of capital start-up costs and ongoing operating expense. Combined with the debt residents typically have accumulated, these cash needs can be tremendous. Usually, young surgeons need to borrow the money, and any bank will expect a detailed financial plan. A new practice may need three to six months or more to generate a positive cash flow, and that’s assuming the practice has a successful start.

Although the surgeon may develop the plan, some professional advice may be necessary, particularly
for the financial projections. It’s a good idea to check with local county medical societies for the names of qualified accountants experienced with medical practices. They can provide information on local costs and a critical review of the plan. Accountants may be useful in introducing a surgeon to bankers or other funding sources.

What coding concerns do surgeons have and what are you advising?

For the most part, surgeons want to be reassured that they’re coding accurately. Some surgeons voiced frustration about having to create a medical record document that seems to have more to do with substantiating the work done for a code than describing the care rendered. Surgeons routinely document surgical care far better than evaluation and management services. As a result, they often do more work than they document and code.

Surgeons should understand the requirements of a consultation (a specific request for advice or opinion) and office and hospital visits. Surgeons also should approach the exam systematically, and document every task they or their staffs perform. It is wise to review the Current Procedure Terminology handbook when it is published each year to verify the documentation elements (history, examination, and decision making), as well as the requirements for the levels of these elements in the codes.

What are the partnership issues for surgeons?

First and foremost is compensation. Surgeons want compensation in group practices that fairly and equitably reflect personal effort and promote productivity. They also want systems that foster group cohesion and cooperation. In some cases, these expectations are in conflict. The solution that all group members will consider “fair” will differ for each group and will change as personal goals evolve. It is important to review the compensation formula each year to make sure it is still regarded as fair and in line with the work ethic of the group and the individuals in it.

You say that surgeons seem to have an optimistic attitude about their practices. Do you think this trend will continue?

Surgeons have usually found the clinical side of practice rewarding, regardless of socioeconomic concerns. This feeling won’t change. As to whether they will continue to be upbeat on practice management depends on improvements in public health policy on issues of fair and equitable reimbursement, tort reform, liability cost controls, and the issues that affect the fundamental patient-physician relationship. Time will tell, but surgeons appear to be approaching the challenges positively and proactively.

Tom Loughrey is CEO of Economedix, a national practice management consulting and training company. He can be reached at 877/238-5303 or at tloughrey@economedix.com. Tom can also be heard every other week on Wednesdays at 3 pm Eastern time, noon Pacific, doing a Practice Management Teleconference for Fellows of the College and their staff. More information is available at http://www.facs.org/ahp/workshops/teleconferences.html.
Resident and Associate Society: An update

by Danielle A. Katz, MD, Syracuse, NY

The members of the Resident and Associate Society (RAS) had the opportunity to meet in October at the Clinical Congress in New Orleans, LA, to review the events of the past year and to set a course for the upcoming year. Meetings of both the RAS Executive Committee and the Council of Representatives were held during the Congress. There were many familiar faces and many new ones looking to participate.

New committee chairs and officers were elected: Danielle Katz, MD (Chair, RAS); Michael Sutherland, MD (Vice-Chair, RAS); Gregory Cherr, MD (Secretary, RAS); Andrea Silver, MD, and Jacob Moalem, MD (Co-Chairs, Membership Committee); Juan Paramo, MD, and Suzanne Cutter, MD (Co-Chairs, Communications Committee); Barry Jenkins, MD, and Ted James, MD (Co-Chairs, Education Committee); and Faisal Qureshi, MD (Chair, Issues Committee).

The RAS symposium on Surgical Residents: Students or Employees—And Why It Matters, was well attended and featured excellent presentations by J. Patrick O’Leary, MD, FACS, Michael Reichgott, MD, Joseph Keyes, JD, and Eric Grogan, MD. Each panelist provided a unique perspective on the issue, but all agreed that residents embody characteristics of both students and employees, in different capacities. The presentations were followed by a stimulating question-and-answer session that generated zealous and thought-provoking discussion.

Looking to the future, RAS plans to continue to increase its service to the College by having members serve on numerous ACS committees and by collaborating with other divisions on projects relevant to residents. We plan to continue to reach out to all surgical specialties to get more residents playing active roles within the College, to recognize the importance of the ACS in addressing issues that affect all surgeons, and to recognize that today’s residents are the future of the ACS and of surgery itself. We are ready for another exciting and productive year and invite all residents and Associate Fellows to get involved and help shape the future.

Dr. Katz is an orthopaedic surgeon and assistant professor of orthopaedic surgery, State University of New York Upstate Medical University, Syracuse, NY, and current Chair of the Resident and Associate Society.

