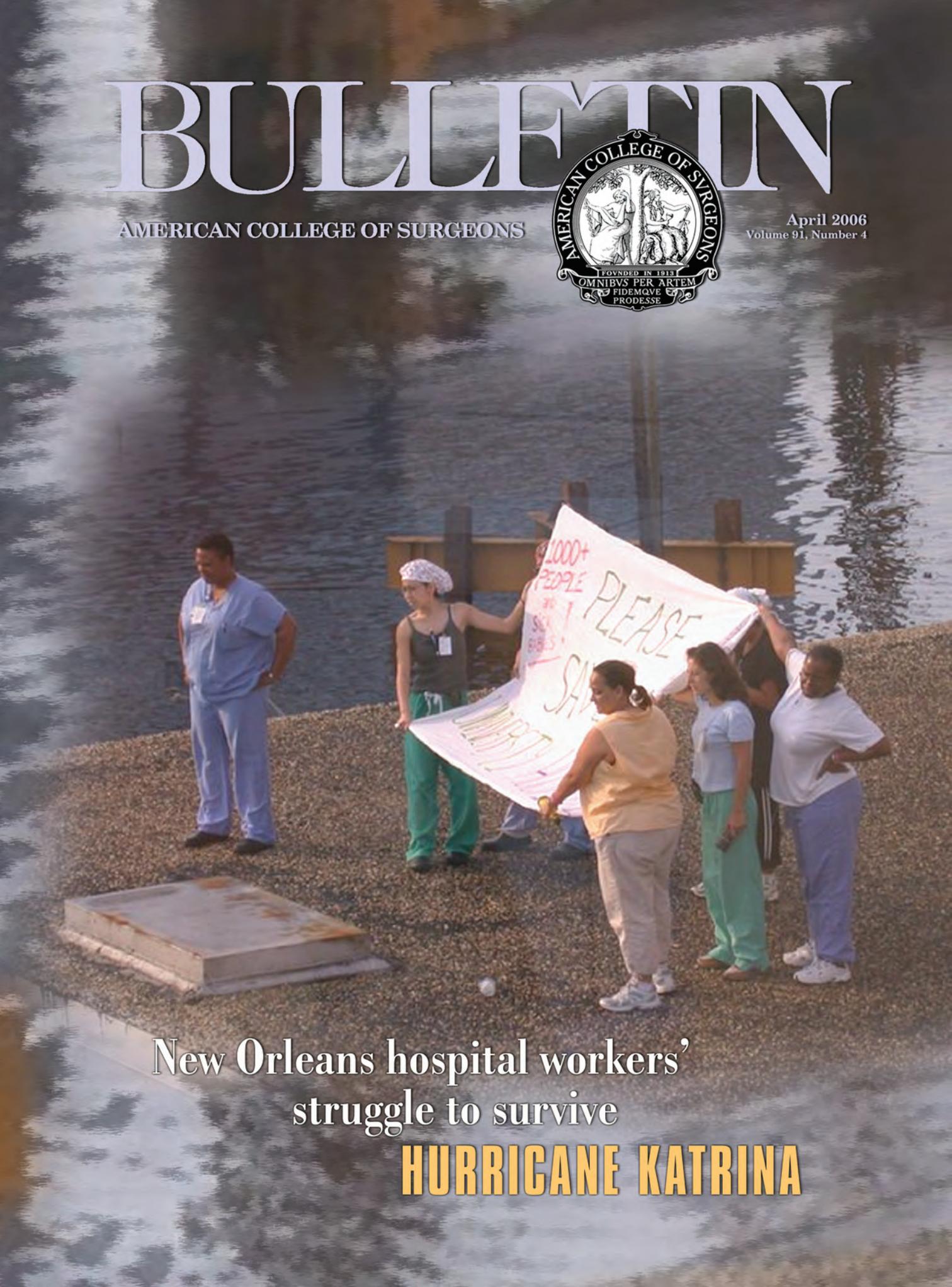


BULLETIN

AMERICAN COLLEGE OF SURGEONS



April 2006
Volume 91, Number 4



New Orleans hospital workers'
struggle to survive

HURRICANE KATRINA

BULLETIN

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On the cover: Hurricane Katrina tested the skills and fortitude of New Orleans hospital workers (see article, page 8). Photo courtesy of Lynn Harrison, MD, FACS.

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Future meetings

Clinical Congress

- 2006** Chicago, IL,
October 8-12
2007 New Orleans, LA,
October 7-11
2008 San Francisco, CA,
October 12-16

Spring Meeting

- 2006** Dallas, TX,
April 23-26
2007 Las Vegas, NV,
April 21-24
2008 To be announced

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

AMERICAN COLLEGE OF SURGEONS

• DIVISION OF EDUCATION •



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From my perspective

In the coming years, surgeons are going to be expected to produce evidence of their ability to provide safe, effective, quality care. They will also have to maintain clear records of their participation in lifelong learning experiences. To help surgeons maintain their credentials and competitive edge in the continuously changing health care environment, the College has been launching a number of initiatives, many of which have been described previously in this column. Examples include *e-FACS.org*, the College's Web portal, and our new case log system. They all are intended to facilitate surgeons' efforts to provide information to the surgical boards, licensing bodies, and hospitals.

Most recently, the Division of Education has sought to expand the College's accreditation activities. This latest effort was the focus of an article in the March issue of the *Bulletin* and is the primary focus of this column.

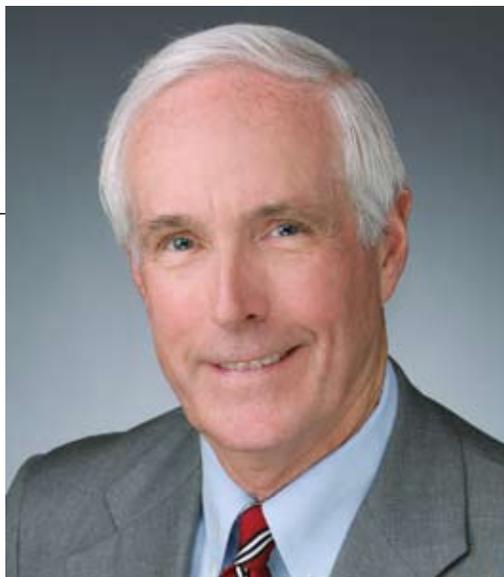
Changing expectations

We all are becoming familiar with the surgical boards' evolving requirements for maintenance of certification. As an educational and professional association committed to helping surgeons to provide quality surgical care, the American College of Surgeons has developed a number of programs to assist surgeons in their efforts to comply with the boards' expectations.

It is important to note that the boards aren't the only entities establishing stricter criteria for accepting surgeons into their ranks. Hospitals are facing new demands to prove that they offer quality care for a competitive price. They are taking various steps to prove to payors and consumers why they should be the medical centers that provide patients with care.

Moreover, many health care facilities are coming to the realization that it is beyond their capability to excel in all forms of medical and specialty care. Instead, they are striving to develop teams of health care professionals who can treat certain conditions exceptionally well and achieve the best possible outcomes.

As hospitals seek to advance their reputations, they will undoubtedly become more selective in granting privileges. They will be looking to recruit surgeons who have attained knowledge about and advanced skills in performing certain



“By accrediting institutes, we are ensuring that the advanced education surgeons receive meets the high standards the College has always set for programs bearing its stamp of approval.”

types of procedures. Surgeons who can offer evidence that they have done a number of such operations and experienced successful outcomes are the individuals most likely to find work and to handle the most complex and interesting cases.

Hospitals, medical boards, specialty societies, payors, and others have in many ways created a novel enterprise—one that revolves around improving the quality of patient care. To play an active role in this venture, surgeons and the organizations that represent them need to produce relevant information, standards, and programs.

ACS expands accreditation activities

As one means to this end, the American College of Surgeons is expanding its accreditation activities to include educational institutes. We believe it is important for the College to engage in the accreditation of educational institutes at this time in order to ensure that surgeons remain

competitive and competent in the use of advanced technology, can account for their outcomes, and are able meet new continuing medical education requirements.

Many of you probably read with interest the article on page 8 of last month's issue of the *Bulletin*, entitled "Accreditation of education institutes by the American College of Surgeons: A new program following an old tradition." This article provided details about the College's decision to enter into this new endeavor.

As the authors of the article explained, the College launched the Program for the Accreditation of Education Institutes during the 2005 Clinical Congress in San Francisco, CA. The College-accredited institutes will serve as regional sites where surgeons may learn about and expand their capabilities in new procedures, emerging technologies, and rarely performed procedures. These facilities also will verify that surgeons have obtained knowledge and skills that conform to predetermined standards as set forth by this organization.

Our present goal is to establish a network of regional institutes that provide educational opportunities to practicing surgeons, surgical residents, medical students, and other members of the surgical team to address the spectrum of surgical skills and competencies. We anticipate that surgeons will be able to obtain several levels of education at these institutes. The most basic level of training would involve attending lectures, while more advanced levels would incorporate the various types of high-tech, hands-on experience we can now provide.

The institutes will incorporate state-of-the-art educational methods and technology, including opportunities to learn through the use of simulators and virtual reality. In addition, the institutes ultimately may be involved in collaborative educational research and development conducted under the aegis of the College and may serve as demonstration sites for certain new educational technologies.

Applying for accreditation

We have established two review committees that will be responsible for making accreditation decisions. These committees will apply specific criteria to selecting institutes accredited at two

levels—comprehensive and basic. Institutes may apply for either level of accreditation.

Applications for accreditation and information have been mailed to surgical education institutes and are available through the Division of Education page on the College's Web portal (*e-FACS.org*) and on its Web site (*www.facs.org*). We are in the process of developing an interactive Web page to facilitate dissemination and collection of accreditation materials and information on the ACS-accredited institutes' activities.

On an important path

I want to point out that this project is the result of the dedicated efforts of 18 ad hoc committee members, and I would like to thank them and their Chair, Carlos A. Pellegrini, MD, FACS, for developing this wonderful program.

The ACS Board of Regents and other College leaders believe that these institutes will enable surgeons to participate in the educational experiences they need to maintain certification, to obtain hospital privileges, and to generally meet increasing demands for proof that they have the capability to produce positive outcomes. Moreover, by accrediting institutes, we are ensuring that the advanced education surgeons receive meets the high standards the College has always set for programs bearing its stamp of approval.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

Medicare payment cut blocked

On February 8, President Bush signed S. 1932, the Deficit Reduction Act of 2005 (DRA), into law. The legislation overturns the across-the-board 4.4 percent cut in Medicare physician payments that went into effect January 1 and preserves 2005 payment levels for 2006.

Because the payment cut was imposed on January 1, the effect on payments for services delivered between the first of the year and the law's enactment needed to be addressed. In response, the Centers for Medicare & Medicaid Services (CMS) agreed to reprocess all claims paid at the reduced levels, and physicians were not expected to re-submit those claims.

In addition, upon the bill's enactment, the participation process was reopened for those physicians who may have initially opted out of Medicare this year because of the 4.4 percent payment cut. Physicians had 45 days within the law's enactment to change their participation status and receive full Medicare payment for all services provided during 2006, retroactive to January 1.

Although the law blocks the reimbursement cut for 2006, it omits the larger payment reforms that the College and other physician organizations have been seeking. As a result, without congressional action again this year, an estimated cut of 4.6 percent will go into effect January 1, 2007. Hence, the College continues to ask its Fellows to urge policymakers to reform the Medicare payment system in a manner that ensures that surgeons will be able to remain in practice and that patients will have access to quality surgical care. For example, ACS Executive Director Thomas R. Russell, MD, FACS, sent a special e-mail alert on February 2 to College members requesting their ongoing help in calling on their federal legislators to fix the broken Medicare payment system through major changes in the sustainable growth rate methodology used to determine reimbursement for physician services.

Specifically, the College believes that the Medicare payment formula needs to be changed in a way that accounts for the unique nature of surgery relative to other physician services. Furthermore, the ACS maintains that payment reforms that would link reimbursement to quality incentives and outcomes (pay-for-performance) must be based on physician-led quality improvement efforts, such the federal Surgical Care Improvement Project and the ACS National Surgical Quality Improvement Program. For more information, contact the College's Washington Office at ahp@facs.org.

Details of President's 2007 budget unveiled

Details of President Bush's fiscal year (FY) 2007 budget were released on February 6. The budget proposal allocates \$698 billion to the U.S. Department of Health and Human Services—an increase of more than 9.1 percent from FY 2006. Much of this spending increase is targeted toward pandemic planning and preparedness, protection against bioterrorism, and health information technology investment.

The President proposes to reduce spending for CMS by approximately \$2.5 billion in 2007 and by nearly \$36 billion between 2007 and 2011. The budget plan makes no specific recommendations regarding payment updates for physician services but notes that "The Admin-

istration supports physician payment reforms that do not increase taxpayer, Medicare, or beneficiary costs, such as differential updates initially for physicians that report on quality measures and later for physicians that achieve efficient and high-quality care.”

Also of interest to surgeons, the President’s budget proposal calls for the following measures: (1) eliminate funding for the Preventive Health and Health Services block grants that states now use, in part, to fund emergency medical services systems; (2) reduce National Cancer Institute funding by \$40 million; (3) eliminate funding for the Emergency Medical Services for Children Program and the Traumatic Brain Injury Program; and (4) significantly cut graduate medical education payments to children’s hospitals. Details about the President’s budget plan may be viewed at <http://hhs.gov/budget/docbudget.htm>.

College holds Health Policy Summit

Representatives of the surgical specialty societies participated in a Health Policy Summit that the American College of Surgeons hosted on January 24 in Washington, DC. The agenda for the well-attended meeting included the following: an update on quality improvement activities, such as outcome measurements and reporting; a discussion of possible means for enhancing surgery’s advocacy efforts and public image; and potential payment reforms. Other topics of discussion included plans for developing a health policy institute, imaging, the emergency workforce, trauma care, scope of practice, taxes on surgical procedures, and medical liability reform. For more information, contact ahp@facs.org.

Dr. Opelka chairs AQA surgery workgroup

The Ambulatory Care Quality Alliance (AQA) recently created a surgery and procedure workgroup, which Frank Opelka, MD, FACS, will chair. The panel is charged with examining performance measurements as they relate to surgery and other procedure-based specialties.

Dr. Opelka is associate dean for health care and safety at Louisiana State University School of Medicine, New Orleans, LA. The AQA is a multi-stakeholder organization composed of payors, purchasers, physicians, and consumers, and was formed to address the implementation of quality measures. Until recently, the AQA focused almost exclusively on primary care.

State activity to expand health care coverage

In late January, the State Coverage Initiatives program issued an annual year-in-review report that describes the different paths the states have taken in order to extend health care coverage to Americans who are uninsured. For example, Maryland has passed legislation that requires employers to pay their “fair share,” while Massachusetts is currently considering an individual mandate. The State Coverage Initiatives program is being conducted by The Robert Wood Johnson Foundation and administered by AcademyHealth, a nonpartisan resource for health research and policy. For a copy of the report, *State of the States 2006: Finding Their Own Way*, go to <http://www.academyhealth.org/index.htm>.

HURRICANE KATRINA:

Surgeon survivors recount days of calamity and camaraderie

by Diane S. Schneidman,
Manager, Special Projects



Author's note: *The physicians on call at major medical centers in and near New Orleans, LA, during Hurricane Katrina and its aftermath recall days of darkness, heat, humidity, thirst, hunger, and sleeplessness. Yet, they also have positive memories of patients, residents, attending physicians and surgeons, nurses, administrators, and janitors all pulling together to help one another survive—physically and emotionally—at a time when it often seemed as though the rest of world had abandoned them.*

In this article, several surgeons and surgical residents who withstood the brutal conditions in Louisiana during and after the storm offer their day-by-day descriptions of the experience, from their first warnings of the approaching hurricane through their rescue. They also offer their general observations about how they and their colleagues managed to endure, what went right and wrong, the lessons they learned, and plans for the future. The individuals who contributed to this piece tell their stories with humility, understatement, a bit of sadness, and an intensity that printed words can only partially convey. As Frank G. Opelka, MD, FACS—a colon and rectal surgeon in New Orleans who was off-site at the time of hurricane—stated, “Theirs is a real-life story of people in a desperate situation. They faced the end of life and survived by caring for others in conditions that would petrify you.”

Saturday: Warnings issued

On the evening of Saturday, August 27, final warnings that Hurricane Katrina was headed for landfall in New Orleans sounded throughout the city. Those individuals who had the financial resources, viable modes of transportation, and the physical strength needed to evacuate promptly left town. Others headed for shelter at

A note about the photos

The photos that accompany this article were contributed by Dr. Harrison, Dr. Fung, and Shad Pharaon, MD, a first-year resident at LSU at the time of the hurricane.

the Superdome or the Ernest N. Morial Convention Center or battened down the hatches and hoped for the best. The residents and surgeons who were on call that weekend headed to their institutions in anticipation of an onslaught of emergency patients.

“It was my weekend on call at University Hospital. I rounded on Saturday,” said Lynn Harrison, MD, FACS, a thoracic surgeon. “We kept hoping Katrina was going to pass us by without causing any significant damage. By Saturday night, it was apparent that it was going to hit.” His wife and children evacuated to Tyler, TX, while he helped to coordinate efforts to get patients ready for discharge out of the medical center.

Shawn Stafford, MD, a fourth-year surgical resident at Louisiana State University Health Sciences Center (LSUHSC), was notified that he was part of the “activation team” at University Hospital. His wife, an obstetrics-gynecology resident at LSUHSC, had just given birth to a boy a week before the storm. Dr. Stafford had intended for his wife and their infant to evacuate that day; however, she didn’t want to travel unaccompanied with a baby, especially because the infant was dehydrated and running a fever. They decided the entire family would go to the hospital.

Similarly, Jean Fung, MD, chief surgical resident for LSUHSC and a native of Metairie, LA, was called to the Veterans Affairs’ (VA) hospital on Saturday, because she was on volunteer call for “code gray” emergency situations requiring all house staff to be available to treat incoming critical care patients. According to Dr. Fung, most of the hospital staff and patients took the potential maelstrom in stride that evening: “I brought food—all these frozen dinners—and everyone was giving me a hard time, saying, ‘What do you need those for? We’re not going to be here that long.’ By Tuesday night, they were asking if I had any left.”

Sunday: The waiting

As the hurricane pushed closer to the Gulf Coast on Sunday, efforts to leave the vicinity continued. In the Uptown District, hundreds of New Orleans’ inhabitants began streaming

into Memorial Medical Center, which would suffer the highest death toll of all the city's hospitals by week's end. Already in the facility were 260 hospital patients and individuals in an 82-bed acute care ward run by an independent company.¹

Approximately 75 miles north, physicians in Baton Rouge, LA, were put on alert. "It was three o'clock on Sunday afternoon when I received a phone call from the nursing supervisor saying that Earl K. Long Hospital would soon undergo 'code gray' and that we should head to the hospital. I gathered the other residents on call with me for the weekend and updated them on the disaster protocol," said Paul Gill, MD, a chief surgical resident at LSU who was doing a rotation through E.K. Long Hospital at the time.

When they first arrived at the hospital Sunday afternoon, Dr. Gill and the other residents were greeted by an "awkward quiet" that left them wondering why they had been summoned.

"We proceeded to stay in the call rooms the remainder of the night, watching the television and becoming increasingly interested as we watched this huge, circular cloud encompass the Gulf of Mexico, with the eye heading directly toward the place we all knew as home," Dr. Gill said. "As our interest and curiosity in the news reports grew, so did the eeriness and the howling of the winds outside." By 10:00 pm that evening, wind gusts of 70 to 80 miles per hour were sweeping through Baton Rouge, and a downpour that would continue for 12 more hours began.



August 29: The hurricane rages with 120 mph winds.



The University Hospital surgical ICU after wind blew out a window and flooded the halls.



Charity Hospital. Dr. Pharaon reported, “We thought this stuff was palm tree branches, but we then figured out that these are the mini blinds in the patients’ rooms.”



Water rises in the University Hospital stairway.

Monday: Katrina hits

Hurricane Katrina actually hit New Orleans at approximately 5:30 am Monday, climaxing about four hours later. Rain pelted the Gulf Coast and ferocious winds snapped the trunks of trees, blew out power sources, upended cars, and shattered windows. With each passing hour, it grew ever more apparent that Katrina was going to leave an indelible mark on the Big Easy.

At each of the medical centers, efforts were made to move patients away from windows and into the hallways. Intensive care patients were placed in recovery rooms, which, though lacking in some of the monitoring capabilities of the intensive care unit, were at least located in enclosed, windowless, centralized areas of the facilities.

Fortunately, the hurricane itself caused little structural damage to most of the hospitals. “A sign blew off outside of the hospital and ricocheted against the windows,” Dr. Harrison said. In addition, high winds blew out the windows of a walkway between sections of the facility, according to Dr. Stafford, but no one was injured. All patients were promptly transported to the main building.

Later that day, Katrina left New Orleans. “By late afternoon, we were seeing patches of sun,” Dr. Harrison said. “There were only about six to eight inches of water in the street.”

At the VA, “We actually went outside and walked around that day,” Dr. Fung said.

In the Uptown District, the gusting winds shattered the

glass walkways connecting Memorial's buildings and garages. Water formed a moat around the complex, but little structural damage had occurred. At approximately 4:30 am, the main power lines to the hospital went out and the backup generators switched on. By nightfall, most of the people who had sought shelter in the hospital had dispersed, but hundreds remained, anticipating that it would be easier to leave in a day or two.

