FEATURES

From the surgical suite to the state capitol: Fellows elected to state and local posts 8
Melinda Baker

Surgical patient education: Transformation to a system that supports full patient participation 11
Kathleen Heneghan, RN, MSN; Ajit K. Sachdeva, MD, FACS, FRCSC; and Jack W. McAninch, MD, FACS

Surgical lifestyles: Discovering life's “chapter two” after surgery 20
Marc K. Wallack, MD, FACS

Error reduction through team leadership: Seven principles of CRM applied to surgery 24
Gerald B. Healy, MD, FACS; Jack Barker, PhD; and Capt. Gregory Madonna

“Lion heart”: Saleh Khalef 27
M. Margaret Knudson, MD, FACS; Jay A. Johannigman, MD, FACS; and James Betts, MD, FACS

Governors' Committee on Chapter Activities: Update 34
Richard A. Lynn, MD, FACS

Management of complex extremity trauma 36
Michael D. Pasquale, MD, FACS; Eric R. Frykberg, MD, FACS; Glen H. Tinkoff, MD, FACS; and the ACS Committee on Trauma, Ad Hoc Committee on Outcomes

DEPARTMENTS

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

Dateline: Washington 6
Division of Advocacy and Health Policy

On the cover: The College launches a new patient education program (see article, page 11). Photo courtesy of Punchstock.
NEWS

Dr. Meredith named Medical Director of Trauma Programs 39

Register for the ACS Practice-Based Learning System 40

CME portal tool takes the hassle out of logging your credits 40

Trauma meetings calendar 40

Disciplinary actions taken 41

AWS gears up to celebrate 25 years of service at Clinical Congress 42

Profiles in surgery: Surgery under stress: World War II, Anzio Beachhead 44
George W. Tipton, Sr., MD, FACS

Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings, February 10–11, 2006 50
Paul E. Collicott, MD, FACS

NTDB® data points:
Deposit the bull’s-eye 58
Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

A look at the Joint Commission: Periodic performance reviews 59

Chapter news 61
Rhonda Peebles

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.
SYLLABI SELECT: The content of select ACS Clinical Congress postgraduate courses is available on CD-ROM. These CD-ROMs run in the PC and Mac environments and offer you the ability to keyword-search throughout the CD.

ONLINE CME: Courses from the ACS’ Clinical Congresses are available online for surgeons. Each online course features video of the introduction, audio of session, printable written transcripts, post-test and evaluation, and printable CME certificate upon successful completion. Several courses are offered FREE OF CHARGE. The courses are accessible at www.acs-resource.org.

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

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

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

PRACTICE MANAGEMENT for Residents and Young Surgeons: The CD uses an interactive/lecture format to equip residents and young surgeons with the knowledge to manage their personal surgical future, including: how to select a practice type and location; the mechanics of setting up or running a private practice; the essentials of an academic practice and career pathways; and surgical coding basics.
Since its inception, the American College of Surgeons has sought to uphold the highest standards of professionalism among surgeons. This founding principle is succinctly summarized on the official seal of the College in the words, “to serve all with skill and fidelity.” Although the College and most surgeons and other physicians have long recognized the importance of professional conduct among those who are responsible for providing care to patients, the topic was discussed largely in philosophic ways until recently.

Indeed, since the American Board of Medical Specialties and the Accreditation Council on Graduate Medical Education identified professionalism as one of the six core competencies that all physicians should attain and sustain throughout their careers, the topic has received more widespread attention. Academicians and practicing surgeons have been trying to define this quality and determine why some people behave in a highly professional manner, whereas others act in inappropriate ways. We also have been attempting to determine how best to imbue young physicians in professionalism.

What is professionalism?

The College’s Task Force on Professionalism was formed for the purpose of resolving these issues. One of this group’s first undertakings was to define professionalism. In developing the ACS Code of Professional Conduct, the Task Force determined that professionalism encompasses an individual’s cognitive, moral, and collegial attributes. The group also found professionals possess four core characteristics: (1) specialized knowledge, (2) relative autonomy in practice and the privilege of self-regulation, (3) altruistic service to individuals and society, and (4) responsibility for maintaining and expanding professional knowledge and skills.

The authors of the Code of Professional Conduct state, “A good surgeon is more than a technician, and reliance on technical expertise alone as the basis of professionalism might weaken our claim to public legitimacy.” They also note that although ethical practice and professionalism are interrelated, they are not synonymous. Professionalism extends beyond medical ethics and incorporates surgeons’ relationships with their patients and society. As Kirk and Blank surmise, “‘Professionalism’ denotes the standards of behavior that individual physicians are expected to meet as they provide their specific knowledge and skills to those who seek their counsel, and it is the basis of medicine’s contract with society.”

Professionalism begins in medical school

As these definitions imply, “professionalism” is not an attribute that can be taught or evaluated through our conventional educational techniques and measures, such as lecture, question-and-answer sessions, or laboratory experience and examination. Instead, it is a behavior that must be acquired through example and reinforced over time. Likewise, unprofessional conduct must be identified early on and must carry with it consistent negative consequences.

A recent report in the New England Journal of Medicine proves a premise that many of us have
long maintained: Professionalism begins in medical school. The authors studied 235 graduates of three medical schools who had been disciplined by state medical boards between 1990 and 2003; they found that physicians who were subject to corrective measures had displayed previous unprofessional behavior in medical school. Destructive conduct in medical school most often associated with unprofessional conduct later on in an individual’s career were irresponsible actions and a limited capacity for self-improvement. The authors conclude that “professionalism should have a central role in medical academics and throughout one’s medical career.”

Apparently medical schools are getting the message. I recently had an opportunity to sit in on some medical school classes with my daughter, who is a first-year student, and was impressed by how much of the material focused on professional development. Today’s medical school curriculum seems to cover all aspects of being a medical professional, using a very interactive and less Socratic approach to learning than many curricula I’ve experienced.

As a professional organization, the College continues to accept its responsibility for ensuring that all of its members conduct themselves with dignity and compassion. An official Code of Professional Conduct outlining the surgeon’s responsibilities to each surgical patient and to local communities and society at large was developed by a special Task Force on Professionalism a few years ago. The code was approved by the Board of Regents in June 2003 and was subsequently published in the October 2003 issue of the Journal of the American College of Surgeons. In addition, a CD-ROM entitled Professionalism in Surgery: Challenges and Choices, which outlines the underlying principles in the code, has been developed and is available to our members and all other interested parties. The CD-ROM presents 12 vignettes exploring realistic challenges to an individual’s professionalism, such as fatigue, error, and false diagnosis. It is a valuable resource for practicing surgeons but may also be useful to medical students and surgical residents as they strive to develop this core competency.

We must be good role models

It must be said that classroom and electronic learning programs only go so far in inculcating young people in professional conduct. We must always be aware of the impact our comments and demeanor might have on those who are just starting on the path to a career in surgery. The current stresses and strains of practice today can cause all of us to be somewhat disenchanted from time to time. However, we must remember that it is important not to be negative in discussing surgery as our life’s work with people who are just beginning to think about theirs.

Medical students in particular need positive role models who exude clinical knowledge, technical finesse, and ethical and collegial behavior. Therefore, those of us who interact with these young people must take extra care to be at our best when communicating with them. We must nurture their innate desire to serve others and remind them of the joys and privileges associated with providing surgical care.

Because professionalism begins early in life for surgeons, I urge each of you to ensure that any contact you may have with medical students—whether it is ongoing and in an academic setting or on an occasional basis—is infused with a sense of pride in this profession. We must take responsibility not only for our own level of professionalism but for the conduct of the next generation of surgeons as well.

References


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.
On March 16, the Senate passed S. Con. Res. 83, the Fiscal Year 2007 Budget Resolution, in a 51-49 vote. Before passing the resolution, the Senate unanimously approved an amendment sponsored by Sen. Kay Bailey Hutchison (R-TX) that would create a deficit-neutral reserve fund. The purpose of this fund would be “to ensure that physicians receive an appropriate reimbursement rate under Medicare instead of a scheduled cut, which would threaten the adequate provision of care for seniors and disabled citizens.” Although the amendment does not have the force of law to prevent a 4.6 percent Medicare physician payment cut in 2007, it does demonstrate the Senate’s willingness to address the issue. Cosponsors of the amendment are Sens. Jon Kyl (R-AZ), Dianne Feinstein (D-CA), Susan Collins (R-ME), Elizabeth Dole (R-NC), and John Cornyn (R-TX). For more information about the Medicare fund, contact sfriesen@facs.org.

Also in the Senate budget resolution is an amendment that would provide an additional $7 billion in discretionary spending for such health programs as the National Institutes of Health, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. The amendment passed by a vote of 73 to 27 and was introduced by Sens. Arlen Specter (R-PA) and Tom Harkin (D-IA), the chair and ranking member, respectively, of the Senate Labor-HHS (U.S. Department of Health and Human Services)-Education Appropriations Subcommittee. For more information about this amendment, contact aroberts@facs.org.

The House Budget Committee began consideration of the budget resolution on March 29. At press time, the House had not yet passed its version.

According to a March 30 report from the Office of the Inspector General, the Medicare program allowed approximately $1.1 billion more in billings for consultations in 2001 than it should have, accounting for approximately 75 percent of consultation services Medicare approved that year. Services billed as consultations were improperly paid for the following reasons: they did not meet Medicare’s definition of a consultation (19%, or $191 million), they were billed as the wrong type or level of consultation (47%, or $613 million), or they were unsubstantiated (9%, or $260 million). Consultations billed at the highest billing level and follow-up inpatient consultations were particularly problematic; approximately 95 percent of each was incorrectly coded.

The report recommends that the Centers for Medicare & Medicaid Services urge Medicare carriers to educate physicians about the criteria and proper billing for all types and levels of consultations, with emphasis on the highest billing levels and follow-up inpatient consultations. To view the report, visit http://oig.hhs.gov/oei/reports/oei-09-02-00030.pdf.

The American College of Surgeons and 17 other organizations concerned with trauma care in the U.S. recently sponsored a congressional briefing entitled, “Saving Lives When Minutes Count: Briefing on a Public Health Model for Trauma Systems.” Hosting the briefing were
eight members of Congress: Sens. Bill Frist (R-TN), Lindsey Graham (R-SC), Patty Murray (D-WA), Jack Reed (D-RI), and Pat Roberts (R-KS); and Reps. Gene Green (D-TX), Mike Simpson (R-ID), and Joe Wilson (R-SC). Speakers included Howard Champion, MD, FACS, president of the Coalition for American Trauma Care; J. Wayne Meredith, MD, FACS, ACS Medical Director of Trauma Programs; Col. John Holcomb, MD, FACS, Commander of the U.S. Army Institute of Surgical Research; William Rasco, FACHE, president and chief executive officer of the Greater San Antonio Hospital Council; and Michael Briggs and his daughter Wimberly, members of a South Carolina family that has been affected by trauma.

The briefing attracted more than 50 congressional staff from both the House and the Senate. Approximately 20 state trauma systems coordinators were also at the briefing, affording them an opportunity to provide information to the legislative assistants about what is happening in their respective states with regard to trauma systems development. For more information, contact aroberts@facs.org.

The National Institutes of Health (NIH) recently launched a $50 million research program to determine the best means for improving survival following cardiac arrest or severe trauma. By next spring, the NIH’s Resuscitation Outcomes Consortium, in conjunction with emergency medical services agencies, will conduct clinical trials that will involve public safety agencies, regional hospitals, community health care institutions, and medical centers in 11 regions in the U.S and Canada.

“These initial studies, and those that follow, will change the way all providers of trauma care, military and civilian, care for the most critically injured,” according to Col. Holcomb, the consortium’s trauma co-chair. “For the first time, we will know, based on large and well-designed studies, what interventions really make a difference.” Another College Fellow, David Hoyt, MD, FACS, former Medical Director of Trauma Programs, ACS Division of Research and Optimal Patient Care, is the principal investigator for the San Diego, CA, region. For a complete list of participating regions and for more information, go to http://www.nih.gov/news/pr/mar2006/nhlbi-24.htm.

Classic textbook grassroots advocacy proved successful for the Indiana Obesity Coalition, which led the effort to enact legislation to address problems with the state’s mandatory insurance coverage law for bariatric surgery. S.B. 266, which the Indiana House and Senate unanimously passed and the governor signed March 20, makes statutory changes that will result in the following: protection of physicians in cases where patients cannot be located for tracking purposes (existing law required monitoring of the patient for five years following surgery), the preservation of the confidentiality of the physician and institution when reporting deaths and complications to the department of health, and the reduction of the preoperative, nonsurgical, physician-supervised weight-loss period from 18 consecutive months to six months. For a copy of the legislation, contact jsutton@facs.org.
From the surgical suite to the state capitol:

FELLOWS ELECTED TO STATE AND LOCAL POSTS

by Melinda Baker, State Affairs Associate, Division of Advocacy and Health Policy
Surgeons can serve as advocates at the state and local levels in many different ways: writing letters to legislators, meeting with elected officials, participating in coalitions centered on a specific issue, or becoming involved in an election. All of these activities have a significant impact on advocacy and keep the wheels of democracy turning.