TSI Online reviews the best of the current surgical literature

Be sure to visit The Surgical Index (TSI), a new online service the College is providing for its members and other constituents at http://www.facs.org/tsi/index.html. TSI Online is intended to be a kind of one-stop information shop for surgeons who are committed to staying at the top of their profession. TSI Online has been designed to be easy to use, without a lot of computer wizardry to obscure its central purpose: saving you time while providing you with a highly focused and selective source of ongoing surgical information.

TSI Online is a gateway to the best of the surgical literature and a proven and potent timesaver in the continuing education of surgeons. You will have around-the-clock access to carefully crafted abstracts of the most important developments published in the monthly surgical literature. Easily scanned for the most salient information, the abstracts are composed of an introduction, results, and conclusion, often with...
editorial commentary that is brief, cogent, and, occasionally, skeptical.

The archival database can be searched for past issues of TSI, as well as for specific subjects of interest to individual surgeons, using a simple anatomical coding system with key word subheadings.


Nominations sought for 2005 ACS Surgical Volunteerism Award

The American College of Surgeons Board of Governors’ (B/G) Committee on Socioeconomic Issues, in association with the Pfizer Medical Humanities Initiative, is seeking nominations for the 2005 Surgical Volunteerism Award. The committee members are looking for ACS Fellows who are making a significant contribution to surgical care through volunteer actions. Candidates for this award may practice their surgical volunteerism either in a domestic, international, or military setting. All surgical subspecialties are eligible for consideration.

Nominations should be limited to 500 words, briefly describing the nature of the surgical activity, location, scope and number of patients served, status of the volunteer surgeons (active, retired, military active duty, or reservist), frequency of service, funding sources, and relation to the College, other professional organizations, or charitable institutions.

All nominations will be graded on seven different criteria:

1. **Community impact:** Assess the medical benefit on the local community/medical facility over the previous 12 months. (20 points)
2. **Humanitarianism:** Assess the degree to which the volunteer displays true selfless altruism. (20 points)
3. **Long-term effect:** Assess the potential impact on the community/medical facility in the future—that is, training and facilities that have continued impact. (15 points)
4. **Number of people served:** Assess the number of people helped as a direct result of the project or act of volunteerism. (15 points)
5. **Length of service:** Assess the number of years of activities. (10 points)
6. **Organizational leadership:** Assess the organizational leadership and personal financial support and/or funds raised on the part of the candidate. (10 points)
7. **Frequency of service:** Assess the frequency of service in terms of personal time volunteered over the last year. (10 points)

A survey by the committee, conducted by the Institute for
Health Policy of the Massachusetts General Hospital, determined that approximately 30 percent of American and Canadian surgeons actively participate in more than 250 different volunteer domestic and international organizations. The College is seeking to identify and formally recognize those individual surgeons and volunteer programs.

During this year’s 90th Clinical Congress in New Orleans, LA, the College awarded Theodore J. Dubuque, Jr., MD, FACS, St. Louis, MO, the Surgical Volunteerism Award for his longstanding humanitarian efforts and surgical leadership in providing 18 years of volunteer surgical services to Project Crudem in Milot, Haiti. Courtney M. Townsend, Jr., MD, FACS, Chair, Board of Governors, presented the award, in association with the Pfizer Medical Humanities Initiative, to Dr. Dubuque (see photo, page 18). The plaque read, “In recognition of those surgeons committed to giving something of themselves back to society by making significant contributions to surgical care through organized volunteer activities.”

The deadline for receiving nominations is Monday, February 28, 2005. Please send your nominations to Richard T. MacDowell, MD, FACS, Chair, B/G Committee on Socioeconomic Issues, 36 Windsor Ct., Delmar, NY 12054; fax 518/446-9087; e-mail Mactheknife22@verizon.net.
ONLINE CME: Courses from the American College of Surgeons’ Clinical Congresses are available online for surgeons. The online courses feature printable written course transcripts, audio of sessions, video of the introduction of each session, post-test and evaluation, and printable CME certificates upon successful completion. Several of the courses are offered FREE OF CHARGE. The courses are accessible at: www.acs-resource.org.

BASIC ULTRASOUND COURSE: The ACS and the National Ultrasound Faculty have developed this course on CD-ROM to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. It replaces the basic course offered by the ACS and is available for CME credit.

BARIATRIC SURGERY PRIMER: Developed by Henry Buchwald, MD, PhD, FACS, and Sayeed Ikramuddin, MD, FACS, the primer addresses the biochemistry and physiology of obesity; identifies appropriate candidates for bariatric surgery; and discusses the perioperative care of the bariatric patient, basic bariatric procedures, comorbidity and outcomes, surgical training, and the bariatric surgical and allied sciences team, along with facilities, aspects of managed care, liability issues, and ethics.