Also in the city's Uptown District is Children's Hospital of New Orleans, resting on the edge of the levee of the Mississippi River. When the hurricane struck, more than 700 people were inside that facility, according to Robert Minkes, MD, FACS, then-chief of pediatric surgery at the medical center. Among them were patients and their families, the hospital's chief executive officer, all its vice-presidents, the medical director, several department chairs, two cardiac surgeons, physicians, residents, nurses, and ancillary staff, Dr. Minkes reported.

As the storm lifted without extensively damaging Children's, most of the patients and personnel were confident that the worst was over. The hospital was well prepared to ensure the safety of its patients in the face of a hurricane. "We had enough fuel, food, and water for over a week," Dr. Minkes said. "There was access to the city by roads, air, and the Mississippi River. We, in fact, had a delivery of fuel the day after the storm but diverted most of it to a nearby hospital since we had enough until other reserves arrived."

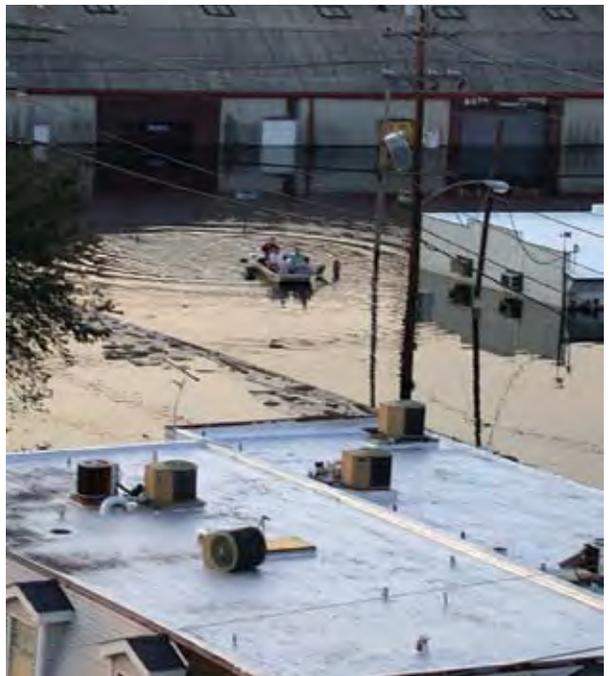
The hospital functioned on generators and Dr. Minkes was even able to perform several operations. "Our emergency room remained open and the neonatal and pediatric intensive care units were operational. Adult and pediatric patients—some ventilated and transports from other facilities, others off the streets—began to show up at our hospital," he said.

For a brief period of time, it appeared that New Orleans had weathered yet another storm. But that night, the situation grew pestilent.

"By about 8:00 pm, it was evident that the water was not receding, but rising," Dr. Harrison said. Moreover, "a Niagara Falls of water" cascaded into the basement of Charity Hospital, which housed the facility's generator and power switches, he recalled, noting that a similar situ-



Post-Katrina view from University Hospital of the oil-slicked floodwaters.



U.S. Navy boats to the rescue.



LSU surgical rounds with patients lined up single-file in the hallway.



Patients waiting to be evacuated from the VA hospital.

her own right away or bag her,” he said. Fortunately, Dr. Stafford and the rest of his team did manage to get the patient breathing independently.

Meanwhile, medical and ancillary staff at E.K. Long Hospital in Baton Rouge received a rude awakening. “An electricity pole crashed down on to the clinic adjacent to our building at about 6:00 am, lighting up the whole parking lot,” Dr. Gill said. “The electricity briefly went out until the generator kicked on.”

The residents and surgeons at E.K. Long Hospital proceeded to conduct patient rounds and then learned that the facility would be the primary triage center for LSU hospital patients. “This meant that any patient evacuated would be sent to us if they were in need of critical care or surgery,” Dr. Gill explained. Suddenly, it was quite apparent why they had been called in for code gray.

Tuesday: The levees break

By Tuesday morning, three feet of water surrounded Charity, University, and the VA hospitals, with the depth of the flooding surging once the levees on Lake Pontchartrain gave way to the groundswell of water.

“We were fine until the levees broke,” Dr. Stafford said. “Once that happened, there was nothing anyone could do” to prevent

ation was developing at University Hospital. Although the generator there was located on the ground floor, “We were told that if we got more than four feet of water, the generator would shut down,” Dr. Stafford said. “I had a patient whom I had been trying to wean off a ventilator, and now we either had to get her off and able to breathe on

the chaos that would grip the city and its medical centers for the rest of the week.

The residents and other physicians at the medical centers responded by preparing patients for immediate discharge to their families or transfer to other facilities. “Early on Tuesday morning, we started taking patients downstairs, anticipating

they would be evacuated. We had to climb up and down stairs to do this because the elevators weren't working," Dr. Fung said. "At the VA, we had two people per patient. We put the patients in sort of a seated position, with one person holding up their back and one taking hold of their feet," she explained.

"I'm only 5'1", so it was hard for me to really carry patients. I had to rely on the guys to help get patients out," Dr. Fung added. "It was mainly the physicians doing the heavy lifting."

For immobile patients, the staff at the VA hospital tried to use "Evacusleds," but the handles kept breaking, Dr. Fung said. "We brought down the intubated patients first, and they were transported to the Superdome." The others remained behind, many for several more days.

Meanwhile, at Charity Hospital, the temperature and humidity created sweltering, unsanitary conditions. Clean bathing water was unavailable. Because the food service facilities were in the basement, all means of food preparation had become inoperable. Canned fruit was about the only form of sustenance safe for consumption, and even that had to be rationed.

As conditions deteriorated, a number of patients' family members and individuals who had sought shelter at the local hospitals grew restive, even threatening. And on the streets of the city, frustration, fear, exhaustion, and anger ignited what can best be described as a war zone. "There were about 20 helicopters in the air, but they



A patient placed in an Evacusled. "It's supposed to be a fast, safe way of transporting patients down the stairwell," said Dr. Pharaon. "They didn't work quite as well as we wanted."



"We were on back-up generators at this point," said Dr. Pharaon. "We had to use orange power cords to get to the red receptacles that were still getting power. These power cords were mainly used to run the IV pumps and fans to cool the patients."



Post-Katrina patient transport at LSU.

never seemed to do anything [in terms of evacuation]. They apparently were just surveying the area,” Dr. Harrison said. “We heard reports of people shooting at the helicopters and stories of looting. We heard windows breaking. We imagined the worst,” he added.

“The most frustrating thing was that we didn’t have any means of communicating. The storm swept all the cell phone antennas, and our beepers didn’t work,” Dr. Harrison said. They were able to get AM radio reception from nearby cities and found that some news agencies were misreporting that people had been evacuated from the hospitals. “We were asking, ‘Do they even know we’re here?’” he said.

“It was almost like they had forgotten us,” Dr. Stafford added. “[The rescue squads] kept saying they would bring us diesel fuel for the generator, but it would never come. Eventually, they did bring us a generator, but it wasn’t powerful enough, so

we drained the fuel and put it in our existing generator.” University Hospital also received some victuals—containers of peanut butter, 10 gallons of water, and some canned ravioli.

“Nobody was in charge. I guarantee you that,” said Norman A. McSwain, MD, FACS, then-chief of trauma surgery at Charity, in a *New York Times* article. “I’d call the governor’s office, and either they didn’t answer the telephone or I’d talk to lower functionaries, and they’d say, ‘The governor’s too busy to talk. We’ll relay the message.’”²

Adding insult to injury, Dr. McSwain said, someone from the state health department had reported that Charity had been emptied. He appealed to HCA, the company that operates Tulane University Hospital across the street from Charity and that had hired 20 medical evacuation helicopters to airlift patients from the hospital’s garage.²

Meanwhile, the staff at Memorial sent out e-mail pleas for assistance to the hospital’s parent company, Tenet Healthcare Corporation. Tenet officials, in turn, contacted the Coast Guard and the National Guard. Workers at the facility cleared an abandoned landing pad on top of the parking lot for use as a heliport. They strung together extension cords from the generator to the landing pad and shined lights to guide the pilots. To get patients to the helipad, hospital personnel passed them through a passageway on the second floor, which led from a maintenance room into the parking garage. Staff then drove patients up a ramp and carried them up three flights of stairs to the landing pad.¹

On the ground, private boats began evacuating the 1,800 New Orleans citizens who had taken shelter at Memorial. These individuals were relocated to dry land and left town on foot or by bus.¹

In Baton Rouge, the anticipated barrage of New Orleans patients in critical condition began. “We started to receive many septic and dehydrated patients. Many patients had horrible soft tissue infections requiring operative debridement. However, by this point, two of our five operating rooms had begun to flood, and there was no air conditioning in these rooms. Even so, we continued to operate as necessary,” Dr. Gill said.

“One gentleman had almost completely amputated his arm, severing every vessel and nerve, while trying to rescue his family from their

flooded house,” Dr. Gill said. The physicians at E.K. Long Hospital were able to salvage the man’s limb and transfer him to another institution the following day. A similar process of “triaging the sick for the sicker” would continue for the next week, he added.

Wednesday: Hope deferred

On Wednesday, the patients and staff at University Hospital received one sign that the rescue teams knew people were still struggling to survive in the facility. “They dropped supplies to us on Wednesday—cans of baked beans, bottled water, and, for some reason, cat food,” Dr. Harrison said. Even so, only enough water was delivered to afford everyone two pints per day—not nearly enough to prevent the residents and nurses lifting patients and carrying them down the stairs in the heat from becoming dehydrated. Many of the residents at the institutions mentioned in this article hooked themselves to IVs to maintain the fluids they needed to stay alive and healthy enough to care for their patients.

Later that day, word came that Charity and University Hospitals would be evacuated, but that promise went unfulfilled for at least another 24 hours.

The situation was growing chaotic at the VA, too. “We were bagging patients by hand. We were doing everything like [it was done] ‘back in the day.’ We didn’t have access to labs. The air conditioning was out. A lot of patients started getting de-



A surgical resident wading to the VA hospital to help.



A surgical resident kayaking to the VA hospital to help.



Treating a patient at LSU.



A sign from the window of the LSUHSC.



New Orleans residents being rescued by the National Guard.

hydrated, and we had to put them on IV fluids,” Dr. Fung said.

Realizing that their friends and colleagues were facing perilous circumstances, some of the residents who were off-site and sharing a building felt helpless being away from their institution and their patients. So they found some kayaks and paddled their way to the VA hospital, Dr. Fung said. It took them two hours to traverse the flooded streets, teeming with debris, sewage, and people trying to make it to shelter or dry land. Once they arrived, they were ready and able to do whatever needed to be done.

“On Wednesday morning, [Children’s Hospital]

lost water pressure and, therefore, running water and full air conditioning capacity. This was the first real threat to our patients’ health,” Dr. Minkes said. To formulate an appropriate response to the increasingly menacing circumstances, Dr. Minkes met with two other College Fellows, Joseph Caspi, MD, FACS, and Timothy Pettitt, MD, FACS. “Dr. Caspi and our chief executive officer, Steve Worley, quickly agreed evacuation was in order.”

“Over the next 24 hours, we evacuated our entire hospital by whatever means we had. The only outside help we had was from the medical community across the country who accepted our patients and sent helicopters to transport some of the children,” Dr. Minkes added.

Drs. Caspi and Pettitt led an evacuation team of six ambulances and several sport utility vehicles (SUVs) to Baton Rouge. Many of the infants were hand-ventilated in the backs of the vehicles, and patients who had families with transportation were promptly discharged.

“As evening approached, we learned that National Guard aircraft were at the airport and could fly out most of remaining ill patients as long as they could get there by 7:00 pm,” Dr. Minkes said. “We quickly mobilized a caravan of about 40 cars, trucks, and sport utility vehicles for transport.”

At University Hospital, one of the staff members text-messaged her husband, telling him to get in their boat and get her out of the facility. “I told my wife, ‘You take the baby and get out,’” Dr. Stafford said. Although the employee’s spouse was willing to bring extra people on the boat, he was concerned that it would be too risky to travel with a boat full of women and a baby because of the pillaging occurring on the streets, even though he had brought a gun with him. He asked Dr. Stafford, who had served for seven years as a Navy Seal, to come along.

His superiors gave Dr. Stafford permission to leave. “I took the boat slowly down the street [to get to one of the evacuation points]. We did see two or three parties of looters at night. When I’d see them approaching, I’d turn off the light on the boat and go more slowly, so they couldn’t spot us,” he said.

“As bad as it was on the inside, it was worse outside. We saw a flow of people trying to evacuate during the daytime. One was an older gentleman with a cooler that he was using as sort of a flota-

tion device to get to the Superdome,” Dr. Stafford added.

Dr. Stafford and his human cargo made it to the airport and were evacuated to Shreveport, LA. “The hardest part was watching the news and knowing that so many of our friends were still there. I called Fox News to call their attention to the fact that many people were still in University Hospital and had not been evacuated,” he said.

Evacuation efforts at Memorial came to a screeching halt on Wednesday evening, leaving behind approximately 115 patients at a facility with generators that had begun to fail earlier in the day. In dismay, the medical personnel took the patients back in for the rest of the night, giving them food, fluids, and cots to rest on, a nurse at the center reported.¹

Thursday: Beginning of the end

On Thursday morning, six helicopters that Tenet had chartered started arriving at Memorial, whisking away the remaining living patients by that evening. Tragically, Memorial’s death toll would reach 45; of that number, 25 had been patients in the acute care ward mentioned previously.¹

That same day, the VA completed evacuation of about two-thirds of all its hospital, nursing home, and rehabilitation patients. “We took the patients down to the loading dock. I triaged the patients and assigned them to evacuation trucks,” Dr. Fung said. “An intern went with the ambulatory patients and residents went with the others. About five trucks came. Sometimes we could only fit five or six patients in a truck if they needed a lot of equipment.”

On their second-to-last trip to the VA, the evacuation truck drivers said they would come back to take the last 50 or so patients sitting in wheelchairs, their charts pinned to their clothes or on chains encircling their necks. The crew did return but said that they were only going to take nonessential hospital staff on the last trip of the day. “The patients were going to have to wait until the next morning,” Dr. Fung said. “To sit and watch these healthy employees and their families being evacuated, some with their pets, while our patients were left behind was very upsetting.”

Even so, as chief resident, Dr. Fung knew she



Rescue helicopters



Rescue boats outside LSU



According to Dr. Pharaon, “I told the colonel, ‘I need one of your biggest trucks.’ This is what we got: ‘deuce-and-a-half.’”



Yellow folders containing name, age, and diagnoses were hung from patients' necks, because they were being transferred to other hospitals.



"From the hospital bed, to the truck lift, into the back of the truck, continuing to hand-bag the patients," said Dr. Pharaon.

had to maintain her composure and ensure that the remaining patients would have a somewhat peaceful evening. "I did have a breakdown for about 10 or 15 minutes when I heard about the decision to evacuate nonessential employees before some of the patients. I just couldn't un-

derstand the logic of it." The health care professionals who remained with the patients grabbed mattresses off of the beds and brought them downstairs for people to sleep on, she said.

Earlier that day, Children's Hospital finished its evacuation. "At about 4:00 am, a state trooper arrived and informed the medical staff that conditions outside the facility were worsening and recommended that the rest of the patients be evacuated at first light. A pediatric intensive care unit nurse, with the help of a family member, was able to secure two state trooper vehicles for the first caravan out that day.

"We asked for two additional vehicles for the final caravan after our last babies were to be evacuated," Dr. Minkes said. "They informed us that they 'broke rank' to come to our hospital and that we were 'low priority.'" Soon after, a helicopter from Miami Children's Hospital arrived to transport the two infants still in the facility, and Dr. Minkes and another physician led the final Children's Hospital caravan to the interstate. "Everyone made it out safely," he noted.

Friday: Final evacuation

"Finally, on Thursday evening, a Black Hawk helicopter touched down to start evacuating the patients at University and Charity Hospitals," Dr. Harrison said. The first to go were infants and immediate postpartum mothers. "For some reason, they took the babies first, and the mothers went on a separate transport. That was probably the hardest thing to watch," he said, adding that the expression

on one mother's face when her baby was being taken away embodied the anguish of the entire experience.

After that, "The wagon train started coming in," Dr. Harrison said, complete with fuel and a generator truck.

On Friday, all of the remaining patients and hospital personnel were evacuated from the hospitals. A total of 40 air boats—each with a crew of one driver and one armed guard—arrived to take patients, physicians, and others to the New Orleans airport.

The airport and its surroundings "looked like a scene out the movie *Tears of the Sun*. It was just a constant stream of people. Every square inch was taken up," Dr. Harrison said. Patients were being ventilated and intubated by family members, trying to make their way through the "milling throng," he added.

In the end, surgery services at Charity and University Hospitals lost only two patients between them, despite the grueling circumstances, according to J. Patrick O'Leary, MD, FACS, chair of the department of surgery at LSUHSC and First Vice-President of the ACS. Dr. O'Leary attributes this remarkable achievement to the skills and spirit of the residents and hospital staff who provided ceaseless, physically demanding care to all those unfortunate enough to be experiencing sometimes life-threatening illnesses while the city where they lived and worked was being washed away. He noted that one resident hand-bagged two patients



The Arkansas National Guard protecting patients and hospital staff from the escalating violence.



Patients and physicians heading out, with armed guards, from the VA hospital for other hospitals in the region. Front left: Adam Grezaffi, a Tulane medical resident. "A week before," Dr. Pharaon said, "this truck was in the Iraqi desert."



A "convoy" of patients leaving the VA hospital.



The convoy crossing the Crescent City Connection.

One elderly patient died en route. Upon their arrival, the evacuation teams cleared out a section of the baggage claim area for the VA patients. They were greeted with some ready-to-eat meals and a couple of cans of Ensure, Dr. Fung said. Finally, at approximately 4:00 pm, the VA patients and personnel were flown to Shreveport and Little Rock, AR.

Dr. Fung proudly noted that in all the days of the flood, "No surgical patient [at the VA] passed away."

Overcoming obstacles

Throughout the six-day ordeal, residents and surgeons had to scale some mountainous hurdles. The biggest obstacles to providing necessary care to the patients in the hospital were "no communication systems, no water pressure, no long-term power supplies," Dr. Opelka said. "So the medical professionals were working in the dark without lights, without water, without food, without cell phones or land lines, and in dark hallways. The obstacles were abounding," he said.

Because the electricity was out, the telephone wires were blown away, and even cell phone towers silenced, communication between the physicians and the rescue squads often was not possible. "It was difficult to know that decisions were being made," Dr. Fung said.

simultaneously for several hours at a time without stopping, and an orderly carried a patient downstairs on his back.

At long last, all of the VA patients and medical personnel also were transported to the airport.

In other cases, physicians were able to make contact with the appropriate agencies, but such communication proved futile. "We were in contact with local, state, and federal agencies, including the Federal Emergency Management

Agency (FEMA) and Homeland Security. We had landlines, Internet access, and intermittent cell phone services. We contacted local police in Orleans and Jefferson Parishes, state officials, and federal agencies asking for armed assistance to deal with the looters,” Dr. Minkes said. “We never got any help. There were three local police officers guarding a supermarket a half-mile down the road, and we never got any assistance.”

Furthermore, without electrical power, it was impossible to take X rays or to conduct other radiographic tests, laboratory capabilities were limited, and many of the modern-day wonders used in surgery and trauma care were rendered useless.

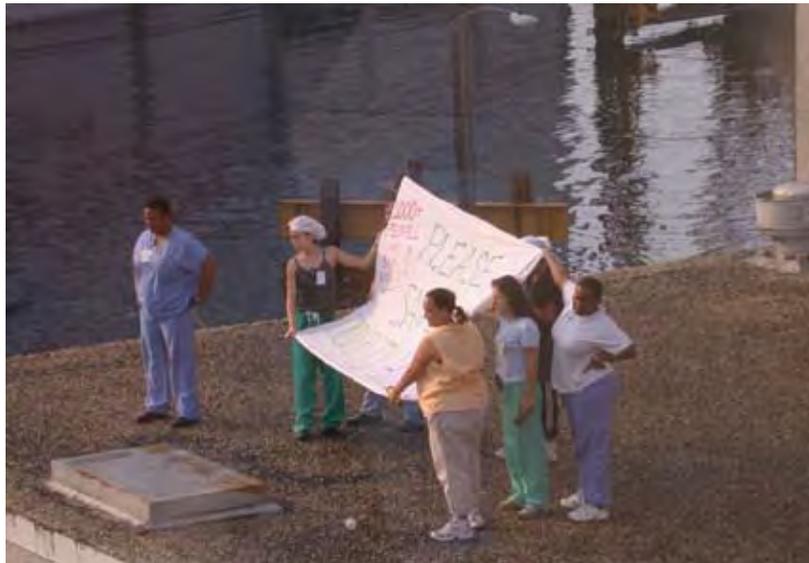
“I had one case where a premature baby needed a central line put in. We did it totally in the dark. It was kind of like wartime medicine,” Dr. Stafford said.

“It was an interesting experience to accept 10 to 20 patients in a row and have at most a sheet of paper to tell you their condition,” added Dr. Gill. The physicians at E.K. Long Hospital had to rely on their own ability to conduct a physical exam and take patients’ histories to provide the appropriate care. “It was a memorable learning experience that taught me that innate instinct and clinical judgment are better able to treat patients than anything else,” Dr. Gill said.

