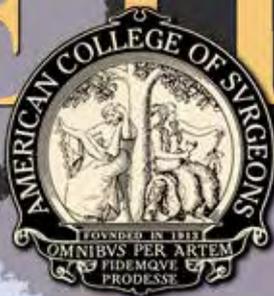


# BULLETIN

AMERICAN COLLEGE OF SURGEONS



July 2005  
Volume 80, Number 7

**RAS-ACS**  
addresses  
residency issues

# BULLETIN

AMERICAN COLLEGE OF SURGEONS



JULY 2005  
Volume 90, Number 7

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**On the cover:** *The Resident and Associate Society of the American College of Surgeons (RAS-ACS) addresses issues pertinent to residents in a series of articles on pages 9-26. (Photos courtesy of Punchstock.)*

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## Future meetings

### Clinical Congress

- 2005** San Francisco, CA,  
October 16-20  
**2006** Chicago, IL,  
October 8-12  
**2007** New Orleans, LA,  
October 7-11

### Spring meeting

- 2006** Dallas, TX,  
April 30-May 3  
**2007** Las Vegas, NV,  
April 22-25  
**2008** To be announced

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

**Space sold by Elsevier**

# From my perspective

I am delighted that for the second year in a row, the *July Bulletin* is devoted largely to issues of importance to, and the activities of, the members of the Resident and Associate Society of the American College of Surgeons (RAS-ACS). This group is a vital component of the College that represents the future of this organization and of our profession in general. In the following pages, members of the RAS and ACS President Edward R. Laws, MD, FACS, address the following issues of relevance to young surgeons: unity in surgery, ACS member benefits, the College as a forum for collaboration, truncated surgical training, and volunteerism.

In addition to providing our younger members with this annual forum for communicating with their colleagues of all ages, the College is working harder than ever to be an organization that represents the interests and concerns of young surgeons, as well as those of more seasoned professionals. This objective has not always been at the top of this organization's priority list. It was only a few years ago that the College formed the Candidate and Associate Society, which evolved into the RAS-ACS just last year to better reflect the inclusiveness of the group.

One of the initial goals of the RAS-ACS was to provide opportunities for residents and Associate Fellows of the College to be exposed to the leadership structure of the College. To this end, the College has designated seats on many of its standing committees for members of the RAS-ACS. We intend to extend RAS-ACS representation to nearly all College committees within the next year or two so that young surgeons will have an even greater voice in advocacy and policymaking decisions that affect them.

## **Broadening influence**

Over the last year, the RAS-ACS has, indeed, become an increasingly influential body, initiating a range of programs and activities that will prepare young surgeons to navigate the changing health care system and to define the evolving leadership role of the next generation of surgeons.

For example, our annual Spring Meeting is truly becoming a major forum of the surgical resident. In fact, the RAS-ACS sponsored the following three sessions Sunday, April 17, at the 2005 Spring Meeting: Clinical Abstract Presentations by Resi-



**“The RAS-ACS is a vital component of the College that represents the future of this organization and of our profession in general.”**

idents, Spectacular Cases from Residents, and Surgical Jeopardy. Furthermore, this year's Spring Meeting included a Life After Residency program designed to arm senior residents with the skills and knowledge they will need to negotiate contracts, examine job offers, and prepare for and register for American Board of Surgery certification. This program will be offered again next year to fourth- and fifth-year residents in any surgical specialty.

The Clinical Congress also features special programs aimed at medical students and residents. In addition, the RAS-ACS sponsors an annual symposium during the Clinical Congress. The topic at the upcoming meeting in San Francisco, CA, will be Truncated Training for the Surgical Resident—The Future or Fallacy?

We are also developing a special curriculum for residents in their first postgraduate year that will appeal to all future surgeons, regardless of their specialty interest. This special curriculum is sched-

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uled to become available in 2007 and will incorporate much of the information published in *ACS Surgery: Principles and Practices*, which is currently available online at no charge to Resident Members of the College.

The RAS-ACS is collaborating with the Division of Education to develop other courses that are relevant to resident education. Some concepts under consideration include a Residents As Managers program that would provide trainees with the skills they need to be successful chief residents and to make the transition to becoming attendings. We also intend to offer a course for residents on conducting research and a RAS-sponsored plenary session at the Clinical Congress.

Moreover, the Regents recently approved the establishment of an American College of Surgeons Foundation, which is intended to raise money to support the organization's education, research, and patient safety programs. Through this foundation, we hope to increase and possibly even double the amount we award in scholarships to residents and young surgeons.

The RAS-ACS is also crafting a resident area of the College's Web portal, which will be pilot-tested this summer. Through its quarterly electronic newsletter, *RAS-ACS News*, the group invited Resident and Associate members to submit their ideas for the content for their area of the Web portal. Future issues of the newsletter will continue the dialogue between the RAS-ACS leadership and membership about what information should be communicated through this area of the Web portal, in addition to tools that will allow surgeons to keep case logs and records of their CME activities online.

### ***Increasing membership***

I am happy to report that membership in the RAS-ACS continues to grow, demonstrating how welcome the College's outreach to residents and other young surgeons has been. To stimulate the involvement of all young people who are interested in pursuing a surgical career, the College is waiving membership dues in the RAS for individuals in their first year of postgraduate training. To ensure member retention, the RAS-ACS is working on strategies to maintain the involvement of more senior residents and to facilitate the transition from Resident Member to Associate Fellow status.

All members of the RAS-ACS receive free subscriptions to the *Journal of the American College of Surgeons*, the *Bulletin*, *ACS NewsScope*, and, of course, *RAS-ACS News*, in addition to free online access to *ACS Surgery*. RAS-ACS members receive the following other benefits as well: free registration at the College's Clinical Congress and Spring Meeting, reduced pricing for the Surgical Education and Self-Assessment Program, information on clinical and research fellowship opportunities, access to the College's job and resume data bank, and eligibility for ACS-sponsored insurance programs.

For all the reasons outlined in this column and given the issues described in this special edition of the *Bulletin*, I believe that program directors should encourage residents to join the RAS-ACS. Our future truly rests in their hands, and we must equip them with the capabilities they will need to secure it. The RAS-ACS seeks to be the best resource available to all surgical residents who are preparing to take our profession, as well as the College, into the future.



*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).

*Announcing the ACS Foundation*

# The future of patient safety just got even brighter.



The new ACS Foundation will underscore the vital role that surgeons play in benefiting society by enhancing and extending life for patients of all nationalities, creeds, and economic levels. It will help surgery continue to advance and make a positive difference in people's lives for many generations to come.

The American College of Surgeons Foundation invites you to take an active and visible role in

continuing to expand research, increasing efforts to enhance patient safety, and doubling scholarship and fellowship funding. We have initiated a program for recognizing significant gifts either publicly or privately. More importantly, there will be no administrative overhead applied to gifts to our Foundation. So, 100% of your donation will actually go to the support of our programs.

*Leading the Challenge to Meet the Need*

*To learn more about the American College of Surgeons Foundation, programs it supports, and opportunities for recognizing your commitment to the advancement of surgery, please call Fred W. Holzrichter, Chief Development Officer, at 312.202.5376 or visit our Web site at [www.facs.org](http://www.facs.org).*



# Dateline Washington

prepared by the Division of Advocacy and Health Policy

## **CMS issues guidance on EMTALA care for aliens**

The Centers for Medicare & Medicaid Services (CMS) issued final guidance on May 9 regarding the use of funds set aside to help hospitals and other providers recoup some expenses incurred when providing care to undocumented aliens under the Emergency Medical Treatment and Active Labor Act (EMTALA). Provisions in the Medicare Prescription Drug Improvement and Modernization Act set aside \$1 billion in funding through 2008 for these services. Under the final rule, the money may be used to cover all medically necessary and appropriate services that physicians furnish to EMTALA patients in both inpatient and outpatient hospital settings, as well as related ambulance services. Although each state will receive federal funding, six states with relatively high numbers of undocumented aliens—California, Texas, Arizona, New York, Illinois, and Florida—will receive larger dollar amounts.

According to the announcement, providers will be able to claim payment for emergency services furnished to eligible patients on or after May 10, once the single contractor responsible for enrolling providers and processing claims nationwide has been designated. All claims must be filed electronically within 180 days of the end of the federal fiscal quarter in which the services were provided. Also of interest, CMS dropped an earlier, controversial proposal to require hospital staff to ask patients directly about their citizenship or immigration status. Information on the program and the new guidance material can be found at <http://www.cms.hhs.gov/providers/section1011/>.

## **Congress continues to review Medicare payment issue**

On May 12, Reps. Clay Shaw (R-FL) and Ben Cardin (D-MD) introduced H.R. 2356, legislation to reform the method used to determine Medicare payments to physicians. H.R. 2356 would repeal the current sustainable growth rate (SGR) methodology, which will cut physician payments by an estimated 4 to 5 percent annually for the next seven years. Instead of the SGR, H.R. 2356 would determine physician payments using the Medicare economic index, which is based on annual changes in physicians' costs to care for patients. While organized medicine views these provisions as the ultimate goal of Medicare physician payment reform, passage of the bill this year is unlikely because of its estimated \$150 billion budget impact.

Meanwhile, Sens. Jon Kyl (R-AZ) and Debbie Stabenow (D-MI) introduced S. 1081, which would provide temporary relief to the Medicare payment crisis. Instead of replacing the current system, the Senate bill would legislate across-the-board payment updates based on inflation in 2006 and 2007.

In related activity, the American College of Surgeons sent a letter on April 22 to the chairs and ranking Democratic members of the key congressional committees that are considering options for addressing the problems in the Medicare physician fee schedule. The letter explains that reduced reimbursements, coupled with increasing expenses, are putting the viability of surgical practices in jeopardy. The letter notes that, unlike other physicians, surgeons cannot recover lost revenue by increasing volume and that the quantity of surgical services has remained relatively stable over the years. The College urged Congress to stop the scheduled Medicare payment reductions from taking

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## **CMS clarifies volunteer faculty payment rules**

effect. The full text of the letter can be viewed at <http://www.facs.org/ahp/views/sgr.html>.

CMS has posted information on its Web site clarifying Medicare direct medical education (DME) payment rules for residency training outside the teaching hospital environment. Answers posted for nine frequently asked questions about payment and documentation policies pertaining to volunteer faculty might interest surgeons.

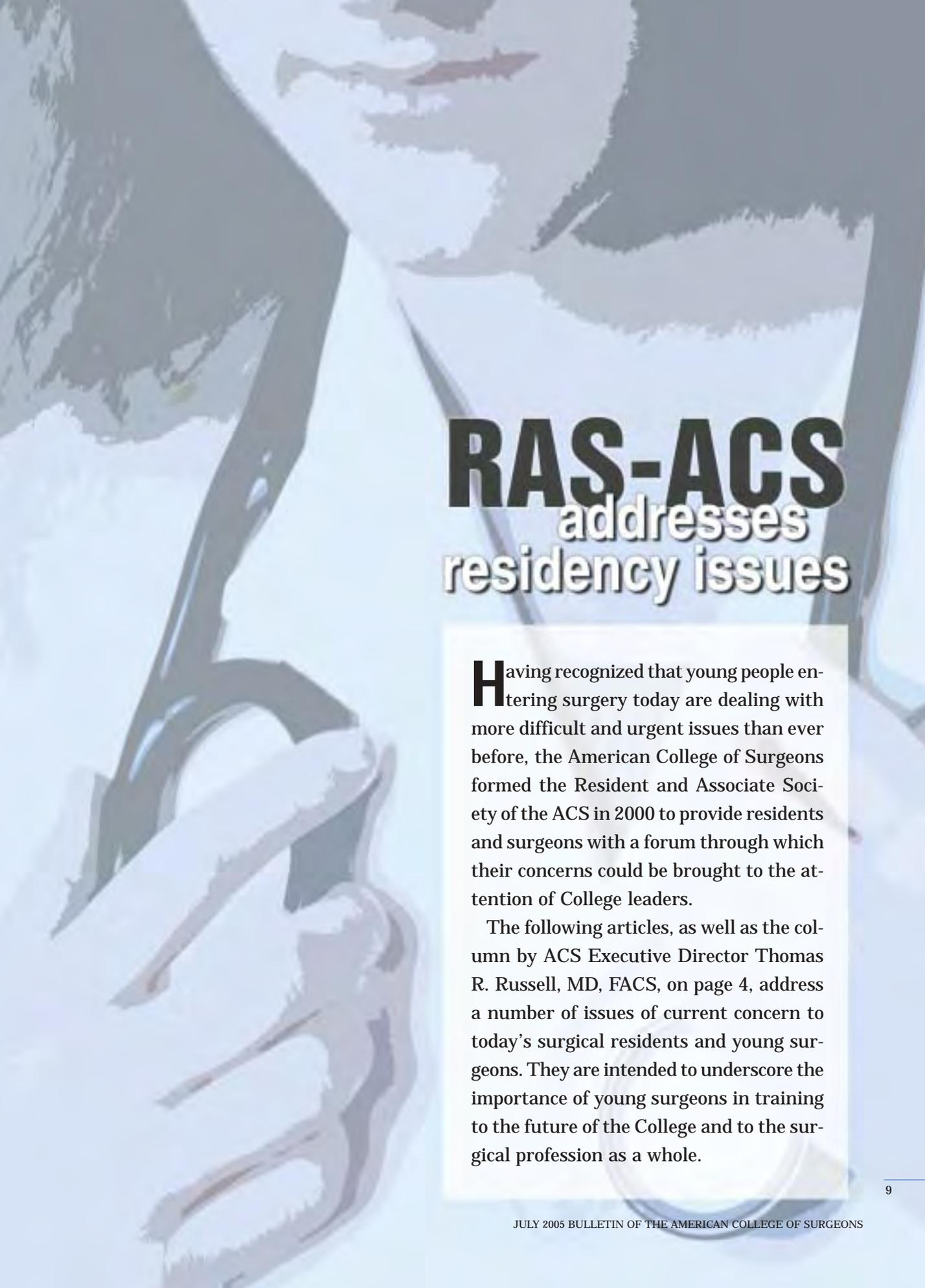
On the Web site, CMS notes that to receive DME payments, teaching hospitals must incur all or most of the direct costs of training a surgical resident in a nonhospital setting. If the outside facility or volunteer teaching faculty incurs costs, the hospital must sign a written agreement to cover those costs to receive payment for them. The agency goes on to state that costs include such items as a portion of a teaching physician's salary and fringe benefits and travel and lodging costs of the residents. Historically hospitals have been reluctant to pay for the costs of off-site training. For more information, go to <http://www.hhs.gov/providers/hipps/non-hospQA.pdf>.

## **Hospital pay-for- performance program applauded**

Premier, Inc., a nationwide alliance of about 1,500 not-for-profit organizations, announced May 3 that a demonstration project on hospital pay-for-performance offers promising evidence that financial incentives may improve quality of care. The CMS/Premier Hospital Quality Incentive Demonstration Project tracks hospital performance using a set of 34 nationally standardized and widely accepted quality indicators and pays annual incentives to top performers among the more than 270 participating hospitals. In just one year, the median performance composite score for all hospitals increased by 7.5 percent, according to the release. The five clinical focus areas of the project include acute myocardial infarction, coronary artery bypass graft surgery, heart failure, pneumonia, and hip and knee replacement surgery. CMS Administrator Mark McClellan, MD, PhD, echoed the findings, concluding that limited performance-based payments can improve quality of care while lowering Medicare program costs.

During the first year of the program, hospitals scoring in the top 10 percent of these quality measures receive a 2 percent point bonus on the Medicare payments for each condition. Those in the second 10 percent receive a 1 percent bonus, while hospitals remaining in the top 50 percent are recognized for their quality. At the end of the first year, static baselines will be set for the top 10 and bottom 20 percent. Any hospitals below the 20 percent bottom baseline at the end of the three-year demonstration will face a 2 percent payment penalty, while those remaining in the bottom 90 percent will receive a 1 percent penalty.

In addition, the U.S. Department of Health and Human Services launched a new Web site April 1 that provides patients with access to comparative hospital performance information on specific quality measures pertaining to heart attack, heart failure, and pneumonia. The Web site, <http://www.hospitalcompare.hhs.gov>, contains government-verified data voluntarily provided by the hospitals themselves.



# RAS-ACS addresses residency issues

**H**aving recognized that young people entering surgery today are dealing with more difficult and urgent issues than ever before, the American College of Surgeons formed the Resident and Associate Society of the ACS in 2000 to provide residents and surgeons with a forum through which their concerns could be brought to the attention of College leaders.

The following articles, as well as the column by ACS Executive Director Thomas R. Russell, MD, FACS, on page 4, address a number of issues of current concern to today's surgical residents and young surgeons. They are intended to underscore the importance of young surgeons in training to the future of the College and to the surgical profession as a whole.



# RAS-ACS promotes unity in surgery

by  
Danielle A. Katz, MD,  
Syracuse, NY



**W**hy should I be a member of the American College of Surgeons? This is a question surgeons, especially those who are in surgical specialties, often ask, and it first arises during residency.

## ***Benefits of membership***

The short and easy answer is that membership offers numerous tangible benefits. For residents, these benefits include free registration for the Clinical Congress, free access to *ACS Surgery* online, free subscriptions to the *Journal of the American College of Surgeons* and the *Bulletin*, reduced rates on the Surgical Education and Self-Assessment Program, free access to the online job bank, discounts on surgical textbooks, and more. The ACS also offers numerous educational programs, and, for general surgeons, it is the primary source of such activities.

However, the College also offers significant educational opportunities for surgeons in other specialties. Postgraduate courses at the Clinical Congress span the spectrum of surgical fields. Furthermore, courses that are relevant to all surgeons, regardless of specialty, include courses on the Accreditation Council of Graduate Medical Education competencies (especially practice-based learning and systems-based practice), the 80-hour workweek, and coding and reimbursement, to name just a few. One ACS course currently under development focuses on the concept of residents as managers and aims to provide trainees with the tools they need to be better chief residents and practicing surgeons.

But there are even better, more lasting reasons to join. The Resident and Associate Society of the College (RAS-ACS) provides an avenue for residents and young surgeons to become actively involved in the organization—to become a part of a community of surgeons. This

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community cultivates and supports opportunities in numerous arenas, including education, research, administration, and politics. Interaction with other surgeons from different regions, backgrounds, and specialties allows for cross-pollination of ideas and approaches that may lead to innovative solutions to problems. The RAS-ACS provides innumerable occasions for surgeons to learn from and collaborate with one another with regard to a wide variety of issues, ranging from new pieces of knowledge to new techniques to volunteerism opportunities and beyond. These types of interactions help us to achieve our collective goal—to provide the best possible care to our patients.

### **Common concerns**

Several issues are relevant to all surgeons, such as the concerns about patient safety that have come to the fore in public discussions about health care. This issue affects all surgeons, across boundaries. Several national organizations (including the American College of Surgeons, the American Society of Anesthesiologists, the Association of Operating Room Nurses, and the Joint Commission on Accreditation of Healthcare Organizations) have been addressing questions about patient safety and the means to improve it. The development and implementation of the National Surgical Quality Improvement Program has been a great step toward objectively assessing surgical practice and patient care. Surgeons must continue to work together to take the lead in assuring the safety and optimal care of our patients.

Professionalism in medicine, and surgery in particular, also is receiving increasing attention from the public. Several surgical organizations have promulgated statements concerning expert witness testimony, indicating the desire of surgeons to take responsibility for maintaining high quality and ethical behavior in this area. Professional, civil behavior is expected both in and out of the operating room. Upholding such standards of professional conduct improves the work environment and increases the credibility of surgeons among colleagues, administrators, patients, and the public.

Surgeons share concerns about many political issues. Escalating liability premiums are changing practice patterns and the geographic distributions of specialists, which, in turn, may significantly influence patient access to care.

Related to this topic is tort reform. Several states now have put caps on noneconomic damages in malpractice lawsuits. Surgeons need to continue to make their voices heard and help legislators understand the impact of their policies on the many facets of medical care.

The growing uninsured and underinsured population within this country is an ongoing challenge. It is imperative that surgeons play an integral role in developing a solution to this problem. If surgeons fail to come together and speak with one voice to help shape the answers to these types of questions, they are likely to find the outcome unsatisfactory.

### **One voice**

The American College of Surgeons strives to be the voice of surgery as a whole. It is impossible for the organization to achieve this goal without input from each of its components. That is why all surgeons, from all specialties and across all types of practices, should get involved. For residents, the first step is to join the RAS-ACS. Get involved. Make your voice heard. Begin to develop the leadership skills necessary to help guide the future of surgery.

