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About the cover...

Complications associated with diabetes have been poorly managed in South Vietnam, but an educational program initiated by David Campbell, MD, FACS, and his colleagues is starting to change that pattern. In this month’s cover story on page 8, Dr. Campbell describes the program, some of the barriers to implementing better diabetic care in Vietnam, and how the seminars are having a curative effect on patient care in that country and, potentially, in India.

Front cover photos courtesy of Dr. Campbell. Back cover art courtesy of Melissa Hagan, Magpie Design.
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From my perspective

I have just returned from the 90th Clinical Congress in New Orleans, LA, with renewed enthusiasm about our plans for the coming year. Many of the ideas for these initiatives came from the loyal volunteers of the College during sessions, meetings, or hallway conversations.

This year’s Clinical Congress in many ways set the tone for the future direction of this organization, with an emphasis on our increasing diversity, unity among all surgeons and other health care professionals, efforts to ensure patient safety, the involvement of young surgeons, and lifelong learning.

Diversity

As you may know, our new President-Elect is Kathryn D. Anderson, MD, FACS, a pediatric surgeon from Los Angeles, CA. Dr. Anderson is the first woman to hold that office in the history of the College. I believe her election represents a turning point for the American College of Surgeons. It signifies that the College recognizes the increasing importance of women and other previously under-represented populations in shaping the future of our wonderful profession.

Our membership is becoming more diverse in other ways as well. For example, more allied health care professionals and affiliate members attended this year’s Clinical Congress than in previous years. The College is embracing nonsurgeon participation in this and other activities in recognition of the fact that all health care professionals are part of the surgical team, and harmony within this group will be important as we move into an era focused on quality improvement and utmost patient safety.

Unity

During the Clinical Congress, Edward R. Laws, MD, FACS, became the fifth neurosurgeon to ascend to the Presidency of the College. Dr. Laws has indicated that he would like his Presidency to be remembered as “the year of unity” for our profession. The College can send no better message to our Fellowship at this time.

It is important that we strive for unity. The growing sophistication of medical practice and the entrenchment of big business and politics have given physicians many issues to disagree about over the last couple of decades. Certainly the College has had its differences with regulatory agencies and other organizations. Frequently, these disagreements revolved around policy, reimbursement, and scope of practice issues. While these are all legitimate bones of contention, the arguments over them only served to divide us and weaken our ability to influence public policy.

Today, we must heal these rifts and begin to build constructive relationships with all of the groups that share our concerns. We need to work diligently and develop a health plan that we can put forward as a basis of reforming our flawed health care system. The Health Policy Steering Committee, chaired by Josef E. Fischer, MD, FACS, of Boston, MA, is working toward this goal. We intend to present the committee’s recommendations to other professional associations and achieve a consensus on the concepts, so that the profession may speak in unison on the direction of health care in this country. Organized medicine needs to take the lead in health system reform in order to ensure that our patients have access to appropriate and necessary care. Who truly looks out for the interests of patients other than the physicians and allied health professionals who deal with their problems day in and day out?
In the further spirit of unity, the College has opened affiliate membership in this organization to other physicians, as well as allied health care professionals, including nurse anaesthetists, surgical technologists, business managers, and so on. We also have continued to work diligently and collaboratively with all the surgical specialty societies to address many of the problems that confront surgeons. Questions about hospital privileges for surgeons who perform procedures in office-based facilities and emergency room coverage are critical concerns at many hospitals. As specialty hospitals are constructed to treat specific diseases, the potential for coverage shortages becomes exacerbated. All members of our profession need to address this possibility. If we don’t, we are putting our personal interests above our patients’ ability to have access to optimal care.

Patient safety
The goal of delivering care safely will define many of our efforts as we go forward in reconstructing the health care system. Many of the general sessions and some of the postgraduate courses at this year’s Clinical Congress centered on patient safety initiatives. For the first time, airline pilots participated in the program in an attempt to bring the lessons learned in their industry into the operating room to help us see how the surgical team can avert preventable error. Again, a key component of efforts to improve patient safety is the development of cohesive patient care teams. A united patient care workforce will add to our ability to build cooperative teams within our hospitals.

Young surgeons
Great strides have been made this last year to embrace medical students and residents in training in the surgical specialties and involve them in our activities. Reflecting our ongoing interest in including these young people in the College, a rejuvenated Resident and Associate Society (RAS) has been inaugurated. In addition to publishing an electronic newsletter and presenting sessions at the Clinical Congress and the Spring Meeting, the RAS has opened the door to resident and Associate Fellow participation on College committees and at the Board of Regents meetings.

Of great concern to both young and established surgeons is the 80-hour workweek for residents, which was instituted throughout the country this last year. Although this rule has resulted in new stresses on programs, there do not appear to be any major intractable problems. Change is often difficult to accept, but this shift in the way we train surgeons is with us to stay and will determine how training programs function in the future.

Lifelong learning
I believe that as the specialty boards move forward with stringent requirements for maintenance of certification, the American College of Surgeons will be a vital resource for all surgeons in training and practice. With the concept of unity as our guiding principle for this year, we will aggressively seek the support and interest of all surgeons in training or in practice to help us present educational programs that meet their needs in terms of developing the key competencies and continuing medical education requirements. If the College can bring all surgeons and health care professionals together to sponsor educational programs that are appropriate for meeting today’s demands, I believe it ultimately will be difficult to practice without membership in this organization.

There is much work to be done, but with a unified approach to addressing our interests in promoting the common good of the surgical patient, I believe that we can accomplish a great deal during this next year. I appreciate Dr. Laws’s call for unity and fully expect to be able to report continued progress next year at this time. While these long-term and overarching goals cannot be completed in one year, we can bring about incremental but essential changes rapidly with your support.

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.
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prepared by the Division of Advocacy and Health Policy

ACS comments on 2005 Medicare fee schedule

On September 24, the College sent strongly worded comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed method of calculating the professional liability insurance (PLI) relative value units (RVUs) in the Medicare physician fee schedule for 2005. The proposal, published in the August 5 Federal Register, remains essentially unchanged from the former methodology of calculating PLI RVUs, except it uses more current data. The resulting RVU changes would produce the largest percentage increase in allowed charges for dermatology, while neurosurgeons would experience the largest percentage decrease.

The College has suggested repeatedly that the agency use premium data for only the primary or dominant specialty providing each service when calculating PLI RVUs for each code. CMS ran a simulation of that methodology but discarded the idea virtually without comment.

CMS also proposed a change in the definition of a supplier of durable medical equipment, prostheses, orthotics, and supplies that would bar physicians from acting as suppliers. The College urged CMS to retain the current definition of a supplier, suggesting that in many cases patients need the items to leave the surgeon’s office. For a copy of the comments, go to http://www.facs.org/ahp/views/medicare2005.html.

Solutions proposed for “crossing the quality chasm”

A new report from the Institute of Medicine (IOM) summarizes strategies and action plans developed by national and community health care leaders at a summit on improving quality. The group convened in January as a follow-up to the 2001 IOM report, Crossing the Quality Chasm. Participants, including LaMar S. McGinnis, Jr., MD, FACS, focused on strategies to improve patient care for five common chronic illnesses.

The strategies shared at the summit include instituting performance-based payment models, implementing evidence-based benefit design, leveraging federal leadership to accelerate the adoption of electronic health records, improving public reporting of quality outcomes, and aligning financial incentives to reward seamless care coordination and self-management. The report also summarizes commitments by national organizations to support the aims delineated in the IOM’s report on the quality chasm. For more information, go to http://www.iom.edu/report.asp?id=22344.

J CAHO and NQF to look at DVT

The Joint Commission on the Accreditation of Healthcare Organizations (J CAHO) and the National Quality Forum (NQF) announced a collaborative project to develop and standardize performance measures for the prevention and care of deep vein thrombosis (DVT). The NQF will be responsible for developing organizational policies, procedures, care practices, and appropriate improvement interventions. J CAHO will create the measure set, as well as the specifications and testing of these measures. A content-specific steering committee will be formed in the weeks to come to provide advice and insights for the final measures. For more information, go to: http://www.jach.org/news+release+archives/caho_092704.htm.
The General Accountability Office (GAO) recently examined a CMS demonstration program that allows higher payments to preferred provider organizations (PPOs) that serve Medicare beneficiaries. Thus far, the demonstrations have attracted relatively few enrollees (98,000, or less than 1 percent of 10.1 million eligible beneficiaries in this demonstration) and did little to expand access to care or save Medicare money. This poor showing came despite higher costs to the program, with CMS projecting an extra cost of $652 per beneficiary.