A few Fellows of the College have taken their advocacy efforts to a higher level by running for state and local offices. Not surprisingly, the same passion to serve that drives someone to be a surgeon can also push that individual to run for public office. The attitude of a caregiver toward a patient is easily translated to public service and care for an entire community.

Electing Fellows

Only a small percentage of Fellows have run for state or local office. Running a campaign can be a grueling effort, taking precious time away from the surgical practice. Campaign event schedules can be intense, culminating in exhilaration and anxiety on Election Day. And, of course, victory is not guaranteed.

The College has identified a number of surgeons who have taken their desire to serve from the surgical suite to their state capitol domes, including the following:

- Rep. Bill Chase, MD, FACS (D-NH)
- Rep. Don Van Etten, MD, FACS (R-SD)
- Sen. Dan Foster, MD, FACS (D-WV)
- Rep. Eric Munoz, MD, FACS (R-NJ)
- Tim Mahoney, MD, FACS (I)

In addition, Representative Munoz and Commissioner Mahoney were asked to fill vacancies left by others, whereas Senator Foster was asked to run 10 days before the filing deadline.

Senator Foster had this advice for other physicians looking to get involved in the political process: “You have to be passionate, want to help, and be a hard worker. You also have to get elected, which is not as easy as it sounds. You need to learn how to get elected.”

In New Hampshire, the State House is especially large, meaning each representative district comprises a very small geographic area. Representative Chase spent approximately $500 on his campaign, knocked on 400 doors in three towns, and defeated an 18-year incumbent. “It’s hard work, but I enjoyed getting out there and meeting all the different people in my community. I just wanted to be able to give back to my community and make a difference... and make a difference... [and] have a life that matters.”

Timing is just as important as passion when it comes to running for political office. Before you decide to run for political office, check with your ACS state chapter and your state’s medical society.

Factors that make a difference

The surgeons interviewed for this article all agreed that education, of themselves and of their colleagues, is key to success in politics. “Both sides are equally passionate about their side of an issue. You need to learn to educate passionately too,” Commissioner Mahoney said.

Representative Van Etten had similar advice. “I’m the only doctor in a legislature of 105. Surgeons are logical and analytical thinkers. Many are surprised by the fact that that’s not necessarily how decisions are made in politics,” he said, add-
“You can’t get married to a bill. You have to educate your colleagues and your constituents on why it’s important and that could take a while. You need to plan ahead. Take small steps.”

Representative Munoz has found that his time-management skills, which are essential for a good surgeon, are helpful in the legislature. “But as a surgeon,” he says, “you are isolated in your knowledge of the system.”

Once elected, most surgeon-legislators agree that regardless of their committee assignments, they are seen as the de facto resource for health matters—legislative and personal. “You need to be accessible to your colleagues on both sides of the aisle,” said Senator Foster.

Health issues matter

Not all of the legislation that elected Fellows work on is related to health care. Representatives, senators, and other elected officials will have limited success if they focus on only one issue. However, because the number of physicians in the state legislatures is limited, Fellows are in a unique position to influence health care in their states.

For example, Representative Chase is currently working on legislation that would help untangle the process of organ donation. In New Hampshire, when people indicate on their driver’s licenses that they want to be organ donors, that information currently sits in the Department of Motor Vehicles database and is not shared with any other agency or health care provider. Representative Chase is working on a bill that would connect that information to the New England Organ Bank.

Meanwhile, Senator Foster is currently working on legislation to increase access to common procedures to help decrease the number of uninsured persons and participating on the West Virginia Healthy Lifestyle Coalition Steering Committee. Convened in May 2005, the coalition is charged with encouraging and supporting healthy lifestyles in the state within four broad categories: Healthy kids/schools, healthy employees, healthy communities, and healthy supports.

Representative Munoz was one of the sponsors of the New Jersey Smoke-Free Air Act, which went into effect April 15. This act prohibits smoking in all indoor public places. An exception in the bill allows smoking in Atlantic City casinos. Several legislators are trying to close that loophole in the next legislative session.

Representative Van Etten is promoting a ballot initiative for the November 2006 election, which would increase the South Dakota cigarette excise tax by $1.00 per pack and increase the smokeless tobacco excise tax from 10 percent to 35 percent of the wholesale price. The first $5 million generated through the tax would be allocated to tobacco prevention, after which 34 percent would go to pay for Medicaid costs for smokers. Another 33 percent would go into a trust fund, and the remaining 33 percent would go to property tax reductions.

Get involved

Besides running for office, all surgeons can participate in a broad range of advocacy activities at the grassroots level, such as writing letters, meeting with legislators, and so on. Surgeons who want to participate in advocacy efforts in their states, learn about current legislative issues, or update the College’s State Affairs staff about potential issues in their states should contact Melinda Baker at 312/202-5363, or via e-mail at mbaker@facs.org.

Author’s note: The College would like to facilitate interaction among Fellows who are serving in elected positions in state and local governments. Please let us know if you have been elected to office so we can include you in this effort.
Transformation to a system that supports full patient participation

by Kathleen Heneghan, RN, MSN, Assistant Director of Patient Education, Division of Education;

Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education;

and Jack W. McAninch, MD, FACS, San Francisco, CA
A patient’s wife sits at the bedside in the hospital, vigilant and ready to assist in the care of her husband following his colorectal surgery. However, she is uncertain what she should be watching for or what she should be doing to help her husband’s recovery. He is discharged the next day with brief instructions about postoperative recovery, including the care of the colostomy. The couple is anxious about home management but told that the home health nurse will come the next day and do the necessary wound and ostomy teaching.

The potential problems with this scenario are evident. The patient and family are lacking the education, skills training, and competence to manage continued recovery post-discharge.

Though major emphasis has been placed on education for health professionals as a method to improve patient safety, there has been less emphasis on standardized education for patients and patients’ families. More than 100 studies have identified that patient education, skills training, and psychosocial support result in significant improvement in surgical outcomes.\(^1\)\(^-\)\(^3\) Despite the positive results from the patient education research, the national emphasis on patient safety and the government initiatives and standards—identifying that patients have the right and responsibility to participate in health care decisions\(^5\)\(^-\)\(^6\)—there has been minimal progress toward implementing standardized educational approaches to support full patient participation. Patients continue to come to the experience of having an operation with limited education to support informed decision making and full participation; they often leave the hospital with minimal skill acquisition for task execution and without the required knowledge to prevent decision errors.\(^6\)\(^-\)\(^9\)

Patients are discharged early and full participation in care is expected, yet there is limited training or validation of skills, and patients are often left to rely only on their memory as they continue their recovery at home. The critical role of the patient as an integral member of the surgical team is essential to achieve transformation to a safer health care system.

ACS vision and goals

The American College of Surgeons is at the forefront to build organizational support for change by implementing a patient education program that strengthens the healing relationship and empowers patients with the skills and knowledge needed for full participation in care. As identified in the Institute of Medicine report, Crossing the Quality Chasm: A New Health Care System for the 21st Century, health care should be safe, effective, patient-centered, timely, efficient, and equitable.\(^4\) Applied to patient education, safety is enhanced when patients can anticipate what is likely to happen and have the skills needed for decision making and providing self-care. An effective program is evidence-based and provides the necessary information to patients so that they can make informed decisions. Patient-centered education provides patients and families with the knowledge and skills needed to help reduce their risks of complications and support them in clinical decision making, in particular, post-discharge. A timely approach provides patients with access to education when needed—for example, before meeting with the surgeon—so that they can intelligently discuss and understand the options presented and to reinforce skills training and self-management postoperatively. An equitable and efficient system is cost-effective and collaborative among practitioners, patients, and specialty groups, and offers quality patient education to all individuals regardless of practice setting or location.

Recognizing the pivotal role of patients in the context of systems-based practice and patient safety, a new patient education program was officially launched in December 2004. The goals of the program are to help patients and their families become fully informed about the operation with current evidence to guide them in their decisions and empower them with the knowledge and skills necessary to fully participate in their hospital care and continued care post-discharge. We aspire to change the way surgical patients are educated, to improve patient health literacy and participation, and to maximize patient safety while supporting health professionals with a source of patient education based on current scientific data.
The program supports patients with educational experiences designed to meet a variety of learning styles and abilities. Education will occur through active engagement of the patient in the learning experience. The cognitive domain will be addressed through print, e-learning, and interactive education. Patient education will include the full spectrum of cognitive elements such as knowledge, decision making, and visualization and mental rehearsal of skills. Skills acquisition will be based on principles of contemporary surgical education. Skills training kits will provide didactic instruction; a clear description of the skill or task to be performed; and, most importantly, the opportunity for guided learning, including practice and demonstration of the skill, assessment of knowledge, and feedback on performance. The final stage of learning—care provided by the patient or family—will be assessed through a variety of patient outcome measures. The science of patient education will advance through a system structured for outcomes analysis and continued quality improvement.

An ACS Patient Education Advisory Committee (see box, this page) was appointed to design and implement a comprehensive patient education program. The first meeting of the advisory committee was in June 2005. Members bring extensive experience as leaders in the area of surgical education along with diversity in specialties, regions, and years in practice. In addition, the members are committed to educating patients so patients can partner with surgeons in management of their care and the transformation to a safer health care system.

Program planning

Curriculum planning for the patient education program began with a comprehensive needs assessment. The assessment included a review of current standards and guidelines, an analysis of the informed consent and surgical patient education literature, a review of patient education material currently available through professional surgical specialty organizations, implementation of a national survey of surgeons and surgical nurses of current patient education and informed consent practice, and expert consensus of leaders in surgery.

The review of current informed consent guidelines and surgical patient education guidelines included material from the Joint Commission for Accreditation of Health Care Organizations—Guidelines for Ambulatory Surgery Patient and Family Education and Planning Your Recovery—the Patient’s Bill of Rights, and informed consent guidelines published by the American College of Surgeons and the American Medical Association (AMA). (See Figure 1, page 14.) The guidelines outline the rights and responsibilities of patients to participate in their care and emphasize that patients must be given sufficient information to make decisions and to take responsibility for self-management activities.

A review of national and international professional surgical organizations’ Web sites was completed as part of the needs assessment of the patient education program. Professional health care organizations and associations are called to set the standard for excellence and commit to improving the system through the use of the best available evidence. They have a key role in their ability to change the culture and disseminate

### Patient Education Advisory Committee members

- Jack W. McAninch, MD, FACS, Co-Chair, San Francisco, CA
- Ajit K. Sachdeva, MD, FACS, FRCSC, Co-Chair, Chicago, IL
- H. Randolph Bailey, MD, FACS, Houston, TX
- A. Brent Eastman, MD, FACS, San Diego, CA
- Richard Finley, MD, FACS, FRCSC, Vancouver, BC
- Thomas R. Russell, MD, FACS, Chicago, IL
- Marshall Schwartz, MD, FACS, Philadelphia, PA
- Patricia L. Turner, MD, FACS, Baltimore MD
- Thomas Whalen, MD, FACS, New Brunswick, NJ

### ACS Staff Members:
- Kathleen Heneghan, RN, MSN, Assistant Director of Patient Education
- Patrice Blair, MPH, Associate Director, Division of Education
- Tanisha Woodson-Shelby, Administrator, Patient Education
information to patients and professionals. The purpose of the assessment was to determine (1) was patient education material available; (2) did the patient information meet the minimal criteria as listed in the Patient Bill of Rights—that is, procedure description, risks, and benefits; and (3) did the patient information meet the complete standards provided by the ACS for surgical informed consent and patient education, which includes a description of what to expect during and following hospitalization. Only six of the 59 surgical specialty organizations currently have complete patient education materials that meet the ACS guidelines for informed consent. Clearly, this represents an opportunity for collaboration and improvement.