Morale and camaraderie

The residents and surgeons attribute much their success to the spirit of fellowship that exists within the New Orleans’ medical community.

“I admire my colleagues and the camaraderie of LSU surgery. Our residents were the last to leave Charity Hospital and cared for many medical patients in the process. Our true morale and character came out in this tragedy, and no one can question that,” Dr. Gill said.



Nurses on the roof of a parking garage signalling for help.



Rooftop evacuation of LSU.

“Everyone was working side-by-side to get everyone out of the hospital safely,” Dr. Fung added. “Watching everyone kind of come together, I was impressed.”



A pilot; two copilots; a photographer; Dr. Pharaon; Jaime Rodriguez, MD; and two patients in a rescue helicopter.



Dr. Pharaon (left) and Dr. Rodriguez in the helicopter.

Furthermore, the physicians, nurses, and other personnel rallied to each other's aid, Dr. Fung said. She noted that one of the anesthesiologists at the VA had recently brought his family to the U.S. from Georgia in eastern Europe. His youngest child had recently become ill. Everyone on staff cared for the child and slept in the recovery room with his frightened family members. They made an all-out effort to ensure the family's prompt evacuation, advocating on their behalf with the VA and military police.

Similarly, Dr. Stafford said, everyone at University Hospital mobilized in support of his wife

and newborn. "Because she's an ob/gyn resident there, she knew everyone, so it worked out well. The staff really looked out for them, making sure my wife had enough to eat so the baby was getting good milk," Dr. Stafford said.

"The attitude among people was amazing. It was almost like summer camp," he added.

But maintaining such unrestrained cooperation was a task in itself. "As an attending surgeon, my most difficult job was trying to maintain morale," Dr. Harrison said. "We had one nurse who just broke down. In situations like this, humor is the best medicine. You try to find what's most distressing and try to find the absurdity in it."

For example, one day some of the nurses took a bed sheet, wrote on it that patients and hospital personnel were trapped inside University and Charity Hospitals, and held it up on the roof of a parking lot to gain the attention of the air rescue teams. When they couldn't attract the desired response, Dr. Harrison yelled down to them, "Try showing a little thigh. Maybe that'll get their attention." The levity of his comment broke some of the tension the nurses were feeling.

Patients and families

Some residents drew strength from their patients as well the other physicians. "One of the residents was upset and worried about ever seeing her family again. A 90-year-old patient took her hand and told her not to worry, [that] everything would work out," Dr. Harrison said, noting that the resident was able to find comfort in the patient's calm demeanor.

Indeed, the physicians almost universally recall that their patients demonstrated strength and resilience in the face of such difficult circumstances. "In general, most of the patients handled it better than I thought they would," Dr. Fung said. "Mainly they were just frustrated because they didn't know what was going on with their families."

Dr. Gill noted that once the patients who were sent to E.K. Long Hospital were resuscitated and coherent, "They all asked where their family members were and how we could contact them. This was by far the hardest emotional aspect

of this experience because we did not know their families' whereabouts, nor did we have any means of communicating with them. Many of these patients were transferred to other institutions for more extensive care. I'm sure their families would not know where they were for days on end."

Personal losses

Physicians also experienced the turmoil of dealing with personal concerns about their families and homes.

"My daughter was displaced in her last year of high school," Dr. Opelka said. "My home is seriously damaged and not fit for living. We will have to rebuild the entire left side of the home. We had no flooding from the ground water, but the loss of my roof caused rain water to fill the left side of the home, upstairs and down. It is now filled with an overwhelming mold and is uninhabitable," Dr. Opelka said.

Dr. Fung said that her residence experienced little damage, although her parents' house in Metairie had accumulated about a foot of water, and her aunt's place was ravaged when Hurricane Rita tore through the Gulf Coast soon after Katrina's assault. Nonetheless, "Everyone evacuated and are all accounted for," she said.

"My home in New Orleans suffered minimal damage," Dr. O'Leary said. "But it took a month to get electricity and clean drinking water." Particularly upsetting to Dr. O'Leary and his wife was the fact that their maid—a close, personal friend—was displaced. When he went searching for her, he found total



Patients waiting at the airport.



Evacuated patients on board a plane to another facility.

devastation in her part of town. Eventually, they learned that she and her family had safely escaped.

In addition, approximately half the residents at LSU "lost everything," according to Dr. Fung.



A life lost to Katrina.

their lives and education. Because many of them are living in the same common area, “It’s kind of like being in college again,” he added.

Some practicing surgeons have relocated to other southern cities or are looking for new career opportunities through the College’s job bank. In addition, Tulane’s medical students and residents have largely relocated to Texas through programs set up at Baylor College of Medicine, the University of Texas in Houston, the University of Texas Medical Branch at Galveston, and Texas A&M Health Science Center College of Medicine.³

At press time, the fate of five or six hospitals in New Orleans remained uncertain, according to Dr. O’Leary. Charity Hos-

pital—the nation’s oldest, continuously operated hospital and largest provider of indigent care—most likely will be condemned. Those hospitals that do rebuild will rely on FEMA monies, he said.

Ochsner Clinic going strong

One medical center in the New Orleans area made it through the hurricane and the eventual flooding relatively unscathed through “a combination of good planning and good luck,” according to George Fuhrman, MD, FACS, a general surgeon at Ochsner Foundation Hospital. That institution is located just outside of New Orleans in Jefferson Parish, far enough away from Lake Pontchartrain to avoid the rising floodwaters that developed after the levees broke. “The floodwaters never got us,” Dr. Fuhrman noted.

As the hurricane approached, the hospital initiated its “wonderful emergency plan,” Dr. Fuhrman said. “We just did what we had to do. We never closed.”

Because the facility did not flood, its generators remained in operation, and all the medical equipment—including scanning devices, respirators,

After the evacuation

Once they were on relatively dry land, most of the medical professionals reported that they just wanted to do the small, day-to-day activities that most people in this country take for granted, such as taking a hot shower, brushing their teeth, and sleeping in an actual bed.

They were soon back to work, though. Once it was possible to reenter New Orleans, “We spent three days touring parts of the ravaged city to recover family/friends from rooftops using john boats and from their homes using elevated 4x4 trucks. Then we set up a system to find all our employees using the Web and [toll-free] numbers,” Dr. Opelka said.

“Then we moved an entire medical school, placed residents into programs, acquired a cruise ship to house residents and students, seized the Port of Baton Rouge to dock the ship, built a 190-trailer park for faculty housing, and restarted clinical practices in new cities,” Dr. Opelka said.

Speaking as one of the residents who was relocated to Baton Rouge, Dr. Stafford said he and his peers “have completely rallied” to rebuild



The back of the Charity Hospital emergency room ambulance ramp.

and so on—was viable. In addition, the facility has its own source of water and was receiving supplies by convoy from Baton Rouge.

Given that Ochsner suffered minimal damage and was able to remain fully operational, it now often finds its emergency room overflowing with patients. Although this situation has created a bit of a drain on the facility, it has provided a good reason for most of the surgical residents and surgeons to stay, Dr. Fuhrman said.

Lessons learned

All of the surgeons and residents who contributed their stories to this article said that this experience taught them some valuable lessons about disaster preparation that should be applied in efforts to restructure New Orleans' hospital system.

Dr. Harrison suggested that all hospitals make sure they have enough fuel to keep their genera-

tors running for at least one week and that the generators be placed above ground. He also suggested that facilities develop better ways to handle sewage and have portable toilets on hand. He also recommended developing better wireless means of communication and stocking supplies of the ready-to-eat meals that the military uses to feed troops in remote areas.

In addition, Dr. O'Leary suggested that the public hospitals have rapid access to helicopters and that they be equipped with more modern equipment that retains charges for extended periods. He also called for increased numbers of armed security personnel to combat looters and other criminals.

The hurricane also wrought some important life lessons as well. Most everyone agrees that this experience reminded them of what matters most—family, community, and providing compassionate care to patients, regardless of what's happening at the time. "The list of what this experience taught me is endless. Humility, trust, appreciation for all we have and take for granted" spring to mind, Dr. Opelka said.

He added that, "More than anything, surviving this crisis is about a group of caring people creating hope for tomorrow." □

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Transitions in surgical training:

The path to surgical leadership in the making of a “good” surgeon

Someone should have advised each of us to take a mental picture of our personal firsts in surgery and keep a little photo album in our memories. Do you remember your first day as an intern? First night of call? First trauma? First time a patient thanked you with tears in his or her eyes? First case you were allowed to do skin-to-skin? First time you did an intubation? First laparoscopic case? First day as senior resident? First Whipple? First day as an attending surgeon? Of course, there are other firsts—some we would rather not discuss. Still, each of these firsts is part of our preparation to care for patients who, along with their families, put their confidence in the abilities of our minds and hands to make them well. Some of these firsts represent the beginning of a new phase in our evolution as surgeons. Much like there are stages of development in human life from oocyte to adult, there are stages in our surgical development from medical student to attending surgeon.

Internship

It was hard to believe that medical school is over. Four years of books, exams, and rotations...finished. Then I found I had another five years of books, exams, and rotations. Welcome to general surgery residency.

Whether you stayed at the institution affiliated with your medical school or forged out to explore a new institution, the first day as an intern is both exhilarating and disconcerting. Internally, you are a combination of adrenaline, nervousness, fear, and confidence. Externally, you are a picture of the competent underling with a personal digital assistant (or pen and



C. Suzanne Cutter, MD,
New York, NY;

Heena Santry, MD,
Chicago, IL;

and

Juan Paramo, MD, FACS,
Miami, FL

paper) on the ready and, with a look of pensive concentration, you are receptive to the yoke also known as the bottom of the pyramid. There is a well-written guide that provides a solid orientation for surgery interns.* Although it was intended primarily for women residents, this guide has been quietly consulted by both genders. With the help of guides such as these, but more importantly, senior residents and attending surgeons, the interns will learn that they are a critical part of the surgery team. Through spending time with patients, charts, and the nursing staff, the intern's knowledge of the patient is often the most comprehensive. In concert with that, the intern is the effector portion of the surgical team who carries out the elements of patient care goals—either directly at the bedside or indirectly by writing orders—beyond the doors of the operating room. One of the most important benefits to the intern is learning credentialed and noncredentialed bedside procedures in the process. These procedures are an early source of confidence and preparation for operative tasks. Each procedure should be viewed as an opportunity for review of pathophysiology (why does the patient need this?), anatomy (what are all the structures in this region?), and decision making (if this does not work, how else can I accomplish the patient's care goals?).

In today's new environment of regulated resident work hours, the stress and strain of sleep deprivation have begun to fade. A postulated benefit is more time for reading in preparation for cases, the U.S. Medical Licensing Examination Step 3, and the American Board of Surgery In-Training Examination. With this transition, there has been a subtle shift in the resident-patient relationship from a relationship-based to a more transaction-based model. Two themes are now emerging. First, night float is often more dreaded than call. The experience can be overwhelming or even frightening, and, perhaps more importantly, it deprives the intern of formal educational conferences for its duration. Second, attending surgeons are now working more hours as they try to survive the pressures of managed care. They are under more stress and strain (perhaps more so than the residents) and it is starting to show.

Hopefully, the interns learn quickly that their

*Walsh DS, et al. *Pocket Mentor: A Manual for Surgical Interns and Residents*. 3rd ed. Westmont, IL: Association of Women Surgeons; 2001.

best strategies for survival are reading to reinforce daily learning experiences, asking questions when in doubt, and calling for help when in peril. It used to be easier to develop the habit of neglecting the personal and social aspects of life. In fact, this breach on lifestyle was one of the major reasons cited by medical students for not selecting a career in surgery. Fortunately, with regulated residency hours, there is more opportunity to avoid this neglect.

Still, an 80-hour workweek is more arduous than most interns' previous experiences in providing surgical care. The adjustment to the responsibility for the front line of patient care on the wards and negotiating bureaucratic, administrative, and interpersonal hurdles can be overwhelming. Strong mentorship and role modeling from senior residents and attending surgeons can ease the transition.

The research years

I am ready for a break...need to catch my breath. Yet, I must be prolific in the lab or I will have wasted two years that could have been spent mastering clinical and technical surgical skills. I have to publish some papers....

The research opportunity

Residents at many academic and nonacademic surgery residency programs interrupt their clinical training for a one- to three-year dedicated research experience. Residency programs view this interruption in several ways. Some programs require it while others strongly urge it. Still others, though they do not have the "manpower" to "lose" a resident to research, will support a resident who is deeply committed to pursuing a research experience. Arranging the research experience is usually left to the resident. Most residents will take two years after their second or third year of clinical training. Although the majority of residents pursue basic science research in the laboratory, more opportunities are arising for residents to pursue clinical, outcomes, and public health research. Residents can pursue research at the same institution as their residency or at another institution if their specific research interests will be better cultivated elsewhere.

The primary reason most residents pursue

dedicated research is career advancement. Those interested in pursuing academic careers in surgery often need an intensive research experience and its resultant publication to achieve their post-graduate fellowship of choice and take the next step toward an academic career. Research also presents an opportunity for residents to become involved in professional societies and begin to network with leaders in the surgical community. In fact, many residents become active in the Resident and Associate Society (RAS) of the College during that time. However, research allows for personal opportunities as well. The timing of research often comes when residents might be burned out by the rigors and hours of their clinical training. The more flexible hours during research allow residents the opportunity to renew their interests in hobbies, travel, and personal relationships. Residents spend more time with friends and family who have been largely neglected and some residents use the time to marry or start a family. These personal opportunities must be carefully balanced, however, with the work of research. The everyday work of research must be diligently pursued and shaped into tangible documentation—presentations, abstracts, posters, and publications—if the original intent of career advancement is to be served.

Maintaining clinical skills

Many residents continue their clinical activities on nights and weekends through moonlighting opportunities. Moonlighting allows a resident in research to maintain clinical skills and earn a substantial amount of money. However, these long nights lead to subsequent days of decreased research productivity and decreased opportunities to reap the quality-of-life benefits of the flexible hours of research. Although moonlighting is often a personal choice of the research resident, some organized research programs explicitly prohibit it whereas some residency programs mandate that their residents continue to take call even while on research. The important thing to remember is that general surgery training is on a five-year timeline. Although a significant portion of time off from the training disturbs the flow, excessive clinical activities during research detract from the quality of the research and can never substitute for the clinical experience gained from working

daily as a surgeon-in-training.

Toward the end of the research experience, most residents have mixed feelings. They feel stress related to completing research and writing manuscripts, anxiety about returning to clinical duties after time away, and sorrow about the pending loss of free time. These feelings are at least partially subdued by excitement about getting back to what attracted each of us to surgery in the first place: operating. It can be difficult at first to regain the clinical and technical skills that no amount of moonlighting or reading would have kept current. The learning curve with daily work as a clinical resident, however, is steep. Medication dosages are relearned and technical skills return with daily practice. However, the most difficult part of the transition is taking on the role of a senior resident. Although clinical and manual skills were likely not mastered as a junior resident, they were at least pursued on the wards, in the clinic, and in the operating room. Personal digital assistant pharmacopeias, textbooks, and atlases exist to allow one to quickly catch up with the clinical and technical skills. A returning resident will need to be more vigilant about using these resources to supplement a knowledge base that might not be fresh. Returning residents are well advised to revisit activities used as an inexperienced intern to renew their clinical skills, such as suturing banana peels and tying knots on scrub drawstrings.

Clinical and technical skills are a small challenge for the returning resident compared with the responsibility of leading the surgery team. The essence of the challenge with returning from research as a senior resident is becoming a leader in the face of all of the feelings of clinical and technical inadequacy. When working as a junior resident before starting research, there was always a more senior resident to run the team. Leadership was not frequently practiced before research and it was likely not cultivated during research. A resident returning from research may be hesitant and lack confidence about becoming a leader. It is important to realize that these feelings are a natural part of making a transition to more responsibility. The confidence will grow gradually. A good leader is cognizant of his or her weaknesses but is not paralyzed by them. A legacy of leadership lessons is part of the senior resident's memories of past residents and attend-

ing surgeons, regardless of if they were effective leaders. Attending surgeons often make good role models and junior residents are a valuable source of feedback. A good leader makes everyone feel good about the work that they are doing day to day but also provides constructive guidance to improve that work. Residency programs with residents who pursue research have administrators who are experienced with the fears of a returning resident, and some know how to foster the trainee's leadership skills in spite of fears. Fellow residents, attending surgeons, and program directors are available to aid in the transition, but the resident returning from research needs to take a proactive role in enlisting that aid.

Although research successes are an integral part of the research experience and important for career development, they can haunt the returning resident for the last few years of residency. Thus, it is essential to complete unfinished data analysis and manuscripts in progress not only expeditiously, but also without detracting from the clinical experience. Developing clinical competence is the focus and research in progress must take a backseat to pursuing clinical excellence. With this in mind, many residents opt to drop certain projects or hand them off to others in order to maintain their focus on building clinical and technical skills. No matter how prolific he or she might be during the research experience, these opportunities will not be available to a poorly trained surgeon. The research experience is an exciting personal and professional opportunity during an arduous training program that undoubtedly increases future career opportunities. However, it should never take away from the real work of becoming a surgeon—taking care of patients and learning when and how to operate. It is only with these latter abilities that a career in surgery can be fulfilled.

Senior resident years

A good surgeon knows more than just how to operate. Good surgeons know when to operate and, more importantly, when not to operate.

Senior residency

The transition from junior to senior resident provides an opportunity to learn how to be a surgeon both within and outside of the operating

room doors. In three years, the individual learns to assert leadership skills and accomplish objectives through the work of others. At the same time, the senior resident is also focused on becoming the most competent and technically skilled surgeon possible. To accomplish these objectives, senior residents are best served by learning to manage these competing demands. The senior resident is most effective when solving problems constructively, being decisive, and knowing when to consult the contributions of others, including attending surgeons, residents, physician assistants, and the nursing staff.

From a practical standpoint, senior residents must learn how to independently perform surgical procedures and manage patient care. Independence in the operating room is dependent on the skills of the resident and the confidence of the attending surgeon. Preparation includes reviewing the anatomy, steps, and interoperative complications of the procedure. Furthermore, knowing the patient's history as well as specific indications for surgical intervention is essential. Knowledge of instrumentation, suture selection, and patient positioning are often assumed. In contrast, managing patient care is more of a subtle art. Although there are many guidelines and recommendations, each individual develops his or her own preferences in areas such as wound care, diet advancement, and management of drains. Leading morning and afternoon rounds provides daily opportunities to develop those skills under the tutelage of the chief resident and ultimately under the supervision of the attending surgeon. Running traumas is the fast-forward version of managing patient care through constant patient assessment, rapid completion of multiple procedures, and minute-by-minute decision making.

Chief residency and fellowship

Achieving chief residency status, whether by longevity or award, embodies the philosophy of the military that states: "Rank has its privileges, but rank has its responsibilities." The best chiefs take responsibility for the actions of the team by commending people in public and chastising them in private. Because senior residents are the buffer between the chief resident and intern levels, more time becomes available to the chief for observation

and evaluation of patients, residents, and situations. The potential benefit is an acquired perspective that allows the chief to eliminate barriers and roadblocks to patient care while developing ways to improve processes.

Fellowship training years are often the best blend of privilege and responsibility. When senior residents are part of the team, the fellow can act as a junior attending surgeon. The focus shifts from managing patient care to learning specialized surgical procedures and developing the finer points of surgical skill. Fellows may be as involved as they choose in patient management while at the same time having their pick of surgical cases.

Overall, beyond providing excellent patient care, teaching is one of the most important responsibilities of the senior resident. Junior residents who are not performing well can become targets of unrelenting criticism and concerted efforts aimed at their removal from the residency program. It requires an insightful and impartial senior resident to recognize early opportunities for intervention. These senior residents realize that providing direction and training to problematic junior residents only furthers their own leadership development while secondarily elevating their status as a teacher and leader. Teaching responsibilities often extend beyond the junior residents to the nursing staff, physician assistants, patients, and patient family members. Knowing when to teach, when to step back, and when to intervene is a reflection of good judgment. The ability to anticipate and manage knowledge deficits in others, problems in team function, and potential complications in patient care separates the adequate senior resident from the effective senior resident.

It may be comforting to many to learn that there is no single best leadership style in surgery. Dictatorial leadership prevails in environments where there is dysfunction and low morale. Empowering leadership prevails in highly functional environments with good morale. Most residency environments fit somewhere between these two extremes. Furthermore, the nature of a particular environment may also lead to challenges to authority. The person in charge is always criticized and accepting that fact makes this transition a lot more manageable. Nevertheless, when you are in charge, people expect you to lead, regardless of if they like you. Good leaders maintain their

calm while providing direction and enabling team members to work effectively.

Attending years

Someone please call the attending! Wait a minute...I am the attending.

Associate Fellow of ACS

Imagine that suddenly, at the end of residency, you are now the attending surgeon. Like any other transition in life, you are back to square one. You have probably spent the last few months negotiating contracts or starting to set up your own practice. You have made your initial applications to Medicare, Medicaid, and the multiple insurance companies. Hopefully, you already have a license to practice in that state, a DEA number, a place to live, transportation arrangements, and a job for your spouse.

