Exchanging trauma education with West African surgeons
FEATURES

Advanced Trauma Operative Management course introduced to surgeons in West Africa 8
Lenworth M. Jacobs, MD, MPH, FACS, Karyl J. Burns, RN, PhD, Stephen S. Luk, MD, FACS, Edward E. Cornwell III, MD, FACS, and Samuel A. Adebonojo, MD, FACS, WACS

Called to serve as a consultant in the OR? What to do 15
Thomas E. Clancy, MD, and Robert T. Osteen, MD, FACS

Aging and the practice of surgery 18
Lazar J. Greenfield, MD, FACS

DEPARTMENTS

From my perspective 4
Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director

Dateline: Washington 6
Division of Advocacy and Health Policy

In compliance 20
...with HIPAA’s NPI provisions
Division of Advocacy and Health Policy

On the cover: The Advanced Trauma Operative Management course in West Africa (see page 8).
NEWS

RTTDC©: New course to improve rural trauma care
Thomas Foley, MD, FACS, James Kessel, MD, FACS, and G. Douglas Schmitz, MD, FACS

Correction notice

Winners of 2005 Residents Trauma Papers Competition announced

Disciplinary actions taken

Trauma meetings calendar

American College of Surgeons investment vehicle survey

ACS award, scholarships, fellowships are available

Contributions sought for 2006 Residents Trauma Papers Competition

Fellows in the news

NTDB™ data points: One on every corner
Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

Chapter news
Rhonda Peebles
Space sold by Elsevier
A shortage in the number of surgical specialists willing to cover calls from emergency rooms is imminent.

So many issues affect the ability of surgeons to provide adequate care to patients. Some of these problems seem to have a more profound impact on certain specialties than on others, but many have global repercussions for the profession. One subject that should be of great concern to all surgeons at this time is the ensuing surgical workforce shortage in this country, particularly with regard to its implications for emergency and trauma care.

**Conventional wisdom**

Not so long ago, experts studying the supply and demand of physicians in this country warned that by now, we would have a glut of physicians. For example, in 1981, the Graduate Medical Education National Advisory Committee (GMENAC) issued a report indicating that if physicians continued to be trained at what was the current rate at that time, the U.S. would have a surplus of 145,000 physicians within 20 years. Hence, the GMENAC report recommended restricting both the number of admissions to medical schools and the number of graduates of international medical schools permitted to immigrate.

Throughout the 1990s, the Council on Graduate Medical Education (COGME), created by Congress in 1986, issued a series of reports that also projected an oversupply of physicians, especially specialists, by the turn of the century. To address this situation, COGME recommended policies to ensure that 50 percent of new physicians would enter primary care, and the other 50 percent would enter specialties. The council also suggested limiting the number of positions available for residency training in U.S. hospitals to 110 percent of the number of U.S. medical school graduates.

**Emerging crisis**

However, more recent studies conducted by Richard Cooper, MD, former dean of the Medical College of Wisconsin, Madison, question previous assessments of the medical workforce, and especially the need for primary care physicians versus specialists. Based on an analysis of the causal links between the nation’s wealth, its demand for health care services, and the expectation that medical professionals deliver these services, Dr. Cooper and his colleagues project that the need for specialty services will actually increase more rapidly than will the need for primary care.

The increasing need for specialty services is already apparent in our hospital emergency rooms. In a 2004 study conducted by the American College of Emergency Physicians, two-thirds of emergency department (ED) medical directors reported inadequate on-call specialist coverage. Additionally, we recently asked the various surgical board representatives whether they anticipate a shortfall in their members’ availability to cover emergencies. Each specialty polled voiced a similar sentiment: a shortage in the number of surgical specialists willing to cover calls from emergency rooms is imminent.

Given the urgency of the situation, we recently held a meeting of surgical specialty societies to address emergency workforce issues. We sought to determine which specialties are most needed in the ED and what factors are contributing to the crisis.

**Contributing factors**

Clearly, too few surgeons are being trained in some specialties, possibly because of the restrictions emanating from GMENAC and COGME. However, a number of other circumstances appear
to discourage specialists from taking emergency call.

Some specialties report that they find it impractical to provide full-service emergency care and still be able to handle a regular caseload. Many surgeons have opted to subspecialize in order to enhance the efficiency of their practices, to a point where they ultimately feel poorly qualified to provide the broad scope of services demanded in the emergency department. Other surgeons feel that they are trapped between declining reimbursement and rising practice expenses.

Furthermore, the skyrocketing cost of professional liability insurance in some states is putting strain on trauma centers. For example, in July 2003 the only Level I trauma center in Las Vegas, NV, closed for 10 days because of the prohibitively high cost of professional liability insurance for many specialists. Limiting the scope of services they provide and their liability exposure to high-risk patients are among the few options available to surgeons seeking to rein in their premium costs.

Another factor inhibiting specialist participation in on-call panels is the Emergency Medical Treatment and Active Labor Act (EMTALA). Passed in 1986, EMTALA originally was intended to ensure that every emergency patient would receive care, regardless of his or her ability to pay. Since its passage, the law has been subjected to numerous regulatory and legal interpretations, which have had perverse consequences. In fact, many specialists have resigned from trauma panels after widely publicized instances of physician sanctions under this law incited concerns about unwarranted legal exposure for physicians who provide trauma care. Others, particularly those in smaller specialties such as neurosurgery, have found that strict interpretation of EMTALA’s on-call requirements can be so onerous that it interferes with their elective surgery schedules.

Additionally, the evolving role of the “general surgical trauma specialist” is proving to be a barrier to participation by other specialties. Thanks to advanced technology, many trauma and critical care patients are treated and monitored through nonoperative means. Hence, there is the potential for a new surgical specialty to emerge, which would center on providing acute care to those patients who do require prompt surgical intervention. These general surgical trauma specialists could perhaps be likened to the “hospitalists” and their effect on internal medicine. In other words, if there is a gap in providing care, someone will fill it.

Need to respond

It is of the utmost importance that the College and the surgical specialty societies work together to avert the pending ED coverage crisis. This problem already is putting great stress on hospitals and on the emergency physicians who need surgical assistance. If these issues are allowed to fester, it is ultimately the patients who need emergency care who will suffer the consequences.

To help alleviate this condition, it has been suggested that the College call for increases in resident training positions, clarification of EMTALA requirements, a rational payment system for full-service hospitals, regionalization of emergency care, and the development of a board of acute surgery. I anticipate that we will continue to discuss these and other ideas with the surgical specialty societies. Because many of you are affected by this situation, I would welcome any input you can provide about how it is playing out in your institution, as well as any suggestions you might have for bringing this situation to a positive resolution.

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
On March 31, the Centers for Medicare & Medicaid Services (CMS) informed the Medicare Payment Advisory Commission (MedPAC) that the projected update to the 2006 physician fee schedule will be -4.3 percent. Unless Congress intervenes, as it has for the past three years, the across-the-board payment cuts will occur because of how the sustainable growth rate (SGR) system is used to calculate annual physician payment updates. Under the SGR system, high rates of total physician spending growth are recouped in future years through reductions in the annual fee schedule update. Because of past spending trends, current estimates indicate that physician services will be reduced annually from 2006 through at least 2011.

CMS informed MedPAC that Medicare spending for physician services increased at the extraordinarily high rate of 15.2 percent in 2004. The service category with the highest rate of spending growth was physician office visits, which increased 29 percent due to greater frequency and intensity. Other services with heightened growth rates include: minor procedures, such as physical therapy and chemotherapy administration (26%); imaging (18%); laboratory and other tests (11%); and prescription medication (11%). Spending for major procedures increased only 3 percent. The CMS letter to MedPAC can be viewed at http://www.cms.hhs.gov/physicians/medpac.pdf.

On April 11, Sens. Daniel Inouye (D-HI), Orrin Hatch (R-UT), Edward Kennedy (D-MA), Mike DeWine (R-OH), Chris Dodd (D-CT), and Kent Conrad (D-ND) introduced S. 760, a bill to reauthorize the Emergency Medical Services for Children (EMSC) program through fiscal year (FY) 2010 with a funding level of $23 million a year. The legislation, which is titled the “Wakefield Act,” was named in recognition of a North Dakota family that suffered terrible losses in a traffic accident earlier this year. The College, the American Academy of Pediatrics (AAP), the American College of Emergency Physicians, and other medical organizations support the bill.

Previously, the College and 24 other organizations cosigned a letter asking House and Senate appropriators for $20 million in FY 2006 funding for the EMSC program. The letter, authored by the AAP, notes that “the EMSC program has made vital contributions toward the 40 percent reduction in the pediatric death rate from injuries that has occurred in the 20 years since its inception.” To read the letter, go to http://www.facs.org/ahp/views/trauma.html#1.

