Retirement:
Exploring the road not taken
FEATURES

College plays pivotal role in Operation Iraqi Freedom 8
Lt. Col. Harry K. Stinger, MD, FACS

Retirement: An opportunity to revisit “the road not taken” 16
Thomas H. Cogbill, MD, FACS

Statement on universal health insurance 21

Statement on the physician acting as an expert witness 22

Ten specialty boards report accomplishments and plans: Part I 24

ACS Officers and Regents 33

DEPARTMENTS

From my perspective 3
Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director

FYI: STAT 5

Dateline: Washington 6
Division of Advocacy and Health Policy

About the cover...
Retirees often find they have arrived at the perfect juncture in life to take the road not traveled. In this month’s cover story on page 16, Thomas H. Cogbill, MD, FACS, discusses surgeons’ concerns about retirement and offers advice for individuals who are considering whether they are ready to explore a different path.
Cover photo © Punchstock.
In memoriam: Ralph A. Straffon, MD, FACS, 1928-2004, remembered by David C. Miller, MD, and Martin I. Resnick, MD, FACS

Fellows and facts

NTDB™ data points: “I didn’t mean to” by Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

Dr. Russell meets with new ACS Surgery editorial board

The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
Officers and staff of the American College of Surgeons

Officers

Claude H. Organ, Jr., MD, FACS, Oakland, CA
President

Anna M. Ledgerwood, MD, FACS, Detroit, MI
First Vice-President

Murray F. Brennan, MD, FACS, New York, NY
Second Vice-President

John O. Gage, MD, FACS, Pensacola, FL
Secretary

John L. Cameron, MD, FACS, Baltimore, MD
Treasurer

Gay L. Vincent, CPA, Chicago, IL
Comptroller

Officers-Elect (take office October 2004)

Edward R. Laws, MD, FACS, Charlottesville, VA
President-Elect

Andrew L. Warshaw, MD, FACS, Boston, MA
First Vice-President-Elect

Henry L. Laws, MD, FACS, Birmingham, AL
Second Vice-President-Elect

Board of Regents

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

Gerald B. Healy, MD, FACS, Boston, MA
Vice-Chair

H. Randolph Bailey, MD, FACS, Houston, TX
Barbara L. Bass, MD, FACS, Baltimore, MD
L. D. Britt, MD, FACS, Norfolk, VA
Bruce D. Browner, MD, FACS, Farmington, CT
Martin B. Camins, MD, FACS, New York, NY
William H. Coles, MD, FACS, Chapel Hill, NC
A. Brent Eastman, MD, FACS, San Diego, CA
Richard J. Finley, MD, FACS, Vancouver, BC
Josef E. Fischer, MD, FACS, Boston, MA
Alden H. Harken, MD, FACS, Oakland, CA
Charles D. Mabry, MD, FACS, Pine Bluff, AR
Jack W. McAninch, MD, FACS, San Francisco, CA
Mary H. McGrath, MD, FACS, San Francisco, CA
Robin S. McLeod, MD, FACS, Toronto, ON
Claude H. Organ, Jr., MD, FACS, Oakland, CA
Carlos A. Pellegrini, MD, FACS, Seattle, WA
Karl C. Podratz, MD, FACS, Rochester, MN
John T. Preskitt, MD, FACS, Dallas, TX
J. David Richardson, MD, FACS, Louisville, KY
Thomas V. Whalen, MD, FACS, New Brunswick, NJ

*Executive Committee

Board of Governors/Executive Committee

Courtney M. Townsend, Jr., MD, FACS, Galveston, TX
Chair

Rene Lafreniere, MD, FACS, Calgary, AB
Vice-Chair

J. Julie A. Freischlag, MD, FACS, Baltimore, MD
Secretary

Donald E. Fry, MD, FACS, Albuquerque, NM
Mary Margaret Kemeny, MD, FACS, Jamaica, NY
Mark A. Malangoni, MD, FACS, Cleveland, OH
Valerie W. Rusch, MD, FACS, New York, NY

Advisory Council to the Board of Regents
(Past-Presidents)

W. Gerald Austen, MD, FACS, Boston, MA
Oliver H. Beahrs, MD, FACS, Rochester, MN
John M. Beal, MD, FACS, Valdosta, GA
Harvey W. Bender, Jr., MD, FACS, Nashville, TN
George R. Dunlop, MD, FACS, Worcester, MA
C. Rollins Hanlon, MD, FACS, Chicago, IL
R. Scott Jones, MD, FACS, Charlottesville, VA
M. J. J urkiewicz, MD, FACS, Atlanta, GA
LaSalle D. Leffall, Jr., MD, FACS, Washington, DC
Lloyd D. MacLean, MD, FACS, Montreal, QC
William H. Muller, Jr., MD, FACS, Charlottesville, VA
David G. Murray, MD, FACS, Syracuse, NY
David C. Sabiston, Jr., MD, FACS, Durham, NC
Richard R. Sabo, MD, FACS, Bozeman, MT
Seymour I. Schwartz, MD, FACS, Rochester, NY
George F. Sheldon, MD, FACS, Chapel Hill, NC
G. Tom Shires, MD, FACS, Las Vegas, NV
Frank C. Spencer, MD, FACS, New York, NY
James C. Thompson, MD, FACS, Galveston, TX

Executive Staff

Executive Director: Thomas R. Russell, MD, FACS
Division of Advocacy and Health Policy:
   Cynthia A. Brown, Director
American College of Surgeons Oncology Group:
   Samuel A. Wells, Jr., MD, FACS, Group Chair
Communications: Linn Meyer, Director
Division of Education:
   Ajit K. Sachdeva, MD, FACS, FRCS, Director
Executive Services: Barbara L. Dean, Director
Finance and Facilities: Gay L. Vincent, CPA, Director
Human Resources: J. J an DeYoung, Director
Information Technology: Howard Tanzman, Director
Journal of the American College of Surgeons:
   Wendy Cowles Husser, Executive Editor
Division of Member Services:
   Paul E. Collicott, MD, FACS, Director
Division of Research and Optimal Patient Care:
   R. Scott Jones, MD, FACS, Director
Cancer:
   David P. Winchester, MD, FACS, Medical Director
Trauma:
   David B. Hoyt, MD, FACS, Medical Director
Executive Consultant:
   C. Rollins Hanlon, MD, FACS
From my perspective

In this column, I bring you exciting news about the American College of Surgeons Professional Association’s (ACSPA) latest effort aimed at helping to stop the professional liability crisis—becoming part of Doctors for Medical Liability Reform (DMLR). To raise the profile of this issue, the ACSPA has joined with a number of medical and surgical specialty societies to form a coalition of 230,000 specialty physicians who support federal medical liability reform.

This is a critically important issue that faces enormous legislative obstacles. Although these important reforms have passed the U.S. House of Representatives many times, the issue has failed to gain necessary support in the Senate. To overcome this roadblock, DMLR has launched a hard-hitting national media campaign targeted at states that are represented by Senators who oppose federal medical liability reform legislation.

DMLR launched this campaign in early February, starting first in Washington state and North Carolina. The patient-centered initiative seeks to educate and inform patients, business leaders, and legislators about the destructive effects that this crisis is having on our health care system and economy. As the campaign moves forward, this public education effort will be launched in a number of other crisis states.

As you well know, enormous medical liability insurance premiums, brought on by escalating jury awards and the high cost of defending against frivolous lawsuits, are forcing surgeons to limit the services they provide, retire early, or relocate their practices. According to the Washington State Medical Association, more than 500 physicians have left that state since 1998 as a result of this crisis. As this problem worsens state by state, the need for common sense federal reforms remains on the national stage.

DMLR’s campaign features a 30-minute “Protect Patients Now” television news magazine that highlights the crisis from the patient’s perspective and urges citizens to call their Senators to voice their support for federal medical liability reform. In addition to airing the program in the states of Washington and North Carolina in early February, a full-page advertisement was placed in the national editions of USA Today, The Wall Street Journal, and The Washington Post.

Fellows can find all of DMLR’s national and grassroots campaign initiatives online at www.ProtectPatientsNow.org, the coalition’s official Web site. I encourage you to review the materials posted there and to discuss them with...
your patients. The site contains a patient advocacy section to assist the general public in supporting the campaign. Similar to the patient brochures that ACSPA distributed to your offices last fall, the DMLR campaign focuses on patient education. To further complement this effort, the ACSPA will soon be distributing campaign buttons to our members that we hope will help stimulate conversation and so encourage surgeons and patients to discuss the crisis openly. Because of its many complexities and a considerable amount of misinformation that has accumulated over the years, the American public faces a steep learning curve with regard to this issue. It is our responsibility, as surgeons who care for many of the sickest and riskiest patients, to help inform the public about the impact the crisis is having on them and on their timely access to high-quality surgical care.

The ACSPA and the American College of Surgeons continue to work aggressively to enact federal medical liability reform. As always, we support a $250,000 cap on noneconomic damages, along with limits on attorney’s fees, statute of limitations reform, collateral source offsets, and abolition of joint and several liability.

Of course, the College is also mindful of the fact that meaningful reforms must include strong standards that determine the qualifications of physicians who serve as expert witnesses. At its February meeting, the Board of Regents approved a new expert witness affirmation statement that sets forth professional principles that should guide the physician or surgeon who acts as a expert for a plaintiff or defendant. The statement appears on page 22 of this issue of the Bulletin. Other specialty societies have found that similar affirmations often prove useful in either bolstering or calling into question the qualifications of physician experts during court proceedings.

Please join in our efforts to bring the facts about this crisis before the public. Patients need access to high-quality surgical care everywhere—not just in a handful of states that have implemented effective reforms. The time to speak out is now.

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.
Members of the College’s Health Policy Steering Committee, along with ACS Executive Director Thomas R. Russell, MD, FACS, met with health policy experts at the Harvard School of Public Health on January 14 to discuss approaches to resolving health care access problems for the uninsured. The meeting was held as part of the committee’s effort to refine an official ACS policy statement on this issue.

The 32nd annual Spring Meeting of the American College of Surgeons will be held in Boston, MA, April 24-27. To emphasize its strong commitment to and support of general surgery, the College devotes its annual Spring Meeting to the interests and needs of the practicing general surgeon. The complete Scientific Program, including registration and hotel reservations, is online at: http://www.facs.org/2004springmeeting/index.html.

LaMar S. McGinnis, Jr., MD, FACS, provided surgery’s perspective at the “Crossing the Quality Chasm Summit” hosted by the Institute of Medicine and the Robert Wood Johnson Foundation in January. More than 250 of the nation’s top health delivery, payment, and policy leaders formulated action plans to address some of the highest priority conditions, including heart failure, pain control in cancer, asthma, depression, and diabetes. Dr. McGinnis also provided advice on cross-cutting health care issues, such as care coordination, measurement, finance, and information technology. The summit action plans developed by national stakeholders will guide federal and state policies and funding priorities that are expected to be included in legislation.