Yes, you are very pleased with your accomplishments, yet there is a lot of insecurity as to what the future will bring. If you have not completed your board examinations, you have to start preparing during this challenging time of transition. You may be moving to a new geographical area and must adjust to the inherent challenges that the new environment brings. First impressions are so important. On the other hand, if you decide to stay in the area where you completed your training, you can only hope that you have made a good impression. If you join the teaching staff in your institution, you may find that colleagues and ancillary staff still view you as the resident or the fellow but not as the attending. Instead of

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learning how to care for patients, you must now learn about asset protection in the current liability environment. You wonder if you can afford liability insurance. You also realize that the 80-hour workweek is over for you. Now there seems to be no limit on how many hours you will have to work—most likely, many more than 80. You find yourself running the marathon for which you have been training. Fortunately, you are ready.

During your first year, you go to work and find you have no patients. You have no phone calls. The busy schedule you had as a trainee now has transitioned to one with plenty of time to spare. Then, your first patient arrives. Now you are the one responsible—you are it! You cannot even think of calling the attending surgeon because *you* are the attending surgeon. Of course, the first case will either be so challenging that there is little you can do to intervene or something so simple a medical student can handle it. Certainly, that first case will not be between these extremes. It will be nothing straightforward.

You may notice that you feel completely different. You had responsibilities as a resident or fellow, but this is different. Now you feel that the patient deserves even more from you: absolute perfection. If you work with residents, you may be initially somewhat reluctant to let them manage the patient or “do the case” in the operating room. Even the prospect of someone else placing a central line on *your* patient frightens you because of risk of pneumothorax that the intern can give your new patient. Then you hear yourself using the phrase, “Let me show you how I like to do this.”



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Now, if you do not work in a teaching program where residents are available to help you, then you are it. The nurses will call you for just about everything, just as when you were an intern. Your emergency room colleagues will want you to see patients in the middle of the night, and you will have to oblige them by going in to the ER. Can you trust their judgment? Is it really necessary to measure the central venous pressure at midnight? Recognizing your limitations is fundamental. Calling for help is no longer a proverbial sign of weakness but of rational safety for your patient. Delegating is more difficult. You may find that you ask yourself questions such as: Can I say “No!” to colleagues who want me to operate on one of their patients? Should I turn down this case? What if my first referral has a complication? Will I ever get patients from that college again?

What about the call schedule? Should I volunteer to take extra call in order to build up my practice or will the older, well-established surgeons take advantage of me? This can turn out to be a double-edged sword. Sure, at the beginning you want as many patients as possible and you definitely want to be available. However, the additional requirements when you are on call can ultimately affect your practice. Just as in your personal life, your professional life should be balanced. It is difficult to comply with your daily obligations when you have been operating all night long while on call the previous day. And as your practice grows, this becomes more difficult. Just like with the 80-hour workweek regulations, you may consider having limited office or operating room hours on your post-call day.

Younger surgeons are up to date, and older surgeons have more experience. What if I lose a patient to an older, well-established surgeon? Is getting a second opinion losing that patient forever? The patient may say, “You look so young. Are you the one doing my surgery? So, how many cases like mine do you do every year?”

Starting and then building your own practice is a tremendous challenge in the current era of fierce competition and the upcoming pay-for-performance restrictions. However, you should be confident and optimistic. It has taken everyone a long time to develop a steady referral base, a good reputation, and a successful practice. Having a mentor during the beginning of your professional career is fundamental. However, finding a mentor is not that

simple. A real mentor is sincere, honest, and, like a personal trainer, not afraid to openly and sincerely discuss with you your strengths and limitations. A mentor is much more than a friend. Having a lifelong mentor is ideal.

Be honest, respect your patients and your colleagues, maintain pristine ethical principles, and be confident. The patients will come. You will be successful as long as you perform the best you can, understand your strengths, and, more importantly, know your limitations. Ask more senior colleagues for their help and get second opinions when necessary. Do not be afraid to ask another surgeon to help you in a difficult case. Communicate with your referring physicians and do not be afraid to say, "No!" if, in your best judgment, that is what is best for your patient.

Be politically active. Praise your profession and be thankful for the gift you've been granted by being a surgeon. The learning process has just begun. Keep reading, continue your research, attend meetings, and become a Fellow of the American College of Surgeons.

ACS Fellowship and beyond

So now you are the surgeon who other colleagues look up to. You have earned everyone's respect and admiration. If you are in the academic environment, you have been able to start and develop your own laboratory and have productive research machinery. You have perfected your teaching skills and everything seems to be running smoothly and efficiently. If you are in private practice, you are well known in your community and have a steady referral basis. Most importantly, you are active in the College.

Yet, even if you are an expert in your field, it is impossible to know it all. Never forget that you were an intern at some point. Sure, things are far different from the TV show *Grey's Anatomy*. But as everything else in life, just when you thought you met your goals and were at the cusp of your career, it is time to recapitulate and start the process all over again. Despite these concerns, you have to be open-minded. Good teachers wish their students will become better than they. Teaching residents is a challenge, but it is also an art. Never forget you were once a student, once a resident, once a junior attending surgeon, and working to become a Fellow of the College. This will facilitate the teach-

ing process and give you better insight on how to teach effectively.

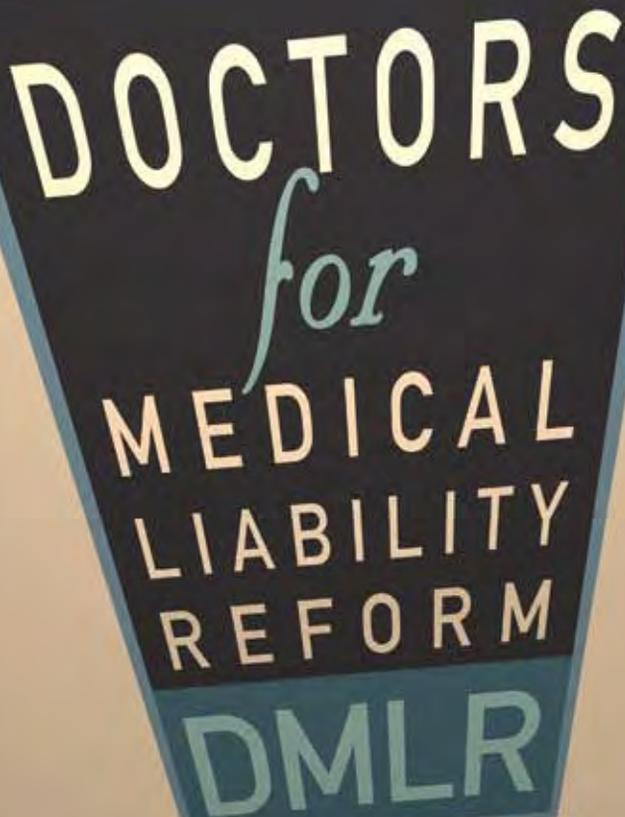
Most likely, you will become a mentor. Your experience is invaluable. Your hard work and dedication have paid off. Younger surgeons are your protégés. But things are not getting any easier. The responsibilities are enormous and the expectations are constantly growing. Some cases may seem monotonous, yet others that are very challenging may not be appealing. You are more aware of your limitations.

Learning is a lifelong process. The College provides many learning opportunities through its annual conferences and courses. Younger faculty members possess an intriguing fund of knowledge and information that they can share with you. If you work in a residency program, you are supposed to teach trainees the art of surgery. Yet, you may be surprised by the many things you can learn from inquisitive residents. The mentor becomes the student. This fact is quite perplexing, but true.

Ask junior partners and younger colleagues for their opinion. They will feel honored by your request and you may learn a few things. Of course, they will not see your question as a sign of weakness but rather as an interesting discussion. Becoming the attending surgeon can be intimidating, but it is also one of your greatest accomplishments. The key is to abide by the same principles and to view challenges as the stimulating forces that will enrich your personal and professional life. Becoming a Fellow of the College makes it even better. □

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DOCTORS
for
MEDICAL
LIABILITY
REFORM
DMLR

2005 update
and prospects
for 2006

by F. Dean Griffen, MD, FACS,
Shreveport, LA

Doctors for Medical Liability Reform (DMLR) is a coalition of several member organizations, including the American College of Surgeons Professional Association (ACSPA) (see Figure 1, page 35). Representing 230,000 physicians and their patients, DMLR's mission has been to break the senatorial filibuster against tort reform by promoting the election of favorable senators through a grassroots approach. It was an off year for senatorial elections in 2005, but DMLR has not been lying dormant. Pursuing the 60 votes needed and hoping to build on the success of the 2004 elections when votes in the Senate for tort reform increased from 49 to 52, DMLR is poised for the 2006 elections.

Working with the consulting firm White House Writers Group, the DMLR steering committee embarked on a grassroots project in 2005 that has successfully laid the base for the final push into the November 2006 elections. The grassroots base has passed benchmark expectations and is ongoing in escalating proportions. Efforts include but are not limited to an interactive Web site (www.protectpatientsnow.org), e-mail outreach, Internet advertising, direct-mail outreach, petition drives, physician outreach, letters to Congress, radio broadcasts, and specific state focus.

The Protect Patients Now Web site received more than 400,000 hits in 2005. Its action center has processed more than 17,000 actions; 8,450 petitions have been signed and 6,039 letters have been sent to members of Congress. The content is kept fresh with new information. It provides an interactive map of the U.S. with specific information about the tort situation in each state. In March 2006, the voting history of each member of Congress and senator was to be provided, as well as a national fact sheet, academic and government analysis, surveys, and anecdotal stories. Keywords direct Web surfers on search engines to the site, making it a dominant, easily found resource. Data show that, excluding the holiday season in December, visits to the site have increased each month.

The e-mail outreach program is designed to direct traffic to the Web site for the purposes of recruitment, education, and mobilization to action. The e-mail list includes 83,000 addresses and continues to grow. A total of 520,352 e-mails have been sent. An e-newsletter will be sent in the very

near future to those contacts requesting updates.

Advertising DMLR on other Web sites with related interests has resulted in 14,374 visits to *www.protectpatientsnow.org*. Key effective Web sites have been identified for future use as the campaign progresses.

In addition to directing patients, physicians, and concerned citizens to the Web site, direct mail has been used to generate signed petitions from patients and commitments for support from physicians, and 82,000 pieces of direct mail have been sent.

DMLR has reached an estimated 23 million people through the medium of radio. Interviews with DMLR spokespersons have been carried by 813 radio stations and have been broadcast 960 times. These interviews have focused on the crisis of patient access to care and the mission of DMLR. The Web site's call to action center has been recommended for use by those concerned.

DMLR efforts for 2005 produced a nationwide grassroots network of 103,123 people as well as a system for the accrual of ever-increasing numbers. But 2006 poses new problems. Unlike in 2004, when already established senators for tort reform were solid favorites for reelection, several are seriously challenged this year. Also, financial resources are more limited. DMLR spent approximately \$10 million in the successful 2004 effort, whereas currently it appears that approximately \$4 million will be available for 2006. Given these facts, working to protect votes from challenged states and working to pick up new votes in one or two additional states (possibly Maryland and Washington) will stretch resources.

Even so, all is not gloomy. There are 18 seats up for election currently held by anti-tort senators compared to 15 held by pro-tort senators, giving favorable odds for successful change. The DMLR think tank of lobbyists and other expert staffers has identified senators in Florida, Nevada, Michigan, New Jersey, and Washington as vulnerable for defeat from among current anti-tort candidates up for reelection (see Figure 2, page 36). Conversely, senators from the current pro-tort states of Missouri, Pennsylvania, Ohio, and Rhode Island seem vulnerable. Additional opportunities for gains exist in the anti-tort states of Maryland, Minnesota, and Vermont where seats are being left open, whereas Tennessee is the only open state on

Figure 1: DMLR member organizations

American Academy of Dermatology Association
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Surgeons Professional Association
American Society of Plastic Surgeons
Neurosurgeons to Preserve Health Care Access
The Society of Thoracic Surgeons

the pro-tort side of the ledger. These elections will almost surely determine the new balance of power in the Senate. ACSPA members, especially those from these 13 earmarked states, must take note and become aggressively involved in the effort to protect their pro-tort candidates who are vulnerable, to seize the window of opportunity to unseat vulnerable anti-tort candidates, and to find and elect favorable candidates for tort reform in states with open seats.

DMLR is a relatively new arm of the ACSPA effort for tort reform, having been in existence only a little more than three years. Uniquely, DMLR has given an opportunity for the surgery community to participate in a much harder-hitting approach to tort reform than it might otherwise entertain under the ACS logo. To some extent, many of us find portions of this approach distasteful. The Web-based animations have been especially criticized, but data show that success requires this more aggressive action. DMLR has also created a phenomenal think tank by providing a venue for pooling the lobbyists and additional expert staff from all of the member groups. Finally, through its involvement in DMLR, the ACSPA can gain value for its investment of financial resources by sharing the costs with other groups, hiring more sophisticated consultants, and undertaking larger projects.

The ACS continues its independent efforts for tort reform, recognizing that liability is among the top concerns expressed by its Fellows every year. The ACS lobbyists are perpetually active on the various coalitions of business, insurance, and medicine, including Health Coalition on Liability

Figure 2: States with close Senate races or open seats 2006

Anti-tort states with close races:	Florida Michigan Nevada New Jersey Washington
Pro-tort states with close races:	Missouri Ohio Pennsylvania Rhode Island
Anti-tort states with open seats:	Maryland Minnesota Vermont
Pro-tort state with open seats:	Tennessee

and Access (HCLA), which is chaired by ACS Washington staff member Christian Shalgian. The ACS Patient Safety and Professional Liability Committee (PSPLC) is also working apart from DMLR to enhance the agenda of the Common Good and any other health care public policymaking groups that tout medical courts as an alternative to tort law. (Watch for an upcoming *Bulletin* article by Common Good founder and chair Philip Howard, JD.)

In the past, DMLR has been totally dedicated to the election of senators for tort reform. As is commonly known, the Senate filibuster has been the ultimate deterrent to federal tort reform. Now that the DMLR action center has become so prolific with no end in sight, efforts have been extended to attempt to influence activities on Capitol Hill. There are no misconceptions; gridlock is the rule. Once elected, no senator's vote has been changed by any attempt to reason over these many years. But one never knows what will be the straw that breaks the camel's back. Some believe that the grassroots campaign has experienced secondary gains, including the enhancement of new state tort law initiatives and the possible softening of jackpot justice jury behavior. The agenda will be increasingly flexible moving forward, seizing any opportunity for progress.

The most compelling data collected in 2005 by the White House Writers Group is also the most

alarming: physicians are not mobilized to seek tort reform. Only 61 posters for office display have been requested. A paltry 21 mini-documentary DVDs have been solicited for use in patient education. There have been 85,935 "contact Congress" e-mails sent to physicians represented by the DMLR coalition. Only 20 percent of these have been opened and the link to Protect Patients Now has been clicked in only 3 percent. Specific to members of the ACSPA, 133,489 e-mails have been sent and received on many different subjects; 23 percent have been opened, and the link has been clicked in 7 percent. Consultants from the White House Writers Group tell us that these numbers exceed industry averages. Even so, they aren't numbers indicating a lust to participate in the pursuit of tort reform.

Contacts from organized medicine are of meager value compared to those from doctor to patient. Surgeons from states in crisis should require no prompt; surgeons from states not in crisis must not be smug. Even though your state may have favorable tort law now, the future is unclear. State law is highly vulnerable to judicial attack, as physicians in Wisconsin recently learned. Which state will be next to fall prey to the judiciary and lose its cap? We are left to wonder. Therefore, we all have strong incentive to pursue federal tort reform. DMLR is eager to provide us with posters, brochures, DVDs, and talking points. Progress in the pursuit of tort reform requires relentless commitment year after year. Ironically, many of us haven't even joined the effort. Success requires our individual participation. Let's start now. [Q](#)

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Role of the rural general surgeon in a statewide trauma system:



by Blaine J. Ruby, MD, *La Crosse, WI*;

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and Ronald S. Gardner, MD, FACS, *Buffalo, WY*

Trauma care in a rural setting is unique and challenging because of long transport distances, difficult communication, variable levels of prehospital care, and limited hospital resources. General surgeons in rural areas are often called upon to provide care to an injured patient in small hospitals with few ancillary services and no additional surgical subspecialists. Regardless of these challenges, there is tremendous need for general surgeons who can deliver surgical and trauma care to patients in these small communities. Statewide trauma systems in sparsely populated states rely heavily on rural surgeons to treat injured patients with rapid triage, resuscitation, stabilization, and transport to a referral center or to provide definitive care themselves. In order to better characterize the role of general surgeons in rural trauma care, the experience in Wyoming will be examined in this article.

Wyoming is a rural state with a population density of only five people per square mile. A surgical practice has been defined as *rural* in communities with a population smaller than 10,000 people and *large rural* for those with a population of 10,000 to 50,000.^{1,2} Only eight communities in Wyoming have more than 10,000 residents and only one city has more than 50,000. Wyoming established a statewide trauma system in 1996. The system consisted of two referral trauma centers in Casper (pop. 49,644) and Cheyenne (pop. 53,011). Other small facilities were designated by the state as area trauma hospitals, community trauma hospitals, or rural triage centers based on available resources. Access to a full-time general surgeon was used as a key criterion for designation.

Survey of rural surgeons

We hypothesized that rural surgeons play a vital role in the success of the statewide trauma system in Wyoming. To better define the role of the general surgeon in rural trauma, we designed a two-part survey instrument that was sent to all 25 general surgeons practicing in rural Wyoming. Surveys were not sent to surgeons located in the cities of Casper or Cheyenne. The first part of the survey focused on resources available at the local facilities in which the rural surgeons practiced. Surgeons were asked about the level of prehospital care, hospital capabilities, and access to surgical subspecialists. In addition, surgeons indicated the referral trauma centers to which trauma patients were transferred from their institutions. The second part of the survey consisted of eight case scenarios with multiple-choice treatment options aimed at defining each surgeon's level of care and commitment to trauma patients.

Twenty-one (84%) of 25 surveys were completed and returned. All rural surgeons had 24-hour access to conventional X rays, computed tomography, and standard laboratory tests. Ultrasound was available to 95 percent of surgeons. An intensive care unit was available to 95 percent of surgeons. Fourteen (67%) surgeons had in-house orthopaedic surgery consultation, but neurosurgeons and cardiothoracic surgeons were not on the staff of any rural facility. Trauma patients were often transferred

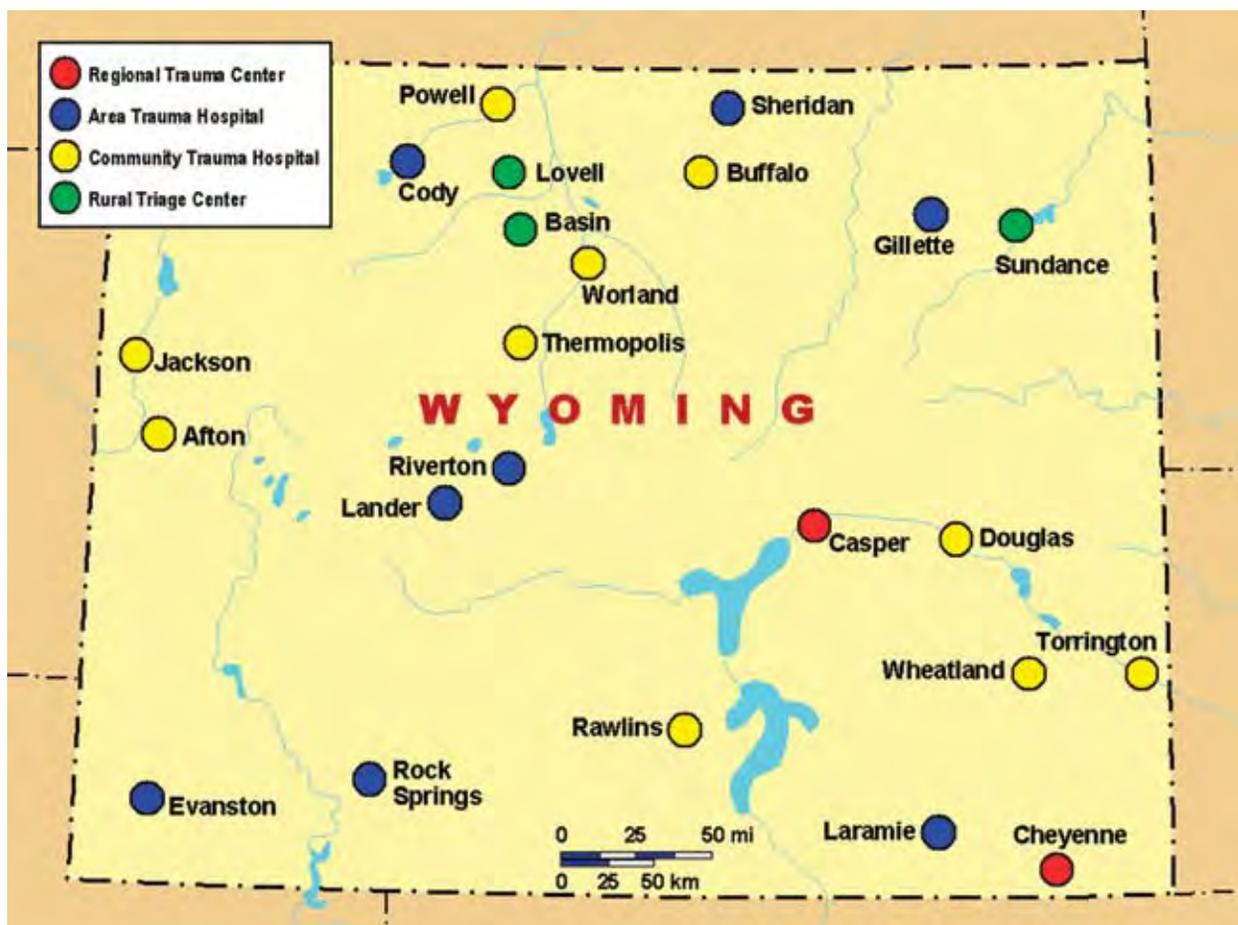
from these rural hospitals for definitive care. The majority of surgeons transferred patients to the two Wyoming referral trauma centers in Casper and Cheyenne. However, a considerable number of surgeons indicated that patients from their facilities were transported to 18 larger hospitals in five adjacent states. Transfer distances ranged from 35 to 600 miles; patients were transported by ground, helicopter, or fixed-wing air services.