The GAO further said that CMS had “exceeded its authority” by allowing 29 of the 33 participating PPOs to limit patient choice of providers offering skilled nursing and home health care, dental care, and routine physical examinations. Patients who went out of network were liable for the full cost of their care, the report said. The complete report can be found at http://www.gao.gov/cgi-bin/getrpt?GAO-04-960.

CMS is expanding coverage of implantable cardioverter defibrillators (ICD) based on new clinical studies showing potential benefits for patients who have never had a heart attack. Based on these results, the draft decision recommends coverage for most of the population studied in the trial, including patients with heart failure, poor left ventricle function, and certain EKG readings. As part of this decision, CMS will work with manufacturers and clinical experts to develop a registry to track progress of patients who receive the device. This is one of what is likely to be more coverage decisions encouraging sponsors to participate in expanded clinical trials. The coverage decision can be read at: http://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=139.

Two-thirds of emergency department medical directors surveyed report shortages of on-call specialists at their hospitals, according to a study released by the American College of Emergency Physicians (ACEP). Survey participants said the problem may cause delays in patient treatment and increase patient transfers between emergency departments.

About 8 percent of the respondents said their hospitals were paying stipends for on-call commitments from specialists, while 15 percent were guaranteeing certain levels of payment for services, and 14 percent were providing some measure of medical liability coverage. ACEP said the study shows further stress on an already strained emergency care system and indicated that it will urge a new government-sponsored Emergency Medical Treatment and Labor Act Technical Advisory Group to address the issue.

ACEP said it next plans to examine whether on-call coverage problems are greater in states with medical liability crises and a high penetration of specialty hospitals and outpatient surgery centers. For more information, go to: http://www.acep.org/1,34081,0.html.
Surgeon leads
Vietnam medical education program

by David Campbell, MD, FACS, Boston, MA
In 1998, Dr. Cao Van Thinh invited me to give a lecture at a meeting in Ho Chi Minh City to celebrate the three hundredth anniversary of the founding of Saigon. I had met Dr. Thinh the year before, when he spent some time at the Deaconess Hospital. Although no funding was available, I was pleased to have the opportunity to visit Vietnam, and in November 1998, I eagerly traveled to Ho Chi Minh City.

Dr. Thinh was a perfect host, driving me all over the city on the back of his motorcycle. My translator for the lecture was Dr. Nguyen Khue, chief of endocrinology at Ho Chi Minh University. She later took me on rounds at Cho Ray Hospital, and I was amazed to see a ward full of patients with amputated limbs secondary to type 2 diabetes.

This epidemic of diabetic complications clearly was a relatively new phenomenon in Vietnam, similar to the experience in the U.S. in the 1960s and 1970s. At that time, my colleagues at the New England Deaconess Hospital and Joslin Clinic and I had played an important role in teaching physicians and patients in the U.S. about the management of diabetic complications, and it seemed this experience could be put to good use in Vietnam. Hence, plans were put into place to try to raise money from industry and bring a team over to teach the following year.

Vietnam 2000

This project, known as the Harvard Vietnam Medical Education Program, finally came to fruition in June 2000. I recruited Chan Cooppan, MD, from the Joslin Clinic, and Hau Pham, DPM, from the podiatry department of the Beth Israel Deaconess Hospital, to accompany me on this educational experience. Dr. Cooppan is in charge of continuing education at the Joslin Clinic and proved to be a great lecturer and fund-raiser. Dr. Pham had left Vietnam as a teenager in 1975 and was anxious to return because he hadn't seen his family in 25 years. Needless to say, a highlight of this trip would be witnessing the reunion of Dr. Pham with his mother and four sisters.

A onetime grant from Chase Bank and smaller amounts from Eli Lilly and Novartis helped to finance the trip. Upon arrival we were quickly put to work conducting ward rounds and leading a major seminar for 200 physicians on diabetes and its complications.

I operated on a carotid aneurysm and did a leg bypass at Cho Ray Hospital, and Dr. Pham and I performed foot surgery at Nhan Dan Gia Dinh Hospital. We noted the lack of communication between services and a curious mix of high-tech and primitive conditions. In particular, there seemed to be little understanding or interest in the diabetic foot problems that contribute to a very high amputation rate.

One physician, Dr. Nguyen Khahn, a surgeon at Nhan Dan Gia Dinh Hospital, however, was impressed with our message and promised to set up a diabetic foot unit at his hospital. All of the physicians we met were extremely welcoming and asked us to return annually and requested that we bring a nephrologist next time. They had just opened their first dialysis unit, although few patients could afford the cost of that treatment. We left Ho Chi Minh City feeling we had made a significant difference and looking forward to our return.

2001 visit

Fund-raising continued to be a concern, but Dr. Cooppan and I managed to get backing from Lilly, Novartis, Aventis, and Bristol Meyer Squibb. We took along on this mission Mark Williams, MD, a nephrologist at Joslin Clinic, his wife Meryl LeBoff, MD, an endocrinologist, and Thahn Dinh, DPM, a podiatrist. We left the U.S. on November 16, unsure how difficult travel would be after the tragedy at the World Trade Center on September 11. As it happened, the flight was uneventful, and we arrived in Vietnam November 18.

The next day, Dr. Khue had us lead an all-day seminar on diabetes and its complications. Turnout from the medical services staff was good, but surgeons were notably absent. The low surgical presence was partly due to a scheduling problem but also typified the extreme difficulty we have found in getting the medical and surgical services to cooperate.

We then traveled by minibus to Can Tho in the Mekong Delta, with Dr. Khue offering a sightseeing tour on the way. We gave another all-day seminar at Can Tho Hospital to a mixed medical-
surgical group. They were very receptive and greatly interested in our presentation.

When not lecturing, we toured the hospital, a run-down French colonial building, with members of our respective specialties. The tour clarified for us that the hospitals in Ho Chi Minh and Hanoi are far ahead of those in rural areas. The physicians expressed great interest in having us return, and the surgeons requested that I demonstrate a leg bypass on our next visit. We returned to Ho Chi Minh tired but exhilarated by the trip to the country and the reception we had received.

The next day was the high point of the trip. Dr. Pham and I went to Nhan Dan Gia Dinh hospital. After rounds, we repaired to the library where Dr. Khanh presented a series of cases he had treated during the preceding year. Using the techniques we demonstrated during our last visit, he salvaged more than 20 limbs. This revelation confirmed that our mission in Vietnam was important and worthwhile. Hope was expressed that these cases could be reported in one of the medical journals to encourage other centers in Vietnam to implement our suggestions. Meanwhile, the nonsurgeons met with Dr. Khue at the medical school for a series of case presentations, and the Vietnamese physicians expressed their appreciation for input from the team.

The team regrouped for a visit to a hospital in the industrial section of Ho Chi Minh. This full-service hospital has a large trauma unit. We took particular notice of a young woman who had been admitted every few months with diabetic ketoacidosis because she could not afford her insulin. The Vietnamese health care system is ostensibly a state-run system, yet people have to pay toward prescriptions and for many other services. For example, meals are not provided by the hospital.
Dr. Khue and her team. Meanwhile, I went to the airport with Dr. Thinh to catch a plane to Hanoi, where I visited the two main hospitals and gave a small presentation to the endocrine group. Both Dr. Dang Hanh De, professor of surgery, and Dr. Pham Thi Hoa, head of endocrine, expressed great interest in having the team come to Hanoi on their next visit to lecture on the management of diabetes and its complications. We left Vietnam excited to see that our previous visit had generated signs of improvement.

2002 visit

For this trip, Drs. Cooppan and Pham and I planned to visit Ho Chi Minh, Danang, and Hanoi. Drs. Khue and Thinh did a great job of getting Vietnamese companies to sponsor us. We were delighted to hear that Dr. Khue had been promoted to full professor but disappointed to hear that Dr. Khahn, who had so enthusiastically adopted our techniques, was no longer working. No one would say what had happened, but we suspect he was forced out for political reasons having to do with his children remaining in the U.S.

Our first three days were spent in Ho Chi Minh City, and we started with our diabetic complications seminar at the medical school. This workshop was primarily aimed at internists and attracted a good crowd. For the next two days, the group split up, with Drs. Cooppan and Khue joining the medical teams for rounds and seminars, while Dr. Pham and I went to Cho Ray Hospital for surgical rounds and then Binh Dan Hospital to meet with Prof. Van Tan and Dr. Thinh. Binh Dan is a surgical hospital, where the staff is

Furthermore, most physicians supplement their extremely modest salaries by seeing patients at their homes or by moonlighting in another field. The last day, the rest of the team headed to Cho Ray Hospital for one more case presentation with

Left to right: Drs. Cooppan, Khue, Thinh, Dinh, Campbell, LeBoff, Williams, and Pham.