Current practices were assessed through a national survey developed and implemented by the ACS Division of Education. The survey was completed by a random convenient sample of 363 surgeons and 820 perioperative nurses in the spring/summer of 2005. The purpose of the survey was to determine the availability of quality patient education materials in surgi-

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**Figure 1: Guidelines for patient education**

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<tbody>
<tr>
<td>Improve patients’ understanding of their assessed needs, options for procedures and anesthesia, and the anticipated risks and benefits of treatment;</td>
<td>Condition information  • When patient should feel better  • Return to and special instructions for daily activities  • Degree of assistance  • Signs and symptoms to watch for  • Home set-up  • Professional person to call after leaving hospital</td>
<td>Nature of illness and course of no treatment  Operation description  Estimated risks of mortality and morbidity  Complications  Benefits  Expectation during and post hospitalization  Alternative treatments including nonoperative14,15</td>
</tr>
<tr>
<td>Encourage patient participation in decision making about care;</td>
<td>Medication information  • Full list with written directions  • Food or drink you should avoid  • Side effects, including dizziness or confusion, which could lead to falls or forgetfulness</td>
<td><strong>Follow-up care</strong>  • Physical exercise  • Wound care directions  • Use of special equipment  • Follow-up tests and visits and transportation coverage  • Insurance review to determine what will be covered  • Home care services or assisted living12</td>
</tr>
<tr>
<td>Increase the likelihood that patients will follow their preoperative and post-procedure instructions;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximize patient self-care skills;</td>
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</tr>
<tr>
<td>Enhance patient participation in continuing care11</td>
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*Upon patient request, these guidelines must be provided, in writing, in a language they can understand.
cal practice, determine the needs of surgeons and perioperative nurses, and determine how the ACS can support and enhance the area of informed consent and patient education. The results identified that the most frequently used methods by surgeons for informed consent were oral review followed by oral review with hand-drawn images. Only 46 percent of surgeons had print material for the majority (greater than 50%) of their procedures. Significant findings of the study included overwhelming support for the ACS to develop easily accessible quality patient education materials with more than 94 percent of surgeons and surgical nurses indicating that it would be helpful for the ACS to develop education and informed consent materials in various formats. The need for patient skills education was very evident. Only 19.5 percent of surgeons and surgical nurses provided patients with any skills education materials and only 33.5 percent provided any opportunity for patients to demonstrate or practice skills required for surgical recovery (see table, this page).

These results are noteworthy because skills training produces the largest effect on reducing complications in surgical patients.1-3 There was a significant increase in the availability of patient education, skills education, and informed consent materials when hospitals and clinics had an active patient education committee.

A literature review on informed consent in surgery and surgical preoperative and postoperative education confirmed gaps in the content and method of delivery. An analysis of 540 consent forms from 157 randomly selected U.S. hospitals identified that 96 percent of informed consent surgical forms indicate the nature of the procedure, but only 26 percent included procedure, risks, benefits, and alternatives, and 14 percent provided adequate information to aid the patient with decision making.16 Evaluations of surgical leaflets identified only 14 percent that were considered suitable for content, 10 percent that met readability standards (eighth-grade level), and none that provided interactive learning simulation.17,18

Gaps were also evident during audiotaped surgical encounters. A review of 1,057 encounters of general and orthopaedic surgery identified that only 9 percent of the encounters met the criteria required for the patients to be fully informed about their surgical procedure.19 Furthermore, assessment of patient understanding and any offering of psychosocial support were rarely provided by physicians during medical encounters.20-25 These outcomes are noteworthy considering professionalism and humanistic communication skills are core competencies for physicians,26 and patient-centered communication increases patient and physician satisfaction, improves clinical outcomes, and decreases the likelihood of malpractice litigation.9,25,27-31 The use of informed consent guidelines by surgeons significantly improved the thoroughness and process of all informed consent categories with patients, including assessment of patient understanding and psychosocial support.32

A review of surgical patient education literature identified significant improvements in patient outcomes (such as length of stay, satisfaction, and compliance with activities) when content was delivered using methods where patients could see the skill performed—skills training, coping empowerment, and psychosocial support. The more robust studies that included all three domains had the largest improvement in all measured areas.1-3 Skills training produced the largest effect on preventing complications.

Availability of patient skills education:
Response of the ACS and the Association of periOperative Registered Nurses, Inc.

<table>
<thead>
<tr>
<th>Material available to visualize skills</th>
<th>Surgeon</th>
<th>Nurse</th>
<th>Surgeons/nurses</th>
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<td>16%</td>
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<td>Material available for patient to practice skills</td>
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Patient outcomes improved across all settings and populations when the information was provided in writing, used pictures, and emphasized the patient’s role in coping.

Timing and usefulness of education are also important elements to surgical patients. Patients expressed concerns that the admission day was confusing and fatiguing, and identified processing educational information on that day as “too much.” A frequent patient request was to obtain information at least one to three weeks in advance of surgery. Patients identified the need for more practical information at discharge. The requests included greater knowledge of their condition, more information about medications, how to manage activities of daily living, how to perform treatments or skills, what complications to anticipate and how to manage them, and support on interpersonal communications—that is, how to discuss their surgery and home care with family and others. Most information provided at discharge was delivered verbally, with only 50 percent of patients receiving any information in writing.

Expert consensus was the final needs assessment strategy for the patient education program. The ACS Patient Education Advisory Committee served as this group of experts. At the first meeting, members were provided information from various sources. Members shared their commitment to focus on patient-centered care, to empower patients, and to address a broad variety of educational levels. The following objectives were developed by the committee:

1. Create patient education resources in various formats to address the knowledge and skills of patients and provide guidance to patients regarding reliable information from the currently available resources. Material will include informed consent guidelines, preoperative and postoperative education, skills education, and discharge instruction. The electronic materials would be available on the ACS Web site.
2. Provide for ease of access and consistent information to all health professionals.
3. Establish national guidelines for patient educational materials and skills training in the preoperative and postoperative setting, with emphasis on the transfer of the requisite knowledge and skills to patients and their families.
4. Develop and evaluate innovative patient education modules, which are interactive and patient-centered and evaluate knowledge and skills performance.

Program implementation

ACS patient education Web site (www.facs.org/patienteducation). Patients and their families frequently turn to the Internet or the lay press for education, only to be exposed to information that is often inaccurate and inadequate to provide the education necessary to assist with decision making. The ACS patient education Web site was developed in collaboration with ACS Communications staff and has been designed to provide reliable patient education from current available resources. Collaboration is being pursued with the surgical professional specialty organizations that currently have material that meets ACS guidelines for informed consent and input from various programs in the College. The Web site contains patient and professional resources from the National Institutes of Health (NIH), the National Library of Medicine, National Practice Guidelines, and surgical and medical specialty organizations. Examples of educational material on the Web site include the following:

- Disease information from the NIH on disease description and management, tests, symptoms, injuries, and surgeries, many with illustrations
- Collaborative surgical information from the ACS and surgical specialty organizations arranged alphabetically by disorder; all surgical content meets the ACS informed consent guidelines
- Medications resources from the NIH drug information site that includes information on prescription and over-the-counter medications and herbs and supplements—drug information includes action; side effects; precautions; administration considerations including dietary, age, disease, and missed dose considerations; storage; emergency; and brand names
- Test and laboratory information from the NIH consumer health information site, including information on the purpose, preparation, and interpretation of the results
- NIH Interactive Education–X-Plain Interac-
tive provides easy-to-understand, animated, and audible tutorials on 80 procedures or conditions
• Cancer information links are provided to the American Cancer Society, National Comprehensive Cancer Network, and Collaborating to Conquer Cancer (C-Change)
• Medical library (PubMed)
• Surgeon locator links patients directly to the ACS Find a Surgeon site
• Pain-management resources: includes The American Society of Anesthesiology, American Pain Foundation, and COMPASS postoperative pain management resources
• Surgical Practice Guidelines from the National Guidelines Clearinghouse

Patient education print and e-learning material. Clear guidelines have been established by the Joint Commission for ambulatory surgical and hospitalized patients on informed consent, patient and family education, home care, and communication. Patients must be given sufficient information to make decisions, to take responsibility for self-management activities, to be involved in decisions, and to be educated to improve individual outcomes. A content analysis of several interactive patient education and risk-management commercial products was completed by the ACS Patient Education Advisory Committee and the ACS Advisory Councils. Following the review, it was determined that the available products in surgical patient education did not address the various goals of the committee.

Under the guidance of the ACS Patient Education Advisory Committee and the ACS Advisory Councils, print and e-learning materials are in development. All patient education material is being developed to meet the needs of persons with low health literacy and slow readers as well as to provide resources for patients with high health literacy. Content experts are involved in the development and review of the material. Educational and instructional design consultants, and the guidelines from the Centers for Disease Control and Prevention for creating easy-to-read print materials, are being used for development of materials.

Figure 2: Sample ACS patient education material
Patients are an integral part of system improvement. All ACS print and Web-based material will have a patient evaluation component to assess the validity of instruction and to determine if current information matches the patient experience and advances the science of surgical patient education. Investigational Review Board approval has been sought to obtain input from nonmedical individuals of various ethnic and educational levels on the usefulness of the new material. Interactive education will also be developed. The committee recognizes the need for quality print and Web-based material and also the need to update the current patient education material offered by the ACS.

Surgical skills patient education. Creating an educational experience that provides the learner with the opportunity to practice is essential for meeting the objective of responsibility for self-management of care. This goal can be achieved through simulations that give the learner the opportunity to learn, develop, and practice skills. Planning is under way for collaboration with surgical specialty organizations, instructional design specialists, and curriculum experts to develop a standardized template for interactive patient skills education. Train-the-trainer activities will be developed as part of this program. An equitable system provides access to high-quality education to all surgical patients.

Informed consent guidelines. Informed consent is basic to fostering open communication and trust in the surgeon-patient relationship. The Agency for Healthcare Research and Quality: Evidence Report/Technology Assessment identifies that incomplete consent is a significant patient safety issue. While the ideals for informed consent are pure, the process is often ineffective and inconsistent. Improper informed consent is also cited in 40 percent to 60 percent of all liability lawsuits, and the majority of liability cases involve issues of poor communication. Standard guides for informed consent specific to the procedure significantly improve thoroughness of information presented and assessment of patient understanding. The ACS is in negotiation with several commercial groups regarding procedure-specific informed consent documents.

Standards for patient education. The ACS has a long-standing commitment to patient safety. The Patient Education Advisory Committee recognizes the importance of patient education derived from evidence-based medicine, skills acquisition, and patient participation as a major strategy to improve patient safety. A statement confirming the importance of patient education was needed to promote awareness of the critical role of patients as integral members of the surgical team. The committee has developed the first draft of an ACS Statement on Principles of Patient Education for the ACS Board of Regents. The statement supports providing patients with the education and skills necessary to contribute effectively in their own care, and affirms the commitment of the ACS to its mission of improving the care of the surgical patient.

The interdependent relationship among patients, surgeons, and health care systems must be considered when designing educational programs on improving patient safety. The ACS is uniquely positioned to address the learning needs of patients and to facilitate a change in the culture to include the patient as an integral member of the surgical team. This change requires implementation and evaluation of patient education and skills acquisition along with train-the-trainer activities to support practitioners with patient skills education. Standardization and enhancement of patient education, discharge instruction, and surgical practice guidelines will provide the necessary infrastructure to support the entire surgical team to reduce complication and improve patient outcomes.

Feel free to contact Ms. Heneghan at 312/202-5352, or via e-mail at kheneghan@facs.org, or Dr. Sachdeva at asachdeva@facs.org, for more information.
References


Dr. McAninch is professor of urology, University of California–San Francisco, and chief of urology, San Francisco General Hospital. He is also a Regent of the College.
Over the past 12 months, I have received two calls from surgical colleagues who had suffered major myocardial events that altered both their professional and private lives. One had to retire from practice and the other worries every day that any pain he feels is related to his heart and then to his demise.

With these two phone calls, I thought back to my own experience. I had open-heart surgery on July 17, 2002, after developing severe angina when running toward Central Park while training for a New York City marathon. An angiogram showed that I needed a quadruple bypass and the hardest decision for a surgeon to make is whether to have major surgery, especially knowing how complicated it can be, as surgical complications are always reviewed weekly for medical students, residents, and faculty alike.

At my hospital, the morbidity and mortality conference is held on Wednesday mornings. As chief of surgery, one of my most cherished duties is to preside over the conference, which dissects the complications and operative misadventures of the previous week. The conference has always been billed as one that gives surgeons hope so they can learn from the mistakes of their peers; but this conference also helps surgeons gain knowledge of their own limitations and an awareness of imperfections that come with failures big and small in the operating room. It is sometimes a sobering experience when otherwise healthy patients, because of chance, have had a bad outcome. It is a weekly reality check.

Left: Dr. Wallack running the 2004 New York City Marathon.