Eight case scenarios were designed to examine the range of trauma care that rural general surgeons would provide to patients with a wide variety of injury severity. Twenty (95%) of 21 surgeons indicated that they would resuscitate and admit a 16-year-old with an isolated, stable splenic injury for nonoperative management, whereas the remaining surgeon elected to stabilize and transfer the patient for definitive care. Similarly, 20 (95%) of 21 surgeons elected to perform splenectomy in a 20-year-old with an isolated, unstable splenic injury; 19 would then admit the patient to their own facility, though one surgeon would stabilize and transfer the patient for definitive care.

Sixteen (76%) surgeons would provide definitive care for an adult with a mild closed head injury and a large scalp laceration, whereas five (24%) preferred to repair the laceration and transfer the patient. In contrast, every respondent would stabilize and transport a patient with severe head injury.

Sixteen (76%) surgeons would admit a patient with an isolated, mid-shaft femur fracture and consult an orthopaedic surgeon. Four (19%) would stabilize and transport this patient, and one (5%) would admit the patient and repair the fracture personally. In a patient with multiple orthopaedic injuries, nine (43%) surgeons would admit the patient to their own facility with subsequent orthopaedic consultation, 11 (52%) would stabilize and transport this patient, and one (5%) would admit the patient and repair the fractures personally.

Twenty (95%) of 21 surgeons chose to place a chest tube and admit a stable young adult with an isolated pneumothorax from a penetrating lateral chest wound. However, in an unstable young adult with a precordial penetrating wound, 12 (57%) surgeons would perform a tho-



Components of 2005 Wyoming statewide trauma system

racotomy followed by transfer for eight surgeons and admission for four. The remaining nine (43%) surgeons would stabilize the patient with chest tube placement and/or pericardiocentesis before transfer to another facility.

At the end of the survey, each participant was asked to provide any additional concerns or suggestions. The most frequently voiced concerns focused on future recruitment and retention of additional general surgeons to these rural locations and the need for upgrades in communication and prehospital care capabilities. Valuable suggestions that have led to improvement of the Wyoming statewide trauma system have origi-

nated from rural surgeons who see problems in the system from a unique perspective.

Survey results

It is clear from the results of this survey that general surgeons in rural Wyoming play a major role in the resuscitation and treatment of trauma patients. The vast majority of surgeons surveyed demonstrated surprising commitment to the definitive care of these patients. This stands in sharp contrast to the disaffection for trauma care expressed by most general surgeons.³ This refreshing characteristic is extraordinarily important to the success of a

statewide trauma system that depends on the skill, leadership, and commitment of general surgeons in large, rural areas.

Shortages of surgeons practicing in sparsely populated areas, resulting from retirements of existing general surgeons and difficult recruitment of replacements, may imperil the efficacy of trauma systems in rural states. These trends should be brought to the attention of health care planners and politicians responsible for trauma systems design. Imagine how differently a trauma system might function in a sparsely populated state like Wyoming if *no* general surgeons were available to provide trauma and surgical care in the small communities distributed throughout vast areas in the state. For example, many small hospitals might be forced to close or curtail services without a general surgeon, resulting in significantly increased transport times to definitive care and more strain on the few remaining components of the trauma system.

Trauma care remains an integral part of a rural general surgeon's practice.^{4,5} This fact underscores the ongoing need for trauma and critical care training as an essential piece of the core curriculum in general surgery residencies. Furthermore, rural general surgeons remain leaders and advocates for trauma care in their regions. They must stay involved in teaching Advanced Trauma Life Support® and Rural Trauma Team Development courses in order to help train other individuals in their areas who care for injured patients. Finally, committed rural general surgeons are essential in helping institutions organize themselves as part of systems designed to provide optimal care to trauma patients in vast geographic regions of North America. 

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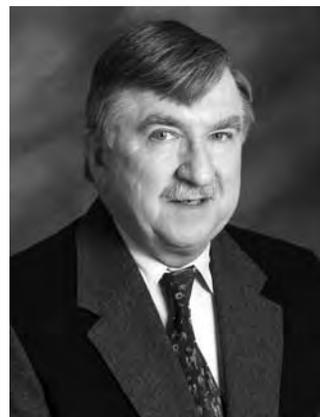
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Ten specialty boards report accomplishments and plans:

Part II

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

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

This issue of the *Bulletin* will feature the reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Surgery, and the American Board of Thoracic Surgery.

The March issue of the *Bulletin* featured the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Orthopaedic Surgery, the American Board of Plastic Surgery, and the American Board of Urology.

The American Board of Neurological Surgery

by William F. Chandler, MD, FACS, Ann Arbor, MI

Resident numbers, neurosurgical match

During the 2004-2005 academic year, there were 94 neurosurgical residency training programs accredited by the residency review committee (RRC) for neurological surgery under the Accreditation Council for Graduate Medical Education (ACGME) in the U.S. As of June 2005, 851 residents were in training and 139 had graduated.

In January 2005, 346 individuals registered for the Neurological Surgery Matching Program. There was a 9 percent decrease in submissions from the previous year, with 257 rank lists submitted; among lists submitted, 222 lists were ranked, and 154 were matched.

PGY1 curriculum

The American Board of Neurological Surgery (ABNS) supports the RRC in an effort to improve the PGY1 experience in neurosurgery. The board believes that neurosurgical program directors should have more control over the educational content of the PGY1 experience, which should include rotations relevant to neurosurgery, such as neurology; emergency medicine; orthopaedic surgery; and ear, nose, and throat.

Resident duty hours

The ABNS is unflagging in its commitment to the welfare of residents and the safe delivery of care to neurosurgical patients. Neurosurgical program directors have rapidly come into compliance with the new ACGME guidelines on resident duty hours. A variety of strategies have been implemented to accomplish the objectives of neurosurgical residency training within these restrictions. They include the use of physicians' assistants and nurse practitioners for the delivery of care, and the use of "night-float" systems, all to ensure compliance with the duty-hour requirements.

There is a widespread perception among neurosurgical educators that we run the risk of developing a "shift-work" mentality among

our residents. We fear that the commitment to excellent care over the course of a patient's illness will not be sensed as keenly by current neurosurgical residents as it has been in the past. The board is concerned about this problem, which has the potential to change the standards of neurosurgical practice that have been developed over decades.

Training

The ABNS continues to advocate efforts to train neurosurgeons in the complete care of cerebrovascular disease, including all of the latest endovascular techniques. Catheter-based techniques to treat aneurysms, vascular malformations, and carotid disease are being taught during residency training, and the ABNS examinations reflect these new procedures.

In addition, the ABNS supports the training of neurosurgeons to provide stereotactic radiosurgery for the treatment of neoplastic, vascular, and functional disorders.

Primary examination

The ABNS written primary examination is administered annually to neurosurgical trainees. This multiple-choice examination covers the breadth of neurosurgery's clinical and basic science curriculum. It may be taken for self-assessment but must be taken and passed for credit toward certification prior to applying for oral examination and certification. For residents entering training after June 30, 1998, the training requirements of the ABNS and the RRC specify that the examination must be passed during training in order to complete residency successfully. Many program directors require trainees to pass the examination before progressing to chief resident.

In March 2005, the primary examination was administered to 528 examinees; 207 took the exam for credit and had a 16 percent fail rate. Among those sitting for the exam, 321 took it for self-assessment.

Oral examination

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

In November 2004, 89 candidates sat for the oral examination, with a 13 percent failure rate. In May 2005, 88 candidates were examined; the failure rate was 8 percent. Each candidate's performance is scored numerically by six examiners. These grades are used to determine the pass/fail status by a computer program so as to maximize objectivity in the process. Standardized questions are now being used for a small portion of the examination.

Maintenance of certification (MOC)

The ABNS issued its first 10-year, time-limited certificates in May 1999. Since then, it has worked to develop all of the components of a neurosurgical MOC program that meets the requirements of the American Board of Medical Specialties (ABMS). The ABNS has now completed work on its MOC program and submitted a revised application to the ABMS.

- Part I, Evidence for Professional Standing, will include evidence of a full, unrestricted medical license, admitting privileges to practice neurosurgery, and a recommendation from the chief of staff of the primary hospital. These will be required every three years.

- Part II, Lifelong Learning and Self-Assessment, will also be a three-year requirement. It will include 150 hours—60 Category 1 and 90 Category 2—of strictly neurosurgical content for continuing medical education hours. Participants will also be required to take a Web-based self-assessment examination, specifically the Self-Assessment in Neurological Surgery (SANS) program developed by the Congress of Neurological Surgeons. This examination provides immediate feedback to participants regarding the correct answer for each of the 200 questions.

- Part III, Evidence of Cognitive Knowledge, will be fulfilled with a secure, comprehensive examination to be taken every 10 years. This will be developed in conjunction with and administered by the National Board of Medical Examiners.

- Part IV, Evidence of Performance in Practice, will be evaluated by review of “key cases.” Every three years, 10 consecutive cases will be submitted on one of the key cases selected from a list of procedures that includes the neurosurgical subspecialties. In addition, participation in a communication assessment tool will be required every three years, most likely a survey developed by the Consumer Assessment of Healthcare Providers and Systems® in conjunction with the ABMS. Feedback about communication skills will be given to the practitioner. The SANS program will contain material to help assess performance and educate in the areas of interpersonal skills, professionalism, practice-based learning, and systems-based practice. In addition, the questionnaire to the chief of staff will assess the participant's involvement in systems-based practice.

Letters and brochures outlining the MOC program were mailed to all ABNS diplomates in 2004 and 2005. At press time, the board was expected to roll out the program in early 2006.

Practice Data Project—NeuroLog

NeuroLog is an Internet-based, data-collection tool developed by the ABNS to facilitate the gathering of information necessary for initial certification and possibly MOC. It is additionally useful to program directors for the collection of resident case logs and other reports for the RRC. The system is highly secure and compliant with the Health Information Portability and Accountability Act.

Applicants for primary certification now use NeuroLog to record all inpatients during a 12-month period. The program compiles the information and creates a summary report that fulfills one of the requirements of the application for certification. Not only does it provide all of the necessary data fields to complete this requirement, but also it is an efficient online mechanism for review of the data by the ABNS professional practice data committee.

Program directors use NeuroLog to accumulate data required for RRC accreditation. It tracks the necessary elements for residents and attending

physicians in order to meet current documentation standards. The cataloging of operative data is streamlined and yields both *Current Procedural Terminology* codes and appropriate ABNS/RRC procedural categories.

The ABNS anticipates that NeuroLog will also be the vehicle for Web-based data entry of key case information.

Revocation of certification

At its meeting in May 2005, the ABNS held hearings on revocation of three certificates. All three were revoked.

ABNS directors

At its spring 2005 meeting in St. Louis, MO, Ralph G. Dacey, Jr., MD, FACS, and Hal L. Hankinson, MD, completed their six years of contributions and leadership on the ABNS. Newly elected directors are Charles L. Branch, Jr., MD, FACS, and Tae Sung Park, MD. New officers for the 2005-2006 year are William F. Chandler, MD, FACS, chairman; and Jon H. Robertson, MD, and Dr. Popp, vice-chairmen. M. Sean Grady, MD, FACS, remains as secretary, and Marc R. Mayberg, MD, as treasurer.

The American Board of Ophthalmology

by William F. Mieler, MD, FACS, Chicago, IL

Certification examinations

The annual meeting of the American Board of Ophthalmology (ABO) was held November 4, 2005, in Philadelphia, PA.

The future dates for examinations were as follows: Written qualifying examination, March 28, 2006, and March 27, 2007; oral examination, June 9–11, 2006, in San Francisco, CA, and October 27–29, 2006, in San Francisco, CA; June 1–3, 2007, in Philadelphia, PA, and October 26–28, 2007, in Cambridge, MA.

The total number of diplomates certified at the November 2004 oral examination in San Francisco was 198; at the June 2005 oral examination in Philadelphia, 216 diplomates were certified. Eighty-four failed the examination and must repeat all six subjects.

The 2005 written qualifying examination was held on April 15 at three sites in the U.S. The questions in this examination were prepared by the written examination committee of the American Board of Ophthalmology and the Ophthalmic Knowledge Assessment Program Committee of the American Academy of Ophthalmology. It is the responsibility of the written examination committee to review and approve the final questions.

Of the 733 participants registered for the 2005 written qualifying examination, 643 took

the examination, 184 failed (28.62%), and 459 passed. Of the 184 who failed, 102 (55.43%) had failed previously. Of the 643 candidates who took the examination, 170 (26.44%) were repeat test-takers, and of these, 102 (60%) failed again. International medical graduates comprised 50 (7.78%) candidates and 24 (48%) failed. U.S./Canadian graduates comprised 593 (92.22%) candidates and 160 (26.98%) failed.

Of the 170 candidates repeating the written qualifying examination, 29 (17.06%) were international medical graduates and 141 (82.94%) were U.S./Canadian graduates. The candidates who passed the 2005 written qualifying examination plus the repeat test-takers from previous oral examinations provided a potential pool of 253 candidates for the November 2005 oral examination and 262 potential candidates for the June 2006 oral examination.

MOC examinations

Beginning in January 2006, two pathways of the maintenance of certification (MOC) process will be available online. The office record review (ORR) is an online self-review of clinical practice and will be available on-demand from January 10 through December 31, 2006. The Periodic Ophthalmic Review Tests (PORT) are Internet-based, self-review tests composed of 50 items each and

which will also be available online, on-demand from January 10 through December 31, 2006. The Demonstration of Ophthalmic Cognitive Knowledge (DOCK) is the secure, proctored, computer-based examination available at approximately 300 computerized testing centers for a period of one month each year. The first DOCK examination will be administered September 1 through September 30, 2006.

Before the 2006 change to the MOC process, the ABO recertification process consisted of a two-month, take-home written examination, certificate renewal examination, written (CREW), and the ORR examination. The 2005 CREW examination was administered as a take-home examination from February 1 through March 31, 2005. Of the 1,041 participants registered for this examination, 1,025 completed the examination, with 1,016 (99.12%) passing and nine (0.88%) failing.

The ORR was administered July 1 through July 31, 2004, and January 1 through January 31, 2005. Of the 148 participants registered for the July 2004 examination, 144 passed the review and four were incomplete. At the January 2005 examination, 621 were registered, with 618 passing and three incomplete.

Representation

The representative to the American College of Surgeons for 2005 was David T. Tse, MD, FACS, Miami, FL. The board's representatives to the residency review committee for the year 2005 were: James S. Tiedeman, MD, Charlottesville, VA; Martha J. Farber, MD, Delmar, NY; and James C. Orcutt, MD, Seattle, WA.

In December 2004 and June 2005, the residency review committee for ophthalmology reviewed 38 of 116 accredited ophthalmology residencies. With few exceptions, most programs continued to receive full accreditation with three- to five-year cycles assigned on the strength of the program's review.

The following directors became officers of the board for 2005: Chair, William F. Mieler, MD, FACS, Chicago, IL; and vice-chair, Donald S. Minckler, MD, Los Angeles, CA.

The two new board directors who took office January 1, 2005, are David W. Parke II, MD, Oklahoma City, OK, and Donald N. Schwartz, MD, Long Beach, CA.

The voting representatives to the American Board of Medical Specialties (ABMS) for 2005 included the following: Edward G. Buckley, MD, Durham, NC; Marilyn B. Mets, MD, Chicago, IL; Richard P. Mills, MD, Seattle, WA; and Dr. Schwartz. Dr. Mieler serves on the board of directors of ABMS, and Denis M. O'Day, MD, FACS, Nashville, TN, is on the ABMS board of governors.

Suzanne T. Anderson—vice-president of Meaghan Jared Partners, Inc., a management consulting firm for physicians, hospitals, and other health care entities in Bellevue, WA—is the board's current public member. In addition to serving as a public member for the ABMS, Ms. Anderson has published and written extensively on health care management issues and recertification.

Board transitions: The ABO honored the following directors at the November 2004 board meeting and expressed appreciation for their contributions: Charles P. Wilkinson, MD (director, 1997-2004; chair, 2004), and Susan H. Day, MD (director, 1997-2004).

General information

A search committee for a new executive director of the ABO was appointed. The position of executive director is a five-year term, renewable for an additional five years. The current executive director, Dr. O'Day, is in the last year of his second five-year term and has been extremely effective as a leader and innovator. The committee interviewed eight excellent candidates for this position and unanimously recommended that John G. Clarkson, MD, be appointed as executive director. Dr. Clarkson is currently the dean of the Leonard M. Miller School of Medicine, formerly known as the University of Miami Medical School, and will be leaving this position when he assumes the office of executive director. Dr. Clarkson will remain on the ophthalmology faculty at the Bascom Palmer Eye Institute of the Leonard M. Miller School of Medicine.

The ABO and the American Academy of Ophthalmology have formed a liaison committee to discuss issues of importance to both organizations regarding MOC as well as primary certification. The representatives of this committee meet twice a year. Of prime importance have been the

discussions surrounding the development of the practicing ophthalmologist curriculum. This is the curriculum developed by the American Academy of Ophthalmology from which the ABO will develop questions for the MOC self-review tests (PORT) and the cognitive examination (DOCK).

An overview of the MOC process of the ABO can be found on its Web site, *www.abop.org*, and is outlined in the ABO newsletter (also available online).

The ABMS, in collaboration with the Federation of State Medical Boards (FSMB), has developed the Disciplinary Alert Notification Service (DANS). One of the requirements to sit

for the ABO examinations is to have a valid and unrestricted license as of the date of initial application and maintain that license throughout certification and MOC. The DANS assists the ABO in reviewing actions that may have been taken by state medical licensing boards on any candidate or diplomate. This new process will ensure that the ABO rules on licensure are maintained.

The task force on competence continues to work toward developing tools for fulfilling the program requirements for accreditation and fulfilling the ABO's expectations for resident evaluation in the competencies.

The American Board of Otolaryngology

by Robert H. Miller, MD, FACS, Houston, TX

Qualifying/certifying examinations

The 2005 written qualifying exam was administered April 15 in Chicago, IL. All candidates then participated in the oral certifying exam, which was conducted on April 16 and 17 by 109 individuals, including American Board of Otolaryngology (ABOto) directors, senior examiners, and guest examiners. Those candidates who did not achieve the qualifying score on the written exam did not receive credit for their oral scores. Exam results are as follows: Among 289 candidates who sat for the written exam, 275 passed and 14 failed; among the 286 who sat for the oral exam, 281 passed and five failed.

Otolaryngology training examination

The otolaryngology training examination was conducted on March 5, 2005, in more than 100 locations. More than 1,100 residents and practitioners participated in the exam. The most recent training exam was held March 4, 2006.

Board of directors

Officers remained unchanged in 2005: Harold C. Pillsbury III, MD, FACS, president; Jesus E. Medina, MD, FACS, president-elect; and Paul A. Levine, MD, FACS, treasurer.

H. Bryan Neel III, MD, FACS, completed his term as a director at the conclusion of the 2004 annual meeting in April, after many years of dedicated service to the ABO. Dr. Neel served as treasurer for six years, in addition to serving on many committees.

Gerald S. Berke, MD, FACS, of Los Angeles, CA, was elected to the board of directors.

Maintenance of certification (MOC)

In 2002, the ABOto began issuing 10-year, time-limited certificates. MOC is the program by which diplomates maintain/renew their certification. Diplomates certified before 2002 are not required to participate in the MOC program but may do so if they wish. As a member board of the American Board of Medical Specialties, (ABMS), the ABO must comply with certain ABMS requirements. More importantly, MOC is a process that promotes lifelong learning and the ongoing provision for up-to-date, high-quality patient care.

The four components of the MOC process include documentation of professional standing, documentation of lifelong learning and self-assessment, evidence of cognitive expertise, and evaluation of performance in practice. The ABOto has instituted part I of the MOC process

and is in the process of developing the other three components.

Neurotology

The ABOto conducted its second neurotology exam on April 18, 2004. Twenty-five examiners and 42 candidates participated; all candidates passed the exam.

Two pathways to permit individuals to take the neurotology exam remain open at this time: one for those who have completed Accreditation Council for Graduate Medical Education residency training in neurotology, and one for those who have not completed such training but who limit their practice to neurotology. The alternate pathway will close after 2011.

Sleep medicine

The ABOto is a sponsoring board of the newly established conjoint subspecialty certificate in sleep medicine. Otolaryngologists who meet the eligibility requirements may take the certifying examination. Otolaryngologists who would like more information about certification in sleep medicine are urged to contact the ABOto office at 713/850-0399.

Additional information

Information on ABOto policies and examinations, as well as information on the Scope of Knowledge Study (which defines the content of ABOto exams and requisite otolaryngology training), is available at www.aboto.org.