Left to right: Drs. Khahn, Pham, Nam, and Campbell on rounds at Nhan Dan Gia Dinh Hospital.
very interested in diabetic foot problems. After rounds and lunch at Professor Tan’s house, Dr. Pham and I each gave a formal lecture on our surgical techniques. We then went to Nhan Dan Gia Dinh Hospital, which had so excited us on our last visit. Dr. Nam had clearly taken over the mantle from Dr. Khanh. We were very impressed with their enthusiasm and determination, and we promised to put on a program for them the next year. As we prepared to leave Ho Chi Minh City, we reflected on the great strides under way at the hospital and the physicians’ enthusiasm for our continuing education program.

Next we flew to Danang. Dr. Khue’s assistant accompanied us and gave us a great tour of Marble Mountain, followed by a hair-raising drive over Hai Van Pass on the only road connecting the north and south. After a relaxing dinner, we spent the next morning giving our seminar to a large group of physicians. The highlight was our interaction with a group of physicians from Hue who spoke about their experience with diabetic foot problems. They clearly recognized the problem and were anxious for us to visit with them the following year. The next day, we went sightseeing—visiting My Son, the ancient capital of the Champa kingdom, and the medieval port of Hoi An. On the way back, we visited China Beach. Throughout this adventure, Dr. Cooppan shared with us his expertise in Hindu and Buddhist culture.

Hanoi, perhaps the prettiest city in Vietnam, was our next destination. Dr. Duong Duc Hoang met us at the airport, and showed us around the center of Hanoi with its many lakes and pagodas.

The next day we met with Prof. Tran Duc Tho and gave our seminar. Again, the turnout was good and the physicians asked plenty of questions that conveyed a genuine interest in our discussion. However, they seemed less well organized in their management of diabetes than their colleagues in Ho Chi Minh and Danang.

Dr. Pham and I meet with Dr. De and his surgical team at Viet Duc Hospital to present our experience with a number of surgical procedures.
India added

In addition to our usual efforts in Vietnam, in 2003 a group in Chennai, India, asked if we would conduct a seminar there on our way home from that year’s Vietnam trip. They had negotiated previously with Harvard International, but the cost of that program was too high. They did offer us some help with transportation expenses, so we agreed to do this program for them on a onetime basis.

The composition of our group was slightly different this year. Dr. Pham had transferred to Boston University Medical Center, so we recruited Tom Lyons, DPM, to the team.

We landed in Ho Chi Minh City November 25. Ho Chi Minh City was the cleanest we had ever seen it because it was the host city for the Southeast Asian Games in soccer. We presented our usual seminar at the university on the complications of diabetes, and physicians from all over southern Vietnam attended.

We asked about Nhan Dan Gia Dinh Hospital, which we had promised to visit on this trip, and got disappointing news. We already knew that Dr. Khahn was no longer at the university, but now we learned that Dr. Nam had given up medicine to concentrate on real estate, which had always provided most of his income. Unfortunately, everyone who had any interest in our work was gone, largely for socioeconomic reasons.

Nonetheless, we were excited to learn that Dr. Thinh and Professor Tan had decided to focus on peripheral vascular disease. After the diabetes conference we went to Binh Dan Hospital to see some patients with vascular disease. One patient with Berger’s disease was of particular in-

Initially, the surgeons expressed disinterest, but we got their attention, and by the end, they were looking forward to our return and a demonstration of our procedures. During the rest of the visit, we toured the museums with Dr. Hoang, and Drs. Cooppan and Pham took a trip to Ha Long Bay.

On the way back to the U.S., we talked about the impressive efforts that the local physicians had made toward our visit, and we took this as a sign that we were making a difference.
terest to us because we rarely see that condition in the U.S., but consequently, we had no real solutions to offer.

We decided that I would do a femoral tibial bypass the following day using an angioscope and valvulotome we had brought with us on our last trip. Another patient with an abdominal aneurysm was scheduled for a computed tomography scan and surgery in two days.

Dinner that night was at the wonderful home of Professor Tan, and a number of the staff from Binh Dan Hospital joined us.

The next morning after breakfast Dr. Thinh and I went to Binh Dan Hospital, while Drs. Cooppan and Khue conducted a seminar at the university, and Dr. Lyons got to take his first sight-seeing trip in Ho Chi Minh City. I performed the first in situ femoral tibial bypass in Vietnam, using an angioscope in a packed and extremely hot operating room.

At the end of the procedure, which went extremely well, I received a standing ovation, lending new meaning to the British term “operating theatre.” Afterward, I lectured the surgical team at Binh Dan Hospital on various aspects of vascular surgery. They were enthusiastic, but because it is only a surgical hospital, it is hard to imagine them developing the multispecialty team needed to treat the complications of diabetes. The day ended with a visit to the Buddhist University followed by dinner at what is known as “the Clinton restaurant” because the former U.S. President ate there a few years ago. We then strolled down “backpackers’” road, where young travelers from Europe and Australia can find inexpensive lodging.

For our last day in Ho Chi Minh City we split up again. Drs. Cooppan and Lyons went with Dr. Khue to Hospital 115 in the suburbs to do ward rounds. Dr. Lyons demonstrated foot debride-
ment at the bedside. I went back to Binh Dan with Dr. Khue to resect the abdominal aneurysm. Given the antiquated instruments and lack of blood availability, the procedure had potential for complications but went very well. The team then regrouped for a farewell lunch, and we agreed to return in April 2005 to participate in a major endocrine diabetes conference. After an afternoon of shopping, we enjoyed a festive dinner with Dr. Thinh and his wife and daughters.

The next day we flew into Hue, a small city of half a million people and the ancient capital of Vietnam, filled with buildings and monuments from the Nguyen Dynasty. After a formal meeting with Dr. Thuy, whom we met last year, and his associates to discuss future collaboration, we toured the medical school and presented our conference. This group has the only meaningful statistics on the management of diabetes and its complications that we have seen in Vietnam, and we talked about publishing some of the data with the help of the Joslin Clinic. After the conference, a plastic surgeon took Dr. Lyons to see a patient with a foot ulcer closed with a rotation flap. It is a sophisticated procedure, which contrasts with the fact that even in Hue, the best center in Vietnam for diabetic foot problems, 30 percent of the patients presenting with neuropathic foot infection will undergo major amputation. One wonders how recurrence can be prevented without a podiatry service to provide good foot care. These sorts of contrasts are a constant theme in Vietnam. We then took a couple of days to do some sightseeing around Hue. We boated up the Perfume River, toured the tombs of the Nguyen kings, crossed the 17th parallel to visit the Phong Nha caves, and, finally, visited the Citadel before taking a plane to Hanoi. Hanoi was in a state of excitement because Vietnam was playing the fa-
vorites, Thailand, in the Southeast Asian soccer games. We unpacked and watched the game at dinner.

The following morning, it was back to work, and we went to the Institute of Gerontology at Bach Mai Hospital. This is the hospital that became famous for successfully dealing with an outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003. Despite the absence of the endocrinologists, who were at a meeting in Singapore, we attracted a good crowd, and there was a lively question-and-answer session at the end. I met with Dr. De and his assistant to discuss some possible surgical collaboration during our next visit.

That evening we attended a faculty dinner and again Dr. Thang expressed his desire to work more closely with us in the future. The following day we went with Dr. Thang and his team to visit Chua Huong (The Perfume Pagoda) a few hours from Hanoi. It was a long drive over terrible roads but well worth the effort.

Our last day in Vietnam, we shopped, then had a final meeting with Dr. Thang. All in all, we left proud of what we had accomplished so far in Vietnam, such as ensuring that there is a center for distal bypass surgery and the possibility of obtaining some real data that will allow us to quantify improvement. There was clearly much more enthusiasm for our mission in Hanoi this time than the last, and we are looking forward to working closely with Dr. Thang in the future.

Our next stop was Chennai, formerly Madras—the capital of Tamil Nadu on the southeast coast of India. The two-day seminar we participated in attracted nearly 400 physicians from all over India and Bangladesh and one physician from Israel. It was officially opened by the Minister of Health for Tamil Nadu and then followed by a speech from the U.S. consul. Communication with the Indian physicians was much easier for us than in Vietnam because English is the official language of India. The physicians are generally well educated and very enthusiastic. In fact, we learned as much from the Indian faculty as they did from us.