On March 29, the College testified before the Medicare Coverage Advisory Committee (MCAC), which is examining the management of chronic wounds. At CMS’s request, the MCAC is assessing the quality of the evidence to support various modalities used in wound care and identifying areas for possible research. Offering the College’s perspective was James Laredo, MD, an Associate Fellow and thoracic surgeon.
from Vienna, VA. In his testimony, Dr. Laredo stressed the need for an assessment of arterial and venous insufficiency and for well-designed, objectively analyzed, randomized, controlled trials. For more information, visit http://www.facs.org/ahp/views/medcartrials.html#1.

CMS announced the appointment of a new technical advisory group (TAG) on March 14 that includes three Fellows of the College. The panel is charged with reviewing Emergency Medical Treatment and Active Labor Act (EMTALA) regulations that affect hospital and physician responsibilities in treating individuals who come to the hospital seeking treatment for a medical condition. Its primary function is to help CMS develop rules that will protect individual rights while minimizing unnecessary burdens on health care providers.

The College nominated or endorsed the three Fellows who were appointed to the 19-member TAG. They are: general surgeon Richard T. Perry, MD, FACS (Phoenix, AZ); pediatric surgeon David W. Tuggle, MD, FACS (Oklahoma City, OK); and neurosurgeon John A. Kusske, MD, FACS (Orange, CA). For more information, go to http://qa.cms.hhs.gov/providers/emtala/emtala.asp.

Lorraine Tafra, MD, FACS, director of the Anne Arundel Medical Center Breast Center in Annapolis, MD, testified on behalf of the College before the FDA’s General and Plastic Surgery Devices Advisory Committee meeting on April 11. The panel convened to discuss and vote on two premarket approval applications for silicone gel-filled breast implants by Inamed and Mentor Corporations. The College’s statement focused on breast reconstruction and augmentation as quality-of-life procedures that should be held to the same standard of scrutiny as other procedures. The full text of Dr. Tafra’s testimony can be viewed at http://www.facs.org/ahp/testimony/breastprostheses.html.

Also of interest, the American Society for Aesthetic Plastic Surgery and the American Society of Plastic Surgeons recently launched a new Web site targeted at women who are interested in getting breast implants. The Web site, www.breastimplantsafety.org, is intended to serve as a resource for educating patients about the implants, offering objective and clinically verifiable information on the topic.
Advanced Trauma Operative Management course introduced to surgeons in West Africa

by Lenworth M. Jacobs, MD, MPH, FACS, Karyl J. Burns, RN, PhD, and Stephen S. Luk, MD, FACS, Hartford, CT, Edward E. Cornwell III, MD, FACS, Baltimore, MD, and Samuel A. Adebonojo, MD, FACS, WACS, Dayton, OH
Following his induction as an honorary member of the West African College of Surgeons (WACS), Claude H. Organ, Jr., MD, FACS, Past-President of the American College of Surgeons, proposed an educational exchange between the two organizations. A dialogue regarding an appropriate course developed between Edward D. Yeboah, MD, president of the WACS, and several authors of this article: E. Cornwell III, MD, FACS, president of the Society of Black Academic Surgeons, Lenworth M. Jacobs, MD, MPH, FACS, past-president of the National Medical Association Surgical Section, and Samuel A. Adebonojo, MD, FACS, past-secretary general of the WACS.

Various educational programs were discussed with a view toward providing practical hands-on experience to West African surgeons, who would be expected to implement and sustain the programs in West Africa. The purposes of this endeavor were to: (1) improve care for severely injured trauma patients in West Africa; (2) develop a professional exchange between trauma surgeons in the U.S. and members of the WACS; and (3) introduce trauma surgeons in West Africa to the techniques of Advanced Trauma Operative Management.

**West Africa**

West Africa comprises 16 countries with 260 million people. Ghana is located in the southwestern portion of the region. It is about the size of the U.K. and slightly smaller than the state of Oregon. Its population is 18.4 million people. The government is a parliamentary democracy with an elected president. Its capital city, Accra, is located on the coast and has a population of 1.5 million people.

Trauma is a significant health care problem in Ghana and one of the leading causes of death in West Africa. In the urban areas, the trauma mortality rate is 69 per 100,000 persons annually, with 75 percent of the deaths secondary to motor vehicle injuries. In the rural areas the incidence of unintentional, nonfatal, penetrating wounds represents 43 per 1,000 persons annually. Therefore, the training of surgeons in the management of trauma was identified as a major need, and the concept of providing training for surgeons in the operative repair of penetrating injuries became an important objective. Such training would assist surgeons in the management of penetrating injuries and, consequently, improve their capacity to care for injured patients. These benefits would be realized immediately. The goal then became to develop an educational experience that could be implemented in West Africa and performed by the surgeons at the same standard as any site in the world.

**A plan**

The WACS selected the Republic of Ghana and its capital city, Accra, as the test site for the implementation of the educational program. The Korle-Bu Hospital is the teaching hospital of the University of Ghana and has a long tradition of educating surgeons. The academic faculty has excellent technical and educational skills and is geographically well located with easy access for surgeons from throughout West Africa. Furthermore, Dr. Yeboah is from Ghana.

The plan was to establish a surgical skills center that would initially train surgeons in the operative management of severe penetrating trauma and proceed to conduct regular training programs in other surgical procedures and for other disciplines. Specialties that would be included are anesthesia, surgical operating room technology, surgical operating room nursing, ophthalmology, and veterinary medicine.

A series of meetings occurred in 2003 to solidify the goals of the program and to develop an operational implementation plan. It was then necessary to seek partners to aid in the procurement of equipment and provide financial support for this transcontinental educational endeavor.

**ATOM**

The Advanced Trauma Operative Management (ATOM) course was a logical choice, fulfilling all the educational prerequisites and technological objectives deemed necessary. One of the prin-
The principles of the ATOM course is that it adheres to a structured educational methodology, ensuring that all students receive the same training. The course significantly enhances surgeons’ confidence in their operative skills and increases cognitive knowledge of management of patients with penetrating trauma. ATOM was developed at Hartford (CT) Hospital and the University of Connecticut in association with expert trauma surgeons from the College’s Committee on Trauma.

Ten sites in the U.S. and Canada have implemented the ATOM course and over 250 surgeons have been trained and certified. The sites are Hartford Hospital-University of Connecticut, Massachusetts General Hospital-Harvard University, St. Michael’s Hospital-University of Toronto, Hospital of the University of Pennsylvania, Johns Hopkins University, Maryland Institute of Emergency Medical Services Shock Trauma-University of Maryland, Vanderbilt University, Loyola University, the University of Miami, and the U.S. Army Trauma Training Center in Miami.

The course is designed to be standardized and completely reproducible. The standardization of the course along with its relational database ensures that all surgeons completing the course have demonstrated to the instructors a similar level of surgical operative competence. Instructors are required to have successfully completed the student ATOM course as well as an instructor course. Each instructor is taught to create the injuries in a standardized manner so each student has a similar surgical challenge.

Learning methods

ATOM was designed to teach surgeons to diagnose and operatively manage penetrating injuries to numerous organs in the abdomen and
Operating rooms in the Surgical Skills Centre in Accra.

Samples of instruments used to support the ATOM course; they were donated to the Surgical Skills Centre.

cHEST, including the bowel, bladder, kidney, ureter, pancreas, duodenum, stomach, diaphragm, liver, inferior vena cava, spleen, and heart. The injuries are produced in live 50 kg swine, which are fully anesthetized and monitored with arterial pressure transducers and EKG monitors. The student objectives are to accurately identify the injuries, develop a clinically safe and acceptable management plan, and then to successfully repair the injuries. The animal must be adequately managed so as to be hemodynamically stable at the end of all the procedures.

To document students’ learning and to ensure a sound educational experience, the students are given pretests online to assess their level of knowledge and confidence regarding the management of patients with penetrating trauma. They are then provided with a CD/video with the correct surgical repairs of the injuries as well as a textbook containing the knowledge content for managing the injuries two weeks before the course.

On the day of the course, the students attend six standardized 30-minute lectures outlining the diagnosis and management of injuries to the organs in the chest and abdomen.

The students then proceed to the surgical skills laboratory. Each student learns from an individual certified ATOM instructor. The instructor gives the student a clinical scenario outlining the injuries to a specific area of the abdomen or chest.

The student is then asked to leave the operating room. The instructor creates injuries using a standardized method that ensures that each student has a similar surgical challenge. The student is invited back into the operating room and is asked to: (1) identify the injuries; (2) provide a plan to operatively manage the injuries; and (3) perform the necessary
surgical repairs. After successfully repairing all the injuries, the student then takes the posttests online.

The importance of completing all the registration and pre- and posttest requirements online is that these data are entered immediately into a relational computer database. This allows for comparison in the educational performance of surgeons at different levels of training, in different areas of the country and the world, and allows for careful evaluation of the areas of cognitive competence in the management of injuries of the various organs. The course can then be modified to accommodate to areas of weaknesses because they are specifically identified.