Surgical lifestyles

Discovering life’s “chapter two” after surgery

by Marc K. Wallack, MD, FACS, New York, NY
With full knowledge of the almost infinite possibilities for failure, I gave consent for the intubation, incision, and invasion of my chest cavity to accomplish the one goal, which was to repair the “blocked coronaries” and allow me to survive. Speaking volumes about the confidence in the people who were brought together as a team, I gave permission for these men and women to hold my heart in their hands and gave up my control. Obviously, this is not easy for surgeons to do. We know too much. Just as at the weekly morbidity and mortality conference where I gently exposed the fallibility of the surgeons in my department, on the morning of the surgery I would expose my own humanity, frailty, and devout trust to those with whom I worked. I clearly understood all the risks but for the present time, the time of the surgery, there could be only one priority and that was to heal and then survive.

**Surgery from another perspective**

As I was rolled down the familiar halls of the operating rooms toward the cardiac suite, my mind was filled with the heavy weight of 19 years worth of memories of those conferences and the element of chance that creeps into all human endeavors. A swirl of facts and dull reminiscences came to light from years of being the operating surgeon in these same rooms. Moreover, the most incredible thought that occurred to me was that my surgeon was someone whom I had actively recruited to perform this procedure—but I had not intended for it to be performed on me.

Like some battles in war, battles in surgery are fought in tight places with fine, precise weapons. Sometimes there is no cavalry to call in times of overwhelming trouble. Not everything ends in typical Hollywood style, with the correctly colored wire on the bomb, about to detonate, cut with just one second to spare. Sometimes the good guys lose. I have seen it so many times in my own general surgery and oncology practice. I hoped and even prayed that this was not such a time. I did not want to be presented at the next morbidity and mortality conference, and I wanted to be an inspiration for my colleagues to show that there can be a “chapter two.”

I entered the cardiac operating room and it was here—in this cold, Spartan room with people who knew and understood the concept of the morbidity and mortality conference—that I was forced to give up control of my future, my vitality, and perhaps my very life. If all went well, I would be represented by a number next week in the department statistics; if it didn’t go well, there would be no more than two pages describing the misadventure played out of the peculiar stage of thoracic and cardiac anatomy, which had ended either in a complication or, worse yet, a death—my death. These thoughts came to an abrupt end with the haunted amnesic properties of sedating drugs, merciful intubation, and intravenous paralytics.

**Awakening**

The awareness that comes with awakening from anesthesia is gradual, fuzzy, and surreal. I only imagined I would be in the cardiac intensive care unit moments before I was discharged to the floor, but I had been there for 12 hours. Most importantly, I did not remember being intubated. I saw my wife’s face and could see the love and the tremendous passion she had for wanting to help me to survive. My children’s eyes were wide open and they did not need to say a word, but I knew that, despite having spent many long hours away from them at many different hospitals in my lifetime as a surgeon, they loved me and wanted me to be in their lives.

I spent three days in the hospital and was discharged on the third postoperative day. Being a surgeon did not help because I knew too much and was constantly worried even at home about potential complications. But as the time passed, despite the success of the surgery, it became apparent that what was left behind, like the uncounted sponge, was a sense of impending doom, a foreboding of the immediate personal mortality that comes with a near miss. Even if cardiac surgery leaves a person alive, it is a near miss.

**Surviving a near-miss**

I am sure that sense of mortality is what my two surgical colleagues were feeling when I talked to them about their myocardial conditions. In the same way that a near-miss car accident might cause a person to drive more slowly, the memory of a near-death experience forces a reinvention of one’s life, a close examination of life passed and missed opportunities. The potential for future missed opportunities of similar magnitude, real
or imagined, lead to an anxiety-depression that does cast a pall over every second of every day that follows the intervention. One might think, “There has to be a way to sort out the whole thing.” The passing of time to allow for mourning is only part of it.

There are battles that can be won with physical prowess, those that can be won with strategy and tactic, and those that can’t be won alone. The sternal wound was healed in weeks. The leg wound was healed in a month. But three years later, the other wounds still continue to heal. How does one overcome the fears and suspicions about the future, tunneling just under the surface? How does one, given past failures, which now seem so irrelevant, navigate the road that lay ahead? Just as the anatomic lesion blocking oxygen delivery distally to a consummate professional to bypass, the psychic lesion was amenable only to a similar, yet disparate professional—a point that all surgeons in distress must understand. However, I knew that, for the most part, there is no room in the collective wisdom of the American success story for weakness, especially weakness of mind.

If a person is to be successful, he or she must be strong. Yet, when that person is abruptly taken by a devastating event, part of the coping mechanism is systemic distress, and that can only be overcome with the help from loved ones and professionals. Surgeons, as a rule, don’t like to consult other professionals, but in my opinion, a life-altering event dictates such circumstances.

**Ways of healing**

If one issue had strengthened for me since the incision, sternal sawing, and vein harvest, it was the conviction that no one is alone. No army commander would go into battle against overwhelming odds without backup. No one intentionally goes into harm’s way alone. Those who go willingly, go with their teams of trusted associates at their side, protecting them and moving them toward the common goals. In my case, it was my wife, my mother, my children, my brother, select friends and colleagues, certain professionals, and a higher being who formed that small platoon to help me fight and claim chapter two of my life.

Sometimes the ways of healing are not explained in surgical texts, are not accounted for in the body of knowledge that we lovingly and carefully pass to those eager to follow in our footsteps. Sometimes the truths are deeper and veiled and cannot be dissected like the saphenous vein. In those cases, the lingering effects of disease are not manifested in decreased, bursting strength; reduced exercise tolerance; and reaccumulating extraluminal foam cells. Long after those complex biochemical properties have been successfully modified, the real lingering effects are located in a different part of the anatomy. These effects—such as fear of the possibility of those chaotic and intricate variables once again coalescing in clinical disease; the pain that the incision on one’s chest caused in another person; or the blame leveled even at oneself for having become ill, causing a person to doubt his or her previous lifestyle choices—are so unacceptably slow to improve. Without attention to these issues, too, there is no meaningful survival and these questions provide the foundation for survival in chapter two.

The selflessness that we regard so highly in our fellow surgeons is what separates those practitioners who should not be in surgery from the practitioners who should. But that laudable characteristic of self-sacrifice is a weapon with two edges. If a similar value were placed on the wisdom necessary to balance one’s life, our successors might learn from our mistakes the way we expect them to learn from our complications. In the weekly conferences, our colleagues might ask for help of all kinds before the fates deal them an unwinnable hand.

I would like to break the cycle of what we could call “altruistic self-destruction” that we as surgeons enter into with pride and that we try to instill and sometimes inflict on those who seek to join us. This approach is not a softening of our mental outlook on ourselves but a “shoring up” of these cracks in the bulwark. In the 21st century, there can be left no room in the American construct for willful blindness from trouble. For me, the new paradigm was to adjust my life to the workplace so I could live and continue to work. For me, it meant to live more with ease, eat well, rest, enjoy family, exercise, get proper medical care, listen to my body, and shut out those who didn’t understand my experience and could not relate to it. It may not be a path for success, but it should allow a person to live.
Choosing and facing a new challenge

One of the most important parts of my rebirth took place just two weeks after my open-heart surgery when, at home, I read Lance Armstrong's book, *It Is Not About the Bike*. I knew then what I had to do to prove to myself that I was ready to engage in life again, that I was not to be a victim, and that I would return to perform my job and be involved with my family and friends. How does one return from such devastation? Can there truly be a second chapter? What scale of victory can possibly overcome such a fantastic and devastating defeat?

For me, my illness was “not about the marathon.” I had run in four New York marathons and numerous shorter road races to “maintain my health” and “keep my vessels open” before my surgery. Therefore, the pinnacle of my ability to control my own destiny lay in 26.2 miles of concrete and steel bridges, aged in the lore of those who completed such races before, and wizened with the sweat and blood of countless generations of those who yearly seek to memorialize an ancient sea battle with a personal triumph. Before this, the marathon was a simple milestone. It was an achievement, make no mistake, that confirmed membership in an elite fraternity that counted those who had sustained a personal victory over adversity and physical and mental limitations; it was proof-positive that the human body was capable of extraordinary feats if the mind so allowed it.

But in 2004, the marathon had the power to be more than just that hallowed parade of those out to test mind and body. It was more than a roll call of heroes, in a traditional Greek tragic sense, in which I again sought membership. In 2004, two years after my surgery, running the marathon marked my return from the dead and indicated that I had reclaimed my life. It was a return from the darkness to the light. The realization was that life could continue, that youth might be regained, and that possibly I had dodged a rather lethal bullet. Gone was the deadly fear of death, of living life unfinished, of bargaining for one more day. Gone were the haunting thoughts of personal and professional frailties, and along with the physical and mental victory, the operating room became comfortable again. Shrinking into the background against the Verrazano Bridge on Staten Island were the thoughts that my life and career would be a tragic footnote in a greater story, which had as its centerpiece something else. The whole affair was starting to look like a speed bump and not a dead end.

The personal journey, which started my career now spanning to four decades, is turning to a new chapter. I believe what I learned, though personal, is important for the discipline of surgery as a whole. If others, as my two colleagues whose major myocardial events prompted me to write this article, can grasp an understanding of what this experience was like for me, perhaps my hard-fought lessons will be of some use other than just an inspirational story of “man runs marathon after heart surgery” on page 16 of the newspaper. Maybe it will cause others to move to chapter two with assuredness so involvement in our careers and in our life can be sustained and maintained.

Author’s note: The author wishes to thank James Feeney, MD, for his assistance in the preparation of this article. Dr. Wallack encourages surgeons to send their comments regarding this article via e-mail to itsthesarg@aol.com.

Dr. Wallack is chief of surgery, department of surgery, Metropolitan Hospital Center, New York Medical College, New York, NY.
Authors’ note: This is the second in a series of articles the authors have prepared for publication in the Bulletin, focusing on how the crew resource management (CRM) training techniques used in aviation may be applied in surgery and health care leadership. In the first article of the series (Bull Am Coll Surg. 2006;91(2):10-15), we presented the basic concepts of CRM training and its possible applications in the operating room. In this article, we focus on the seven principles for leading high-performance teams.

CRM training centers on the following seven skills that leaders of high-performance teams should possess: (1) command, (2) leadership, (3) communication, (4) situational awareness, (5) workload management, (6) resource management, and (7) decision making. This article provides details about why these competencies are important in directing a group of other very knowledgeable professionals and how these abilities may be acquired and applied.

Command

The concept of command should be addressed first to dispel any misconceptions that CRM in health care leadership would have a weakening effect on surgeons’ authority in the operating room. An individual takes command whenever exercising the duties of a team leader. So although health care leadership does empower all team members to offer their input, only one person has the final authority and makes the judgment calls.

Once the leader chooses a course of action, his or her next responsibility is to get the team to rally around the decision. At the same time, individuals who take command in health care leadership situations also must be willing to assume...
responsibility and accountability for their team’s actions. The team should view them as the final authorities, and they should ensure that all of the colleagues’ efforts are coordinated to provide maximum efficacy.

**Leadership**

Leadership is probably the broadest and most complex element of CRM. Leaders allow team members to exercise their rights, obligations, and responsibilities as appropriate for ensuring a safe, efficient, and successful outcome. Leaders maintain a team climate and provide an atmosphere that is conducive to open communication. Leaders act as mentors, teaching fellow team members the unwritten “tricks of the trade,” in terms of conducting a procedure and of understanding the institutional culture. Leaders are professional. They expect excellence from themselves and from the rest of the team. Strong leaders also recognize that conflict often is healthy and can breed better outcomes. However, they also manage and resolve disagreements before they fester into destructive arguments.

**Communication**

Effective communication is the single most important component of health care leadership. A surgeon can have the best diagnostic skills, finely tuned situational awareness, advanced equipment, and excellent decision-making abilities, but without the ability to effectively communicate, all these other attributes are rendered useless in health care leadership.

Communication is the glue that holds teams together. When high-performance groups interact effectively, everything else just naturally falls into place. Teams that fail to communicate are assured negative results.

Communication in health care leadership is best described as the effective and timely exchange of ideas, information, and instruction. Such interactions ensure that messages are clearly received and understood, are two-way, and benefit all involved parties.

The exchange must occur in a timely and effective way to ensure a positive outcome. For example, if during the dissection of the deep lobe of the parotid gland for a recurrent tumor, the assistant notices that the surgeon is about to cut a main branch of the facial nerve, he or she should issue an assertive and confident warning. For example, saying, “Stop! I believe that is the nerve,” would be more effective than saying, “Shouldn’t we be trying to identify the branches of the nerve?”

Methods of ensuring clear communication include the following:

- Inquiry: Using questions to ensure a meeting of the minds
- Advocacy: Tactfully and effectively making a point.