We were overwhelmed by the size of the problem in India. The total population has reached one billion, and the incidence of diabetes among the urban population has now reached 12 percent—the highest in the world. They have the same congenital issues as South Vietnam, but obesity, due to lack of exercise and a high-carbohydrate diet devoid of fresh vegetables, is an added concern.

One unique feature of this conference was a session in which live patients appeared on stage, allowing us to take a history, examine the patient, and then discuss the case directly in front of the audience. Elliot Joslin, MD, and his colleagues used to do a similar program weekly at the Deaconess up till the mid 1980s.

Vijay Viswanathan, MD, director of the Diabetes Research Centre and the M.V. Hospital, put this conference together. He is a great organizer and is determined to create standards of care for the management of diabetes complications in India. His father, a legend within Indian medical circles, built the institute. We received many invitations to put on a similar conference in other parts of India during our next visit to Asia. Our plan at this time is to work with Dr. Viswanathan to create a health plan for diabetic care in underdeveloped countries and to return to India for a few days at the end of our trip to Vietnam in April 2005.

Dr. Campbell is a vascular surgeon at Beth Israel Deaconess Medical Center and associate clinical professor of surgery at Harvard Medical School.
Over the past few years, many state legislatures have made medical liability reform a key issue. Spurring this renewed interest are the annual double-digit increases in medical liability insurance premiums that have forced some surgeons and other high-risk specialists to close their practices or discontinue certain procedures, leading, in turn, to decreased access to care. Other driving factors include the fact that trauma centers have had difficulty meeting coverage requirements for surgical and specialty care, and, in some parts of the country, women report having to travel far from home for obstetrical services.

To respond to these problems, states have typically sought to enact medical liability reforms modeled on California’s Medical Injury Compensation Reform Act (MICRA). Passed in 1975, MICRA includes a $250,000 cap on noneconomic damages, modifications to the collateral source rule, mandatory periodic payments of future damages, and a sliding scale for plaintiff attorneys’ contingency fees. MICRA is considered the “gold standard” in reform, and the College, the American Medical Association, and national specialty societies believe legislation of its type best addresses the problems with our current tort system at both the state and federal levels (see page 18).

State experience with caps

Perhaps the most critical, and most controversial, component of MICRA is the cap on noneconomic damages. These damages are generally defined as compensation for physical and emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other intangible nonmonetary losses. The personal injury bar and many consumer groups fiercely oppose caps on noneconomic damages, making it difficult to pass them as part of a broader medical liability reform package.

Those states that have passed caps have often gone with a dollar amount that is higher than MICRA’s $250,000 limit. In many cases, an annual inflation adjustment has been incorporated, because one of the criticisms of MICRA is that the amount of the cap has stayed the same for almost 30 years. The chart on page 18 listing states with caps shows that most of them exceed the $250,000 limit.

During the 2004 legislative session, almost every state that considered legislation containing a cap on noneconomic damages as part of medical liability re-
form placed that cap above the MICRA level of $250,000. Only the District of Columbia, Iowa, and Georgia held true to the MICRA cap, but their bills were either still under consideration (DC), vetoed (Iowa), or defeated in the legislature (Georgia). This trend is likely to continue, especially in those state legislatures where medical liability reform is an extremely contentious issue and the cap level is seen as a negotiating tool.

**Trends and alternatives**

Even though the College and other medical organizations consider MICRA to be the ideal method of medical liability reform, political realities in some states have impeded the enactment of these reforms. Instead, some elements of MICRA may be adopted, or other viable options, such as medical review panels or alternative dispute resolution mechanisms, may be considered. Some alternative reforms are as follows.

1. “I’m Sorry.” Some states have recently enacted legislation loosely referred to as “I’m Sorry” laws. Since 2003, five states have adopted this approach, with four doing so this year. Colorado was the first state to adopt this reasonable reform, with Ohio, Oklahoma, Wyoming, and North Carolina following suit.

What exactly does an “I’m Sorry” law do, and why should it interest physicians? For years, physicians have found frustrating their lawyers’ advice that they not talk to a patient or family member when an adverse incident or outcome occurs. Physicians generally are compassionate, caring, and honorable individuals. It goes against a physician’s natural inclination to withhold an expression of sadness or an apology for a procedure that failed to turn out as anticipated, regardless of whether a mistake was made. Defense attorneys warn that such conversations could be construed as admissions of guilt in medical liability lawsuits. Yet, in many cases, patients or families have indicated that if the physician had just sat down with them, explained what happened, and apologized for the mistake, they might not have filed a lawsuit.

North Carolina recently passed an “I’m Sorry” law. Under this statute, “Statements by a health care provider apologizing for an adverse outcome in medical treatment, offers to undertake corrective or remedial treatment or actions, and gratu-

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**MEDICAL LIABILITY REFORMS SUPPORTED BY THE ACS**

- Cap noneconomic damages at $250,000 with no limits on economic damages.
- Eliminate the collateral source rule to allow introduction into evidence any collateral source payments and allow offsets for those payments.
- Modify joint and several liability so that defendants are only liable for their own portion of noneconomic and punitive damages.
- Allow periodic payment of damages for future damages over $50,000.
- Establish a sliding scale for attorney contingency fees of up to 40 percent of the first $50,000; 33-1/3 percent of the next $50,000; 25 percent of the next $500,000; and 15 percent of any amount over $600,000.

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**STATE CAPS ON NONECONOMIC DAMAGES**

<table>
<thead>
<tr>
<th>State</th>
<th>Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>$400,000*</td>
</tr>
<tr>
<td>California</td>
<td>250,000</td>
</tr>
<tr>
<td>Colorado</td>
<td>300,000</td>
</tr>
<tr>
<td>Florida</td>
<td>500,000*</td>
</tr>
<tr>
<td>Hawaii</td>
<td>375,000*</td>
</tr>
<tr>
<td>Idaho</td>
<td>250,000*</td>
</tr>
<tr>
<td>Indiana</td>
<td>250,000</td>
</tr>
<tr>
<td>Kansas</td>
<td>250,000</td>
</tr>
<tr>
<td>Louisiana</td>
<td>500,000 (total damages)</td>
</tr>
<tr>
<td>Maryland</td>
<td>635,000</td>
</tr>
<tr>
<td>Michigan</td>
<td>349,700*</td>
</tr>
<tr>
<td>Mississippi</td>
<td>500,000</td>
</tr>
<tr>
<td>Missouri</td>
<td>565,000</td>
</tr>
<tr>
<td>Montana</td>
<td>250,000</td>
</tr>
<tr>
<td>Nebraska</td>
<td>1,750,000 (total damages)</td>
</tr>
<tr>
<td>Nevada</td>
<td>350,000*</td>
</tr>
<tr>
<td>New Mexico</td>
<td>600,000 (total damages)</td>
</tr>
<tr>
<td>North Dakota</td>
<td>500,000</td>
</tr>
<tr>
<td>Ohio</td>
<td>350,000*</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>300,000*</td>
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<tr>
<td>South Dakota</td>
<td>500,000</td>
</tr>
<tr>
<td>Texas</td>
<td>250,000</td>
</tr>
<tr>
<td>Utah</td>
<td>400,000</td>
</tr>
<tr>
<td>Virginia</td>
<td>1,700,000 (total damages)</td>
</tr>
<tr>
<td>West Virginia</td>
<td>250,000*</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>410,000</td>
</tr>
</tbody>
</table>

*Indicates exceptions to cap; bold notes annual adjustments.

Source: AMA Advocacy Resource Center.
inous acts to assist affected persons shall not be admissible to prove negligence.”

Oklahoma used slightly different language in its “I’m Sorry” law, which is modeled on the Colorado statute. Those states permit a physician to express sympathy, commiseration, condolence, compassion, or a general sense of benevolence to the patient, the patient’s family, or a representative of the patient for an injury sustained as the result of an unintended outcome. If a physician makes such a statement, it cannot be admitted into evidence and used as an admission of liability.

2. Letting the voters decide. Some state constitutions prohibit caps on noneconomic damages. In those cases, it has been necessary to take the issue to the voters, with Oregon and Wyoming doing so in 2004. Both states have ballot initiatives in November asking voters to approve constitutional amendments, and with public opinion polls showing strong support, these amendments are expected to pass despite a bitter fight by the personal injury lobby.

Ballot initiatives in Florida deal with issues beyond caps on noneconomic damages. The Florida Supreme Court has approved four constitutional amendments: one from physicians and three from trial attorneys. The physician initiative would restrict attorney contingency fees to 30 percent of the first $250,000 awarded in a medical liability lawsuit and 10 percent of all damages in excess of $250,000. On the opposing side, the trial attorneys will likely procure a spot on the ballot for two amendments. The first would revoke the medical licenses of physicians who have been found at fault in three or more cases of medical malpractice, and the second would entitle patients and their families to access to all medical records.