When surgeons across all specialties can come together to work toward a common goal, the possibilities are limitless. We have the power to secure the best possible care for our patients and to guide the future of our profession, and we have a responsibility to work together to achieve these aims. □

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*Dr. Katz is assistant professor of orthopedic surgery, State University of New York Upstate Medical University, Syracuse, and Chair of the RAS-ACS.*



# Benefits of ACS membership to specialty surgeons

by  
Edward R. Laws, MD, FACS,  
Charlottesville, VA

**M**any of you know that the theme for my year as President of the American College of Surgeons has been one of unity in surgery. As the fifth neurosurgeon to become President of this marvelous organization, I am particularly sensitive to the issues of surgical specialty representation within the College. While we are all proud of the expertise that exists in the various specialties and subspecialties, we must remember that we all have similar roots in general surgery. We acknowledge our debt to the discipline of surgery, its basic concepts, techniques, and rewards, and the common infrastructure of surgical science. Currently we enjoy an atmosphere of collegiality and teamwork, which are essential aspects of successful operative procedures and successful patient care. We all share a focus on the patient and the inspiring challenge of confronting and correcting disease.

The American College of Surgeons provides a collegial forum in which to share goals and frustrations. It offers support for medical students, interns, and residents in every area of surgery. The College's list of benefits, accomplishments, and resources is lengthy, but I would like to highlight certain aspects of access to the College for

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young surgeons and resources that exist in the College for all of surgery, including the specialties.

### **Access for young surgeons**

- Medical Student Program at the Clinical Congress.
- Resident Membership and Associate Fellow Membership in the ACS.
- Local representation in ACS chapters.
- Organizational representation through the young surgeons and the ACS Governors who represent all specialties in surgery.
- Participation in the Surgical Forum.
- Attendance at the Clinical Congress, Spring Meeting, and ACS courses in practice management, surgical techniques, surgical education, leadership, clinical trials, and Advanced Trauma Life Support.<sup>®</sup>
- Self-assessment and continuing education opportunities, exemplified by the Surgical Education and Self-Assessment Program, the Clinical Congress, and the *Journal of the American College of Surgeons*.
- Multispecialty aspects of the *Journal of the American College of Surgeons* and the *ACS Bulletin*.
- ACS Web site and upcoming Web portal.
- Participation in the development of evidence-based surgery, patient safety initiatives, and quality and outcome improvement programs.

### **ACS resources**

- Local, state, and federal advocacy activities mediated by the Washington Office and the American College of Surgeons Professional Association and the chapters.
- Verification and standard-setting activities, including cancer programs and the National Cancer Database; trauma programs and the National Trauma Data Bank<sup>™</sup>; and the American College of Surgeons Oncology Group for clinical trials in the treatment of surgical oncological disease.
- American College of Surgeons publications.
- Public relations programs of the American College of Surgeons.
- Scholarships and fellowships for residents and young surgeons.

It is evident that the American College of Surgeons works diligently and with great vigor to provide young surgeons with a large variety of career development opportunities. We hope young surgeons appreciate these activities and become involved in them for the advancement of patient care and for enhancement of the goals of surgery for all of us who practice the art and science of our challenging discipline. 

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**Dr. Laws** is W. Gayle Crutchfield Professor of Neurosurgery, University of Virginia, Charlottesville, and the 85th President of the American College of Surgeons.





# The College as a forum for collaboration

by Joshua Rosenow, MD, Chicago, IL

**W**e are entering a new era of surgical training and practice. Those of us who trained before work-hour regulations were instituted will be partners and colleagues with surgeons who performed their residencies under the new system. Academic faculty must contend with the increasing pressure to obtain funding, while reimbursements decline and house staff assistance grows scarcer. The relationship between resident and faculty is undergoing a wholesale reassessment, as is the entire system of graduate medical education that gave rise to the title of “resident.” Overhead and liability costs are spiraling upward, while payment is heading downward. Never have surgeons, especially young ones, had a greater need for an organization like the American College of Surgeons.

When I was a neurosurgical resident, the chair of the department introduced me to the College because of my intent to become involved in organized medicine. My first ACS meeting was dominated by an effort to produce a statement regarding the then-imminent work-hour regulations. Though the debate was often rather contentious, we came together as surgeons with a common goal—to preserve the quality of resident training and to provide patients with the best care possible. One message stood out: the leadership of the College was truly counting on our group to produce something they could work with. Since then, the Resident and Associate Society of the ACS (RAS-ACS) has continued to explore issues of importance to young surgeons, such as the relationship between residents and staff, the length of surgical training, and family leave for residents.

The changes in practice and training that have occurred and continue to evolve make involvement in the College more relevant today than ever. Much of what we are experiencing now is uncharted territory. No one has decades of experience in surgical practice under the conditions we now face. The ACS provides a forum for young surgeons from all specialties to share ideas and work together. An orthopaedic program in Texas may have just the

solution to the workforce problems that the otolaryngology program in Pennsylvania has been experiencing. College organizations such as the Committee on Trauma coordinate national policy and research on issues of importance to all surgeons. The National Trauma Data Bank™ and the American College of Surgeons Oncology Group allow surgeons from multiple disciplines to collaborate on scientific endeavors while the Clinical Congress provides a forum for the presentation of the results of those efforts.

For many years, medicine has been a rather fractious profession. Such fragmentation has only served to reduce our influence in Washington, DC. Many of the surgical subspecialties have relatively few members, limiting their legislative influence. Through involvement in an umbrella organization like the College, our numbers are greater, which increases our clout and enables surgeons to be proactive and shape the debate. This strength becomes ever more important as issues such as pay-for-performance programs, tort reform, and negative Medicare payment updates come to the fore.

The College is the one forum that allows all surgeons opportunities for collaboration, leadership development, and advocacy. Through the College, we speak with one voice. □

**Dr. Rosenow** is a neurosurgeon at Northwestern University Medical Center, Chicago, IL, and serves on the Executive Committee of the RAS-ACS.



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**S**ome leaders are born. Their natural inclination to take charge of situations is evident at a tender age, and they seem to spend their childhood waiting for their turn to lead. Some leaders are made. Their skills are carefully crafted through hours of diligent preparation.

Leaders take many forms: leaders who have natural charisma and magnetism that draw others to follow them; leaders so deluded by their title that their inadequacies escape the attention only of themselves; leaders who are benevolent and whose strength lies in maintaining peace and good favor; leaders who are dictators and use compulsory compliance to mask their lack of negotiation skills; leaders who are lame ducks and are half-heartedly tolerated until retraining or dismissal relieves the organization of this weight; and leaders who are visionary, successfully impart a shared vision onto the group, and inspire each individual. We are exposed to all of these types of leaders in the field of surgery and remain hopeful that the visionary within each of us will develop.

### ***Insights***

Insight into the current state of leadership training in surgical residency can be gained by examining the origins of our leaders. Claude H. Organ, Jr., MD, FACS, Immediate Past-President of the American College of Surgeons (ACS), pondered this issue. As a result, he presented his related study during his presidential address to the Southwestern Surgical Congress in 1985. To identify the top echelons of American surgery, he and others developed a model based on a point system according to 15 positions of influence in the field of surgery (such as prominence in the College, the American Board of Surgery, and that board's Residency Review Committee; chairs held within the National Institute of Health's surgery study section, surgical societies, or departments of surgery; or editorships of major surgical journals or textbooks) held between 1945 and 1985.<sup>1</sup> Of the 460 surgeon leaders he identified, 8 percent accumulated 30 percent of the assigned points. Based on this point system, 7 percent of the 72 institutions analyzed

## **Not your father's specialty:**

### **Preparing Residents and Associates for collaborative leadership**

by **C. Suzanne Cutter, MD,**  
Flushing, NY,

and **Jeffrey S. Upperman, MD, FACS,**  
Pittsburgh, PA



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contributed 47 percent of the leadership appointments.

Were these leaders somehow compelled to train at these institutions? Were these institutions better skilled at preparing leaders? The author was asked, “Was there an interlocking pattern of friendship, discipline, or institutions in this leadership?” We may not be able to answer these questions definitively, but the track records of the institutions identified in this study are difficult to dispute.

It would be interesting to revisit Dr. Organ’s analysis at this time since both the breadth and nature of surgical leadership have changed. Who are the contemporary leaders in surgery? Politics is a burgeoning pursuit for surgeons as evidenced by: the successes of Senate Majority Leader Bill Frist, MD, FACS (R-TN); the recent election of freshmen members of Congress who are also Fellows of the College, including Reps. Tom Price (R-GA), Joe Schwartz (R-MI), and Charles Boustany (R-LA); and the appointment of Vice-Admiral Richard H. Carmona, MD, FACS, as surgeon general. Nancy Snyderman, MD, FACS, and Sanjay Gupta, MD, FACS, entered the field of broadcast journalism, and are now well-known national medical correspondents. With the emergence of translational research, an increasing number of well-funded surgeons are contributing to our field as accomplished physician-scientists. In what ways can leadership training prepare residents for these vocations?

### **Leadership characteristics**

To design and develop leadership programs, we must first establish a definition of leadership and determine the characteristics of a leader. This is not a trivial task. Most dictionaries attempt to define leadership in terms of an office held or a capacity filled. Wiley W. Souba, MD, ScD, MBA, has devoted considerable effort to analyzing leadership in surgery. He says that focusing on who is in charge is no longer adequate, asserting that “Leadership is created in and emerges from the relational space that connects people—accordingly, leadership development involves building high-quality connections between people.”<sup>2</sup> Leadership is about building and leveraging professional relationships to accomplish the objectives of an organization, its leaders, or other members of the group.

Representatives of the American Association of Medical Colleges authored a text on academic medi-

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“It is better to lead from behind and to put others in front, especially when you celebrate victory when nice things occur. You take the front line when there is danger. Then people will appreciate your leadership.”

—Nelson Mandela,  
1993 Nobel Laureate

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cine that includes an entire chapter on leadership as collaboration. The authors stated, “Now, however, a more relational model of leadership is emerging—one that conceptualizes leadership as collaborative, as about making sense together of the unknown and making meaning in a community of practice. This model means that not only do leaders require cognitive knowledge (know-what) and advanced skills (know-how); they also need an understanding of systems (know-why) and self-motivated creativity (care-why).”<sup>3</sup>

Last July, Toby Cosgrove, MD, FACS, a cardiovascular surgeon, was named chief executive officer of the Cleveland Clinic. When interviewed shortly after his appointment, Dr. Cosgrove said that he would “devote all of my abilities to the success of this organization and the patients it serves. But I will need everyone’s help to keep the Clinic moving forward. As we act as a unit, the possibilities are endless.” The threads that link each of these individual insights together are the character traits of the leader. These traits were aptly described during antiquity by Sun-tzu as wisdom, integrity, humanity, courage, and discipline.<sup>4</sup>

While it is difficult to impart character traits on any individual beyond childhood, each of us can be trained to lead. However, the contemporary surgical training environment is far different from that of many of the surgery faculty who may design the curriculum. Patients are exercising their autonomy

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as never before and arrive at office visits armed with data and questions. Also, some surgeons find that their role is being marginalized due to the increased use of invasive nonsurgical procedures performed by other specialists. These changes are altering the physician-patient relationship. However, in many cases, the results are positive.

### **Recent progress**

The College and other organizations have taken a proactive posture in encouraging leadership skills in surgeons. The close of the 2003 Clinical Congress signaled the start of the College's "Year of the Resident." During the subsequent 12 months, residents were welcome to participate in College governance by holding seats on standing committees and closely interacting with the Board of Governors. Recently, the ACS hosted a course on leadership for Fellows. Perhaps this program could be expanded to include residents, as does the upcoming ACS Chapter Leadership Conference. These activities provide Resident and Associate Members with instructive exposure to conflict resolution, negotiation skills, consensus building, and compromise. Similarly, the Association of Academic Surgeons (AAS) and the College will cosponsor a seminar entitled *The Tough Work of Leadership* during the 2005 Clinical Congress. Next winter, the AAS will hold an interactive training module entitled *Fundamentals in Leadership* at the Academic Surgical Congress 2006.

Clearly, these programs are timely, insightful, and enriching to all surgeons, but are they sufficient to meet the needs of surgeons in training? Both faculty and residents at certain institutions have pondered this question and determined that residents need more leadership training than they receive.

Recently, Baylor Medical Center developed and administered a survey to determine residents' perspectives on the importance of key leadership skills as well as their individual competence in each of those skills.<sup>5</sup> More than 50 percent believed they lack competence in leadership skills. According to these residents (greater than 75% of respondents), ethics was the only skill area in which they believed they possessed more than minimal competence. These authors call leadership training a mandate. Leadership action was also described similarly in a recent review of the literature, which assessed the state of pediatric surgery training in the U.S.

and made recommendations on its reformation. In the final analysis, "persistent, bold, proactive leadership" was considered a mandate that will benefit physicians, patients, and their families. Baylor has now developed a "novel educational curriculum" for leadership training.<sup>6</sup> This curriculum has proven successful in the environment of the 80-hour work week by establishing very specific objectives and criteria for evaluating the curriculum.

Other medical specialties have already adopted leadership training for their residents. At the Cleveland Clinic, internal medicine interns participated in a one-day teambuilding and leadership training retreat. Post-retreat questionnaires indicated "significant increases in attendees' agreement that good leaders challenge the process, make decisions based on shared visions, allow others to act, recognize individual contributions, and serve as good role models."<sup>7</sup> Psychiatrists and pediatricians have had similar successes.<sup>8,9</sup> These examples indicate a perceived need for leadership training in surgery and that a formal curriculum may be effective.

### **Leveraging requisite variety**

Even with these strides at the national and local levels, an aspect of leadership development has been neglected. Periodically, we need to glance around our institutions and medical centers to notice our patterns for selecting new colleagues to join our teams. Is the diversity of the organization limited to administrative and ancillary staff? Have we opened ourselves to interactions and collaborations with individuals from other genders and ethnic groups?

The College, surgical programs, and medical institutions have demonstrated their openness to gender diversity but could do more to promote ethnic diversity. Examples of how women are gaining acceptance in the leadership of surgery include the election of Kathryn D. Anderson, MD, FACS, as President-Elect of the College, the inclusion of women on the ACS Board of Governors and Board of Regents, the appointment of women as department chairs and program directors at several institutions, and the acceptance of women into subspecialty fellowships. Nevertheless, the College believes that more can be accomplished, as evidenced by a recent study conducted by Olga Jonasson, MD, FACS, in cooperation with the College to determine whether the number of women in leadership roles in surgery is proportionate to their presence in the

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field. Although women comprise 14 percent of surgeons listed in the American Medical Association Physician Master File, they fill only 2 to 4 percent of leadership positions in national surgical societies, represent 4.6 percent of ACS Fellows, and hold less than 7 percent of the director seats of the certifying boards of the American Board of Medical Specialties.<sup>10</sup>

The representation of African-Americans, Latinos, and other ethnic groups is less impressive. The historic and recent elections of LaSalle D. Leffall, Jr., MD, FACS, and Claude H. Organ, Jr., MD, FACS, illustrate the College's efforts. Yet, the American Association of Medical Colleges noted that of the 9,366 surgical faculty in 2004, only 3 percent were black, 4 percent were Hispanic (Cuban, Mexican, Puerto Rican, and multiethnic), and 0.14 percent were Native American.<sup>11</sup> Although declining enrollment of these underrepresented ethnic groups in U.S. medical schools does contribute to the problem to some degree,<sup>12</sup> many of these individuals would excel in positions of leadership. To do so, however, these individuals will need both mentoring and support. Embracing ethnic diversity as a resource remains an undervalued and underutilized avenue for competitive advantage, growth, and success. The reasons for this apparent lack of insight and the accompanying insufficient action remain unclear.

Dr. Souba speaks of observing the "Law of Requisite Variety," which tells us that survival is dependent on the capacity to move beyond tolerance of diversity and heterogeneity and actually cultivate and embrace them. "The organization should

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// It unsettles most people to think that a changeless God imposes a changing pattern of our understanding.... //

Z.V. Kanisseril  
and M.A. Kaallumpram<sup>13</sup>

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always try to maximize its internal variety (or diversity)" because it "equips the organization to deal with change."<sup>2</sup> In general, surgery follows these principles. Our institutional boards often comprise individuals from disparate health care and non-health care backgrounds. Likewise, our operating room teams are composed of both physicians and nonphysicians. The potential for growth and success is a by-product of this structured conflict. Heterogeneity does lead to conflict, and many of us view conflict as a negative experience and, unfortunately, the process of resolution as a contest. Dr. Souba points out that, "Organizations and teams that learn to harness conflict and use it constructively come up with better solutions and more creative ideas."<sup>2</sup>

### ***Perfecting preparation***

Our profession faces the challenge of finding a way to adequately prepare surgeons and surgical residents for positions of leadership, whether within the academic institution or beyond its walls. This preparation must simultaneously advance an agenda of competence, compassion, and courage, while embracing the diversity that is very slowly permeating surgery. This diversity is more reflective of the communities from which we draw our patient base.

The topic of leadership and preparation of future leaders in the field of surgery is timely at this juncture. Surgery is under enormous external and internal pressures, including dictates from managed care organizations, a malfunctioning tort system, and reduced reimbursement from Medicare and other payors. Recent additional pressure has come from the heirs apparent of the field: medical



**Dr. Cutter** is a general surgery resident at New York Hospital Queens, Flushing, NY, and Co-Chair of the RAS-ACS Communications Committee.

students and residents. A much vilified 80-hour work week has made it more challenging to use current systems to deliver health care and declining enrollment in surgical residency programs has made the future uncertain. Collectively, these forces have squeezed much of the luxury out of the surgical lifestyle, instigated decreased job satisfaction, added more stress to the working environment, and, in some instances, have led to an exodus into new endeavors or retirement.

### **From dialogue to action**

We find that inclusion of this topic in the ongoing dialogue with the College membership and constituency is essential. Thus, we leave you with what we believe are provocative thoughts that may lead to measured action to alleviate some of the challenges to budding surgical leaders.

- We need to reflect on and process sociopolitical issues that affect surgeons when determining how best to train young surgical faculty.
- The current medical environment poses new challenges to the profession, and we need a diverse group of surgeons to confront these obstacles.
- The standard criteria for selecting and process for developing surgeon leaders are outmoded. New approaches that embrace diversity are needed to address the unique forces confronting our specialty.
- It is important to maintain access to the knowledge and wisdom of more experienced College members while encouraging and developing the talents of Residents and Associates.

We hesitate to become the voice of the proverbial voiceless. However, we do hope that our observations will stimulate further discussion. There are signs that others are likewise interested in expanding the literature related to surgical leadership. The value of such written contributions will be evidenced by individuals who are thereby compelled to act. Each surgeon would benefit from a sense of purpose for the present combined with a prophetic concern for the future. 

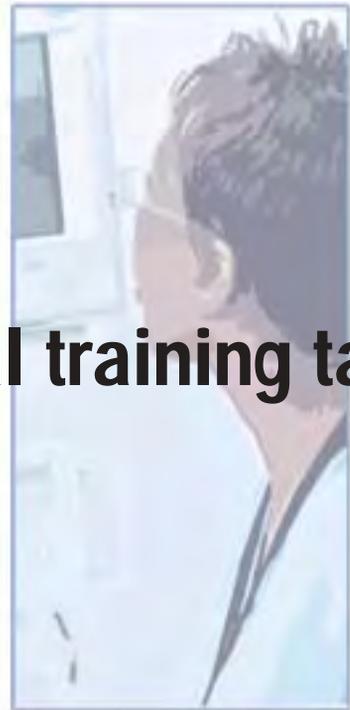
### **References**

1. Organ CH Jr: The interlocking of American surgery. An analysis of surgical leadership in the United States, 1945 through 1985. *Am J Surg*, 150(6):638-649, 1985.

2. Souba WW: New ways of understanding and accomplishing leadership in academic medicine. *J Surg Res*, 117(2):177-186, 2004.
3. Bickel J, Croft K, Marshall R: Developing Leaders in Academic Medicine. In: *Enhancing the Environment for Women in Academic Medicine* (online). Washington, DC: American Association of Medical Colleges, 1996.
4. Sun-tzu: *Sun-tzu: The Art of War: The First English Translation Incorporating the Recently Discovered Yin-ch' ueh-shan Texts/Translated with an Introduction and Commentary by Roger T. Ames*, First ed. New York, NY: Ballantine Books, 1993.
5. Itani KM, Liscum K, Brunnicardi FC: Physician leadership is a new mandate in surgical training. *Am J Surg*, 187(3):328-331, 2004.
6. Awad SS, Hayley B, Fagan SP, et al: The impact of a novel resident leadership training curriculum. *Am J Surg*, 188(5):481-484, 2004.
7. Stoller JK, Rose M, Lee R, et al: Teambuilding and leadership training in an internal medicine residency training program. *J Gen Int Med*, 19(6):692-697, 2004.
8. Steiner JL, Mazure C, Siggins LD, et al: Teaching psychiatric residents about women and leadership. *Acad Psychiatry*, 28(3):243-246, 2004.
9. Lee MT, Tse AM, Naguwa GS: Building leadership skills in paediatric residents. *Med Educ*, 38(5):559-560, 2004.
10. Jonasson O: Leaders in American surgery: Where are the women? *Surgery*, 131(6):672-675, 2002.
11. American Association of Medical Colleges: Table 16: Sex, Race/Hispanic Origin, and Department. In: *U.S. Medical School Faculty, 2004*. Washington, DC: AAMC, 2004.
12. Ford HR: Mentoring, diversity, and academic surgery. *J Surg Res*, 118(1):1-8, 2004.
13. Kanisseril Z, Kaallumpram M: *Glimpses of Mar Thoma Church History*, First ed. New Delhi, India: Kalpana Printing House, 2003.

