Doctors for Medical Liability Reform

Getting the Word Out
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About the cover...

Doctors for Medical Liability Reform has launched a comprehensive campaign, referred to as Protect Patients Now, aimed at persuading U.S. senators who have blocked passage of liability reform bills and candidates opposed to such legislation to rethink their position. The cover story on page 8 describes the multiple facets of this effort and tells how surgeons can get involved in it through the American College of Surgeons Professional Association.
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From my perspective

I have just returned from eastern Africa, where I visited rural and missionary hospitals in Kenya and the southern Sudan. The latter area, of course, has been in the news a great deal the last several months due to the humanitarian efforts under way to salvage the lives of thousands of displaced Sudanese people who have borne the strife of many years of civil war.

While in Africa, I had the opportunity to observe first-hand surgeons working in primitive operating rooms and performing lifesaving procedures. Orthopaedic injuries, ravaging infections, neurological problems, and obstetrical catastrophes were commonplace among the patients in these hospitals.

To see what these volunteer physicians were able to accomplish, despite the austere working conditions and mismanagement of the countries’ resources, was truly an eye-opening experience. I thought I would share just a glimpse of that world with you by including some of the photos from my trip on the following pages.

The enthusiasm and esprit de corps that the American surgeons and the staffs they had assembled demonstrated was unwavering and contagious. Their minds were not focused on the reimbursement, regulatory, and liability concerns that so frequently vex surgeons. Rather, they showed sincere and genuine humanitarianism in their efforts to help these unfortunate patients who otherwise would have no choices and no opportunities to receive necessary care.

This experience reinforced my belief that the profession of surgery and the people who compose it have so much to offer to the world. Our years of training and understanding of diseases give us the power and privilege to affect the lives of other humans.

Discouragement at home

So often in my travels I am besieged by surgeons expressing the discouragement they feel because they believe our health care system has presented them with nothing but broken dreams and promises. Their upset is the result of a health care system in this country that is becoming extremely regulated and that is often managed by people outside of our profession. In addition, they know that their public image has been eroded and that the public—to some extent—believes that they are more interested in the bottom line than they are in taking care of people. These surgeons are angry about the present and extremely pessimistic about the future. They complain about the state of the surgical profession and predict its unraveling. They would never recommend medicine, much less surgery, to young people as a career choice.

It is sad to see professional surgeons who are unhappily delivering health care services. However, while I can certainly understand and relate to their grievances, I also realize that all professions have problems and are feeling the effects of outside influences.

Operation Giving Back

Although the practice of medicine has not been tainted for all members of our community, a sizable number of physicians and surgeons continually express deep-rooted frustration with their choice of profession. What can we do to improve the morale of surgeons in this country and enhance

To help surgeons discover new opportunities in volunteer activities in this country and around the world, the ACS Board of Governors’ Committee on Socioeconomic Issues has initiated a program called Operation Giving Back.
their public image? Why not provide a focus on the reason why so many of us became surgeons in the first place—to serve humanity?

There are a number of opportunities in this country and around the world through which surgeons can get involved in missionary programs similar to the one I described earlier. These projects can help surgeons give freely of their skills and knowledge to sustain the lives of people who often have nowhere else to turn. Our participation in such activities reminds us of why we decided to choose medicine as a career.

To help surgeons discover new opportunities in this area, the ACS Board of Governors’ Committee on Socioeconomic Issues has initiated a program called Operation Giving Back. Based on the vision of the committee’s Immediate Past-Chair, Andrew Warshaw, MD, FACS, from Boston, MA, and current Chair Robert Stephens, MD, FACS, of Scottsdale, AZ, Operation Giving Back will serve as a comprehensive resource for surgeons who would like to learn more about domestic and international volunteer opportunities. This program will reach out not only to surgeons but to volunteer agencies, corporate and private philanthropies, and policymakers.

Many surgeons already are committed to volunteering, and we plan to develop an accurate profile of these individuals and their efforts. This information will enable us to effectively support public and legislative policies aimed at encouraging surgeons to provide more volunteer services. These initiatives will help us to protect surgeons who lend their skills and talents to underserved
populations in this country. Additionally, this volunteer profiling system will allow us to better define the broad scope of surgeon-volunteer activities, whether they are conducted within an individual’s local community, regionally, or outside the U.S.

**Restoring hope**

Many of us chose a career in surgery because we wanted to serve humanity. Operation Giving Back, which will be spearheaded by Kathleen M. Casey, MD, FACS, Newport, RI, will allow the College to develop a Web site and a registry that will assist surgeons who are interested in volunteering their services to quickly match their interests with where they are most needed in this country as well as in other areas of the world.

We need to restore a sense of purpose and enthusiasm in ourselves and in our surgical colleagues. I believe that this program, as well as our continued effort to improve the health care system in this country, will do much to make surgeons feel good about themselves and this profession.

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.
Dateline Washington
prepared by the Division of Advocacy and Health Policy

Senate passes patient safety legislation

The U.S. Senate unanimously passed the Patient Safety and Quality Improvement Act on July 22 (H.R. 663 as amended by S. 720). This landmark agreement was reached after nearly a year of bipartisan negotiations involving Sen. Judd Gregg (R-NH) and Sen. Edward Kennedy (D-MA). Specifically, the legislation would create a legal framework through which patient safety organizations (PSOs) may voluntarily and confidentially collect information from providers about medical errors. The PSOs would then analyze the data and suggest system changes to prevent future harm to patients.

Thomas R. Russell, MD, FACS, Executive Director of the College, responded to the Senate’s action with a press release stating that Senators Gregg and Kennedy “should be congratulated for working in a bipartisan manner to pass this important legislation.” A joint House and Senate conference committee will now negotiate the differences between the Senate and the House versions of the Patient Safety and Quality Improvement Act, which passed early last year. The College will be working to ensure that the conference committee finishes its work and that strong patient safety legislation is signed into law before Congress adjourns for the year. To see a copy of the ACS press release, please go to http://www.facs.org/news/patientsafetypassed.html#1.

Medicare fee schedule proposed rule issued

On July 27, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule containing changes for the 2005 Medicare physician fee schedule. Major changes affecting surgeons include:

• Updating the geographic practice cost indices for physician work and practice expenses to reflect 2000 census data.
• Refining practice expense relative value units (RVUs) for a large volume of codes and updating malpractice RVUs for all codes. CMS did not change the way the malpractice RVUs were computed; it simply updated the existing methodology using more recent data. As a result of the proposed revisions, neurosurgery will experience an estimated payment loss of 0.6 percent.
• Implementing a fee schedule conversion factor update of 1.5 percent, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MPDIMA).
• Increasing the deductible to $110 for 2005, and by the same percentage as the premium increases thereafter. That modification also is the result of a change made by the MPDIMA.

Overall, vascular surgery is projected to experience a 4 percent increase in payment. All other surgical specialties except ophthalmology and urology will see 1 or 2 percent increases. Ophthalmology is expected to secure the same amount overall as in 2004. The picture is much less clear for urology because of the uncertainty over the final amount Medicare will pay for drugs, but CMS estimates that the specialty will lose 2 to 13 percent of its current reimbursement.

Comments on the proposed regulation are due September 24, 2004.
ACS discusses quality initiatives with CMS

To see the proposed regulation, go to http://www.cms.hhs.gov/physicians/pfs/default.asp.

Dr. Russell and R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, met with CMS Administrator Mark McClellan, MD, PhD, in August to discuss planned expansion of the ACS National Surgical Quality Improvement Program to additional private sector hospitals. The College emphasized its interest in working with the agency to promote effective quality improvement efforts, as well as its conviction that evidence-based, risk-adjusted outcomes measurement is key to evaluating the quality of surgical care.

CMS has been looking at potential quality improvement incentive programs and demonstration projects aimed at better understanding trends in surgical complications. Dr. Jones has worked closely with the agency during its development of the Surgical Care Improvement Program that will be implemented by CMS’s Quality Improvement Organizations next August.

Guidance issued on HIPAA privacy rule and law enforcement

The U.S. Department of Health and Human Services Office for Civil Rights (OCR) recently released guidance on its HIPAA (Health Insurance Portability and Accountability Act) Privacy Frequently Asked Questions Web page. The directive identifies the circumstances under which the privacy rule allows covered entities to disclose protected health information to law enforcement officials. To view the OCR guidance, please go to http://www.hhs.gov/ocr/hipaa.

ACS replies to inpatient rule on graduate medical education

The College has submitted comments in response to CMS’s proposal to redistribute “unused” resident positions and proposed changes to policy regarding volunteer training in the nonhospital setting. Both provisions are included in the 2005 hospital inpatient prospective payment systems proposed rule. The College recommended changes to the criteria CMS will use to judge whether a hospital meets the requirements of gaining new residency slots.

The College also opposes the requirement that hospitals pay “volunteer” teaching faculty for nonhospital site training costs. Additionally, the College asks CMS to extend the existing one-year moratorium on changes to graduate medical education policy regarding financial arrangements between hospitals and teaching physicians training at non-hospital sites to all specialties, and not limit it just to family practice, as is currently the case. The full text of the College’s comments can be found at: http://www.facs.org/ahp/views/gme8.html#1.
The U.S. House of Representatives has passed medical liability reform legislation numerous times in recent years. Unfortunately, the legislation continues to stall out in the Senate, where, at best, 49 senators have voted to allow consideration of liability reform (60 votes are necessary). After attempts to pass the bill in the Senate three times in two years, it became clear that the medical community needed to try a different approach. A mutual desire to break the Senate logjam was the impetus for forming a new coalition, Doctors for Medical Liability Reform (DMLR).

Last year, the American College of Surgeons Professional Association (ACSPA) helped to establish the DMLR. In addition to the ACSPA, founding members of the coalition included: Neurosurgeons to Preserve Health Care Access, the American Association of Orthopaedic Surgeons, the American College of Emergency Physicians, the Society of Thoracic Surgeons, the American College of Obstetricians and Gynecologists, and the American College of Cardiology. The American Academy of Dermatology Association, the National Association of Spine Specialists, the American Urological Association, and the American Society of Plastic Surgeons have subsequently joined the coalition.

The DMLR is using a variety of aggressive public relations and advocacy tools to highlight how the nation’s out-of-control liability system is jeopardizing patient care in order to in-
crease public support for federal medical liability reform and gain the support of all candidates for national office.

Television news magazines

The DMLR campaign, referred to as Protect Patients Now, began this past February. The Protect Patients Now initiative features 30-minute news magazines that are currently airing on cable television throughout four states—North Carolina, Georgia, South Carolina, and Washington. These states were chosen because they are in the midst of a serious medical liability crisis and they are each having a U.S. Senate election in November. While the Washington State race is between a sitting senator and a member of Congress, the Geor-
I Pledge to Protect Patients Now!

I recognize that the citizens of the state of _________________ and across the country are facing an unprecedented healthcare crisis.

Skyrocketing medical liability insurance premiums caused by escalating and unlimited jury awards are forcing doctors to limit services, retire early, abandon patients or move to a friendlier state, creating a vacuum of care where patients no longer have access to critical medical services.

As a U.S. senator or candidate for U.S. Senate with the public interest at heart, I,

__________________________________

pledge that I will unequivocally support medical liability reform in the United States Senate seeking passage of federal legislation that would include an effective limit on non-economic damages, also known as “pain and suffering.”

This cap will not limit economic compensation awarded for lost income, inability to work, long-term care or medical expenses.

__________________________________

Signature

__________________________________

Print Name

__________________________________

Date

Pledges must be signed, dated and returned to:
Doctors For Medical Liability Reform
2121 K Street NW, Suite 325
Washington, DC 20037
Phone: 703.299.9470 Fax: 703.299.9478

The pledge that DMLR is asking politicians to sign.
gia, North Carolina, and South Carolina races are open seats, guaranteeing that new U.S. senators will be elected in those states this November. It is of critical importance that the senators elected in all four states support federal medical liability reform.

The news magazines feature physicians and patients telling the story of how the medical liability crisis is affecting access to medical care in their community. Physicians from a variety of specialties tell of how they are being forced to retire early, move to other states, or limit the medical services they offer. Patients and family members relate their stories about how loved ones suffered irreversible damage because a physician was unavailable, because their doctor moved out of state, or how they were unable to find a specialist.

Web site
While each news magazine is only being aired in the specific state for which it was produced, everyone can view all four news magazines on the DMLR Web site, www.protectpatientsnow.org. In addition, a video featuring highlights from all four state news magazines is available on the Web site. Physicians and patients can download the videos and share the files with other individuals.

The news magazines include a request for individuals to contact their senators and representatives and the candidates for these offices urging them to support federal medical liability reform. The DMLR Web page allows individuals to e-mail their senators and representatives with this important request.

Twenty states are currently experiencing a medical liability crisis, while only seven states are considered to be “safe” states. The remaining 23 states are potentially headed for a crisis. A detailed breakdown of how each state is affected by this problem is also available on the DMLR Web site.

Pledge
In an effort to identify which senators, representatives, and candidates for office are willing to support federal medical liability reform, the DMLR is asking all of them to sign a pledge (see opposite page). The list of individuals who have signed the pledge can be found on the DMLR Web site.

Grassroots teams
In each of the four states, the DMLR has created grassroots teams of physicians and patients who are meeting with public officials and the media to help drive home the messages put forth in the news magazines. Surgeons from Georgia, South Carolina, North Carolina, and Washington who are available to help with this effort should contact the ACSPA Washington Office at 202/337-2701.

Newspaper advertisements
DMLR has also been running various newspaper advertisements focused on the need for federal medical liability reform. The advertisements demonstrate the effect that the medical liability crisis is having on the economy of the states that are in crisis. In addition, ACSPA ran newspaper advertisements in Georgia and South Carolina announcing the launch of the Protect Patients Now campaign.

The DMLR will continue to run the news magazines throughout the fall. Surgeons are encouraged to visit the Web site www.protectpatientsnow.org to keep abreast of the DMLR’s activities.
The search for a surgical partner can be a complicated and arduous process. The choice is on a par with finding a spouse, with equally serious ramifications. Questions arise as to the ability, affability, and work ethic of a new workmate. What will this person be like?