Nevada voters will decide on a series of ballot initiatives relating to medical liability reform. Ballot Question #3, supported by the medical community, would impose a firm cap of $350,000 on noneconomic damages per action; repeal joint and several liability for economic damages as is currently the case for noneconomic damages; limit attorney contingency fees; and permit periodic payment of future damages. Two others, Ballot Questions #4 and #5, written by personal injury lawyers, would repeal existing medical liability reforms and make it impossible for the Nevada legislature to enact any reforms in the future.

A few states have taken a slightly different approach. Although their constitutions may not directly prevent the enactment of caps on noneconomic damages, there is fear that a less-than-sympathetic state supreme court could hear a case and declare the caps unconstitutional, which has happened in Illinois and Ohio. Physicians in Michigan, Ohio, and Texas realized that one way to address this threat was to elect supreme court justices who support caps on noneconomic damages. They were successful in their efforts, but Texas went a step further in 2003 with voters approving a constitutional amendment clearly allowing the legislature to enact caps.

3. Municipalities enact reforms. An innovative approach to enacting medical liability reform is under way in Illinois. In response to the Illinois General Assembly’s refusal to pass meaningful medical liability reforms, two municipalities enacted reforms of their own. Marion and Carbondale, two downstate Illinois cities severely affected by the loss of surgeons and other high-risk specialists, approved similar ordinances under the rubric of home rule authority granted by state statute. Because there is some question as to whether home rule actually permits the towns to enact reforms in this way, it will be up to the courts to decide when cases may be filed under these city ordinances.

The reforms in the Marion ordinance include: limiting noneconomic damages to no more than three times the damages awarded for economic loss; requiring that lawsuits resulting from treatment given in Marion be filed in the local Williamson County circuit court; holding the losing party responsible for all costs, including court costs and attorneys’ fees; basing economic damages on tangible loss for cost of past and future medical and hospital expenses, loss of income, and other property loss; and exempting from liability emergent or acute care that is provided within the city in a usual and customary manner.

4. Alternative dispute resolution (ADR). The principal objective of alternative dispute resolution is to promote quicker and less costly resolution of claims. Because the U.S. civil justice system has exceptionally high administrative costs (lawyer fees, expert witness fees, insurance com-
pany overhead), most of the business sector has aggressively adopted ADR. The health care community has lagged behind.

ADR can take many forms, such as mediation, arbitration, mini-trials, summary jury trials, moderated settlement conferences, and hybrids of any of these approaches. Some ADR programs are voluntary (both parties voluntarily agree to try to resolve their dispute with a particular ADR system), while others are mandatory (the parties have no choice; they are required by statute or contract to participate in the ADR process). If participation is voluntary, the ADR decision is more likely to be binding on the parties. If participation is mandatory, the ADR decision is often, but not always, nonbinding.

The College supports the inclusion of statutory provisions in federal medical liability reform directing the U.S. Secretary of Health and Human Services to provide grants to states for the development and implementation of ADR programs. States would have flexibility in devising their ADR programs as long as federal standards were met. These standards should require ADR systems to incorporate some sort of disincentive to proceeding through the court system so that ADR would be a cost-effective and faster way of resolving claims rather than a costly “add-on” to the litigation process. At a minimum, the ADR decision should be admissible in court if the parties proceed to litigation.

Utah is one state that has adopted an ADR process, which includes pretrial screening, mediation, and arbitration. State law requires that a prelitigation hearing be conducted on a medical malpractice claim to determine its merit before a lawsuit may be filed in court. The panel is composed of an attorney, a physician, and a member of the public. The decision of the panel is nonbinding and cannot be referenced in any future legal proceeding.

Under Utah’s arbitration statute, physicians may enter into a predispute binding arbitration agreement with a patient. The physician must give a special, easy-to-read written disclosure to the patient when presenting the arbitration agreement, must ask the patient to read it, and must answer any questions the patient might have. Patients may decline to sign the agreement but must still receive care. A patient also may rescind an agreement within 10 days of signing it. Agreements are automatically renewed annually unless terminated with written notice at the anniversary of the agreement.

Patients may have legal counsel for an arbitration proceeding, and may request mandatory mediation before arbitration. If arbitration is selected, both parties may agree to a single arbitrator. In other cases, a three-arbitrator panel is selected: one by the patient, one by the health care provider, and the third agreed to by both parties. The arbitration proceeding may be split into the issues of fault and damages, and the parties may agree to change the arbitrator on damages if they wish. Once the panel is finished with its deliberations and an award is determined, the damages are filed as a judgment against the provider in the appropriate district court.

**Moving forward**

As states continue to struggle with the medical liability insurance crisis, surgeons can expect legislatures to consider various solutions to the problem. While many of the approaches discussed in this article fall short of MICRA, they are positive steps toward stabilizing the marketplace and should be considered part of an overall medical liability reform strategy. For those states that have enacted tort reforms, the approaches in this article may add to and enhance their liability laws.

When many legislatures convene in early 2005, reform advocates will again take their case to policymakers, the courts, and the people. ACS chapters are encouraged to actively participate in these reform efforts by joining medical liability reform coalitions, contacting state legislators, holding advocacy days at the capitol, and other grassroots activities. To help the chapters in these efforts, the College has created a Medical Liability Reform Action Guide that contains valuable advocacy resources. It may be accessed at http://www.facs.org/ahp/proliability.html. In addition, State Affairs staff are available to assist with grassroots advocacy.
Residents and medical students in the 21st century:

Better, worse, or just different?

by Zsolt T. Stockinger, MD, FACS, Michael S. Ellis, MD, FACS, and Norman E. McSwain, Jr., MD, FACS, New Orleans, LA

About a year ago, the New Orleans Surgical Society met to hear Louisiana surgeon and then-president of the American Medical Association, Donald J. Palmisano, MD, FACS, discuss the professional liability crisis gripping American medicine. During the informal reception afterward, the discussion turned, as it often does these days, to another perceived crisis in American surgery—the move to the 80-hour workweek and the training of surgery residents in general. As one can imagine, the spectrum of views offered on this subject was diverse, ranging from rebellious to resigned, from uncaring to understanding. Most of the discussants agreed that the current crop of surgery residents is a different breed than we were when in training. Of course, we had heard practicing surgeons say the same of us, and, most likely, the current residents will make the same comments about their successors, if they aren’t already. Nonetheless, we bemoaned the fate of American surgery, reminiscing about surgical training during the previous millennium.

At one point, one of the authors happened to mention that he had organized the first house staff organization at Charity Hospital, around 1973. At the time, working conditions were bad (sighs all around), hours were long (understanding nods), pay was inadequate (shrugs), and demands were made—and met (gasp). His experience demonstrated the potential power of organized medicine, but as the story unfolded, it begged the question of whether residents really were different in those days.

Changing priorities

Today’s medical literature is rife with articles about the impact of the 80-hour workweek¹,² and the changing priorities of medical students as they select careers.³⁻⁶ Perusing just a few recent publications shows that medical educators are concerned about the possible negative effects of the rules on both residents and patients.² Apparently even some surgery residents, while enjoying the improved lifestyle afforded by the new rules, feel that they negatively affect patient care.² There are concerns that current trainees (students and residents) have an unrealistic view of the work hours and call schedule of practicing surgeons.⁷⁻⁸

But how does today differ from yesterday? To answer this question, we decided to turn to the Service Employees International Union’s Committee of Interns and Residents—the largest house staff organization in the country, representing trainees in seven states or territories. Founded in 1957, this group was instrumental in achieving the one-in-three call schedule and other needed benefits. Perusing their Web site (www.cirseiu.org), one finds that today’s hot topics include the 80-hour workweek (of course), maternity leave, collective bargaining, and overtime pay. “A limit on resident work hours means healthier patients, healthier residents, and a healthier medical community,” sayeth the Web site,⁹ although one-quarter to one-third of residents themselves, in at least two studies, have said they believe that work-hour limitations will negatively affect patient care.²
Meanwhile, three young physicians have filed a class-action lawsuit against the National Residency Matching Program (NRMP), attacking the FREIDA residency database, the American Association of Medical Colleges’ survey of house staff stipends, the Accreditation Council on Graduate Medical Education, and the match itself. In the complaint, the physicians argue that these activities are anticompetitive and restrict salaries, despite the fact that the NRMP has two medical student board members and was founded in part by medical students because of the gross inequities in the resident selection process before its inception in 1952.