The American Board of Surgery

by Frank R. Lewis, Jr., MD, FACS, Philadelphia, PA

The American Board of Surgery (ABS) held its summer meeting June 26–28, 2005. Following are decisions reached at this meeting.

New ABS chair and directors

The tenure of ABS chair Barbara Bass, MD, FACS, ended June 30, 2005. Dr. Bass was thanked by all for her outstanding leadership and multiple new initiatives during the year.

Jeffrey L. Ponsky, MD, FACS, Cleveland, OH, was selected by the directors as the next ABS chair for the 2005-2006 year.

Five new directors were selected in 2005 and began their term officially with the June meeting: Karen Borman, MD, FACS; John Hanks, MD, FACS; Larry R. Kaiser, MD, FACS; Leigh Anne Neumayer, MD, FACS; and Randolph Sherman, MD, FACS. Drs. Borman and Neumayer were chosen from panels of nominees submitted by the Advisory Council for General Surgery to fill ACS positions on the board, whereas Dr. Hanks was nominated by the Southern Surgical Association, Dr. Kaiser by the American Board of Thoracic Surgery, and Dr. Sherman by the American Board of Plastic Surgery.

In January 2005, the ABS created three at-large director positions, to be added to the current 32 directors who are nominated by specific surgical organizations. The new positions will be filled from panels of nominees submitted directly to the ABS through open nomination by individuals or organizations (including self-nomination), rather than the traditional process of nomination only through sponsoring organizations. Candidates may not be nominated from institutions from which there is a presently sitting ABS director. The ABS is interested in increasing representation of surgeons in private or group practice to ensure its standards are appropriate for the needs of today's practicing surgeons. The institution of three at-large positions is intended to further this goal; in addition, the ABS will continue to work with its established nominating organizations toward ensuring a diverse board membership that is representative of the U.S. surgical community.

Criteria for nomination are as follows:

- Board-certified in surgery for at least 10 years
- Significant experience with resident surgical education

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- Extensive experience in surgical practice
 - Highly regarded by surgical peers
 - Experience as an ABS examination consultant or associate examiner highly desirable
 - Diversity in gender, race, and/or community practice setting desirable

Applications for the at-large positions will be accepted until September 1, 2005. At-large directors will have the same term, six years, as directors from sponsoring organizations and the same duties, including participation in three board meetings and three oral examinations each year (approximately three to four weeks total). ABS bylaws prevent a director from serving after age 65. A final determination of the new members was made in early January.

New certification status reporting

In response to requests from diplomates, the ABS decided at its June meeting to institute a new method of reporting a diplomate's certification history as well as to create a new type of certification status. Up until now, the ABS has used only the three status descriptions used by the American Board of Medical Specialties (ABMS): *In the examination process* (denoting that an individual has an approved application), *certified*, and *not certified*. Although the ABMS will continue to use these three classifications, the ABS will use for its own reporting of status several classifications in addition to the ABMS status classifications: *recertified*, *recertified (clinically inactive)*, *suspended*, *revoked*, and *deceased*. A start and end date will also be listed next to the status if applicable.

This expanded reporting will provide a more accurate and detailed description of a diplomate's certification history, particularly for diplomates who have retired from practice but require verification of past certification. In addition, the status *recertified (clinically inactive)* is a new designation created in response to diplomates who are not in active practice and are therefore unable to supply a list of operative cases but who wish to maintain their certification. These diplomates will not furnish operative data or practice assessments to the ABS and are differentiated from actively practicing diplomates. Diplomates who wish to convert from clinically inactive status to active recertified status will be required to

provide the additional practice requirements mandated by Part IV of the maintenance of certification (MOC) process.

Recertification examination in surgery

The recertification examination committee last month took a fresh look at the recertification examination in surgery in light of feedback from recent examinees. Over the past few years, diplomates have communicated to the ABS that the recertification examination contains items that do not seem directly relevant to the practice of general surgery. The recertification examination committee addressed these concerns for the 2005 recertification examination by analyzing the examination's content and deleting questions involving specialty content judged to be outside the core surgical knowledge reasonably required of a surgery diplomate.

Instituted in 1983, the recertification examination in surgery is seen by the ABS as a minimum standard of core knowledge fundamental to all practicing surgeons regardless of specialty. It is designed to focus on common problems faced by a specialist in surgery and to ensure that diplomates are staying current with medical literature and the latest treatment information as their careers progress. While the recertification examination committee sought to better define the examination's core content, no strong relationship between diplomates' specialty practice area and examination performance has ever been demonstrated—diplomates who have specialized in a particular field such as vascular surgery do as well on the examination as diplomates who have a broad practice in general surgery. The committee's recent work reinforced the examination's purpose while still recognizing the inherent heterogeneous nature of general surgery.

To further assist diplomates in preparing for the recertification examination, the ABS has posted on its Web site, www.absurgery.org, a complete examination content outline. This outline will also include the subjects within specialty areas that are considered important for the general surgeon to be familiar with, such as the following:

- Transplantation: Criteria for brain death and complication of immunosuppressive drugs
- Gynecology: Treatment of venereal lesions,

management of post-partum perineal infections, endometriosis involving the gastrointestinal tract, management of a rectovaginal fistula, and the evaluation of abdominal pain during pregnancy

- Urology: Management of operative ureteral injury and postoperative testicular torsion
- Anesthesiology: Analgesia in carcinoma of the pancreas and malignant hyperthermia

In making these changes, the recertification examination committee thought it was important to respond to diplomates' concerns regarding the examination and ensure that it focuses on surgery core content, while maintaining the examination's integrity as a measurement of surgical knowledge.

MOC

In developing the MOC program, the ABS realizes the importance of correlating the program's requirements to those of other organizations that also play a critical role in diplomates' practice. For the June board meeting, the ABS invited representatives of three such organizations—the Centers for Medicare & Medicaid Services (CMS), the Federation of State Medical Boards (FSMB), and the American College of Surgeons—to discuss their own initiatives for continuing professional development, particularly as they relate to the MOC requirement for assessment of performance in practice.

Dr. Bass, ABS chair for 2004-2005, began the session by presenting an overview of the ABS' MOC requirements as currently proposed, emphasizing the need to partner with outside organizations to avoid redundancy and provide meaningful standards that will lead to practice improvement and better patient care. She also highlighted the key role of the ABS and its diplomates in establishing standards for surgeons by surgeons before external entities define these parameters. By being proactive in the quality improvement debate, diplomates of the ABS can demonstrate their commitment to high-quality care to other organizations and the public and reinforce the meaning of board certification as an indicator of superior training and knowledge.

David Hunt, MD, FACS, medical officer for the CMS and an ABS diplomate, was the first guest speaker. Dr. Hunt also serves as the government

task leader for the Surgical Care Improvement Partnership (SCIP), the CMS' main surgical quality initiative. Dr. Hunt proposed working with the ABS toward safer, higher-quality outcomes by helping individual surgeons in meeting both organizations' goals while decreasing administrative barriers. He suggested that surgeons working in a SCIP hospital and participating in the ACS' National Surgical Quality Improvement Program (NSQIP) or CMS collection process could meet the new CMS requirements for quality assessment in hospitals. He also stressed that the CMS wants surgeons' input to create realistic and practicable solutions but cautioned that the CMS will move forward with its initiative whether surgeons act or not.

The next presentation was by Steve Schabel, MD, chair of the maintenance of licensure committee of the FSMB. Dr. Schabel began by noting that currently physicians are "licensed for life." The FSMB, however, recently asserted that state medical boards "have a responsibility to assure physicians maintain competence throughout their practices" and is looking at MOC as a way to fulfill this. Dr. Schabel also emphasized that the FSMB and MOC have the same goal—to protect the public—and the ABS MOC program, since it is created by surgeons, is better than any alternative from the FSMB. He also brought forth the issue of diplomates who are certified indefinitely, saying that the ABS and the ABMS needs to strongly encourage these diplomates to participate in MOC in order for it to be accepted widely as a viable program.

R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, then gave an overview of the development of NSQIP and its possible integration with MOC. He discussed NSQIP's introduction into Veterans Affairs (VA) hospitals and the subsequent sharp reduction in mortality and morbidity rates. Dr. Jones went on to explain how NSQIP is now being implemented at private hospitals across the U.S. and how the ACS is working to bring NSQIP to individual surgeons. To illustrate the latter, Dr. Jones demonstrated the ACS' new Web portal, accessible through its Web site, where surgeons can log in and confidentially track their outcome data. Surgeons would also be able to access the portal using a personal digital assistant (PDA).

The portal is currently in its pilot phase and could potentially provide another means for fulfilling the MOC practice assessment requirement.

Following these presentations, the directors of the ABS discussed various options for practice assessment that would add value, be accessible, and not be overly time-consuming for diplomates. It was agreed that surgeons should track and assess their performance in a manner that will lead toward practice improvement. The directors also evoked the need to assess diplomates' patient communication skills. Quality improvement programs such as SCIP, NSQIP, the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®), or even robust morbidity and mortality could fulfill some or all of the MOC requirement, which would not be verified until five years after recertification, or no earlier than 2010 for diplomates who recertified in 2005.

New advisory councils

At the January 2005 meeting, the ABS created three new advisory councils to complete the subspecialty structure of component boards and advisory councils. The new councils were in the areas of transplantation; gastrointestinal surgery; and trauma, burns, and critical care. These groups will be added to the existing component boards in Vascular Surgery and Pediatric Surgery and the Surgical Oncology Advisory Council (SOAC). Specific appointing organizations were designated to appoint members to each of these councils, and two additional specialty organizations were added to the appointing organizations for the SOAC. At the completion of this process, all specialty areas that operate within the rubric of general surgery are now included in the ABS structure and have formal input to the standing committees and executive committee of the ABS.

Surgical critical care certifying exam

At the June board meeting, the ABS also approved a policy change regarding the certifying examination in surgical critical care (SCC). As it is not uncommon for residents to pursue a SCC fellowship during their general surgery residency, these residents may now take the SCC certifying examination immediately fol-

lowing the fellowship rather than waiting until they have become certified in general surgery. Previously such residents had to wait to take the SCC examination until they had completed residency and been certified in general surgery, which often meant they were taking the SCC examination five or six years after completing the fellowship. Residents who are successful on the examination, however, will not be deemed certified in SCC until they achieve certification in general surgery.

An additional change in the SCC examination—that a surgical diplomate of the ABS who completed an anesthesia critical care fellowship would be admitted to the certification process in surgical critical care—was adopted. This change was made in acknowledgment of the fact that the curriculum of anesthesia critical care programs is now essentially identical to those in surgical critical care.

Lastly, a change was made at the January 2005 meeting in which it was decided to admit diplomates of all the ABMS surgical boards to the surgical critical care certification process if they complete an accredited SCC fellowship and the ABS SCC examination. Thus, specialists in neurosurgery, orthopaedics, and other surgical specialties may now become SCC certified by the ABS.

Vascular surgery certificate approved

On March 17, 2005, the ABS received approval from the ABMS to offer a primary certificate in vascular surgery, opening the opportunity for vascular surgeons in the U.S. to become directly board-certified in vascular surgery without first becoming certified in general surgery. Although five other ABMS member boards currently offer more than one primary certificate, the ABS will be the first surgical board to do so.

The application for this new certificate was made by the ABS in partnership with the Society for Vascular Surgery and the Association of Program Directors in Vascular Surgery. The new certificate will provide the flexibility to create new types of vascular surgery training programs, such as one consisting of three years of general surgery training followed by three years of vascular surgery training, leading directly to certification in vascular surgery.

American Board of Surgery: Summary of 2004-2005 examinations

Examination	Number of examinees	Pass no. (%)	Fail no. (%)	Total # diplomates
Qualifying	1,287	999 (77.6)	288 (22.4)	
Recertification	1,562	1,445 (92.4)	118 (7.6)	15,312
Vascular surgery (qualifying)	127	106 (83.5)	21 (16.5)	
Vascular surgery (recertification)	153	148 (96.7)	5 (3.3)	1,371
Surgical critical care (qualifying)	108	92 (85.2)	16 (14.8)	2,178
Surgical critical care (recertification)	99	76 (76.8)	23 (23.2)	985
Hand surgery (qualifying)	5	5 (100)	0 (0)	231
Hand surgery (recertification)	27	22 (81.5)	5 (18.5)	114
Pediatric surgery ITE	72	---	---	
IT/SBSE	7,456	---	---	
Certifying	1,252	1,044 (83.4)	208 (16.6)	50,418
Vascular surgery CE	117	98 (83.8)	19 (16.2)	2,463
Total	12,265			

N/A = Not applicable

ITE/SBSE = In-training examination/surgical basic science examination

4,737 examinees, excluding the ITE/SBSE and pediatric ITE examinees.

Vascular surgeons will still have the option of completing a full surgery residency and becoming certified in general surgery before entering vascular surgery training.

With this approval, the ABS has decided that it will now offer only a primary certificate in vascular surgery, to be fulfilled by completion of a minimum of two years of vascular surgery training. The certificates of current vascular surgery diplomates will be automatically converted to the new primary certificate when they recertify in vascular surgery. One-year vascular training programs will be granted a three-year window to transition to two-year accreditation in order to fulfill this new requirement. Pending approval from Accreditation Council on Graduate Medical Education's (ACGME) Residency Review Committees and the ACGME itself, the new certificate will go into effect July 1. Eligible individuals will be able to submit an application before then for the 2006 qualifying examination in vascular surgery. The requirement for prior

certification in general surgery will continue until the official implementation of the new certificate on July 1.

LCSB appeals board denies ABVS appeal

The American Board of Vascular Surgery (ABVS) applied to the ABMS for independent vascular board status in May 2003. This was opposed by the ABS on the basis that a validated and respected method for vascular surgery certification was already in place and had been used since 1982; more than 2,200 vascular surgery diplomates of the ABS are certified. The initial application was heard in December 2003 by the Liaison Committee for Specialty Boards (LCSB) and was denied. ABVS appealed this decision and the appeal was heard by a specially appointed panel of the LCSB in February 2005. The final decision of this group was published in March 2005 and the denial of independent board status was upheld.

The American Board of Thoracic Surgery

by Carolyn E. Reed, MD, FACS, Charleston, SC

The American Board of Thoracic Surgery (ABTS) will offer specialty pathways and will increase the operative requirements for candidates for certification.

In response to current practice patterns in thoracic surgery, and to ensure adequate preparation for contemporary thoracic surgery practice, the ABTS has revised the standards required of individuals to qualify for entrance into its certification process.

The board has established two primary pathways to certification, a cardiothoracic surgery pathway and a general thoracic surgery pathway. An additional special certificate pathway will be established for candidates who complete the cardiothoracic surgery pathway and plan to perform congenital heart surgery. The new operative case requirements are on the board's Web site at www.abts.org.

The new specialty pathways and operative case requirements will be effective for individuals entering a thoracic surgery residency in July 2007 or later.

After much deliberation and in consultation with other thoracic surgery organizations, including the Residency Review Committee for Thoracic Surgery (RRC-TS), the Joint Council for Thoracic Surgery Education (JCTSE), and the Thoracic Surgery Directors Association (TSDA), the board has established new operative case criteria, with revised case requirements for both primary pathways and added qualifications for congenital heart surgery.

Maintenance of certification

In response to an initiative by the American Board of Medical Specialties, the ABTS along with the other medical certifying boards has begun the transition toward a maintenance of certification (MOC) program to replace the current recertification process. In March 2005, the board mailed to each diplomate an outline of the current MOC plan, which has the following four components: (1) professional standing, (2) life-

long learning and self-assessment, (3) cognitive expertise, and (4) evaluation of performance in practice. Diplomates were asked to comment on the existing MOC plan; the board will revise the proposal based on the feedback received.

Recertification

Diplomates who hold time-limited certificates are expected to continue with the recertification process until MOC is implemented. Diplomates certified after 1975 must recertify within 10 years of the date of the original certification in order to maintain their certification. Diplomates with time-limited certificates may apply within three years of the expiration of their certificate. Diplomates of the Board of Thoracic Surgery and the ABTS who were certified before 1976 do not require recertification and are considered to hold unlimited certificates.

The deadline for submitting recertification applications is May 10 of each year. A valid ABTS certificate is an absolute requirement for entering the recertification process. The only pathway for renewal of a lapsed certificate will be to take and pass the Part I (written) and the Part II (oral) certifying examinations. Additional information concerning the recertification requirements can be found in the annual *Recertification Booklet of Information*.

Inactive status

Diplomates holding a valid ABTS certificate and who expect to be clinically inactive for a period of one year or more may apply for inactive status. Application must be made, in writing, to the board, and approved, in writing, in advance of the granting of inactive status. Activities calling for such status might include, but are not limited to, academic sabbaticals, advanced studies, elected/appointed political offices, temporary disability from illness, or appointment to administrative positions. For more information on the new inactive status policy, visit the board's Web site at www.abts.org.

ABTS recertification activity (current through 2005)

Date of orig. cert.	Total # cert.	Total # recert. first time	% recert. first time	Total # recert. second time	% recert. second time	Total # recert. third time	% recert. third time
Before 1976	N/A	68	–	4	–		
1976	160	142	89	128	80	34	21
1977	146	129	88	108	74	20	14
1978	154	141	92	119	77		
1979	158	147	93	121	77		
1980	110	100	91	90	82		
1981	131	124	95	111	85		
1982	159	147	92	126	79		
1983	136	122	90	108	79		
1984	135	125	93	106	79		
1985	120	119	99	102	85		
1986	147	140	95	85	58		
1987	141	137	97	53	38		
1988	136	129	95	–	0		
1989	159	155	97	–	0		
1990	122	114	93	–	–		
1991	122	118	97	–	–		
1992	142	139	98	–	–		
1993	141	131	93				
1994	156	148	95				
1995	159	151	95				
1996	160	113	71				
1997	121	43	36				

Examinations

The board administered its ninth criterion-referenced part II (oral) examination to 132 individuals June 10–11, 2005. The pass rate for the examination was 86 percent. The next oral exam will be held June 2–3 in Chicago.

On December 5, 2005, the board administered its thirteenth criterion-referenced part I (written) exam to 164 individuals. The pass rate for the examination was 85 percent. This was the second time the written exam was administered in a computer-based format at Pearson Profes-

sional Testing Centers. By offering the exam in a computer-based format, the candidates were able to take the exam at a site conveniently located close to their homes. The ABTS would like to acknowledge and thank the American Board of Surgery (ABS) for helping to make the computer exam possible.

Pathways and requirements for certification

Certification by the ABTS may be achieved by completing one of the following two pathways and fulfillment of the other requirements outlined in the board's booklet:

1. Successful completion of a full general surgery residency (five years) approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada, followed by the successful completion of a two- or three-year, ACGME-approved thoracic surgery residency. Certification by the ABS is optional for individuals who started their thoracic surgery residencies in July 2003 or after.

2. Successful completion of a categorical-integrated six-year thoracic surgery residency. Before this pathway is implemented, the RRC-TS must first approve institutions to offer such programs. As of this report, no institutions have received accreditation for a categorical-integrated thoracic surgery residency.

Joint training program

The ABTS and ABS worked closely together to develop joint training programs leading to the possibility of certification by both boards. Institutions interested in offering the joint training program may apply for accreditation with the RRC-Surgery and RRC-TS.

Applications

The deadline for submitting applications for certification is August 1 each year. All requirements must be fulfilled at the time the application is submitted. The ABTS is no longer able to accept applications pending certification by the ABS.

In-training examination

The 2005 in-training exam was administered online on April 16 and April 23 to 375 residents and fellows. The in-training examination con-

sists of general thoracic and cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination. The 2006 in-training examination is April 1 and April 8.

New board of directors

At the 2005 fall meeting, Richard H. Feins, MD, FACS, was elected vice-chair of the ABS. The following thoracic surgeons were elected to be directors of the ABTS: George L. Hicks, Jr., MD, FACS, representing the Thoracic Surgery Directors Association; Bruce W. Lytle, MD, FACS, representing the American Association for Thoracic Surgery; and Richard J. Shemin, MD, FACS, representing the American Surgical Association. 

International Guest Scholar reflects on experiences in the U.S.

by Emil F. Popa, MD, Bucharest, Romania

Editor's note: In 2004, Emil F. Popa, MD, was one of 10 ACS International Guest Scholars and the first participant from Romania. In the pages that follow, he explains the details of his U.S. visit.

I found out about the ACS International Guest Scholarship in 2003. I work in one of the most important hospitals in Romania, on a team of surgeons dealing with general surgery and cases of surgical oncology. Our hospital is one of the two main oncology centers in Bucharest. I have long been interested in treating peritoneal malignancies with chemohyperthermia and I was very grateful for this international guest scholarship, because it created the opportunity to see this method used in a U.S. hospital.

I planned my U.S. travel with the intention to visit four of the most important medical centers in the U.S.: Washington Hospital Center–Washington Cancer Institute, Washington, DC; The University of Texas, M.D. Anderson Cancer Center, Houston; The University of Washington, Seattle; and Memorial Sloan-Kettering Cancer Center, New York, NY.

Washington, DC

I began my visit in Washington, DC, at the Washington Cancer Institute. I was the



A map of Dr. Popa's route through the U.S.

guest of Paul H. Sugarbaker, MD, FACS, and his wife, who were very hospitable hosts.