Implementation in West Africa

It was immediately apparent at the inception of the planning process that it would require the complete involvement of the leadership of the West African College of Surgeons, the Korle-Bu Teaching Hospital of the University of Ghana, the Ministry of Health of Ghana, and the senior surgeons and anesthesiologists at the teaching hospital.

To achieve a successful outcome, Dr. Yeboah and Rudolph Darko, MD, chief of surgery and head of research at the Korle-Bu Teaching Hospital at the University of Ghana, along with Dr. John Quartey, the previous president of the WACS; Dr. Adebonojo, the past-secretary general of the WACS; and Dr. N.A. Adu-Aryee, a senior surgeon, came to Hartford Hospital and the University of Connecticut to audit and participate in an ATOM course. Dr. Darko was certified as an instructor of the ATOM course. He will serve as the principal investigator of future ATOM courses in Accra, where they are to be conducted under the appropriate academic and clinical auspices in West Africa.

To maximize the exposure of West African surgeons to the ATOM course, they were given an opportunity to audit the six lectures on penetrating trauma. Fifty surgeons, along with five previous presidents of the WACS, attended the course. A number of these surgeons also inspected the skills center and observed their colleagues performing the operations.

Course support

It was a major logistic and financial challenge to conduct a surgical skills course with live animals using full anesthesia and Institutional Animal Care and Use Committee support in a remote location. Johnson & Johnson and their subsidiary companies, Codman Surgical Instruments, Ethicon Sutures, and Ethicon Endo-Surgical, provided financial and equipment support for two operating rooms, each with two operating tables for a total of four. Around each of the four tables, the necessary surgical instruments, anesthesia machines, sterilizers, and support equipment were provided. These resources were donated to the Korle-Bu Teaching Hospital.

Opening Ceremony for the Surgical Skills Laboratory in the ATOM course. Front row, left to right: Mr. Person; Dr. Nwariaku; Dr. Jacobs; Prof. Giwa-Osagie, MD, past-president of WACS; Dr. Yeboah; Moses Dansha, then-Deputy Minister of Health; Christine Rada, representative, U.S. Embassy; Prof. C.N. Tagoe, provost; and Dr. Cornwell.
University of Nigeria Teaching Hospitals; and four from Ghana: Korle-Bu Teaching Hospital, the 37th Military Hospital, Komfo Anokye Teaching Hospital, and the Police Hospital. These surgeons completed the pretest, attended the lectures, and successfully completed all the trauma procedures in the skills laboratory.

The ATOM instructors included: Dr. Jacobs, Stephen S. Luk, MD, FACS, assistant professor of surgery, University of Connecticut, and medical director of the ATOM course, Hartford Hospital and University of Connecticut; Dr. Cornwell, professor of surgery and chief of trauma, Johns Hopkins Hospital, Baltimore, MD; Peter Ekeh, MD, MPH, FACS, assistant professor of surgery, Wright State University School of Medicine, Dayton, Ohio; and Fiemu Nwariaku, MD, FACS, FWACS, associate professor of surgery, University of Texas Southwestern Medical Center, Houston. William Dyckman, research technologist, Hartford Hospital, provided anesthesia and veterinary support services in collaboration with the anesthesia department at the University of Ghana. The local faculty was Dr. Darko and Dr. Adu-Aryee. Eight other senior surgeons assisted during the operative procedures and audited the course.

Discussion

The involvement of international and local faculty had the advantage of exposing a significant number of local surgeons and anesthesiologists to the concept of advanced surgical skill acquisition and the ATOM process. A sense of ownership was fostered at the Korle-Bu Teaching Hospital and the University of Ghana Medical School that created confidence and pride in successfully implementing the course with the same standards used in North America.

The ATOM course in West Africa has also allowed for in-
ternational comparisons. Surgeons in different parts of the world are educated in different educational systems (British, French, American, and so on) but are expected to successfully repair injuries in any patient anywhere in the world. One of the important outcomes of the ATOM course and its relational database is that there is the potential to identify successful operative procedures in any international geographic location and incorporate them into the educational content of the course.

A challenge of the ATOM course in West Africa that was successfully overcome was the implementation of a paperless electronic evaluation process. The students took the pretests in their country of origin via the Internet and successfully completed their posttests via the Internet in Ghana. All scores were accessible online in Accra. Immediate certification of successful completion of the course and continuing medical education credits were provided.

Conclusion

The successful completion of the course generated considerable enthusiasm. A courtesy call to the president of the Republic of Ghana, John Agyekum Kufuor, was arranged. The Honorable Minister of Health, Major Courage Quashigah; the director general of the Ghana Health Service, Prof. Agyeman Badu Akosa; and Dr. Yeboah led a delegation of the ATOM course leadership to meet with the President, His Excellency Mr. John Agyekum Kufuor. The ATOM leadership attending this meeting included: Dr. Jacobs, founder of the ATOM course; Dr. Darko, chief of surgery and the principal investigator of the ATOM course in Ghana; Rev. Myles Fish, chief executive officer of International Aid; and Mr. Person of Johnson & Johnson International. President Kufuor endorsed the concept of the ATOM course and pledged the country’s support for the ongoing implementation of a structured educational program for surgery, as he believes this will be a significant benefit to the citizens of Ghana and the entire region of West Africa.

Within one week of the completion of the course, one of the major objectives was fulfilled. Immediate benefit to a severely injured patient was realized when Dr. Darko managed a patient with a severe gunshot wound to the liver and was able to use one of the techniques taught in the ATOM course with a successful outcome. The patient has done well.

An additional benefit of the educational program was the opportunity to develop social and professional friendships. The kind and generous hospitality that the West Africans offered to the visiting group was exceptional. The concept of surgeons interacting with their colleagues and learning from each other was never more evident than in Accra, Ghana.

References


Dr. Jacobs is professor of surgery and chairman, department of traumatology, University of Connecticut School of Medicine, and director, trauma program, Hartford Hospital, Hartford, CT.

Dr. Burns is research scientist, trauma program, Hartford Hospital, Hartford, CT.

Dr. Luk is assistant professor of surgery, University of Connecticut School of Medicine, trauma program, Hartford Hospital, Hartford, CT.

Dr. Cornwell is professor of surgery and chief, adult trauma service, Johns Hopkins University School of Medicine, Baltimore, MD.

Dr. Adebonojo is professor of surgery and chief, surgical services, Wright State University School of Medicine, Dayton, OH.
At some time, most surgeons have been approached by another surgeon asking for advice or operative assistance due to unexpected problems or questions in the operating room. Regardless of whether we find these requests flattering or annoying, they should be regarded as calls for help from our colleagues. As surgeons, our social contract with patients and colleagues dictates a prompt and professional reply.

The unplanned nature of the intraoperative consultation and communication errors regarding the nature and degree of assistance required can potentially lead to confusion and inappropriate care. As surgical care becomes increasingly subspecialized, the frequency of these interactions will probably increase. We suggest some guidelines for approaching the intraoperative consultation.
What's your role?

Some operative consultations are of such an urgent nature that the consultant must rapidly enter the operative field for direct surgical assistance without an opportunity to review the pertinent data; such instances commonly involve uncontrolled hemorrhaging. In all other situations, the consultant should take sufficient time to review the patient’s medical history, preoperative workup, and relevant radiologic studies. The first goal should be to identify the nature of the consultation by determining: (1) exactly what the surgeon wants from the consultant; (2) whether the problem is medical, social, intellectual, or technical; and (3) whether the preoperative diagnosis is correct.

Identification of the information or expertise the primary surgeon needs, while seemingly straightforward, is the most important part of the interaction. In many cases, surgical or technical advice is sought. A senior surgeon may be able to offer suggestions on how to proceed with a difficult operation.

In other cases, a primary surgeon may seek out a more experienced colleague for assistance in decision making. For instance, when faced with an unusual or unexpected finding on frozen section examination of a specimen, a primary surgeon may ask a colleague for data on the natural history of this condition. Some surgeons, particularly when operating on a malignancy that appears unresectable, seek the solace of a colleague who might reinforce this opinion. Other surgeons may not require technical advice or data but, nonetheless, seek the support of a senior member of their department when an operation becomes far more extensive than anticipated. The consultant’s primary role here may be to validate what the primary surgeon already knows. Most of these consultations require little, if any, direct operative involvement and minimal patient responsibility.

Nature of request

The consultant should determine whether the nature of the request is primarily medical, social, intellectual, or technical. Consultations of a medical nature typically involve an intraoperative judgment regarding whether to proceed with an operation or how to respond to an unexpected finding. Similarly, these questions may be of a more intellectual nature, where a surgeon seeks experiential knowledge to guide further operative management. Queries may be purely technical, although often the raising of these so-called technical issues is really a search for surgical guidance or judgment in disguise. Technical, intellectual, and medical questions may require a consultant to briefly scrub in on a case to get a better sense for the operative field, but usually do not require direct surgical involvement.