**Dr. Upperman** is a pediatric surgeon at Children's Hospital of Pittsburgh, PA, and Immediate Past-Chair of the RAS-ACS.





# How long should surgical training take?

by Juan Carlos Paramo, MD,  
Miami Beach, FL

**T**he implementation of the 80-hour workweek in American residency programs has aroused significant debate within the surgical community regarding the length of surgical training. Currently, surgical residents have to be trained more efficiently in less time and are expected to provide perfect, error-free care once they graduate into the real world of surgical practice.

## ***Cultural changes***

The surgical culture has transformed as well. The motivations to pursue a surgical career have changed. There is a team rather than individual approach to patient care. Residents' expectations are now different, with lifestyle quality being an important determinant of career choices among medical graduates and an increasing priority for the emerging generation of surgeons.

Although many residents today have demonstrated a growing unwillingness to train for many years, most do want to pursue subspecialty training. Those individuals who currently opt for a surgical career now face dramatic differences in atti-

tudes, expectations, and the way they are perceived by the already established surgical family.

The younger generations of surgeons who go into practice have to deal with the current professional liability crisis, decreased reimbursement, and the public's expectations of state-of-the-art care as a *sine qua non*. Becoming a good surgeon is a complex, lengthy process, especially when new quality-assessment tools are being instituted with a continually growing emphasis on patient safety.

## ***How long?***

It is in this changing environment that some have questioned how long general surgery training should take. As the clinical experience obtained by

residents decreases with the 80-hour workweek, it has been suggested that the traditional five years of residency are too few to create proficient surgeons, and that additional years of training are necessary. But in reality, is five the magic number of years required to learn the art of surgery? Experience garnered through decades of training general surgery residents tells us that it is. Yet, from a purely technical standpoint, how many cases does one really need to perform to be proficient? Defining mandatory basic skills is difficult because a surgeon is more than a technician. The development of a resident into a competent surgeon requires much more than just exposure to a certain number of cases.

A well-rounded surgeon has a very complex set of competencies, including pristine ethics and a vast fund of knowledge about when, how, and why to operate, as well as when and why not to do so. The principles of general surgery are broad and extensive. Whatever the cost, we cannot lower our training standards and sacrifice the quality of prospective surgical graduates. Just as inadequate raw materials will create an inadequate end product, inadequate training will create inadequate surgeons. Minimum requirements are necessary so that when residents go into surgical practice, they feel comfortable dealing with the diverse types of cases and situations they will encounter in their communities. Hence, no one knows with certainty how long it will take for residents to achieve this level of expertise.

A different issue arises for those surgeons who pursue academic careers. These very dedicated individuals reinforce their training and experience with research and laboratory work, significantly lengthening their years of postgraduate education. With the current work-hour limitations, those residents who want to be the surgical educators of the future may ultimately require even longer training periods than the ones currently in place.

Because of the time constraints associated with the current system, more efficient methods of educating residents are being developed. Surgical residency programs are using the laboratory as a learning tool, virtual reality simulation training, and a modular curriculum. Experience gained from the military as well as from the airline industry proves that practice makes perfect. This totem can be applied to surgical training through the use of simu-

## RAS-ACS symposium to address these issues

The Resident and Associate Society of the American College of Surgeons (RAS-ACS) symposium at the 91st Clinical Congress in San Francisco, CA, will explore the question of “Truncated training for the surgical resident—The future or fallacy?” The session will take place Sunday, October 16, 1:00 to 4:00 pm.

Each year the RAS sponsors a symposium on a topic targeted at surgery residents and young surgeons. This year’s presentation will examine the issue of training for residents proceeding to surgical specialties. The aim will be to provide insight into the future of surgical training and how truncated training would affect the trainees, training programs, and patients. Attention will be paid to the possible advantages and pitfalls of reducing the number of years a surgical specialist has to train. The discussion will also focus on the effects of altered training on limited work hours, long-term finances, and family life.

The objective of the annual symposium is to discuss topics that not only challenge the College currently but that may also affect the future. The symposium this year will consist of four speakers, who will offer opinions on both sides of the issue to generate maximum discussion. Each panel member will speak for 20 minutes and will take questions at the end of the entire session.

This year’s panel includes Barbara Bass, MD, FACS, a Regent and the current chair of the American Board of Surgery. She will start the discussion by giving us her insights into both the short- and long-term impact of truncated training. To help us understand the pitfalls of this type of training, Lawrence Levin, MD, FACS, will share with us the experiences of the plastic surgery division at Duke University Hospital, Durham, NC. A third speaker will discuss the reasons why vascular surgery has adopted truncated training as the primary mode of training young surgeons. Finally, Amit Kumar, MBBS, a vascular surgery fellow at Rochester (NY) University, will give the trainees’ perspective.

Attendance is open to all RAS members as well as all residents, fellows, and medical students. An open-microphone discussion will promote audience participation.

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lators that provide limitless opportunities to practice in a safe environment. Surgical residents may need to complete homework assignments in order to fulfill their academic requirements.

Subspecialty training raises different issues. Some surgical subspecialties are attempting to implement fast-track specialization. This perspective is rooted in the assumption that training pathways that focus on core topics related to that subspecialty will provide similar, if not better, education in less time.

But, again, how much training does one really need in order to be surgically proficient in a subspecialty? Despite individual differences in performances, both from an academic and practical standpoint, general surgery training is a core precursor pathway that is necessary to provide the fundamental basis of surgical knowledge and technique. It provides the common grounds and standards for the creation of a strong platform from which additional specialized training may progress.

How long this basic general surgery training should take varies according to subspecialty, with some requiring completion of a full five-year program before additional subspecialty training begins. Some people have challenged this approach, and the current standards required to enter certain subspecialties, such as plastic, cardiac, thoracic, vascular surgery, and others, may disappear in the future. Whether it is possible to learn surgical principles and technique regardless of the case is a subjective question. Likewise, how a general skill can be transferred into a specialty-specific skill varies according to the individual surgeon. But, do you need to be a “super-pluri-potential” general surgeon before going into a subspecialty? Is reduced training time for specialists a disaster waiting to happen? Are we weakening surgical training and sacrificing quality by letting all these changes happen?

### **Demand versus need**

There is a public demand for subspecialized surgeons, the best in their field. But, in reality, there is a public need for well-rounded general surgeons, especially in rural communities. Arbitrarily creating a line that divides fundamental from specialty training is impossible. Surgery cannot be compartmentalized; yet, for example, if your area of interest is breast surgery, do you really need to be profi-

cient in trauma and transplantation? Is performing a pancreatectomy relevant to a plastic surgeon? Does a cardiac surgeon need formal training in colorectal surgery? Which skills are truly necessary and transferable?

These questions present surgical educators with an enormous challenge as to how we deliver the necessary skills and knowledge to the next generation. Lowering standards to fit lifestyles is unacceptable, especially in an era of surgical quality improvement programs, possible pay-for-performance, the growing predominance of volume as an indicator of quality, and the persistent liability crisis. Inadequate training will initiate a domino effect that will yield significant consequences for the future of surgery.

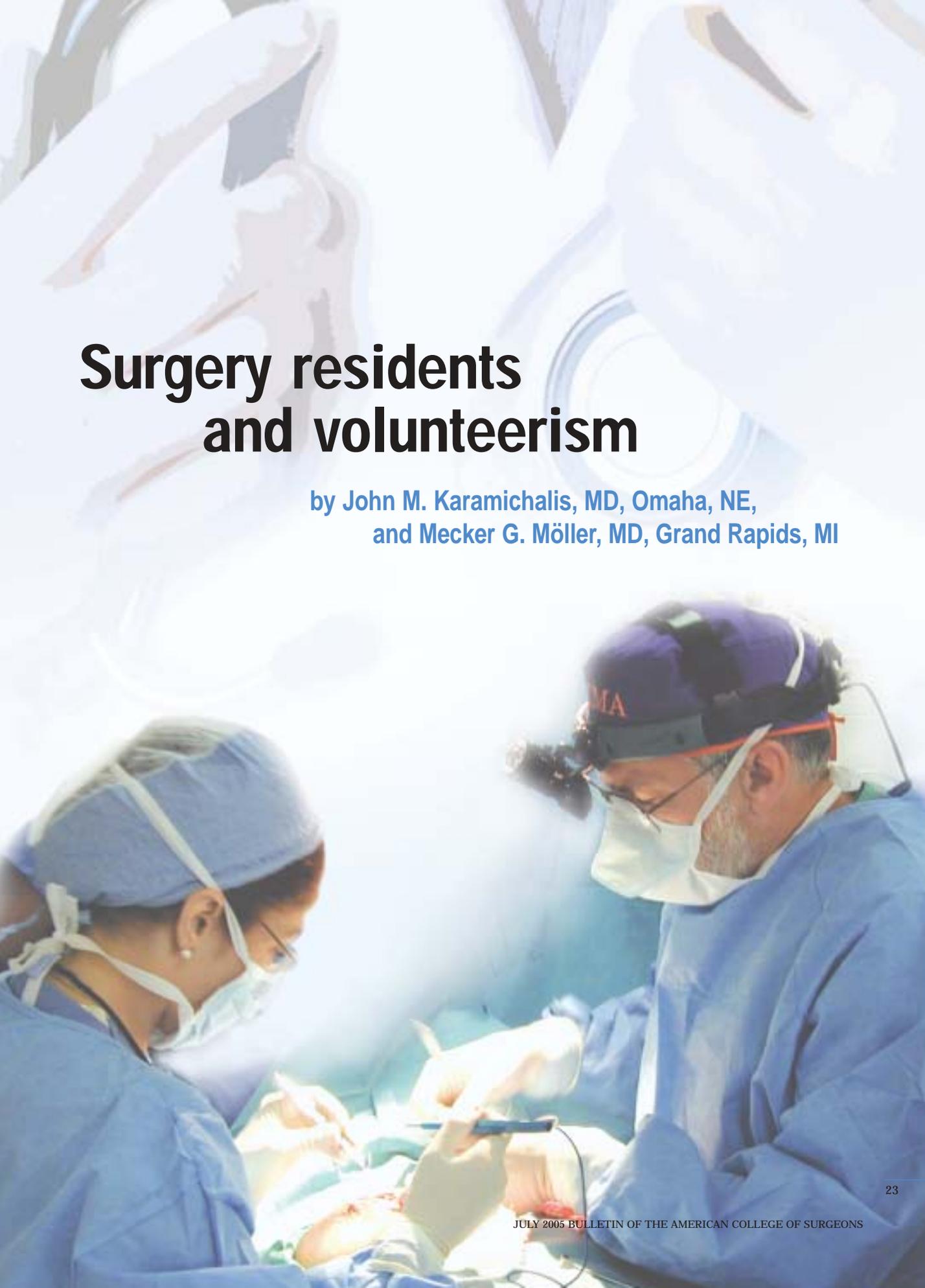
I consider myself an old-fashioned young surgeon. I believe training is a lifelong effort and part of a never-ending contract with our patients. Yes, all surgeons are not created equal, but, even accounting for individual differences, surgeons are natural-born leaders. We cannot turn back. Changes are here to stay. What we need to do is adapt to the new culture, modify the current teaching schemas, and defy the present challenges with quality and patient safety as our endpoints, while maintaining the fundamental values of surgery.

Today’s surgical residents and young surgeons are the future of our profession. The important task is to instill the motivation, dedication, honor, service, respect, honesty, responsibility, and other core values of our profession in the new generation, regardless of how long their training takes. □

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**Dr. Paramo** is a surgical oncologist at Mount Sinai Medical Center, Miami Beach, FL. He is the Co-Chair of the Communications Committee of the RAS-ACS.





# Surgery residents and volunteerism

by John M. Karamichalis, MD, Omaha, NE,  
and Mecker G. Möller, MD, Grand Rapids, MI

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// You make a living by what you get,  
but you make a life by what you give. //

—Winston Churchill

It was another hot morning in the small town of Valladolid, located on the Yucatán peninsula of México. It was 7:00 am and already hundreds of people were standing in long lines, hoping to be seen in our improvised clinic in an old school on the edge of the city.

From babies to elders, our patients had been waiting since dawn. Many of them walked three or four hours from their villages to be seen by the American physicians. The women were dressed in colorful Mayan outfits, their skin tanned from many years under the sun. We received hundreds of shy smiles while making our way to the clinic. Many of the elderly patients only spoke Mayan; the youngsters helped to translate in rudimentary Spanish. We learned that some of the adolescents refused to speak Mayan to avoid possible discrimination from the “mestizos.” Translating to English was sometimes a challenge.

Some patients told us candidly of their long wait to receive medical care. Many times they had to choose between paying for their travel expenses to town or feeding their children. Some patients had advanced medical problems that we could only help by listening to them and giving them medication for symptomatic relief. We made arrangements for those individuals with advanced bone problems to see a group of orthopaedic surgeons who were coming months later. Those patients needing surgical treat-

ment were sent to the local hospital, where we had set up two operating rooms.

### ***Rewarding experience***

Almost every year, a couple of residents from our residency program use their vacation time to participate in medical mission trips like this one arranged through International Medical Assistance, and many others have traveled to Africa and Vietnam through other organizations. Some surgeons and residents have brought their children along to instill in them the spirit of giving and compassion and to expand their view of the world. Throughout the years, surgeons and residents from all over the country have volunteered their time and resources to help the underserved; this article describes just one more of those experiences.



The crowd of patients waiting on the first day.

Overleaf: Dr. Bruce Bonnell (right) and Dr. Möller performing an operation in Valladolid.

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From October 1 to October 15, 2001, we were two surgical residents working as part of the team of surgeons, anesthesiologists, and nurses from different parts of the U.S. spending two weeks on this mission trip. They were two intense weeks filled with satisfaction. We had the opportunity not only to operate, but to serve as scrub nurses, circulators, and occasionally as anesthesiologists, giving conscious sedation. We learned to improvise when the surgical tools we needed were unavailable and to economize on supplies. We also learned to appreciate the work done by those people who prepare an operating room suite. We mopped the floor and washed and sterilized the equipment for the next surgical day.

For us, this mission became a life-changing opportunity not only to provide care, but to truly understand the nobility of our profession. This

experience stimulated our growth as human beings, our respect for other caregivers, and our drive to continue making a positive change in the world around us. The best reward at the end of the day was knowing that our hands helped to change somebody's life, hopefully for the better. The sincere gratitude in our patients' eyes, their humble smiles, and their uncountable hugs, brought us closer to humanity and were the greatest gifts we received during those weeks. When we look back on this mission trip, we realize that our patients gave us even more than we gave them.

There are numerous opportunities in this country and around the world for surgeons to get involved in missionary programs. 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



Dr. Möller with a baby she delivered.



Dr. Oreste Romeo and Dr. Möller washing instruments.



Medical staff with the “post-op ladies”—patients who had cholecystectomies, breast lumpectomies, hysterectomies, and other general surgery operations.

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activities reminds us of why we chose medicine as a career.

As members of the human race, our real need is to serve and not to be served, for it is in service to others, not in the materialism and individualism so prevalent in our Western culture, that lasting rewards come.

Volunteerism is of pivotal importance to the College and to many of its members and, hence, the subject has attracted much attention in recent years. In recognition of the importance of volunteerism and the contributions many surgeons make, and after closely examining the extent of volunteer involvement among members of the College, the Board of Governors’ Committee on Socioeconomic Issues launched “Operation Giving Back” (OGB). The findings from their study demonstrated the great breadth and depth of involvement and underscored the fact that many surgeons consider volunteerism an integral component of their professional identity.

Under the direction of Kathleen M. Casey, MD, FACS, OGB serves as a comprehensive resource center for surgeons investigating volunteer oppor-

tunities. The OGB is intended to educate and inspire those organizations and individuals interested in surgical volunteerism: volunteer agencies, philanthropists, policymakers, the public, and so on.

The Resident and Associate Society of the ACS hopes to encourage resident participation in volunteer activities by providing information about both domestic and international surgical opportunities. Supervised residency electives may provide advanced insight into such issues as health policy, cultural and economic influences on health care, and potential career paths, as well as broader exposure to surgical approach and pathology. The benefits from volunteerism during surgical training are tremendous. □

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**Dr. Karamichalis** is a chief resident in general surgery, University of Nebraska Medical Center, Omaha, NE, and a member of the RAS-ACS Executive and Education Committees.

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**Dr. Möller** is a fourth-year resident in general surgery at Michigan State University, Grand Rapids, MI, and a member of the RAS-ACS Communications Committee.

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**O**n March 29, 2005, ACS Executive Director Thomas R. Russell, MD, FACS, and ACS Regent and Trauma Consultation Committee Chair Brent Eastman, MD, FACS, convened a meeting of the surgical specialty societies to discuss emerging issues regarding the surgical workforce and the future of emergency and trauma care. The purpose of this gathering was to initiate a dialogue among the specialties regarding the nationwide problem of inadequate surgical specialty coverage for emergency care. Participants also sought to determine the potential leadership roles of the specialty societies and the College in confronting this challenge.

Although the organizations did not agree on one clear path for solving the problem, they did reach a general consensus regarding the many factors that have contributed to it and on a range of options that merit further review. This article summarizes highlights of the discussion.

## *ACS and surgical specialty societies review emergency workforce issues*

*by Geoff Werth,  
Government Affairs Associate,  
Division of Advocacy and Health Policy*

### PHYSICIAN WORKFORCE CRISIS

According to Edward Salsberg, director of the Center for Workforce Studies at the Association of American Medical Colleges (AAMC), the science of forecasting physician supply and demand is still evolving, but it is apparent that earlier predictions of an oversupply of specialists and an undersupply of primary care physicians missed the mark. Despite improvements in methodology, however, current efforts to forecast both supply and demand remain hampered by the following factors: uncertainty about the future role of international medi-

cal school graduates, retirement patterns among the growing number of woman physicians, lifestyle demands of younger physicians, the future role of nonphysician providers, and the ability to retrain physicians in practice.

To meet the anticipated significant increase in demand for physicians, the AAMC recommends a 15 percent increase in medical school graduations by 2015. To meet this goal, the AAMC suggests the following: (1) eliminating the cap on the number of residents that Medicare graduate medical education payments support; (2) expanding public and private research and analysis; (3) provid-

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ing medical students with up-to-date data and information for career plans and specialty choice; and (4) promoting efforts to address the needs of underserved areas and populations through an expansion of the National Health Service Corps and other efforts to develop a diverse workforce. Mr. Salsberg explained that important policy questions for the specialty societies will continue to emerge as the physician workforce evolves to meet increasing demand.

#### SPECIALTY ON-CALL COVERAGE

James Mitchiner, MD, FACEP, representing the American College of Emergency Physicians (ACEP), presented information on emergency department overcrowding and specialty coverage.

Dr. Mitchiner explained that the updated 2003 Emergency Medical Treatment and Active Labor Act (EMTALA) regulations remain a contentious issue between hospitals and physicians. These regulations have had a paradoxical effect on access, leading to reduced specialty on-call coverage and increased “dumping” to tertiary hospitals. Surveys that the California Medical Association and the U.S. Department of Health and Human Services Inspector General conducted have indicated that the on-call problem is somewhat serious for certain specialties, notably plastic surgery, neurosurgery, neurology, and thoracic surgery. According to the 2000 American Medical Association Physician Marketplace Report, 61 percent of general surgeons and 33 percent of surgical subspecialists report giving EMTALA-mandated care during a typical week. Bad debt related to this care is significant: 27 percent of total bad debt for general surgeons and 17 percent for subspecialists.

Dr. Mitchiner described the following options for hospitals attempting to meet the EMTALA on-call regulations: (1) enforce on-call responsibilities; (2) hire specialists/“hospitalists” for specific on-call duties known as “exclusive contracts”; (3) pay per diem stipends; (4) guarantee reimbursement per case or per relative value unit; (5) institute a hybrid model that includes a stipend and a payment guarantee; (6) offer hospital-paid medical liability coverage; and/or (7) require emergency department on-call service as a condition for obtaining hospital privileges.