Today, medical students’ chief concerns regarding selection of specialty are controllable lifestyle and intellectual challenge. General surgery in particular has been knocked for its “lacked breadth in expertise, limitations over stress, control over one’s time, regularity of schedule, adequacy of leisure time, and income commensurate to workload.” Other specialties considered to have a “poor lifestyle” are also decreasing in popularity. Yet despite this trend, most general surgeons say they would choose this same specialty again.

Our concerns as residents

By coincidence, while we were discussing submitting this article to the Bulletin, a third-year medical student rotating on the surgical service asked what our program offers to encourage young people to complete their residency here. In our day, to paraphrase President Kennedy, we asked not what the program could do for us, but what we could do for the program.

In 1973, the Charity Hospital house staff placed before the administration the following eight demands:

1. A “crash cart” on every floor. At the time, there was one for the entire hospital.
2. Privacy screens for patients. All patients were, and still are, housed in barracks-style wards.
3. Some sort of cooling system for the patient wards. Not even floor fans were available.
4. Bedside commodes for patients.
5. Air conditioning in the resident call rooms. Residents would sleep on the roof of the hospital, because of the unbearable heat of the New Orleans summer.
6. A place to park.
7. Health care insurance for house staff.
8. A raise of $50 per month, for a monthly of income of $225.

As you may notice, four of these items were directly related to patient care, two were related to working conditions, and only the last two directly affected the residents’ pocketbooks. To discuss work hours would have been inconceivable, and to discuss lifestyle meant that one actually expected to have a life. Surprisingly, all of these demands were ultimately met.

What’s different

So what is different today, 30 years and a generation after the demands set forth in 1973? Are the physicians and surgeons of the future more self-centered, demanding to have actual lives while we were content to have jobs? Do the surgeons of the future actually dare to differentiate between having a life and a job, when we thought the two were synonymous? Is it possible that we cared more about our patients, while they care more about themselves? Are we training surgeons or shift workers?

Or is it possible that patient care has changed to the point where residents no longer need to fight for patients’ rights? Are we now finally confronting the fact that one-third of a resident’s time is spent performing activities with marginal educational value, and that with better communication between physicians and nurses, residents can sleep more and be paged less? Can anyone honestly say that he or she would have preferred less sleep, fewer days off, and less time with their families while in residency, regardless of in which decade it was?

What it means

In other words, are we finally allowing our trainees to say that there has to be a better way? Halsted did it, a century ago, and reformed American surgical education as a result. As Halsted reformed surgical training a century ago, so we must now. The challenge will be controlling the revolution, not preventing it. Our role as surgeons will be to shape the reformation within the confines placed upon us. It will mean showing our medical students that the surgical specialties are desirable career choices. It will mean training efficient, knowledgeable, and caring surgeons who, to borrow a phrase from the military, “fight smarter, not harder.”
will mean placing renewed emphasis on the idea that, as surgeons, we are responsible for our patients, only now instead of being at the bedside always, we will ensure the appropriate continuity of care. It will mean teaching residents that there is a difference between being aware of the clock and watching it.

Better, worse, or just different? Maybe the question we should ask is, “Do you want to ride the bus, or drive it?”

The views expressed in this article are those of the author(s) and do not reflect the official policy or position of the U.S. Department of the Navy, U.S. Department of Defense, or the U.S. Government.

References


Dr. Stockinger is an active duty U.S. Navy surgeon at Naval Medical Center, Portsmouth, VA; he recently completed his trauma surgery fellowship at Tulane University/Charity Hospital, New Orleans, LA.

Dr. Ellis is an otolaryngologist and clinical professor of surgery, Louisiana State University School of Medicine. He was a founder and first president of the Charity Hospital Association of Residents and Interns, New Orleans, LA.

Dr. McSwain is professor of surgery and general surgery residency program director, Tulane University, and director for trauma services, Charity Hospital, New Orleans, LA.
Edward R. Laws, MD, FACS, a neurosurgeon from Charlottesville, VA, was installed as the 85th President of the American College of Surgeons (ACS) during the Convocation ceremonies that preceded the College’s 2004 Clinical Congress in New Orleans, LA. Dr. Laws is the W. Gayle Crutchfield Professor of Neurosurgery at the University of Virginia, Charlottesville.

A native of New York City, Dr. Laws is a 1963 graduate of The Johns Hopkins University School of Medicine, Baltimore, MD, where he also served as a surgical intern under Alfred Blalock, MD, FACS, (1963-1964), and as a resident in neurological surgery at the Johns Hopkins Hospital under A. Earl Walker, MD. He became a diplomate of the American Board of Neurological Surgery in 1972. Dr. Laws also served at the National Communicable Disease Center while in the U.S. Public Health Service, where he reached the rank of Lieutenant Commander (1964-1966). Following completion of his residency, he was assistant professor of neurological surgery at Johns Hopkins, and served as a neurosurgeon at The Johns Hopkins Hospital in Baltimore, until 1972.

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

A Fellow of the College since 1974, Dr. Laws has served as an active participant in and leader of numerous College activities. He became President-Elect in 2003 and served as Chair of the ACS Board of Regents from 2001 to 2003. A Regent of the College since 1995, Dr. Laws was a member of the Board’s Executive Committee (1998-2000), Chair of the ACS Finance Committee (2002-2003), and Chair of the Nominating Committee of the Board of Regents (2000).

Furthermore, Dr. Laws served as a member of the Board of Governors, as a member and Chair of the College’s Advisory Council for Neurological Surgery, and as Chair of the Scholarship Committee. Dr. Laws also served as the ACS Representative to the American Joint Committee on Cancer, and to the Executive Committee and Credentials Committee of the Virginia Chapter of the College.

In addition to his service to the College, Dr. Laws has held many leadership positions in organized surgery, including being a founding member of the American Pituitary Association, the Brain Surgery Society, the International Society of Pituitary Surgeons, and the Society for Neurooncology. He has served as president of the American Association of Neurological Surgeons (1997-1998), the Pituitary Society (1997-1998), and the Congress of Neurological Surgeons (1983-1984). Currently, he is president of the World Federation of Neurosurgical Societies. He is a member of the American Surgical Association and American Neurological Association.

Dr. Laws has exemplified a
commitment to the dissemination of surgical knowledge, having served as editor of the journal *Neurosurgery* (1987-1992) and having served as a member of many editorial boards, including the Journal of the American College of Surgeons, *Journal of Neurosurgery*, *Cancer*, and the *Journal of Clinical Endocrinology and Metabolism*. In addition to his editorial board work, Dr. Laws is the author or co-author of hundreds of articles that have been published in peer-reviewed medical journals. He has served as editor or co-editor of more than 10 books, including *Management of Pituitary Tumors: The Clinician’s Practical Guide* and *Brain Tumors: An Encyclopedic Approach*, and has been the writer or co-writer of more than 100 medical textbook chapters.

Dr. Laws has devoted a major part of his distinguished career to surgical research. He has been awarded numerous research grants, including the Umfrid Memorial Grant for Pituitary Research, the Page and Otto Marx Foundation Grant, the Ranieri Grant for Pituitary Research, and the Ernest Grant for Brain Tumor Research. He also has been a principal or co-investigator on dozens of research projects, including studies investigating the treatment of brain tumors, Parkinson’s disease, temporal lobe epilepsy, acromegaly, and Cushing’s disease.

Additionally, Dr. Laws has served as visiting professor and a guest lecturer at major medical meetings around the world. He is an Honorary Member of Surgical and Neurosurgical Societies in Canada, Australasia, Japan, Italy, Germany, Peru, and France. Other honors include membership in Alpha Omega Alpha and Sigma Xi.

Dr. Laws currently resides in Charlottesville, VA, with his wife Margaret.

Richard B. Reiling receives Distinguished Service Award

The Distinguished Service Award—the highest honor awarded by the American College of Surgeons—was presented to Richard B. Reiling, MD, FACS, of Charlotte, NC, during the Clinical Congress last month in New Orleans, LA.

In presenting the Distinguished Service Award to Dr. Reiling, the Board of Regents recognized Dr. Reiling for his dedicated service to the College, his service on College committees, his contributions to the profession of surgery as a gifted surgeon, and his distinctive service to the surgical community as a distinguished professor. Dr. Reiling was also commended for his active and tireless volunteer spirit as reflected in the countless hours he has spent actively serving surgical organizations in addition to the ACS and in acknowledgment of the positive leadership he has shown throughout his surgical career.