Consultations may be of a more social nature as well; a surgeon might call in a subspecialist when he or she believes the consultant’s “turf” is involved. In other circumstances, “social” consultations might reflect an obligation of the primary surgeon to involve another specialist if unforeseen complications arise. Additionally, when faced with a difficult case that seems likely to result in legal action, some surgeons will solicit early support from colleagues. In general, these so-called social concerns require minimal if any direct involvement on the consultant’s part, but do imply the assumption of some responsibility by “blessing” the procedure.

Direct operative assistance is sometimes requested. For instance, unexpected bowel involvement may be discovered during attempted resection of a pelvic mass, prompting a general surgery consultation. In such cases, it is essential for the consultant to clarify in advance which parts of the procedure he or she is expected to perform, and also which aspects of postoperative care each team will be responsible for. In precisely defining roles, the consultant surgeon acts much like a subcontractor for the operation. It is entirely appropri-
ate that a consultant have access to specialized or personal surgical instruments and, occasionally, a surgical team from his or her own specialty.

Sometimes a surgeon finds that the complexity or details of an operation are sufficiently outside his or her area of expertise that complete operative management by another surgeon would be more appropriate. This situation calls for an intraoperative transfer that would require the consultant to assume full responsibility for patient care after the operation. For any degree of operative assistance, the consultant also is responsible for judging the appropriateness of the requested intervention. It may be impossible to perform the requested procedure with the incision and exposure provided by the consulting team. In some cases it is appropriate to discuss elements of the case with available family members, or even to elect to perform the operation at a later date after a full discussion of options with the patient.

Assessing preoperative diagnosis

Finally, it is crucial for the consultant to assess the preoperative diagnosis and judge whether it was correct. When operative findings show that a working diagnosis is incorrect, the consultant’s potential for involvement in the case can range from advice to operative management and postoperative care. If the preoperative diagnosis is correct, however, the role of the consultant is generally much more limited, as the primary surgeon presumably is able to handle the issues and technical maneuvers associated with that diagnosis.

Surgeons performing intraoperative consultations should be aware that reimbursement is different than for office or inpatient consultations. Although reimbursement guidelines vary between states and insurance plans, intraoperative consultations of an intellectual nature often are not reimbursed. Brief, informal consultations may be considered a professional courtesy between colleagues. More extensive consultations may be billed as an inpatient consult, provided that full documentation is provided. Surgical “standby” services, in which a consultant scrubs in for an operation to offer advice but does not perform the procedure, are generally nonbillable and unpaid services.

Despite the time and expertise required, rarely may a consultant collect a fee for “standby” services in the absence of a prior negotiation or agreement between surgeons and their facility. For operative assistance, payment may be sought as an “assistant” if the procedure performed is one in which assistance is permitted by a given insurance plan or Medicare policy, and if resident assistance is unavailable. Alternatively, a consultant may bill as “co-surgeon” with the primary surgeon; however, such arrangements require an agreement between the surgeons and their facility regarding the percentage of fee to be collected by each surgeon. A consultant may bill separately for operative services if such services are associated with a new or different diagnosis (for instance, when consulted for an open biopsy of a new liver lesion detected during laparotomy performed for a gynecologic problem).

The acute nature and breadth of potential scope of intraoperative consultations can lead to miscommunication and confusion regarding roles. By precisely defining the question at hand, the nature of the consultation, and, if necessary, the specific operative or technical assistance requested, the consultant surgeon can help to maximize appropriate patient care.

Dr. Osteen is a senior surgeon, division of surgical oncology, Brigham and Women’s Hospital, Harvard Medical School, Boston, MA.
The February issue of *Annals of Internal Medicine* carried an article and an editorial about the failure of older physicians to stay abreast of medical advances and “to practice according to the latest medical standards.” As expected, the press picked up the topic and asked questions about how it should influence the selection of a physician. It would be naïve to assume that similar questions will not be raised about the performance of aging surgeons.

Although we all know we are getting better as we accumulate birthdays, some mental and physiological changes with aging are inescapable. The question has always been, at what point do the changes of senescence begin to affect performance?
Retirement survey

In the early 1990s, members of the American Surgical Association participated in a survey on surgeons’ attitudes toward retirement. I learned that many surgeons fail to prepare for a life after surgery, and although some have a predetermined age of retirement, others plan to evaluate themselves or wait for some event to force the issue. The danger of the latter attitude is obvious in terms of risk to patient care and to the surgeon’s reputation. Diminished endurance and strength prompt most surgeons entering their 50s to begin reducing the frequency and complexity of their cases. But what should determine how long a surgeon should continue to operate?

What the survey lacked was an objective measure of the effects of aging in surgeons. The rationale for such a study is to provide objective feedback to surgeons and to let outside agencies know that we are aware of the potential problem and are addressing it on the basis of objective data analysis.

CANTAB

After some experimentation, my colleagues who had assisted with the retirement survey and I found a sensitive and highly reproducible test of cognition, reaction, and movement times that could be administered in 20 minutes. This Cambridge Neuropsychological Test Automated Battery (CANTAB) has been validated in all age groups and in thousands of people. With the support of the College, we began administering it to volunteers over age 45 attending the Clinical Congress in 2001. Over the past four years, we have tested a total of 303 surgeons, and look forward to completing the five-year study this year by retesting as many of them as possible.

Test results are provided only to each surgeon’s private physician so that it becomes a part of his or her medical record.

We also have some idea of surgeons’ preparation for and attitudes toward retirement, based on a survey instrument completed by all age groups who have visited the CANTAB booth each year. Our preliminary findings indicate that surgeons are not immune to the cognitive decline that affects everyone with advancing age. Cognitive losses were most evident in surgeons who had already retired, but it’s impossible to determine whether this deterioration is the cause or the effect of retirement. The self-evaluation data drawn from the survey indicate that surgeons often inaccurately estimate their own cognitive status.

Completely unexpected was the finding that surgeons as a group have much faster reaction and movement times than age-matched controls and that this ability is preserved with age. Whether this is a feature of selection or training is a fascinating question that deserves further study. We are also anxious to learn how surgeons will use the information provided by the tests.

Retest

At the 2005 Clinical Congress, and possibly at the 2006 Spring Meeting, we will retest all volunteers from previous years to measure any changes in performance and to determine whether these differences in ability relate to the surgeon’s assessment of his or her practice. Surgeons who have been tested previously are asked to return to the CANTAB booth for retesting at the upcoming Clinical Congress in San Francisco, CA, or at the next Spring Meeting in Dallas, TX. Surgeons who have not been tested but would like to participate are encouraged to contact me at surgerynews@facs.org.

Dr. Greenfield is professor and chair emeritus, department of surgery, University of Michigan, Ann Arbor, MI. He is Editor-in-Chief of Surgery News.
In compliance...

...with HIPAA’s NPI provisions

by the Division of Advocacy and Health Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) included provisions for a national provider identifier (NPI). NPIs are now being issued and physicians must have them by May 23, 2007.

Rather than have each health insurance plan issue its own identifying numbers for physicians and other providers, the federal government will issue a single number for use by all health plans and in all HIPAA transactions. Each physician will be assigned only one NPI, which will remain the same over time. The Centers for Medicare & Medicaid Services is responsible for administering the NPI.

Surgeons must complete and submit the application form for an NPI, although in many instances their practices will submit the application. Although all physicians may have an NPI, those who transmit HIPAA entries, including claims, must have one. Each payor will decide when to begin using the NPI, and surgeons must have obtained one by the time the first payor requires the NPI.

Applications will be processed and NPIs issued by an “enumerator” operating under a contract to CMS. The enumerator will also be a resource to health care providers, assisting them in completing applications, resolving problems, and answering questions.

Implementing the NPI by all payors will be a big undertaking. They will have to make changes in their systems to accept the new number and request NPIs from all of their members, including hospitals and other providers. Once the effective date of May 23, 2007, arrives, “legacy” or existing identifiers will be prohibited in HIPAA electronic transactions.

Payors can convert to the new NPI system anytime between now and the deadline, although none is ready to make the switch any time soon. Furthermore, small health plans have an additional year, until May 23, 2008, to convert. Thus, physicians will see only limited relief from the present multinumbering systems for nearly two years. It may be up to three years if they are enrolled in a small health plan that takes advantage of the extension of the deadline.

It is important to be sure that your system can handle the NPI and that the office staff knows how to enter it. Be sure to check that it will be in advance of the first payor converting to the NPI.