#### IMPACT ON TRAUMA CENTERS

J. Wayne Meredith, MD, FACS, Chair of the ACS Committee on Trauma, discussed the specialty coverage problem and its effect on trauma centers. Dr. Meredith described the trauma care coverage problem as an economic issue. Reimbursement, not physician ethics, is the root cause of the problem, he said. As the demand for trauma care continues to increase, the supply of trauma caregivers is determined by the ability of qualified caregivers to enter the trauma care “market” or industry. Present barriers prevent surgeons who practice in community hospitals, specialty hospitals, and ambulatory surgical centers from joining trauma centers. Certainly, EMTALA regulations have resulted in specialists relinquishing hospital privileges to avoid emergency call responsibilities, partly due to litigation fears. New obstacles to recruiting surgical residents into trauma care also have arisen, including the increasingly nonoperative nature of the work as well as lifestyle issues.

#### ADDRESSING THE CRISIS

Dr. Eastman described the “perfect storm” of convergent forces that led to the specialty coverage crisis in emergency and trauma call panels. Decreased reimbursement, fewer medical school applicants, an aging surgeon population, lifestyle issues, liability threats, and unintended consequences from EMTALA all play a large part. He noted that when chairs of the surgical boards were asked recently whether they anticipated a sufficient number of specialists to provide adequate coverage of emergency department and trauma call panels in the next five years, every one of them replied, “No.” He warned that this crisis is being inadequately addressed at the national and local levels, and that the specialty societies must decide how to address the situation or risk further erosion of the emergency care safety net.

Dr. Eastman also presented for consideration and discussion among the specialty societies such relevant issues as:

- Increasing the number of surgical specialists being trained.
- Addressing geographic distribution problems.

- 
- Examining the issue of fair payment.
  - Integrating the trauma system into the emergency system/disaster planning.
    - Regionalizing for more efficient use of limited surgical specialists according to a “trauma model.”
    - Developing exclusive contracts for unassigned emergency patients.
    - Creating hospital-supported reimbursement methods such as stipends or payment guarantees.

According to Dr. Eastman, steps should be taken to integrate trauma, emergency, and disaster planning systems. He also noted that the future of emergency care in the U.S. depends on the availability of surgical specialists for the emergency department and trauma call panels. The specialty societies must join forces and face this challenge together, he added.

#### A NEW SPECIALTY?

The future of trauma surgery as an attractive field of practice has been the subject of much discussion throughout the nation. One idea under consideration in the trauma community is the introduction of a new specialty of emergency or acute care surgery, practitioners of which would provide a broad scope of services. George Velmahos, MD, FACS, director, division of trauma, emergency surgery, and surgical critical care at Massachusetts General Hospital, Boston, noted that over the last several decades, trauma surgery has become a well-established specialty within general surgery. This subspecialty has spawned great advances in the care of severely injured patients. However, the increasingly nonoperative nature of trauma care, resident work-hour regulations, and lifestyle and job satisfaction issues may be making trauma surgery a less attractive career choice. At the same time, it is becoming increasingly difficult to recruit other surgical specialists to provide on-call trauma services. As a result, many complex specialty services are provided by residents, rather than fully trained surgeons. Dr. Velmahos described the trauma community’s proposal to combine trauma care with new emergency surgery services, such as treatment for bleeding, obstructions, perforations, and infections. Physicians providing this care would function as mem-

bers of dedicated in-hospital surgical teams to increase operative experience without compromising the care of injured patients.

Dr. Velmahos acknowledged that the development of this proposal faces many difficult challenges, including: the incorporation of specialties, such as orthopaedics and neurosurgery; defining “emergency” care; the impact on the “elective surgeon” workload; and methods to provide seamless coverage through interaction with non-surgical critical care teams. Nonetheless, he maintained that compelling evidence suggests that adequately trained trauma surgeons could safely provide high-quality acute emergency care, noting that in 2002, 57 percent of the operations performed by trauma surgeons were emergency procedures. He described the potential benefits of this new specialty in terms of improved care, research, finances, and quality control.

#### NEUROSURGERY’S PERSPECTIVE

Speaking on behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), Alex Valadka, MD, FACS, associate professor of neurosurgery at Baylor College of Medicine, stressed that neurosurgeons play a crucial, unique, and irreplaceable role in the treatment of patients with brain and spinal cord injuries. Central nervous system injury accounts for the majority of morbidity and mortality in trauma patients and for the largest share of trauma-related expenses. Dr. Valadka noted that in Scandinavia, non-neurosurgeons attempted to surgically treat intracranial bleeding with very poor results, concluding that it is better for patients to be transferred immediately to a neurosurgeon rather than receive care from other surgical specialists. He added that rapid stabilization and transport to a facility capable of providing definitive neurosurgical assessment and treatment are often pivotal factors in recovery.

Dr. Valadka explained that neurosurgery is the smallest of the three surgical specialties most involved in emergency care, with only 3,178 practicing board-certified surgeons (compared with 35,403 general surgeons and 22,711 orthopaedic surgeons). Furthermore, the overall workload for neurosurgery has increased. For example, the

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number of elective cranial procedures increased 50 percent between 1988 and 2001. In addition, a survey of more than 1,000 AANS and CNS members showed that two-thirds of those individuals practicing at Level I or II trauma centers reported increases in the number of neurosurgery emergency cases in the past two years.

Neurosurgeons want to participate in their regional trauma systems but are finding it increasingly difficult to do so. They are unable to provide full-service emergency care and maintain a stable elective practice because of the elective surgery schedule and the amount of uncompensated care involved. Also, a concentration in neurosurgical emergency cases has persisted because of an inadequate number of neurosurgeons to provide 24/7 on-call coverage, the tendency of neurosurgeons in outlying hospitals to drop cranial and pediatric privileges, and the desire of at least some neurosurgeons at those institutions to eliminate emergency coverage altogether. Many neurosurgeons believe emergency care increases the likelihood of a liability claim. Hence, they have restricted their practices or moved to less litigious states. (More than one-third of 1,000 neurosurgeons surveyed report having been sued by a patient seen through their hospitals' emergency departments.)

The AANS and CNS further recommend the development of emergency neurosurgical care systems with external control over designation of regional centers and consideration of state-supported programs to designate trauma centers.

## GENERAL CONCLUSIONS

A specialty workforce crisis is emerging, and it is affecting the emergency departments and trauma centers first. The problem is especially apparent in the increasing difficulty of finding surgeons to take emergency call, particularly in smaller specialties, such as neurosurgery and hand surgery.

The causes of the problem are varied and complex; therefore, their solutions will require careful thought. Simply producing more specialists will not be enough. In fact, for some specialties that solution is infeasible. Economic and environmental factors also must be addressed. Appeals to professional ethics won't solve the problem, because

the environmental stresses on emergency care are removed from ethics. Imposing unreasonable requirements on professionals in order to reconstruct systems that worked in the past won't work either.

More creative ideas, such as the ones that follow, are needed.

- Surgical and nonsurgical specialties, as well as other stakeholder groups, should collaborate to develop new systems of care.

- New systems that include more regionalization of emergency care need to be developed.

- Short-term solutions that make it more financially feasible for specialists to take emergency call, such as stipends, are acceptable but may be unsustainable over the long run.

- Legislative solutions to some of the contributing problems, such as the liability crisis, must be pursued.

- Increasing surgeons' understanding of EMTALA is essential. In addition, improving the profession's understanding of reimbursement rules pertaining to emergency care and advocating for rational policy changes is important.

- Medicare should create and fund additional training slots.

- The controversial notion of creating a surgical specialty dedicated to emergency care warrants further exploration.

- Public education and media relations campaigns could help to improve awareness of these issues and help promote the necessary changes.

The College and the surgical specialty groups will continue to work collaboratively to develop and promote policy solutions to ease the pressure on the nation's emergency care safety net. □

91st Annual  
**Clinical Congress**

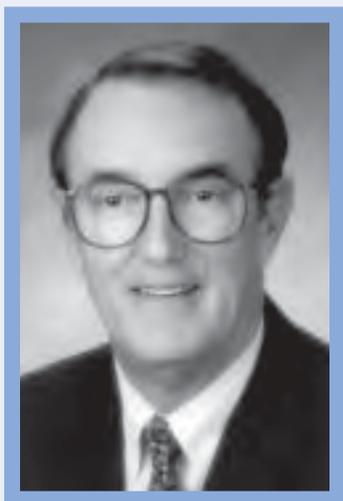
October 16-20, 2005  
San Francisco, CA



SAN FRANCISCO CONVENTION & VISITORS BUREAU

**Preliminary Program**

## FROM THE CHAIR, BOARD OF REGENTS COME TO THE 2005 CLINICAL CONGRESS



Dear Colleagues:

An outstanding educational opportunity and the largest surgical meeting in the country, the 91st Annual Clinical Congress of the American College of Surgeons offers you the unique opportunity to learn the latest from the best. The 2005 meeting, Education for the Spectrum of Surgical Practice, will be held October 16-20, 2005, at the Moscone Convention Center, San Francisco, CA. On behalf of the entire College, I would like to extend our warmest invitation to you to join us.

The Clinical Congress will afford you the opportunity to advance your knowledge in the traditional surgical areas as well as learn about the latest innovations in surgery. Participants will choose from a variety of educational offerings, including named lectures, skills-oriented and didactic postgraduate courses, general session panels, specialty and multidisciplinary sessions, the Surgical Forum sessions, and video-based education sessions. Papers will be presented on leading-edge clinical research, and extraordinary scientific and technical exhibits will be on display.

The program spans virtually every area of contemporary surgical research and practice, including critical topics such as Acute Pancreatitis, GU Trauma, and Novel Stage Modalities for Lung Cancer. Innovative and hot topics include an Update on Stem Cell Applications; Complications in Surgery: Getting Out of Trouble in the Operating Room; and GERD Today: Medicate, Inject, Staple, or Wrap? Sessions also will be offered on Strategies to Minimize Surgical Infections, Avoiding Complications in Laparoscopic Cholecystectomy, and Management of Colorectal Hepatic Metastases.

The Clinical Congress offers numerous didactic postgraduate courses including Evidence-Based Decisions in Cancer Management and Review Course in Cardiac and Thoracic Surgery for Certification and Maintenance of Certification Candidates. Our hands-on skills courses provide a unique opportunity to learn the latest techniques from the experts in the field. Courses include Stereotactic Breast Biopsy, Ultrasound in the Acute Setting, Laparoscopic and Hand-Assisted Laparoscopic Colon Resection, and Team Training in Surgery: Lessons from Aviation.

The Clinical Congress offers a wide range of educational opportunities that will enable you to keep abreast of the latest scientific developments in surgery. By attending this premier educational program, you will learn how to meet the various professional challenges that you face today and will likely encounter in the future. I hope you will plan to join us in San Francisco this year.

With best wishes,

A handwritten signature in black ink that reads "Edward M. Copeland III". The signature is written in a cursive, flowing style.

Edward M. Copeland III, MD, FACS  
Chair, Board of Regents

# EDUCATION FOR THE SPECTRUM OF SURGICAL PRACTICE

The College has a 91-year tradition of providing excellence in educational offerings across a broad range of topics. This year's Clinical Congress continues this long-standing tradition and features exceptional clinician presenters and an extensive array of activities. Surgeons may advance their skills and knowledge based on their learning needs, whether in areas of contemporary surgical practice, leading-edge research, advances in technology, professional competence, or clinical applications of new developments in the basic sciences. Attend the 91st Clinical Congress, and continue your own tradition of seeking excellence in education and surgical patient care.

## GOAL AND OBJECTIVE

The Clinical Congress is designed to provide individuals with a wide range of learning opportunities, activities, and experiences that will match their educational and professional development needs. By the conclusion of the Clinical Congress, participants should gain and be able to apply the knowledge to improve their current practice, research, and care of surgical patients.

## NAMED LECTURES

### **Opening Ceremony and American Urological Association Lecture**

Michael D. Maves, MD, FACS, *Chicago, IL*

### **John H. Gibbon, Jr., Lecture: Surgery for Atrial Fibrillation**

James L. Cox, MD, FACS, *Naples, FL*

### **Charles G. Drake History of Surgery Lecture**

J. Patrick O'Leary, MD, FACS, *New Orleans, LA*

### **Scudder Oration on Trauma: Trauma—Personal Reflections**

C. Thomas Thompson, MD, FACS, *Tulsa, OK*

### **Ethics and Philosophy Lecture: Medical Progress and Health Care Access—Can They Be Reconciled?**

Daniel J. Callahan, PhD, *Garrison, NY*

### **Commission on Cancer Oncology Lecture: Evidence-Based Cancer Treatment for Populations or Individuals?**

William C. Wood, MD, FACS, *Atlanta, GA*

### **I.S. Ravdin Lecture in the Basic Sciences: The**



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### **Times of Our Lives—Physiologic Variability during Critical Illness and Recovery**

Timothy G. Buchman, MD, PhD, FACS, *St. Louis, MO*

### **Distinguished Lecture of the International Society of Surgery: Evidence-Based Surgical Practice—Is It Possible?**

Jonathan L. Meakins, MD, FACS, *Headington, UK*

### **Martin Memorial Lecture: Science and Politics—How Rich a Mixture Do We Want?**

Donald Kennedy, PhD, *Stanford, CA*

## CONVOCATION AND ANNUAL MEETING OF FELLOWS

The Convocation Ceremony will take place from 6:00 to 8:00 pm, Sunday, October 16, at the Moscone Convention Center. The Annual Meeting of Fellows will take place from 7:30 to 8:30 am, Thursday, October 20, at the Moscone Convention Center.

## GENERAL SESSION HIGHLIGHTS

- **What You Need to Know About Maintenance of Certification**
- **The Highly Reliable Operating Team**
- **Regional Support for Skills Training through ACS-Accredited Education Centers**

- **Strategies to Minimize Surgical Infections**
- **Evaluation and Management of Thyroid Disease for the Surgeon**
- **The Devil's in the Details: Avoiding Complications in Laparoscopic Cholecystectomy**
- **Management of Colorectal Hepatic Metastases**
- **Interventionalists of the Future**
- **GERD Today: Medicate, Inject, Staple, or Wrap?**

#### MULTIDISCIPLINARY PROGRAMS

- **Tissue Engineering**
- **Complications in Surgery: Getting Out of Trouble in the Operating Room**
- **Perineum Trauma**
- **Surgical Simulators: 2005**
- **Update on Stem Cell Applications**

#### SPECIALTY SESSIONS

- **Acute Pancreatitis**
- **What's New in Pediatric Urology?**
- **Novel Staging Modalities for Lung Cancer**
- **Endoscopy: Contemporary Management of Peripheral Nerve, Spine, and Brain**
- **Interventional Bronchoscopy Rediscovered**
- **Controversies in the Management of Carotid Disease**
- **Thyroid Neoplasms in Childhood: Management and Controversies**
- **Therapeutic Advances in the Treatment of Brain Metastatic Tumors**
- **Controversies in the Management of Lower Extremity Ischemia: An Update**

- **Medical Liability: Its Effects on Delivery of Care from Primary to Tertiary Levels and the Threat to Our Academic Medical Centers**

- **An Integrated Approach to the Diabetic Foot: Staying One Step Ahead of Managed Care**

- **Controversies in the Management of Venous Disease**

- **Advances in the Management of Eyelid and Orbital Malignancies**

#### ADDITIONAL ACTIVITIES

- **Approximately 22 video-based education sessions, including:**

- Movie Classics from the Past**

- Antireflux Surgery: Specific Challenges**

- Ciné Clinics on Gastric Surgery and Colon and Rectal Surgery**

- **More than 250 leading-edge research papers presented at Surgical Forum and Papers Sessions**

- **More than 150 peer-reviewed scientific exhibits**

- **Approximately 250 technical exhibits**

- **Special program for residents**

- **Special program for medical students**

# SCIENTIFIC PROGRAM REGISTRATION

Register Online & Save Time—[www.facs.org](http://www.facs.org)

American College of Surgeons  
91st Annual Clinical Congress  
San Francisco, CA  
October 16–20, 2005

Three easy ways to register:

Online: (The fastest way to register!)  
[www.facs.org](http://www.facs.org)

Fax:  
800/682-0252 (U.S. only)  
312/202-5003 (all other locations)

or

Mail:  
American College of Surgeons  
Attn: Registration Services  
PO Box 92340  
Chicago, IL 60675-2340

ACS FELLOWSHIP ID NUMBER		
FIRST NAME AND MIDDLE INITIAL		LAST NAME
MAILING ADDRESS (HOME OR WORK)		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE
COUNTRY		
TELEPHONE		FAX
E-MAIL		

## SPECIALTY

- SUR - General Surgery
- THO - Cardiothoracic Surgery
- CRS - Colon & Rectal Surgery
- OBG - Gynecology & Obstetrics
- NEU - Neurological Surgery
- OPT - Ophthalmic Surgery
- ORT - Orthopaedic Surgery
- ORL - Otolaryngology
- PED - Pediatric Surgery
- PLA - Plastic & Maxillofacial Surgery
- URO - Urology
- VAS - Vascular Surgery
- Other:

▶ The deadline for advance registration is August 29 for U.S. and Canadian registrants and August 8 for international registrants.

▶ Consideration deadline: August 29 for U.S. and Canadian registrants and August 8 for international registrants. Refunds will not be issued after these dates.

▶ Do not include hotel deposit with this form. It will delay your registration.



Check here if ADA (Americans with Disabilities Act) accommodation is desired. An ACS staff person will contact you.

Daytime Phone: \_\_\_\_\_

CATEGORY	U.S. Entry (U.S. Resident) (US\$)	Int'l (International) (US\$)
<input type="checkbox"/> Fellow of the American College of Surgeons	No fee	No fee
<input type="checkbox"/> Initiate	No fee	No fee
<input type="checkbox"/> Associate Fellow	No fee	No fee
<input type="checkbox"/> Resident Member	No fee	No fee
<input type="checkbox"/> Medical Student—Member	No fee	No fee
<input type="checkbox"/> Affiliate Member	No fee	No fee
<input type="checkbox"/> Guest physician (U.S. and Canada)*	\$590	\$640
<input type="checkbox"/> Guest physician (international)*	\$590	\$640
<i>Please read important membership notice prior to selecting.</i>		
<input type="checkbox"/> Surgical resident—with verification letter*	\$215	\$240
<input type="checkbox"/> Medical student—Nonmember with verification letter*	\$20	\$20
<input type="checkbox"/> Hospital administrator (nonphysician)	\$290	\$340
<input type="checkbox"/> Hospital purchasing agent	\$250	\$300
<input type="checkbox"/> Medical association personnel	\$250	\$300
<input type="checkbox"/> Nurse—Nonmember*	\$250	\$300
<input type="checkbox"/> Surgical assistant—Nonmember*	\$250	\$300
<input type="checkbox"/> Surgical technician—Nonmember*	\$250	\$300
<input type="checkbox"/> PhD—Nonmember*	\$390	\$450
<input type="checkbox"/> Commercial press	\$440	\$490

(Company name) \_\_\_\_\_

\*Includes membership application fee.