During the two weeks spent in the U.S. capital, I had the opportunity to observe very interesting surgical interventions, especially for peritoneal malignancies. Professor Angelescu, the former chief of the surgical department where I work and who guided my activity in my residency years, had met Dr. Sugarbaker and they had been corresponding about chemohyperthermia and how we might use it in our hospital in Romania, so I was pleased to be given the opportunity to wit-

ness Dr. Sugarbaker applying it. I saw several interventions for malignant and benign mesotheliomas. I was impressed by the complexity of these operations and the skills of the surgeons and the entire team. Because this kind of pathology is very rare, it was very interesting to see how it is treated at Washington Cancer Institute.

Dr. Sugarbaker also presented many interesting cases from his archives. I had the opportunity to study the files of those cases and to contribute a paper about the prognosis of peritoneal mesotheliomas in young women treated with

chemohyperthermia. He gave me a lot of articles and books in the surgical oncology field. I was also able to observe Dr. Sugarbaker's colleagues in several surgical procedures, such as rectal resections for carcinomas and hepatectomies for metastases from colonic cancers.

During our visit to Washington, DC, we took advantage of the great weather and visited many museums, memorials, and institutions, including the National Museum of Natural History, the National Air and Space Museum, and the National Gallery of Art, the White House, the Library of Congress, the Washington Monument, and the Jefferson Memorial.

I left Washington regretting that I didn't have enough time to visit everything that I had wanted to see, but I was satisfied by the plans that I made with Dr. Sugarbaker to apply chemohyperthermia in Romania.

Dr. Sugarbaker accepted my invitation to visit Romania; unfortunately, I was still in the U.S. when he went. However, as a result of my visit to the Washington Cancer Institute and Dr. Sugarbaker's visit to Bucharest, we began a project of treating abdominal malignancies by chemohyperthermia in collaboration with colleagues from Greece.

New Orleans

I arrived in New Orleans, LA, two days before the beginning of the American College of Surgeons 90th annual Clinical Congress, and although it was a very rainy day, I went out to visit



Dr. Popa (right) with Dr. Itani at the International Guest Scholar luncheon during the Clinical Congress.



Dr. Popa on a trip through the swamps and to Seven Oaks Plantation, Louisiana.

the sites of this beautiful city. I was very impressed, of course, with the architecture, especially in the French Quarter. At the hotel, I had the opportunity to meet the other International

Scholarship Guests.

The Clinical Congress was a unique experience. I was impressed to see so many famous surgeons from so many countries—many of whom I already

knew by name from their books or published papers.

For a long time I had been looking forward to a meeting with Kamal M. Itani, MD, FACS, my mentor, who was of great help in preparing my paper for the Congress and in choosing the hospitals that I was going to visit. It was very encouraging to know that he was nearby when I needed support, before and during the Congress. During the Congress, I attended several conferences and meetings.

It was a great honor and pleasure to see the Convocation ceremony. It was an impressive event. After the Convocation, at the President's reception for new Fellows, I had the opportunity to become better acquainted with my colleagues, the International Guest Scholars.

At the opening ceremony, my colleagues and I were a little nervous while we were introduced along with other guests. The lecture from this event by Harvey V. Fineberg, MD, PhD, as part of the American Urological Association—"Crossing the Quality Chasm in Health Care"—was very interesting and instructive.

That same day, I attended several other sessions, including The Management of Early Breast Cancer, Gastrointestinal Disease, Gastrointestinal Stromal Tumors of the Stomach, and Paraesophageal Hernia.

Over the next several days, I participated in many activities related to international interests. At the reception for the international visitors, I had more time to converse with my colleagues. I hope that our



Dr. Pops in front of the M.D. Anderson Cancer Center.

meeting in New Orleans was just the beginning of our collaboration and friendship during years to come. The International Relations Committee (IRC) breakfast meeting the next day was very useful for the exchange experience that took place during our U.S. visit and for future international schol-

ars. At the international guest luncheon that afternoon, it was a great honor to receive the diploma and a stipend from the IRC. I was proud to see a photograph of my colleagues and me in the *Clinical Congress News*. And in the evening, colleagues from East Carolina University held a very pleasant reception

honoring International Guest scholars. On Wednesday, my colleagues and I participated in The College's International Travelers, 2004: International Perspectives on Surgery. I presented my paper, Romanian Surgery at the Beginning of the Third Millennium. All international scholars presented very interesting papers. That same morning, I attended another very interesting conference: The New Technology and the Changing Role of the Surgeon Worldwide.

After the Congress, my wife and I visited a few places in Louisiana, including a bus trip, guided by a driver with many stories of the Old South, on highways suspended over swamps and Lake Pontchartrain. We visited the Twelve Oaks Plantation and later took a cruise on the Mississippi river on the Natchez steamboat. The next day we visited the swamps, whose wonderful landscapes reminded us of the Danube Delta in Romania.

Houston

After New Orleans, we traveled to Houston, TX, to visit the M.D. Anderson Cancer Center. I stayed for two weeks in the department of surgical oncology, under the supervision of Eva Singletary, MD, FACS.

I was very impressed with the huge Medical Center of Houston and especially the M.D. Anderson Cancer Center. I am interested in studying breast cancer and I had the opportunity to observe open biopsies with needle (wire) localization, lumpectomies, lymphatic mapping and sentinel



Dr. Popa at the Space Needle in Seattle, WA.

lymph node biopsies with vital dye (isosulphane blue) and radionuclide, axillary dissections, mastectomies (simple, modified radical mastectomy, and skin-sparing mastectomy), and breast reconstructions (prosthetic implant and transverse rectus abdominis myocutaneous flap). It was a great privilege to observe Dr. Singletary, a renowned specialist in breast surgery, performing these procedures. I also visited the frozen section room and observed the procedures used to localize the tumors (by X rays), to ink the margins of the resection specimen, and to identify the positive sentinel lymph nodes by touch imprints. In addition, Gary J. Whitman, MD, assistant professor of radiology section of breast imaging, allowed me to

observe as he performed procedures related to another field, radiology, including directional vacuum-assisted breast biopsy (mammotomy), fine-needle aspiration biopsy, and core needle and image-guided core needle biopsies (stereotactic or ultrasound-guided).

Observing techniques used in breast cancer was very useful, as I was able to apply what I had learned—specifically, ultrasound-guided wire localization—when I performed surgery on an axillary recurrence after breast cancer when I returned to Romania.

We enjoyed our stay in Houston and were able to visit places such as the Johnson Space Center at NASA, the Museum of Fine Arts, the Menil Collection, the Byzantine Fresco Chapel Museum, and the Museum of Natural Sciences.



Dr. Popa at the Thanksgiving Day Parade in New York City.

modern techniques I observed in the operating rooms, including robotic surgery in laparoscopy and the DaVinci system in esophageal and esogastric junction surgery.

Dr. Pellegrini provided much guidance throughout my entire visit. He also provided me with many interesting articles and book chapters, written by him and his team. Observing Dr. Pellegrini's surgical department helped me to improve my techniques in laparoscopic esogastric junction surgery. After my visit, I performed surgery on a combined hiatal hernia (type III), using the laparoscopic approach to perform the dissection, prepare the esophagus and the crura, and perform a Nissen fundoplication.

During our visit in the northwest, we visited the Space Needle; the Experience Music Project; the Science Fiction Museum; the new, modern library; the Seattle Art Museum with the Hammering Man sculpture at the entrance (the so-called soul of Seattle); and the Pike Place Market, which reminded us of Romanian markets. We also took the ferryboat to Whidbey Island and admired this quiet, wonderful spot surrounded by beautiful nature.

New York

We then went to New York for a three-week visit to Memorial Sloan-Kettering Cancer Center, under the guidance of Douglas Wong, MD, FACS, chief of colorectal service. As part of my doctoral thesis, I studied rectal cancer, so I was eager to see the surgical procedures applied by Dr. Wong and his team.

Seattle

After Houston, we went to Seattle, one of the most beautiful cities my wife and I have ever visited. We admired the beautiful landscapes, with mountains, the ocean, and Lake Washington, which we could see out the window every day, covered with fog in the morning and in a sunny light in the afternoons.

I visited the University of Washington as a guest of ACS Regent Carlos Pellegrini, MD, FACS. During the two-week visit, I had the opportunity to see some of the most modern procedures in surgery and to observe many surgical interventions, such as minimally invasive treatment for achalasia and other esophageal dysmotility and laparoscopic myotomy; the treatment of gastroesophageal and gastroesophageal-laryngeal

reflux diseases; laparoscopic antireflux procedures (Nissen fundoplication, partial fundoplication Dor, anchoring of the posterior fundus to the crura and the esophagus); functional evaluation of the esophagus (endoscopy upper-gastrointestinal contrast study, preoperative evaluation, 24-hour pH monitoring, manometry); and the treatment used for sliding hiatal hernia type I, rolling-paraesophageal hernia type II, combined type III hernia, and the therapeutic approach for Barrett's esophagus and esogastric junction carcinoma. I also had the opportunity to observe surgical laboratory trainings on pigs: laparoscopic treatment for umbilical hernia with dual mesh and the laparoscopic training for gynecology residents. I was especially interested in the

I was very impressed with this famous hospital and I had the opportunity to see a lot of surgical procedures and to study in the library for my thesis. I observed many colorectal surgical interventions, including right and left hemicolectomies, rectal resections with total mesorectal excision and colorectal or coloanal anastomosis with colonic J pouch anastomosis or coloplasty, laparoscopic total mesorectal excision with nerve preservation, local excision for early rectal cancer with negative resection margins, and local therapy in patients with stage IV disease. In the afternoons, I attended team meetings and participated in discussions regarding early diagnosis, staging, and surgical treat-

The International Guest Scholar program began in 1968 with funds provided through the legacy of a former director of the College, Paul R. Hawley, MD, FACS(Hon). This program has enabled 191 scholars from 66 nations to attend the Clinical Congress. A recent survey of former scholars shows that more than half have become International Fellows, many have become chairs of their academic departments, and quite a few have maintained a relationship with some of the surgeons they met during the period of their scholarship. For more information on the International Guest Scholar program, contact Kate Early, at kearly@facs.org, tel. 312/202-5281.

ment of colorectal cancer. Seeing how the diagnosis of colorectal cancer is established, using the correlation between clinical data and endoscopic and endorectal ultrasonographic data, was one of the most interesting components of my visit. I also observed how endorectal ultrasonography is used for the staging of colorectal cancer. I intend to use endorectal ultrasonography with my patients, and since my visit, I have attended a course in Romania on echography.

I was very pleased with my visit to Memorial Sloan-Kettering. Dr. Wong gave me valuable guidance for my doctoral thesis and helped me with bibliographic sources, articles, and book chapters, which was of great assistance.

Besides very interesting scientific activities, we had a great time in New York visiting famous and beautiful places. We liked Central Park, Ellis Island, the Statue of Liberty, Brooklyn Bridge, The Flat Iron Building, Chinatown, and South Street Seaport. We visited many museums, as well as the Lincoln Center, the Metropolitan Opera House to see Puccini's *La Boheme*, and a piano concert at Carnegie Hall.

Conclusion

Besides the remarkable scientific activity that I observed during my visit, I was very impressed with the quality of the people that I met—their professionalism, genuine kindness, and politeness. I hope that this visit has sparked a basis for a scientific collaboration with many U.S. physicians and that we have made strong

friendships that will last for years to come. Furthermore, after visiting members of such a renowned scientific and professional society, I am eager to apply for ACS Fellowship.

This report reflects only a small part of the many interesting and beautiful things that my wife and I saw during our visit to the U.S., and I hope to have the opportunity to visit again in the future.

After I returned home, I discussed this great scholarship with many of my colleagues and publicized the opportunity to apply for future ACS traveling scholarships by publishing a notice with *Chirurgia*, the journal of the Romanian Surgical Society. I hope that many Romanian surgeons will have the opportunity to travel to U.S. medical centers and enhance their medical experience.

Editor's note: *Dr. Popa says that touring the U.S. was of great benefit to his career. Since his visit, Dr. Popa has obtained board certification in general ultrasonography and has begun performing endorectal ultrasonography for rectal cancer staging. He is seeking to organize a special surgical department for treatment of colorectal cancer; based on the model used at Memorial Sloan-Kettering Cancer Center in New York, one of the places he visited. He has also performed surgeries that he observed during his visit to the University of Washington in Seattle.*

Dr. Popa is a senior general surgeon and clinical researcher at Coltea Hospital, Bucharest, Romania.

Profiles in Leadership

Thomas R. Russell, MD, FACS

Fellow of the American College of Surgeons since 1979. Executive Director, American College of Surgeons.

“The American College of Surgeons is the most relevant, significant organization serving all surgical specialties. It espouses the life values of surgery and is without question the one organization best suited to serve all surgeons and surgical patients. The College stands for the right things, and I fully believe in its mission.”

“The College elevated my personal surgical practice from the micro level, where I was serving a single patient at a time, to a much larger scale that allowed me to practice in a way that had much greater reach. It gave me the opportunity to affect many patients through service and influence beyond my individual practice. The College served to make the world a little smaller for me, and it opened new, wider avenues for professional growth and service.”

“The College is the surgeon’s most important source of lifelong learning. A gift to the ACS Foundation presents a unique opportunity to make a lasting difference in our profession and to elevate one’s practice beyond borders. The Foundation will listen and will use your financial contributions to carry forward your personal and professional direction, whether it be for scholarships, research activities, or surgical patient safety.”

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

For information about joining the Fellows Leadership Society, please contact the Foundation via telephone at 312/202-5376, via e-mail at fholzrichter@facs.org, or by visiting the ACS Web site at www.facs.org.



We invite you to consider joining
Dr. Thomas R. Russell
in the Fellows Leadership
Society of the American
College of Surgeons.



Fellows become AAS officers

The Association for Academic Surgery (AAS)—a not-for-profit organization that encourages young surgeons to pursue academic surgery careers and supports them in becoming investigators and educators—has announced the results of its elections and appointments at its annual business meeting in February. Ohwafiemu E. Nwariaku, MD, FACS, was elected by AAS membership to serve as 2006-2007 president-elect. Jeffrey Upperman, MD, FACS, was appointed by the AAS president to be the information and technology committee chair.

According to the AAS' guidelines for presidential candidates, the AAS president should have the best interest of the association in mind, time and dedication for the task, an international reputation as a surgeon and/or researcher, and ability to communicate decisively and clearly. Dr. Nwariaku will serve as AAS president in 2007. He is associate professor of surgery at the University of Texas Southwestern Medical Center, vice-chairman for research in the department of surgery, associate professor at the Southwestern Graduate School of Biomedical Sciences, and medical director at the Parkland Memorial Hospital's surgical endocrinology clinic. His vision for the organization is to "work to make the AAS an inclusive organization which prepares all young academic surgeons for successful careers



Dr. Nwariaku



Dr. Upperman

in academic medicine." Dr. Nwariaku specifically wants to expand mentoring programs and promote diversity within the organization.

In his new role at AAS, where he previously served as membership committee chair, Dr. Upperman—a pediatric surgeon at the Children's Hospital of Los Angeles, CA—will lead the committee in providing a forum for introducing AAS membership to new and emerging technologies, developing and enhancing the organization's Web site, and evaluating and assessing technologies through the AAS'

annual meeting information technology poster session.

The AAS' mission is to provide a forum for senior surgical residents and junior faculty members to present papers on subjects of clinical or laboratory investigations; promote interchange of ideas between senior surgical residents, junior faculty, and established academic surgeons; and facilitate communication among academic surgeons in all surgical fields.

For more information on the AAS, visit www.aasurg.org, or call 310/437-1606.

Fellows in the news

The University of Chicago's Dallas B. Phemister Career Achievement Award was given to **John R. Benfield, MD, FACS**, of Los Angeles, CA. Dr. Benfield is a thoracic surgeon, professor emeritus of surgery at University of California (UC)—Los Angeles and UC—Davis, and president of the Thoracic Surgery Foundation for Research and Education. He accepted his award at the University of Chicago Medical and Biological Sciences Alumni Association meeting at the Clinical Congress in San Francisco, CA, in 2005.

Pauline Chen, MD, FACS, of Haverhill, MA, was named the co-winner of the *Virginia Quarterly Review's* (VQR) Staige D. Blackford Prize for best nonfiction work of 2005. Dr. Chen's essay, "Dead Enough?: The Paradox of Brain Death," was published in the Fall 2005 issue of VQR.

Craig S. Derkay, MD, FACS, has been selected to lead the American Society of Pediatric Otolaryngology in May. A professor of otolaryngology—head and neck surgery at Eastern Virginia Medical School in Norfolk, VA, Dr. Derkay is the youngest physician to hold this office.

Catherine deVries, MD, FACS, a pediatric urologist with Primary Children's Medical Center in Salt Lake City, UT, and founder of International Volunteers in Urology (IVU), has been awarded the American



Dr. deVries with a patient.



Dr. Campbell with a patient.

Medical Association's (AMA) Nathan Davis International Award in Medicine (see photo, top left). Each year, this award honors one U.S. physician for outstanding international service in the areas of medical practice, education, or research, whose influence reaches the international patient population and changes the future of their medical care. Dr. deVries was scheduled to receive this award at a ceremony in March in Washington, DC.

Henry M. Kuerer, MD, PhD, FACS, of Houston, TX, director of the Breast Surgical Oncology Training Program and an associate professor at M.D. Anderson Cancer Center, has been awarded the American Society of Clinical Oncology Merit Award and the M.D.

Anderson Associates' Kanojia Clinical Fellow Award. This honor recognizes research Dr. Kuerer had conducted as part of his one-year fellowship at M.D. Anderson for breast surgical oncology in 1997. In addition, Dr. Kuerer will assume the role of chair of the Society of Surgical Oncology this year.

The AMA Pride in the Profession Award was bestowed on two Fellows—**William P. Schecter, MD, FACS**, of San Francisco, CA, and **Sylvia D. Campbell, MD, FACS**, of Tampa, FL (see photo, top right). This award honors U.S. physicians who practice medicine in areas of challenge or crisis or who devote their time to volunteerism or public service. These awards were to be conferred at a ceremony in March in Washington, DC.

The following comments were received in the mail or via e-mail regarding recent articles published in the *Bulletin* and the "From my perspective" columns written by Executive Director Thomas R. Russell, MD, FACS.

Blunt suture needles

I was pleased to see the statement on blunt suture needles published in the November *Bulletin* (Statement on blunt suture needles. *Bull Am Coll Surg.* 2005;90(11):24). I have been using blunt suture needles to close the fascia for more than 10 years in an institution that has its own surgical residency program. During this period, I never had any member of the surgical team get a needle puncture injury from the blunt suture needles. I tried to convince the other surgeons to use them, but most of them refused because of lack of scientific proof. I hope that after reading this statement, all surgeons will adopt it in their surgical practice, especially those teaching the surgical residents. My heartfelt thanks go to the College and the members of the Committee on Perioperative Care.

**Narayan Deshmukh, MBBS,
FACS
Sayre, PA**

P4P

The latest idea to increase government control of physicians is pay for performance, or P4P. The following excerpt appeared in the November 2005 *Bulletin* (Paying for quality: Making policy and practice work for patients. *Bull Am Coll Surg.* 2005;90(11):8-13): "In his testimony before the U.S. Senate Committee on Finance in July, Mark Miller, executive director of MedPAC, stated, 'MedPAC has concluded that Medicare is ready to implement pay for performance [P4P] as a national program and that differentiating among providers based on quality is an important first step toward purchasing the best care for benefi-

ciaries and assuring the future of the program.'"

Translated, this statement says, "Medicare will pay physicians according to how well they practice medicine." Note the acronym "P4P" is consistent with other government acronyms, a subtle suggestion that the term has already entered mainstream usage.

Since the November issue, I have read several *Bulletin* readers' comments and am surprised some were in favor of P4P. Also, to my disappointment, the American Medical Association and the College both came out in favor of P4P, if what I read is correct.

I assume physicians have been so indoctrinated in the past 20 years to laws, regulations, bureaucracy, and administrative doctrine that this latest step barely gets our attention.

P4P assumes physicians do not have personal and professional qualifications to give patients the best medical care without a financial incentive. It requires physicians to follow evidence-based medicine, which means to "practice by the book." But illnesses are often atypical and require treatment other than that suggested by evidence-based medicine. The physician, not a bureaucratic formula, should decide how to best treat patients.

The real reason for P4P may be to provide a mechanism for paying doctors less since Medicare is under pressure from Congress to reduce costs.

P4P, if adopted, will add to 111,000 pages of Medicare regulations. There will be wrangling over its administration. We will be one step closer to socialized medicine. More and more physicians will not participate in Medicare if they can make that choice.

**Robert G. Small, MD, FACS
Oklahoma City, OK**

Louis Wright and Henry Cave

Your recent article on Drs. Louis T. Wright and Henry W. Cave (Louis

T. Wright and Henry W. Cave: How they paved the way for Fellowships for black surgeons. *Bull Am Coll Surg.* 2005;90(10):22-29) brought back pleasant memories.

Many years ago, at the request of my family physician—Richard A. Taylor, a close friend of Dr. Cave—I spent two summers at Roosevelt Hospital, where Dr. Cave was chief of surgery. I rotated between surgery and pathology. It was an unforgettable experience.

Dr. Cave became my mentor. Both Drs. Cave and Taylor encouraged me to become a physician. Under their watchful eyes, I became an obstetrician, gynecologist, and gynecologic oncologist. When I asked how I could repay them, they answered, "Give back to others." This has become my mantra.