Although applications have been accepted via the Internet since May 23, other routes to apply for an NPI will become available later this summer. The enumerator is scheduled to accept paper applications starting July 1 and will accept a file of bulk applications from large groups still later, probably by September.
The NPI is a 10-digit number, consisting of nine numbers plus a check digit in the tenth position. It contains no embedded information about the person it identifies. Changes in the information on the NPI application must be reported to the enumerator within 30 days of the change.

It is possible that a given surgeon will have multiple applications for an NPI made on his or her behalf. This will occur if he or she is in multiple practice settings and each practice decides to apply for NPIs for all of their physicians. Do not worry if this happens. The enumerator is to check the records of previously issued NPIs to see if one has already been issued before assigning a new NPI.

Declaring a specialty requires either consulting a list of specialty codes on the Internet or writing the specialty in English for the enumerator to convert to the proper code. In addition to the specialties that the College recognizes, transplant surgery and oral and maxillofacial surgery are considered specialties. General surgeons are recognized as just plain “surgery” and have code 208600000X. The subspecialties of surgery are pediatric, plastic and reconstructive, hand, critical care, oncology, trauma, and vascular surgery.

Several specialties have more than one specialty code. For example, hand surgery appears under orthopaedic surgery, plastic surgery, and surgery, each with different code numbers. Plastic surgery appears twice: once as its own specialty and again as the plastic and reconstructive subspecialty under surgery. This is an important point to remember for individuals who are in a subspecialty and expect the enumerator to enter the code for you. For example, a hand surgeon who wants to be classified under orthopaedic surgery should put down “orthopaedic surgery, hand surgery.”

Surgical practices may also have to register other professional staff, such as advanced practice nurses and physicians assistants. Their specialty codes are under the headings of “nursing service providers” and “physician assistants and advanced practice nursing providers.”

Adoption of the NPI is the latest step in implementing the administrative simplification provisions of HIPAA, which was enacted nine years ago. Electronic transactions and code sets and security standards already are in place. The privacy rules under HIPAA have made a number of changes in office procedures.

Other standards call for creating health identifiers for employers, so health plans and employers can exchange information electronically. Standards for claims attachments and unique identifiers for health plans are still under development.
A new course was unveiled to the members of the Committee on Trauma (COT) during the 2004 Clinical Congress. The Rural Trauma Team Development Course© (RTTDC) is the product of several years of work by the ad hoc Rural Trauma Committee (RTC) of the COT.

In 1997, the RTC began an ongoing discussion of the issues and problems that rural surgeons and physicians face, culminating in the higher morbidity and mortality rates of rural trauma patients. Multiple factors that interfere with the timely delivery of care have been identified. Many of these variables, such as geographic isolation, financial limits on resources, discovery time of injured patients, distance to definitive medical care, and so on, are inherent to the rural trauma setting and difficult to change.

However, the RTC maintains that the time delays in the assessment and resuscitation of the injured patient can be improved through educational outreach to the rural hospital staff. An informal survey of rural hospitals/clinics revealed that most could mobilize three individuals to attend to the trauma patient. These three individuals historically have had a limited ability to efficiently coordinate the use of resources necessary to effectively care for these patients. It became obvious to the committee that the small, rural facility staff would benefit most from an educational program that would show them how to organize a trauma team. The result is the RTTDC, designed to train rural hospital or clinic personnel in the team approach to the initial assessment and resuscitation of the injured patient with an emphasis on early transfer to definitive care.

The participants are rural hospital personnel who, for the purposes of the course, are divided into three member teams composed of: (1) physicians or physician extenders; (2) nurses; and (3) nurses, paramedics, emergency medical personnel, clerks, or technicians. Laboratory tech-

---

**COT members who contributed to RTTDC**

| James Anderson, MD, FACS, Casper, WY | June Heilman, MD, FACS, Pocatello, ID |
| Donald Barker, MD, FACS, Chattanooga, TN | David Kappel, MD, FACS, Wheeling, WV |
| Reginald Burton, MD, FACS, Lincoln, NE | Donald Kauder, MD, FACS, Philadelphia, PA |
| David Clark, MD, FACS, Portland, ME | James Kessel, MD, FACS, Columbia, MO |
| Cris Criberti, MD, FACS, Fort Collins, CO | West Livaudais, MD, FACS, Salem, OR |
| Brad Cushing, MD, FACS, Portland, ME | Joseph Lohmuller, MD, FACS, Davenport, IA |
| Mary Fallat, MD, FACS, Louisville, KY | William Long, MD, FACS, Portland, OR |
| Thomas Foley, MD, FACS, Marshalltown, IA | John Middleton, MD, FACS, Billings, MT |
| Eric Frykberg, MD, FACS, Jacksonville, FL | Dale Oller, MD, FACS, Raleigh, NC |
| William Ganz, MD, FACS, Coeur D'Alene, ID | Scott Peterson, MD, FACS, Phoenix, AZ |
| Ron Gardner, MD, FACS, Buffalo, WY | L.R. Scherer, MD, FACS, Indianapolis, IN |
| Dean Gubler, MD, FACS, Portland, OR | G. Douglas Schmitz, MD, FACS, Torrington, WY |
| Steve Hamar, MD, FACS, Fargo, ND | Gregory Timberlake, MD, FACS, Jackson, MS |
nicians, X-ray technicians, respiratory therapists, and other ancillary care practitioners also may participate. The students are encouraged to participate as a team in all course activities.

RTTDC is considered an excellent educational tool for a Level I or II trauma center’s outreach education program. It is designed to be portable and taken directly into the rural community. Likewise, it is modular and can be given in one eight-hour session or up to four two-hour sessions. The cost of the program is minimal, and some course expenses have been supported through grant funds. A limited amount of equipment is required: specifically, an LCD projector, an intubation mannequin and intubation equipment, and chest needle aspiration and chest tube equipment. Space requirements consist of a room large enough to accommodate the student lectures and two smaller breakout rooms for patient scenario stations. Initial courses have been given at hospitals, a fire department, a conference center, a clinic, and a high school gym.

The state COT chairpersons or their designees are in charge of the course in each state. RTTDC requires a course director who is a surgeon, an experienced Advanced Trauma Life Support® (ATLS®) instructor, a trauma center director or designee, and approved by the state COT chair. A course coordinator from the trauma center and a coordinator at the local facility also are needed. It is recommended that prior to presenting the initial program, the director have previous exposure to the course.

A ratio of one instructor per two teams is required. All course material is contained on one CD.

Initial courses have been very well received, reinforcing our belief that there is a definite need for such a course. Anecdotal information from course participants indicates that patients have benefited from teams taking the course. At press time, 23 courses involving more than 400 participants had been held. Requests for future courses have been voluminous.

It is interesting that in this same time period at least two other countries have developed and held courses with similar material and philosophy. This would seem to indicate the universal need for this type of course. On October 16, before the 2005 ACS Clinical Congress in San Francisco, CA, the RTC will host a meeting between the committee members and any of our international colleagues who are interested in RTTDC and those who are developing or have developed similar courses.

Members of the COT who have contributed their time, talent, or educational material to the course are listed in the box on page 22. Additional material was used with the permission of the ATLS and Prehospital Trauma Life Support® courses and Trauma.org.

Individuals who would like to offer a course at their hospital should contact their state’s COT chairperson or the Level I or II trauma center to which they refer patients.

Dr. Foley is a general surgeon on staff at the Marshalltown (IA) Medical and Surgical Center, and a member of the COT.

Dr. Kessel is director of trauma, University of Missouri Hospital and Clinics, Columbia, MO, and a member of the COT.

Dr. Schmitz is a general surgeon on staff at Community Hospital, Torrington, and Platte County Memorial Hospital, Wheatland, WY. He is the Wyoming state COT chair and medical director for the state trauma program.

**Correction notice**

In the April 2005 Bulletin “Socioeconomic tips” column titled “Frequently asked ACS Coding Hotline questions,” there were two errors.

- The first error was in the fourth question involving billing for a number of procedures, including placing a jejunostomy tube. Both the question and answer erroneously used the phrase “g-tube” instead of “j-tube” to refer to the jejunostomy tube.
- The second error was in the next-to-the-last item about coding for an office visit within the global period for an open breast biopsy. The answer said the ICD-9-CM code to indicate an unspecified breast mass was “L11.72.” The correct ICD-9-CM code is “611.72.”
The ACS Committee on Trauma announced the winners of the 2005 Residents Trauma Papers Competition at its annual meeting March 3-5, in Washington, DC. This year, 13 regional winners received prize money of $500, with additional first place prize money of $1,000 and second place prize money of $500. The Residents Trauma Papers Competition is funded by the Eastern and Western States Committees on Trauma, and Region VII (Iowa, Kansas, Missouri and Nebraska), Wyeth Pharmaceuticals, and the American College of Surgeons.