In an effort to be responsive to its members’ requests for a symbol they might use for individual business purposes, the College has developed a special mark for its Fellows. The new “slogan logo” underscores the fact that ACS members are “committed to excellence” and is available online. Only Fellows of the American College of Surgeons may use this symbol, and they must abide by the guidelines that have been developed to govern its use. To access the guidelines and an electronic copy of the logo, visit http://www.facs.org/members/sloganlogo/disclaimer.html.

The American College of Surgeons (ACS) and HEALTHeCAREERS, an online network of health care association career center Web sites, have entered into an agreement to provide ACS Career Opportunities, an online surgical career center, for its members. As part of this growing network, ACS Career Opportunities is participating in a system that links nearly one million health care professionals from more than 200 disciplines with thousands of medical groups, hospitals, and other health care employers. To post a resume at no cost or a job opportunity at competitive classified advertising rates, visit the ACS homepage at www.facs.org and click on the “Job Bank” link in the left-hand column.
**Dateline Washington**

prepared by the Division of Advocacy and Health Policy

**GAO issues report on assistants at surgery**

The General Accounting Office (GAO) issued a controversial report in January entitled Medicare Payment Changes Are Needed for Assistants-at-Surgery (GAO-04-97). Written in response to a directive from Congress to look at the potential effects of allowing Medicare fee schedule payments for certified registered nurse first assistants, the report concludes that Congress may want to consider consolidating all Medicare payments for assistant at surgery services into the hospital inpatient prospective payment system. This would include assistant at surgery services by all provider types—both physician and nonphysician—without regard to employment status.

Because Medicare’s Part A hospital payments are intended to cover assistant at surgery services that are provided by hospital employees, and those payments are not reduced when a Part B payment to an assistant at surgery is made under the physician fee schedule, GAO believes that the program may be paying too much for some hospital surgical care. The College and other surgical and nonsurgical specialty organizations have already begun educating Congress about the very serious implications of such a radical policy change. To view the full report, visit http://www.gao.gov/new.items/d0497.pdf. The College’s comments on the report may be viewed on the Web at: www.gao.gov (select the “GAO Reports” option and follow the instructions to access GAO-04-97).

**Scope of practice legislation introduced**

The American College of Surgeons recently joined a coalition of physician organizations to support the Veterans Eye Treatment Safety (VETS) Act, H.R. 3473. This bill would prohibit nonphysicians from performing eye surgery within the Department of Veterans Affairs (VA) health care system. The legislation comes in response to a decision at the Robert J. Dole Veterans Affairs Medical Center in Wichita, KS, to allow an Oklahoma-licensed optometrist to perform laser procedures. The College believes the VA decision sets a dangerous precedent and poses a serious threat to patient safety.

Surgeons are encouraged to write their legislators and urge them to cosponsor the VETS Act by visiting the College’s Legislative Action Center at http://capwiz.com/facs/mail/oneclick_compose/?alertid=4521361.

**National provider identifier established**

The Centers for Medicare & Medicaid Services (CMS) published a final rule on January 23, establishing an individual national provider identifier (NPI) for each health care provider, including physicians, to use in filing and processing claims. As mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the NPI will replace current identifiers issued by the various payors. All physicians who electronically transmit claims or related transactions, such as verification of a patient’s enrollment in a health plan, must obtain a single NPI and use that 10-digit number for all transactions with all payors. The NPI is expected to significantly reduce administrative costs for both providers and payors.
The NPI will contain no embedded information about the person it identifies. A CMS contractor, known as the “enumerator,” will process applications for NPIs during a two-year enrollment period beginning May 23, 2005. Surgeons need not take any action now to receive an identifier; additional information about NPI implementation, including the details of the application process, will be available in the future.

The regulation may be viewed in its entirety at http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf.

On January 28, CMS released the guidelines that hospitals must use to report information to the agency’s quality improvement organization’s data warehouse. Under provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA), hospitals are required to submit data on all patients for a total of 10 quality measures that relate to three serious medical conditions—acute myocardial infarction, heart failure, and pneumonia. A number of hospitals began voluntarily transmitting this data in October 2003, but the MPDIMA provides an added incentive for submitting the data—a full market basket payment update in fiscal year 2005. Hospitals that do not provide the data will receive a payment update of 0.4 percentage points below the market basket.


The Institute of Medicine (IOM) has established an ad hoc committee to report on the future of emergency care in the U.S. This 18-member group, which includes C. William Schwab, MD, FACS, from the University of Pennsylvania Medical Center, met for the first time February 2-4 to begin looking at safety net issues resulting in emergency department crowding, prehospital emergency medical services, patient flow, information technology, finance, rural emergency care, and emergency preparedness. The IOM has asked the College to provide data and background information that may be useful to the committee, as well as assistance identifying other experts and resources that might help to inform the committee’s deliberations. Those surgeons interested in following the progress of the committee may do so at http://www.iom.edu/project.asp?id=16107

ACS Cross Country, a monthly newsletter produced by the College’s Division of Advocacy and Health Policy, digests state issues affecting surgeons at the local level. Check http://www.facs.org/ahp/crosscountry.html monthly to learn more about current ACS activities and grassroots initiatives that are planned or are under way throughout the country.
College plays pivotal role in Operation Iraqi Freedom

by Lt. Col. Harry K. Stinger, MD, FACS, Tacoma, WA
Paratroopers armed with machine guns, mortars, and grenades were not the only U.S. Army soldiers who parachuted onto Bashur Airfield in Northern Iraq with the 173rd Airborne Brigade on the evening of March 26, 2003. Nine paratrooper-surgeons and medics from the 250th Forward Surgical Team (FST), based in Fort Lewis, WA, also jumped with the 173rd assault troops to perform lifesaving trauma procedures on any infantry personnel who sustained combat injuries (see photo 1, right). Two Humvee cargo trucks loaded with an operating table, an operating room tent, a generator, and enough supplies to perform 10 resuscitative procedures were pushed out of aircraft and parachuted to the drop zone ahead of the jumpers. This step was critical so that the surgical team could unload and set up to perform forward resuscitative surgery.

I served as the Commander of the 250th FST. Three other surgeons also were assigned to the 250th and currently are supporting the 173rd Airborne Brigade in Northern Iraq: Lt. Col. Robert Rush, MD, a general surgeon; Maj. Benjamin Starnes, MD, an Associate Fellow of the College and a vascular surgeon; and Maj. John Devine, MD, an orthopaedic surgeon (see photo and biographical information on page 15).

Preparation

We started planning the jump into Iraq with the Italy-based 173rd Airborne Brigade while still at Fort Lewis. Only five days

1. The 250th FST members who parachuted into Iraq to open up the Northern Front in Operation Iraqi Freedom. Standing from left to right: Brad West, CRNA; William Goldsworth, OR tech; Robert Novak, LPN; Abel Tavares, OR tech; Robert Burns, trauma medic; Luke Fullerton, trauma medic; Dr. Stinger; and Dr. Devine. Front: Glen Carlsson, CEN, trauma nurse. In the background are the C-17 Aircraft that they would soon board for Iraq.

2. 173rd paratroopers loading the C-17 assault aircraft that would drop them over Northern Iraq.
prior to the actual jump, we loaded the entire team onto an Air Force cargo plane, which flew us directly to Italy, where we joined forces with the paratroopers of the 173rd Airborne Brigade. Once in Italy, we immediately began parachute-rigging our Humvees and equipment for a combat jump into Iraq (see photo 2, page 9, and photo 3, right).

For me, the jump into Iraq was a routine mission. I had practiced this exercise many times, usually in Louisiana, while assigned to the 82nd Airborne Division at Fort Bragg, NC. Back in the states, we learned many valuable lessons that ensured the forward surgical team’s success. One technique was to pack 20 units of type O negative packed red blood cells into two iced styrofoam chests and cargo-strap them to the front passenger seats of each of the two parachute-rigged Humvees (termed “heavy-drop” Humvees by the team’s medics) (see photo 4, right). This process yielded 20 units of packed O-cells with which to transfuse combat casualties. The technique of rigging vehicles and artillery guns with parachutes to be pushed out of the back of cargo aircraft onto the drop zone (DZ) has replaced the famous glider infantry forces of World War II, which then had the job of landing their gliders on the DZ with jeeps and heavy artillery guns on board.

**FSTs**

We were actually the first forward surgical team to parachute into combat since World War II. The late Charles Rob, MD, FACS, a world-renowned vascular surgeon then serving in the Royal Army Medical Corps in World War II, pioneered the first airborne forward surgical teams with the British 1st Airborne Division in the North Africa campaign. Dr. Rob made two combat jumps with the British in World War II. He set up his forward surgical team under very austere conditions, yet they were very successful at saving wounded British paratroopers. Along with Norman Rich, MD, FACS, and Craig Llewellyn, MD, both at the Uniformed Services University of Health Sciences, Dr. Rob was my main inspiration and mentor since the start of my surgical career. After a long and distinguished surgical career, Dr. Rob passed away in 2001.

The need for a small, easy-to-insert surgical capability became evident during the U.S.-led invasion of Grenada in 1983. At that time, the smallest Army unit that could perform surgery was a mobile Army surgical hospital (MASH). Because of its large weight and size, the first MASH did not make it into Grenada until four days after the invasion started. This prompted the Army to develop the FST to meet the need for a small, readily
5. The Sonosite ultrasound was invaluable for FAST exams and peripheral vascular assessments. The ultrasound console, three probes, and two batteries all fit into a small portable backpack.

6. Once the paratroops secured the airfield, cargo planes full of additional troops, ammunition, food, water, and medical supplies landed next. The FST trucks and personnel that did not jump were brought in by C-17 cargo planes at night.

7. Three DRASH tents that comprise the 250th FST. The apical tent on the far right is the ATLS/pre-op tent; the two to the left are the operating room and SICU/post-op tents.

8. The 250th FST operating room fully set up and ready to receive casualties. Fortunately, casualties in the north were light.

deployed surgical team that could perform resuscitative trauma surgical procedures on U.S. soldiers from the moment the fighting began. By 1986, Army surgical squads were organized and actually jumped in with U.S. paratroops during the invasion of Panama in 1989. These small squads had to wait for aircraft to land before they could access their operating tables, anesthesia machines, and other heavy equipment.

The U.S. Army fielded the first airborne FSTs in the early 1990s. These units had the advantage of being able to parachute their heavy operating
room tents, generators, and equipment into the combat zone ahead of the paratroopers on parachute-rigged Humvees. This system ensured that wounded GIs would have immediate access to lifesaving trauma resuscitation within the “golden hour” from the moment the fighting started. The FST also enabled U.S. casualties to survive long-distance air transport back to larger hospitals located in Germany and in the continental U.S.