Dr. Reiling currently serves as medical director of the Presbyterian Cancer Center in Charlotte, NC, and as an active surgical staff member at Presbyterian Hospital and Presbyterian Matthews Hospital (Charlotte, NC). He is also an emeritus member of the surgical staff at Kettering Medical Center (Dayton, OH), Miami Valley Hospital (Dayton), and Good Samarian Hospital (Dayton), and on leave of absence from Riverside

![Dr. Reiling](image-url)
Dr. Reiling graduated cum laude from Harvard Medical School in 1967 and then interned at Boston City Hospital's Harvard Surgical Service (1967-1968). He remained at that institution and completed his residency in general surgery (1968-1970, 1971-1973). At the same time he was completing his residency, Dr. Reiling was also an instructor of surgery at Harvard Medical School (1968-1973). In 1970, he completed a fellowship in surgery at the Lahey Clinic Foundation.

After completing his postgraduate training, Dr. Reiling joined the U.S. Air Force (USAF), serving at the USAF Medical Center at Wright Patterson Air Force Base, OH, (1973-1975) where he acted as chief of general surgery (1974-1975) and director of medical education (1974-1975).

Dr. Reiling returned to surgical education after his service in the military: he has held the position of assistant clinical professor of surgery at Wright State University School of Medicine, Dayton, OH, (1979-1981) as well as associate professor of surgery (1991-2000).

Dr. Reiling, currently associate clinical professor of surgery (1982-1990, 2000-present), was an associate director of general surgery residency (1990-2000), and clinical professor of surgery (2000-present) at the university. As a Fellow of the American College of Surgeons since 1977, Dr. Reiling has made outstanding contributions to and on behalf of the College. He is currently an acting surveyor (1993-present) and a member (1999-present) of the College's Commission on Cancer; an ACS Delegate to the American Medical Association (1994-present); Chair of the Development Committee (2001-present); former Chair of the College's Board of Governors' Committee on Ambulatory Surgical Care (1994-1997); former ACS representative as a member (1993-1997), Vice-Chair (1993-1997), and Chair (1996-1997) of the Joint Commission on Accreditation of Healthcare Organizations' Professional and Technical Advisory Committee/Ambulatory Health Care; former member of the College's Subcommittee on Standards Development (1992-1997); former member of the Board of Governors' Committee on Ambulatory Surgical Care (1992-1997); and a former ACS Governor-at-Large representing the state of Ohio (1991-1997).

Furthermore, Dr. Reiling served as President of the Ohio Chapter (1986-1987), Chair of the Socioeconomic Committee of the ACS Ohio Chapter (which was quite active in state and federal activities), and editor of the Ohio Chapter newsletter (1988-2003). In his intense involvement with the Ohio Chapter, he served on the council of the chapter for over 25 years. He is still an active member of both the Ohio and North Carolina Chapters of the College.

In addition to Dr. Reiling's involvement with the College, he has also been an active member and leader of numerous organizations within the medical community, including the American College of Physician Executives; American Medical Association; American Society of Clinical Oncologists; American Society of Gastrointestinal Endoscopists; Breast Surgery International; International Association of Endocrine Surgeons; Société Internationale de Chirurgie; Society for Surgery of the Alimentary Tract; and Society of Surgical Oncology.

Furthermore, Dr. Reiling has held key leadership positions in a number of societies, including co-chair of the Association of Community Cancer Centers Guidelines Committee (1999-2001); member of the board of trustees and currently treasurer of the Association of Community Cancer Centers (2000-present); delegate to the Ohio State Medical Association (1994-2000); Commission on Cancer cancer liaison physician (1979-2000) and chief of medical staff (1982) of the Kettering Medical Center; chairman of the editorial committee of OHIO Medicine (1989-1994); and president of the Dayton Surgical Society (1980-1981). Dr. Reiling was also president and founder of the Greater Metropolitan Physicians, Inc., as well as a founding member of the Wright Choice Health Care Plan and the Ohio Surgical Panel, Inc.

The College's Board of Regents is pleased to recognize Dr. Reiling's continued and dedicated service to and on behalf of the College and the surgical community by naming him the 2004 recipient of its highest honor.
College names three Honorary Fellows

Honorary Fellowship in the American College of Surgeons was awarded to three prominent surgeons from Brazil, Egypt, and China during Convocation ceremonies at last month's Clinical Congress in New Orleans, LA. The awards presentation is one of the highlights of the Clinical Congress. The recipients were:

Mohamed A. Ghoneim, MD, MD (Hon). Dr. Ghoneim is director and professor of urology at the Urology-Nephrology Center, Mansoura, Egypt.

Angelita Habr-Gama, MD. Professor Habr-Gama is a full professor and director of the Department of Gastroenterology and of the Colorectal Unit at the University of São Paulo Medical School, São Paulo, Brazil.

Shu You Peng, MD. Dr. Peng is director of the Institute of Surgical Sciences, Second Affiliated Hospital of the Zhejiang Medical School; head of the department of surgery at the Sir Run Run Shaw Hospital of the Zhejiang Medical School; and professor of surgery at the Zhejiang Medical School, Hangzhou, People's Republic of China.

Presenting the Honorary Fellowships on behalf of the College were: Carlos A. Pellegrini, MD, FACS, University of Washington, WA; Jack W. McAninch, MD, FACS, San Francisco, CA; Bruce D. Browner, MD, FACS, Farmington, CT; and H. Clark Hoffman, MD, FACS, Bellevue, WA.

During the College's Convocation ceremonies this year, 1,301 surgeons from around the world were admitted into Fellowship. With a membership of more than 66,000, the College is the largest organization of surgeons in the world.

Sir Rickman Godlee, President of the Royal College of Surgeons (England), was awarded the first Honorary Fellowship in the College during the College's first Convocation in 1913. Since then, 387 internationally prominent surgeons, including the four chosen this year, have been named Honorary Fellows of the American College of Surgeons.

Citation for Prof. Mohamed A. Ghoneim

by Jack W. McAninch, MD, FACS, San Francisco, CA

Mr. President, I am honored, both professionally and personally, to present to you Prof. Mohamed A. Ghoneim of Mansoura, Egypt, for Honorary Fellowship in the American College of Surgeons.

Professor Ghoneim is professor and chairman of the department of urology in Mansoura, Egypt. He received his medical school and undergraduate training at the University of Cairo and completed his surgical training in 1965 at the University of Cairo hospitals. Completion of this training was followed by fellowships in urological surgery in England, Canada, and the U.S. He returned to Egypt and Mansoura University as a lecturer in urological surgery in 1976.

His remarkable accomplishments began to unfold after his return. Mansoura University is in the central Egyptian delta, peripheral to all major centers and cities. Dr. Ghoneim single-handedly developed and funded
Mr. President, it is my honor to introduce Professor Habr-Gama, a general and colorectal surgeon from São Paulo, Brazil, for Honorary Fellowship in the American College of Surgeons. Professor Habr-Gama has been associated with the University of São Paulo since 1962, obtaining first her medical degree in 1966 and then continuing there for her training in gastroenterology and proctology. In 1978, she joined the faculty and was promoted through the ranks to become a full professor and the head of the department of gastroenterology in 1988. Since 1995, she has also served as the head of the division of coloproctology in the very prestigious Hospital Dos Clínicas of the University of São Paulo, Brazil.

Professor Habr-Gama is a member of many international surgical societies, including the American College of Gastroenterology, the American College of Surgeons, The International Society of Digestive Surgery (formerly the Collegium Internationale de Chirurgia Digestiva), the Royal Society of Medicine, the International Society of Colon and Rectal Surgeons, and the International Society of Gastrointestinal Endoscopy.

Professor Habr-Gama has taught and been personal advisor to a myriad of students at the graduate or postgradu-
Mr. President, it is indeed a distinct honor for me to present to you this evening Prof. Shu You Peng from Hangzhou, China, for Honorary Fellowship in the American College of Surgeons.

Shu You Peng was born and raised in the city of Meizhou in Guangdong Province in Southern China. He received his medical training at Zhejiang University in Hangzhou, China, where he graduated with honors in 1955. His surgical training was at the Second Affiliated Hospital of Zhejiang Medical University, also located in Hangzhou. During his years of residency, he published 15 papers. Upon completion of his surgical training, he became an attending surgeon and lecturer in surgery at the hospital where he trained.

In 1981, he became an associate professor and was invited to the U.K. as a visiting professor. He spent four years doing independent research at Charing Cross Hospital in London, the Royal Victoria Hospital of Queens University in Belfast, Ireland, and then at the Royal Hallamshire Hospital in Sheffield, England. His primary research was acute pancreatitis, and his secondary research dealt with issues associated with portal hypertension and ischemia of the colon. While in the U.K., he published four papers and became a member of the Royal Society of Medicine of the United Kingdom.