Seventy-five years ago, your next partner would have been described as male and self-sacrificing. He would have done a residency that required that he literally live at the hospital with no time for any other activities and no remuneration. He would have operated in a less-than-sterile environment with a small staff and little more than scalpels and ether with which to work.

A surgeon who was just entering practice 10 years ago would have been described slightly differently. Potential partners at this time could have been either male or female. These individuals would have been accustomed to operating in a sterile operating room with many technological resources and a large operating team at the ready. However, one adjective would have remained the same over the years. Surgeons of 10 years ago continued to be seen as self-sacrificing. They would have gone through residencies that still offered minimal remuneration and punishing hours that left little time for family life or other interests. Through the years, these rigorous training regimes were believed to be vital in the production of competent surgeons.

So what will potential partners look like in this century? Everyone hopes for a partner with cool confidence, high-tech capabilities, incisive decision-making capabilities, and a slavish devotion to work. A futuristic “Star Trek”-like physician comes to mind. But, with new regulations affecting the number of hours residents may work, the image may be different than expected. The new generation of surgeons will have had limited work hours and will have been required to take less call. They will have been forced to take a day off every week and will have been permitted to sleep after long nights awake. All of these new ways of training residents will definitely affect the way surgeons approach...
their work, but in what way, no one can be sure. Hence, the question still lingers: what will my next partner be like?

Catalyst for change

Before attempting to answer that question, we should consider how and why the work-hour reforms came about. The movement toward resident work-hour reforms started with the March 5, 1984, death of Libby Zion at a New York City hospital. Her influential father, Sidney Zion, a noted New York, NY, newspaper columnist and a lawyer, questioned the decision-making abilities of an allegedly sleep-deprived and unsupervised junior resident who was involved in the treatment that Ms. Zion received. Mr. Zion pressured the Manhattan district attorney to convene a grand jury to look into criminal wrongdoing on the part of both the physicians and the hospital for allowing such conditions to exist.

In December 1986, the grand jury issued its report. While no criminal indictments were made, the grand jury did criticize resident education, especially work hours and resident supervision. These issues, particularly resident work hours, became the cause célèbre, and the politicos raised the banner.

In June 1987, the New York Department of Health was forced to form a committee to examine the issues raised in the grand jury report. Heading this panel was Bertrand Bell, MD. The committee spent June to October 1987 formulating resident work-hour reforms and addressing the other concerns raised in the report. As a result of the committee’s work, on July 1, 1989, the 405 regulations, commonly known as the “Bell regulations,” went into effect in New York. (See table on page 14).

Over the course of the next decade, the issue of work-hour reforms would become a national hot topic. General public awareness rose, especially in the context of medical errors. Medical student and resident groups pressed for more reforms and advocacy groups petitioned such organizations as the Occupational Health and Safety Administration. Legislation was even introduced into Congress. All of this activity eventually led the Accreditation Council on Graduate Medical Education (ACGME) to develop and implement work-hour restrictions for all resident training programs. The ACGME’s rules took effect July 1, 2003, and closely resemble the Bell Commission’s standards. The ACGME is committed to enforcing these regulations. Not even the very elite institutions are immune from enforcement. Indeed, both Yale University’s surgical program and Johns Hopkins’ internal medicine program have been threatened with loss of accreditation for failure to comply.

Answering the cynics

Whenever change occurs, naysayers start raising their objections. Skeptics of work-hour reform have voiced a multitude of reasons why the reforms are bad for surgical training, including the lack of continuity of care, an erosion of the work ethic, lesser quality of care, a poorer educational experience, weakened skills, and inadequate readiness for practice. These critics portray your next partner as a buffoon with Frankenstein’s hands, Homer Simpson’s brain, and SpongeBob Squarepants’s sense of responsibility.

What these critics fail to see is that the reconfigured training programs will stress not only residents’ development of clinical and scientific skills, but will treat them with the same humanity we expect them to extend to their patients. How can we expect such behavior of them if we do not set the example?

It is our contention that if surgical educators make the system more humane, more caring and well-balanced surgeons will emerge, and, ultimately, we will see improved patient outcomes and increased student interest in surgery. From the infancy of our careers, surgeons acknowledge the importance of compassion and humanity in medicine. When we graduate medical school, we take the Hippocratic Oath, proclaiming that “…warmth, sympathy and understanding may outweigh the surgeon’s knife or the chemist’s drug.” We also acknowledge the importance of healthy spirits in our patients.

In the January 20, 2003, issue of Time magazine, Mehmet Oz, MD, FACS, a highly respected New York, NY, cardiac surgeon, describes a program of massage, yoga, and meditation that he has developed to help his patients manage pain and reduce anxiety. Leaders in other difficult fields also recognize the need for compassion and balance. Colin Powell, soon after he was promoted to Lieutenant General of the U.S. Army, assumed command of 75,000 men. In his initial address to them, he stated:
The Army is to be enjoyed, not endured. Have fun in your command. Don’t always run at a breakneck pace. Take leave when you’ve earned it. Spend time with your families. I don’t intend to work on weekends unless it’s absolutely necessary. And I don’t expect you to do it either. Anyone found logging Saturday or Sunday hours for himself or his troops had better have a good reason.4

Most surgeons know that our patients need compassion, spiritual fulfillment, and a balanced lifestyle to thrive, and we admire individuals in other fields who also recognize these needs. Yet, in our residency programs, which are certainly less grueling than training for the battlefields of Iraq, we have failed to set an example. We show little compassion, humanity, or respect for our residents’ personal health and well-being. We make them work long hours, deprive them of sleep, take them away from their families and other interests, have them perform ridiculous “scut” work, and then expose them to many other stressors, such as low financial remuneration and heavy workloads. This situation can lead to burnout, depression, and ill physical health. Burnout is defined as a syndrome of emotional exhaustion, depersonalization, and a sense of low personal accomplishment. It differs from depression in that it applies only to the job, while depression affects all aspects of life. All levels of physicians, from chairpersons to interns, are susceptible. Burnt-out physicians are described as angry, irritable, and impatient.5,6

For the individual resident, burnout often leads to many professional and personal problems, including substance abuse, family strife, decreased job satisfaction, cynicism, and a lack of humanism, compassion, and professionalism. Academic and practicing physicians need to be concerned about this problem because it frequently translates into a poorer educational experience, less interest in surgical careers, suboptimal patient care, and decreased patient satisfaction.

A large body of literature on such topics as sleep deprivation and burnout supports these conclusions. Veasey and colleagues reviewed 50 articles regarding resident sleep deprivation, 10 of which were focused specifically on surgical residents.7 Overall, they found that surgical residents with acute, chronic sleep deprivation reported increased feelings of anger, confusion, and fatigue. Their motor skills deteriorated, and the number of surgical complications in their caseload increased. Furthermore, for residents in general, the rate of motor vehicle accidents increased with sleep deprivation.

Griffith and others studied the effect of intern workload on patient satisfaction and found that, among medical interns, the heavier the workload on the day of admission for a patient, the lower the overall patient satisfaction.8 Shanafelt looked at burnout among medical residents and found that it was quite common and was associated with self-reported suboptimal patient care.6 And, lest we think that practicing surgeons are immune, Campbell reported that burnout characteristics exist in up to one-third of practicing surgeons, that younger surgeons are more susceptible, and that

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one major contributory factor for surgeon burnout is the perceived imbalance between career, family, and personal growth.9

**The right path**

Ultimately, we must ask ourselves whether we are traveling the road most likely to lead to optimal surgical care. Or, should we strive to produce surgeons who are not only technically and clinically excellent, but also more humane? We charge that we need to emphasize the latter approach for the sake of the patients and the residents themselves. And the first step toward training more caring residents is to treat them more compassionately. The implementation of work-hours regulations is not the complete answer but a part of the solution. We urge you to not approach work-hour regulations with skepticism but with optimism. No studies in New York prove that there has been a decline in the clinical and technical abilities of surgeons because of work-hour reforms. Quite the contrary; an October 2002 study at Cornell University looked at the institution’s faculty and resident attitudes toward the changed work hours and at the effects on case numbers and American Board of Surgery In-Training Examination (ABSITE) scores. The study found that lifestyle and basic education had improved. It reported only the perception of a negative impact on patient care but no data to substantiate this belief. Additionally, the ABSITE scores improved, and the case numbers remained approximately the same, if not higher.10

In conclusion, we as educators must meet the following challenges:

1. Embrace the work-hour regulations as a step in the right direction toward fulfilling our duty to produce whole physicians, ones who heal with compassion and humanity.
2. Look into other ways to promote resident well-being.*
3. Study New York City residents to see whether the 405 regulations have affected them.
4. Revamp the education process for residents to fit into the ACGME regulations.
5. Use the changes to attract a broader scope of medical students.

We must reconsider Hippocrates’ charge so as to remember why we are in this profession and recall the saying, “Physician, heal thyself.” We must teach our residents to embrace the definition of a physician as a skilled, compassionate healer. In this way, your next partner may not only resemble the cool portrait of the technically skilled surgeon, but also the Norman Rockwell image of a caring physician.

**References**


*In an excellent article on physician well-being, Shanafelt has suggested five areas in which organizations can accomplish this goal, including the provision of adequate support services and minimal work-home interference.5

Dr. Wallack is professor of surgery, New York Medical College, New York, NY.
Cooperstown surgeons throw a pitch for rural surgery

by Michael S. Gold, MD, FACS, Randall Zuckerman, MD, Patrick Dietz, MD, FACS, Steven J. Heneghan, MD, FACS, and James Bordley IV, MD, FACS, Cooperstown, NY
The growing crisis in rural general surgery in the U.S. is well documented, with articles addressing this problem having appeared sporadically in the surgical literature over the last 20 years. While some of the problems facing rural surgeons have been adequately described, general surgeons have not engaged in a concerted effort to find effective solutions. Surgical programs are of critical importance to the professional and financial viability of the hospitals and to the communities those institutions serve, not only because they provide medical care to the residents, but because they also are usually major local employers.

Recently, the surgical community has demonstrated renewed interest in seeking solutions to the problems besetting rural areas. One impediment to developing an appropriate response, however, is the lack of data regarding the state of rural surgery and the unique challenges surrounding rural surgical practice. Of the several hundred projects catalogued in the 2003 database of ongoing federally funded rural health research, only one study addressed general surgery.

Nonetheless, we do know a few facts about rural surgery and the individuals who practice it. For example, we know that rural surgeons perform a larger number and a greater variety of procedures than their urban or academic counterparts. We also know that rural Americans are older, poorer, and often medically underserved. It is estimated that only 15 percent of physicians and less than 10 percent of surgeons practice in these areas, while 25 percent of the U.S. population resides there. The number of general surgeons needed to adequately care for the rural population is projected to be 19 percent of the total.

This gap is increasingly difficult to close because rural surgeons are aging, and younger surgeons are often reluctant to take rural jobs. The average rural hospital medical staff member is 49 years old. Professional isolation and a diverse caseload add to the complexity of rural practice. Hence, this crisis requires a two-tiered response: (1) changes in residency training and education; and (2) improvements in practice environment.

A dedicated forum

As a rural teaching hospital in Cooperstown, NY, (pop. 2,100) the surgeons at Bassett Healthcare have become increasingly aware of the complex issues facing rural practices. As part of an effort to better tailor our residency program toward rural practice, we have come to recognize the multiple issues related to appropriate training, recruitment, and retention of rural surgeons. We have concluded that a dedicated forum is needed to address the issues facing rural surgeons and have, therefore, established a center for rural surgery. The Robert Keeler Foundation, learning of this proposed program, has provided a generous five-year grant to establish the Mithoefer Center for Rural Surgery (MCRS), memorializing James Mithoefer, MD, FACS. Dr. Mithoefer practiced surgery at Bassett Hospital from 1950 until his untimely death at the age of 47 in 1962. The goals of the MCRS fall into the broad categories of addressing training and educational requirements of rural surgeons, improving outcomes at rural practices, and raising national awareness in both the medical and political communities.

Bassett Hospital is a 184-bed acute-care hospital affiliated with Columbia University and located in rural central New York State. With the inclusion of its hospital and multiple outpatient facilities, Bassett spans nine counties and is the largest employer in one of them—Otsego County (population 60,000). In addition to health care, the main regional industries include farming, higher education, and tourism. Bassett Hospital was established in 1922 as a not-for-profit corporation and was planned as a model of academic health care delivered in a rural environment by employed physicians in a closed-staff group practice. The mission statement of Bassett includes patient care, medical research, and education.

Bassett currently has residency programs in general surgery, internal medicine, and primary care and a transitional internship. The general surgery residency program has two five-year categorical positions and two additional preliminary positions for two years. Third-year medical students from Dartmouth Medical College, Rochester University, and Columbia University College of Physicians and Surgeons are present throughout the year as well. We have a long tradition of training surgeons who practice in rural communities. Fifty-six residents
have graduated from the program in more than 50 years.

Our research
A recent survey of actively practicing surgeons who graduated from our program analyzed the influence that a rural-based training program had on their choice of practice location and on their preparation for practice.

Bassett’s graduates practice in rural locations at a significantly higher percentage than national averages. We and others have found that a rural upbringing is a significant predictor of choosing to practice in a rural location. Indeed, 80 percent of our graduates grew up in locations they described as rural. Of the 27 residents who practice general surgery, 18 (67%) currently practice in rural communities, while nationally only 10 percent of general surgeons practice in rural locations. Of 21 residents who completed fellowship training, eight (38%) practice in rural locations. Seventy-three percent of graduates who chose rural practices were satisfied with that choice while 55 percent of urban practitioners were satisfied. Of the 56 graduated surgeons, 85 percent raised in rural areas and 12 percent reared in urban environments chose to practice in rural communities. Although residents with a rural background may preferentially choose a training program like Bassett’s, it is also clear that this type of rural-based program produces a higher percentage of surgeons who will practice in more remote locations.