Each FST in Operation Iraqi Freedom consisted of 20 personnel: four surgeons, five nurses, a medical operations officer, and 10 enlisted medics who specialize not only in trauma surgical procedures but also in the pre- and postoperative care of combat casualties. All surgeons and nurses were board-certified in their respective specialties and used state-of-the-art equipment and techniques to provide the best trauma care to U.S. troops who happened to be injured in the line of duty.

“By far, the most useful item was the Sonosite portable ultrasound,” says Dr. Rush (see photo 5, page 11). “The FAST exam was very useful as a triage tool, as the injured paratroopers we work on have tremendous physiologic reserve. This diminishes the reliability of routine vital signs in making triage decisions. We also used the Sonosite to screen for traumatic pseudoaneurysms, assess the adequacy of vascular repairs, and eventually even assess congenital heart defects in young Iraqi children.”

Other items of equipment unique to the team were quick set-up, quick-strike deployable rapid assembly shelters (DRASHs), compact anesthesia machines, I-Stat lab cartridges, and oxygen concentrators instead of pressurized oxygen tanks. “Because of pressure considerations at altitude, the familiar pressurized oxygen tanks cannot be delivered to the battlefield from Air Force aircraft,” says Dr. Rush. “Everything we use is delivered by air, either parachuted to the ground or delivered by tactical aircraft landings. That was my mission—I had to tactically air-land the second half of the team from Air Force cargo planes on the night of 29 March, three days after Dr. Stinger’s parachute insertion.” (See photo 6, page 11.) Dr. Rush has deployed on four long-term U.S. Army missions to foreign countries since completion of his surgical residency at Ohio State in 1995.

All of the team’s equipment was fully transportable on just six cargo Humvees. (By the way, the term “Humvee” is derived from the acronym for highly mobile multipurpose, wheeled vehicle, HMMWV). In contrast, it would take a minimum of four standard 18-wheelers to transport a MASH. Unlike a MASH, however, the FST was not a complete hospital; it was just the surgical section of a hospital that performed resuscitative, as opposed to definitive, surgical pro-
Getting started

Set-up time took only one to two hours, depending on field and tactical conditions. For the initial parachute assault, only one tent was parachuted onto the objective area in the cargo bed of a Humvee. This single tent served as the operating room tent until the other tents and gear arrived. Once the paratroopers secured the airfield, follow-on Air Force cargo planes then landed with the rest of the team’s personnel and two additional tents. Subsequently, three DRASH tents were erected, one of which served as a preoperative tent, another as the operating room tent, and the third as a postoperative/intensive care unit tent.

The 250th FST initially set up near an abandoned but usable airstrip in northeast Iraq named Bashur Airfield. This remote airfield was situated in Kurdish-held territory between two mountain ranges. Fortunately, the Kurdish militia had succeeded in subduing all hostile forces in and around the airfield, so that there was no enemy fire on the drop zone when the 173rd paratroopers jumped on the evening of March 26. Buildup of combat power in and around the airfield proceeded. In mid-April the mission changed and the 173rd Airborne Brigade had to repack their equipment and convoy 178 kilometers south to the oil-rich city of Kirkuk, Iraq. This city was of vital strategic importance, and it was critical that American forces quickly take control of the city to avert civil unrest. My team had to be divided into two echelons again in order to preserve surgical capability during the convoy. A five-member team remained behind to care for a soldier with a gunshot wound to the hip, awaiting evacuation to Germany.

Once the team reunited 18 hours later on a military airfield in Kirkuk, it was fully mission-capable once again (see photos 7-9, pages 11-12). While in Kirkuk, the FST took care of American soldiers, coalition forces, Iraqi civilians, and enemy combatants. The spectrum of trauma cases included fractures, fragment injuries, gunshot wounds, knife wounds, burns, and blunt injuries as well. The team performed major vascular repairs, thoracotomies, wound and burn debridements, as well as fracture reductions. “Not every surgeon has had the opportunity to

...
operate to the sound of explosions and small arms fire in the background,” Dr. Starnes noted.

Establishing order

Kirkuk turned out to be a coalition success story. The 173rd paratroopers set up safe houses within Kirkuk and immediately began backing up the local police and establishing order and civil functions. Terrorist attacks were minimized. I believe the people of Kirkuk are very happy to have Americans there and are very thankful that we freed them from a miserable dictator.

After the combat operations of the war were over, the FST took on the civil affairs job of helping to reinforce the medical infrastructure within the city (see photo 10, page 12). This required hospital assessments of critical shortages. While touring these facilities, members of the team received occasional indirect enemy fire but remained undeterred.

Enthusiastic to meet their surgical colleagues in war-torn Iraq, the FST surgeons then made liaison trips to the two largest hospitals in Kirkuk, Saddam Hospital and Kirkuk General Hospital. The Kirkuk physicians resented having Saddam’s name affiliated with one of the institutions and immediately renamed it Azadi Hospital; Azadi translates as “freedom” in the Kurdish language. (Kirkuk’s ethnic composition is 60% Kurdish, 20% Turkish, and 20% Arab).

Surprisingly, the medical infrastructure functioned well before and during the war, with the exception of constant intimidation and threats of Saddam’s intelligence officers, who tended to make life particularly hard on Iraqi doctors. The brave Iraqi surgeons who stayed in Kirkuk during the war were at constant risk of harassment and imprisonment.

Drs. Rush and Starnes and I immediately began giving surgical lectures and grand rounds, as well as assisting with laparoscopic and other surgical cases (see photos 11-13, page 13 and this page). Iraqi surgeons are up to date on the latest surgical techniques, but they lack the medical and infrastructure resources necessary to consistently deliver state-of-the-art care. The 250th FST implemented a number of projects, such as providing medical/surgical oversight to the Kirkuk emergency medical system and developing a plan for physician continuing medical education.

One of the first requests from the Iraqi surgeons was for a copy of the College’s latest edition of the Surgical Education and Self-Assessment Program (SESAP). They had older editions, but were unable to obtain SESAP 11. I called the College, and the ACS leadership immediately agreed to ship four SESAP books to the surgeons of Kirkuk. Dr. Rush and I formally presented them to the surgical department chiefs at both Kirkuk hospitals on behalf of the American College of Surgeons, and they were very enthusiastically received (see photo 14, this page). In fact, Shabander Tahir, MD, chief of
Biographical information

Lt. Col. Harry Stinger, MD, FACS, received his medical degree from the Uniformed Services University of the Health Sciences (USUHS) Medical School in Bethesda, MD, in 1985 and completed his surgical residency at Boston (MA) University Medical Center in 1995. Dr. Stinger, who joined the Army at age 22, volunteered for Army Airborne or “jump” school when he was a first-year medical student at USUHS.

Lt. Col. Robert Rush, MD, also graduated from USUHS and completed his general surgery training at Ohio State University Medical Center, Cleveland.

Maj. Benjamin Starnes, MD, is a graduate of Jefferson Medical College at Thomas Jefferson University in Philadelphia, PA, who completed his surgical training at Walter Reed Army Medical Center in Washington, DC.

The four surgeons of the 250th FST, from left to right: Dr. Rush, Dr. Devine, Dr. Stinger, and Dr. Starnes.

True leaders

Although I am proud to have commanded a successful mission to Kirkuk, I must deflect the credit for this forward surgical team’s achievements to our medical sergeants. The sergeant is the backbone of the Army. Army officers lead by example and use their rank to get the sergeants the time and materials that they need to train their soldiers and accomplish the mission. The U.S. Army should be proud of the high-caliber sergeants serving our country.

The opinions expressed in this article are those of the author and do not necessarily reflect the views of the U.S. Army Medical Department, the U.S. Army, or the U.S. Department of Defense.

Bibliography

Photographic and Historical Archives, 173rd Airborne Brigade, Vicenza, Italy.

The surgeons of Kirkuk wish to send their sincere thanks to the College for their generous contribution of four SESAPs, which have not only updated our clinical knowledge, but have boosted our morale and confidence as well.” Additionally, Dr. Tahir and I organized the American-Iraqi Surgical Association, an informal association that we intend to develop into a formal Iraqi Chapter of the American College of Surgeons.
Retirement: An opportunity to revisit “the road not taken”

by Thomas H. Cogbill, MD, FACS, LaCrosse, WI

If you had asked me 30 years ago what I would be doing on October 31, 2003, delivering the presidential address to the Wisconsin Surgical Society would have been an unimaginable response. In October 1973, I had just returned from a summer of hitchhiking and backpacking across Canada because my mother had refused to let me work for the Forest Service as a smoke jumper in Oregon. Although I was in my second month of my first year of medical school, I was still working as a disc jockey two nights a week from 2:00 to 6:00 am. I was born, raised, and educated in New England. I had never been to Wisconsin, nor did I ever think of going to Wisconsin. How has all of this happened? The answer is, I do not really know.
"The Road Not Taken"

Several weeks ago, I read the excellent convocation address that Susan Dentzer delivered to Dartmouth College freshmen this fall. Ms. Dentzer is a 1977 Dartmouth graduate with a degree in English who now works as a health correspondent for PBS’s News Hour. Her address focused on interpretations of Robert Frost’s poem “The Road Not Taken.” This poem has always been one of my favorites, but like nearly everyone, I remembered only the last three lines: “Two roads diverged in a wood, and I—I took the one less traveled by, and that has made all the difference.” These lines are often quoted out of the context of the entire poem as an expression of self-congratulation, Ms. Dentzer said, not unlike a precursor to Frank Sinatra’s rendition of “My Way” or Jon Bon Jovi’s “It’s My Life.” The phrase “the road less traveled” has become an American trademark expression for independence and individuality. But is this interpretation the only one possible? Certainly not—after all, the poem was entitled “The Road Not Taken,” not “The Road Less Traveled.” Reading the entire poem gives a clearer view of Frost’s intended themes.

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though, as for that, the passing there
Had worn them really about the same,
And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference.

The narrator describes each of the roads and concludes that they look nearly the same—neither is well-traveled. He looks carefully down each one, realizing that it is not likely that he will ever be able to come back to go down the road not taken. His final statement declaring that he took the road less traveled is uttered with a sigh. Ms. Dentzer feels that Frost was telling us that our choices viewed retrospectively seem more clear and correct than at the time we are actually making them. The roads that we do not choose to go down are just as important in shaping the course of our lives as the ones we do choose, and Frost laments what might have been had he traveled the road not taken.

Finding my path

My career path decisions have never been easy or straightforward. I am not one of those people who always wanted to be a physician or knew that he wanted to be a surgeon. After getting into medical school, I struggled to decide whether to attend. Once in medical school, I was convinced that I would be an old-time general practitioner until the third-year surgery rotation at Denver General Hospital knocked my socks off. After completing my surgery residency at the University of Colorado, I agonized over whether to take a more traditional university academic track or join a group practice with a small surgery residency at Gundersen Clinic in La Crosse, WI. As Robert Frost said, “way leads on to way.” In retrospect, I am absolutely convinced that each road less traveled that I selected was exactly the right choice for me, and I have been lucky to have had a very fulfilling career in surgery—regardless of what may have occurred on the roads not taken.