Registration Subtotal \$ \_\_\_\_\_ \$ \_\_\_\_\_

- Please register me for the Medical Student Program (students only)..... No fee
- Please register me for the Surgical Resident Program (residents only)..... No fee
- Please register me for the Resident and Associate Society Symposium..... No fee
- Please register me for the Rural Surgeons Meeting..... No fee
- Please register me for the Senior Surgeons Meeting..... No fee

(Form continues on back)

POSTGRADUATE COURSES

<input type="checkbox"/> 101	SC01	Mammography for the General Surgeon.....	\$325	<input type="checkbox"/> 122	SC20	Advanced Breast Ultrasound* .....	\$790
<input type="checkbox"/> 102	SC02	Breast Imaging for the General Surgeon.....	\$250	<input type="checkbox"/> 123	SC21	Bedside Procedures Workshop .....	\$850
<input type="checkbox"/> 103	SC03	Surgical Education: Principles and Practice.....	\$300	<input type="checkbox"/> 124	SC22	Team Training in Surgery: Lessons from Aviation .....	\$400
<input type="checkbox"/> 104	SC04	Vascular Ultrasound* .....	\$775	<input type="checkbox"/> 201	PG01	The Business Aspects of Health Systems Management .....	\$390
<input type="checkbox"/> 105	SC05	Advanced Stereotactic Breast Biopsy.....	\$275	<input type="checkbox"/> 202	PG02	Charting a Sound Course for Surgical Practices .....	\$450
<input type="checkbox"/> 106	SC06a	Laparoscopic and Hand-Assisted Laparoscopic Colon Resection—Lecture .....	\$375	<input type="checkbox"/> 203	PG03	Current Management of Gastrointestinal Hemorrhage .....	\$390
<input type="checkbox"/> 107	SC06b	Laparoscopic and Hand-Assisted Laparoscopic Colon Resection—Workshop* .....	\$825	<input type="checkbox"/> 204	PG04	Evidence-Based Decisions in Cancer Management.....	\$390
<input type="checkbox"/> 108	SC07	Computers and the Internet for the Practicing Surgeon .....	\$375	<input type="checkbox"/> 205	PG05	Vascular and Endovascular Surgery.....	\$375
<input type="checkbox"/> 109	SC08	Foundations in CPT and ICD-9-CM Coding.....	\$350	<input type="checkbox"/> 206	PG06	Pitfalls in the Initial Evaluation and Management of the Trauma Patient.....	\$390
<input type="checkbox"/> 110	SC09	Head and Neck Ultrasound* .....	\$775	<input type="checkbox"/> 207	PG07	Urology Review Course.....	\$375
<input type="checkbox"/> 111	SC10	Ultrasound in the Acute Setting* .....	\$790	<input type="checkbox"/> 208	PG08	Breast Cancer Update.....	\$390
<input type="checkbox"/> 112	SC11	Breast Ultrasound* .....	\$1,050	<input type="checkbox"/> 209	PG09	Colon Carcinoma.....	\$350
<input type="checkbox"/> 113	SC12	Abdominal Ultrasound* .....	\$1,000	<input type="checkbox"/> 210	PG10	Emergency Abdominal Surgery in the Modern Era.....	\$390
<input type="checkbox"/> 114	SC13	Lymphatic Mapping and the Significance of Sentinel Node Biopsy .....	\$400	<input type="checkbox"/> 211	PG11	Surgery of the Thyroid Gland.....	\$375
<input type="checkbox"/> 115	SC14	Mastering Surgical and Office-Based Coding .....	\$350	<input type="checkbox"/> 212	PG12	Review Course in Cardiac and Thoracic Surgery.....	\$750
<input type="checkbox"/> 116	SC15	Stereotactic Breast Biopsy.....	\$775	<input type="checkbox"/> 213	PG13	Management of Common Infections in a General Surgery Practice.....	\$375
<input type="checkbox"/> 117	SC16	Contemporary Bariatric Surgery 2005.....	\$850	<input type="checkbox"/> 214	PG14	Postradiation Breast Reconstruction.....	\$350
<input type="checkbox"/> 118	SC17	Using Advanced Multimedia in PowerPoint Presentations .....	\$375	<input type="checkbox"/> 215	PG15	Disaster and Mass Casualty Management .....	\$390
<input type="checkbox"/> 119	SC18a	Personal Data Assistant (PDA) Lecture 10/18 AM: Workshop 10/19 AM.....	\$400	<input type="checkbox"/> 216	PG16	Prevention and Early Diagnosis of Anal Cancer .....	\$375
<input type="checkbox"/> 120	SC18b	Personal Data Assistant (PDA) Lecture 10/18 PM: Workshop 10/19 PM.....	\$400	<input type="checkbox"/> 217	PG17	Introduction of Pain Management and End-of-Life Care .....	\$490
<input type="checkbox"/> 121	SC19	Ultrasound Instructors Course* .....	\$100				

\* Requires prerequisite for registration.

† Cancellation Policy: Registration and postgraduate course fees will be refunded if a written request is received at the College and postmarked no later than August 8 for international registrants or August 29 for U.S. registrants. A \$50.00 handling fee will be retained.

- The American College of Surgeons reserves the right to cancel any regularly scheduled session prior to the start of the meeting.
- Formal, written confirmation will be mailed to all registrants within 10 business days of receipt.
- Please ensure legibility prior to mailing or faxing.
- Payment must accompany registration. Purchase orders are not accepted.

Fees payable in U.S. funds to: American College of Surgeons

Check (enclosed)     MasterCard     VISA     American Express

Card number \_\_\_\_\_ Exp. \_\_\_\_/\_\_\_\_    Registration amount \$ \_\_\_\_\_

Card issued to \_\_\_\_\_    PG Course fee amount \$ \_\_\_\_\_

Signature \_\_\_\_\_    Total amount \$ \_\_\_\_\_

## POSTGRADUATE COURSES

**Prerequisite for all postgraduate ultrasound courses:** Registrants must have completed a course in basic ultrasound in order to register for these courses. Three options are available to meet the prerequisite:

1. Completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons.
2. Completion of the CD-ROM course, Ultrasound for Surgeons: The Basic Course. The CD-ROM is available for purchase online at [www.facs.org](http://www.facs.org) in the ACS Publications and Services Catalog or by contacting ACS Customer Service at 312/202-5474.
3. Completion of a comparable course elsewhere.

Please include the following documents with your registration form:

- CME certificate.
- Certificate of completion.
- Registration confirmation/verification.

If you do not have one of these documents, please contact the organization that sponsored the course to obtain one of these documents. Your registration will not be processed until the National Ultrasound Faculty has approved your accompanying documentation.

**Application courses:** The following courses require a completed application to register. Applications can be found on the American College of Surgeons Web site.

- SC06 Laparoscopic and Hand-Assisted Laparoscopic Colon Resection
- SC19 Ultrasound Instructors Course
- SC20 Advanced Breast Ultrasound

### SC01

#### **Mammography for the General Surgeon**

CHAIR: Darius S. Francescatti, MD, FACS, *Chicago, IL*  
5 credits

Saturday, October 15, 1:00–6:30 pm  
Fee: \$325

This one-day course will emphasize the acquisition of fundamental skills in viewing and analyzing the normal mammogram. Similarly, in a stepwise fashion, the characteristics of the abnormal mammogram will be delineated and categorized into analytic patterns; calcifications, nodular densities, asymmetry, and architectural distortion will be discussed. Pathologic image correlation of presented material will be stressed. The clinical correlation of the mammographic image and the selection of biopsy techniques will be discussed. Breast sonography, a vital component in the analysis of image-detected breast cancer, will be incorporated into clinical scenarios to more closely parallel and reflect the decision-making pro-

cess general surgeons face in practice today. The important aspects of formulating a clinical treatment plan based on mammographic and sonographic findings will be facilitated and reinforced by interactive case presentations between course participants and a panel of surgical experts in the field of breast surgery.

### SC02

#### **Breast Imaging for the General Surgeon**

CHAIR: Darius S. Francescatti, MD, FACS, *Chicago, IL*  
4 credits

Sunday, October 16, 8:00 am–12:30 pm  
Fee: \$250

This course is designed to provide the practicing surgeon with increased imaging skills in the analysis of both mammographic and breast sonographic images. Emphasis will be placed on correlating normal breast anatomy to both image types. The pathology of breast disease will be highlighted by analyzing these kinds of images and correlating the pathophysiology presented to the image seen.

### SC03

#### **Surgical Education: Principles and Practice**

CHAIRS:

Mary E. Maniscalco-Theberge, MD, FACS, *Washington, DC*

Michael R. Marohn, DO, FACS, *Baltimore, MD*  
6 credits

Sunday, October 16, 8:30 am–12:30 pm and 2:00–5:00 pm  
Fee: \$300 (includes workshop)

The objective of this course is to enhance the teaching skills of surgeons active in student and/or resident teaching. The principles of adult learning, needs assessment, questioning and feedback skills, and performance evaluation will be reviewed. In addition, participants will develop a thorough understanding of the practical applications of these principles, both in and out of the operating room. This course includes a workshop with interactive, small-group discussion.

### SC04

#### **Vascular Ultrasound**

CHAIR: R. Eugene Zierler, MD, FACS, *Seattle, WA*  
5 credits

Sunday, October 16, 12:00 noon–5:30 pm  
Fee: \$775 (includes workshop)

The objective of this course is to provide the practicing surgeon and surgical resident with core education and training in the indications, techniques, advantages, and limitations of ultrasound examinations in the diagnosis and treatment of patients with vascular diseases. Emphasis will be given to those procedures that require some surgeon participation in image acquisition, such as intraoperative ultrasound. The surgeon should be able to obtain optimal images to improve therapy and direct treatment in the operative setting. This course includes a hands-on workshop with live and/or inanimate models.

#### SC05

### **Advanced Stereotactic Breast Biopsy**

CHAIR: Richard E. Fine, MD, FACS, *Marietta, GA*  
4 credits  
Sunday, October 16, 1:00–5:30 pm  
Fee: \$275

This course will provide those surgeons already using stereotactic breast biopsy with the requisite number of continuing medical education (CME) credits required for the stereotactic recredentialing process. Topics will be discussed didactically and in interactive case presentation format. This four-hour course will stress practical solutions to targeting dilemmas, in-depth mammographic lesion analysis, mammographic/pathologic correlation, image-guided intervention, and the rationale for stereotactic versus ultrasound-guided biopsy.

#### SC06

### **Laparoscopic and Hand-Assisted Laparoscopic Colon Resection**

CHAIR: Deborah A. Nagle, MD, FACS, *Philadelphia, PA*  
5.5 credits lecture  
5.5 credits workshop  
Monday, October 17, 9:45 am–4:00 pm and Tuesday, October 18, 8:00 am–3:00 pm  
Fee: \$375 lecture (5.5 credits), \$825 hands-on workshop (5.5 credits)

The objective of this course is to increase the participants' knowledge and skill in laparoscopic colon surgery and to support and practice the acquisition of more advanced laparoscopic skills, such as hand-assisted laparoscopic colon resection. The second day of this course includes a hands-on workshop with live and/or inanimate models.

Course participants will: (1) review the anatomy of the intestine as it relates to laparoscopic resection; (2) learn hand-access laparoscopic (HAL) techniques and how to use HAL as a bridge to more advanced skills; (3) learn laparoscopic techniques for bowel mobilization and devascularization; (4) learn laparoscopic techniques for extracorporeal and intracorporeal anastomoses; and (5) recognize and review surgical oncology principles as they apply to laparoscopic intestinal resection.

#### SC07

### **Computers and the Internet for the Practicing Surgeon**

CHAIR: Ronald B. Hirschl, MD, FACS, *Ann Arbor, MI*  
5.5 credits  
Monday, October 17, 9:45 am–12:30 pm and 1:30–4:45 pm  
Fee: \$375 (workshop only)

This hands-on computer course will educate surgeons about the use of the Internet in daily practice, including: connecting to the Internet; the use of search engines; accessing the literature; using the new ACS portal and case activity list; and using available resources for evidence-based medicine and decision support, such as educational and clinical tools and drug databases.

#### SC08

### **Foundations in CPT and ICD-9-CM Coding**

CHAIR: Albert Bothe, Jr., MD, FACS, *Chicago, IL*  
6 credits  
Monday, October 17, 9:45 am–1:00 pm and 2:00–5:30 pm  
Fee: \$350 (includes workshop)

This basic course will introduce participants to Current Procedural Terminology (CPT) and to the diagnosis coding portion of International Classification of Diseases (ICD-9-CM). Participants will use office and hospital notes to determine the appropriate components of the three required elements of evaluation and management (E/M) coding. At the conclusion of the course, participants will understand the differences between coding and reimbursement principles and how to navigate CPT and the diagnosis sections of ICD-9-CM. They will be able to describe the key components for choosing CPT E/M codes and use diagnosis and CPT coding principles to ensure clean claim submission. Participants must bring their copy of *Current Procedural Terminology (CPT) Coding*, 2005 edition. This course includes a workshop with coding exercises.

SC09

**Head and Neck Ultrasound**

CHAIR: Robert A. Sofferan, MD, FACS, *Burlington, VT*  
7 credits

Monday, October 17, 9:45 am–5:45 pm  
Fee: \$775 (includes workshop)

The objective of this course is to provide the practicing surgeon with knowledge and practical skills in the application of diagnostic and interventional head and neck ultrasound. The program will consist of lectures and hands-on skill stations, using a variety of ultrasound equipment. Live model and phantom moulages will be used to develop skills in head and neck ultrasound imaging and ultrasound-guided head and neck biopsy.

SC10

**Ultrasound in the Acute Setting**

CHAIR: Mark G. McKenney, MD, FACS, *Miami Beach, FL*

7 credits

Monday, October 17, 9:45 am–5:45 pm  
Fee: \$790 (includes workshop)

The objective of this course is to familiarize the participant with areas of ultrasound that general surgeons frequently use to evaluate patients with acute surgical problems. The participant will learn how to conduct focused ultrasound examinations through individual hands-on experience and will acquire an understanding of the essentials of ultrasound technology and physics. The hands-on portion of this course will include live and/or inanimate models.

SC11

**Breast Ultrasound**

CHAIR: Mark A. Gittleman, MD, FACS, *Allentown, PA*  
7.5 credits

Monday, October 17, 9:45 am–5:45 pm  
Fee: \$1,030 (includes workshop)

The objective of this course is to introduce the practicing general surgeon to a focused module in diagnostic and interventional breast ultrasound. The program will consist of lectures and hands-on skill stations using a variety of ultrasound equipment. Live models and phantom breast moulages will be used to develop skills in breast ultrasound imaging and ultrasound-guided breast biopsy.

SC12

**Abdominal Ultrasound**

CHAIRS:

Maurice E. Arregui, MD, FACS, *Indianapolis, IN*  
Junji Machi, MD, PhD, FACS, *Honolulu, HI*

8 credits

Tuesday, October 18, 7:30 am–12:00 pm and 1:30 pm–5:30 pm

Fee: \$1,000 (includes two workshops)

The objective of this course is to provide the practicing surgeon and surgical resident with basic, advanced, and updated education and training in abdominal ultrasound (including transabdominal, intraoperative, and laparoscopic ultrasound) as it is used in the diagnosis and treatment of abdominal diseases. This one-day course will consist of lectures and individual hands-on sessions. Human and porcine models, excised liver, and phantom moulages will be used to develop skills in abdominal ultrasound imaging and ultrasound-guided procedures. Endoscopic ultrasound and anorectal ultrasound also will be discussed.

SC13

**Lymphatic Mapping and the Significance of Sentinel Node Biopsy**

CHAIR: Armando E. Giuliano, MD, FACS, *Santa Monica, CA*

7 credits

Tuesday, October 18, 8:00–5:00 pm

Fee: \$400

The objective of this course is to teach the basic intellectual and practical aspects of sentinel lymph node dissection. Participants will learn about the use of sentinel node biopsy for melanoma and breast cancer. They will learn different techniques for performing the procedure and will understand the use of radioisotopes and lymphoscintigraphy. In addition, the histopathologic evaluation of sentinel node and the controversies surrounding special techniques will be discussed.

SC14

**Mastering Surgical and Office-Based Coding**

CHAIR: Albert Bothe, Jr., MD, FACS, *Chicago, IL*  
7 credits

Tuesday, October 18, 8:00 am–12:00 noon and 1:00–5:00 pm

Fee: \$350 (includes workshop)

This course will build on the coding principles discussed in the foundations course (SC08) and apply them to surgical scenarios. These concepts will be expanded to include Medicare reimbursement rules and guidelines for surgical coding. Participants will apply the skills learned to the coding of hands-on surgical case scenarios, including vascular access, coding for breast surgery and reconstruction, gastrointestinal endoscopy, colon surgery, vascular cases, gallbladder, lesions, and wound repairs.

At the conclusion of the course, participants will understand the American Medical Association's definition of the surgical package, Medicare's definition of the global surgical package, and when to apply modifiers to surgical procedures and office encounters. They will also be able to identify the elements of explanation of benefit forms that the physician should review, to analyze physician profiles, and to recognize situations that may pose risk to the physician or practice. Participants must bring their copy of *Current Procedural Terminology (CPT) Coding*, 2005 edition. This course includes a workshop with coding exercises.

#### SC15

### **Stereotactic Breast Biopsy**

CHAIR: Arthur G. Lerner, MD, FACS, *White Plains, NY*  
8 credits

Tuesday, October 18, 8:00 am–5:15 pm

Fee: \$775 (includes workshop)

The objective of this course is to introduce the surgeon to the principles and practice of stereotactic biopsy as a minimal access means of obtaining tissue samples for diagnosing indeterminate or suspicious mammographic lesions. An overview of radiation safety issues as related to stereotaxis, as well as the technical efficacy and cost analysis of stereotactic versus other alternatives, will be presented. It is highly recommended that participants complete the skills-oriented postgraduate course Breast Imaging for the General Surgeon before taking this course.

#### SC16

### **Contemporary Bariatric Surgery 2005**

CHAIRS:

Henry Buchwald, MD, PhD, FACS, *Minneapolis, MN*

Sayed Ikramuddin, MD, FACS, *Minneapolis, MN*  
14 credits

Tuesday, October 18, 8:00 am–4:40 pm and 6:30 pm–8:45 pm

Wednesday, October 19, 8:00 am–5:30 pm

Fee: \$850

This intense, two-day course will feature didactic presentations, panels, and video operations to provide a broad overview of bariatric surgery. Participants will be able to describe the epidemiology, etiology, and incidence of morbid obesity and outline the physiologic basis for bariatric surgery. Criteria for identification of appropriate surgical candidates will be outlined, and various bariatric surgical procedures, such as laparoscopic adjustable gastric banding, vertical-banded gastroplasty, gastric bypass, and duodenal switch will be presented. The pre-, intra-, and postoperative care associated with each procedure will be described, along with the possible postoperative complications and their appropriate management and prevention strategies. In addition, principles underlying a multidisciplinary approach to bariatric surgery and the consequences of postbariatric weight loss will be discussed, along with the psychological aspects of caring for the bariatric surgery patient, postoperative reconstructive surgery, and bariatric surgery in the adolescent. Video operations, primarily featuring laparoscopic techniques, will be shown. The world-renowned surgeons who performed these filmed procedures will be in attendance to participate in discussions.

#### SC17

### **Using Advanced Multimedia in PowerPoint® Presentations**

CHAIRS:

David A. Krusch, MD, FACS, *Rochester, NY*

William D. Hardin, Jr., MD, FACS, *Birmingham, AL*

6 credits

Tuesday, October 18, 8:30 am–12:00 noon and 1:30–5:00 pm

Fee: \$375 (workshop only)

The objective of this course is to teach participants how to use electronic multimedia tools to create robust scientific presentations. The following topics will be covered in this hands-on computer course: brief PowerPoint basics; elements of an effective PowerPoint scientific presentation; adding and manipulating static images; adding sound to a presentation; basic video acquisition techniques and recommendations; basic video editing in preparation for integration into a presentation; integrat-

ing video objects into a presentation; screen action capture techniques for purposes of tutorial/examples; and publishing a presentation.

## SC18

### Personal Data Assistant

CHAIRS:

David A. Krusch, MD, FACS, *Rochester, NY*

Ronald B. Hirschl, MD, FACS, *Ann Arbor, MI*

6.5 credits

Lecture: Tuesday, October 18, 1:30–5:00 pm

Workshops: (choice of one)

18(A): Wednesday, October 19, 8:30 am–12:00 noon

18(B): Wednesday, October 19, 1:30–5:00 pm

Fee: \$400 (includes workshop)

This hands-on computer course will highlight the role of personal data assistants (PDAs) and the use of interactive information in the surgeon's daily practice. The workshop session is designed for beginners who have never owned or used a PDA and will feature a hands-on demonstration of the uses and functions of PDAs. Use of the ACS case logging system will also be covered in this course. PDAs will be provided to participants. Participants must attend the lecture session and select one workshop session.

## SC19

### Ultrasound Instructors Course

CHAIR: Reid B. Adams, MD, FACS, *Charlottesville, VA*

4 credits

Wednesday, October 19, 8:00 am–12:30 pm

Fee: \$100 (includes workshop)

The course is designed to provide the experienced surgeon sonographer with the skills necessary to teach ultrasound to surgical residents at the local level and to practicing surgeons at the national level.

## SC20

### Advanced Breast Ultrasound

CHAIR: Richard E. Fine, MD, FACS, *Marietta, GA*

7 credits

Wednesday, October 19, 8:00 am–5:00 pm

Fee: \$790 (includes workshop)

The didactic portion of this course is designed to provide the physician currently using breast

sonography in clinical practice with an advanced understanding of ultrasound to more effectively use this imaging modality. The practice incorporation of ultrasound guidance with innovative new devices for the diagnosis and treatment of breast cancer in both the office setting and the operating room will be stressed. Image to pathologic correlation and new pathologic diagnostic indications will be presented. The use of three-dimensional breast ultrasound in the evaluation of breast tumors will be discussed. At the conclusion of this part of the course, the faculty will address questions relating to the topics discussed. Faculty will be available throughout the course to answer questions individually.

The workshop section will focus on an in-depth understanding of improving the ultrasound image quality based on the ultrasound machine settings and tools. Practical understanding of the use of ultrasound with both established and new technology will be emphasized. Workstations will also highlight the use of three-dimensional sonography, cryoablation, cryo-assisted tissue sampling, vacuum-assisted devices for both treatment and diagnosis of breast lesions, and ultrasound-assisted placement of radiation catheter implants for localized brachytherapy following lumpectomy. Workstations will include live and/or inanimate models.