Additionally, we examined the common concerns among rural surgeons. They are as follows:

1. Inadequate training in subspecialties. The practice of general surgery in a rural community differs significantly from urban practice. Rural surgeons spend 27 percent of their time performing endoscopic, gynecologic, orthopaedic, urologic, and otolaryngology procedures, in contrast to the 5 percent of their time that urban or academic surgeons devote to operations outside of the classic realm of general surgery. Current general surgery residency training often provides residents with inadequate grounding in the necessary subspecialty skills, offering only basic exposure to these disciplines. As our volume in general surgery at Bassett has grown and our resident hours have been limited, we have found ourselves reducing exposure to orthopaedics, gynecology, hand surgery, otolaryngology, and urology to the basic minimums required. In essence, we are moving away from one of our strengths: the ability to provide a structured, graduated experience in those subspecialty areas needed for a rural practice.

2. Isolation and heavy caseloads. Many factors affect the level of satisfaction for general surgeons in rural communities. Rural surgeons have larger, more diverse caseloads than their urban counterparts. Isolation is often an issue, and access to continuing education, consultants, and quality improvement programs is limited. Frequent call, inadequate assistance, and difficulty in obtaining coverage for vacation time are other problems that must be addressed to increase job satisfaction and, thereby, improve retention.

3. Lack of outcome studies. Outcome studies are becoming increasingly important nationally, par-
particularly for high-risk, low-volume surgical procedures. Major private sector groups, such as Leapfrog, have suggested regionalization of complex cases to improve outcomes and assure patient safety. Which of these procedures rural surgeons are performing and the associated outcomes are unknown.

4. Financial viability of hospitals. Although significant focus has been placed on the availability and importance of primary care in rural communities, less attention has been given to the critical importance of a surgical program on small rural hospitals. It is estimated that surgical programs represent at least 40 percent of hospital admissions and account for more than 50 percent of hospital revenue. Often the fate of rural hospitals depends on a viable surgical program, the mainstay of which is usually general surgery. The loss of the general surgeon(s) will produce significant financial distress, which may well lead to hospital failure. Given the importance of surgery to rural hospitals, it is interesting that no surgical topics were on the agenda of the recent annual meeting of the National Rural Health Association.

Rural surgery curriculum

We recognize that multiple aspects of our training program allow us to attract and train surgeons for rural locations. Because we have a closed-staff group practice with subspecialists interested in teaching, we are able to develop a rural-track, categorical residency that provides a graduated experience in subspecialty skills needed in rural practice, while still fulfilling the requirements for categorical general surgery. A proposed curriculum has been developed.

While controversy exists regarding the wisdom of offering a rural-specific curriculum instead of standard residency rotations, there is no doubt that surgical residents graduating today are only partially equipped for practice in small hospitals in rural communities. Indeed, in his presidential address to the Southern Surgical Association in 1994, Richard J. Field, Jr., MD, FACS, presented a strong case for implementing such a curriculum and reported that both he and his son, who joined his practice in rural Mississippi, completed an additional postresidency year of training to obtain more experience in orthopaedics, urology, and ob/gyn.6

Our goal is to develop a program that initiates subspecialty surgical education at the PGY-1 year, then builds on this as a continuing process over the next four years. The rural track residents, at senior levels, will be involved in decisions and procedures in needed subspecialties. During rotations with the subspecialty faculty, the residents will have a direct training experience and increasing responsibility. At the PGY-4 level, the resident will join a general surgery graduate of our program in a small rural community hospital. This will provide a varied, senior-level experience with limited access to subspecialists. Because rural surgeons often provide the only endoscopy at rural hospitals, endoscopic experience will be emphasized throughout the five years of residency. A two-month elective to further develop specific needed skills for his or her chosen rural practice will be provided at the PGY-5 level. An additional educational component is the development of the Mithoefer Rural Surgery...
Fellowship. Trained general surgery graduates who plan to practice in rural areas will have access to individually designed experiences for three to six months in subspecialties that are in demand in their communities.

Upcoming efforts

We are conducting two nationwide surveys, one of general surgeons and the other of rural hospitals. The study of general surgeons looks at lifestyle issues, professional isolation, educational needs, surgical care provided, and recruitment issues. The resulting data will be used to: (1) create programs that address the specific concerns of rural surgeons; (2) develop a repository of information; (3) guide policymakers in developing programs; and (4) promote opportunities in rural surgery. The hospital survey will determine the financial effects of the surgical program on rural hospitals. Additionally, we will ascertain which issues and difficulties impede recruitment of general surgeons for rural practices. The MCRS is partnering with Dartmouth Medical College and Rochester University to clarify surgical outcomes in rural hospitals and to further assess the financial impact of surgical programs on hospital revenue.

Plans also are under way to host a national conference next spring focusing on the issues of rural surgery. Leaders in this field will be invited to present information on the current status of rural issues with an emphasis on rural surgery. Our goal is to bring to the forefront the issues facing rural surgeons in light of what we believe is an impending crisis in rural health care in the U.S. We have established a Web site, www.centerforruralsurgery.org, which will be used as a resource for rural surgeons. The results of our surveys will be posted on the site.

National attention needed

The issue of rural general surgery warrants national attention. To avert further deterioration in the availability of surgical care in rural America, we need to understand and address the complex factors related to appropriate preparation of surgeons who can comfortably practice in rural communities and will choose a rural lifestyle. Only with a full comprehension of these complex factors can we arrive at possible solutions.

The financial importance of surgical programs to rural hospitals must also be fully studied. Outcomes of routine and complex surgical procedures in rural hospitals must be known if appropriate decisions on referral to tertiary care centers can be made. We believe the MCRS can serve as a focal point to address these emerging issues.

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“This is no drill”: 

Pearl Harbor as a mass-casualty event

by

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On December 7, 1941, a mass-casualty event occurred. It was over in a few hours. It was completely unexpected and we were totally unprepared for it. It happened on the island of Oahu in the Hawaiian Islands when the Japanese attacked Pearl Harbor without warning. In the end, 2,404 U.S. Army and Navy men perished, and 1,178 were wounded.

Almost no one believed it was real at first. Walter Lord, in his popular book Day of Infamy, described the shocked disbelief people felt in the first moments of the attack.* The band on the deck of the battleship Nevada had just launched into “The Star-Spangled Banner” as the colors were being raised at 8:00 am. They stopped momentarily as a torpedo struck the nearby Arizona, but resumed and continued until another bomb hit their own deck, the American flag halfway up the flagpole. Finally the alarm sounded: “All hands, general quarters. Air raid! This is no drill!”

Actually, the attack had started minutes before, 10 miles to the north. Dive bombers descended on Wheeler Field, where all the American P40 fighters were based. All the planes at Wheeler were destroyed within minutes.

My role

When Pearl Harbor was attacked, I was a captain in the U.S. Army Medical Corps stationed on the island of Oahu, HI, at the North Sector General Hospital in Schofield Barracks—then the largest post in the Army, with about 40,000 troops, including the Army Air Corps. At that time, the North Sector General Hospital was the largest hospital in Hawaii, with 1,000 beds. Tripler General Hospital was only a small wooden hospital at Fort Shafter, and the Navy had a hospital at Pearl Harbor. As chief of septic surgery, I was assigned to a section of the surgical service that treated trauma cases, infections, and burns. I had about 100 beds on two wards and almost that many patients. My wife Lee and I had quarters near the hospital.

That Sunday morning we were just getting ready for breakfast. Lee was to play the organ for church; her father was Chief of Chaplains for the Hawaiian Department. We heard a tremendous roar overhead and ran outside to see what was happening. A lot of planes were flying directly over the house, only about 100 feet up. Lee recognized the situation right away, saying, “Those are Japanese planes; they have rising suns on the wings.” I said, “No, they’re our planes, probably on maneuvers.” I also thought that the hospital could have been conducting an exercise, so I decided I had better get over there. Lee drove me to the hospital, dropped me off, and made her way toward the post chapel, where she was scheduled to play for the morning service. Japanese planes strafed her car, but fortunately Lee was unharmed.

This is war

I was the first physician to arrive at the hospital. As I started into the hospital entrance, an ambulance roared in. I ran to it, and looking in, I saw four soldiers who been virtually blown apart. One was already dead. I could hear bombs going off at Wheeler Field about a mile away, and for the first time I realized that this really wasn’t a drill. Just then Maj. Ed DeYoung, MD, who lived just across the street, came running up. He was chief of radiology. I told him, “Ed, this is a war, and we’re going to have hundreds of wounded. Why don’t you look at all of them, and send the severely wounded up to the operating room? Major Heaton (chief of surgery) will be here soon and can take care of the ‘big’ cases. Send the arm, leg, and head wounds to me.”

I had a well-equipped surgical dressing room on one of my wards, which had an operating table and equipment. I ran up to my ward and told all ambulant patients to report for duty. This freed up about 60 beds, and we put additional beds down the central aisle and on the porches. I called for the plasma and instruments, and patients began to arrive. The first patient had the top of his head blown off, exposing his brain. I wondered what the “big” cases were like over in the operating room. The patient recovered and was the first wounded American to return to his hometown. He was met at the railroad station in Boston, MA, with a band and given a hero’s welcome. He sent me a newspaper clipping about it. (Several of my other re-

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Opposite page: Entrance to Schofield Barracks, March 1941.
covered patients from those first days appeared in a special issue of Life magazine, which reported that they had been killed. Actually, they had been unconscious for a period of time and had no dog tags, so no one knew who they were. They thought the whole misunderstanding about their "untimely demise" was very amusing.

The attacks continued for several hours, the Japanese planes repeatedly firing on the barracks at Schofield. The hospital was at the end of the row of barracks and received repeated strafings. I could hear them coming and thought seriously of diving under the operating table each time. Fortunately, only one patient was hit; he took a bullet in his cast but was uninjured.

The wounds varied, and many were quite severe. I started treating for shock and doing debridements. Local anesthesia was adequate for some, but others required general anesthesia. Our only nurse anesthetist was busy in the operating room with Major Heaton, but Cpt. Bob Hoagland of the medical service came over to help. We had just been issued a new anesthetic called Pentothal. We got out a box, read the directions, and used it on many patients with excellent results.

Lessons lost

The fact of the matter was that we were unbelievably ignorant of trauma treatment in two important aspects. Debridement had been introduced in World War I but had become a largely forgotten procedure. Fortunately, the Honolulu Medical Society had invited John J. Moorehead, MD, chief of trauma for the New York subway system, to lecture in Honolulu. Dr. Moorehead had served in World War I and remembered the lessons learned in that conflict. Most surgeons in Honolulu, including Major Heaton and myself, attended the lecture. Dr. Moorehead explained the concept of debridement and delayed primary closure, among the most important principles in wound treatment to emerge from World War I. The last lecture was about three days before the Japanese attack. Dr.
Moorehead was still on the island at the time and was able to give invaluable help at Tripler Hospital in treating the hundreds of trauma patients who were pouring in.

Sadly, the lessons relearned in this mass casualty event were ultimately lost again. About 10 days after the attacks, the Army Surgeon General sent a group of distinguished surgeons to Hawaii to see what we had done. The wounds were all healing well with no infection. The consultants marveled at this development and asked how we treated the wounds. We explained that we did a careful debridement, irrigated the wounds, sprinkled in a little sulfanilamide powder (kept in salt shakers), left the wounds open, and did a delayed primary closure after three days. Their conclusion was, “That sulfa powder is wonderful.” Completely missing the point of the debridement and delayed primary closure, they reported back to the Surgeon General on the miracle of sulfa powder, and soon a sulfanilamide packet was in every soldier’s first aid kit. When the North African campaign started in 1942, wounds were treated with the application of sulfa powder. Debridement was ignored, and the wounds became infected. Missing the point again, the Surgeon General put out a new order not to use sulfa powder.

Another lesson learned in World War I also was forgotten, this one involving the treatment of shock. In World War I, physicians found that whole blood transfusion and administration of normal saline IV was very important. However, by the time World War II started, the Surgeon General and National Research Council opined that in traumatic shock the blood was thick and the hematocrit high; therefore, plasma, rather than whole blood, was the fluid of choice. Blood was given only in cases of sepsis, and then in small amounts of 100 to 150 ml. We administered it by the direct method, with donor and patient lying side by side. We did not give blood for traumatic shock. Instead we gave freeze-dried plasma in small amounts, about 200 ml. We did try to give normal saline, but we had to
make it ourselves using distilled water from a small still in the operating room. We put it in a Salversan flask, a glass cylinder about 12 × 1½ inches with an outlet at the bottom, to which we attached an old rubber tube and a needle. The tube was sterile but so full of pyrogens that the patient would often get a fever of 104 degrees Fahrenheit or so after receiving this homemade solution. Consequently, we gave very little of it. We also didn’t know that much of the dried plasma was contaminated with hepatitis virus, because it was prepared from pooled lots of blood.

This poor shock treatment had disastrous results. Hospital mortality was about 20 percent, as compared with only 2 percent in Vietnam. Finally, in 1943, Edward D. Churchill, MD, FACS, surgical consultant for North Africa, recommended that blood be given in traumatic shock. But until then, the Surgeon General refused to send blood overseas because in his opinion: (1) plasma was best for the treatment of shock; (2) it was impossible to administer blood forward of the general hospitals in the communication zones; and (3) shipping space was too scarce. Fortunately, though, in 1943, the European Theater Surgeon established blood banks in time for the Normandy landings in 1944. Certainly this action saved thousands of lives.

Aftermath

However, none of these advances were available to us at Pearl Harbor. I worked all day December 7. That night a total blackout was ordered, and we could not turn on the lights, so I worked under a blanket with flashlights. The next morning, December 8, I was tired, hot, and depressed. At least 100 wounded soldiers were still awaiting treatment. I had no idea where Lee was or if she was safe. Dejected, I went out on the porch to get a breath of fresh air. The post was deserted because all of the troops had gone out to their field positions. I thought the Japanese had landed and our troops had pulled out. Someone had a radio playing, and I heard President Roosevelt speaking to Congress. He was saying that this day “will live in infamy” and asking Congress to declare war on Japan. Then they played “The Star-Spangled Banner.” When it came to the line, “the bombs bursting in air gave proof through the night that our flag was still there,” I looked out and, by golly, the flag was still there. This scene perked me up, and I went back to work. It required 48 straight hours of work to take care of all the casualties.