The last year has been very challenging for me with the arrival of several significant milestones—my 50th birthday, 25th wedding anniversary, 20th year at Gundersen, and, most significantly, the departure of our youngest child, Allison, to attend college in Maine. The profound effect of these changes caught my wife Jan and me by surprise. The inescapable realities are that we are growing older and we are not immortal.

As a result, I have begun to think a great deal about the next significant career decision—when to retire from surgery. Talking with others about their views on this topic has produced a wide range...
of opinion. When I was in my third year of practice I ran into a close friend who had just completed his training. He asked me whether I’d still be doing surgery in five years, because he was already prepared to quit! I was dumbfounded because I truly loved surgery and still do. Equally disturbing, in a different way, was a recent conversation with a friend who has been in practice for over 30 years. When I asked him when he thought he would retire he replied, “Oh, never. What else would I do?”

When to retire

Just as important as how one begins his or her career and builds a practice is to know when to quit. This decision is a very personal matter, and the correct time most definitely differs for each individual. Many factors play a role in this decision.

Age 65 has obviously become the artificial standard for retirement because that’s when people become eligible for Medicare, retirement plans, and Social Security benefits. Interestingly, the designation of 65 as retirement age dates back to the time of Otto Von Bismark’s Germany in the early 1900s, when the average life span was only 60 to 62 years. There has been discussion in Washington recently about raising the ages for eligibility for government retirement programs to 68 or 70.

Personal financial situation clearly affects the decision of when to retire and depends upon investments, ongoing expenses, and sound planning. I will leave this discussion to individuals more knowledgeable about these subjects.

Each of us ages at a different rate, but physiologic changes will eventually and inevitably affect everyone’s ability to practice, especially in a specialty like surgery, which depends so much upon motor skills. Significant impairments in eyesight—presbyopia and lens opacification—are evident in nearly all of us by age 50, requiring us to rely on brighter lights and corrective lenses. Although changes in fine motor and cognitive skills can be demonstrated through objective testing by age 45, these characteristics are usually well preserved through age 60. Simple endurance for long cases or long clinic days, especially modified by night call, probably plays a greater role than most of us would like to admit.

Do not depend upon other people to tell you that it is time to quit. Even a trusted colleague or close friend is rarely able to make this sort of suggestion. One’s personal health or a spouse’s health problem may precipitate an earlier than expected career change or retirement.

Another factor that may influence the decision to retire is family medical history—one’s own, and one’s spouse’s. This issue has clearly affected Jan’s and my decision about timing our retirement. Jan’s parents died at ages 56 and 69. The availability of affordable health insurance also may force an individual to continue employment, especially in the setting of serious health problems for themselves or their family.

Satisfaction with one’s current job is multifactorial depending upon case mix and continued love of surgery. These are often modified by outside influences, such as government regulation, compliance programs, insurance and managed care issues, and reimbursement. An individual’s ability to adapt to evolving techniques by acquiring new skills will often affect the decision to quit or change jobs. An adverse medical malpractice environment based upon expensive premiums or personal experience with a painful lawsuit has led many surgeons to “hang up their spikes.”

Finally, a person’s interests outside of work or even a desire to pursue another career altogether may prompt the decision to retire from surgery. Equally influential would be if the individual had a lack of any other serious interests. This list of factors affecting the decision about when and how to retire is far from comprehensive, and there are many other factors at play.

A study

The Wisconsin Surgical Society is a unique blend of young surgeons, established surgeons, and retired surgeons. Through scientific and social interactions we have been able to learn from one another. Many of my thoughts concerning retirement have been formulated after talking with members of this group. Capitalizing on the diversity of our society, I sent a survey to each active and senior member this fall to solicit opinions and information pertinent to retirement issues. I would like to publicly thank Richard B. Windsor, MD, FACS, and his wife Mary Anne for their assistance in designing the questions that were included.

A total of 163 members completed and returned
their surveys for a surprisingly good 54 percent response rate. Surveys were received from 113 active and 50 retired surgeons. Of them, 36 (22%) have participated in medical missions, most frequently in Central America, Africa, and Southeast Asia.

The 113 active surgeon respondents covered a wide range of ages. Fifty percent of the active surgeons said they planned to retire before age 65. Activities and interests outside of medicine that are of the highest priority to our members who are currently in practice include family (86%), followed by travel and active sports (see Table 1, right). The most popular participant sports mentioned were golf, running, cycling, and skiing. Finally, it was heartening to see that 92 percent of active surgeons would choose surgery again for their career (see Table 2, right). However, equally interesting were responses from seven (6%) surgeons who might have taken another road for a variety of reasons, ranging from the regulatory atmosphere, reimbursement, and lifestyle issues to other overriding interests.

The 50 retired surgeons left practice between the ages of 48 and 80, with a mean of 64.3 years old. Of the retired surgeons 80 percent said that the timing of retirement was just right for them, but 12 percent indicated that they either elected to leave practice or had to quit too soon. Retirees said they devote much of their time to family, travel, and church activities (see Table 1). More retirees are spectator sports enthusiasts than active sports participants; golf is their most popular active sport. Finally, 88 percent of retired surgeons would choose surgery again for their career but 8 percent would have considered something else (see Table 2). One member would rather have been an architect, two others would have pursued a different branch of medicine, and two felt that the work was too hard or disruptive for the rewards obtained.

I learned a lot about retirement from this survey. We have a very responsive group of surgeons, and most of them have enjoyed or are enjoying their careers in surgery. Those surgeons who might have selected a different path can also teach us a lot about surgical careers. I wish that we had included a question about what career outside of medicine each member might have chosen if medicine had not been an option.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Top priority activities outside of medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Active surgeons (N = 113)</td>
</tr>
<tr>
<td>Family activities</td>
<td>97 (86%)</td>
</tr>
<tr>
<td>Travel</td>
<td>83 (73)</td>
</tr>
<tr>
<td>Active sports</td>
<td>76 (67)</td>
</tr>
<tr>
<td>Spectator sports</td>
<td>51 (45)</td>
</tr>
<tr>
<td>Church</td>
<td>46 (41)</td>
</tr>
<tr>
<td>Educational courses</td>
<td>32 (28)</td>
</tr>
<tr>
<td>Service organizations</td>
<td>15 (13)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2</th>
<th>“Would you choose surgery as your career again?”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Active surgeons (N = 113)</td>
</tr>
<tr>
<td>Yes</td>
<td>104 (92%)</td>
</tr>
<tr>
<td>No</td>
<td>7 (6)</td>
</tr>
<tr>
<td>Maybe</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

Finally, I feel that our group has managed to maintain many interests outside of medicine, including a wide variety of pursuits, and 22 percent have given back to more needy populations through outreach programs.

One more source of advice about preparing for retirement is an article written by former Wisconsin Surgical Society president Robert E. Condon, MD, FACS, entitled “Easing the transition to retirement: When, where, and how?” Three points in his treatise ring true for me:

- “For those to define themselves only or primarily by their profession, ‘what I do’ becomes the same as ‘who I am.’”
- “The availability of time and of much more control over how it is spent provides an opportunity to fulfill ambitions that may have been deferred while engaged in an active surgical practice.” In other words, go back and explore a road not taken.
• “So get another life before quitting surgical practice. If you do, you’ll find retirement as enjoyable, or even more enjoyable, than your previous career.”\(^3\)

**Final words of advice**

Retiring from any profession is difficult, but retiring from surgery may be even harder for some of us because of its unique attributes. Do you ever look at yourself in the mirror and say, “I can’t believe that I cut people open for a living?” Believe me, they won’t let you do this after you retire.

I have learned a lot from my early investigations into the decision to retire. A happy retirement from surgery depends upon sound planning done well in advance of leaving practice. Although I am not yet ready to retire from surgery, and at the risk of sounding like a neophyte expounding on this topic, I have created a primer for retirement planning focusing on the nonfinancial aspects of this subject.

1. As the survey respondents reinforced, stay close to your family. The hospital and OR will go on without you and you without them; the same cannot be said for family.

2. As my grandfather would say, always have something to look forward to.

3. Be of some use. In John Irving’s *Cider House Rules*, Dr. Larch tells Homer Wells that he may stay at the orphanage indefinitely, but he must “be of some use.” Getting involved with medical mission, literacy, and other volunteer programs are all good examples of how to “be of some use.”

4. Take care of yourself. Although the dice do not always roll in our favor, staying healthy for retirement years is something to strive for, and obviously many of our members have made staying robust a priority.

5. Do not lose track of your closest confidants. Old friends are priceless commodities, and relationships may be difficult to reclaim if they are not maintained.

6. Do not forsake your favorite activities and interests during your busy practice years. Our survey demonstrates that most members of the Wisconsin Surgical Society have many interests outside of medicine. These are activities that can be expanded with more available time.

7. Philosophical and spiritual realms are also of great importance and often are put on the back burner when running a busy practice. Retirement can be a great time to consider those questions you spent hours and hours discussing in college.

8. Do not forget all of those paths not traveled along the way. Retirement can be an extraordinarily valuable opportunity to go back and explore some of these roads not taken.

Thank you for your indulgence of my musings. I especially want to thank the members of the Wisconsin Surgical Society for the great honor of serving as their president. I am glad we came to Wisconsin.

**Editor’s note:** This article is adapted from the presidential address that Dr. Cogbill delivered at the 2003 joint meeting of the Wisconsin Surgical Society and the Wisconsin Chapter of the American College of Surgeons in Milwaukee, WI, on October 31, 2003.

**References**


---

Dr. Cogbill is program director, general surgery residency, Gunderson Lutheran Health System, LaCrosse, WI, and associate clinical professor of surgery, University of Wisconsin-Madison.
Statement on universal health insurance

The American College of Surgeons endorses universal access to care within our current pluralistic health care system.

The achievement of universal health insurance coverage should be completed incrementally over the next decade, with some features perhaps being implemented on a state-by-state basis according to local priorities and needs.

The American College of Surgeons should invest in and promote information technology to improve the effectiveness, quality, and safety of patient care. Reducing health care costs in this fashion is much more desirable than containing costs by rationing care. Administrative reforms, such as the use of a standard health insurance claim form throughout the country, should also be pursued.

This statement was approved by the Board of Regents at its February 2004 meeting.
Statement on the physician acting as an expert witness

Physicians understand that they have an obligation to testify in court as expert witnesses on behalf of the plaintiff or defendant as appropriate. The physician who acts as an expert witness is one of the most important figures in malpractice litigation. In response to the need to define the recommended qualifications for the physician expert witness and the guidelines for his or her behavior, the Patient Safety and Professional Liability Committee of the American College of Surgeons has issued the following statement. The statement is an adaptation of guidelines developed by the Council of Medical Specialty Societies and several other medical groups.