SYLLABI SELECT: The content of select ACS Clinical Congress postgraduate courses is available on CD-ROM. These CD-ROMs are able to run in the PC and Mac environments and offer you the ability to word-search throughout the CD, along with the convenience of accessing any of the courses when you want, and where you want. The 2004 CD will be available in October.

PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons: The CD uses an interactive/lecture format to arm surgeons with basic financial management skills. The course is designed to educate and equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children) and proper planning for financial stresses related to their surgical practice.

These fine educational products are available for your learning convenience.

These products can be purchased by calling ACS Customer Service at 312/202-5474 or by visiting our E-LEARNING RESOURCE CENTER at www.acs-resource.org.

For more information contact Dawn Pagels, MBA, at dpagels@facs.org, or tel. 312/202-5185.
2005 Health Policy Scholarships available

The American College of Surgeons is offering health policy scholarships to subsidize attendance and participation in the Leadership Program in Health Policy and Management at Brandeis University, Waltham, MA. The course takes place May 15-20, 2005. The $8,000 award is to be used toward the cost of tuition, travel, housing, and subsistence during the participation in the program.

One of the scholarships is reserved for general surgeons and is fully funded by the College. The College is pleased to announce that a number of the surgical specialty societies will partner with the ACS to cosponsor a scholarship for a member in good standing of both the College and their society to attend this intensive health policy program. The participating societies supporting scholarships are the American Academy of Ophthalmology, the American Association of Neurological Surgeons, the American Society of Colon and Rectal Surgeons, the American Society of Plastic Surgeons, the American Urogynecologic Society, the Society of Thoracic Surgeons, and the Society for Vascular Surgery.

General policies covering the granting of the Health Policy Scholarships are:

• The award is open to surgeons who are general surgeons or members in good standing of the one of the above societies, as well as of the American College of Surgeons. Applicants must be at least 30 years old but under 55 on the date that the completed application is filed.
• The award is to be used to support the recipient during the period of the course. Indirect costs are not paid to the recipient or to the recipient’s institution.
• Applications for this scholarship must consist of the following items: one copy of the applicant’s current curriculum vitae, and one copy of a one-page essay discussing why the applicant wishes to receive the scholarship.
• Applications for this award may be submitted even if comparable applications to other organizations have been made. If the recipient accepts a similar scholarship from another agency or organization, the Health Policy Scholarship will be withdrawn. It is the responsibility of the recipient to notify the Scholarships Section of the ACS, which administers this program, of competing awards.
• The Health Policy Scholarship must be used in the year for which it is designated. It cannot be postponed.
• The scholar is required to serve one year as a pro tempore member of the Health Policy Steering Committee of both the ACS and his or her specialty society following completion of the course. This obligation includes participation in meetings of the organizations’ health policy committees.
• A brief report of the scholar’s experiences and activities is due at the conclusion of the scholarship period. A simple accounting is also required.

The closing date for receipt of applications is February 1, 2005. All applicants will be notified of the outcome of the selection process by March 31, 2005. Questions may be directed to the ACS Scholarships Administrator at 312/202-5281. Requirements for the Health Policy Scholarships are posted on the ACS Web site at http://www.facs.org/member services/research.html.

Please send applications for this scholarship to Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
ACS Career Opportunities
The American College of Surgeons’ online job bank

A unique interactive online recruitment tool provided by the American College of Surgeons, a member of the HEALTHeCAREERS™ Network

An integrated network of dozens of the most prestigious health care associations.

Candidates:
• View national, regional, and local job listings 24 hours a day, 7 days a week—free of charge.
• Post your resume, free of charge, where it will be visible to thousands of health care employers nationwide. You can post confidentially or openly—depending on your preference.
• Receive e-mail notification of new job postings.
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Employers:
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Questions?
Contact HealtheCareers Network at 888/884-8242 or candidates@healthecareers.com for more information.
Contributions sought for 2005 Clinical Congress in San Francisco

Paper sessions
The ACS Program Committee and the ACS Division of Education invites surgeons and surgical residents to submit abstracts for clinical paper sessions at the 91st annual Clinical Congress, to be held October 16–20, 2005, in San Francisco, CA. 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 co-author is a Fellow of the College. Individuals making submissions should strictly adhere to the following instructions:

1. The abstract should provide adequate information and objective data for proper evaluation.
2. The abstract must be limited to one 8½” × 11” page, with 1” top and bottom margins and a left margin of 1½”. 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 address, fax number, and pertinent information regarding medical school affiliation and other institutions where 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 the abstracts is Monday, March 1, 2005. Submissions should be mailed to the American College of Surgeons, Division of Education, Program Committee, 633 N. Saint Clair St., Chicago, IL 60611, Attn: Molly Clear.