Skillful communicators also recognize the barriers to communication. Barriers to communication include steep hierarchies, fatigue, stress, cultural differences, and many other complications. Almost without exception, studies of the human factors related to adverse events prove communication failure to be a causal factor.

**Situational awareness**

Situational awareness is defined as an understanding of what is happening in the surrounding environment and why. It may seem that this is an obvious statement, but the fact is, no one is omniscient. An effective leader relies on the team to promote situational awareness through effective communication about what is occurring.

A key to situational awareness is reviewing the past and using that knowledge to draw conclusions about the present scenario. Individuals who have situational awareness go on to monitor the current circumstances, accurately predict what’s likely to happen next, and prepare the team for the anticipated outcome.

**Workload management**

Workload management involves organizing tasks in such a way that the workload is equitably distributed among the team members. An effective team is ready for any contingency and prevents any individuals from becoming overwhelmed while others have too few tasks. Effective team leaders “plan the work and work the plan.” A comprehensive briefing before a procedure ensures everyone is doing the right job at the right time, and effective communication and situational awareness throughout the procedure allow everyone to stay on task. Effective leaders also know how to delegate to make certain neither they nor anyone else on the team is overtaxed.
Resource management

Resource management is the optimal use of all available information and other forms of internal and external forms of assistance available to the team. Like workload management, it calls for making maximal use of what is available to create a positive outcome.

During the preoperative briefing, the team should spend some time discussing potential needs and identifying the resources available to satisfy those demands. If a resource is not immediately available, the team should determine how to access it. The team leader should think ahead about which resources will be of greatest necessity and make sure that the people using the instruments understand their functions and how to apply them.

Decision making

Decision making is the process of determining and implementing a course of action and evaluating the outcome. If communication is the glue that holds a team together, good decision making is the desired end product of health care leadership.

Following are three approaches to decision making, each having its place and its advantages and disadvantages:

- Collaborative: The democratic method under which every person has a final say. Leaders of high-performance teams are strongly discouraged from using this approach.

- Unilateral: One person makes the decisions. This method is fast and effective, but problems could arise if the team is not fully trained to step in should something prevent the leader from completing the mission.

- Consultative: The leader establishes a collegial rapport with the team members and captures their collective wisdom. The leader must know when and how to stop gathering data and avoid letting perfection be the enemy of good.

Ultimately, we have found that the consultative approach is most effective in coordinating high-performance teams of intelligent, skilled professionals.

Conclusion

The seven principles of CRM can be applied effectively in health care leadership. The proper and careful application of these concepts will ensure that the surgeons effectively lead surgical teams in the provision of high-quality care.
by: M. Margaret Knudson, MD, FACS, San Francisco, CA;

Jay A. Johannigman, MD, FACS, Cincinnati, OH; and

James Betts, MD, FACS, Oakland, CA
The following e-mail initiated the incredible journey of Saleh Khalef, a young Iraqi boy whose courage earned him the nickname “Essed” (Arabic for “Lion Heart”) and who touched the lives of hundreds of people from an Air Force base in southern Iraq to a compassionate community in northern California. Saleh’s story demonstrates what is possible when surgeons work together, be they military or civilian surgeons, trauma or pediatric surgeons, located in a modern pediatric hospital or in a tent in the desert. Saleh’s story is a reminder of what a privilege it is to be a surgeon with the skills to save a life.

E-mail from Dr. Johannigman to Dr. Knudson, 19 October 2003:

From: Jay A. Johannigman
To: Peggy Knudson, MD
Subject: Saleh

Dr. Knudson,

I need your pediatric trauma expertise. Yesterday afternoon we were called by our outside perimeter gate and told that there was a Red Crescent vehicle with a child in it. When we got out there, we found a desperately ill child who had picked up a land mine eight days ago and it exploded, maiming him and killing his brother. The civilian hospital in Nasiriya apparently explored his abdomen and found liver lacerations, greater curve of the stomach lacerations, and descending colon injuries.

We transported him back to our facility with flies clinging to all of his dressings, which were purulent and had obviously not been changed in days. When I opened his abdominal dressing, his entire anterior abdominal wall was gone from necrotizing gangrene secondary to the blast effect, and there is evisceration of small bowel. We took him to the OR and I was able to mobilize his small bowel into a central position and repaired a few obvious serosal spot injuries from shrapnel. The right upper quadrant had a large purulent biloma from his suture hepatorrhaphy and I found a missed antral injury. His greater curvature was soaked into his colon with what appeared to be O-silk sutures to repair the stomach. The descending colostomy was viable. We had to resect his abdominal wall out laterally to put him into an IV irrigation bag for a silo.

I was able to manually place a Dobhoff feeding tube across the pylorus and into the jejunum. We also took down the right hand dressing and were staring at the distal radius necrotic, dried out and purulent. We revised that to a formal mid forearm with our orthopaedic surgeon. The left hand has no fingers left, only a partial thumb. His left eye had a tarsorrhaphy and the globe is blown and necrotic. I have never seen anything like this. We debrided the O-ethibond sutures used to close his facial wounds and took him to the ICU. We made it through the night and he is extubated and talking to his father. I am going to take him back for a second washout tomorrow.

Any words of wisdom? Say some prayers!

Saleh and his 16-year-old brother, Dia, lived in the small town of Bada’a, north of Nasiriya, Iraq. His father, Raheem, drove a taxi for a living while his mother, Hadia, cared for the family’s three young children. Saleh and Dia were just returning to their school, which had been closed for seven months while it was occupied by Sunni militants who were holed up there. On the way home from that first day of school, Saleh picked up what he thought was a ball, but then began to cry as he realized what it was. His brother Dia ran to his side, but before he could grab the device from Saleh, it exploded. Saleh was rendered unconscious, his abdomen torn open, his right hand gone, and a piece of shrapnel torn through his left eye, lodging in his brain. Dia was missing much of his right thigh and had shrapnel lodged in his neck. He was still conscious and was rushed by car to Saddam Hussein Hospital in Nasiriya, where he bled to death. The younger boy was rushed to a small hospital closer to the scene, but later transferred to the larger hospital in Nasiriya, 40 miles away. It soon became clear, however, that even that hospital lacked the facilities and the expertise to care for such severe injuries. The physicians provided
basic care but informed Saleh’s parents that his only hope of survival would be in the hands of the American physicians.

The next day, Raheem drove to Tallil Air Base and begged the medical personnel to accept Saleh in transfer. Eventually, the young child was presented to Dr. Johannigman, who was deployed to Tallil Air Base during Operation Iraqi Freedom. Dr. Johannigman is the chief of trauma at the University of Cincinnati, the Chair of the Committee on Trauma for the State of Ohio, and a reservist in the Air Force. Dr. Johannigman and his fellow surgeons at Tallil performed the initial surgery on Saleh and then undertook the formidable task of attempting to provide intensive care support in a makeshift hospital that was in the desert.

E-mail from Dr. Johannigman to Dr. Knudson, 21 October 2003:

From: Jay A. Johannigman
To: Peggy Knudson, MD
Subject: Saleh, Part II

I am feeling pretty bad right now. Saleh had a major upper gastrointestinal bleed and we had to reoperate. We found a classic perforated duodenal ulcer at his previous repair of the anterior wall of the stomach and found both a leak and the site of arterial hemorrhage, which had been responsible for the bleeding. We transfused him four units of blood, a major amount for a 20 kg kid. We almost lost him. Once again, he extubated easily and is back in the silo. His pulse is down to 120 and he is awake and oriented, talking to us and pleading in Arabic for water. He has the heart of a lion! (The Arabic name for lion is Essed.)

We held a prayer service for him and several soldiers touched his head as they prayed. His father and I have become very close and I am reminded of my own son at home, who is the same age as Saleh. Keep your fingers crossed.

• • •

Despite the complications and the need for repeated trips to the operating room, Saleh continued to thrive. Someone managed to track down some cans of Ensure, so Saleh was able to get some
nutritional support. The orthopaedic surgeon, Eric Fester, MD, worked hard to preserve function in Saleh’s remaining hand. However, there was no material to provide any reasonable coverage for his abdomen, thus placing him at risk for continued sepsis and for the development of intestinal fistulae. Dr. Knudson, who had been successful in introducing the wound VAC (KCI, San Antonio, TX) dressing into the San Francisco General Hospital, had some ties with that company’s local representatives. She was soon put in contact with Charlie Blitz from KCI’s international division, who approved her request to ship the VAC materials over to Iraq. Within 72 hours, Dr. Knudson received the DHL package tracking number and followed the shipment’s progress as it left Southampton, UK, for London-Heathrow, then on to Bahrain, and finally to Baghdad.

When a DHL delivery truck arrived full of wound VAC materials on a Sunday, neither Dr. Knudson nor Dr. Johannigman could believe the generosity of the KCI company in donating the machine and all the accompanying dressing materials. Within hours, Saleh’s abdomen was covered for the first time with a “real” dressing.

Soon, however, another problem arose. Dr. Johannigman’s tour was almost over, and he was concerned for the child’s fate once he left. Dr. Knudson called her friend and colleague, James Betts, MD, FACS, the surgeon-in-chief and director of trauma at Children’s Hospital, a Level I pediatric trauma center in Oakland, CA. Drs. Betts and Knudson had worked together for many years as part of the ACS Committee on Trauma in northern California. Dr. Betts met with senior administrators from Children’s Hospital, who generously agreed to accept the child in transfer if all the physicians who would be caring for Saleh would donate their time, and if the Air Force could arrange transportation. The generosity of the Children’s Hospital in Oakland and the expertise of their medical staff opened a door of opportunity that would provide a ray of hope thousands of miles away.

Three weeks after his arrival at Tallil Air Base, young Saleh and his father were loaded onto an Air Force Critical Care Aeromedical Transport unit and were heading to Ramstein Air Base in Germany, for the first leg of a 36-hour plane ride to Children’s Hospital in Oakland. The going was not smooth, however, as Saleh was febrile and having difficulty breathing. He was accompanied by Robert Singler, MD, the Air Force anesthesiologist who had worked on him in the temporary operating room in the tent at Tallil.

E-mail from Dr. Singler to Dr. Johannigman, 10 November 2003:

From: Col. Robert Singler
To: Jay A. Johannigman

Saleh has arrived here in Oakland via REACH helicopter from Travis Air Base and is in terrific
hands with Dr. Betts. I have just finished a lengthy and cordial discussion of Saleh’s entire course. The care team has plans to do all the things we wish we could have done at Talil, and he is scheduled for his first operation here tomorrow.

The last leg of the flight was much like those previously, with repeated oxygen desaturation events. A new issue was the first rigor that I had seen, which persisted for 20-30 minutes until Tylenol and the next dose of antibiotics took hold. [Saleh’s] Dad is holding up well and wanted me to express his profound gratitude, Jay, for all that you have done. The Iraqi community here (in Oakland) has already established an account and is collecting donations for Saleh’s care and to support the family left behind.

• • •

When Dr. Knudson walked into the ICU at Children’s Hospital and first saw Saleh, she had to walk out to be sure that his father did not see the shocked look on her face. A veteran trauma surgeon who has cared for numerous seriously injured adults and children at the University of California/San Francisco General Medical Center, Dr. Knudson was not prepared for what she saw: an emaciated, 38-pound child with facial scars; a missing eye, limb, and hand; and a cry that was gut-wrenching. She later learned that Saleh wanted only to “hide under the bed and be left to die” when he first arrived. On many occasions, his father was unable

Loading onto Air Force Medical Air Evacuation Unit for transport to Germany.

Skin-grafted abdomen six weeks after the initial injury.
to console him, and it was clear that he missed his mother.

Quickly, the team of surgeons, headed by Dr. Betts, began their work on Saleh, removing the central line that had made him septic, and replacing it with a clean one for much needed nutrition. A computed tomography scan of his head demonstrated the shrapnel in the brain, and he subsequently developed seizures as a complication. Despite his malnourished state, however, his abdominal wound was clean and was already showing signs of healing under the VAC dressing. A plastic surgeon worked on his ear, face, and remaining hand, while an ophthalmologist performed several operations to prepare his socket for an artificial eye. The ICU team and rehabilitation therapists worked diligently to speed his recovery. In January 2004, Saleh was finally able to be treated as an outpatient, although he and his father lived in

Children's Hospital Oakland, two months after injury. Pictured are Dr. Knudson, Saleh’s father Raheem, Dr. Johannigman, Saleh, and Dr. Betts.

Reunited with his mother and baby brother in Oakland one year later.
housing provided by the hospital on the grounds of Children’s Hospital.