## SC21

### Bedside Procedures Workshop

CHAIR: George C. Velmahos, MD, PhD, FACS, *Boston, MA*

7.5 credits

Wednesday, October 19, 8:00 am–5:30 pm

Fee: \$850 (includes workshop)

The objective of this workshop is to teach surgeons how to perform three bedside procedures: percutaneous dilational tracheostomy, percutaneous endoscopic gastrostomy, and percutaneous vena caval filter placement. Bedside procedures have been shown to be safe, convenient, teachable, and cost-effective. Reimbursement rates are significant. Surgeons will be expected to perform these procedures with increasing frequency in the near future. Other specialists treating critically ill patients, such as medical intensivists, pulmonologists, cardiologists, and anesthesiologists, will compete with surgeons in this field. Surgeons should be adequately prepared to take an early lead in performing procedures at the bedside. This course will include a lecture portion and a hands-on workshop with inanimate models.

SC22

**Team Training in Surgery: Lessons from Aviation**

CHAIRS:

Jack Barker, PhD, *Miami, FL*

Donald W. Moorman, MD, FACS, *Boston, MA*

6 credits

Wednesday, October 19, 8:30 am–12:00 pm and 1:30–4:30 pm

Fee: \$400

Approximately 25 years ago, mechanically sound aircraft were crashing because of crew errors. To reduce these errors, Crew Resource Management (CRM) training, which emphasizes leadership and teamwork skills, was initiated. The goal of this course is to introduce surgeons and other team members, such as anesthesiologists and nurses, to the techniques that will help the operative team to reduce errors. Topics will include team functioning and leadership models, communication techniques, error science, mental models, pre- and postoperative briefings, competence, and a culture of accountability. The format will be interactive, allowing individuals several opportunities for “hands-on” teamwork practice. A team-training module from Beth Israel Deaconess Medical Center will be presented. Multidisciplinary teams from hospitals are welcome to attend and participate, which will help introduce team training to medical centers.

PG01

**The Business Aspects of Health System Management: The Surgeon’s Role in Health System Leadership**

CHAIR: Paul A. Taheri, MD, MBA, FACS, *Ann Arbor, MI*

6 credits

Sunday, October 16, 8:30 am–12:00 pm and 1:30–5:00 pm

Fee: \$390

This one-day course is designed to deliver fundamental business and managerial tools to practicing physicians and surgeons, nurse managers, and administrative personnel. The course introduces the first-year master of business administration curriculum in a one-day course and applies business principles to the delivery of health care. Topics include economics, cost accounting, financial accounting, reimbursements, operations management, and physician leadership. The program is a condensed version of an existing University of Michigan management training program that has been delivered

in various formats to more than 1,000 physicians in health systems across the country. The program’s roots are derived from an academic setting, but the design and content focus on physicians practicing in many different environments. The goal of this session is to provide the clinician and administrator with the necessary tools to change their delivery of health care *tomorrow*.

PG02

**Charting a Sound Course for Surgical Practices**

CHAIRS:

Charles D. Mabry, MD, FACS, *Pine Bluff, AR*

Frank G. Opelka, MD, FACS, *Boston, MA*

7 credits

Monday, October 17, 9:45 am–12:15 pm and 1:15–5:45 pm

Fee: \$450

This educational seminar is designed for surgeons interested in improving the management and efficiency of their surgical practices. This course will involve lectures as well as skills laboratories, with the participants collaborating with the instructors to solve real-life practice management problems. The course will equip surgeons with the management knowledge and skills to position their practices for market challenges now and in the future.

PG03

**Current Management of Gastrointestinal Hemorrhage**

CHAIR: Jeffrey H. Peters, MD, FACS, *Rochester, NY*

6 credits

Monday, October 17, 9:45 am–1:00 pm and 2:00–5:30 pm

Fee: \$390

The objective of this course is to foster surgeons’ understanding of current epidemiologic, diagnostic, and therapeutic options for patients presenting with gastrointestinal bleeding. Topics will include aggravating factors, resuscitation by the surgeon, diagnosis and treatment using endoscopy, diagnosis and treatment using angiography, indications for surgery, and operative approaches.

PG04

**Evidence-Based Decisions in Cancer Management**

CHAIRS:

Miguel A. Rodriguez-Bigas, MD, FACS, *Houston, TX*

Michael A. Choti, MD, FACS, *Baltimore, MD*

6 credits

Monday, October 17, 9:45 am–12:45 pm and 2:00–5:30 pm  
Fee: \$390

The objective of this course is threefold: (1) to discuss and review controversial issues in the management of patients with breast, rectal, or endocrine neoplasms and melanoma; (2) to discuss quality-of-life issues for rectal cancer patients; and (3) to discuss the correlation between hospital and surgeon volume to outcomes in cancer patients. Topics will include: the management of metastatic neuroendocrine malignancy, including surgical and systemic therapy of metastatic disease; the management of rectal cancer, including sphincter preservation, cancer recurrence, and quality-of-life issues; and the management of melanoma, including primary and metastatic disease.

PG05

### **Vascular and Endovascular Surgery: Technical Problems in the Operating Room—Tips on Avoidance and Management**

CHAIR: Gregorio A. Sicard, MD, FACS, *St. Louis, MO*  
6 credits

Monday, October 17, 1:30–5:00 pm and Tuesday, October 18, 1:30–5:00 pm  
Fee: \$375

This course will emphasize the practical issues associated with the resolution of complications arising during vascular and endovascular procedures and will offer advice regarding their avoidance.

PG06

### **Pitfalls in the Initial Evaluation and Management of the Trauma Patient**

CHAIR: Robert C. Mackersie, MD, FACS, *San Francisco, CA*  
6 credits

Tuesday, October 18, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$390

The need for rapid decision making in the care of the trauma patient, coupled with the frequent diagnostic uncertainty and/or the presence of occult injuries, may lead to serious errors in diagnosis and management. Errors made in the setting of rapid physiologic deterioration associated with severe injury may lead to increased morbidity and mortality. The objective of this course is

to provide new knowledge to participants that can be readily incorporated into their practices, so they can avoid common errors in the management of severely injured patients. The course is designed for practicing general surgeons who participate in the care of injured patients. Pitfalls in the management of specific injury types, such as vascular, lung, and cardiac injuries, and traumatic brain injury will be discussed along with a more general approach to avoiding errors in the management of pediatric, geriatric, blunt abdominal, and other types of trauma. The format will be didactic, with ample opportunity for interaction with the speakers.

PG07

### **Urology Review Course**

CHAIRS:

Richard D. Williams, MD, FACS, *Iowa City, IA*  
Jerome P. Richie, MD, FACS, *Boston, MA*

6 credits

Tuesday, October 18, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$375

This course will include a full review of urology. Faculty will review five domains of urology: pediatric urology; oncology and urinary diversion; obstruction, calculous disease, and trauma; impotence, infertility, and infection; and incontinence and voiding dysfunction.

PG08

### **Breast Cancer Update**

CHAIR: Michael J. Edwards, MD, FACS, *Little Rock, AR*  
6 credits

Tuesday, October 18, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$390

Surgical diagnosis and management of breast diseases have been the focus of research efforts and new technology over the past decade. As knowledge has increased regarding tumor biology and genetics, new technology has emerged for diagnosis, ablation, and surgical management. After attending the course, participants will be familiar with the various combinations and permutations in the treatment of malignant and premalignant breast disease. They will also have the opportunity to review the latest randomized trials and emerging treatments and technologies for managing breast cancer.

PG09

**Colon Carcinoma**

CHAIR: Bruce A. Orkin, MD, FACS, *Washington, DC*  
6 credits  
Tuesday, October 18, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$350

This session will focus on current concepts in the diagnosis and management of colon carcinoma. A wide range of approaches will be discussed.

PG10

**Emergency Abdominal Surgery in the Modern Era**

CHAIR: Kenneth W. Sharp, MD, FACS, *Nashville, TN*  
6 credits  
Tuesday, October 18, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$390

Topics for discussion include the organization and development of the emerging emergency surgical service, damage control procedures for the nontrauma surgeon, management of abdominal compartment syndromes, laparoscopic management of the acute abdomen, gastrointestinal bleeding, and colorectal emergencies.

PG11

**Surgery of the Thyroid Gland**

CHAIR: Jeffrey F. Moley, MD, FACS, *St. Louis, MO*  
6 credits  
Tuesday, October 18, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$375

This course will address issues pertinent to surgical management of thyroid disease, including pathology, physiology, differential diagnosis of benign and malignant thyroid conditions, and surgical and medical treatment of thyroid diseases.

Technical aspects of diagnostic and therapeutic procedures will be discussed, and therapeutic neck dissection as it pertains to thyroid cancer will be presented. Lastly, preventative thyroidectomy for patients with inherited thyroid cancer syndromes will be discussed.

PG12

**Review Course in Cardiac and Thoracic Surgery for Certification and Maintenance of Certification Candidates**

CHAIRS:

David A. Fullerton, MD, FACS, *Denver, CO*  
David H. Harpole, MD, FACS, *Durham, NC*  
Fee: \$750  
Tuesday, October 18, 8:30 am–12:00 pm and 1:30–5:00 pm, and Wednesday, October 19, 8:30 am–12:00 pm and 1:30–5:00 pm  
12 credits

This review course will cover a broad range of topics in cardiac and thoracic surgery for individuals preparing for certification and maintenance of certification examinations.

PG13

**Management of Common Infections in a General Surgery Practice**

CHAIR: Mark A. Malangoni, MD, FACS, *Cleveland, OH*  
6 credits  
Wednesday, October 19, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$375

The objective of this course is to provide evidence-based guidelines for the diagnosis and management of infections commonly encountered by general surgeons and to present solutions that will help reduce the risk of infection for patients based on established practices and evolving research. Topics to be discussed include soft tissue infections (breast abscess, hidradenitis suppurativa, perirectal infections, necrotizing soft tissue infections), intraabdominal infections (acute appendicitis, acute diverticulitis, biliary tract infections, postoperative intraabdominal abscess), nosocomial infections (surgical site, pneumonia, intravascular catheter), and techniques for lowering the incidence of infection.

PG14

**Postradiation Breast Reconstruction**

CHAIR: Scott L. Spear, MD, FACS, *Washington, DC*  
6 credits  
Wednesday, October 19, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$350

An increasing number of patients request breast reconstruction. The tumor's location, size, cell type, and presence or absence of metastases, a patient's comorbid conditions, and other factors will dictate the need for adjunctive therapy. Often, a need for radiation

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therapy, before or after reconstruction, will affect the surgical oncologist's and plastic surgeon's choices for reconstruction. Many surgeons consider radiation therapy to be a contraindication to reconstruction, or a factor that precludes certain reconstructive choices. This course will discuss the effects of radiation therapy, both before and after reconstruction. Topics for discussion will include the indications for radiation therapy in breast cancer, the effects of radiation on the skin envelope (preconstruction) and the reconstructed breast, as well as indications and contraindications for specific types of reconstructive methods. Risks and complications will be discussed. Speakers for the panel may include a surgical oncologist, radiation oncologist, and plastic surgeons.

PG15

### **Disaster and Mass Casualty Management**

CHAIR: Eric R. Frykberg, MD, FACS, *Jacksonville, FL*  
6 credits

Wednesday, October 19, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$390

A mass casualty disaster is any major man-made or natural event that produces so many injured victims at once that on-site medical resources are overwhelmed and unable to care for all victims without external assistance. Societal infrastructure is disrupted. The most common and most likely disasters to confront us are those involving bodily injury, thus mandating the integral involvement of surgeons in planning and care. The medical management of true mass casualty disasters differs markedly from the routine care of injured patients in emergency rooms and trauma centers, requiring a paradigm change in concepts, approaches, and mindset. The purpose of this course is to educate surgeons in an all-hazards approach to the basic principles and practices of planning, organizing, and caring for this unique and challenging setting, including threat assessment, epidemiology, injury patterns, triage, incident command, available resources, and postevent recovery. Participants will learn the level of anticipation and decision making necessary for a successful disaster response.

PG16

### **Anal Intraepithelial Neoplasia**

CHAIR: Mark L. Welton, MD, FACS, *Stanford, CA*  
6 credits

Wednesday, October 19, 8:30 am–12:00 pm and 1:30–5:00 pm  
Fee: \$375

Upon completion of this course, participants will understand the epidemiology and natural history of anal human papilloma virus infection, the use of high-resolution anoscopy (HRA) as a tool to manage patients at risk for anal cancer, the use of HRA in the clinic and in the operating room, how to recognize and biopsy anal high-grade squamous intraepithelial lesions (HSIL) or precancerous lesions, how to devise a treatment plan for someone with HSIL, the role of HRA in managing perianal and incidentally noted superficially invasive anal cancer, and the role of HRA in following patients who have been treated for invasive anal cancer with combined modality therapy.

Strategies for managing patients both in the office and in the operating room will be presented, followed by a series of practical demonstrations including a slide show designed to emphasize the recognition of lesions.

PG17

### **Introduction to Pain Management and End-of-Life Care**

CHAIR: Geoffrey P. Dunn, MD, FACS, *Erie, PA*  
12 credits

Tuesday, October 18; 8:30 am - 5:00 pm, and Wednesday, October 19, 8:30 am–5:00 pm  
Fee: \$490

This course shall be a one-time requirement of 12 credit hours, which fulfills the State of California mandate for medical licensure. Practicing surgeons are advised to consult the Medical Board of California for further information regarding this requirement.

The goal of the course is to provide the surgeon with information necessary for basic competency in the management of acute and chronic pain and the treatment of terminally ill patients, consistent with the American College of Surgeons Statement of Principles of Palliative Care (2005).

Surgeons of all specialties can expect to encounter patients suffering with acute and chronic pain, occasionally in the setting of terminal illness during which many other burdensome symptoms and unique problems occur. Deficiencies in pain management and care of the dying patient by the medical profession have been documented in several large series, most noteworthy the SUPPORT study of 1995.

## GENERAL INFORMATION

Registration is open to all physicians and individuals in the health care field. Registration includes a name badge, program, and entrance to the exhibits and all sessions other than postgraduate courses. Registered attendees may purchase postgraduate course tickets based on availability. Advance registration is strongly encouraged. Please use one of the following registration options:

*Internet*—Register online at [www.facs.org](http://www.facs.org). Visa, MasterCard, or American Express payment of all applicable fees must be paid at the time of your online registration.

*By mail*—Complete and mail the registration form to: American College of Surgeons, Attn: Registration Services, P.O. Box 92340, Chicago, IL 60675-2340. Payment may be made by check (payable to ACS) or credit card.

*By fax*—Complete the form and fax to 800/682-0252 or 312/202-5003. Credit card payments only.

**Payment of applicable fees must accompany the registration form.** Space in postgraduate courses cannot be reserved without payment. All fees are payable in U.S. dollars. Purchase orders are not accepted. If registration is submitted by fax or online, the original form from this program is not required.

### INITIATES

Initiates of ACS will automatically be registered for the Clinical Congress and need only to return the registration form if postgraduate course or social program event tickets are desired.

### FAMILY/GUESTS

Accompanying spouses, guests, and young adults (16 years or older) may register under the Social Program category, which includes a badge, admittance to the exhibit area, shuttle buses, and all sessions other than postgraduate courses. Social Program registration is not intended for physicians. Spouses and guests who are physicians must register under the appropriate physician category in order to receive CME credit or display physician credentials. The Social Program registration fee is nonrefundable. (See page 50 for more information.)

### CONFIRMATION

Official confirmation will be mailed to the address provided on your registration form within 10 business days of receipt. Please allow adequate time to receive



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confirmation before calling the ACS Registration Office.

### NAME BADGES

Prior to the meeting, each advance registrant will receive an official name badge, attendance verification card, and postgraduate course ticket(s), if applicable. Individuals who do not receive a name badge in the mail may pick up their credentials on-site.

If advance registration is not possible, bring the completed registration form with proper credentials to the on-site registration area at the Moscone Convention Center. There is no on-site registration fee for Fellows, Initiates, Associate Fellows, Resident Members, Medical Students, or Affiliate Members.

### POSTGRADUATE COURSES & FEES

Only registered meeting attendees may purchase postgraduate course tickets. Seating capacities are limited, and ticket requests will be filled on a first-come, first-processed basis. Postgraduate course tickets may be purchased on-site in San Francisco, subject to availability. All courses require a ticket for admission. Tickets may only be exchanged before the beginning of a course and may only be exchanged for another course. Course syllabi will be distributed on-site in San Francisco.

A complete listing of postgraduate courses begins on page 37.

#### REGISTRATION LOCATION AND HOURS

Registration locations and hours are listed below:

	Moscone Convention Center	Hilton San Francisco
Saturday, Oct. 15	*	12:30–6:00 pm
Sunday, Oct. 16	10:00 am–5:00 pm	7:00 am–5:00 pm
Monday, Oct. 17	7:30 am–5:00 pm	8:00 am–4:30 pm
Tuesday, Oct. 18	7:00 am–4:00 pm	*
Wednesday, Oct. 19	7:00 am–4:00 pm	*
Thursday, Oct. 20	7:00 am–12:00 pm	*

\*Registration not available.

#### REGISTRATION FEES AND CREDENTIALS

Category	On or before 8/8 (intl.) or 8/29 (U.S. or Canada)	After 8/8 (intl.) or 8/29 (U.S. or Canada)
ACS Fellow (2005 dues paid)	No fee	No fee
Initiate	No fee	No fee
Associate Fellow	No fee	No fee
Resident Member	No fee	No fee
Medical Student Member	No fee	No fee
Affiliate Member	No fee	No fee
Guest physician*	\$590	\$640
Surgical resident nonmember*	215	240
(with verification letter)		
Medical student nonmember*	20	20
(with verification letter)		
PhD nonmember*	390	450
Hospital administrator (nonphysician)	290	340
Hospital purchasing agent	250	300
Medical association personnel	250	300
Nurse nonmember*	250	300
Surgical assistant nonmember*	250	300
Surgical technician nonmember*	250	300
Commercial press	440	490
Social Program	50	75

\*Please read important membership notice (next section).

Commercial representatives may obtain the commercial registration form by faxing a request to 312/202-5003.

#### RESIDENT AND MEDICAL STUDENT MEMBERSHIP

**Your registration for Clinical Congress is waived if you are an ACS member.** Medical students in U.S. medical schools accredited by the Liaison Committee on Medical Education (LCME) and accredited Canadian medical schools are eligible to apply for Medical Student Membership. The application fee is \$20 and is nonrefundable. Annual dues are not required, but membership expires upon graduation from medical school. The surgery department's chair must sign the application or submit an accompanying letter verifying the student's current status. For a full list of benefits, visit [www.facs.org](http://www.facs.org).

Resident Membership in the American College of Surgeons is open to all surgical residents enrolled in an accredited graduate education program and to surgeons in surgical research or fellowship programs acceptable to the College. The application fee is \$20 and is nonrefundable. All applications must include the program director's signature endorsing the applicant's good standing in an accredited program. Annual dues of \$20 are required, along with a report form recording appointments for the next year, representing the progress of the resident in graduate education. For a full list of benefits, visit [www.facs.org](http://www.facs.org).

\*The American College of Surgeons is pleased to offer discounted registration fees for residents and medical students. Please submit a letter verifying educational status with the completed registration form to expedite processing. Residents should obtain a letter from their program director; students should contact their department chairs. Nonmembers who pay the applicable registration fees will have their membership application fees waived if they apply for membership by December 31, 2005.

#### DEADLINE FOR REGISTRATION

The registration deadline for international registrants is August 8, 2005. The deadline for U.S. and Canadian registrants is August 29, 2005. Registrations received and postmarked after the deadlines will be billed according to the pricing structure published on the registration form.

#### VISA INFORMATION

International Fellows, guest physicians, and meeting attendees: Please be aware that the process of obtain-

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ing a visa to attend meetings in the U.S. takes much longer than in the past. You are strongly urged to apply for a visa as early as possible, preferably at least 60 days before the start of the meeting.

You may request a letter from the College welcoming you to the meeting, if you feel it would be helpful, by contacting the International Liaison Section via e-mail at: [postmaster@facs.org](mailto:postmaster@facs.org) or by fax at 312/202-5001.

### CANCELLATION

Refunds will be issued if written requests are postmarked no later than August 8 for international registrants and August 29 for U.S. registrants. A \$50 handling fee will be retained for all refunds. Cancellations and registrations postmarked after the deadline will be ineligible for refunds.

Conference attendee substitution from one individual to another is not permitted.

The American College of Surgeons reserves the right to cancel any regularly scheduled session before the start of the meeting and assumes no responsibility for nonrefundable airline tickets or other travel costs. The ACS will make every effort to immediately notify registrants of cancellations.