I didn’t know where Lee was for several days, until a chaplain came to see me in the hospital and brought a letter from her. She didn’t say she was OK or ask if I was OK. She just wrote, “Go back to the quarters and let Val out,” referring to our little Boston bull terrier. (Actually, Lee Hardaway, Women’s Air Raid Defense (WARD), January, 1942.
the military police had already released all pets, and I took care of Val at the hospital.) Lee and the other women and children had been evacuated to Honolulu the night of the seventh. They had to go past Pearl Harbor to get to Honolulu, and they witnessed the terrifying spectacle of the whole Pacific fleet in flames. The guards at Pearl Harbor heard this blacked-out vehicle approaching from the north and assumed it was Japanese. They fired on it with machine guns, breaking the windows. Fortunately everyone dropped down onto the floor, and no one was hurt. The women and children were housed in the gymnasium of a school in Honolulu. Most were evacuated back to the states as soon as possible. However, the Army started a radar air

raid warning unit at Ft. Shafter. They could not hire local women because most were Japanese. So they hired Army and Navy wives, forming the Women’s Air Raid Defense (WARD). Other than nurses, these were the first women in the U.S. Army. Lee joined this organization, tracking the positions of enemy planes on a large board, as the information was received on headphones from a remote radar station. Three months later, Lee picked up a radar report that Japanese planes were approaching Hawaii, and as she plotted their positions she could hear the planes overhead and the sound of bombs nearby. Fortunately, they found no targets. The Japanese continued to shell the coast and to attack shipping in the surrounding waters in an attempt to isolate the Islands. In fact, when Lee and I finally returned to the mainland in 1943, our convoy was attacked—unsuccessfully—by Japanese submarines.

The Japanese attack on Hawaii could be called the first mass casualty situation in the modern sense of an unexpected disaster with large numbers of people wounded when they were not fighting in a declared war. We have had many mass casualty situations since then, September 11, 2001, being the most notable. Since World War II and, more recently, post-9/11, we have been making progress in terms of preparing for these disasters and learning from previous experiences. Hopefully, the medical community will never again be caught as unprepared for a mass-casualty event as we were at Pearl Harbor.

Dr. Hardaway is a retired Brigadier General in the U.S. Army Medical Corps.
Gynecologic Cancer Awareness Month: Sharing knowledge, strengthening awareness

The Gynecologic Cancer Foundation (GCF) declared September 1999 to be the first annual Gynecologic Cancer Awareness Month (GCAM). The proclamation was simple and powerful—focus on gynecologic cancers for one month each year in order to educate women about these diseases. By using education to build awareness about gynecologic cancers and the critical importance of scheduling an annual exam, GCF and its founding organization, the Society of Gynecologic Oncologists (SGO), hoped women would learn about risks, common symptoms, and prevention. Over time, this heightened awareness would improve early detection rates and reduce the impact of gynecologic cancers.

Five years later, September continues to be a time for educating the public about these diseases. Over the years, however, GCAM has also taken on a broader meaning for advocates, survivors, and women across the U.S., who mark it as a time of support, knowledge, and hope for the more than 80,000 women affected by these conditions annually.
This development is due, in part, to the types of awareness-building activities that GCF, gynecologic-oncologists, and supporters have undertaken over the last five years. From working with the media to disseminate information about gynecologic cancers to implementing a grassroots letter campaign that urges individual governors to declare GCAM, physicians and supporters have become proponents of GCAM in their local communities. These cooperative efforts among gynecologic oncologists, women, and the health care community have resulted in an aggressive public education campaign that generates results and spreads critical messages and true understanding.

Advancing the cause

Recent developments for GCAM include the creation of the first annual report on gynecologic cancers, called *The State of the State of Gynecologic Cancers: An Annual Report to the Women of America*. This first-ever report, prepared by SGO members in 2003, details the latest scientific and medical information about the five most common gynecologic cancers: cervical, ovarian, uterine, vulvar, and vaginal cancer. It also provides the most current incidence numbers, risk factors, symptoms, and prevention information. As an annual report, *The State of the State of Gynecologic Cancers* offers a snapshot in time, recording advances in the field of gynecologic cancer research and treatment, and, therefore, offering a record of knowledge and hope to women and their health care professionals. And because the report is widely distributed, it has become yet another tool for greater understanding and prevention, strengthening GCAM’s power in the community.

A broadening reach

This year, GCF will build on the success of the first *State of the State of Gynecologic Cancers* by offering the second annual report with information about the latest medical and scientific findings, key research, treatment, and prevention details. The report is being distributed this month and is also available online at www.thegcf.org or at the Women’s Cancer Network at www.wcn.org.

Additional GCAM activities in September 2004 will include the fifth distribution of GCAM publicity kits to more than 3,500 individuals and providers in the U.S. This kit provides information about gynecologic cancers and details ways in which individuals can create events and activities to engage their communities in gynecologic cancer awareness. Member feedback and reports indicate that this kit provides supporters with the right tools to activate friends, family, and local groups in the fight against gynecologic cancers.

As in previous years, GCF is also urging governors to declare GCAM in states across the U.S. In 2004, GCF’s state GCAM campaign has taken on the goal of “50 or bust” and seeks to have all governors declare September as GCAM. Governor proclamations are another way to raise the level of awareness about gynecologic cancers and focus women on the importance of getting an annual exam and gynecologic screening.

Advocacy

Legislative efforts will also play a part in GCAM this year as SGO and GCF specifically focus on legislation introduced on November 4, 2003: H.R. 3438, J ohanna’s Law: The Gynecologic Cancers Education and Awareness Act. “J ohanna’s Law” was conceived by Sheryl Silver, who lost her sister, J ohanna, to ovarian cancer following a three-and-a-half year battle with the disease.

The bill would authorize a national gynecologic cancers early detection and awareness campaign. SGO worked with the bill’s sponsor, Rep. Sander Levin (D-MI) to ensure that education programs not only would be directed toward women, but at their physicians and payors as well. SGO also identified Rep. Kay Granger (R-TX) as the other lead sponsor, ensuring bipartisan support for the bill. The major provisions of the bill are:

- National public service announcements. The U.S. Department of Health and Human Services (HHS), working with the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC), would develop and place public service announcements encouraging women to talk to their physicians about their risk for gynecologic cancers. These advertisements would call attention to early warning signs and risk factors based on the best current
medical information. As part of the national campaign, a standard brochure would be developed and available to the public with information about gynecologic cancers.

- Grants to local and national organizations. The CDC, in consultation with NCI, would award demonstration grants to local and national not-for-profit organizations to test different outreach and education strategies, including incentive programs directed at physicians, payors, and women. The Secretary of HHS would be required to report to Congress and make recommendations regarding the barriers to early detection and which methods were most effective in getting women treatment for gynecologic cancers.

SGO strongly supported Johanna’s Law, given their understanding of how public education affects women’s knowledge of gynecologic cancers and research and treatment options.

To promote the passage of this bill, SGO and the Ovarian Cancer National Alliance have planned congressional visits and a reception on Capitol Hill this month to promote the legislation and the need for increased federal investments in gynecologic cancer education and awareness.

**SGO’s mission**

As the national medical specialty society of physicians who are trained in the comprehensive management of reproductive tract malignancies, SGO independently and with the cooperation of other specialty organizations, including the American College of Surgeons, works to improve the overall care of women with gynecologic cancers. This purpose is advanced by supporting research, setting standards of practice in prevention and treatment, providing members with specialty-focused learning, and working with allied organizations to raise awareness of gynecologic cancers among women.

The ACS is one of the organizations that SGO cooperates with on a continuous basis. For example, SGO members are actively encouraged to join the College. SGO also works with the College’s Commission on Cancer to encourage hospitals, treatment centers, and other facilities to improve their quality of patient care through various cancer-related programs.

“Through our common cause—the unified and comprehensive medical and surgical care of women with reproductive tract cancers—SGO and the College have a basis for advancing treatment and ensuring that women receive the best care possible,” James W. Orr, Jr., MD, SGO president, said.

**Highlights of the 2004 “State of the State of Gynecologic Cancers”**

- SGO has reviewed the literature regarding OvaCheck, a serum-based diagnostic test for ovarian cancer. While SGO recognizes the importance of accurate early detection biomarkers for ovarian cancer, in the opinion of SGO, more research is needed to validate the test’s effectiveness.
- New advances in the use of brachytherapy for the treatment of vaginal cancer allow the use of needles to deliver the radiation directly to the tumor, making it possible to deliver the treatment in one to two hours, rather than over several hours or even days.
- Recent studies have shown that the combined use of estrogen and progestin does not increase the risk of endometrial cancer.
- Results from a prospective, randomized, multi-institutional trial determined that the combination of three chemotherapeutic agents (doxorubicin, cisplatin, and paclitaxel) were better than two (doxorubicin and cisplatin) in the treatment of advanced and recurrent endometrial cancer.
- The combination of two drugs, cisplatin and topotecan, proved more effective in treating inoperable recurrent cervical cancer than platinum alone, according to a recent Gynecologic Oncology Group study.
SGO, founded approximately 35 years ago, now has more than 1,000 members—99 percent of all gynecologic oncologists—who make it the leading organization for the field in the U.S. The membership also includes the most prominent medical oncologists, radiation oncologists, and basic scientists involved in gynecologic cancer treatment and research.

Gynecologic oncologists receive an additional three to four years of intensive training and research experience in the field of female reproductive tract malignancies of the ovary, endometrium, vulva, and vagina. The majority of SGO members are gynecologic oncologists, including:

- All trained and board-certified gynecologic oncologists in the U.S.
- All individuals who head academic divisions of gynecologic oncology in U.S. medical schools.
- All directors of fellowship training programs in gynecologic oncology.
- All participants in the NCI-funded collaborative clinical research group, Gynecologic Oncology Group.

The society's members provide unified, comprehensive care to women with reproductive tract cancers from diagnosis to completion of treatment, including surgery, chemotherapy, radiation therapy, and supportive care.

“This level of training and expertise in the field of women’s reproductive tract cancers establishes gynecologic oncologists as the preferred providers of care during gynecologic cancer treatment,” said Dr. Orr. “Therefore, we focus our energies on moving the field of gynecologic cancer care forward, in conjunction with our partners in health care and other professional societies, such as the College.”

SGO urges women to see a gynecologic oncologist if they suspect or are diagnosed with a gynecologic cancer. Most women with ovarian cancer have advanced-stage disease at diagnosis and surgical cytoreduction is critically important to survival. Numerous studies suggest that women with ovarian cancer who are treated by experienced surgeons typically live two to three years longer than those whose initial surgeries were performed by surgeons with a lower volume of these complex surgeries. “In addition, gynecologic oncologists are specially trained to perform surgical staging of endometrial and ovarian cancers, including pelvic and aortic lymph node dissection, which allows for customized treatment options,” Dr. Orr said.

As part of its outreach to other health professionals and providers, SGO also encourages others to use the joint referral guidelines developed by SGO and the American College of Obstetricians and Gynecologists to assess women with suspected indicators of ovarian cancer. Combined with the knowledge of the early symptoms and early detection test for gynecologic cancers, these referral guidelines can help improve care for women with these diseases.

**GCF’s mission**

In 1991, SGO established the GCF with the mission of heightening public awareness about gynecologic cancer prevention, early diagnosis, and proper treatment and to support research and training related to gynecologic cancer prevention and care. GCF advances this multifaceted mission through awareness, education, and research programs.
As part of its public awareness and educational efforts, GCF partners with numerous advocate, survivor, nursing, and health care organizations committed to quality cancer care for women. GCF also benefits from physician members of the SGO who volunteer to share their knowledge in radio and television interviews, print publications, and public seminars sponsored by GCF.

The organization’s activities include year-round media and public outreach programs with a specific focus on Gynecologic Cancer Awareness Month. To support its awareness campaigns, GCF develops public service announcements, media releases, and an array of educational materials in English and Spanish. The foundation also sponsors numerous outreach courses across the country and harnesses the support of SGO physicians, who participate in media interviews about gynecologic cancers on a regular basis.

"GCF is leading the charge to inform women about gynecologic cancers," said Karl C. Podratz, MD, PhD, FACS, chairman of GCF and a member of the ACS Board of Regents. “Our belief is that awareness is the first step to saving lives and we aim to provide women with the tools they need to protect their gynecologic health,” Dr. Podratz said.

GCF’s Web site, the Women’s Cancer Network (www.wcn.org), is a premiere resource for women’s cancer information and contains one of the first online cancer risk surveys for women, which was developed by SGO physicians.

To date, GCF has awarded grants totaling more than $1.5 million to promising young investigators to encourage research in the field of gynecologic oncology. Its training program with the National Cancer Institute has supported five GCF/NCI fellows and, together, GCF and NCI are funding a new scholar’s program. Since the program’s inception, GCF has funded 30 research grants and will offer 10 new grants in 2005.

As a testament to its credibility and record of accomplishment, GCF was named by Worth magazine as one of “America’s 100 Best Charities” from a pool of more than 819,000 charities in the U.S.

“Through its direct outreach to women and support organizations regarding gynecologic cancer awareness, prevention, and detection, GCF continues to drive understanding on the personal level about these diseases,” said Dr. Podratz. “Our founding organization, SGO, and other specialty societies such as the College, strengthen our educational hand continuously with women by supporting our engagement and outreach efforts, and serving women daily with their cancer care.”