One year later, after more than 32 operations, Saleh is able to attend school in Oakland, while his father works in environmental services at Children’s Hospital. He has learned English and is able to write and draw with the aid of a prosthetic device. He will require more surgery to close his large abdominal hernia and continues to see Dr. Betts on a regular basis, but for now, he is enjoying the recent arrival of his mother, two younger sisters, and new baby brother, who have been granted political asylum. He continues to serve as a reminder to all of us that through the generosity and expertise of many individuals working together, something can be salvaged from the wreckage of war.

**Disclaimer**

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Air Force or the U.S. government.

**Authors’ note:** San Francisco Chronicle newspaper photographer Dianne Fitzmaurice won a Pulitzer Prize in 2005 for her photo essay of the “Lion Heart” story.

**Dr. Knudson** is professor of surgery, University of California, San Francisco, and attending trauma surgeon, San Francisco General Hospital. She is also Vice-Chair of the ACS Committee on Trauma.

**Dr. Johannigman** is Colonel, USAFR MC FS, associate professor of surgery and chief, division of trauma and critical care, University of Cincinnati, OH. He is Chair of the Ohio COT.

**Dr. Betts** is surgeon-in-chief and director of trauma services, Children’s Hospital, Oakland, CA, and clinical professor of surgery and urology, University of California, San Francisco.
The ACS Board of Governors’ Committee on Chapter Activities (GCCA) was founded in 1972, with the stated purpose of “serv[ing] as an advocate for all of the College’s Chapters, and monitor[ing] and report[ing] on Chapters’ activities, resources, and issues.” This committee reports to the Board of Governors and Board of Governors’ Executive Committee and is staffed by the College’s Division of Member Services. The GCCA has four subcommittees: Advocacy and Coalitions (Gary Brian Williams, MD, FACS, Chair), Meetings and Organization (Alfred Edward Chang, MD, FACS, Chair), Membership and Diversity (Sally E. Carty, MD, FACS, Chair), and International Activities (Anton Nicholas Sidawy, MD, FACS, Chair).

The GCCA is an extremely important committee in the sense that the chapters are really where the grassroots movement for Fellows begins. Without chapters, it becomes impossible to get day-to-day problems from the local level to the Chicago, IL, office and the Board of Governors. The GCCA is charged with being the portal between individual chapters and the College as a whole; we can be a direct link between the everyday practice of surgeons and the Officers and Regents of the College. Furthermore, the College has greatly expanded its advocacy assistance and services available to College chapters—the Committee on Chapter Activities is available, ready, and willing to respond to problems if the need arises. It is a privilege to chair this committee.

**Advocacy and coalitions**

In 2005, there were several conference calls with State Advocacy Representatives, which led to the issuance of a letter to Chapter Presidents and Governors. This open letter discussed the importance of advocacy activities at the state level and the offer of assistance from the College State Affairs staff to help chapters with advocacy training or state advocacy strategies and programs.

In addition, the Surgery State Legislative Action Center (SSLAC) was a more effective tool in 2005: 2,598 letters were sent to state legislators via the SSLAC, compared with the 845 letters sent in 2004.
The SSLAC was particularly useful for states where proposals for cosmetic surgery taxes and medical liability reform bills were on the table.

The state legislative affairs staff is currently looking into purchasing or subscribing to an online system for tracking legislation.

Meetings and organization

The Subcommittee on Meetings and Organization updated its chapter performance checklist—it is now a measure of performance indicators, comparable to a report card.

The four performance indicators for chapters are as follows:

• Sustainable leadership, which measures chapter representation, including councils, Young Surgeons, Association of Women Surgeons, Committee on Trauma representatives, surgical department chairs, ACS Governors-at-Large, and so forth.

• Supportive administrative structure, which assesses the number of meetings and conference calls held each year, the number of representatives sent to the Leadership Conference and Resident-Associate Society annual meeting, and other similar participation.

• Enthusiastic member involvement, indicated by contact with initiates, membership market share, provision of continuing medical education (CME) and Resident competitions/awards, and so on.

• Worthwhile member services, including CME programs, general membership meetings, communications such as newsletters and Web sites, and advocacy activities.

The GCCA has prepared and distributed indi-

continued on page 64

Members of the Governors’ Committee on Chapter Activities

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Leopold M. Waldenberg, MD, FACS
Gary Brian Williams, MD, FACS, Chair, Advocacy and Coalitions Subcommittee
Tatsuo Yamakawa, MD, FACS

Dr. Lynn is a general and vascular surgeon in private practice in West Palm Beach, FL, and is Chair of the Governors’ Committee on Chapter Activities.
Because of the combination of soft tissue, osseous, vascular, and nerve involvement, complex extremity trauma requires prompt and precise evaluation and management to attain optimal outcome. Patients sustaining these unique injuries are at high risk for ischemia, wound infection, delayed union or non-union, and chronic pain, not only because of the anatomy of their injury, but also the prevalence of associated multisystem trauma and systemic problems related to the mechanism of injury. Although the treatment goal remains extremity salvage, these injuries carry a high potential for morbidity and amputation.

Prognostic factors for limb salvage following complex extremity trauma include the following:
- **Time:** There is a linear and direct correlation between delay in revascularization and limb loss
- **Mechanism:** Blunt or high-velocity penetrating trauma has a worse outcome than simple, low-velocity penetrating trauma
- **Anatomy:** Lower extremity vessels have worse prognosis of salvage than upper extremity vessels; the popliteal artery has the overall single worst prognosis for salvage
- **Associated injuries:** Severe associated injuries decrease the ability to pursue limb salvage
- **Age and physiologic health:** Older patients and those with significant comorbidity have a higher risk for amputation
- **Clinical presentation:** Patients presenting in shock and those with extensive soft tissue destruction are more likely to undergo primary amputation
- **Environmental circumstance:** Forward combat zone, austere environment, and multicasualty events may warrant primary amputation as a logistic necessity.

Unfortunately, the data regarding the management of complex extremity trauma are conflicting and Class I studies are lacking. In an effort to provide guidance and a rational approach to the initial evaluation and treatment of complex extremity trauma, the ACS Committee on Trauma, Ad Hoc Committee on Outcomes, has combined recommendations based on the best available evidence with expert consensus in preparing the protocol shown in the figure on this page. This protocol provides an algorithmic approach to complex, penetrating, and blunt extremity trauma and is supplemented by the Eastern Association for the Surgery of Trauma (EAST) practice management guidelines for penetrating trauma to the lower extremity (www.east.org). The protocol takes into account the prognostic factors listed previously and provides information regarding the diagnosis and treatment of complex extremity trauma. Technical aspects of limb salvage and amputation are also discussed. Because of space constraints, the annotations for the algorithm have not been included; however, they can be found on the American College of Surgeons Web site (www.facs.org) and on the ACS Web portal under the trauma com-

*This site also provides more detailed discussion on arterial and venous injuries.*
Purpose

To evaluate the care given to trauma patients in relationship to the eventual health status and well being of the patient and his/her family after a course of treatment is completed. This evaluation would encompass all areas of care including prevention, pre-hospital, resuscitation, interventions, intensive care, floor care, disposition, and rehabilitation. The evaluation would be specific to outcomes achieved in all of the above-mentioned areas.

Objectives

- Evaluate and publish existing outcome information on trauma care.
- Identify meaningful outcome end-points for trauma care delivery and establish trauma center benchmarks with respect to the following parameters:
  — Mortality
  — Morbidity
  — Return to pre-injury activity and quality of life
  — Patient and family satisfaction
- Identify methods to evaluate care plans for outcome assessment.
- Establish evidence-based guidelines for the treatment of specific injuries that can be prospectively measured and studied with respect to outcomes.
- Collaborate with the Performance Improvement and Patient Safety, Trauma Registry, and National Trauma Data Bank® subcommittees to study existing outcome information and establish guidelines that can be utilized by trauma centers in their care of injured patients.
- Collaborate with the Office of Evidence-Based Surgery of the American College of Surgeons in the development of outcomes-based guidelines for trauma care.

Roster

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Dr. Pasquale is chief, division of trauma/surgical critical care, Lehigh Valley Hospital, Allentown, PA, and associate professor, Penn State University.

Dr. Frykberg is professor of surgery, University of Florida College of Medicine, and chief, division of general surgery, Shands Medical Center, Jacksonville, FL.

Dr. Tinkoff is medical director, trauma program, Christiana Care Health System, Newark, DE, and clinical associate professor, Thomas Jefferson University, Philadelphia, PA.
J. Wayne Meredith, MD, FACS—the Richard T. Myers Professor and chairman and director, division of surgical sciences, at Wake Forest University School of Medicine in Winston-Salem, NC—has been named the new Medical Director of Trauma Programs of the American College of Surgeons. Dr. Meredith’s term as Medical Director began in March.

A 1974 graduate of Emory University in Atlanta, GA, Dr. Meredith earned his bachelor of arts degree in physics. He earned his medical degree in 1978 from Bowman Gray School of Medicine in Winston-Salem. He performed his general surgery internship (1978–1979), general surgery residency (1979–1984), research fellowship (1981–1982), and cardiothoracic surgery residency (1984–1986) at Bowman Gray/North Carolina Baptist Hospital. From 1986 to 1987, he had a trauma/critical care fellowship and was a visiting assistant professor of surgery and trauma at Oregon Health Sciences University Hospital in Portland.

Dr. Meredith has spent much of his professional life in Winston-Salem, both at Bowman Gray and at Wake Forest University. From 1987 to 1990, he was assistant professor of surgery at Bowman Gray; from 1990 to 1997, he was associate professor. At that same time, he was associate director from 1990 to 1993, and director from 1993 to 2003, of the burn center at Wake Forest University Baptist Medical Center (BMC). From 1987 to 2002, Dr. Meredith served as medical director of the trauma center at Wake Forest BMC, and from 1996 to 1997, he was the interim chairman and associate program director in the department of general surgery at Wake Forest University School of Medicine.

Currently Dr. Meredith is residency program director and chair of the department of general surgery (since 1997), is director of the division of surgical sciences, and holds a cross-appointment at the Institute for Regenerative Medicine (since 2004) at Wake University School of Medicine. In addition, since 2000 he has been the chief of surgery at North Carolina Baptist Hospital.

Dr. Meredith became a Fellow in 1990. He has been a member of the ACS Committee on Trauma (COT) since 1991. He has been a member of the Trauma Verification (1994–2002) and Verification Review (1996–2002) Committees and he served as Chair of the National Trauma Data Bank® (NTDB®) Ad Hoc Committee (1997–2002), and he was COT Chair from 2002 to 2006. Currently Dr. Meredith is a member of the Trauma Systems Ad Hoc Committee (since 1999) and the national faculty of the Advanced Trauma Life Support® (ATLS®) (since 2002), and member of the Board of Directors (1994–present) of the North Carolina Chapter, where he was President in 2005.

In addition to his activities with the College, Dr. Meredith has been an active participant in other groups, such as the Eastern Society for the Surgery on Trauma, where he was president in 2003, and the Southeastern Surgical Congress, where he was president in 2005. He was nominated as treasurer of the Southern Surgical Society in December 2005, and is on the board of managers of the American Association for the Surgery of Trauma.

Dr. Meredith assumes the role of Medical Director with...
the expiration of his four-year term as COT Chair. As Medical Director, he will serve as liaison between the COT and the Board of Regents. He will also lead the staff of the following programs: ATLS, NTDB, Verification/Consultation Program for Hospitals, and Trauma System Planning and Evaluation.

In addition to this part-time, volunteer position as Medical Director, Dr. Meredith maintains a surgical practice in Winston-Salem.

Register for the ACS Practice-Based Learning System

The ACS Practice-Based Learning System (case log system) allows surgeons to track their cases and outcomes in a convenient and easy-to-use manner. This system allows surgeons to compare their outcomes with those of their colleagues in a confidential manner. The system also assists surgeons in identifying opportunities for training that are available through learning modules on the College’s Web portal or from other providers.

The American Board of Surgery has identified Practice-Based Learning and Improvement as a core competency. In the future, the case-logging system could support the submission of case logs for maintenance of certification requirements.

This system is available only to members of the American College of Surgeons. To register for the system, log on to the College’s Web portal at http://efacs.org/portal/page/portal/ACS_Content/ACSSvcs/MEMBERBENEFITS.

CME portal tool takes the hassle out of logging your credits

If you are frustrated by trying to keep track of “all of those pieces of paper” to verify your continuing medical education (CME) credits, take advantage of the online CME tracking system, an electronic tool available to members of the College through e-FACS.org, the ACS Web portal. Simply log on at www.efacs.org and click on the “My Page” link in the blue bar at the top of the home page. You can easily enter your current and past CME hours and create a centralized log of your credits.