**Randall D. Bloomfield, MD,
FACS**

**Editor, *Bulletin of the Medical
Society of the County of Kings
Brooklyn, NY***

Emergency room coverage

We have read with interest your discussion of surgeon coverage of emergency room patients (From my perspective. *Bull Am Coll Surg.* 2005;90(10):4-5).

We at WakeMed Health and Hospitals in Raleigh, NC, are the beneficiaries of solid support from our hospital administration, which has allowed us to expand from a group of four general surgery-trauma surgeons to our present strength of 10. We provide 24-hour in-house coverage and supervise a group of surgical and off-service residents from the University of North Carolina.

We agree that acute care surgery is a realistic designation for the work we do. Our care of trauma patients requires that we perform occasional, and often very complex, operations. A regular schedule in broad general surgery helps us to maintain operative capabilities. We maintain two office/clinic sites and are the beneficiary of a large emergency

department referral volume.

The hospital administration that has supported us so well has likewise provided hospital-faculty teams in orthopaedics; ear, nose, and throat-facial surgery; and urology. Five community neurosurgeons and two plastic-reconstructive surgeons generously support our patients.

We realize that this pattern of emergency surgical care is not universally available but we regard it as ideal.

I think the concept of "surgical hospitalist" is an inevitable solution, as hospitals come to terms with the lack of qualified surgeons willing to provide uncompensated trauma/critical care coverage.

William G. Sullivan, MD, FACS
Raleigh, NC

Presidential Address

Dr. Anderson's Presidential Address at the 2005 Convocation (Presidential Address: Crises in humanity. 2005;90(12):10-16) presented a wonderful historical resume. It contained a remarkable summary of the brilliance of our predecessors. It is a good read that brings one up to speed.

As Winston Churchill said, "The pessimist sees the difficulty in every opportunity. The optimist, the opportunity in every difficulty."

E.G. Rawling, MD, FACS,
FRCSC
Toronto, ON

College public relations

I have been a Fellow for 10 years, a tenure that has coincided exactly with the managed care movement. I support a new public relations program for the College. Appearances and recognition are very important because they allow an organization to forward its agenda and achieve its goals. Hopefully the energies of the College will soon focus more on stabilizing our profession by concentrating on the Fellows, the surgeons, and the business of surgery.

The College's role in public policy

(certification, the Committee on Trauma, the Commission on Cancer) is important for the greater good, but its voice and agenda are dependent on the stable and successful delivery of surgical services to people. Some may assume that this delivery of quality services by surgeons will just go forward, no matter what forces are brought to bear on the practicing surgeon. I do not believe this. Outside forces are redefining the delivery of surgical services, and the marketplace is eroding our previous stable position. I wish it were the College that defined our services and assisted more in our economic issues. Public relations is part of an equation; the other part is using the recognition to forward the agenda and achieve goals. Of vital importance are the well-being of the Fellows and their practice of surgery. They are, after all, the College's "raison d'être."

George Grice, MD, FACS
Charleston, SC

Congratulations on your article in the January ACS Bulletin ("From my perspective." *Bull Am Coll Surg.* 2006;91(1):4) suggesting it is time to educate the public about the College, its members, and its standards. In fact, the initiative is overdue. Without it, the public remains uninformed about the high standards and initiatives of the College and its members. Without it, the College and its members will never be able to differentiate themselves from the mediocre, leaving the public little information that is vital to their safety, knowledge, and well-being.

This editorial may have been Dr. Russell's best because it rallies an entire organization to action to do what it does most effectively: inform the public about what it does to improve the public's standard of living.

As a vascular surgeon, I am acutely aware of the identity crisis we face in the minds of the public, as is the experience of the Society

for Vascular Surgery (SVS), which has created its own communications committee to address the issue. Why remain faceless when we have so much to offer and the public has a thirst for knowledge?

Carlo A. Dall'Olmo, MD, FACS
Member, Communications
Committee, SVS
Flint, MI

I believe the editorial in the *Bulletin* was right on and well written. I have grown up in an era where, initially, I was always taught that it was not professional to "advertise." I have noticed, unfortunately, that some hospitals advertise directly for physicians without regard to their real qualifications (such as being a Fellow of the College and other credentials). This approach has become the hospitals' way of marketing themselves, frequently at the expense of well-trained surgeons. The public doesn't understand this fact. They frequently have no idea what the American College of Surgeons is or represents. More and more patients are self-referring, partly because of the convenience and availability of information on the Internet. I really believe it is a service to our patients to know more about the College and quality issues. I am strongly in favor of promoting this organization through whatever means.

Richard Andrassy, MD, FACS
Houston, TX

Dr. Martin/the ACS Archives

I was delighted to see Dr. Mannion's brief article about Franklin Martin, founder of the College, and his review of Martin's two-volume autobiography, *The Joy of Living* ("Franklin Martin: "The founding father." *Bull Am Coll Surg.* 2006;91:32-33). As Dr. Mannion states, the book is a wealth of information, not just about Martin's life, but about the history of medicine, the history of Chicago, the history of World War I, and much

more about the period 1857-1935, when Dr. Martin lived and kept records. Not only is it informative and insightful, but also extremely entertaining and well-written. Readers taking the time to find this now out-of-print work will be richly rewarded.

What Fellows should also know is that the autobiography is the “tip of the iceberg” in terms of original source material as found in the ACS Archives. Dr. Martin and his wife, Isabelle, beautifully preserved their “memoirs” in a 43 volume set of three-ring binders with news clippings, photographs, programs, Clinical Congress materials found nowhere else, and scrapbook items of their travels. They kept dozens of notebooks, diaries, and bound mate-

rials, among them Dr. Martin’s own surgical casebooks. Dr. Martin used some of this material in writing the book, but hundreds of pages of materials—including candid photographs and correspondence with surgical and other leaders of the day—that didn’t make it into the book can be found in the ACS Archives. Dr. Martin was a tremendous record-keeper, and thanks to his work, the rich history of the American College of Surgeons is being preserved.

Unique, turn-of-the century records of some Chicago hospitals and medical schools with which Dr. Martin was connected—many no longer in existence or merged with others—will soon become available in the ACS Archives after de-

acidification treatment. They will be a major resource for historians of medicine and health care from that period.

Fellows and other researchers are invited to visit the Archives and peruse some fascinating materials. Several other books and articles about our history are waiting to be written. For samples from the Archives, visit “Highlights from the Archives,” a monthly feature on www.facs.org.

Susan Rishworth
ACS Archivist, Division of
Member Services
Chicago, IL

Resident training

My pediatric surgery group at the Medical College of Virginia is both academic (full-time) and private, as we cover all the hospitals in Richmond without residents. Believe me, we see with clarity both sides of the discussion of resident training hours and our duties to patients.

I believe we must begin a process of discussion with all parties—residents, insurers, academic training centers, and private practice surgeons—before new mandates (like those already in place in Europe) are dropped in our laps.

The excellent report by Dr. Warshaw’s group, which was presented at the meeting, is the beginning of this solid data collection and is much needed. I sincerely hope the College will take center stage in the process and fight attempts to further reduce resident hours in surgical training.

Surgeons are different. As Ambroise Paré stated to a critic of “surgery” in the sixteenth century, “Lessons of surgery are learned by the hand....” Reading is necessary, but time in the trenches cannot be further reduced without loss to the profession. We must fight for that—our patients deserve it and our heritage demands it.

Charles Bagwell, MD, FACS
Richmond, VA

ACS Career Opportunities

The American College of Surgeons’ online job bank

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NETWORK

PERSONAL FINANCIAL PLANNING AND MANAGEMENT

FOR RESIDENTS AND YOUNG SURGEONS

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OBJECTIVES

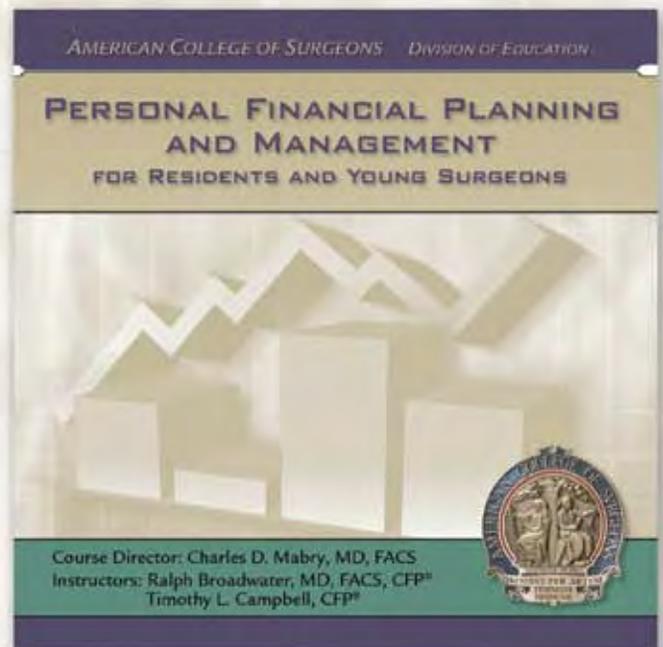
At the end of the course, the participants will be able to describe:

- The essentials of personal financial management as they relate to young surgeons in practice and residents and their families.
- The impact of interest rates and time upon loans, compound interest, and the implications for debt management.
- The building blocks necessary for the surgeons to invest successfully.
- The importance of time in reducing the risk of investing.
- The basics of mutual funds, stocks, bonds, and other investment vehicles.
- How to evaluate and choose a financial advisor.

INTENDED AUDIENCE:

- Surgical residents and surgeons recently in practice.

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A look at the Joint Commission

Unannounced surveys

As of January 1, all on-site surveys by the Joint Commission are unannounced, meaning organizations receive no advance notice of their survey date. However, the Joint Commission gives organizations an opportunity to provide 10 “blackout” dates to be avoided each year.

The benefits of an unannounced survey are as follows:

- It allows the organization to focus on preparing for their next patient, not on their next survey
- It validates an organization’s continuous systems improvement efforts, rather than a simple standards compliance exercise at a point in time
- It provides a more accurate picture of an organization’s actual day-to-day performance

Under the unannounced sur-

vey process, Joint Commission surveyors may return to a site sooner than three years. After a health care organization undergoes its first unannounced survey, its next survey will occur 18 to 39 months later. Preestablished criteria determine the timing of the survey, triggered by priority focus process data.

The following are exceptions to unannounced surveys:

- Initial surveys
- Bureau of Prisons and Department of Defense facilities
- Office-based surgery practices with less than 1,500 annual visits
- “Very small” programs, including ambulatory organizations that provide surgery/anesthesia or medical/dental services

Previously, when surveys were announced, the Joint

Commission required organizations to notify the public of the opportunity to request a public information interview to share concerns with surveyors. With the advent of unannounced surveys, organizations must now encourage patients and the public to contact the organization’s management with any concerns at any time. If the concerns cannot be resolved at the organizational level, the organization should encourage individuals to share their concerns with the Joint Commission.

Each month, this column will focus on activities of the Joint Commission that are relevant to surgeons. For more information on the Joint Commission, and to sign up for Joint Commission e-mail newsletters and announcements, visit *www.jcaho.org*.

Trauma meetings calendar

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

- **Trauma and Critical Care 2006—Point/Counterpoint XXV**, June 5–7, Williamsburg, VA.

Complete course information can be viewed online (as it be-

comes 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.

NTDB® data points

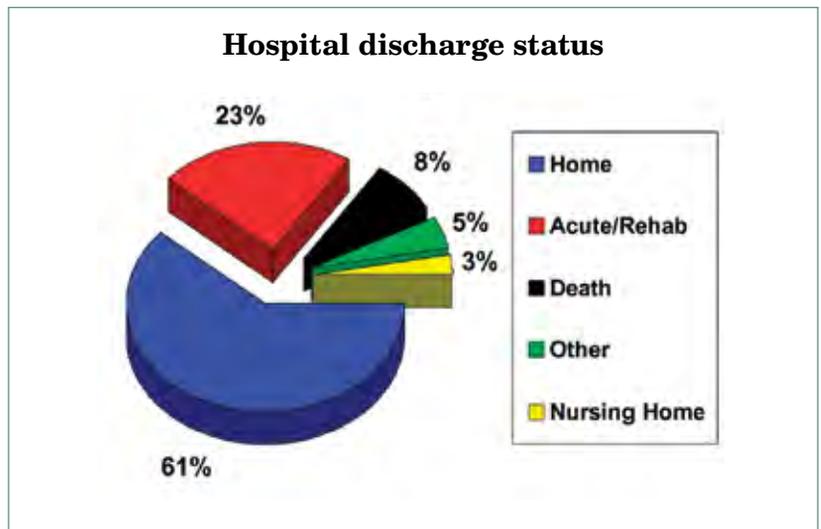
Come fly with me

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

Many people compare medicine to the aviation industry when it comes to safety concerns. Both industries involve high-risk environments, highly trained teams, high regulation, and a hierarchal structure. Aviation has made significant strides in safety over the past two decades and, in doing so, has created a culture of safety. But how safe is aviation in reality?

Civil aviation is divided into the commercial and general aviation categories; it excludes military aviation. Commercial aviation includes all the airlines that many people are familiar with and use in daily life. There are more than 11 million departures each year. General aviation encompasses 96 percent of U.S. aircraft and 60 percent of all flight hours. This latter category also includes all the single-engine airplanes that most student pilots train in and ultimately fly after they earn their private pilot's license.

In 2004, there were close to 50 million hours of civilian flights and 621 million passengers. During this same time, there were 1,715 civil aviation accidents, including 556 general aviation fatalities and 79 commercial fatalities. In contrast, other transportation-related deaths in 2004 were as follows: automobiles, more than 42,000 deaths; railroads, 865 deaths; and boating, 830 deaths.



To examine the occurrence of these injuries in the National Trauma Data Bank® Dataset 5.0, we used cause of injury codes (E codes) for aircraft in transit/powering (E 841), for aircraft at landing (E 840), and due to/caused by cataclysm (E 908/909). There were 736 records for these E codes, with 451 being discharged to home, 168 sent to acute care/rehab, 22 sent to nursing homes, 35 other, and 60 deaths. These data are depicted in the figure on this page. This group of patients had an average length of hospital stay of 7.6 days, an intensive care unit length of stay of close to three days, and an average injury severity score of 13.7; the age group most largely represented among these patients was age

45 to 54 years. Similarly, the average age of private pilots is 46 whereas the average age of commercial pilots is 45.

Putting aviation in perspective by comparing it with other modes of travel, if someone were to ask you, "Come fly with me," you could go along and feel safe.

Throughout the year, we will be highlighting the work of the NTDB through brief monthly reports in the *Bulletin*. The full NTDB *Annual Report Version 5.0* 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, please contact Rhonda Peebles toll-free at 888/857-7545 or rpeebles@facs.org.

Louisiana Chapter convenes in New Orleans

In spite of the horrific destruction caused by Hurricane Katrina, the leaders of the Louisiana Chapter agreed to continue their traditions by meeting in New Orleans. The 2006 annual meeting was held January 20–22 at the Marriott Hotel and was attended by nearly 100 members and residents. A highlight of this year's event was the award presented to Charles L. Black, MD, FACS, who was honored for his many years of worldwide, volunteer surgical service, which included a mission with the renowned physician and humanitarian, Albert Schweitzer, MD. The first Charles L. Black, MD, FACS, Humanitarian Award, which was developed and granted by the Louisiana Surgical Association, was also named for Dr. Black (see photo, this page). The award was presented to him by Lester W. Johnson, MD, FACS, at a black-tie gala at Arnaud's.

This year's education program featured presentations by faculty members from Tulane and LSU, as well as presentations by (all MD, FACS) Frank Arko; Matthew Mutch; Frank G. Opelka; Ajit K. Sachdeva, FRCSC; Dan Smith; and Thomas R. Russell, ACS Executive Director. In addition, Fred Cerise, MD, the Louisiana State Health Commissioner, also addressed the group. During the business meeting, new officers were elected (see photo, this page).

Southwest Missouri hosts governor

For the first time in its 57-year history, the Southwest Missouri Chapter hosted the state's governor: Gov. Matt Blunt (R) attended the chapter's 2005 annual meeting on October 3 (see photo, this page). The governor discussed the Missouri tort reform bill, which had gone into effect August 28. The new law places caps on noneconomic damage (pain and suffering) awards, requires an affidavit of merit from a physician in the *same* specialty before an action can be filed, and mandates that trials



Louisiana Chapter: Left to right: Dr. and Mrs. John T. Preskitt (Dr. Preskitt is a Regent of the College); Dr. and Mrs. Black; and Dr. Russell.



Louisiana Chapter officers, left to right (all MD, FACS): Robert P. Marshall, Vice-President; Kevin Sitting, President; Dr. Johnson, Immediate Past-President; Gus Colon, President-Elect; and Daniel J. Frey, Secretary.



Governor Blunt (right) addresses SW Missouri Chapter members as Immediate Past-President John Bumberry, MD, FACS, looks on.

Chapter meetings

For a complete listing of all of the ACS chapter education programs and meetings, please visit the ACS Web site at <http://www.facs.org/about/chapters/index.html>.

(CS) following the chapter name indicates a program cosponsored with the College for Category 1 CME credit.

April 2006		
Date	Event	Location/contact information
April 21–22	North and South Dakota (CS)	Location: Mitchell Holiday Inn, Mitchell, SD Contact: Terry Marks, 605/336-1965
April 28–30	Virginia (CS)	Location: Kingsmill Resort, Williamsburg, VA Contact: Susan McConnell, 804/643-6631
May 2006		
May 3–6	Chile	Location: Hotel Sheraton, Santiago, Chile Contact: Pedro Uribe Jackson, MD, FACS, 562/264-1878
May 4	Belgium	Location: Ostend Thermae Palace, Ostend, Belgium Contact: Jean-Marie Collard, MD, FACS, 32-2-764-1464
May 6	Northern California (CS)	Location: Nikko Hotel, San Francisco, CA Contact: Annette Bronstein, 650/992-1387
May 8	Metropolitan Philadelphia (CS)	Location: Union League of Philadelphia, Philadelphia, PA Contact: Lauren Brinjac, 888/633-5784
May 9–10	Ohio (CS)	Location: Westin Great Southern Hotel, Columbus, OH Contact: Brad Feldman, 877/677-3227
May 11	Vermont (CS)	Location: Topnotch Resort and Spa, Stowe, VT Contact: Jeanne Jackson, 802/847-9440
May 11–13	West Virginia (CS)	Location: The Greenbrier, White Sulphur Springs, WV Contact: Sharon Bartholomew, 304/598-3710
May 18–19	Michigan (CS)	Location: Grand Traverse Resort, Traverse City, MI Contact: Tom Plasman, 517/336-7586
May 21–23	Illinois (CS)	Location: Starved Rock State Park, Utica, IL Contact: Carolyn Koch, 309/786-4227
May 26–29	Florida (CS)	Location: Gasparilla Inn & Cottages, Boca Grande, FL Contact: Robert Harvey, 904/384-8239
June 2006		
June 1	Brooklyn & Long Island (CS)	Location: La Guardia Marriott, East Elmhurst, NY Contact: Teresa Barzyz, 516/741-3887
June 2–4	Maine (CS)	Location: Asticou Inn, Northeast Harbor, ME Contact: Joel Lafleur, MD, FACS, 207/596-6636
June 8–11	Missouri (CS)	Location: Lodge of the Four Seasons, Lake Ozark, MO Contact: John Adams, Jr., MD, FACS, 573/443-8773
June 15–17	Alabama	Location: Marriott Grand Hotel, Point Clear, AL Contact: John Hooton, 205/776-2106
June 18–21	Oregon & Washington State (CS)	Location: Sunriver Resort, Sunriver, OR Contact: Kelly Smith, 503/494-5300

take place in the county where the negligence is alleged.

Before Governor Blunt's remarks, Edwin Cunningham, MD, gave a presentation on the management of carotid stenosis. Later in the meeting, the following new officers were elected (all MD, FACS): Dan Cardwell, President; Charles Mace, President-Elect; and J. Randolph Mullins, Secretary/Treasurer.

2006 Leadership Conference

The 2006 Leadership Conference will be held June 11-13 at the Washington Court Hotel in Washington, DC. On Sunday, June 11, special concurrent sessions will be targeted to Young Surgeons and Chapter Leaders and Chapter Executives. The Health Policy Forum will begin on Monday, June 12, and Capitol Hill Visits will begin on June 13.

All chapters should send one or two officers, one or two Young Surgeons, and the Chapter Administrator. In addition, members of the various leadership groups of the College are encouraged to attend, including members of the Advisory

Councils, the Board of Governors, the Committee on Trauma, and Cancer Liaison Physicians. Resident and Medical Student Members of the College are also welcome.

Registration can be completed online at the College's Web site at <http://www.facs.org/about/chapters/chapleadership2006.html>. For questions or to obtain a registration form, please call the Chapter Hotline at 888/857-7545. The registration deadline is June 1.

Chapter anniversaries

Month	Chapter	Years
March	Brazil	54
	Southern California	54
	Massachusetts	52
	Nevada	41
	New Hampshire	54
	Puerto Rico	56
	South Dakota	54
April	Metropolitan Chicago	51
	Mississippi	53
	Oklahoma	56

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CHARM (Not Shown)

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#S12 Solid 14K Gold \$125

MONEY CLIP (Not Shown)

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(Indicate finger size)

TIE BAR

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