**Recommended qualifications for the physician who acts as an expert witness:**

- The physician expert witness must have a current, valid, and unrestricted license to practice medicine in the state in which he or she practices.
- The physician expert witness should be a diplomate of or have status with a specialty board recognized by the American Board of Medical Specialties, as well as be qualified by experience or demonstrated competence in the subject of the case.
- The specialty of the physician expert witness should be appropriate to the subject matter in the case.
- The physician expert witness who provides testimony for a plaintiff or a defendant in a case involving a specific surgical procedure (or procedures) should hold current privileges to perform those same procedures in a hospital that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA).
- The physician expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should be actively involved in the clinical practice of the specialty or the subject matter of the case during the time the testimony or opinion is provided.
- The physician expert witness should be able to dem-
onstrate evidence of continuing medical education relevant to the specialty or the subject matter of the case.

- The physician expert witness should be prepared to document the percentage of time that is involved in serving as an expert witness. In addition, the physician expert witness should be willing to disclose the amount of fees or compensation obtained for such activities and the total number of times he or she has testified for the plaintiff or defendant.

**Recommended guidelines for behavior of the physician acting as an expert witness:**

- Physicians have an obligation to testify in court as expert witnesses when appropriate. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.
- The physician expert witness should review all the relevant medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.
- The physician expert witness should be prepared to distinguish between actual negligence (substandard medical care that results in harm) and an unfortunate medical outcome (recognized complications occurring as a result of medical uncertainty).
- The physician expert witness should review the standards of practice prevailing at the time and under the circumstances of the alleged occurrence.
- The physician expert witness should be prepared to state the basis of his or her testimony or opinion and whether it is based on personal experience, specific clinical references, evidence-based guidelines, or a generally accepted opinion in the specialty. The physician expert witness should be prepared to discuss important alternate methods and views.
- Compensation of the physician expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a physician expert witness to link compensation to the outcome of a case.
- The physician expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records, and subject to independent peer reviews. Moreover, the physician expert witness should willingly provide transcripts and other documents pertaining to the expert testimony to independent peer review if requested by his or her professional organization. The physician expert witness should be aware that failure to provide truthful testimony exposes the physician expert witness to criminal prosecution for perjury, civil suits for negligence, and revocation or suspension of his or her professional license.
Ten specialty boards report accomplishments and plans: Part I

Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the Bulletin to keep Fellows and other interested readers abreast of any changes in the procedures of the various boards.

The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the Bulletin contains reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Plastic Surgery, and the American Board of Urology.

The April issue of the Bulletin will feature the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Orthopaedic Surgery, the American Board of Surgery, and the American Board of Thoracic Surgery.
Resident numbers/neurosurgical match

For the 2002/2003 academic year, there were 95 accredited neurosurgical residency training programs in the U.S. Eight hundred twenty-six residents were in training. One hundred thirty-six graduated in June. In January 2003, 301 individuals registered with the neurological surgery matching program, and 252 submitted rank lists. Two hundred thirty-two were ranked and 137 matched. Over the past five years, the number of individuals registering for the match has declined by 22 percent, but the number of rank lists submitted declined by only by 2 percent.

Primary examination

The American Board of Neurological Surgery (ABNS) administers a written primary examination annually to neurosurgical trainees and neurosurgeons reentering the certification process. The multiple-choice examination covers the breadth of neurosurgery's clinical and basic science curriculum. It may be taken for self-assessment but must be taken and passed for credit prior to applying for oral examination and certification. For residents entering training after June 30, 1998, the residency review committee (RRC) for neurological surgery and ABNS training requirements specify that it must be passed during training in order to successfully complete the residency program. Many programs now require trainees to pass the examination before progressing to chief resident.

In March 2003, the primary examination was administered to 498 examinees. Two hundred and fifteen took it for credit and had a 14 percent fail rate. Two hundred eighty-three took it for self-assessment.

Oral examination

Oral examinations, the final step in the initial certification process, are administered by the ABNS each spring and fall to neurosurgical practitioners who have applied for certification. Candidates must have met the requirements of graduation from accredited training programs, hold unencumbered licenses and hospital privileges, demonstrate good professional standing as assessed by mentors and peers, and show satisfactory practice performance through review of a minimum of one year's consecutive cases.

In November 2002, 90 candidates sat for oral examination, with an 11 percent failure rate. In May 2003, 90 individuals were examined, with 8 percent failing. Candidate performance is scored numerically by six examiners. Their grades are used to determine pass/fail status by computer program so as to maximize objectivity in the process. Standardized questions are now being tested for a portion of the examination.

As of July 16, 1997, residents entering Canadian training programs are ineligible for ABNS certification. This policy was reviewed by the board in November, when a representative of the Canadian board participated in discussions. After extensive debate, no change was made in ABNS policy.

Maintenance of certification (MOC)

The ABNS issued its first time-limited certificate in May 1999. Since then, it has developed many of the components for an MOC program in preparation to meet the requirements of the American Board of Medical Specialties. Evidence of professional standing will require unrestricted licensure and some manner of evaluation by peers. Cognitive expertise will be assessed with a secure multiple choice examination that covers basic, as well as practice-specific, specialty knowledge. The examination should be in place by 2006.

Methodologies for demonstration of involvement in lifelong learning and self-assessment are being considered. Part of the requirement will be fulfilled by periodic completion of the self-assessment in neurological surgery program produced by the Congress of Neurological Surgeons. The ABNS is also working with the American Association of Neurological Surgeons to develop a program that will document fulfillment of continuing medical education requirements.
Other means are under consideration to comply with the practice performance requirement. They will likely include an outcome analysis of key cases (such as lumbar disk surgery and AVM, and so forth) and a period collection of consecutive cases for review similar to what is required for primary certification.

**NEURO-LOG**

NEURO-LOG is an internet-based data collection tool developed by the ABNS to facilitate gathering of information necessary for primary certification and MOC, as well as RRC resident case log accumulation and residency site reviews. The system is highly secure and compliant with the Health Insurance Portability and Accountability Act of 1996.

1. Applicants for certification: Once neurosurgical training is completed, candidates usually apply for certification. As a component of this process, they must submit a 12-month summary report of inpatients. NEURO-LOG provides all the necessary data fields to complete this requirement and an efficient online mechanism for review of the data by the professional practice data committee.

2. Program directors and RRC: NEURO-LOG has also been adapted for use by program directors to accumulate the data required for RRC accreditation. It tracks the necessary elements for residents and attending physicians to meet current documentation standards. The cataloging of operative data is streamlined and driven by a hierarchical "drill down" paradigm that yields both CPT codes and appropriate ABNS/RRC procedural categories. As an added advantage, users can learn the CPT code structure.

3. MOC: While the exact criteria for practice data documentation as one component of the MOC process has yet to be defined, NEURO-LOG will be amended to meet those standards once clarified. Diplomates certified by the ABNS prior to 1999 will not be required to enter the MOC process, but would be free to use NEURO-LOG for their own purposes, such as practice assessment. The system gathers rudimentary demographics, as well as diagnostic, procedural, and simplified outcome information.

**Revocation of certification**

The ABNS has amended its bylaws to provide the board more discretion in revocation of certification. At its meeting in May 2003, a hearing was held on revocation of one certificate; the certificate was not revoked.

**Resident duty hours**

While committed to the welfare of our residents and the safe delivery of care to patients, the ABNS, RRC, and Society of Neurological Surgeons have major concerns regarding the new restriction on resident duty hours mandated by the Accreditation Council for Graduate Medical Education (ACGME). There is serious concern that the lack of flexibility will adversely impact resident opportunities and expectations for continuity of care, overall operative experience, and development of essential neurosurgical discipline and professionalism.

The ACGME rejected a proposal from the board for a specialty-wide exemption to the requirements, particularly those aimed at the senior resident experience. Recently, however, the ACGME and RRC have extended the 80-hour requirement to 88 hours for programs that have obtained local IGME approval and filed appropriate forms describing the educational value of such an extension and how resident fatigue will be monitored. The extensions will be valid until the next RRC site review for that particular program. The ABNS appreciates the leadership of the American College of Surgeons in bringing together the opinions of its surgical specialty boards and societies in order to develop a strong statement of concern to the ACGME.

**ABNS directors/officers**

At its spring 2003 meeting, David G. Piepgras, MD, FACS, and R. Michael Scott, MD, completed their six years of contributions and leadership on the American Board of Neurological Surgery. Newly elected directors are M. Sean Grady, MD, FACS, and Robert L. Martuza, MD, FACS. New officers are Arthur L. Day, MD, FACS, chairman; Volker K. H. Sonntag, MD, FACS, vice-chairman; and Marc R. Mayberg, MD, FACS, treasurer. Ralph G. Dacey, Jr., MD, FACS, remains as secretary.
Certification examinations
The fall oral examination and meeting of the American Board of Ophthalmology (ABO) was held November 8-10, 2002, in San Francisco, CA. The annual meeting took place October 24, 2003, in Cambridge, MA.

The future dates for examinations are as follows:

The total number of diplomates certified at the November 2002 San Francisco and June 2003 Philadelphia oral examinations was 437 (236 in San Francisco, 201 in Philadelphia). Fifty-five failed the examination and must repeat all six subjects.

The 2003 written qualifying examination was held April 11, 2003, at three sites in the U.S. The questions in this examination were prepared by the written examination committee of the American Board of Ophthalmology and the ophthalmic knowledge assessment program committee of the American Academy of Ophthalmology. It is the responsibility of the written examination committee to review and approve the final questions.

Of the 732 individuals who registered for the 2003 written qualifying examination, 628 took the examination, 209 (33.3%) failed, and 419 passed. Of the 209 who failed, 121 (57.89%) failed previously. Of the 628 candidates who took the examination, 202 (32.2%) were repeaters, and of these 121 (59.9%) failed again.

International medical graduates constituted 11.94 percent (75 candidates) of the examination and 36 failed (48%). U.S./Canadian graduates constituted 88.06 percent (553 candidates) and 173 (31.28%) failed.

Of the 202 candidates repeating the written qualifying examination, 39 (19.3%) were international medical graduates and 163 (80.7%) were U.S./Canadian graduates.

The candidates who passed the 2003 written qualifying examination, plus the repeaters from previous oral examinations, provide a potential pool of 244 candidates for the October 2003 Cambridge oral examination and 244 potential candidates for the May 2004 San Francisco oral examination.

Recertification examinations
The future dates for examinations are as follows:
Certificate renewal examination, written (CREW), February 1-March 31, 2004 (this is a take-home examination with two months to complete); Office record review (ORR), January 1-31, 2004, and July 1-31, 2004 (given twice a year with one month to complete).

The 2003 CREW examination was administered as a take-home examination February 1-March 31, 2003. Of the 476 registered for this examination, 470 completed the examination, with 458 passing (97.45%) and 12 failing (2.55%).