While you’re visiting e-FACS.org, be sure to click on the “New on e-FACS.org” link at the bottom of the home page to check out the newest resources and tools that have been added to the portal. In addition, news feeds in the “Communities & Specialties” area of the Web portal provide the latest and most current information from a variety of reputable sources, so be sure to visit e-FACS.org every day.

Trauma meetings calendar

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

- **Trauma and Critical Care 2006—Point/Counterpoint XXV**, June 5–7, Williamsburg, VA.
- **Advances in Trauma**, December 8–9, Kansas City, MO.

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

The following disciplinary actions were taken by the Board of Regents at its February 10, 2006, meeting:

- Mark D. Gilliland, MD, a plastic surgeon from Houston, TX, was expelled from the College. Dr. Gilliland had been charged with violation of sections 1(b) and (f) of the College Bylaws following suspension of his license to practice medicine in the State of Texas. His medical license was suspended after Dr. Gilliland was charged with intoxicated assault and failure to stop and render aid in a hit-and-run incident that took place on March 9, 2005. Dr. Gilliland has been the subject of more than one previous disciplinary action from the Texas Board of Medical Examiners.

- A general surgeon from Memphis, TN, was admonished following charges of violation of the ACS Bylaws Article VII, Sections 1(f) and (i) related to the surgeons’ advertising practices.

- An orthopaedic surgeon from Redwood City, CA, was placed on probation. This surgeon had been charged with violation of ACS Bylaws Article VII, Sections 1(b) and (f), after the California Medical Board placed his license to practice medicine on probation for four years with terms and conditions. That disciplinary action was imposed following charges of gross and repeated negligence, excessive prescribing, and failure to maintain adequate and accurate medical records in the care and treatment of two patients.

- A general surgeon from Agoura Hills, CA, was admonished after being charged with violation of ACS Bylaws Article VII, Section 1(f). This surgeon is alleged to have made public statements endorsing murder to support an animal rights organization that the surgeon is affiliated with.

- A vascular surgeon from Los Angeles, CA, had his membership privileges with the College restored to full and unrestricted. This surgeon had been charged with violation of Bylaws Article VII, Sections 1(a) and (f), in October 2003 and was subsequently placed on probation in February 2004. The College took disciplinary action following a felony conviction involving domestic violence that was later reduced to a misdemeanor and eventually expunged from this member’s record after compliance with the California Diversion Program.

ACS Career Opportunities

The American College of Surgeons’ online job bank

A unique interactive online recruitment tool provided by the American College of Surgeons.

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

Residents:

- View national, regional, and local job listings 24 hours a day, 7 days a week—free of charge.
- Post your resume, free of charge, where it will be visible to thousands of health care employers nationwide. You can post confidentially or openly—depending on your preference.
- Receive e-mail notification of new job postings.
- Track your current and past activity, with toll-free access to personal assistance.

Contact phaar@facs.org for more information.
AWS gears up to celebrate 25 years of service at Clinical Congress

Thirty years ago, few women even considered becoming physicians, let alone surgeons, because there were not many role models to encourage female students to enter the medical profession. However, as a result of the guidance and advocacy offered by organizations like the Association of Women Surgeons (AWS), women now make up more than 50 percent of medical students and 20 percent of physicians, and a growing number are choosing the field of surgery.

In recognition of this growing trend and in celebration of its 25th anniversary, the AWS will host a black-tie gala on Friday, October 6, just before the 2006 American College of Surgeons Clinical Congress in Chicago, IL. Kathryn D. Anderson, MD, FACS, President of the College, will be the featured guest speaker at a dinner celebrating the occasion, and other eminent woman surgeons will be highlighted as AWS takes a retrospective trip through the history of women in surgery. An educational program will follow on Saturday, October 7.

For more information or event details, visit www.WomenSurgeons.org or e-mail info@WomenSurgeons.org. The association is headquartered at 5204 Fairmont Ave., Ste. 208, Downers Grove, IL 60515; tel. 630/655-0392.

RESIDENCY ASSIST PAGE

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

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

www.facs.org/education/rap/index.html

For additional information, please contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354.
The American College of Surgeons and the National Ultrasound Faculty have developed “Ultrasound for Surgeons: The Basic Course” for surgeons and surgical residents on CD-ROM.

The objective of the course is to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications.

The CD can be purchased online at http://www.acs-resource.org or by calling Customer Service at 312/202-5474.

For additional information, contact Linda Stewart, tel. 312/202-5354, e-mail lstewart@facs.org.

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The ACS designates this educational activity for a maximum of four Category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity. The American Medical Association has determined that physicians not licensed in the U.S. who participate in this CME activity are also eligible for AMA PRA Category 1 credit.
Profiles in surgery

Surgery under stress: World War II, Anzio Beachhead

by George W. Tipton, Sr., MD, FACS, Austin, TX

In 1944, the battle for Anzio Beachhead demonstrated how doctors, nurses, and medical personnel performed their duties under the most stressful, difficult, and appalling circumstances.

In Italy during World War II, the Germans were holding firm at the Cassino-Gustav Line 75 miles south of Rome. Anzio Beachhead was an attempt by Allied forces to bypass that stalemate by sea, outflanking the Germans and capturing Rome. We failed this objective. Instead, we barely held onto our beachhead, a half circle, six by 12 miles in size. It became a desperate defensive battle for us. For more than four long months, the battle continued with attacks and counterattacks.

My organization, the 15th Evacuation (Surgical) Hospital, already had been in three combat campaigns by this time and was now in the middle of the fourth (Anzio). Our unit had replaced the 95th Evacuation Hospital during its first week of activity. The 95th had been decimated when a German dive-bomber, chased by a Spitfire, jettisoned its five anti-personnel bombs directly on the 95th Evacuation Hospital. Among the casualties were 28 dead—including three nurses, two medical officers, 14 enlisted men, one Red Cross worker, and six patients—and 64 wounded.

We arrived on Anzio two days later and were greeted by a barrage in the hospital area that killed two nurses just yards away.

Earlier, in North Africa, none of us was prepared for the concept of mass casualties or the magnitude of severe and extreme trauma, often involving multiple body systems, brain, thorax, abdomen, bones, and burns. At times these were combined in the same casualty. By the time Anzio was under way, we had learned and had become experienced, competent, and even expert. For the time, we were “state of the art” in quality trauma care. We were a big-time emergency room and trauma center.

In World War II, evacuation hospitals were the first surgical units in the “chain of casualty care” to do the definitive surgery on battle casualties. We were a MASH (mobile army surgical hospital)-type unit, but we were designated “semi-mobile” (a SMASH unit, as I named it) in that we had enough organic vehicles to allow us to split our hospital and leapfrog our units as the fighting front varied.

Normally, ahead of us in a battle, casualties at the Division level (the fighting troops) were gathered and supported to be transported back to us for definitive surgery.

However, the distances on Anzio were so short, division medical units were bypassed. Casualties were delivered directly to us on the battlefield. On the beachhead, all medical units were side-by-side in a specific area of the battlefield. We gave the Germans our map coordinates, hoping for no hos-
tile fire and depending on their accuracy.

In the hospital area, we had one 750-bed evacuation hospital, two 400-bed evacuation hospitals (including the 15th), one field hospital, one medical battalion, several division clearing stations, and other medical auxiliary units. Thus, there were approximately 2,000 hospital beds (cots) under canvas servicing 80,000-plus troops. All hospitals could expand.

Triage was initiated upon arrival to our unit. The wounded were examined and evaluated. As dictated by the triage, the severely wounded were re-suscitated, rehydrated, and transfused. Procedures were initiated for stabilization, and patients were made ready for surgery, preferably with vital signs on the upgrade or normal. We were very aggressive in this endeavor and were remarkably successful.

We had capabilities of almost a full range of operations and medical care for that period of time. Some of our senior surgeons were Fellows of the College, but only one was board certified, and that was in gynecology and obstetrics. All our senior surgeons were experienced and had good training. We were enhanced with auxiliary surgical and subspecialty teams.

A primary threat to our safety was our location. We were in the middle of an active and very noisy battlefield. Our own 155 mm “Long Tom” artillery was close on each side. Our 90 mm anti-aircraft artillery was directly in back of us, firing right over our heads. These were used also as tactical artillery. Both were favorite German targets. The 90 mm anti-aircraft cannons behind us had a penetrating whipping muzzle blast, which was almost painful.

The Germans had various cannons, each with a different noise and killing characteristics.
Dr. Tipton’s diary: Excerpts from 1944

These diary excerpts discuss the moments after a heavy artillery barrage had hit Dr. Tipton’s area.

The shelling stopped. I rushed outside and saw light and smoke through holes in ward tents. I ran toward the tents. Something hit my right knee. My knee collapsed. I stumbled and fell flat. “You don’t hear the one that gets you.” I wasn’t wounded. I had hit the “Patients’ Latrine” sign as I was running full tilt. (Later I wrote, “You won’t be a hero or even get a Purple Heart if you are felled by a latrine sign.”)

I ran into ward #18, where the smoke and holes were. Our fine neurosurgeon, Don Wrork, arrived at the same time. The place was filled with acrid smoke (cordite)—couldn’t see five feet ahead.

I got a flashlight and started examining injured men. Don was doing the same. Incidentally, all the patients in that ward seemed dazed, sitting hunched over the side of their cot or on the ground. Very quiet and still. No moaning, no screaming.

Then I went to ward #19 and ran into the ward technician, who said that two men had been killed there but none injured.

I went to the other wards—only one man injured.

No other wards got direct hits, only shell fragments. Then learned that no one in our enlisted men’s area was hit. Then that no officers or nurses was hit. Really a miracle!

Final check showed 16 men were hit, four were killed outright, but one man with a hole through his larynx was taken to the OR “STAT.” He died on the OR table from irreversible blood loss. Another man with massive thoracoabdominal wounds died just before sun-up. There were more than 30 hits within 100 yards of my tent.

In cool weather, we could hear their muzzle blasts, sounding like kettledrums. The Germans also had 280-mm railway cannons that really disturbed the atmosphere. These cannons were kept in tunnels during the day, doing their deeds at night, adding to our sleep deprivation, as well as to the danger.

During one 24-hour peak period, our own artillery fired more than 20,000 shells. The German artillery answered in kind. The noise factor was stressful.

Another continuous threat were the German air attacks. Early each morning, 15 to 20 Messerschmidt 109s and Focke Wulf 190s would dive-bomb and strafe full throttle directly above us. These tactics were repeated at frequent intervals during the day. We witnessed intense dogfights between these planes against our own Spitfires and P-38s. Several planes of all types were shot down.

At night, Heinkel 111s, Junker 88s, and other large German bomber would drop flares, which seemed to float down endlessly. Flares converted the battlefield into an eerie yellow-orange daylight. Then the German planes dropped bombs and strafed. During these German aircraft raids, our own anti-aircraft defenses were at nonstop peak activity. The noise was extreme and very disruptive. Shells by the thousands flew overhead.

Early on, the Germans mounted powerful counterattacks. Our capture was a distinct possibility. So I buried my German Luger pistol, for which I had traded a valuable bottle of Scotch with an English soldier in North Africa. Also buried were my German...
binoculars, or “Dienstglas” (also a trade), my German-made camera, and my diary. I didn’t want to be captured holding German equipment.

Initially, we operated with our helmets on, which was very tiring, and only a few surgeons continued this practice. Besides, the patients were unprotected. Later in April, our Army engineers put 2” planking over the operating tents for protection from “hail,” or anti-aircraft shell fragments and spent bullets falling to the ground in showers.

While all this was occurring, doctors, nurses, and technicians doing complicated, difficult, and delicate operations in the hospital tents had to remain upright and continue operating—there was no choice, even though our basic instincts were screaming, “Hit the dirt.” If not heroic, it took a lot of dedication and a full measure of courage to work in this kind of environment. There were no foxholes in the operating tents or ward tents.

Inside our tents, we were blind—but not deaf—to what was going on, making it difficult to judge outside explosive noises, incoming and outgoing, usually both.

Sometimes the ground just shook violently, without any subsequent explosion.

Our physicians, nurses, and technicians were superb, staying “at it” and operating while shells, bombs, and “hail” fell around them.

During the first few nights on Anzio, we dug in our own cots to just below ground level and surrounded them with sandbags. Our digging was restricted because of the shallow water table. We rigged a roof over our cots with sandbags as protection from hail. Later, as the water table subsided, we dug deeper. Thus, we spent four months sleeping underground.

On the beachhead, we had priority in personnel, equipment, medications, and supplies. Great army logistics prevailed under difficulty. Food even was upgraded.