The quality of the paper and a balanced program remain the Program 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 Molly Clear at 312/202-5325 or mclear@facs.org.

Scientific exhibits sought
The Program Committee also invites the submission of abstracts for the scientific exhibit/poster session at the 91st annual Clinical Congress in San Francisco, CA.

Beginning in January 2005, printed application forms may be obtained by contacting Lisa Richards at 312/202-5385 or lrichards@facs.org. The online application will be available on our Web site, www.facs.org. Please note that paper applications will be phased out after the 2005 Congress, and abstract submission for the 2006 Congress will be effected online only.

The abstracts will be peer-reviewed by a select group of Program Committee members, 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 rental of any additional items in the exhibit space. The abstract submission deadline is 5:00 pm Central time, Tuesday, March 1, 2005.
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• 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.
As the weather changes and recreational pursuits take us from the beaches to off-road, it is time to look at the alarming increase in all-terrain vehicle (ATV) injuries. That lawn mower-like engine sound emanating from the dirt hill across the way is not a grounds crew working on the lawn, but more likely than not is a youth, often less than 16 years of age, atop an ATV designed for adults. With dirt flying, engines roaring, one unhelmeted youth with no formal training or education in the operation of this potentially dangerous motorized vehicle is just having a great time. A great time, that is, until one of the 37,000 annual injuries sends him or her to the emergency room for treatment.

The National Trauma Data Bank Annual Report 2003 contains close to 16,000 records relating to off-road vehicles that include ATV injuries. The age group representing less than 16 years of age in the NTDB™ accounts for 30 percent of the injuries and 27 percent of the deaths. These data are similar to what has been reported by the Consumer Product Safety Commission last fall, which found that children under 16 accounted for 37 percent of all injuries and 33 percent of all ATV deaths.

However, this sport is not wasted on our youth. A sector of the adult population engages in this activity as well. Unfortunately, this sector often ventures out without wearing proper safety equipment, such as a protective helmet, and may add the variable of drinking while off-roading. In fact, when looking at the fatal off-road vehicle injuries contained in the NTDB, more than half of the fatalities that were tested had alcohol present. These data are depicted in the graph on this page.

Readers may have noticed a recurring theme from month to month in this column: exhibit responsible behavior and proper utilization of safety equipment and the risk of injury declines. However, for this type of vehicle, there is also the issue of untrained children riding ATVs that are designed for heavier adults. The center of gravity may not allow for the off-road experience that they are looking for or expecting. A lightweight youth climbing a steep slope on a heavy machine lends itself to flipping over and often leads to tragedy. Simple preventive measures are needed in order to stop the yearly increase in ATV injuries and fatalities. For more information on ATV injuries and their prevention, visit the Committee on Trauma’s Injury Prevention and Control Subcommittee at http://www.facs.org/trauma/atv.html.

Throughout the year, we will be highlighting these data through brief monthly reports in the Bulletin. For a complete copy of the National Trauma Data Bank Annual Report 2003, visit us online at http://www.ntdb.org. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.
New Chapter in Turkey

The College now has 32 International Chapters, and the newest one is located in Turkey. On Saturday, October 9, the College’s Board of Regents approved the formation of the Turkey Chapter. Cemalettin Topuzlu, MD, FACS, the Governor from Turkey, successfully shepherded the development of the Turkey Chapter, including conducting a poll of College members in Turkey for their approval, drafting bylaws, and coordinating the election of provisional officers. On October 10, the official charter for the Turkey Chapter was presented at the Annual Meeting of the Board of Governors (see photo, right).

The provisional officers of the new Turkey Chapter include: President, Kemal Alemdaroglu, MD, FACS; Vice-President, Cemalettin Topuzlu, MD, FACS; Secretary, Gürsel Soybir, MD, FACS; Treasurer, Tansu Salman, MD, FACS; Governor-at-Large, Cemalettin Topuzlu, MD, FACS; At-Large-Member, Özdemir Aktan, MD, FACS.

The other International Chapters include Argentina, Australia-New Zealand, Belgium, Brazil, Chile, Colombia, Ecuador, France, Germany, Greece, Hong Kong, India, Ireland, Israel, Italy, Jamaica, Japan, Lebanon, Mexico-Federal District, Mexico-Nor-Occidental, Mexico-Northeast, Panama, Peru, Philippines, Saudi Arabia, South Korea, Spain, Switzerland, Thailand, Uruguay, and Venezuela.