Upon his return to Hangzhou in 1986, he was made a full professor and appointed chairman of the department of surgery at the Second Affiliated Hospital, where he has trained numerous residents and fellows over the past 18 years.

In 1994, he was appointed senior consulting surgeon to a new hospital in Hangzhou that bears the name of its benefactor, Sir Run Run Shaw. The hospital was built with the expressed purpose of bringing modern Western medicine to China. Sir Run Run Shaw asked Loma Linda University to supply both administrative
personnel and clinical professors to provide this Western expertise. The original contract was for five years but then was extended twice for a total of 12 years. I had the privilege to be the first visiting professor to the hospital in 1994 and have been able to return each year for the past 10 years.

It was during the first two years of my stay at Sir Run Run Shaw Hospital that I became aware of the unusual talents of Prof. Shu You Peng. He is a master surgeon, never in a hurry, making each stroke purposeful so that operating time is minimal. It is an absolute joy to watch him split a liver and remove a large tumor from the quadrate lobe adjacent to the vena cava using a simple suction/cautery dissector of his own design that allows him to do these resections with minimal blood loss. Many of our surgeons would consider these tumors inoperable. However, I have watched him do these resections, and I have been able to review the five-year survival rates, which are unbelievably good. His follow-up records and documentation of each case are commendable, and his concern for each patient is remarkable. With all of his talents, he is perhaps the most humble of all surgeons with whom I have had the privilege to work and to know.

Since completing his surgical training in 1963, he has been the author or coauthor of 370 papers and several additional papers that are yet to appear in print. In addition, Professor Peng holds membership in 13 different societies, including the Pancreas Club of the United States, and sits on the editorial boards of five different journals. This past winter, he was awarded the highest honor the Chinese government can bestow to a person of science or technology—that being the Ho Leung Ho Lee Foundation Award, which is given to those individuals who have achieved outstanding innovation or made extraordinary contributions in science or technology. At an early age, Shu You Peng started playing the violin. His passion for playing this instrument continued up to his university years, but at that point he stopped playing because of time constraints with his other studies. However, he did develop a love and appreciation for classical music that continues to this day. His involvement in sports has included swimming, volleyball, and Chinese chess, and, like many Chinese people, he took up table tennis. He became a competitive player through his years of surgical training. At one point, he was the inter-university table tennis champion of Zhejiang Province.

Mr. President, it is with great pleasure that I present Prof. Shu You Peng, an extraordinary man, a gifted yet humble surgeon and educator, and a personal friend, for Honorary Fellowship in the American College of Surgeons.

International Guest Scholarships announced

The American College of Surgeons is pleased to announce International Guest Scholarships for competent young surgeons from countries other than the U.S. and Canada who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $8,000 each, provide the scholars with an opportunity to visit clinical, teaching, and research programs in North America and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons Clinical Congress.

The complete requirements for this scholarship program will appear in the January 2005 issue of the Bulletin. Additional information may be obtained online on the College’s Web site at http://www.facs.org/member/services/research.html.
NTDB™ data points

“Study this”

by Richard J. Fantus, MD, FACS, Chicago, IL, and John Fildes, MD, FACS, Las Vegas, NV

When looking at the introduction in the Annual Report for 2003 of the National Trauma Data Bank™, the following statement stands out: “The purpose of this report is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.”

To that end, we wish to highlight a few of the 105 studies, reports, and analyses that have been performed to date on the information contained in the National Trauma Data Bank. The table on this and the next page is a sampling of these activities.

As evidenced by the depth and breadth of topics listed, the goals of the largest accumulation of trauma data anywhere are being met. These data are open to researchers and other interested parties. There is an online data application at http://www.facs.org/trauma/ntdbapp.html and an NTDB Reference Manual available as well at http://www.facs.org/trauma/ntdbmanual.pdf.

The American College of Surgeons Committee on Trauma encourages you to take a look and make a request for these data.

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### Project title

- A Need for Trauma System Reorganization in the Changing Surgical Educational Environment
- A New Measure of Injury Severity Based on ICD-9 Injury and Pre-Existing Condition Codes
- A Phase II/III Randomized, Controlled and Open-Labeled Trial of a Second Generation HBOC for the Pre-Hospital Resuscitation of Hemorrhagic Shock Patients
- Assessment of Potential Usage of Hemostatic Bandage in Non-Military Trauma Setting
- Base Deficit in the Pediatric Population: A Predictor of Outcomes?
- Benchmarking, Withdrawal of Care, Variability in Diagnosis & Management and Research into Evaluating, Improving, and Auditing the NTDB
- Burn Patient Mortality National Trends
- Characteristics of Near-Fatal Suicide
- Coordination, Communication, Expertise, and Information Technology Use in a Dynamic Environment.
- Current Screening Criteria for Blunt Cerebrovascular Injury (BCVI) May be Inadequate
- Data Visualization to Identify Trauma Patients at Risk for Medical Error
- Determining the Cost of Trauma
- Distal Radius Fractures in Elderly Patients
- Does ICP Monitoring Affect Outcome In Severely Brain-Injured Patients?
- Effect of AAST Injury Scale on Outcome in Pediatric Splenic Trauma
- Effects of Ultrasound FAST Exam in Decreasing Time to OR in Patients with Hemoperitoneum Due to Blunt Trauma Injury
- Evaluation of NTDB As Reference Database for Trauma Center Outcome Studies
- Examination of Injury Severity and Hospital Charges by Mechanism of Injury in Pediatric Patients
- Functional Outcome of Trauma Patients Admitted to Higher Versus Lower Level or Undesignated Centers
- Functional Status following Blunt and Penetrating Carotid Artery Injuries
- Gender Differences in Outcomes in Pediatric Trauma
- Identifying Quality Outliers Using Severity-Adjusted Mortality Rates or Functional Discharge Status: Does It Make a Difference?
- Impact of Obesity on Outcome of Trauma Patients
- Incidence of VAP Caused by Gram-Negative Bacilli in Trauma ICU Patients
- Infections Complications in Trauma Patients—Does Hypothermia Increase the Risk?
- Intra-Abdominal Peritoneal Lavage Study following Abdominal Trauma
- Morbidity and Mortality Associated with Airbag Deployment in Children
- Mortality after Pelvic Fracture: The Effects of Hemodynamic Shock and the Use of External Fixation
- National Assessment of Alcohol-Related Injury: Do We Have An Estimate of the Impact?
- National Variability in Pre-Hospital Care for Trauma
- Neural Network Decision Algorithm for Pre-Hospital Injury Severity Risk Assessment
- Never Too Old: National Survey of Intentional Injury in the Elderly Using the NTDB
- Partnership for Development and Dissemination of Outcomes Measures for Injured Children
- Patterns of Trauma in Middle Aged Motorcyclists
- Potential Patient and System Factors That Influence Discharge from Acute Care to Inpatient Rehabilitation
- Predictive Value of Early Hospital Assessment on Outcome in Pediatric Trauma
- Presence of Emergency Medicine Residency Programs at Level I Trauma Centers: Is There an Effect on Trauma Patient Outcome?
- Prognostic Indicators Predictive of Mortality in Geriatric Patients: When Is Resuscitation Futile?

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continued on next page
It is through evaluation and research that we further the care of the injured patient.
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 our Web address, http://www.ntdb.org.
If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Project title (continued)
Re-Calculation of TRISS Survival Statistic Co-Efficients Utilizing the NTDB Data Set
The Burden of Suicide on Trauma Centers
The Combinations of Race and Ethnicity on Rates and Results of Drug and Alcohol Screening in Trauma Patients
The Effect of Payment Source and Race on Resource Utilization and Outcomes Following Major Trauma
The Effect of Pulmonary Artery Catheter Use on Mortality in Critically Injured Patients
The Effect of Vena Cava Filters on the Survival of Trauma Patients at High Risk for Venous Thromboembolism
The Impact of Volume on Geriatric Trauma Outcome
The Use of Pre-Hospital Data for Mortality Prediction: A Comparison of Neural Networks with Revised Trauma Score
Trauma and Pregnancies Risk Factors and Outcomes
Traumatic Hip Fracture Surgery Outcomes and Complications
Use of Double Contrast CT Scan in Blunt Abdominal Trauma
Variation in Rates of Tracheostomy in Trauma Patients with Acute Respiratory Failure
Violence Prevention in Pediatric Population
Volume-Outcome Relationship in Trauma Centers: Is It a Function of Patient Risk?