The competition is open to surgical residents and trauma fellows in the U.S., Canada, and Latin America. Papers are submitted to the individual state or provincial chair. Winning papers are selected and sent to each region chief so they can conduct a regional competition. Papers describe original research in the area of trauma care and/or prevention categorized in either basic laboratory research or clinical investigation.

Winning papers from 13 regions were presented at the scientific session at the Committee on Trauma meeting, and the final four winners were announced at the trauma banquet. Winning senior authors and their spouses received an expense-paid trip to the meeting. Gregory J. Jurkovich, MD, FACS, Chair of the Regional Committees on Trauma, served as moderator.

The 2005 final winners were as follows:

**First Place, Basic Laboratory Research:** John M. Hwang, MD; A novel adhesion pathway (α5β1 integrin) for neutrophil recruitment in ischemia-reperfusion injury.

**Second Place, Basic Laboratory Research:** Aaron M. Cheng, MD; Stored packed red blood cell transfusion upregulates inflammatory gene expression in circulating leukocytes.

**First Place, Clinical Investigation:** Felicia Ivascu, MD; Rapid warfarin reversal in anticoagulated trauma patients with intracranial hemorrhage progression and mortality.

**Second Place, Clinical Investigation:** Stephanie P. Acierno, MD; An estimation of the number of deaths and severe injuries that might be prevented by addressing incompatibility between passenger vehicles and light truck vehicles.
Space sold by Elsevier
Disciplinary actions taken

The Board of Regents took the following disciplinary actions at their October 9, 2004, meeting:

• Michael D. Landreneau, a general surgeon from Eunice, LA, was expelled from the College. He was charged with violation of Article VII, Sections 1(a), (b), and (f) of the ACS Bylaws following revocation of his medical license by the Missouri State Board of Healing Arts on April 14, 2003, due to a felony conviction for endangering the welfare of a child.

• A neurosurgeon from Indianapolis, IN, was admonished following charges of violating Article VII, Sections 1(f) and (i) of the Bylaws for providing expert witness testimony that was found to be false and misleading.

• A general surgeon from Nashau, NH, Nicola J. Miragliuolo, was suspended from the College. She was charged with violation of Article VII, Sections 1(b) and (f) of the Bylaws. The suspension came after voluntarily surrendering her license to practice medicine in New Hampshire while allegations of professional misconduct were pending.

• Ramesh K. Srungaram, a general surgeon from Houston, TX, was suspended due to charges that he violated Article VII, Sections 1(b) and (f) of the Bylaws. The charges followed disciplinary action by the Texas State Board of Medical Examiners, which found that the surgeon provided substandard care to four patients and placed his license on probation with terms and conditions.

• The Board of Regents admonished a vascular surgeon from Memphis, TN, following charges that he violated Bylaws Article VII, Sections 1(f) and (i) in providing expert witness testimony that was alleged to be inconsistent and not impartial.

The following disciplinary actions were taken by the Board of Regents at their February 12, 2005, meeting:

• Farid Afra, a general surgeon from Beverly Hills, CA, was expelled from the College. He was charged with violation of Article VII, Sections 1(b), (c), and (f) of the Bylaws following disciplinary action by the California Medical Board, which placed his license on probation for five years with terms and conditions. The California Medical Board found that the surgeon had committed acts of gross and repeated negligence, incompetence, and dishonest and corrupt acts.

• An otolaryngologist from Chapel Hill, NC, was placed on probation following charges that he violated Article VII, Section 1(b) and (f) of the Bylaws. The action occurred following disciplinary actions by the Nebraska, Kentucky, and North Carolina Medical Boards for reasons related to this surgeon’s history of substance abuse.

• William O. Murtagh, a plastic surgeon from Maumee, OH, was suspended from the College for violating Article VII, Section 1(b) of the Bylaws after entering into a consent agreement with the Ohio Medical Board, which resulted in the placement of his license on probation with terms and conditions. The state medical board took this action based on the surgeon’s history of alcohol addiction.

• A general surgeon from Providence, RI, was admonished after being charged with violation of Article VII, Sections 1(f) and (i) of the Bylaws for providing expert witness testimony that was false or misleading.

Trauma meetings calendar

The following continuing medical education courses in trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

• Advances in Trauma, December 9-10, 2005, Kansas City, MO.
• Trauma and Critical Care 2006, March 16-19, Las Vegas, NV.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
The American College of Surgeons is considering offering a proprietary investment vehicle (mutual fund) as a benefit of Fellowship. The College envisions that this investment fund will be administered by a separate entity and will retain Cambridge Associates to provide advice on the fund’s asset class allocation, as well as the selection of the most appropriate investment firms to manage those assets. At the outset, the fund’s assets will be invested in accordance with a base allocation ratio of 70 percent equities and 30 percent fixed income securities.

Because asset allocation, diversification, and periodic rebalancing back to target are essential elements of successful portfolio management, the College would propose the following fund structure:

<table>
<thead>
<tr>
<th>Type of investment</th>
<th>Target allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. large cap equities</td>
<td>20%</td>
</tr>
<tr>
<td>U.S. small/mid equities</td>
<td>15%</td>
</tr>
<tr>
<td>Non-U.S. equities</td>
<td>15%</td>
</tr>
<tr>
<td>Inflation hedging</td>
<td>15%</td>
</tr>
<tr>
<td>Emerging markets</td>
<td>5%</td>
</tr>
<tr>
<td>Total equities</td>
<td>70%</td>
</tr>
<tr>
<td>Bonds/cash</td>
<td>30%</td>
</tr>
<tr>
<td>Total portfolio</td>
<td>100%</td>
</tr>
</tbody>
</table>

The advantages to the Fellowship by investing in the ACS fund would include:

- Professional, institutional quality management.
- Diversification by asset category and security. Each of the above asset classes will have investments in a minimum of 40 securities.
- Favorable and convenient investment and redemption capabilities.
- Direct offering to investors, without sales charges, brokerage commissions (Rule 12b-1 marketing expenses) or third-party intermediary.
- Excellent way for younger Fellows to initiate and sustain a weekly or monthly payroll deduction savings program.
- Clear and understandable reporting.

We cannot guarantee future performance. Because of the volatility inherent in a 70 percent/30 percent allocation, there is some risk of short- and intermediate-term loss of principal to the investors. However, with the proposed high level of diversification, the oversight of Cambridge Associates, and professional management, we would hope to outperform a comparable blended benchmark over a full market cycle and longer time periods.

The College’s endowment fund has done well following asset allocation, diversification, and periodic rebalancing policies. That fund has generally performed above the median of Cambridge Associates client base. The favorable performance has led to the College’s investigation and consideration of offering a proprietary investment vehicle. Your survey responses will assist the College with its investigation, and your participation is requested.

The survey also is available online at [http://www.facs.org/members/investmentsurvey.html](http://www.facs.org/members/investmentsurvey.html). If you have any comments, please send them to Ms. Gay Vincent, Comptroller, at gvincent@facs.org.
ACS award, scholarships, fellowships are available

George H.A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award of the American College of Surgeons, July 1, 2006–June 30, 2011

This award is developed through the generosity of The Clowes Fund, Inc., of Indianapolis, Indiana. The purpose of the award is to provide five years of support for the research of a promising young surgical investigator. The award consists of a grant of $40,000 for each of five years and is not renewable thereafter.

General policies concerning the granting of the George H. A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award are:

• The award is restricted to a Fellow or Associate Fellow of the College who has completed specialty training in a residency or an accredited fellowship in general surgery or a surgical specialty within the preceding seven years and has received a full-time faculty appointment at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. The applicant’s academic appointment may not be above the level of assistant professor. Applicants should provide evidence (by publication or otherwise) of productive initial efforts in laboratory research.

• The award may be used for salary support or other purposes at the discretion of the recipient and the institution. Indirect costs are not paid to the recipient or to the recipient’s institution.

• The American College of Surgeons Scholarships Committee will look favorably upon applicants who have received investigator-initiated, peer-reviewed research awards (for example, NIH K08 grants) or grants from industry sources. The committee will not consider applicants who have received research career development type awards from the American Heart Association or other professional societies. It is the responsibility of the recipient to notify the College’s Scholarships Administrator to request approval if another source of scholarship/fellowship funding is received.

• Approval of the application is required from the administration (dean or fiscal officer) and the head of the applicant’s department or administrative unit. This approval would involve a commitment to continuation of the academic position and facilities for research during the entire period of the award. Furthermore, it must be assured that at least 50 percent of the applicant’s time will be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

• The applicant must submit a detailed research plan and propose a budget for the five-year period of the award. The applicant also is required to submit a cover letter of approximately 400 words that describes the career objectives, how these career objectives will be achieved, and how the research protocol furthers the applicant’s career development. The Scholarships Committee of the College requires an annual progress report from the recipient, on which annual renewal is based.