The ORR was administered July 1-31, 2002, and January 1-31, 2003. Of the 105 registered for the July 2002 examination, 104 passed the review and one incomplete. At the January 2003 examination, 299 were registered, with 296 passing and three incomplete.

Representation
The representative to the American College of Surgeons for 2003 was David T. Tse, MD, FACS, Miami, FL. The board’s representatives to the residency review committee for 2003 were Susan H. Day, MD, San Francisco, CA; Richard P. Mills, MD, FACS, Seattle, WA; and James S. Tiedeman, MD, Charlottesville, VA.

In December 2002 and May 2003, the residency review committee for ophthalmology reviewed 67 of 121 accredited ophthalmology residencies. With few exceptions most programs continued to receive full accreditation with three-to-five-year cycles assigned on the strength of the program’s review.

The following directors became officers of the board for 2003: chairman, M. Bruce Shields, MD,
FACS, New Haven, CT, and vice-chairman, Charles P. Wilkinson, MD, Baltimore, MD.

The two new board directors who took office in January 2003 were Ivan R. Schwab, MD, FACS, Sacramento, CA, and Martin Wand, MD, Hartford, CT.

The voting representatives to the American Board of Medical Specialties (ABMS) for 2003 were: Edward G. Buckley, MD, FACS, Durham, NC; Richard P. Mills, MD, FACS, Seattle, WA; M. Bruce Shields, MD, FACS, New Haven, CT; and Charles P. Wilkinson, MD, Baltimore, MD. Denis M. O’Day, MD, FACS, Nashville, TN, serves on the executive committee of the ABMS.

General information

The American Board of Ophthalmology has formed a task force on competency in response to the Accreditation Council for Graduate Medical Education mandate to have the training programs teach and evaluate in the seven competencies. These competencies are patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Ophthalmology has added a seventh competency in surgery. Working groups were selected for each of the competencies and the output of these groups was reviewed at the annual meeting of the American Academy of Ophthalmology in November 2003.

A pilot study has been conducted at the oral examinations using ethics/professionalism patient management questions. These questions focused on communication to the public, surrogacy, and unnecessary surgery. The failing rate in the ethics/professionalism questions was similar to the failure rate of the overall performance. However, in most cases, the same individuals who failed the overall examination did not fail the pilot study questions.

The American Board of Ophthalmology continues to transition the recertification process into a program of maintenance of certification (MOC). The MOC draft plan for ophthalmology and the plans for all of the other 23 boards were submitted on July 1, 2003, to the American Board of Medical Specialties for review. The ophthalmology plan includes four major components—continuing medical education credits, an office record review process, periodic self-assessment review tests, and demonstration of ophthalmic cognitive knowledge.

The American Board of Otolaryngology

by David E. Schuller, MD, FACS, Columbus, OH

Qualifying/certifying examinations

The 2002 written qualifying exam was administered to 267 candidates in three locations (San Francisco, CA, Chicago, IL, and Boston, MA) on September 30. Of these candidates, 259 qualified to take the oral certifying exam, which was conducted by approximately 90 individuals, including American Board of Otolaryngology (ABO) directors, senior examiners, and guest examiners on April 26 and 27. Two hundred and fifty candidates passed the exam and were certified.

Beginning in 2004, the written qualifying and oral certifying exams will be conducted in the spring, with the written exam offered on April 23, and the oral exam on April 24 and 25.

Otolaryngology training exam

The otolaryngology training exam was conducted March 1, 2003, in more than 100 locations. It was the sixth year that the exam has been prepared and conducted by the ABO. More than 1,100 residents and practitioners participated in the exam. The next otolaryngology training exam is scheduled for March 6, 2004.

Board of directors

The following individuals continue to serve as officers in 2003: David E. Schuller, MD, FACS,
president; Harold C. Pillsbury III, MD, FACS, president-elect; Gerald B. Healy, MD, FACS, executive vice-president; and H. Bryan Neel III, MD, FACS, treasurer

Willard E. Fee, Jr., MD, FACS, and Michael E. Johns, MD, FACS, completed their terms of service at the conclusion of the 2003 annual meeting in April, after many years of dedicated service to the ABO. Over the past several years, the board of directors has been reduced by attrition, from 25 to 18 members. This process is now complete.

Senior examiners

Senior examiners serve as the core group of experienced oral examiners, along with ABO directors. Senior examiners are elected to a five-year term, and are eligible for reelection to one additional term after a hiatus of three years. To be elected as a senior examiner, an individual must have served as an ABO examiner at least twice. He or she must be prominent in the specialty, especially in the areas of patient care and medical education, and must demonstrate an interest and ability in the creation of educational and test materials. Steven M. Parnes, MD, FACS, and Randal S. Weber, MD, FACS, completed their terms of service after the 2003 annual meeting. Charles M. Luetje II, MD, FACS; Maisie L. Shindo, MD, FACS; and Thomas A. Tami, MD, FACS, were elected as new senior examiners.

American Board of Medical Specialties

The American Board of Medical Specialties (ABMS) is the umbrella organization of the 24 recognized certifying organizations in the U.S. representatives to the ABMS assembly this year are the author; Gerald B. Healy, MD, FACS; and Robert H. Miller, MD, FACS. Alternate representatives are Harold C. Pillsbury III, MD, FACS; Dean M. Toriumi, MD, FACS; and Gayle E. Woodson, MD, FACS.

Maintenance of certification

In 2002, the ABO issued its first 10-year, time-limited certificates. Maintenance of certification (MOC) is the program by which diplomates will renew/maintain their certification. Diplomates certified prior to 2002 are not required to participate in the MOC program, but may do so if they wish. MOC replaces more simplistic renewal programs that consisted of periodic examinations only. As a member board of the ABMS, the ABO must comply with certain ABMS requirements. More importantly, MOC is a process that promotes lifelong learning and the ongoing provision for up-to-date, high-quality patient care.

The four components of the ABO MOC process include documentation of professional standing, documentation of lifelong learning and self-assessment, evidence of cognitive expertise, and evaluation of performance in practice. All areas are currently under development.

Neurotology

The ABO will conduct its first neurotology exam on April 26, 2004. An examiner preparation exam was conducted in late April 2003. The most compelling reason for development of the neurotology exam is to ensure that individuals who complete Accreditation Council on Graduate Medical Education (ACGME)-approved neurotology subspecialty training programs are, in fact, qualified to diagnose and treat neurotologic and lateral skull base diseases and disorders. In addition, the basic ABO certificate does not test the body of knowledge defining medical and surgical neurotology. As a public trust, the ABO is obligated to assess and certify that those trained in neurotology are qualified to practice the subspecialty, just as it is obligated to examine candidates and issue primary certificates in otolaryngology.

Two pathways have been established to permit individuals to take the neurotology exam: one for those who have completed ACGME residency training in neurotology, and one for those who have not completed such training, but who limit their practice to neurotology. The alternate pathway will close after 2011.

Additional information

Information on ABO policy and examinations, as well as information on the scope of knowledge study (which defines the content of ABO exams and requisite otolaryngology training), can be found online at www.aboto.org.
Examinations

Oral examination: A total of 222 candidates sat for the oral examination September 12-14, 2002. One hundred ninety-two candidates passed and 30 failed, with a failure rate of 13.5 percent. In September 2001, 236 candidates took the oral examination. One hundred eighty-two candidates passed in 2001 and 54 failed, with a failure rate of 22.9 percent. The 2002 failure rate was 9.4 percent lower than the previous year. The usual failure rate range has been 17-25 percent. The board anticipates 216 candidates for the 2003 oral examination. As of September 15, 2002, The American Board of Plastic Surgery (ABPS) had certified 6,499 plastic surgeons.

Written or qualifying examination: The first computer-based test (CBT) format for the written or qualifying examination was held on October 18, 2002, for 242 candidates. Results of the 2002 written examination were distributed on December 22, 2002. One hundred eighty-six of the total of 242 candidates passed the written examination, with a failure rate of 23.1 percent. In 2001, 190 of a total of 241 candidates passed the written examination, with a failure rate of 21.2 percent, which was consistent with prior years. The 2003 examination will continue with the CBT format and was scheduled for October 20, 2003, at test centers across the country. Approximately 240 candidates were expected to sit for the 2003 written examination.

Subspecialty certification in surgery of the hand (formerly, certificate of added qualifications in surgery of the hand): ABPS administered the 2002 subspecialty certification in surgery of the hand examination to 46 ABPS diplomates, 28 of whom were recertifying. Thirteen of 18 diplomates passed the hand surgery examination. The failure rate was 4.2 percent. A total of 23 diplomates sat for the 2002 hand surgery recertification examination, 21 passed, and the failure rate was 8.7 percent. The 2002 certification examination in surgery of the hand were administered in computer test centers around the country from August 11 through September 21, 2003. The board expected 45 candidates, 27 of whom are recertifying. Results were to be announced in November.

Recertification

The first recertification examination was offered on April 25, 2003. One hundred three diplomates took the examination and 99 passed, while three failed, for a 97 percent passing rate. Seventy-eight of those diplomates participating possessed time-dated certificates that would expire in 2005; 25 were lifetime certificate holders. The cognitive examination was offered as a CBT format in four modules: Comprehensive plastic surgery, cosmetic/breast surgery, craniomaxillofacial surgery, and hand surgery. A subspecialty certificate in surgery of the hand was accepted in lieu of the hand surgery module cognitive examination component of the recertification program. A number of changes, reflecting the recommendations of the American Board of Medical Specialties’ Task Force on Competency, have been made in the recertification process. The four key components of professionalism, knowledge, lifelong learning, and performance in practice are incorporated into the recertification program. Diplomates are collecting an operative log for six months for assignment to an examination module in the areas of their practice profile.

General surgery training years

A task force for evaluation of core competency in surgery is currently evaluating training issues.

Revocation of certification

The American Medical Association periodically reports sanctions to diplomates’ licenses and ABPS contacts the state medical licensing board in question for original documents. Plastic surgeons with revoked state medical licenses are referred to the Ethics Committee for revocation of certification. To date, the board has revoked certification for 33 diplomates.
The board developed and adopted its own code of ethics in November 2001. Previously, the board subscribed to the American Society of Plastic Surgeons code of ethics. Issues specific to board candidates, diplomates, and directors are added to the new board code. The ABPS code of ethics is supplied to every candidate and is available on the board’s Web site.

Subspecialty issues
The American Board of Plastic Surgery, Inc., continues to be committed to the engagement, development, and recognition of subspecialty interests for the purpose of advancing the core of the entire specialty. The board’s four advisory councils have been working since May 2000, contributing to the work of the recertification process. The advisory councils reflect the four identified subspecialty modules for the recertification program: comprehensive plastic surgery, cosmetic plastic surgery, craniomaxillofacial surgery, and hand surgery. The members include board directors and nominees from plastic surgery subspecialty organizations. The board is also currently using subspecialty expertise to develop journal review questions for self-learning for the Plastic and Reconstructive Surgery Journal. These items will add to the items in the public domain that diplomates can access as they prepare for recertification.