### ACCREDITATION

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

### CONTINUING MEDICAL EDUCATION CREDIT

The American College of Surgeons designates this educational activity for a maximum of 48.5 category 1 credits toward the American Medical Association (AMA) Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

The AMA has determined that physicians who are not licensed in the U.S. and participate in this continuing medical education (CME) activity are also eligible for AMA PRA category 1 credits.

### CME CERTIFICATES

The Clinical Congress Program Book will contain an attendance verification card for recording CME credits. CME certificates will be issued in the registration area beginning Monday, October 17.

### CONVOCATION AND ANNUAL MEETING

The Convocation Ceremony will take place from 6:00 to 8:00 pm, Sunday, October 16, at the Moscone Convention Center. Family members of Initiates do not need to register to attend the Convocation Ceremony only.

The Annual Meeting of Fellows will take place from 7:30 to 8:30 am, Thursday, October 20, at the Moscone Convention Center.

### RAS SYMPOSIUM

Each year the Resident and Associate Society (RAS) sponsors a symposium on a topic targeted at surgery residents, fellows, and young surgeons. This year's symposium—Truncated Training for the Surgical Resident: The Future or Fallacy?—takes place Sunday, October 16, from 1:00 to 4:00 pm, and will examine the issue of truncated training for residents proceeding to surgical specialties. The aim will be to provide insight into the future of surgical training and how truncated training would impact trainees, training programs, and societal needs. Attention will be paid to the possible advantages and pitfalls of reducing the number of years a surgical specialist has to train.

The discussion will also focus on the role of truncated training in the world of limited work hours, as well as its long-term financial benefits and effect on family life. Attendance is open to all RAS members as well as other residents, fellows, and medical students. An open-microphone discussion will promote audience participation.

### MEDICAL STUDENT PROGRAM

Students from all four years of medical school are invited to attend the Clinical Congress and participate in a program designed specifically for medical students who may be interested in pursuing surgery as a career. The program will begin Sunday, October 16, with a welcome luncheon, orientation, and keynote address. A special afternoon session on career options in surgery will include presentations by a dozen surgeons representing different specialties. Topics on Monday, October 17, will include selecting residency programs; preparing for a surgical residency; considering options for surgical practice in the community, academe, or military; and balancing professional and personal commitments. Likely reforms in surgical training are the fo-

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cus of the sessions on Tuesday, October 18, along with the emerging technologies and scientific advances that will change the practice of surgery in the coming years. Receptions each day provide plenty of time for interaction with faculty, other surgeons, residents, and students, including a special reception on Tuesday with program directors. Be sure to take advantage of this unique opportunity. Students must be enrolled in a Liaison CME-accredited medical school to participate. For additional information, please contact Rosemary Morrison at 312/202-5018 or [rmorrison@facs.org](mailto:rmorrison@facs.org). To register, please use the registration form on pages 35-36 or register online at [www.facs.org](http://www.facs.org). Early registration is encouraged, as space is limited.

#### RESIDENTS PROGRAM

Surgery residents from all training levels are invited to participate in a special program designed to assist with planning for posttraining careers and making the transition from training to practice. Several sessions and receptions are planned, with topics such as pursuing career opportunities as academic or community surgeons, surviving the first three years in practice, time management, leadership development, conflict resolution, stress management, and balancing personal and professional commitments. Join residents from other programs and interact with experts who can share techniques for managing the residency experience more effectively and for being better prepared for life after residency. For additional information, please contact Cherylann Sherman at 312/202-5424 or [csherman@facs.org](mailto:csherman@facs.org). Residents must be enrolled in an American Council for Graduate Medical Education-accredited program in order to participate. To register, please use the registration form on pages 35-36 or register online at [www.facs.org](http://www.facs.org).

#### RURAL SURGEONS MEETING

The Advisory Council for General Surgery Subcommittee on Rural Surgery will present an open forum Tuesday, October 18, 4:00–5:30 pm, in the Hilton San Francisco. The subcommittee was formed after the initial forum in 2003 with the mission of improving the patient's access to quality surgical care in the rural setting by identifying and addressing the needs of surgeons in this unique environment. The meeting will involve roundtable discussions about the particular interests and challenges of rural Fellows and about how the College can help Fellows serving such a specialized population.

#### SENIOR SURGEONS MEETING

The College is again sponsoring an open forum during the Clinical Congress where retired surgeons and their spouses may explore the various options available to them in estate and financial planning. The forum is scheduled for Tuesday, October 18, 1:30-3:00 pm, in the Hilton San Francisco. This session is sponsored by the Division of Member Services as part of a continuing effort to assist members who are nearing retirement age, or those who are currently retired, and are in need of new ideas and innovative resources to enhance their ability to manage their money now and in the future.

#### AFFILIATE GROUP FUNCTIONS

Groups planning social functions or business meetings in conjunction with the Clinical Congress will need to make arrangements through the ACS. For more information and to request a function space request form, please contact ACS Convention and Meetings at 312/202-5034.

#### SCIENTIFIC AND TECHNICAL EXHIBITIONS

The Scientific Exhibition is a forum of more than 150 exhibits presenting completed research, research in progress, and case reviews. Innovative surgical practices and teaching methods will also be presented. Scientific Exhibits will be open during registration hours.

The Technical Exhibition comprises more than 250 companies displaying their products and services. The exhibition provides an excellent opportunity to explore the surgical marketplace by comparing products firsthand and planning purchases. Technical Exhibit hours are: Monday through Wednesday, 9:30 am-3:30 pm; Thursday, 9:30 am-12:00 noon.

#### SHUTTLE BUS SERVICE

Complimentary shuttle bus service will be provided for all registrants at regular intervals between the Moscone Convention Center and most designated ACS Clinical Congress hotels. Schedules and routes will be available at the Convention Center and participating hotels.

#### CLINICAL CONGRESS NEWS

The official Congress newspaper, *Clinical Congress News*, will be distributed at the Moscone Convention

Center and at major hotels each morning during the Clinical Congress.

#### CHILD POLICY

The ACS policy regarding children is as follows:

- Younger than 12—not permitted on Social Program tours.
- Younger than 16—not permitted on exhibit floor or in scientific sessions.
- 16 and older—must have a badge to enter exhibit area or meeting rooms.

This policy includes infants in strollers and arms.

#### CHILD CARE

ACCENT on Children's Arrangements, Inc., has planned an exciting activity center for the children of ACS attendees. ACCENT is a nationally recognized professional child care company organized to provide on-site children's activities in a nurturing, safe, and educational environment. Camp ACS welcomes children ages six months to 12 years. For more information, please visit the Web site at [www.facs.org](http://www.facs.org).

#### HELP AND INFORMATION

The Help and Information Center will be located at the Moscone Convention Center and will be available during registration hours. Assistance with general information, travel, housing, local information, and a messaging center will be available.

#### FRIENDS OF BILL W

Friends of Bill W will meet Monday, October 17, through Wednesday, October 19, 7:00–8:30 pm, at the Hilton San Francisco.

#### SOCIAL PROGRAM

A Social Program is offered. Participants must pay a nonrefundable fee, which entitles them to attend scientific sessions, view the technical and scientific exhibits, purchase event tickets, use the shuttle service, and receive a travel tote bag that will include brochures from local merchants, a visitor's guide, a map, and more.

Surgeons and allied health personnel who are registered in their respective categories may purchase event tickets for themselves and are not required to pay the

Social Program registration fee. Because tour capacities are limited, advance registration is strongly encouraged. For more information, please visit the Web site at [www.facs.org](http://www.facs.org).

*Important note:* All tours will depart from and return to the Hilton San Francisco. For personal comfort, we strongly recommend comfortable walking shoes and layered clothing for all tours. Unless otherwise indicated, all lunches referred to are included in the price of the tour. Children younger than 12 years of age are not permitted on Social Program tours unless otherwise indicated. All children 12 years and older must be accompanied by an adult.

Registration forms must be received by August 8, 2005 (international), or August 29, 2005 (U.S. and Canada), to receive a badge and tickets before the meeting. Registrations received after deadline date will be held for pickup at the Social Program registration desk in San Francisco.

#### TRANSPORTATION

Fly United and save on airfare to San Francisco. Special meeting saver airfares are available on United Airlines.

Choose from the following savings options:

- Receive 5 percent off lowest applicable domestic discount fares, including first class.
- Receive 10 percent off mid-week coach fares purchased seven days in advance.
- Obtain 5 percent additional discount on the above fares if tickets are purchased at least 30 days in advance of your travel date.

Area/zone fares based on geographic location are also available with no Saturday night stay required. Minimum stay two nights; seven-day advance purchase required. (Zone fares are not available through online ticket purchase; please call United Airlines.)

These special discounts are available by calling the airline directly (independently or through a travel agent). Be sure to indicate the name of the meeting to which you will be traveling, and refer to the ACS file number to obtain the special fare.

United Airlines  
800/521-4041  
8:00 am-10:00 pm (ET)  
ACS File 501CR

#### **Car rental**

Avis is the official car rental company for the 2005 Clinical Congress. Special meeting rates and discounts

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are available on a wide selection of GM and other fine cars. To receive these special rates, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

Avis reservations: 800/331-1600  
Web site: [www.avis.com](http://www.avis.com)  
AWD number: B169699

#### GENERAL HOUSING INFORMATION

Support ACS in many ways by booking your room through ITS at one of the official Clinical Congress hotels.

#### **Applying for hotel accommodations**

The following housing procedures apply to all general registrants of the Clinical Congress. If you are a Regent, Officer, Past Officer, Advisory Council Chair, Governor, recipient of the Distinguished Service Award, or standing committee Chair and are applying for the Hilton San Francisco, please use the special housing application sent to you.

#### **Housing procedures**

The ACS has appointed ITS to coordinate housing for the 91st Annual Clinical Congress. Reservation requests will be processed on a first-come, first-served basis and must be received by **September 16, 2005**. Requests received after the deadline or after the room blocks are filled are subject to rate and space availability. Housing requests may be made using one of the following options:

*Online*—Go to [www.facs.org](http://www.facs.org) and visit the “Travel Information” page in the Clinical Congress section. Complete the hotel reservation form via the housing link. Credit card deposit only.

*Phone*—Call ACS/ITS at 800/650-6928 or 847/282-2529 between the hours of 8:00 am and 5:00 pm CT, Monday through Friday. Credit card deposit only.

*Fax*—Complete the hotel reservation form and fax to 800/521-6017 or 847/940-2386. Credit card deposit only.

*Mail*—Complete the hotel reservation form and mail with check or credit card deposit to: ACS/ITS, 108 Wilmot Road, Suite 400, Deerfield, IL 60015-5124.

Please do not send requests directly to the hotel or to the ACS office; doing so will only delay processing. ACS/ITS will send you a reservation acknowledgment. Please verify the acknowledgment for accuracy. It is the only acknowledgment you will receive. If you do not receive an acknowledgment via e-mail or fax (within 72 hours)

or mail (within seven days) after sending a request, please contact ITS at the numbers indicated.

#### **Deposit policies**

All reservations must be accompanied by a deposit of \$200 per room paid by check (payable to “ACS 2005” in U.S. funds drawn on a U.S. bank) or credit card (American Express, VISA, MasterCard, Diners Club, or Discover). The deposit guarantees the room for late arrival on the day of arrival only. Credit cards will be charged when the reservation is made.

#### **Changes and cancellations**

Do not call or write the ACS office to change or cancel your reservation. Changes to or cancellation of your reservation should be made with ACS/ITS until September 27, 2005, 5:00 pm (CT). Beginning October 3, 2005, you must contact the hotel directly to make any changes. Please ask for a confirmation number if canceling or changing your reservation directly with the hotel.

Deposits are refundable only if cancellations are made at least 72 hours before arrival date. Reservations canceled after September 16, 2005, are subject to a \$23.50 processing fee. Allow 90 days for processing of a refund.

#### **San Francisco hotels**

For information about hotel locations and rates, please refer to the program planner sent via mail or visit the Web site at [www.facs.org](http://www.facs.org). 

# Socioeconomic tips

## A potpourri of items

by the Division of Advocacy and Health Policy

This month's column highlights a number of policy changes that affect surgeons and their staffs, including: an updated Medicare ambulatory surgical center (ASC) list; authorization to release protected health information from a patient using an interpreter; a recent change in Aetna's unbundling rules; and changes in Medicare's appeals process.

### **Changes to ASC list**

Medicare released a new list of procedures that may be done in an ASC. It is effective for dates of service on or after July 5, 2005. The new list contains 65 additions and five deletions. A complete list of changes, including the amount the facility gets paid for the codes that have been added, is available on the College's Web site at [www.facs.org](http://www.facs.org). No changes have been made to the facility payment amounts.

The Centers for Medicare & Medicaid Services (CMS) said they received a number of requests for inclusion of laparoscopic cholecystectomies on the list. However, they did not add them because of the risk that the laparoscopic procedure would have to be converted to an open procedure, necessitating a transfer to the hospital for the open procedure.

According to CMS, the deletion of the five codes will not pose a problem of access to care for beneficiaries. Three of the deleted codes are performed 50 percent or more of the time in physicians' offices. They are code 21440, *Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)*; code 23600, *Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation*; and code 23620, *Closed treatment of greater humeral tuberosity fracture; without manipulation*. The resources required to perform code 53850, *Transurethral destruction of prostate tissue; by microwave thermotherapy*, are greater than the highest payment to the facility. Finally, code 69725, *Decompression facial nerve, intratemporal; including medial to geniculate ganglion*, is always performed as an in-

### **Around the corner**

#### **July**

- Quarterly update to 2004 Medicare fee schedule effective July 1.
- Quarterly update to 2004 Correct Coding Edits effective July 1.
- Paper national provider identifier applications may be submitted effective July 1.
- Revised Medicare ASC list effective for dates of service on or after July 5.
- Economedix will hold a teleconference July 13 on Creating an Effective OSHA Compliance Program. For more information and to register, go to <http://yourmedpractice.com/ACS>.
- ACS-sponsored basic and advanced coding workshops for surgeons and their office staff July 14 and 15 in Chicago, IL. To register, visit the ACS coding workshop Web page at <http://www.facs.org/ahp/workshops/index.html>.

#### **August**

Economedix will hold two teleconferences this month. The first, on August 10, will be Physician Compensation Formulas of Successful Practices. The second, on August 24, is on Effective Personnel Management...Hiring, Evaluations, and Terminations. For more information and to register, go to <http://yourmedpractice.com/ACS>.

patient procedure. For more information, go to <http://www.cms.hhs.gov/media/press/release.asp?Counter=1438>.

### **Authorization for interpreters**

Surgeons who receive federal funds, such as Medicare or Medicaid reimbursement, must use an interpreter when dealing with a patient who speaks a foreign language or has a hearing impairment. Interpreters, in the course of fulfilling their responsibilities, are likely to receive health infor-

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mation that is protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule. Recently, the U.S. Department of Health and Human Services (HHS) issued a clarification stating that authorization is waived in the following circumstances:

- The interpreters are members of the physician's workforce either as employees, contractors, or volunteers. They already are covered by the privacy rule.

- The interpreter's employer is a business associate of the practice. Many practices have contractual arrangements with private commercial companies or community-based organizations that should satisfy the business associate agreement requirement of the privacy rule.

- The interpreter is a family member or friend of the patient. The practice may either get the patient's authorization or reasonably infer, based on professional judgment, that the patient agrees to the disclosure of protected health information to the interpreter.

- The physician's office contacts a telephone interpreter service. The interpreter explains to the patient that he or she is available to help the patient communicate with the physician and others in the practice. If the patient accepts the interpreter's help, the practice may conclude, based on professional judgment, that the patient is amenable to the disclosure of protected health information and may proceed without having a signed business associate agreement. For more information, go to <http://www.hhs.gov/ocr/hipaa>.

### ***Aetna's unbundling rules***

Effective June 15, Aetna began allowing payment for both CPT code 76872, *Echography, transrectal*, and code 76942, *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*, if both are performed at the same time by the same physician.

### ***Medicare's appeals process***

Legislation passed in 2000 and 2003 made sweeping changes to the Medicare appeals process. The biggest changes are uniform appeals procedures for both Part A and Part B claims; establishment of reduced decision-making time frames; the establishment of qualified independent contractors,

a new entity, to process second-level appeals or reconsiderations; and the transfer of administrative law judges, who hear the third level of appeal, from the Social Security Administration to HHS. All fiscal intermediary initial determinations made on or after May 1 are subject to the new appeals procedures. Carrier initial determinations made on or after January 1, 2006, are subject to the new rules. Complete details will appear in the *Bulletin* later in the year. □

## Dr. Dudrick receives Jacobson Award

Stanley J. Dudrick, MD, FACS, a general surgeon from Waterbury, CT, became the eleventh recipient of the Jacobson Innovation Award of the American College of Surgeons during a ceremony June 10, 2005, at the College's headquarters in Chicago, IL.

Initiated in 1994, the award honors living surgeons or surgical teams who have been innovative in the development of a new technique in any field of surgery. The award is made possible through a donation from Julius H. Jacobson II, MD, FACS, a general vascular surgeon known for his pioneering work in the development of microsurgery. Dr. Jacobson is director emeritus and the Distinguished Service Professor of Surgery at the Mount Sinai School of Medicine of the City University of New York.

Dr. Dudrick received the award in honor of his major contributions to science, medicine, and education through his initial research and ongoing contributions to the field of nutritional support for surgical patients. He is currently professor of surgery at Yale University School of Medicine, New Haven, CT.

Dr. Dudrick was born in Nanticoke, PA, and received a bachelor of science degree in biology with honors from Franklin and Marshall College, where he graduated cum laude in 1957 as president of his class. He was awarded the Williamson Medal as the outstanding member of the graduating class. Likewise,

he was president of his graduating class at the University of Pennsylvania (Philadelphia) School of Medicine and the "Intern of the Year" at the Hospital of the University of Pennsylvania, where he undertook his surgical residency under the tutelage of Jonathan E. Rhoads, MD, FACS. Dr. Rhoads had a longstanding interest in surgical nutrition, especially using peripheral infusions of 10 percent dextrose and casein or fibrin hydrolysates.

Dr. Dudrick conceived the idea of concentrating intravenous nutrients and delivering them via a large bore central venous vessel to prevent thrombophlebitis, the limiting factor with peripheral vessels. To avoid the criticism of weight gain as fat and water, he grew two beagle puppies from six weeks of age to adulthood, one eating normal dog chow and the other receiving nutrients totally by vein. Remarkably for the time (and even now), the two dogs grew and developed normally.

Dr. Dudrick was required to provide daily care for these animals throughout this period and also alter their electrolytes, protein/calorie ratio, and vitamin content and concentrations to result in normal growth and development. The end results of this dedication to the project were two adult beagles that were indistinguishable from each other. This landmark discovery was first published in the proceedings accompanying the meeting of the International So-



Dr. Dudrick

ciety of Parenteral Nutrition in 1966 and in the *Surgical Forum* in 1967.

The next step was to apply the technique to a human being. At the Children's Hospital of Philadelphia, an infant was born with almost complete small bowel atresia, a lethal condition at the time. Dr. Dudrick and this team were asked to attempt to maintain the infant in hopes that the gut would adapt and regain adequate absorptive function as the child grew. Unfortunately, this was not to be. However, growth and development proceeded normally otherwise, once again proving the hypothesis that with appropriate intravenous nutrients, minerals, vitamins, and clinical care, normal growth and development were possible.

News of this accomplishment spread rapidly worldwide, and a new treatment modality was spawned. Along the way, Dr. Dudrick and his team demonstrated the technique of safe, long-term central venous catheterization, which prior to this time was thought to be too dangerous to be practical. They demonstrated that total parenteral nutrition (TPN) using essential amino acids was a therapeutic option for renal failure; small bowel fistulas could close spontaneously if nutrition was restored and maintained; immune incompetence could be reversed by TPN if secondary to protein-calorie malnutrition, even in patients with significant tumor burden; and many other seminal discoveries.

Dr. Dudrick's team also took

TPN to the research laboratory to work out such perplexing problems as gastrin as a trophic hormone for the gut and to dispel the fear that TPN would stimulate tumor growth out of proportion to enteral nutrition.

Dr. Dudrick became a Fellow in 1970, and has served as a Governor (1979-1985); a member of the Committee on Medical Motion Pictures (1981-1990), the Pre- and Postoperative Care Committee (1974-1980, and the Executive Committee, 1974-1977); and as Co-Chair of the Surgical Education and Self-Assessment Program (1993-1995). He also served on the Editorial Subcommittee for the *Manual of Surgical Nutrition*.