**Getting involved**

GCF and SGO welcome the involvement of specialty societies such as the College and individuals in its GCAM activities and year-round efforts to promote gynecologic cancer awareness. To learn more about how you can help, please contact Karen Carlson, executive director, Gynecologic Cancer Foundation, tel. 312/658-0750, or by e-mail at kcarlson@thegcf.org.
Surgical technologists are individuals with specialized education who function as members of the surgical team in the role of scrub, circulator, or as assistant personnel to perioperative registered nurses. With additional education and training, some surgical technologists function in the role of surgical first assistant.

There are more than 350 surgical technology programs that are accredited by the Accreditation Review Committee for Educational Programs in Surgical Technology—a collaborative effort of the Association of Surgical Technologists, the American College of Surgeons, and the American Hospital Association, under the auspices of the American Medical Association’s Committee on Allied Health Education and Accreditation. Accredited programs provide both didactic education and supervised clinical experience based on a core curriculum for surgical technology.

Most programs require a high school diploma as a minimal entrance requirement. Accredited programs may be offered in community and junior colleges, vocational and technical schools, the military, universities, and structured hospital programs in surgical technology. The accredited programs vary from nine to 15 months for a diploma or certificate to two years for an associate degree.

Graduates of accredited surgical technology programs are eligible for certification by the Liaison Council on Certification for Surgical Technology, an administratively independent body from the Association of Surgical Technologists consisting of representative certified surgical technologists, a surgeon, a registered nurse, and the public.

The American College of Surgeons strongly supports adequate education and training of all surgical technologists, supports the accreditation of all surgical technology educational programs, and encourages examination for certification of all graduates of accredited surgical technology educational programs.
Fellows of the American College of Surgeons (ACS) serve as expert witnesses on behalf of both plaintiffs and defendants in medical liability cases. By providing testimony that is fair and accurate, the expert witness can contribute to a just outcome and improve the quality of surgical care.

The College has developed an Expert Witness Affirmation that declares the witness will uphold certain professional principles in providing expert evidence or expert witness testimony (see next page). The affirmation is consistent with the ACS Statement on the Physician Acting As an Expert Witness and is intended for voluntary use by ACS Fellows who wish to make explicit their commitment to knowledgeable and ethical expert witness testimony.

Those Fellows who testify may sign the affirmation and give it to the attorney representing the party on whose behalf they intend to testify. The document is for the Fellow’s personal use and files; please do not forward it to the College.

During litigation, the affirmation can be used to examine the witness and enhance the qualifications of those who have signed it. Conversely, witnesses who chose not to sign the affirmation can be cross-examined about their failure to do so. Such affirmations have proven useful to members of other organizations that have similar statements and may assist in the promulgation of credible and appropriate expert testimony.
Expert Witness Affirmation

As a member of the medical profession and the American College of Surgeons, I affirm my duty, when giving evidence or testifying as an expert witness, to do so solely in accordance with the merits of the case. Furthermore, I declare that I will uphold the following professional principles in providing expert evidence or expert witness testimony.

1. I will always be truthful.

2. I will conduct a thorough, fair, and impartial review of the facts and medical care provided, not excluding any relevant information.

3. I will provide evidence or testify only in matters in which I have relevant clinical experience and knowledge in the areas of medicine that are the subject of the proceeding.

4. I will evaluate the medical care provided in light of generally accepted standards, neither condemning performance that falls within generally accepted practice standards nor endorsing or condoning performance that falls below these standards.

5. I will evaluate the medical care provided in light of the generally accepted standards that prevailed at the time of the occurrence.

6. I will provide evidence or testimony that is complete, objective, scientifically based, and helpful to a just resolution of the proceeding.

7. I will make a clear distinction between a departure from accepted practice standards and an untoward outcome.

8. I will make every effort to determine whether there is a causal relationship between the alleged substandard practice and the medical outcome.

9. I will submit my testimony to peer review, if requested by a professional organization to which I belong.

10. I will not accept compensation that is contingent upon the outcome of the litigation.

Name _______________________________________________________________________

Signature _____________________________________________________________________

Name of Certifying Board _______________________________________________________________________

Date Certified __________________ Date Recertified __________________
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Minimally invasive breast biopsy. Rena B. Kass, MD, Penn State Hershey Medical Center, and Wiley W. Souba, MD, SCD, FACS, Penn State Hershey Medical Center, Hershey, PA.

Approximately 1 million women undergo breast biopsy each year. Traditionally, the surgical standard has been excisional biopsy, but this method has associated morbidities, cosmetic defects, and costs. In addition, when performed for cancer, as many as 50 percent of excisional biopsies are found to have positive margins. The development of the core-needle biopsy (CNB) offers an accurate, less invasive, and less morbid means of providing a pathologic diagnosis. Compared with fine-needle aspiration, CNB is more likely to yield an adequate tissue sample. The core needle can be used with stereotactic or ultrasound guidance for those lesions visualized by mammography or ultrasound, respectively. Even for palpable lesions, ultrasound can enhance diagnostic yield by directing the needle to different areas within a mass for sampling, thereby avoiding areas of necrosis. CNB is now widely accepted and used. This review discusses several of the new modifications of the CNB technique that enhance the minimally invasive breast biopsy.

Biopsies performed with an automated 14-gauge gun require that four or five cores be obtained from separate passes through the skin. This technique may result in pathologic upgrading by up to 30 percent on subsequent surgical excision, as a result of insufficient volume of the initial core tissue. By obtaining larger tissue volumes, the vacuum-assisted core biopsy (VACB) device has reduced the frequency of understaging of lesions showing atypical ductal hyperplasia or ductal carcinoma in situ. These devices employ an 8- or 11-gauge needle with a rotating cutter attached to a vacuum system. This design allows a single placement of the needle through a 5-mm nick in the skin. Upon activation, the core specimens are delivered ex vivo through the barrel of the needle for collection. Circumferential rotation of the needle allows for the removal of greater volumes of tissue; for stereotactic VACB, this technique can result in complete radiographic removal of the lesion in 50 percent to 70 percent of diagnostic biopsies. Hemostasis is obtained by direct pressure or, rarely, by the use of the harmonic scalpel.

In addition to its economic and cosmetic advan-
tages, VACB appears to be preferred by patients over the standard open biopsy. In a series of 88 patients who underwent directional 11-gauge VACB and who were asked to fill out a follow-up questionnaire, 83 percent reported feeling excellent during the biopsy, and no patient reported a retrospective preference for a surgical biopsy. Another benefit of VACB is that it does not interfere with subsequent radiographic interpretations. Huber and colleagues reported that VACB with the 11-gauge needle rarely resulted in any changes that altered the mammographic or ultrasound appearance of the breast at six-month follow-up. These outcomes are in contrast to the well-documented radiographic changes seen after open surgical biopsy. Such changes include focal architectural distortion, increased focal density, focal skin thickening and retraction, fat necrosis, and occasional calcifications; these changes may contribute to the slightly higher recall rate of patients with a history of benign breast biopsy.

Approximately 80 percent of breast biopsies reveal benign pathology. Although a 14-gauge core may suffice in documenting the benign nature of these lesions, patient preference may dictate complete removal of the mass. The diagnostic capabilities, low cost, and low morbidity of VACB, in conjunction with patients' increasing preference for more minimally invasive techniques, has led to its use in the complete percutaneous excision of lesions. Hence, the outpatient diagnostic procedure is transformed into a therapeutic procedure with little addition of time and no additional needle placement. For complete removal, it is important to initially place the needle aperture under and parallel to the lesion. The needle should then be rotated 45 degrees clockwise and counterclockwise at each level as it is gently lifted to avoid bisecting the mass. Johnson and colleagues have reported on the efficacy of the 8- and 11-gauge handheld VACB (Mammotome; Ethicon Endosurgery, Cincinnati, OH) for the ultrasound-guided percutaneous removal of benign-appearing masses. Johnson and colleagues reported a 100 percent radiographic resolution as seen on a six-month follow-up mammogram after VACB. Fine and coworkers reported that 98 percent of patients had no palpable evidence of the lesion at six months, and 73 percent had no evidence of the lesion on repeat ultrasound. The average lesion was 18 (± 6) mm and was removed in 16 (± 10) minutes.

Two new percutaneous devices deliver large, intact samples under radiographic guidance in one pass. The en-bloc (Neothermia, Natick, MA) is a vacuum-assisted electrosurgical device that encapsulates the lesion and then retracts it through the skin. The needle of the EnCapsule device (Rubicor, Redwood City, CA) delivers a loop that circumscribes the mass using radiofrequency while concurrently deploying a retractable plastic bag. In a report of a multicenter trial of the EnCapsule device that was presented in April at the American Society of Breast Surgeons, successful results were found for lesions less than 2.0 cm in size. These devices, like the Mammotome, can be used in an outpatient setting under local anesthesia but have the added benefit of preserving specimen architecture; in addition, they may provide a more accurate assessment of size and margins. Although these developments are promising for future approaches to cancer surgery, all the percutaneous devices (including the Mammotome) currently have FDA approval only for the excision of benign masses.

This month at ACS Surgery Online

New and revised chapters are published each month online at www.acssurgery.com. ACS Surgery Online recently featured these chapters:

- Soft tissue infection, by Mark A. Malangoni, MD, FACS, and Christopher R. McHenry, MD, FACS.
- Procedures for management of ulcerative colitis, by Robert R. Cima, MD, FACS, FASCRS, Tonia Young-Fadok, MD, MS, FACS, FASCRS, and John H. Pemberton, MD, FACS, FASCRS.
- Asymptomatic carotid bruit, by Claudio S. Cinà, MD, SpChir(ITALIA), MSc, FRCSC; Catherine M. Clase, MB, BChir, MSc, FRCPC; and Aleksandar Radan, MD, BSc, FFA.
- Postoperative and ventilator-associated pneumonia, by Craig M. Coopersmith, MD, FACS, and Marin E. Kollef, MD.
Patients whose lesions are found to be cancerous should undergo subsequent open surgical reexcision. Further evaluation is needed to assess potential thermal artifacts produced by these tools on unsuspected cancers.

Ductoscopy—the performance of endoscopy through a cannulated nipple duct—has been recently introduced as a supplemental tool for the investigation of nipple discharge and for the evaluation of women at high risk for cancer. Visualization and biopsy of papillomas (a frequent source of nipple discharge) and other lesions may now be performed intraductally through the ductoscope. Alternatively, biopsy of these lesions can be performed percutaneously by core needle devices triangulated with the ductoscope. Whether this biopsy technique can eliminate the need for formal duct excision still needs to be evaluated.

Today, these techniques allow for more accurate diagnosis and better surgical planning of cancerous and high-risk lesions. In addition, they allow benign breast lesions to be percutaneously removed with minimal cosmetic deformity in a cost-effective, well-tolerated, timely manner in the outpatient setting. The role of these devices in the percutaneous removal of cancers in combination with other techniques is currently under investigation; these devices are likely to play an important role in the emerging field of minimally invasive breast cancer surgery.

References

The 2004 annual meeting of the American Medical Association’s (AMA’s) House of Delegates (HOD) took place June 11-16 in Chicago, IL. The College, through its well-respected delegation, weighed in on numerous issues of interest to the surgical community, advocating on behalf of all surgeons. This meeting provided a forum for national specialty society and state medical society delegates to discuss and vote on policy matters of concern to all physicians, as well as provide direction to the AMA through the election of officers.

Expert witness affirmation

Joined by seven surgical specialty societies, the College continued its efforts to bring attention to the need for stronger AMA policy regarding expert witness testimony in medical liability lawsuits. At this meeting, the resolution authored by the College focused on the AMA implementing an expert witness affirmation for AMA members similar to guidelines in the College’s Statement on the Physician Acting As an Expert Witness. Most of the testimony presented at reference committee hearings was supportive. However, it was suggested that the AMA also work with national specialty societies to study mechanisms for reporting unethical testimony. The HOD adopted the resolution with the additional requirement that the study be completed. The College looks forward to working with the AMA on this important issue.

Specialty hospital study

In light of the recent federal moratorium on new construction of specialty or “boutique” hospitals, and due to the increase in state-level conflicts associated with the building of these facilities, the College and four other surgical specialty societies introduced a resolution calling on the AMA to comprehensively review the issue. Strong support was expressed for this resolution, and the HOD adopted it with minor modifications.

Specialty hospital study areas:
• Wide-ranging impact on the provision of health care.
• Competitive pressures and tactics used to prevent construction of specialty hospitals.
• Known and potential benefits, including quality of care improvements, patient satisfaction, and cost-effectiveness.
• Financial impact on community hospitals and “safety

In accordance with Article I, Section 6, of the Bylaws, the Annual Meeting of the American College of Surgeons is called for seven-thirty o’clock in the morning of Thursday, October 14, 2004, at the Ernest N. Morial Convention Center, New Orleans, LA. This session constitutes the annual business meeting of the Fellows, at which time Officers and Governors will be elected, and reports from officials will be presented. Items of general interest to the Fellows will also be presented. Each Fellow is respectfully urged to be present.

John O. Gage, MD, FACS
Secretary, American College of Surgeons
August 2, 2004
net” institutions, access to emergency and trauma care services, and the quality of physician training programs.

- Appropriateness of physician referral patterns.

**Medical education council**

For the first time in its history, the College sponsored a candidate for an AMA election. Due to an unexpected resignation, a position was open on the Council on Medical Education. Richard Reiling, MD, FACS, joined four other delegates in a spirited and collegial campaign. While his bid for the office was unsuccessful, the campaign did increase Dr. Reiling’s visibility within the House of Delegates and provided tangible evidence of the College’s involvement in the AMA.

**Surgical caucus**

Because both the HOD and ACS Board of Regents were meeting in Chicago simultaneously, a number of College leaders participated in the Surgical Caucus program, which focused on what surgical organizations are doing to improve the quality of surgical care. Edward Copeland, MD, FACS, Chair of the Board of Regents; Edward Laws, MD, FACS, ACS President-Elect; and Josef Fischer, MD, FACS, a Regent, discussed the many ACS activities focused on this important area. They also reiterated the College’s strong commitment to collaborating with the AMA and national specialty societies and to participating in the policymaking process of the AMA House of Delegates.