In appreciation

New officers/directors
The new directors elected to the ABPS are Walter L. Erhardt, Jr., MD, FACS; Theodore N. Pappas, MD, FACS (representative from the American Board of Surgery); A. Michael Sadove, MD, FACS; and William M. Swartz, MD, FACS. ABPS officers for 2003-2004 are Bruce L. Cunningham, MD, FACS, Minneapolis, MN, chair; Lawrence L. Ketch, MD, FACS, Boulder, CO, chair-elect; John A. Persing, MD, FACS, New Haven, CT, vice-chair; and Carolyn L. Kerrigan, MD, Lebanon, NH, secretary-treasurer.

New appointees to the advisory councils to the board: Bahman Guyuron, MD, FACS, and James H. Wells, MD, FACS.

The American Board of Urology
by Mani Menon, MD, FACS, Detroit, MI

Exams
The certification process of the American Board of Urology (ABU) incorporates a qualifying examination (Part I) and a subsequent certifying examination (Part II). Admissibility to the qualifying examination requires that the applicants have completed or be within six months of satisfactorily completing an Accreditation Council on Graduate Medical Education (ACGME)-approved urology residency program. Admissibility to the certifying examination requires that the candidates have passed the qualifying (Part I) examination, have 18 months of clinical practice experience in a single community, submit an acceptable practice log, and receive satisfactory peer reviews.

On August 10, 2003, a total of 307 candidates completed the qualifying (Part I) examination. The examination was given in booklet form, and was a cognitive, multiple-choice examination. Of the 307 candidates who sat for the written qualifying (Part I) examination, 252 passed and 55 failed. As has been true in other years, practitioners—U.S. or foreign-educated—who have previously failed the examination had a high failure rate on reexamination.

For the past 10 years the pass level for the qualifying examination has been set by the criterion
reference method, equated to a previous benchmark test, using the Rasch model. The passing score will vary according to the difficulty of the examination for any year. Thus, although examination may vary in difficulty from year to year, the probability of passing (pass rate) is based solely on the ability of the candidate pool in any given year. This is a fair and defensible methodology, which does not impose an arbitrary pass/fail point.

The 2003 certifying (Part 2) examination is a standardized oral examination that consists of six protocols on which the candidate is tested. In February 2003, 281 candidates took the certifying (Part 2) examination; 245 (87%) passed and were certified; 36 (13%) failed. The board uses a modified Rasch model for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. Consistent with the board’s commitment to continually improving its evaluation processes, in 1995 the board applied a dual scoring system for the oral examination protocols. Separate grades are utilized for information gathering and diagnosis, and for problem solving and patient management. This has resulted in a significant increase in statistical reliability. The board is pleased with this scoring technique for the oral examination.

**Certification**

The board requires completion of certification within five years of completion of an ACGME-approved residency program; extensions are granted for approved fellowship training. Failure to complete certification within the time allotted requires reentry into the certification process at the qualifying examination (Part I) level after first passing a preliminary examination.

In 1992, the board began its mandatory recertification process for all diplomates with 10-year time-limited certificates, which have been issued since 1985. Currently, all trustees of the American Board of Urology recertify during their tenure on the board. The process consists of multiple components. These various components provide the diplomate with different opportunities and ways to document his or her competence. A modular, written, open-book examination consists of five subject areas from which the diplomate will choose three with which he or she is most comfortable. Each module has 20 questions, for an individual examination of 60 questions. Other components include peer review, a surgical log review, and a continuing medical education requirement. In addition, at the board’s discretion, hospital/office chart reviews, an oral interview or examination, and/or a site visit may be required.

Diplomates may enter the recertification process up to three years before expiration of the primary certificate. Upon successful recertification, the diplomate is issued a certificate valid for 10 years from the date of expiration of the original certificate. The 2002 recertification process was the first year that included diplomates recertifying for their second time. In November 2002, 350 diplomates sat for recertification; 344 diplomates (98%) successfully completed the recertification process. The pass rate was consistent with previous years. Currently, there is discussion among the ABMS member boards regarding maintenance of certification that would entail, among other things, ongoing monitoring of physicians by the certifying boards. The ABU is actively discussing the maintenance of certification issue, but the trustees have significant concerns regarding the implementation of the proposal.

**Officers and trustees**

Current officers and trustees are: Paul F. Schellhammer, MD, FACS, president; Robert E. Weiss, MD, FACS, vice-president; Joseph A. Smith, Jr., MD, FACS, president-elect; Robert C. Flanigan, MD, FACS, secretary-treasurer; Peter C. Albertsen, MD, FACS; David A. Bloom, MD, FACS; Peter R. Carroll, MD, FACS; Michael J. Droller, MD, FACS; Mani Menon, MD, FACS; Linda M. D. Shortliffe, MD, FACS; Howard M. Snyder III, MD, FACS; and W. Bedford Waters, MD, FACS.
ACS Officers and Regents

Officers/Officers-Elect

Claude H. Organ, Jr.
President
General surgery
Emeritus professor, department of surgery, University of California, San Francisco
San Francisco, CA

Anna M. Ledgerwood
First Vice-President
General surgery
Professor of surgery, Wayne State University
Detroit, MI

Murray F. Brennan
Second Vice-President
General surgery
Chairman, department of surgery, Memorial Sloan-Kettering Cancer Center
New York, NY

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

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

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

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

Henry L. Laws
Second Vice-President-Elect
General surgery
Birmingham, AL
Board of Regents

Edward M. Copeland III
Chair
General surgery
Edward R. Woodard 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
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

William H. Coles
Ophthalmic surgery
Professor emeritus,
State University of New York
Chapel Hill, NC
Board of Regents (continued)

A. Brent Eastman
General surgery
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

Alden H. Harken
Cardiothoracic surgery
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

Jack W. McAninch
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

Robin S. McLeod
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
Board of Regents (continued)

Carlos A. Pellegrini
General surgery
Henry N. Harkins Professor and chairman, department of surgery, University of Washington Seattle, WA

Karl C. Podratz
Gynecology (oncology)
Joseph I. and Barbara Ashkins Professor of Surgery, and professor of obstetrics and gynecology, Mayo Clinic Rochester, MN

John T. Preskitt
General surgery
Attending surgeon, Baylor University Medical Center Dallas, TX

J. David Richardson
Vascular surgery
Professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine Louisville, KY

Thomas V. Whalen
Pediatric surgery
Professor of surgery and pediatrics, and chief of pediatric surgery, Robert Wood Johnson School of Medicine and Dentistry New Brunswick, NJ
In memoriam:

Ralph A. Straffon, MD, FACS, 1928-2004, remembered

by David C. Miller, MD, Ann Arbor, MI, and Martin I. Resnick, MD, FACS, Cleveland, OH

Former ACS President Ralph A. Straffon, MD, FACS, passed away January 22, 2004, following a 10-year fight with metastatic prostate cancer.

Ralph Atwood Straffon was born at home on January 4, 1928, in Croswell, MI, to Lloyd Straffon and Verle Rice, lifelong residents of that farming and lumber town in Michigan’s “thumb.” Verle passed away on the seventh postpartum day, and following the death of his mother, Ralph lived for two years with his maternal grandparents in Long Beach, CA. In 1930, Lloyd married Florabelle Lautner, a Croswell native and Michigan State University graduate; shortly thereafter, two-year-old Ralph Straffon returned to Michigan.

Athlete/academic

Ralph’s childhood was marked by an intense work ethic that would culminate in academic and athletic success. He worked in his father’s hardware store and as a mechanic at the Ford Motor Company garage. He was an Eagle Scout and, in his senior year of high school, excelled as the starting fullback and linebacker for the Croswell High School varsity football team. The team finished the season undefeated (7-0) and was named 1944 Class C State Champion by the Detroit Free Press. Ralph was named to the first-team All State football squad in recognition of his outstanding individual performance.

Dr. Straffon graduated from Croswell High School and was awarded an alumni regent scholarship at the University of Michigan, Ann Arbor. After an academically rigorous freshman year, he returned to Croswell to work in a cement block factory with the goal of getting in better shape for the upcoming football season. However, a ruptured appendix and a prolonged recuperation deferred his return to the university. Upon recovery, he enlisted in the U.S. Army, serving as a “trust trooper” in the unit of 1,000 American troops deployed to maintain stability in the Venezia Giulia region of Italy and playing saxophone for fellow soldiers. Shortly before Christmas 1947, he returned home to resume his career as a student athlete.

In 1949, Dr. Straffon enrolled in the University of Michigan Medical School and continued to pursue a varsity letter in football as a fullback. His first semester schedule included gross anatomy in the morning and football practice each afternoon. While his medical classmates took a pathology exam, Dr. Straffon carried the football against Army in an unforgettable game at Yankee Stadium; later came the famous “Snow Bowl” football game, when Michigan beat Ohio State, sending the Wolverines to the Rose Bowl and a 14-6 victory over the heavily favored University of Southern California.

Pioneer

Dr. Straffon received his medical degree from the University of Michigan in 1952 and devel-
oped a keen interest in surgical disciplines. He initially accepted an appointment as an orthopaedic resident but during his internship transferred into the general surgical program. In 1954, he became an assistant resident in general surgery under Frederick Coller, MD. In 1955, Reed Nesbit, MD, FACS, chairman of urology, offered him a residency position in the urology program. As part of the commitment to the training of surgeon-scientists, Dr. Nesbit provided him with an opportunity to spend one year at the Peter B. Brigham Hospital in Boston, MA, to study renal physiology and the burgeoning science of renal replacement therapy under the mentorship of nephrologist John Merrill, MD. In Boston, he focused his research efforts on the complementary disciplines of artificial renal dialysis and renal transplantation. Applying the principles he learned in Boston, Dr. Straffon and his colleagues instituted a hemodialysis program during his residency program at Michigan.

In 1959, upon completion of his training, Dr. Straffon accepted an appointment to the department of urology at the Cleveland (OH) Clinic. He established a busy clinical practice and in his earliest years witnessed several important advances in the science and art of renal replacement therapy and organ transplantation.

He was appointed chairman of the department of urology at the Cleveland Clinic in 1963, and throughout his 20 years in that position, renal transplantation was the primary focus of his clinical and scientific efforts. In 1963, he participated in the first cadaveric renal transplantation at the Cleveland Clinic and the recipient lived more than 20 years following the procedure. During this period, Dr. Straffon also published manuscripts on multiple transplant issues, including the long-term clinical outcomes of the earliest cadaveric transplants, the imperative need for expansion of the cadaveric donor pool, and the association between primary renal disease and long-term allograft function.