• While holding the award, the recipient is expected to attend the Clinical Congress of the American College of Surgeons in 2007, 2009, and 2011 to present reports to the Scholarships Committee.

• Upon completion of the five-year funding period, the recipient will be required to submit a summary of research progress and to provide information regarding current academic rank, sources of research support, and future plans.

The closing date for receipt of completed applications is August 1, 2005.
The American College of Surgeons is offering two-year resident research scholarships. Eligibility for these scholarships is limited to the research projects of residents in surgery or a surgical specialty.

**American College of Surgeons Resident Research Scholarships.** These scholarships are supported by the generosity of Fellows, chapters, and friends of the College to encourage residents to pursue careers in academic surgery.

**Ethicon Scholarship of the American College of Surgeons for the Study of Surgical Wound Healing.** This scholarship is funded by a grant from Ethicon, Inc., to encourage residents to pursue careers in academic surgery. The scholarship is intended primarily to stimulate interest in the healing of soft tissue and minimally invasive surgery. Proposals may include the biology of wound repair, complications of wound repair, or the application of new technologies to clinical problems.

**Wyeth Scholarship of the American College of Surgeons.** Wyeth Pharmaceuticals has provided an unrestricted educational grant to the ACS to fund a Resident Research Scholarship. The purpose of the scholarship is to provide two years of laboratory experience to residents performing surgical research related to biological and physiological aspects of inflammation.

General policies covering the granting of the American College of Surgeons Resident Research Scholarships are:

- The applicant must be a Resident member of the College who has completed two postdoctoral years in an accredited surgical training program in the U.S. or Canada at the time the scholarship is awarded, July 1, 2006, and shall not complete formal residency training before June 2008. Scholarships do not support research after completion of the chief residency year.
- The scholarship is awarded for two years, and acceptance of it requires commitment for the two-year period. The award is to support a research plan for the two years of the scholarship, July 2006 through June 2008. Priority will be given to the projects of residents involved in full-time laboratory investigation. Study outside the U.S. or Canada is permissible. Renewal of the scholarship for the second year is required and is contingent upon the acceptance of a progress report and research study protocol for the second year, as submitted to the Scholarships Section of the College by May 1, 2007.
- Application for these scholarships may be submitted even if comparable application to other organizations has been made. If the recipient accepts a scholarship/fellowship from another agency or organization, the ACS Resident Research Scholarship will be withdrawn. It is the responsibility of the applicant to notify the Scholarships Section of the College of competing awards.
- The scholarship is $30,000 per year; the total amount is to support the research of the recipient and is not to diminish or replace the usual or expected compensation or benefits of the recipient. Indirect costs are not paid to the recipient or to the recipient’s institution.
- The scholar is expected to attend the Clinical Congress of the American College of Surgeons in 2008 to present a report on the research as part of the Surgical Forum, and to receive a certificate at the Annual Meeting of Fellows.
- Approval of the application is required from the administration (dean or fiscal officer) of the institution. Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor who will be super-

Application forms may be obtained upon request from: Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or from the College’s Web site at http://www.facs.org/memberservices/lowes.html.
The American College of Surgeons is offering two-year faculty research fellowships, through the generosity of Fellows, chapters, and friends of the College, to surgeons entering academic careers in surgery or a surgical specialty. The fellowships are to assist surgeons in the establishment of new and independent research programs. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years, to support the research. Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons.

One of the fellowships is named to honor Franklin H. Martin, MD, FACS, founder of the American College of Surgeons. C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care. One of the fellowships is named to honor C. James Carrico, MD, FACS, and is designated for research in trauma and critical care.

General policies covering the granting of the American College of Surgeons Faculty Research Fellowships are:

- The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

- This award may be used by the recipient for support of his/her research or academic enrichment in any fashion that the recipient deems maximally supportive of his/her investigations. The fellowship grant is to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient’s institution.

- Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award.

- The College encourages the applicant to leverage the funds provided by this fellowship with time and monies provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

- The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

American College of Surgeons Faculty Research Fellowships, July 1, 2006–June 30, 2008

The American College of Surgeons is offering two-year faculty research fellowships, through the generosity of Fellows, chapters, and friends of the College, to surgeons entering academic careers in surgery or a surgical specialty. The fellowships are to assist surgeons in the establishment of new and independent research programs. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years, to support the research. Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons.

One of the fellowships is named to honor Franklin H. Martin, MD, FACS, founder of the American College of Surgeons. C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care. One of the fellowships is named to honor C. James Carrico, MD, FACS, and is designated for research in trauma and critical care.

General policies covering the granting of the American College of Surgeons Faculty Research Fellowships are:

- The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

- This award may be used by the recipient for support of his/her research or academic enrichment in any fashion that the recipient deems maximally supportive of his/her investigations. The fellowship grant is to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient’s institution.

- Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award.

- The College encourages the applicant to leverage the funds provided by this fellowship with time and monies provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

- The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

American College of Surgeons Faculty Research Fellowships, July 1, 2006–June 30, 2008

The American College of Surgeons is offering two-year faculty research fellowships, through the generosity of Fellows, chapters, and friends of the College, to surgeons entering academic careers in surgery or a surgical specialty. The fellowships are to assist surgeons in the establishment of new and independent research programs. Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years, to support the research. Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons.

One of the fellowships is named to honor Franklin H. Martin, MD, FACS, founder of the American College of Surgeons. C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care. One of the fellowships is named to honor C. James Carrico, MD, FACS, and is designated for research in trauma and critical care.

General policies covering the granting of the American College of Surgeons Faculty Research Fellowships are:

- The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

- This award may be used by the recipient for support of his/her research or academic enrichment in any fashion that the recipient deems maximally supportive of his/her investigations. The fellowship grant is to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient’s institution.

- Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award.

- The College encourages the applicant to leverage the funds provided by this fellowship with time and monies provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

- The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.
• A minimum of 50 percent of the fellow’s time must be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.
• The fellow is expected to attend the Clinical Congress of the American College of Surgeons in 2008 to present a report to the Surgical Forum, and to receive a certificate at the Annual Meeting of Fellows.

The closing date for receipt of applications is November 1, 2005. Application forms may be obtained upon request from: Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or http://www.facs.org/memberservices/acsfaculty.html.

Contributions sought for 2006 Residents Trauma Papers Competition

Papers are now being accepted by the ACS Committee on Trauma for the 2006 Residents Trauma Papers Competition, which will be held during the Committee on Trauma’s annual meeting, March 16-18, 2006, in Chicago, IL.

The Residents Trauma Papers Competition is open to general surgical residents, surgical specialty residents, and trauma fellows in the U.S., Canada, and Latin America. The papers should describe original research in the area of trauma care and/or prevention categorized in either basic laboratory research or clinical investigation. Papers should be sent to the appropriate ACS State/Provincial Chair. If the chair is unknown, individuals may contact the ACS Trauma Office for that information at 312/202-5380, or go to www.facs.org/dept/trauma/regional.html.

The papers competition has been funded by the Eastern and Western States Committees on Trauma, Region VII Committees on Trauma, Wyeth Pharmaceuticals, and the American College of Surgeons.

Deadline for submission of papers to the Region Chief is November 15, 2005. Further information may be obtained on the ACS Web Site at http://www.facs.org/trauma/traumapapers.html or by contacting the ACS Trauma Office by phone, 312/202-5380, or via e-mail, cmorris@facs.org.
Fellows in the news

The Joint Commission on Accreditation of Healthcare Organizations recently announced the appointment of Peter B. Angood, MD, FACS, as vice-president, chief patient safety officer, and co-leader of the Joint Commission International Center for Patient Safety. The center will identify, gather, analyze, and disseminate patient safety solutions, both in the U.S. and abroad. The center also is intended as a means of encouraging continuous attention to safety-focused, systems improvement efforts. Dr. Angood has conducted extensive research in telemedicine, medical education, injury prevention, outcomes management, and resource utilization.

The king and queen of Spain awarded the Gold Medal of the Mutua Foundation to Juan A. Asensio, MD, FACS, at a ceremony in Madrid. Dr. Asensio received the honor for his work in managing difficult cardiac, thoracic, and vascular injuries, as well as his efforts in ex-sanguinization research, trauma prevention, and human rights advocacy. He is professor and chief, division of clinical research in trauma surgery, and director, trauma outreach program, department of surgery, division of trauma, University of Medicine and Dentistry of New Jersey, Newark.

Past recipients of the Gold Medal of the Mutua Foundation award include the following internationally recognized Fellows: Thomas Starzl, MD, FACS, University of Pittsburgh, PA, a pioneer in organ transplantation; Donald Trunkey, MD, FACS, University of Oregon, Portland, a leader in trauma surgery; and Seymour Schwartz, MD, FACS, Rochester (NY) University, Past-President of the American College of Surgeons. The Mutua Foundation is one of Spain’s most prestigious academic, scientific, and philanthropic organizations.