LaMar S. McGinnis, Jr., MD, FACS, chair of the College’s delegation, continues his service as Secretary of the Surgical Caucus, with Dr. Reiling serving as a Member At-Large.

College leaders in AMA House of Delegates activities are: Dr. McGinnis, ACS Delegation Chair, Atlanta, GA; Charles Logan, MD, FACS, Little Rock, AR; Dr. Reiling, Charlotte, NC; Amilu Rothhammer, MD, FACS, Colorado Springs, CO; Tom Whalen, MD, FACS, New Brunswick, NJ; and Patricia Turner, MD, ACS Representative to the AMA Young Physicians Section, Washington, DC.

The ACS Delegation Staff Liaison and Surgical Caucus Administrator is Jon Sutton, State Affairs Associate, ACS Chicago Office; tel. 312/202-5358, or e-mail jsutton@facs.org.

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**The American College of Surgeons**

The American College of Surgeons was instrumental in helping me to become an effective and informed general surgeon for 37 years. I consider it a privilege to help continue the good works of the ACS through the FLS.”

— Benny R. Cleveland, M D, FACS, Boerne, TX

For information about joining the Fellows Leadership Society, please contact the College’s Development Office via telephone at 312/202-5338, via e-mail at bliebig@facs.org, or visit the ACS Web site at www.facs.org/development/develop.html
ACS Career Opportunities
The American College of Surgeons’ online job bank

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

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

Candidates:
• View national, regional, and local job listings 24 hours a day, 7 days a week—free of charge.
• Post your resume, free of charge, where it will be visible to thousands of health care employers nationwide. You can post confidentially or openly—depending on your preference.
• Receive e-mail notification of new job postings.
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Employers:
• Nationwide market of qualified surgical candidates.
• Resume Alert automatically e-mails notices of potential candidate postings.
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Questions?
Contact HealtheCareers Network at 888/884-8242 or candidates@healthecareers.com for more information.
RAS-ACS to sponsor sessions at Clinical Congress and Spring Meeting

by Juan Carlos Paramo, MD, Miami Beach, FL

The members of the Resident and Associate Society of the American College of Surgeons (RAS-ACS) invite all surgical residents, Associate Fellows, young surgeons, and Fellows of the College to the RAS Symposium entitled Surgical Residents: Student or Employee—And Why It Matters. The session will take place during the 2004 Clinical Congress in New Orleans, LA, Sunday, October 10, 2004, 1:00-4:00 pm. For more information, contact Peg Haar, Resident and Associate Society staff liaison, Division of Member Services, at 312/202-5312 or via e-mail at phaar@facs.org.

Also, surgery residents at all PGY levels are invited to participate in a special program designed by the ACS Division of Education to assist with planning for post-training careers and making the transition from training to practice. For additional information regarding the residents’ program, please contact Cherylnn Sherman at 312/202-5424 or via e-mail at csherman@facs.org.

Every Resident or Associate Fellow of the ACS is automatically a member of the RAS-ACS. The RAS is governed by a Council of Representatives that meets every year at the Clinical Congress. Any person interested in becoming more involved with the RAS should attend the Council of Representatives meeting Sunday, October 10, 2004, 8:00-10:00 am. At that meeting we will help you become an official delegate to the council from your local College chapter. Once on the Council of Representatives, there are opportunities to serve on numerous committees throughout the ACS, including the Board of Governors’ committees, RAS committees, and other national, local, and resident level meetings. Becoming involved is an amazing opportunity to work on problems in the surgical community at a national level, networking with the leaders of surgery and offering input that helps them keep the needs of residents and young surgeons in mind.

Spring Meeting

Contributions are now being sought for RAS-sponsored sessions at the 2005 Spring Meeting, April 16-19, in Hollywood, FL. Continuing with our goal of making the Spring Meeting the “Meeting of the Resident,” three different resident-oriented programs are being offered. All programs will take place Sunday, April 17, 2005.

The first session, Clinical Abstract Submissions from Residents, will provide a forum where residents can present their research and disseminate the latest advances in surgery.

The second session, Spectacular Cases from Residents, will enable residents to present extraordinary cases to a group of expert panelists for discussion. The third session, Surgical Jeopardy, will be an exciting competition of surgical knowledge among teams of residents from all over the country.

The deadline for submission of abstracts is November 26, 2004. To submit abstracts or for additional information, please contact Julie Aikins at 312/202-5433 or jaikins@facs.org.

Dr. Paramo is a surgical oncologist at Mount Sinai Medical Center, Miami Beach, FL. He is Chair of the RAS Communications Committee.
ONLINE CME: Courses from the American College of Surgeons’ Clinical Congresses are available online for surgeons. The online courses feature printable written course transcripts, audio of sessions, video of the introduction of each session, post-test and evaluation, and printable CME certificates upon successful completion. Several of the courses are offered FREE OF CHARGE. The courses are accessible at: www.acs-resource.org.

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

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

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

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

These fine educational products are available for your learning convenience.

These products can be purchased by calling ACS Customer Service at 312/202-5374 or by visiting our E-LEARNING CENTER at www.acs-resource.org.

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

The University of Michigan (Ann Arbor) Medical Center, section of vascular surgery, announces the availability of training positions for postdoctoral physician candidates in vascular biology through a National Institutes of Health T32 training grant, Vascular Surgery: Research Training in Vascular Biology. These positions include both didactic teaching and laboratory investigation. Basic and translational research are available. A highly developed didactic curriculum has been conceived to address key issues in research design, statistical methods, writing and speaking skills, and grant-writing capabilities.

All prospective candidates must be citizens of the U.S. or foreign nationals with permanent resident or immigration visas. Fellowships will be offered only to those candidates who have completed at least two years (usually three years) of graduate education in surgery. Fellowship appointments can start from postgraduate years three to six.

For further information and application materials, contact Thomas W. Wakefield, MD, FACS, University of Michigan Medical Center, Section of Vascular Surgery, 1500 E. Medical Center Dr., TC2210/0329, Ann Arbor, MI 48109; tel. 734/936-5820, e-mail thomasww@umich.edu.

New program for surgery residents unveiled

The American College of Surgeons, through its Division of Education, unveiled a new program for surgery residents, Life after Residency, on April 23, 2004, prior to the commencement of the 32nd annual Spring Meeting in Boston, MA. The program covered a broad range of important nonclinical topics for surgery residents, and was chaired by Michael J. Zinner, MD, FACS.

Thomas V. Whalen, MD, MMM, FACS, delivered a presentation on practice management; Robert S. Rhodes, MD, FACS, provided an update from the American Board of Surgery; and Ajit K. Sachdeva, MD, FACS, FRCSC, provided an overview of the educational activities of the American College of Surgeons. Michael J. Sutherland, MD, Secretary of the College’s Resident and Associate Society, highlighted the activities of the society. Presentations were also delivered on managing the stresses of a medical practice, personal financial planning, reducing liability exposure, and targeted job searching. A total of 52 surgery residents attended this program and the feedback from the residents was extremely positive.

The program will be offered again, with some minor changes, on Friday, April 15, 2005, prior to the 33rd annual Spring Meeting of the College in Hollywood, FL. For further information on this resident program, please contact Patrice G. Blair, Associate Director, Division of Education, at pblair@facs.org.

Trauma meetings calendar

The following Continuing Medical Education Courses in Trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

• Advances in Trauma, December 10-11, 2004, Kansas City, MO.
• Trauma and Critical Care—2005, March 21-23, 2005, Las Vegas, NV.
• Trauma and Critical Care—2005: Point/Counterpoint XIV, June 6-8, 2005, Atlantic City, NJ.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
Report of the 2004 Japan Traveling Fellow

by George K. Gittes, MD, FACS, Kansas City, MO

My traveling fellowship to Japan spanned a 15-day period, April 1-16, 2004. Initially, I attended the Japan Surgical Society Congress, which met at the main convention center in Osaka. From there I traveled to Kyoto University and Juntendo University in Tokyo to visit and lecture at those institutions.

While at the Japan Surgical Society (Figure 1, this page), I was able to give two lectures, the first being part of the pediatric surgery section of their Surgical Forum equivalent. My lecture was entitled Activin vs. BMP Signaling in Pancreatic Islet Development.

I also gave a second lecture at the Japan Surgical Society, which was a broader topic presentation to the general meeting of the Japan Chapter of the American College of Surgeons, entitled TGF-β Superfamily Signaling in Pancreatic Development. During this session, Tatsuo Yawakama, MD, FACS, current Governor of the Japan Chapter of the ACS, graciously served as my host. While attending the Osaka meeting, I also served as the Society of University Surgeons’ representative to the Japan Surgical Society meeting in reciprocity to the frequent attendance by the President of the Japan Surgical Society at the Society of University Surgeons meeting.
After the Japan Surgical Society Congress, I traveled to Kyoto University (Figures 2 and 3, page 48 and this page). My host in Kyoto was Dr. Ryuichiro Doi, a prominent general surgeon and basic scientist in the department of surgery at the university. While visiting Kyoto University I was given a grand tour of both the university and the medical center, which were quite impressive and quite large. Kyoto University is the number one recipient of Nobel Prizes in Japan.

In addition, I had the opportunity to tour the surgical research facilities and to meet with several of the surgeon-scientists and research residents (or at least the Japanese equivalent of such) working in the surgical laboratories. Of note, these individuals typically spend at least three to four years working in basic science. One such fellow, Dr. Masayuki Koizumi, who is working in a similar field of study to mine (pancreatic differentiation and development), has asked and will be allowed to come to my laboratory for a two-year fellowship in Kansas City, MO, starting in July of 2005.

During this visit, I also gave a one-hour seminar on my research, and found the level of sophistication and understanding among the attending scientists and surgeons very impressive. During this visit I also was able to reunite with a former Japanese research fellow from my laboratory who had spent two years with me and returned to Japan approximately two years ago. He is working at the Kobe General Hospital.

After my visit to Kyoto University (Figure 3)
University, I departed to Tokyo to visit Juntendo University, one of the premier sites for pediatric surgery in Japan (Figures 4 and 5, page 49 and this page). I received a tour of the hospital, with a particular focus on the children's hospital component, and I observed several surgical procedures being performed in the operating rooms, which were equipped with state-of-the-art technology for laparoscopic pediatric surgery. My capable hosts during this segment of the trip were two pediatric surgeons, Dr. Atsuyuki Yamataka and Dr. Hiroyuki Kobayashi. As a result of my visit, Dr. Kobayashi and I have elected to co-author an upcoming biliary atresia chapter in the Blumgart text on Surgery of the Liver, Biliary Tract, and Pancreas.

In addition, I have since happily helped in the preparation of many of the abstracts from Juntendo University for submission to American pediatric surgical meetings. While at Juntendo University I presented a campus-wide seminar related to pancreatic development and differentiation, with many elite Japanese basic scientists and endocrinologists in attendance.

As another indicator of the good will this experience imbued, a surgical research fellow who had been sent from Juntendo University to work at another laboratory in this country has recently moved to my laboratory for two-and-one-half more years. We agreed to bring her into our lab due to an unexpected shake-up at the other laboratory.

On my day of departure from Tokyo, I was able to have a breakfast meeting with Dr. Yawakama. We had a wonderful meeting, which represented a great send-off from what was a fantastic educational and life experience for me. I wish to thank the American College of Surgeons for affording me the opportunity to experience this fellowship.

Dr. Gittes is the Thomas Holder/King Ashcraft Chair of Pediatric Surgical Research and professor of surgery, University of Missouri, Kansas City, and Children's Mercy Hospital, Kansas City, MO.

RURAL SURGERY, from page 20

References

Committee on Perioperative Care: Update

by Lena M. Napolitano, MD, FACS, Baltimore, MD

The Committee on Perioperative Care (CPC) was established in 2002 as a standing committee of the American College of Surgeons functioning under the authority of the Board of Regents. The CPC was formed by combining the Committee on Operating Room Environment and the Pre- and Postoperative Care Committee into one committee to provide a continuum across all processes related to surgical care.

The CPC has responsibility for: nominating the I. S. Ravdin Lecture in the Basic Sciences; assuming a leading role in the development of programs related to perioperative care and the operating room environment; encouraging and providing expertise for the development of measurement tools to define and disseminate the best practices of perioperative care; and monitoring federal and state activities and industry development affecting the care of the surgical patient. Administrative support for the CPC is provided by the College’s Office of Evidence-Based Surgery, Division of Research and Optimal Patient Care.

Over this past year, we have noted a number of recent developments in the area of perioperative care that should be highlighted. Many of the items mentioned here are available on (or will soon be added to) the CPC Web site at www.facs.org/about/committees/cpc/index.html.

**AORN latex guideline**

Natural rubber latex allergy is a significant medical concern, since it may result in serious and life-threatening complications. Prevention of this complication is key, since currently there are no curative treatment strategies. The recently revised Association for Operating Room Nurses (AORN) Latex Guideline provides important information regarding this issue, and has been reviewed and endorsed by the CPC. The complete AORN Latex Guideline can be obtained on the CPC Web site and on the AORN Web site.1

**Sharps injuries prevention**

The Centers for Disease Control and Prevention (CDC) estimates that hospital-based health care personnel, reflecting an average of 1,000 sharps injuries per day, sustain 385,000 needlesticks and other sharps-related injuries each year.2 The International Sharps Injury Prevention Society has estimated that health care workers in the U.S., approximately 5.6 million strong, suffer as many as 800,000 sharps injuries (mostly needlesticks) each year. That’s one out of every seven workers accidentally stuck by a contaminated sharp every year.3 It is believed that only one out of three needlesticks is even reported. More than 2,100 health care professionals will incur a needlestick-related injury daily, as estimated by the National Institute for Occupational Safety and Health (NIOSH).4 According to NIOSH, organizational controls are vital in a prevention strategy to curb needlestick injuries to health care workers, including worker training, eliminating unnecessary sharps, and placing disposal containers where sharps are used. The CPC has approved publication of an article entitled Preventing Sharps Injuries in the Operating Room, authored by Ramon Berguer, MD, FACS (CPC member), and Paul Heller, MD. The article was accepted for inclusion in the September Journal of the American College of Surgeons.