Beyond his exceptional work in transplantation, Dr. Straffon’s career was marked by additional contributions to clinical urology, including more than 170 peer-reviewed publications and nearly 50 book chapters. He refined the surgical management of renal vascular hypertension, including various techniques for aortorenal bypass as well as less common approaches to renal revascularization such as splenorenal and hepatorenal bypass, and was a founding member of the Urological Society of Transplantation and Vascular Surgery.

**Leader**

Although his clinical contributions were multiple and far-reaching, no assessment of Dr. Straffon’s contributions to urology would be complete without considering his profound effect on the content and quality of urologic patient care and education, as well as the influence of urology within the greater medical community. Much of his impact was an extension of his longstanding belief in the importance of teamwork, his superior personal skills, and his unique ability to recognize and cultivate the talent of his colleagues and trainees.

After stepping down as chairman of urology, his institutional influence at the Cleveland Clinic continued to escalate. He served successfully as the chairman of surgery (1983-1987) and vice-chairman of the board of governors and chief of staff (1987-1999). Dr. Straffon also distinguished himself as a leader in the national urologic community as evidenced by his presidency of the American Board of Urology (1997) and his chairmanship of the urology residency review committee from 1978 to 1980.

The American Urological Association (AUA) recognized the magnitude of his accomplishments when the organization presented him with the Hugh Hampton Young Award (1983) and the Gold Cane Award (2003). Dr. Straffon also served as president of both the American Association of Genitourinary Surgeons (1985-1986) and the Clinical Society of Genitourinary Surgeons (1986-1987) and was a visiting professor at more than 45 institutions during the course of his academic career.

His initial exposure to the nuances and policies of the broader medical community came during his service as an AUA representative to the Council of Medical Specialty Societies. In this capacity, his extensive leadership and interpersonal skills were quickly recognized as evidenced by his election to the presidency of
this council. He also served on the American College of Surgeons’ Advisory Council for Urology.

In 1980, while attending the American College of Surgeons Clinical Congress in Atlanta, GA, he learned of his unexpected selection to replace Frank Hinman, Jr., MD, FACS, as an ACS Regent. He represented the urology community in this position from 1980 to 1989, and in 1990, he served as First Vice-President of the College. One year later, in 1991, Dr. Straffon was elected the 72nd President of the American College of Surgeons—only the third urologist to hold this position of international prestige and respect. The first was J. Bentley Squire, MD, FACS, from New York, who held that office from 1932 to 1933 and, interestingly, the second was Straffon’s mentor, Dr. Nesbit, who served from 1967 to 1968.

Dr. Straffon considered his 12 months as ACS President to be an unparalleled highlight of his illustrious career. In this role, he traveled extensively and was recognized as the embodiment of American surgical expertise. Dr. Straffon enjoyed an incomparable chance to see the world and learn from international leaders in urology, general surgery, and other surgical disciplines. During his presidency, he was named an honorary fellow of both the Royal College of Surgeons (Edin) and the College of Surgeons in South Africa.

Following his tenure as College President, Dr. Straffon remained chief of staff at the Cleveland Clinic until his formal retirement in 1999. Not unexpectedly, his athletic prowess and enthusiasm remained strong. Indeed, until 2001, he was an active member of the Gordon Trophy Tennis Team for Seniors, a national-caliber traveling tennis team based in Cleveland. His ties with University of Michigan football remained strong as well; he enjoyed regular reunions with his Rose Bowl champion teammates, including their 50th anniversary celebration in 2001, where Dr. Straffon and his teammates were individually recognized on the field during the University of Michigan football game.

Ralph Straffon’s career was one of extraordinary achievement in the clinical arena (surgical and nonsurgical), in the educational domain, and in the organizational citizenship that is required of a complete physician.

In his personal life, Dr. Straffon raised five sons with Cary Higley, his wife until 1985. The loss of his son, Daniel Higley, to leukemia at the age of 20 increased his sympathy for those under his care. Dr. Straffon is survived by Shirley L. Gilmore, whom he married in 1987, and four sons: David A. Straffon of Kuala Lumpur, Malaysia, and J on R. Straffon, Peter A. Straffon, and Andrew L. Straffon, all of Shaker Heights, OH. He also had two stepchildren, Scott Gilmore and Leslie McConnell of Toronto, ON, and 11 grandchildren.

Dr. Miller is a PG5 resident in urology at the University of Michigan, Ann Arbor.

Dr. Resnick is the Lester Persky Professor and chairman, department of urology, Case Western Reserve University School of Medicine, Cleveland, OH.

Change your address online

Just visit www.facs.org and go to the “Members Only” tab.
The American College of Surgeons and the National Ultrasound Faculty have developed “Ultrasound for Surgeons: The Basic Course” for surgeons and surgical residents on CD-ROM.

The objective of the course is 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.

Replaces the basic course offered by the American College of Surgeons.*

A printable CME certificate is available upon successful completion.

CD will install the necessary software (PC or Mac).

The learner is offered two attempts to pass a multiple-choice exam with a minimum score of 80% at the completion of the program.

Residents must submit a letter from their director/chair to document residency status.

Only one user per CD is allowed. Online access is needed to register the CD and to take the exam.

$300 for nonmembers

$225 for Fellows of the College

$125 for residents with letter proving status

$90 for Candidate and Associate Society members

(Additional $16 for shipping and handling of international orders)

The CD can be purchased online at www.facs.org or by calling Customer Service at 312/202-5474.

For additional information, contact Dawn Pagels, tel. 312/202-5185, e-mail dpagels@facs.org

*The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this educational activity for a maximum of 4 Category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity. The American Medical Association has determined that physicians not licensed in the U.S. who participate in this CME activity are also eligible for AMA PRA Category 1 credit.
Fellows and facts

A retired Fellow of the College, David J. Dahl, MD, FACS, and his wife Annabelle, recently devoted two weeks to a Global Volunteers team that taught conversational English to elementary and high school students in Hungary. Global Volunteers is a not-for-profit organization based in St. Paul, MN, which offers short-term service opportunities in 20 countries. Dr. Dahl resides in Pasadena, CA.

David E. Eibling, MD, FACS, professor of otolaryngology at the University of Pittsburgh (PA) School of Medicine, received a presidential citation award at the 107th annual meeting of the American Academy of Otolaryngology-Head and Neck Surgery Foundation. Other Fellows honored during that meeting also are on staff at the University of Pittsburgh, including Charles D. Bluestone, MD, FACS, and Barry E. Hirsch, MD, FACS; both were recipients of distinguished service awards.

The Pituitary Network Association will honor the College’s President-Elect, Edward R. Laws, MD, FACS, by naming him the organization’s Gentle Giant of 2004. The award will be presented May 5 in conjunction with the annual meeting of the American Association of Neurological Surgeons (AANS). Dr. Laws is the Immediate Past-Chair of the College’s Board of Regents and is a past-president of the AANS and of the Pituitary Society. He is the W. Gayle Crutchfield Professor of Neurosurgery and professor of medicine at the University of Virginia, Charlottesville.

Children’s National Medical Center in Washington, DC, announced the appointment of Kurt D. Newman, MD, FACS, to the position of executive director of the Joseph E. Robert, Jr., Center for Surgical Care. The center encompasses the division of anesthesiology, gastroenterology, general pediatric surgery (including plastic surgery), orthopaedics, ophthalmology, and otolaryngology. Dr. Newman is a member of the board of commissioners of the Joint Commission on Accreditation of Healthcare Organizations and is a Past-President of the Metropolitan Washington Chapter of the College.

Kendall Reed, DO, FACS, was named dean of the College of Osteopathic Medicine at Des Moines (IA) University. Dr. Reed, a surgical oncologist, has served as chair and professor of the department of surgery since 1990 and as interim dean since March 2003.
Anyone who has children is very familiar with the phrase, “I didn’t mean to.” Their statement implies that whatever they just did was an “accident.” How often, though, was this outcome predictable and, with proper supervision or advice, preventable? For years we have used the word “accident” when referring to motor vehicle related events. Using the word accident in all cases of motor vehicle related events as in the past implies that the event happened by chance or without an apparent cause. This concept further implies that the event or crash may not have been potentially preventable.

But after years of hearing the stories and seeing the results, it is obvious that many of these events are far from accidental. In the trauma vernacular of motor vehicle related events, we have gotten away from using the word accident. What once was called an MVA or motor vehicle accident has been changed to MVC (motor vehicle crash).

We previously reported in the January Bulletin that the National Trauma Data Bank™ (NTDB) began the transition to the use of the external cause of injury code (E-code) groupings that were developed by the international injury prevention community. E-codes define both the manner and the mechanism of the event. The manner relates to the intent behind the injury (unintentional, suicide or self-inflicted, homicide or assault, intent not able to be determined, legal intervention, or act of war). The graph on this page displays the number of records contained in the Annual Report for 2003 that fall into the various intent categories. The mechanism, on the other hand, is what caused the injury: for example, a fall, a motor vehicle, a firearm, or one of several other mechanisms. There is an excellent two-page table in Appendix C that stratifies the E-codes by manner and mechanism.

The mission of the American College of Surgeons Committee on Trauma is “to improve the care of the injured through systematic efforts in prevention, care, and rehabilitation.” By adopting this internationally accepted grouping of E-codes, researchers will gain insight into the cases that are contained in the NTDB. This insight will, in turn, allow for the initiation of prevention strategies and the ability to track progress through future reports of the NTDB.

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.facs.org/trauma/ntdbannualreport2003.pdf. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, via e-mail at mneal@facs.org.
Dr. Russell meets with new ACS Surgery editorial board

ACS Executive Director Thomas R. Russell, MD, FACS, met recently with the ACS Surgery: Principles and Practice editorial board. Noting that “the College’s role is in support of quality of care,” Dr. Russell discussed future initiatives in surgical education with the board.

The group also discussed the newly published 2004 bound edition of ACS Surgery, which is the first to feature a new editorial board: Wiley Souba, MD, FACS, Chair (Penn State College of Medicine); Mitchell P. Fink, MD, FACS (University of Pittsburgh Medical School); Gregory J. Jurkovich (University of Washington School of Medicine); Larry R. Kaiser, MD, FACS (University of Pennsylvania School of Medicine); William H. Pearce, MD, FACS (Northwestern University Feinberg School of Medicine); John H. Pemberton, MD, FACS (Mayo Medical School); and Nathaniel J. Soper, MD, FACS (Northwestern University Feinberg School of Medicine).

ACS members are entitled to special discounts for ACS Surgery, plus a $30 special offer. Visit http://www.acssurgery.com/learnmore.htm or call 800/545-0554 for more information. (This offer expires March 31, 2004; mention code S42SBF1.)

Next month in JACS

The April issue of the Journal of the American College of Surgeons will feature:

Original Scientific Articles
- Assessing a Regional Trauma System
- Prevention of Adhesions to Polypropylene Mesh

Surgical Forum
- Herbal Medicine Use in Surgical Patients

Education
- Well-Being of Surgery Residents Before the 80-hour Work Week

What’s New in Surgery
- Vascular Surgery