For his contribution to science and patient care, Dr. Dudrick has been recognized worldwide

for the development of TPN. He has been a James IV Surgical Traveler; received the Joseph B. Goldberger Award in Clinical Nutrition (corecipient with Jonathan E. Rhoads, MD, FACS), the Brookdale Award in Medicine from the American Medical Association, and the American Surgical Association's Flance/Karl Award; and enjoys honorary fellowships in prestigious surgical societies on every continent except Africa and Antarctica. The annual Stanley J. Dudrick Research Scholar Award was initiated by the American Society for Parenteral and Enteral Nutrition in 1985 in recognition of Dr. Dudrick's research leadership and developing TPN.

Today, all graduating medical students consider TPN as part

## Jacobson Innovation Award recipients

**1994, Professor Francois Dubois**, Paris, France: Laparoscopic cholecystectomy.

**1995, Thomas Starzl, MD, FACS**, Pittsburgh, PA: Liver transplantation.

**1996, Joel D. Cooper, MD, FACS**, St. Louis, MO: Lung transplantation and lung volume reduction surgery.

**1998, Juan Carlos Parodi, MD**, Buenos Aires, Argentina: Treatment of arterial aneurysms, occlusive disease, and vascular injuries by using endovascular stented graphs.

**1999, John F. Burke, MD, FACS**, Boston, MA: Development and implementation of a number of innovative techniques in burn care, including the codevelopment of an artificial skin (Integra™).

**2000, Paul L. Tessier, MD, FACS (Hon)**,

Boulogne, France: Development of a new surgical specialty (craniofacial surgery).

**2001, Thomas J. Fogarty, MD, FACS**, Portola Valley, CA: Design and development of industry standard minimally invasive surgical instrumentation, especially for cardiovascular surgery.

**2002, Michael R. Harrison, MD, FACS**, San Francisco, CA: Creator of the specialty of fetal surgery and developing techniques of fetoscopy for minimally invasive fetal technology.

**2003, Robert H. Bartlett, MD, FACS**, Ann Arbor, MI: Pioneer in the development and establishment of the first extracorporeal membrane oxygenation (ECMO) program.

**2004, Harry J. Buncke, MD, FACS**, San Francisco, CA: Microsurgery and replantation.

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of the routine armamentarium of physicians for the treatment of difficult nutritional problems for both adult and pediatric patients. Hospital and medical school departments have dedicated TPN teams, and an entire industry exists to support this

treatment modality.

The American College of Surgeons is proud to present its 2005 Jacobson Innovation Award to Stanley J. Dudrick, MD, FACS.

The Jacobson Innovation Award is administered by the

Honors Committee of the College. Original thought combined with the first presentation of work that has led to a milestone in the advancement of surgical care is the main criterion for choosing a recipient of the award.

## **JACS centennial symposium: Cherishing the past, shaping the future**

In celebration of 100 years of publishing excellence for surgeons, the *Journal of the American College of Surgeons (JACS)* will host a symposium during this year's Clinical Congress in San Francisco, CA, as part of the celebratory events that will take place throughout the week. To be held on Monday, October 17, at 4:00 pm in the Hilton San Francisco, the symposium will honor the role *JACS* played in the formation of the American College of Surgeons in 1913.

First published as *Surgery, Gynecology & Obstetrics* by Franklin H. Martin, MD, in July 1905, the journal was renamed

the *Journal of the American College of Surgeons* in 1994. During the symposium, five renowned leaders in publishing will provide perspectives on the importance of scientific publishing for surgeon education and patient safety. Seymour I. Schwartz, MD, FACS, Editor Emeritus of *JACS*, will moderate the session. The speakers will be: Andrew Warshaw, MD, FACS, co-editor-in-chief, *Surgery*; George Lundberg, MS, MD, ScD, editor-in-chief, *Medscape General Medicine*, and adjunct professor of health policy, Harvard School of Public Health; Claude H. Organ, Jr.,

MD, FACS, former editor-in-chief, *Archives of Surgery*; Jerome Kassirer, MD, former editor, *New England Journal of Medicine*; and Timothy J. Eberlein, MD, FACS, Editor-in-Chief, *Journal of the American College of Surgeons*.

All attendees are invited to a reception immediately following this symposium, which will also be attended by members of the *JACS* editorial board, guest speakers, the members of the College's Board of Regents, *JACS* authors, and ad hoc reviewers. For more information, contact [whusser@facs.org](mailto:whusser@facs.org).

## **ACS NSQIP launches new Web site**

The American College of Surgeons has announced that the ACS National Surgical Quality Improvement Program (ACS NSQIP) has launched a new Web site, [www.acsnsqip.org](http://www.acsnsqip.org). The new site outlines the program's evolution, including detailed information about the data collected,

reporting capabilities, nurse training, and a list of hospitals that are participating in the program.

The "Getting Started" section includes step-by-step instructions outlining the enrollment process to help surgeons, nurses, and quality improvement staff

initiate participation at their hospital. New online features include the ability to apply online or request a program presentation by ACS NSQIP representatives. Visit [www.acsnsqip.org](http://www.acsnsqip.org) today or call 312/202-5213 for more information.

**Space sold by Elsevier**

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# Dr. Kappel receives Meritorious Achievement Award from ACS COT

David A. Kappel, MD, FACS, a plastic surgeon from Wheeling, WV, received the Meritorious Achievement Award of the American College of Surgeons (ACS) Committee on Trauma (COT) during its annual meeting held March 4, 2005, in Washington, DC. The Meritorious Achievement Award recognizes Dr. Kappel's many contributions to the care of injured patients as well as his efforts on the local level to further the mission of the Committee on Trauma.

Dr. Kappel has served the COT in many capacities, particularly in the state of West Virginia. He served as a member (1981-present), President-Elect (2002), and President (2003) of the West Virginia Chapter of the College and Chair (1997-present) of the West Virginia Committee on Trauma. In addition, he served as Chair of the State Advisory Committee on Trauma (1998-present) and as an instructor for the Advanced Trauma Life Support® (ATLS®) program (1981-present). Dr. Kappel is the 37th recipient of the award since its inception in 1972, and he was chosen by the COT Executive Committee in honor of his long-time support of, and personal commitment to, the care of trauma patients.

Dr. Kappel attended West Virginia University School of Medicine, Morgantown, where he received a MD degree in 1969. He became a Fellow of the American College of Surgeons in 1981.



From left to right: J. Wayne Meredith, MD, FACS, Chair, COT; Dr. Kappel; and Gregory J. Jurkovich, MD, FACS, Chair, Regional Committees, COT.

Dr. Kappel is currently on staff at Ohio Valley Medical Center and Wheeling Hospital, both in Wheeling; Trinity Medical Center East, Steubenville, OH; and East Ohio Regional Hospital, Martins Ferry, OH. He has been a private practice plastic surgeon at Plastic Surgery, Inc., since 1976.

In addition to his membership in the American College of Surgeons, Dr. Kappel holds memberships in many prominent U.S. surgical and medical associations, including the American Society of Plastic and Reconstructive Surgeons, American Society for Surgery of the Hand, American

Burn Association, and the American Medical Association and Western Trauma Association.

The mission of the COT is to improve all phases of the management of the injured patient including prehospital care and transportation, hospital care, and rehabilitation; to prevent injuries in the home, in industry, on the highway, and during participation in sports; to establish and implement institutional and systems standards for care of the injured; to provide education to improve trauma care; and to cooperate with other national organizations with similar objectives.

# Profiles in Leadership

## Richard B. Reiling, MD, FACS

Fellow of the American College of Surgeons since 1977. Medical Director, Presbyterian Cancer Center, Charlotte, NC; Chair, ACS Committee on Development; Recipient, 2004 ACS Distinguished Service Award; member, Mayne Heritage.

*"The mission of the College strongly appeals to my own personal life mission—dedication to the care of the surgical patient. This goal leads to many opportunities, all of which need appropriate funding. The Development Program is dedicated to this subsequent mission of securing funding to further the research, scholarship, and educational activities of the College.*

*"The College has provided me with an avenue to work and thrive in an environment of high ethical standards required for dedication to the care of the surgical patient—the College mission and my own professional goal. The College is the only true source of mission to the surgical patient and as such to the surgeon.*

*"It's a privilege to be involved in the legacy of the perpetuation of care and concern for surgical patients now and in the future."*

Dr. Reiling supports the College financially through active membership in the Fellows Leadership Society.

For information about joining the Fellows Leadership Society, please contact the College's Development Office via telephone at 312/202-5376, via e-mail at [fholzrichter@facs.org](mailto:fholzrichter@facs.org), or by visiting the ACS Web site at [www.facs.org](http://www.facs.org).



**We invite you to consider joining  
Dr. Richard B. Reiling  
in the Fellows Leadership  
Society of the American  
College of Surgeons.**



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## 2005 Health Policy Scholars announced

Eight surgeons were selected to attend the new Leadership Program in Health Policy and Management at Brandeis University in May 2005. The scholars were selected by committees consisting of ACS Health Policy Steering Committee members and representatives of the surgical specialty societies who co-sponsored the scholarships.

Each health policy scholarship included participation in the weeklong intensive course, followed by a year's service as a pro tem member of the College's Health Policy Steering Committee and the equivalent body for the surgical specialty society the physician represented. The scholars are:

**ACS/American Society of Colon and Rectal Surgeons Health Policy Scholar:** Frank G. Opelka, MD, FACS, Beth Israel Deaconess Medical Center, Boston, MA.

**ACS Health Policy Scholar for General Surgery:** Gregory S. Cherr, MD, Buffalo Hospital, Buffalo, NY.

**ACS/American Association of Neurological Surgeons Health Policy Scholar:** Gary M. Bloomgarden, MD, FACS, Yale University School of Medicine, New Haven, CT.

**ACS/American Academy of Ophthalmology Health Policy Scholar:** Philip A. Edington, MD, FACS, Center for Sight, Stockton, CA.

**ACS/American Society of Plastic Surgeons Health Policy Scholar:** Kevin C. Chung, MD, FACS, University of Michigan, Ann Arbor, MI.



Dr. Opelka



Dr. Cherr



Dr. Bloomgarden



Dr. Edington



Dr. Chung



Dr. Silvestry



Dr. Wetchler



Dr. Morasch

**ACS/Society of Thoracic Surgeons Health Policy Scholar:** Scott C. Silvestry, MD, FACS, Thomas Jefferson University, Philadelphia, PA.

**ACS/American Urogynecologic Society Health Policy Scholar:** Stewart J. Wetchler, MD, FACS, Wetchler & Dineen Gynecology, Infertility, Urogynecology, Newport News, VA.

**ACS/Society for Vascular Surgery Health Policy Scholar:** Mark D. Morasch, MD, FACS, Northwestern Memorial Hospital, Chicago, IL.

## College announces a new shared research award

The American College of Surgeons, the American Association for the Surgery of Trauma (AAST), and the National Institute for General Medical Science (NIGMS) announce a program that will provide supplemental funding to an individual who receives a NIGMS Mentored Clinical Scientist Development Award

(K08) for surgeon scientists working in the field of trauma in the early stages of their research careers.

The ACS and AAST are offering this award jointly with the NIGMS as a means to facilitate the research career development of individuals pursuing a career in surgical research. This award

will provide financial support over and above that offered by the NIGMS K08 mechanism.

For further details, please see the College's scholarships Web page, <http://www.facs.org/memberservices/research.html>, or contact the Scholarships Administrator at [kearly@facs.org](mailto:kearly@facs.org).



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## CME ONLINE

### Web casts of select sessions

The Division of Education of the American College of Surgeons is making sessions from Clinical Congress 2004 available online at:

[www.acs-resource.org](http://www.acs-resource.org)

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#### Clinical Congress 2004

- 
- CR04) Locally Advanced Rectal Cancer: Strategies for Success  
Moderator: Robert D. Fry, MD, FACS, Philadelphia, PA
- 
- GS09) Practice-Based Learning and Improvement: What Every Surgeon Needs to Know  
Moderator: Ajit K. Sachdeva, MD, FACS, FRCSC, Chicago IL
- 
- GS16) Contemporary Management of Benign Breast Diseases  
Moderator: Wiley W. Souba, MD, FACS, Hershey, PA
- 
- GS23) Barrett's Esophagus/Nissen Fundoplication and Its Role in the Prevention of Cancer  
Moderator: Carlos A. Pellegrini, MD, FACS, Seattle, WA
- 
- GS30) Management of Malignant/Benign Biliary Strictures  
Moderator: Michael G. Sarr, MD, FACS, Rochester, MN
- 
- GS32) Safety in the Operating Room: Lessons Learned from Aviation and Other Systems  
Moderator: Julie Ann Freischlag, MD, FACS, Baltimore, MD
- 
- GS40) Cutting-Edge Trauma Surgery: What's Proven, What's Not  
Moderator: George C. Velmahos, MD, PhD, FACS, Los Angeles, CA
- 
- GS51) Breast Surgery: Has the Knife Lost Its Edge?  
Co-Moderators: Edgar D. Staren, MD, PhD, FACS, Toledo, OH  
Darius S. Francescatti, MD, FACS, Chicago, IL
- 
- PL03) Management of the BRCA-Positive Patient  
Moderator: S. Eva Singletary, MD, FACS, Houston, TX

#### Spring Meeting 2004

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- 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

Additional sessions from the 2003 and 2002 Clinical Congresses, and the 2003 Spring Meeting, are also available. Please visit [www.asc-resource.org](http://www.asc-resource.org) for details.

**For more information, contact Dawn Pagels, MBA, at [dpagels@facs.org](mailto:dpagels@facs.org).**

- Each session is offered separately.
- Printable written course transcripts.
- Audio of sessions.
- Video of introduction of session.
- Post-test and evaluation.
- Printable CME certificate upon successful completion.

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## NTDB™ data points

# It's in the bag

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

The air bag is an amazing feat of engineering that puts Newton's laws of motion to the ultimate test. As a moving car hits a stationary object and abruptly stops, it is the unabated forward motion of the driver into the steering wheel and windshield that causes significant morbidity and mortality.

In the instance of a driver having the luxury neither of distance nor time, the air bag was designed to evenly reduce the forward momentum of a motor vehicle driver over the short distance in front of the steering wheel in one-twentieth of a second. To accomplish this task, a sensor consisting of a mechanical switch is tripped by a frontal impact that is comparable to running into a brick wall at 8 to 14 miles per hour (mph). A microchip with an accelerometer translates this motion and sends a signal to the air bag inflation system.

This system is similar to a solid rocket booster, where solid propellant ignites, resulting in the production of a large volume of gas. The gas causes rapid deployment of the air bag from the steering wheel at a rate of 200 mph, and over the next one second, gas quickly dissipates through vent holes, allowing the driver to move. Deployment is often accompanied by the release of a dust



consisting of cornstarch or talcum powder, which is used to lubricate the air bag.

Air bags have come a long way from their initial use in World War II as inflatable crash landing devices for airplanes. Production cars first offered air bags as an option in 1974. By model year 1998, all new passenger cars (1999 for light trucks) were required by law to have driver and passenger air bags and safety belts.

According to the Insurance Institute for Highway Safety, 52 percent of the over 207 million cars and light trucks on U.S. roads today have driver air bags. Even though we are only halfway there, air bags have saved over 15,000 lives in the past 20 years. Furthermore, statistics show that passenger cars fitted with airbags have approximately a 30 percent reduction in fatalities over comparable cars without air bags.

## Correction notice

In the May 2005 "NTDB data points" column (page 44), the colors in the graph were inadvertently switched. The "seat belt used" portion of the pie chart should be the lighter

color, indicating that 21 percent of the total number of teenage driver fatalities wore seat belts, as opposed to 79 percent who did not wear seat belts.

The editors regret the error.

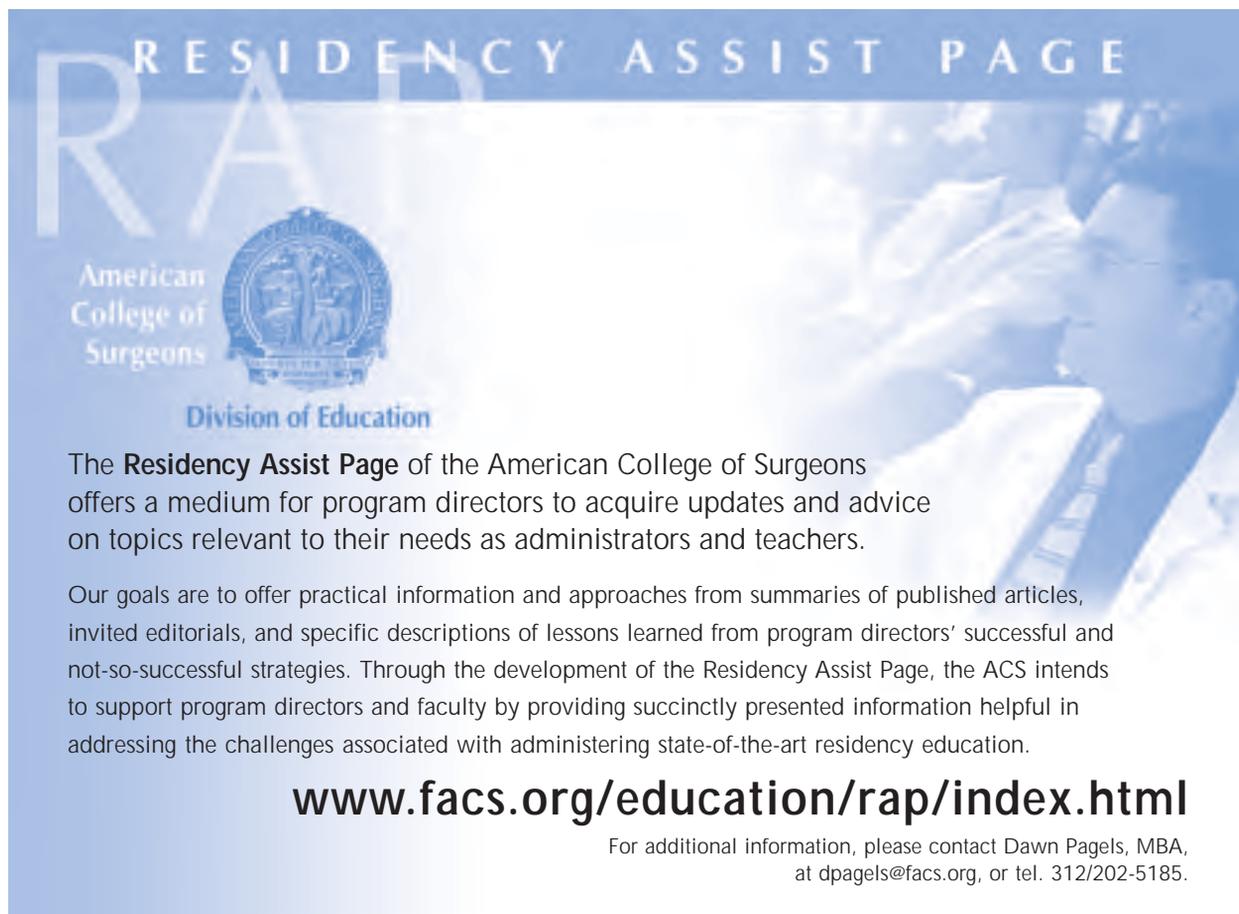
When looking at the records contained in the National Trauma Data Bank *Annual Report 2004*, there are close to 70,000 records of drivers involved in motor vehicle crashes where air bag deployment data are available. There are 435 deaths (2.54%) out of 17,101 drivers with air bags deployed, versus 2,276 deaths (4.38%) out of 52,009 drivers without air bags. This represents roughly a 40 percent improve-

ment in survival for drivers involved in a motor vehicle crash when an air bag deployed. These data are depicted in the graph on the previous page.

The goal of any restraint system is to help save lives. The air bag falls into the category of supplemental restraint system. In order to maximize their effectiveness and reduce air bag related injury, seat belts must be properly worn. After all, it's in

the bag only after the belt is on.

Throughout the year, we will be highlighting these data through brief monthly reports in the *Bulletin*. The full NTDB *Annual Report Version 4.0* is available on the ACS Web site as a PDF file and a PowerPoint® presentation at <http://www.ntdb.org>. If you are interested in submitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at [mneal@facs.org](mailto:mneal@facs.org).



**RESIDENCY ASSIST PAGE**

**RAP**

American College of Surgeons

Division of Education

The **Residency Assist Page** of the American College of Surgeons offers a medium for program directors to acquire updates and advice on topics relevant to their needs as administrators and teachers.

Our goals are to offer practical information and approaches from summaries of published articles, invited editorials, and specific descriptions of lessons learned from program directors' successful and not-so-successful strategies. Through the development of the Residency Assist Page, the ACS intends to support program directors and faculty by providing succinctly presented information helpful in addressing the challenges associated with administering state-of-the-art residency education.

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For additional information, please contact Dawn Pagels, MBA, at [dpagels@facs.org](mailto:dpagels@facs.org), or tel. 312/202-5185.