**ACS statement**

Surgical technologists are unlicensed assistive personnel who, in many institutions, participate as a member of the surgical team. At present, there are no federal or state requirements for accreditation of surgical technologists or of their training programs. The AORN position statement on unlicensed assistive personnel provides information regarding
supervision of surgical technologists, but does not address the issue of training.5
The Board of Regents recently approved a statement on surgical technology training and certification, authored by the CPC, which is published in this issue of the Bulletin on page 32.

Infection prevention project
Postoperative infection is a major cause of patient injury, mortality, and health care cost. The Centers for Medicare & Medicaid Services (CMS) and the CDC, along with a number of national organizations, including the American College of Surgeons, are working together to develop the Surgical Infection Prevention Project, a national health care quality improvement project to prevent postoperative infection. The project’s goal is to improve the selection and timing of prophylactic antibiotics, both important factors in effective prophylaxis for surgical site infection.

Main objective: To decrease morbidity and mortality associated with postoperative infection in the Medicare patient population

Process objective: To increase the use of the following care processes for surgical patients:
- Antibiotics within one hour before surgical incision.*
- Prophylactic antibiotic consistent with current recommendations.
- Discontinuation of prophylactic antibiotics within 24 hours after surgery.

The national Surgical Infection Prevention Project recently published an advisory statement providing guidelines for antimicrobial prophylaxis for surgical site infection, including specific suggestions regarding antimicrobial selection.6 This information can be obtained on the CPC Web site; and summary information including PowerPoint™ slides can be accessed via the Surgical Infection Prevention Project Web site.7

2004 I.S. Ravdin Lecture
Thomas E. Starzl MD, PhD, FACS, will present the I.S. Ravdin Lecture in Basic Sciences at the ACS 90th annual Clinical Congress on Wednesday, October 13 (1:30-2:15 pm). Dr. Starzl is known to most surgeons as the Father of Transplantation. He is professor of surgery at the University of Pittsburgh School of Medicine, and their transplant program is named in his honor as the Thomas E. Starzl Transplantation Institute.

Dr. Starzl not only laid the groundwork for an entire new field of medicine, but throughout his career he has continued to make among the most significant, landmark advancements in medicine and science—from identifying better ways to control organ rejection to offering novel approaches to enhance understanding of disease process. In more recent years, he has made important discoveries about tolerance, which have completely changed the face and conventional paradigms of transplant immunology. Dr. Starzl has also earned the additional distinction of being one of the most prolific scientists in the world as well as the most cited scientist in the field of clinical medicine.

This year marks the 50th anniversary of the first successful kidney transplant and is the 50th anniversary of organ transplantation, further highlighting this important field of medicine. The United Network for Organ Sharing (UNOS) also celebrates its 20-year anniversary of incorporation this year as an integral part of the U.S. system of organ donation and transplantation. Since the inception of UNOS, nearly 350,000 organ transplants have been performed in the U.S., and more than 200,000 transplant recipients are alive today.8 UNOS has operated the national Organ Procurement and Transplantation Network under federal contract since the network was begun in 1986, and has served as a model for the development of transplant systems worldwide.9

Educational activities
The CPC will sponsor or co-sponsor the following panel presentations at the 2004 ACS Clinical Congress:
- The Operating Room of the Future (G544): Wednesday, October 13, 1:30-3:00 pm.
- Selected Topics in Perioperative Pain Management (G506): Monday, October 11, 10:00 am–12:00 noon.
- Perioperative Care of the Anemic Patient (G556): Thursday, October 14, 9:30 am–12:00 noon.

*Due to the longer infusion time required for vancomycin, it is acceptable to start this antibiotic (when indicated for beta-lactam allergy) within two hours prior to incision.
• Terrorism, Disasters, and Mass-Casualty Events: The Challenge for Surgeons (GS35): Wednesday, October 13, 2:30–5:00 pm (cosponsored with the Committee on Trauma).
• Appropriate Use of Antibiotics (GS29): Tuesday, October 12, 1:00–3:00 pm.
• Operating Room Management for Surgeons (GS19): Tuesday, October 12, 8:00–10:30 am.
• Measurement of Quality in Surgical Care (GS52): Wednesday, October 13, 3:00–5:30 pm.
• Advances in the Prevention and Treatment of Sepsis and Septic Shock (GS11): Monday, October 11, 1:30–4:30 pm.

The committee is also in the process of updating its Web site, and encourages members of the American College of Surgeons to communicate with us regarding content that would be useful to our membership. Contact the CPC at mfitzgerald@facs.org or call 312/202-5319.

References

Applications sought for 2005 Wylie Scholar Award

The Pacific Vascular Research Foundation is accepting applications for the 2005 Wylie Scholar Award in Academic Vascular Surgery. The award was established by the foundation to honor the legacy of Edwin J. Wylie, MD, by providing research support to outstanding vascular surgeon-scientists.

The award is designed to enhance the career development of academic vascular surgeons with established research programs in vascular disease. The award consists of a grant in the amount of $50,000 per year for three years. Funding for the second and third years is subject to review of acceptable progress reports. This three-year award is nonrenewable and may be used for research support, essential expenses, or other academic purposes at the discretion of the scholar and the medical institution. The award may not be used for any indirect costs.

The candidate must be a vascular surgeon who has completed an accredited residency in general surgery and who holds a full-time appointment at a medical school accredited by the Liaison Committee on Medical Educators in the U.S. or the Committee for the Accreditation of Canadian Medical Schools in Canada.

Applications are due by February 1, 2005, for the award to be granted July 1, 2005. Applications may be obtained from the Pacific Vascular Research Foundation’s Web site at www.pvrf.org, via e-mail at info@pvrf.org, or by writing to the Pacific Vascular Research Foundation, Wylie Scholar Award, 3627 Sacramento St., San Francisco, CA 94118.
Claims coding reference and education database

ACS Coding Today features:

– Complete CPT, HCPCS Level II, and ICD-9 codes.

– Current Medicare Correct Coding Initiative bundling edits, national and local fee schedules, and Medicare policy information.

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The only coding database that contains ACS billing and coding tips!

Special discount pricing: Only $199 for the first user, $50 for each additional user—a $590 value!
ACS and SAGES to sponsor joint session at 2005 Spring Meeting

The American College of Surgeons and the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) will sponsor a joint Welcome and Assembly session during the 33rd annual Spring Meeting, which will be held April 16–19, 2005, at the Westin Diplomat Resort and Spa, Hollywood, FL. For the first time, the two organizations will conduct a joint meeting day on Saturday, April 16.

The College and SAGES are cosponsoring this session as part of the 2005 Surgical Spring Week, which is being presented in conjunction with the American Hepato-Pancreateo-Biliary Association (AHPBA). For the first time, the ACS, SAGES, and AHPBA are holding their respective spring meetings in a back-to-back format, thus providing an opportunity for participants to attend each group’s meetings within one trip. The SAGES meeting dates are April 13–16, the AHPBA will convene April 14–17, and the ACS Spring Meeting occurs April 16–19.

ACS Spring Meeting

To emphasize its strong commitment to and support of general surgery, the American College of Surgeons devotes its annual Spring Meeting to the interests and needs of the practicing general surgeon. The objective of the Spring Meeting is to provide practicing surgeons with information so that participants can apply the knowledge acquired to enhance the care of their surgical patients.

The Advisory Council for General Surgery has planned a program for the Spring Meeting that will be of interest to all general surgeons. The 2005 Excelsior Lecture, Primary Hyperparathyroidism: The Changing Surgical Paradigm, will be delivered by Jon A. van Heerden, MB, FACS, FRCS, FRCS(Edin)(Hon), on Sunday, April 17.

A number of skills-oriented postgraduate courses are scheduled over the four days, including: Breast Ultrasound; Vascular Surgery; Minimal Access Surgery; Breast Imaging for the General Surgeons; Charting a Sound Course for Surgical Practices: A Course in Practice Management for Surgeons by Surgeons; Multidisciplinary Approaches to Multisystem Trauma: Issues and Priorities; Mobile and Wireless Computing: Practice Applications; and Mastering Surgical and Office-Based Coding.

Sunday’s program will highlight a number of programs for residents, including Clinical Abstract Submissions from Residents; Spectacular Cases from Residents; and Surgical Jeopardy.

The ACS will be accepting abstract submissions and spectacular cases from residents electronically only; they can be sent via e-mail to Julie Aikins at jaikins@facs.org. The deadline for both submissions is November 26, 2004.

The meeting will be held at the Westin Diplomat Resort and Spa, located on the Atlantic Ocean and Intracoastal Waterway, just 10 minutes from the Fort Lauderdale/Hollywood Airport and 30 minutes from the Miami International Airport.

SAGES accepting abstracts

SAGES will be accepting oral and poster abstract submissions for its meeting during the 2005 Surgical Spring Week online only (video abstracts must be mailed to SAGES along with the actual video). Further information and instructions are available at www.sages.org/abstracts or by contacting the SAGES office at 310/437-0544. The deadline for submission of oral, poster, and video abstracts is September 17, 2004.

Additional information regarding the program and registration will be forthcoming on the College’s Web site at www.facs.org.
Announcing a new instructional CD-ROM

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

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

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

Bariatric Surgery Primer

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

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

American College of Surgeons • Division of Education
with the American Society for Bariatric Surgery
Highlights of the ACS Board of Regents and the ACSPA Board of Directors meetings

June 11-12, 2004

by Paul E. Collicott, MD, FACS, Director, Division of Member Services

American College of Surgeons (ACS)

Following is an update on College programs that were approved or discussed at the June 2004 meeting of the Board of Regents.

Statements

The Board of Regents approved two statements. First, they gave their approval to a revised version of the College’s Statements on Principles, which is available online at www.facs.org/fellows_info/statements/stonprin.html, and will also be available in pamphlet form.

The Board of Regents also approved a Statement on Surgical Technology Training and Certification, which the Committee on Perioperative Care developed with a focus on the training and certification of surgical technologists (see page 32). Accredited programs for surgical technologists vary in length and degree. The statement emphasizes College support of adequate education and training of all surgical technologists.

Scholarships

The American College of Surgeons awards approximately $1.5 million annually in scholarships. At its June 2004 meeting, the Board of Regents approved a new health policy scholarship, fully funded by the College and open to Fellows in general surgery. The Regents also approved three additional cosponsored health policy scholarships: ACS/American Society of Plastic Surgeons Scholarship, ACS/Society for Vascular Surgery Scholarship, and ACS/American Society of Colon and Rectal Surgeons Scholarship. The scholarships will be open to members in good standing of both the College and the cosponsoring society. These scholarships will first become available in 2005. For more information on ACS scholarships, please visit the College’s Research Scholarships, Fellowships, and Awards page online at http://www.facs.org/memberservices/research.html.

Web portal project

The Regents approved a business plan for the College to develop a Web portal for its
members. A Web portal is an electronic information delivery system that allows visitors (that is to say, ACS members) to personalize their own home pages by telling the portal developer what subject areas are of interest to them. It also allows the portal developer to “push” information to its members based on those interests. The main goal of this project is to improve and extend the relationship between the College and its members. The project will unify the various College Web sites into an integrated Internet presence, and it will allow the College’s members to customize what they see when accessing College Web documents and, thus, simplify the process for members to access the information they are seeking online.

Volunteerism site

The Board of Regents approved funding for the development of an ACS surgical volunteerism Web site as the final element of the “Giving Back” project that the Board approved in 2001. Andrew L. Warshaw, MD, FACS, who was Chair of the Governors’ Committee on Socioeconomic Issues at that time, initiated the project as a way of identifying and promoting volunteer programs to which surgeons contribute, as well as to create communication and linkage between those opportunities and surgeons wanting to give a part of themselves back to society.

In 2002, the committee produced a report outlining the results of a membership survey that it had conducted, and in 2003, the committee awarded the first of its Surgical Volunteerism Awards. The awards are given to recognize individuals who make significant contributions to surgical care through organized volunteer activities. This year, the award will be presented to Theodore J. Dubuque, Jr., MD, FACS, a general surgeon from St. Louis, MO, for his international volunteer work in Haiti.

The volunteerism Web site will be developed and directed full-time by Kathleen M. Casey, MD, FACS. Initially, the site will operate through the College’s existing Web site and eventually through the Web portal.

Resident and Associate Society

The Board of Regents approved a name change for the Candidate and Associate Society to better reflect its constituency. Resident and Associate Fellow participation in College activities has grown and changed, resulting in an expanded role for the society. The society is now called the Resident and Associate Society. The society also revised its Bylaws, an action that the Board approved. The revised Bylaws best reflect the current needs, practices, and governance of the society.

Chapter Leadership Conference

In May, the College held a leadership conference in Washington, DC, for its Chapter Officers and Young Surgeon Representatives. The Division of Advocacy and Health Policy arranged for approximately 100 attendees to visit with their legislators as part of the chapter visit program to discuss such issues as medical liability reform, Medicare physician payment, and federal support for trauma systems. (See related article on page 33 of the August 2004 Bulletin.) Largely as a result of these visits, a majority of both House and Senate members signed “Dear Colleague” letters to the Administrator of the Centers for Medicare & Medicaid Services, seeking relief from the Medicare payment crisis.

Public profile

At its February 2004 meeting, the Board of Regents approved, in concept, a business plan to formalize a process for enhancing the public profile and visibility of the College. The Board also approved a proposal to create a steering committee to govern the project. At its June meeting, the Board approved the funding for implementation of the program. The goals of the program are twofold: (1) to increase public awareness of the role surgeons play in patient care and the role of the College as a patient advocate; and (2) to increase Col-
lege members’ and other surgeons’ understanding of issues that are important to the public and how to communicate the surgical community’s concerns.