Ronald B. Berggren, MD, FACS, has been named the recipient of the 2005 John C. Gienapp Award presented by the Accreditation Council for Graduate Medical Education (ACGME). The award, named for the first executive director of the ACGME, honors Dr. Berggren for his significant lifetime contributions to the ACGME and graduate medical education. A plastic surgeon in Galena, OH, Dr. Berggren is professor emeritus, Ohio State University Medical College.

Timothy J. Eberlein, MD, FACS, Editor-in-Chief of the Journal of the American College of Surgeons (see photo, this page), was elected president of the Society of Surgical Oncology (SSO) March 5, during the organization’s 58th Annual Cancer Symposium in Atlanta, GA. Dr. Eberlein is Bixby Professor and chairman, department of surgery, Washington University School of Medicine, St. Louis, MO. He is also surgeon-in-chief, Barnes-Jewish Hospital, and Olin Distinguished Professor and director of the institution’s Siteman Comprehensive Cancer Center.

Under Dr. Eberlein’s direction, the Siteman center recently received the National Cancer Institute’s comprehensive cancer center designation. This distinction recognizes Siteman’s broad-based research, outreach, and educational activities and provides the cancer center with $21 million in research funding.

Dr. Eberlein succeeds S. Eva Singletary, MD, FACS, of Houston, TX, as the SSO’s president. Other Fellows newly elected to the SSO executive council are as follows: Raphael E. Pollock, MD, PhD, FACS, Houston, TX (president-elect); Nicholas J. Petrelli, MD, FACS, Newark, DE (vice-president); V. Suzanne Klimberg,
Glenn W. Geelhoed, MD, FACS, has been named the 2005 recipient of the Medical Mission Hall of Fame Award. Dr. Geelhoed received the award in recognition of his continued distinguished and voluntary service to patients in medically underserved areas throughout the world. Each year, Dr. Geelhoed recruits students to join him in international medical missions. He is professor of surgery, George Washington University Medical Center, Washington, DC.

The Henry Ford Wyandotte Hospital (HFWH), Detroit, MI, presented the 2005 Joseph L. Cahalan Physician Star of Excellence Award to Krishna Sawhney, MD, FACS. The annual award recognizes physicians who have attained the admiration of their peers due to their commitment to medical practice, the institution, and/or service excellence. Dr. Sawhney has been a member of the HFWH medical staff for 15 years. He also is chief of surgery, downriver region, for the Henry Ford Health System and is clinical associate professor of surgery at Wayne State University School of Medicine.
NTDB™ data points

One on every corner

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

The events of 9/11 had a profound effect on all of our lives. We carry it with us each day as we go about our normal business. However, in our “business,” we have a greater obligation to be prepared in the event of another unthinkable act. How prepared are we? What are our local, regional, and national resources? How involved should we be with disaster preparedness?

The Committee on Trauma’s Subcommittee on Disaster and Mass Casualty Management has a statement, which can be found at http://www.facs.org/trauma/disaster.html, stating that the surgical community should have a major role in providing leadership, multidisciplinary planning, management, and triage relating to disasters involving physical trauma. They also recognize that the existing infrastructure of trauma centers and trauma systems are especially suited to handle the large casualty burdens following natural and man-made disasters.

What is the public’s perception of the trauma system and the importance of trauma centers? According to a recent Harris poll commissioned by the Committee on Trauma and the Coalition for American Trauma Care, the majority of Americans believe that having a trauma center nearby is equally important as, or more important than, having a fire department or police department. This public concept of a trauma center on every corner is far from reality. There are over 4,915 hospitals in the U.S. and, according to a 2002 national inventory of hospitals, there are only 190 Level I and 263 Level II trauma centers. Seven hundred additional hospitals provide some other level of trauma care. The 2004 Annual Report of the National Trauma Data Bank™ contains data submitted from 405 of these U.S. trauma centers. These data are depicted in the graph on this page.

Our level of preparedness is not quite up to the public’s perception of a trauma center on every corner. We have a lot of work to do. Adequate funding is the only way to make progress. Each year a line item is included in the federal budget for trauma system development. This necessity gets funded at a little over $3 million—not a lot if you consider that there are 50 states, territories, and the District of Columbia. We need to work on funding in order to improve trauma systems development, which in turn will improve the infrastructure for disaster preparedness. We encourage you to participate in the College’s advocacy initiatives on Capitol Hill. It is both educational and rewarding to get involved in shaping our future.

Throughout the year, we will be highlighting these data through brief reports monthly in the Bulletin. The full NTDB 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.
Chapter news

by Rhonda Peebles, Division of Member Services

To report your chapter’s news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

New York Chapter visits state legislators

Representatives of the New York Chapter participated in an advocacy day in Albany, the state capital, on March 15 (see photo, below). During the daylong program, the chapter representatives visited with their legislators to discuss various issues, including a proposed tax on ambulatory surgery centers. This tax, which has been endorsed by the Greater New York Hospital Association and the Service Employees International Union—Local 1199, has been included in the 2005-2006 state budget. Along with other statewide surgical specialty societies, the New York Chapter opposes this proposed tax. For further information, contact Heather Bennett, JD, Executive Director, at bennett@bennettfirm.com.

Connecticut advocates for ultrasound reimbursement

With assistance from the College’s Washington Office, the Connecticut Chapter has been meeting with Oxford Health Plans to secure reimbursement for ultrasound services provided by surgeons. In its deliberations with Oxford, the Connecticut Chapter repeatedly noted that the insurer’s current reimbursement policy restricts the availability of minimally invasive diagnostic procedures and requires patients to undergo open procedures when clinical circumstances would permit less invasive procedures. The Connecticut Chapter intends to meet with other insurers as well.

Chapter anniversaries

<table>
<thead>
<tr>
<th>Month</th>
<th>Chapter</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>Colorado</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Maryland</td>
<td>48</td>
</tr>
<tr>
<td>June</td>
<td>Alberta, Canada</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Arkansas</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Connecticut</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Metropolitan Washington (DC)</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Ecuador</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Germany</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Greece</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Idaho</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Ireland</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Israel</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Maine</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Mexico—Northeast</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Mexico—Nor-Occidental</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Minnesota</td>
<td>34</td>
</tr>
</tbody>
</table>

2005 Advocacy Day: New York Chapter members who participated included (left to right): Noah S. Finkel, MD; A. Philip Fontanetta, MD; Armin Tehrany, MD; John Olsewski, MD, FACS; Dana Mannor, MD; William Walsh, MD; Barry S. Savits, MD, FACS; William Marx, DO, FACS; Joseph Suarez, MD; Eugene Nowak, MD, FACS; Jeffrey Lozman, MD; Barry Gloger, MD; and Ms. Bennett. Not pictured but participating: Arthur Cooper, MD, FACS; William Doscher, MD, FACS; Soumitra Eachempati, MD, FACS; Christopher C. Max, MD, FACS; Mark E. Williams, MD, FACS; and Steven Burger, MD, FACS. (Note: The non-FACS physicians in the picture are members of the NY Society of Orthopaedic Surgeons.)
<table>
<thead>
<tr>
<th>Month</th>
<th>Chapter</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>June (contd.)</td>
<td>New Mexico</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>New York</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Western New York</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>North Dakota</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Oregon</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Spain</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Wisconsin</td>
<td>34</td>
</tr>
</tbody>
</table>

**Chapter meetings**

For a complete listing of all of the College’s Chapter education programs and meetings, please visit the Chapter homepage at [http://www.facs.org/about/chapters/index.html](http://www.facs.org/about/chapters/index.html).

**Oregon**, June 30-July 2, Sunriver Resort. Contact: John Mayberry, MD, FACS, 503/494-5300.

**North Carolina**, July 8-10, Grove Park Inn, Asheville. ACS representatives: Edward R. Laws, MD, FACS, President, and Cindy Brown, Division of Advocacy and Health Policy. Contact: Carol Russell, 919/467-3818.


**Montana-Wyoming**, August 4-6, Buffalo Bill Historical Center, Cody, WY. ACS representatives: Thomas R. Russell, MD, FACS, Executive Director, and Paul E. Collicott, MD, FACS, Director, Division of Member Services. Contact: Todd Beckstead, MD, FACS, 307/577-4229.

**Lebanon**, September 8-10, Beirut. Contact: Michel Daher, MD, FACS, 961/158-1714.


**Turkey**, September 17-18, Istanbul University. Contact: Cemalettin Topuzlu, MD, FACS, 90-212/347-6300.

**Connecticut**, November 2, Sheraton Four Points, Meriden. ACS representative: Bruce Browner, MD, FACS. Contact: Christopher Tasik, 203/674-0747.

**Massachusetts**, November 19, Dedham Hilton Hotel, Dedham, MA. Contact: Marie Foley, 978/927-8330.