NY conducts practice management workshop

On October 2, the New York (NY) Chapter co-hosted a one-day practice-management workshop for surgical residents, which took place at the New York Athletic Club in New York City. Topics that were covered included New York State’s professional discipline process, employment contracts and partnership agreements, and professional liability insurance purchasing considerations. In addition to the New York State Chapter, other statewide specialty societies that also cohosted the education program included the American College of Obstetricians and Gynecologists (District II), the New York Chapter of the American College of Physicians, New York State Academy of Family Practice, New York State Ophthalmological Society, New York State Society of Orthopaedic Surgeons, and New York State Thoracic Society.

New Jersey tackles new taxes on surgeons

The New Jersey legislature passed two new taxes to support uncompensated hospital care, and the New Jersey Chapter is actively advocating their repeal. The one new tax of 8.2 percent will be levied on nonhospital-owned outpatient surgical cen-
The second new tax of 6 percent, which is a sales tax, will be levied on all nonreconstructive, elective, cosmetic procedures—such as Botox applications, liposuction procedures, breast procedures, and others. In a letter sent to all newspapers in the state, Paul LoVerme, MD, FACS, the Chapter President, pointed out that currently, New Jersey hospitals receive $381 million dollars for charity care, while New Jersey physicians receive nothing. For more information about these new taxes, visit the New Jersey Chapter’s Web site at http://www.nj-acs.org/, or call Art Ellenberger, Executive Director, at 973/239-2826.

In unrelated news, the New Jersey Chapter’s 2005 Pilgrimage will be to the Quincentennial (500th) Anniversary of the Royal College of Surgeon of Edinburgh, the oldest surgical society in the world. A variety of programs will be held as part of this special historic celebration. For more information, please visit the New Jersey Chapter Web site, or phone Mr. Ellenberger.

New Mexico conducts annual meeting

On August 6, the New Mexico Chapter conducted its annual meeting and education program in Albuquerque. During the meeting, in addition to electing new officers (see photo, top left), Thomas R. Russell, MD, FACS, the College’s Executive Director, presented the 2003 Distinguished Philanthropist Award to William Kridelbaugh, MD, FACS. Dr. Kridelbaugh was the 14th recipient of this College recognition award, having established a Charitable Remainder Unitrust naming the College as a beneficiary (see photo, bottom left).

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New Chapter Web site

The President of the Argentina Chapter, Alberto Cariello, MD, FACS, announced in August that the Argentina Chapter has developed a Web site to communicate with its members. The Web site is available online at http://www.capituloargacs.org.ar. The Web site includes information on the history of the Argentina Chapter, the Chapter Officers, the Argentina Committee on Trauma, and scholarships for surgeons.
Announcing a new instructional CD-ROM

“I welcome the CD-ROM published this month by Dr. Buchwald and Dr. Ikramuddin, both international leaders in the field and faculty members at the University of Minnesota, the institution that has provided the most leadership in the development of this remarkable field. It provides excellent basic knowledge that can serve as an introduction for budding bariatric surgeons, as a review for those who are already in the field, as an overview for our nonsurgical colleagues.”

— Walter J. Pories, MD, FACS

“Every general surgery training program, indeed, every general surgeon, has a need to be well-informed in bariatric surgery. This disk, presenting the very best of basic bariatric surgical knowledge, brings the viewer extremely close to the subject and provides him/her with a good intellectual grasp of the field. It is a must-have enduring educational gem.”

— George S. Cowan, MD

by Henry Buchwald, MD, PhD, FACS, FACS
and Sayeed Ikramuddin, MD, FACS

Bariatric Surgery Primer

Course objectives:

- Describe the epidemiology, etiology, incidence, and demography of morbid obesity, and outline the energy metabolism and biochemistry of obesity, as well as the physiologic basis for bariatric surgery.
- Identify appropriate candidates for bariatric surgery and to discuss the pre-, intra-, and postoperative care of the bariatric patient, as well as patient selection, assessment, and preparation.
- Identify and clearly discuss the following bariatric procedures: laparoscopic adjustable gastric banding, vertical banded gastroplasty, gastric bypass, biliopancreatic diversion/dudodenal switch, and gastric pacing.
- Describe the comorbid conditions of morbid obesity and the outcomes following bariatric surgery.
- Describe the training of the bariatric surgeon, the bariatric surgical and allied sciences team, and requisite hospital facilities, aspects of managed care, and liability issues in this field.
- Discuss the ethics of bariatric surgery.

For more information, contact Dawn Pagels at dpagels@facs.org, or tel. 312/202-5185

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