Area naming request
The Board of Regents approved a request from the Committee on Development to name a specific area of the College headquarters building to honor a Fellow for his or her philanthropy. The first such resolution is as follows:

Be it resolved, that in recognition of his outstanding career of dedicated service to the profession of surgery, and as an expression of gratitude for his philanthropic support, the Board of Regents of the American College of Surgeons hereby declares the twenty-sixth floor, north conference room shall hereafter and for all times be known as the Frank T. Padberg, MD, FACS, Conference Room.

Member benefits
The Job Bank has approximately 350 jobs listed. College members can access the Job Bank through the ACS Members link on the College’s home page: http://www.facs.org.

CJC
The Central Judiciary Committee (CJC) is a Regental committee that handles the general supervision and direction of disciplinary matters under the Board of Regents. The CJC consists of five Fellows, three of whom must be Regents, who are appointed by the Board. The committee has developed and implemented a definitive procedure to handle the complaints that it continues to receive regarding the irresponsible expert witness.

JACS
Timothy J. Eberlein, MD, FACS, became Editor-in-Chief of the Journal of the American College of Surgeons (JACS) earlier this year. The Journal will celebrate its 100th anniversary in 2005, and a new five-year contract with the Journal’s current publisher will take effect on January 1, 2005. The contract brings with it the addition of the printing and dissemination of the Bulletin along with JACS.

The Journal continues to publish all accepted abstracts for the Surgical Forum, presented during the Clinical Congress. This year, 247 abstracts were accepted. As of May 31, 2004, the JACS Online CME-1 program had logged more than 47,000 CME-1 credits at no cost to Fellows of the College. Nearly 7,000 Fellows are now participating in the Web-based program.

AMA
The College’s representatives in the American Medical Association’s (AMA’s) House of Delegates have provided the ACS with a strong presence with the AMA’s decision-making process. The delegation has succeeded in passing resolutions addressing policy issues of interest to surgeons and has significantly increased the participation of surgeon delegates in the surgical caucus.

Strategic planning
The Board of Regents heard reports from the directors of the various ACS areas and divisions on their plans and goals for the next five years. This type of strategic planning is an important and ongoing process for the Board of Regents. Following is a summary of the reports presented.

Ms. Cynthia A. Brown, Director, Division of Advocacy and Health Policy, listed the following opportunities that exist for her division:
• Expand the College’s practice management activities.
• Strengthen workforce analysis and policy development programs.
• Hire a policy analyst with strong statistical and data management skills.
• Move to a larger, modern, more conveniently located facility in Washington, DC.
• Expand the benefits offered to chapters, and augment state advocacy services.
Direct more resources to informing the public about the College’s work to improve patient care.

Ms. Linn Meyer, Director of Communications, listed programs that are needed in her area:
- Establish a formal “Committee on Issues” to identify topics of importance to the public and to develop official position statements on those matters.
- Communicate those positions to all College constituencies.
- Expand and intensify current efforts to communicate vigorous activities in standard setting, quality measurement, and quality improvement.
- Reinstate the national advertising program.
- Develop and expand the content of the Web portal for Fellows, and the Web site for others.
- Enhance efforts to harness and employ all existing and evolving communications vehicles.

Ajit K. Sachdeva, MD, FACS, Director, Division of Education, listed the following potential programs for his area:
- Develop and implement a comprehensive and modular Continuing Surgical Education Curriculum for practicing surgeons.
- Develop and implement a multidimensional education program on the Internet for practicing surgeons.
- Develop and implement a comprehensive program of experiential courses, preceptorship, and monitoring of outcomes.
- Establish a national comprehensive education/skills center.
- Establish a network of regional ACS-accredited education/skills centers.
- Establish national program for verification/certification of the knowledge and skills of surgeons.
- Develop and establish a national program for accreditation of institutional programs.
- Develop and implement a comprehensive patient education program in surgery.

Mr. Howard Tanzman, Director, Information Technology, listed the needs in his area:
- Personalized/targeted communications; single sign-on.
- The ability to access College resources anywhere/anytime.
- E-learning capabilities.
- Outcomes measurement.
- E-communities.
- Informatics in daily practice/practice Internet-based medicine.

Timothy J. Eberlein, MD, FACS, Editor-in-Chief, Journal of the American College of Surgeons, listed the following goals for JACS:
- Become the best surgery journal in the world.
- Enhance the reputation of JACS with improved quality.
- Increase impact factor.
- Provide the College with increased advertising revenue.
- Provide the College with increased international subscriptions and members.
- Increase the number of revenue-sharing supplements to JACS.
- Capitalize on the benefits of Clinical Congress and solicit additional manuscripts for publication.
- Complete and refine seamless E-publishing.

Paul E. Collicott, MD, FACS, Director, Division of Member Services, outlined the following goals for his division:
- Dedicate an annual budget item for retention and recruitment.
- Generic College “Exhibit” with staff to attend national surgical meetings, especially when Executive Director is on the program.
- Increase visibility and recognition of “FACS” publicly and professionally.
- Automatic free first-year membership for all surgical residents.
• Automatic transition from Resident membership to Associate Fellow membership.
• Recognition of training programs with 100 percent enrollment.
• Recognition of group practices with 100 percent enrollment.
• Consider hiring full-time individual as a recruiter for all membership categories.
• Recognition of volunteer recruiters.
• Increase relevancy of Clinical Congress to ACS membership.
• Increase Health Policy Scholarships to include all specialties within College.
• Provide Selected Readings and Surgery News free of charge to all Resident members.
• Provide management services for chapters when requested.

R. Scott Jones, MD, FACS, is the Director of the Division of Research and Optimal Patient Care. Cancer, Trauma, and the Office of Evidence-based Surgery (OeBS) are housed within this division:

Cancer:
• Improve use of the National Cancer Data Base (NCDB).
• Establish standards of cancer care.
• Emphasize quality improvement and safety.
• Support cooperative groups, such as the American College of Surgeons Oncology Group.
• Facilitate cancer programs’ public reporting.
• Support education programs.
• Support Commission on Cancer and American Cancer Society.
• Expand Approvals Program.

Trauma:
• Improve use of the National Trauma Data Bank™ (NTDB™).
• Emphasize quality improvement and safety.
• Support education programs.
• Expand Approvals Program and Trauma Systems.
• Promote research.

Office of Evidence-Based Surgery:
• To become Continuous Quality Improvement Unit, and house:
  — An Office of Best Evidence to accumulate, assimilate, and communicate best evidence.
  — An Office of Outcomes to lead the ACS National Surgical Quality Improvement Project (NSQIP) and collaborate with the NCDB and NTDB.
  — An Office of Surgical Innovation to monitor new technology, new techniques, and new knowledge, and to develop new programs.
  — An Office of Clinical Trials to develop infrastructure research grant acquisition and management and sustain scholarly inquiry and research proposal writing. This office also would establish a Surgical Research Promotion Unit to:
    1. inform the surgical profession about how today’s research is promoting the quality of tomorrow’s care;
    2. set standards, establish curricula, provide organization and structure and general oversight for research, education, and training;
    3. enhance career development in research;
    4. define and maintain optimal surgical research workforce; and
    5. establish better communications with leaders of the National Institutes of Health.

The Board was asked to evaluate and rank the potential programs and activities that were discussed. The evaluations will be collected, collated, and analyzed; afterward, the results will be shared within the College’s leadership, and follow-up will occur in October.

American College of Surgeons Professional Association (ACSPA)

A number of programs for medical liability education and advocacy efforts have been conducted under the auspices of the ACSPA. Generally speaking, those programs are aimed directly at Fellows and their patients...
and are conducted by the ACSPA. Other activities are carried out through Doctors for Medical Liability Reform (DMLR), of which the ACSPA is a member. Some of the ACSPA liability activities are as follows:

- Patient education brochures were distributed to Fellows last fall.
- Campaign-style lapel buttons, “Will a surgeon be there?” were designed and distributed. The buttons were intended to facilitate dialogue between surgeons and patients about the impact that the liability crisis is having on access to high-quality care.
- Planned distribution of reprints of pertinent articles from consumer magazines and newspapers that surgeons can place in their waiting rooms.
- ACSPA joined with the ACS Mississippi Chapter to fund a newspaper ad campaign across the state during the legislature’s special session. The session was called to put pressure on members of the Mississippi House of Representatives who have been stalling reform efforts. A similar ad was placed in a New Jersey paper last fall to support a “House Call” public education campaign on liability issues.

Following are some of the DMLR activities:

- Campaign launched in February that ran 30-minute television news magazines in Washington State and North Carolina. DMLR plans to run a similar campaign in South Carolina and Georgia during the summer. Filming has also taken place in Florida, Illinois, and Pennsylvania.
- Newspaper advertising, Web sites, and other public relations efforts are being used to put pressure on senators who have opposed medical liability reform. National ads have been placed in the Wall Street Journal and USA Today. Local ads have appeared in the Washington Post, Seattle Post-Intelligencer, and Roll Call.

The advertisements received considerable attention. In testing the effectiveness of the message points, research indicated refinements that can be made in future ads, and confirmed that the television news magazines were particularly effective. Plans are under way to raise and dedicate political action committee (PAC) funds from the member organizations to direct toward more politically focused print advertisements.

So far in the 2003-2004 election cycle, the ACSPA-SurgeonsPAC raised $331,500 in contributions from approximately 1,250 members. The PAC Board continues to raise funds through a variety of venues. The telephone education and fund-raising program that began in late April collected $44,000 in pledges in the first two weeks.

Also in the 2003-2004 election cycle, the ACSPA-SurgeonsPAC donated to the election campaigns of 77 candidates and leadership PACs. The PAC Board of Directors concluded that participating in the 2004 political party conventions in July and September would be beneficial to surgery. Members of the PAC’s President’s Circle and ACSPA leaders had the opportunity to attend the July Democratic National Convention in Boston, MA, or the late-August Republican National convention in New York, NY. The ACSPA-SurgeonsPAC is currently working with three other medical organizations to plan health care events at the conventions.
CME ONLINE

Web casts of select sessions

The Division of Education of the American College of Surgeons is making sessions from Spring Meeting 2004 and Clinical Congress 2003 available online at: www.acs-resource.org

Spring Meeting 2004

GS01) Assembly for Surgeons
   A Town Meeting-Facing The Inevitable Surgical Quality And Outcomes Made Public
   Moderator: Shukri F. Khuri, MD, FACS

GS04) Genetics And Cancer: Implications For Surgeons
   Moderator: Murray F. Brennan, MD, FACS

GS05) Excelsior Surgical Society/Edward D. Churchill Lecture
   Optimal Management of Pancreatic Cancer
   Lecturer: Andrew L. Warshaw, MD, FACS

Clinical Congress 2003

GS02) The Role of Surgery for Peptic Ulcer Disease in the Helicobacter pylori Era
   Moderator: Bruce E. Stabile, MD, FACS

GS05) New Technology: What’s Proven, What’s Not
   Moderator: Christopher K. Zarins, MD, FACS

GS06) Recognition, Management, and Prevention of Operating Room Catastrophes
   Moderator: Christopher R. McHenry, MD, FACS

*GS08) Acquiring Skills to Perform New Procedures: Principles, Challenges, and Opportunities
   FREE OF CHARGE
   Moderator: Ajit K. Sachdeva, MD, FACS, FRCSC

GS13) Key Issues in Management of Rectal Cancer
   Moderator: David A. Rothenberger, MD, FACS

GS16) Sentinel Lymph Node Biopsy for Breast Cancer
   Moderator: Armando E. Giuliano, MD, FACS

GS18) Groin Pain Management
   Moderator: Robert J. Fitzgibbons, Jr., MD, FACS

*GS21) Patient Safety
   FREE OF CHARGE
   Moderator: Frank C. Spencer, MD, FACS

GS29) Management of Necrotizing Pancreatitis
   Moderator: Andrew L. Warshaw, MD, FACS

GS36) Unexpected Findings at Laparoscopic Cholecystectomy
   Moderator: W. Scott Melvin, MD, FACS

*GS37) American College of Surgeons and the Core Competencies: Innovative Approaches for a New Era
   FREE OF CHARGE
   Moderator: Ajit K. Sachdeva, MD, FACS, FRCSC

GS47) Operative Techniques for Bad Situations
   Moderator: David V. Feliciano, MD, FACS

MD07) Postoperative Enterocutaneous Fistulas
   Moderator: Herand Abcarian, MD, FACS

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*GS10) Patient Safety
   FREE OF CHARGE
   Moderator: Frank C. Spencer, MD, FACS

For more information, contact Dawn Pagels at dpagels@facs.org.
Earlier this year the American College of Surgeons’ Committee on Trauma partnered with Cognos Corporation, the maker of Enterprise Business Intelligence Software. Cognos makes several tools to search within data warehouses, as well as tools to create data “cubes” based upon the desired output. Cubes are optimized data sets that enable users to quickly perform analyses on specific sets of data points.

According to any standard dictionary, the mathematical definition of the word “cube” is the third power of a number or quantity. Cubing a number takes any number and rapidly increases its value. The National Trauma Data Bank™ is a very large data warehouse to start with. By applying sophisticated software such as this we have created a user-friendly interface to provide rapid descriptive information that would otherwise require an understanding of database query language to accomplish.

The cube presorts data to allow multiple dimensions (variables) to be examined at one time. PowerPlay, the name for this Cognos product, enables you to analyze data over the Internet directly from any Web browser. Imagine that there is a Rubik’s Cube® of data that is eight columns by eight columns by eight columns. This cube has been pre-fashioned using some of the Cognos data tools. The individual user accesses this “cube” over the Internet and by utilizing PowerPlay software is able to take this cube and manipulate these columns of data. These data can then be formatted in tabular form or in one of several types of graphic output.

This is an extremely powerful tool that is currently available online. There is an interactive demonstration cube available on the NTDB Web site. If you go to www.ntdb.org and look for the rectangle on the right-hand side of the page, you will see the link to NTDB online. There are online instructions as well as a short tutorial. Data are powerful, and to the third power, data are exponentially more powerful.

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 new 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.