Blood for transfusion pre-
sented few problems. The British Field Transfusion Unit was in charge of the blood bank supply. This unit drew blood from troops in the Naples area and shipped it to Anzio by landing ship tank. We had learned early that plasma was not a substitute for whole blood. We still used plasma for some situations, such as blood volume and burns. Whole blood was used to replace blood loss. We used whole blood generously.

It took our laboratory approximately 30 to 45 minutes to cross-match the blood. Consequently, in severe blood-loss shock cases, we used noncross-matched, low-titre O-type blood and plasma for immediate replacement when judgment required it. We had few reactions. When cross-matched blood was verified, it was substituted immediately, and the noncross-matched transfusion ceased.

We had no plastic bottles, tubing, or catheters; instead, these were made of glass, rubber, or metal. Rope was strung along canted tent poles to hang intravenous solutions.

On Anzio, our hospitals were in the middle of extremely intense action. I know of no similar experience in World War II for functioning hospitals to be in the middle of an active battlefield for this length of time. We were not just in the combat zone but in the actual battlefield.

I am proud of our achievements. We exerted maximum effort toward our commitment to do our utmost for our wounded. We worked harder than at any time in our lives. It was worth it, and I would not have missed it!

Editor’s note: It is worth noting that Dr. Tipton appeared previously in the Bulletin 52 years ago. Dr. Tipton wrote “The tissue audit committee in an open staff hospital: Three years’ results from Brackenridge Hospital,” which was published in the July-August 1954 edition (Bull Am Coll Surg. 1954;39(4):159-161, 191-192).

The 50-plus years between contributions is believed by the editors to be a record unmatched in the Bulletin’s history. It certainly merits an acknowledgment and a “thank you” to the author on behalf of our readers.

Dr. Tipton is a retired general surgeon in Austin, TX.

Dr. Tipton in his initial foxhole, under his cot. Several days later, he dug the cot down to dirt level, surrounded it with two to three layers of sandbags, and put a roof of sand-filled plasma boxes on top.

Dr. Tipton’s bunk in the fourth foxhole after engineers dig the soldiers in, better and deeper, with revetments and sandbags on the roof to stop the bullet and shell-fragment hail. A general told the doctors, “You’re in a fool’s paradise.”
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.

The American College of Surgeons Division of Education presents the Personal Financial Planning and Management Course for Residents and Young Surgeons, which uses an interactive/lecture format to arm surgeons with basic financial management skills. The course is designed to educate and equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children), and proper planning for financial stresses related to their surgical practice.

Orders may be placed through ACS Customer Service at 312/202-5474 or via the College’s Web site at: www.acs-resource.org.
For more information, contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354.
Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings

February 10–11, 2006

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

American College of Surgeons Professional Association (ACSPA)

As of November 30, 2005 (end of election cycle), the ACSPA-SurgeonsPAC had raised $516,000. In addition, $291,000 had been pledged to the PAC via the telephone fundraising campaign.

Of 215 U.S. members of the Board of Governors, 138 (64%), contributed to the PAC (for an average contribution of $381). The number of contributors represents a 16 percent increase over the number provided in the October 2005 Board of Regents report.

In the 2005/2006 election cycle, which ends November 30, 2006, contributions have been made to 103 candidate and leadership PAC committees. The ACSPA-SurgeonsPAC has organized nine political fundraiser events.

In 2005, Doctors for Medical Liability Reform (DMLR) launched a nationwide grassroots recruitment and advocacy campaign, called “Getting the Nation Behind Us.” DMLR’s focus in 2005 was to identify, educate, and recruit likely supporters. This year, some of the highlights of the coalition’s efforts include the following:

• Radio interviews with DMLR physicians and surgeons, which were broadcast 960 times on 813 stations, and heard by more than 23 million people
• A mailing from the DMLR to approximately 83,000 physicians (including all Fellows), patients, and concerned citizens, educating them about the medical liability crisis and encouraging their support
• Compilation of an e-mail list of 84,000 people as part of an ongoing online recruitment, education, and mobilization effort
• The Web site, protectpatientsnow.org, redesigned as a user-friendly source of pertinent information and up-to-date news
• A series of clever animations created and distributed via the Internet
• Online ads displayed 16 million times
• A mini-documentary produced for the Web on the medical liability crisis and the threat to patient access to care
The DMLR’s executive committee met in February to make plans for continuing this campaign. Once the plans are finalized, the ACSPA will decide its level of participation in the coalition.

**American College of Surgeons (ACS)**

**ACS standing committees**
The Board of Regents approved the addition of Associate Fellows, Resident Members, and Affiliate Members of the College as official categories of membership on the standing committees of the College. It is the Regents’ desire to have their formal involvement in the College; the Regents also believe that their participation will complement the activities of the College.

**e-FACS.org**
The College’s Web portal, e-FACS.org, was officially launched on January 10 for all members of the College. The availability of this new members-only benefit was announced through e-mail, the Bulletin, and Surgery News. The portal contains 38 communities, of which 12 are specialty communities and 10 are subspecialty communities under the general surgery category; the remainder comprises special interest communities.

**HealthCareers (job bank)**
As of January 19, there were 787 active jobs listed and 46 posted résumés on the HealthCareers site. The site, a valuable membership tool, logged approximately 30,000 hits in 2005 with an average of 82 hits per day.

**Board of Governors**
The Board of Governors, at its adjourned meeting on October 19, 2005, requested a discounted fee for residents to enroll in the postgraduate courses at the Clinical Congress. As a result of this request, the Division of Education will develop a tiered fee schedule.

**Resident and Associate Society (RAS)**
An anonymous donation has enabled the RAS to award two scholarships for 2006 to defray costs associated with conference registration, travel, and participation. These scholarships will allow young surgeons to develop skills required to become leaders of the future in surgery. The scholarships will be awarded competitively.

As its primary focus for 2006, the RAS has been working to develop new programs, engage medical students, and expand membership. An outline for the Residents as Managers course has been completed. The course is slated to debut in the upcoming year.

Michael J. Sutherland, MD, RAS Chair, will moderate a general session, Emerging Technology in Surgical Education, at the 2006 Clinical Congress. The RAS will also host Residents’ Day during the Spring Meeting and focus on resident-presented papers, interesting cases, and the ever-popular Surgical Jeopardy.

In an effort to increase interaction with the medical students, the RAS is developing a recruiting flyer to distribute to all second-year medical students in the U.S. The goal is to increase awareness of the new Medical Student membership category.

**Operation Giving Back (OGB)**
A strategic planning session was held in December 2005 to review and prioritize the five programmatic goals of OGB: Domestic volunteer programs, international volunteer programs, disaster response, resident involvement, and retiree involvement. In late December, OGB received notification from Pfizer Medical Humanities Initiative (PMHI) of the approved proposal for support of OGB. The contributions of PMHI in support of OGB are acknowledged and appreciated.

**Advisory Councils for the Surgical Specialties**
An open forum for rural surgeons will be reprised for the next Clinical Congress. Sponsored by the Advisory Council for General Surgery Subcommittee on Rural Surgery, the forum continues to address concerns voiced by members who serve a rural or small-town patient base.
The Advisory Council for Neurological Surgery has focused on the issue of emergency care. The Executive Committee of the American Association of Neurological Surgeons (AANS) is opposed to the concept of delegating neurosurgical care of trauma patients. The Advisory Council is serving as a liaison between the AANS and the ACS regarding this issue.

The Advisory Councils continue to develop specialty-sponsored programming presented at the Clinical Congress. In addition, the Advisory Council for General Surgery continues to propose timely topics for the Spring Meeting.

Advocacy

Members of the Board of Regents were informed about the broad range of activities taking place in Washington, DC, that hold implications for the way surgical services are delivered and reimbursed under federal, state, and private sector programs. Activities in these areas have placed increasing demands on College resources. Following are some of the areas in which the College has focused on maintaining a leadership role:

- The American Medical Association (AMA) Consortium for Performance Improvement, composed entirely of physician organizations, has assumed the role of developing performance measures. R. Scott Jones, MD, FACS, co-chairs the Consortium’s perioperative care workgroup, which is in the final stages of developing the group’s first performance measure for surgery. The College has placed other measures corresponding to the Surgical Care Improvement Project target areas on the Consortium’s agenda for the spring.

- The National Quality Forum (NQF)—a multistakeholder group that includes physicians, hospitals, health plans, government agencies, employers, and consumer organizations—has the role of validating measures developed by other organizations, with special emphasis on measures that are useful for public reporting. The College is a member of the NQF, but its involvement has been very task focused. No staff or surgeons are permanently assigned to actively participate in NQF proceedings.

- The Ambulatory Care Quality Alliance is a second multistakeholder group organized by internists, family physicians, and health insurance plans. Consumer groups and employers also sit at the table. The College and the Society of Thoracic Surgeons are the first surgical groups appointed to this steering committee.

- As a step toward providing the leadership that surgical specialty societies are hoping for, the College formed an ad hoc internal task force of surgeons to review and refine potential broad-based measures of surgical performance. The measures were shared with the specialty societies, pared down, and then further refined. A joint letter was prepared for the Centers for Medicare & Medicaid Services in an effort to expand—and correct—the Physician Voluntary Reporting Program measures applicable to surgery.

In yet another advocacy area, the Patient Safety and Professional Liability Committee (PSPLC) collected and reviewed approximately 461 surgical claims that closed in 2003-2004 with payment or loss (defense) expenses greater than $25,000. The next step will be to move into a formal closed-claims program. In the meantime, the PSPLC will review the database information after which it will submit a report with options and recommendations.

Thomas R. Russell, MD, FACS, Executive Director of the College, and the staff of the Washington Office hosted a Health Policy Summit in Washington, DC, to share perspectives and develop collaborative efforts among surgical specialty society leaders, 2005 winners of the health policy scholarship, and the Health Policy Steering Committee (HPSC). Issues on the agenda included value-based purchasing and Medicare physician payment. A joint meeting of the HPSC and health policy scholars was held the following day to review conclusions reached during the summit.

The College has organized the surgical
specialty societies into a “surgical quality alliance” to help coordinate efforts and strategies with respect to various organizations involved in the development, validation, and selection of performance measures to be used in implementing value-based purchasing programs in the public and private sectors.

To enhance surgery’s input into the Medicare policymaking process, the College collaborated with surgical specialty societies and others to support the nomination of Karen R. Borman, MD, FACS, ACS Governor, to the Medicare Payment Advisory Commission (MedPAC). In addition, 31 members of Congress co-signed a letter supporting the appointment of a surgeon to the Commission. The letter also highlighted the fact that only two surgeons have served on MedPAC since it inception in 1997.

Also of interest, John R. Clarke, MD, FACS, ACS Governor, was appointed as the College’s representative to the NQF’s Patient Safety Taxonomy Consensus Standards Maintenance Committee.

The College informed the governor and the Chamber of Commerce in the state of Georgia that it would not hold meetings in Georgia until the state recognizes general surgery as a unique specialty in its certificate-of-need (CON) statute. Under the current statute, general surgery is defined as a “multispecialty,” and, as such, is ineligible for an exemption that single specialties have from obtaining a CON when building ambulatory surgery centers.

Frank G. Opelka, MD, FACS, testified on behalf of the College before the House Energy and Commerce Health Subcommittee. Dr. Opelka expressed the College’s concern that cuts in reimbursement payments will have negative effects on surgeons’ ability to practice and on Medicare patients’ access to needed surgical care. He further demonstrated how the current Medicare payment system fails to recognize the nature of surgery and how the current sustainable growth rate system disproportionately affects surgical reimbursement. He also highlighted the College’s support for quality improvement programs and the success of its own programs as possible models for surgical value-based purchasing programs.

The College organized two briefings for MedPAC staff, in which several surgical members of the AMA/Specialty Society Relative Value Update Committee (RUC) participated, to provide them with its analysis of the relativity of the Medicare fee schedule and to describe the development of more data-driven methods that the surgical societies are using in the RUC process to evaluate changes in work. As a follow-up to its initial meeting with MedPAC staff, the College sent a letter reiterating points that it had made during the meeting.

Representatives from the College, the Coalition for American Trauma Care, and the American Trauma Society, met with Laura Ott, U.S. Department of Health and Human Services (HHS) Deputy Assistant Secretary for Legislation, to discuss the importance of the Health Resources and Services Administration’s (HRSA) Trauma-EMS (Emergency Medical Services) Program. The main purpose of the meeting was to convince HHS and the Bush Administration to include the program in its budget for fiscal year 2007. Ms. Ott was very enthused about the program and assisted the College in setting up a meeting with the HRSA Administrator for further discussion.

The College participated in a meeting to explore the formation of a Congressional caucus in support of EMS issues. In addition to discussing the role and formation of a caucus, the meeting participants worked toward identifying common ground on some of the leading issues confronting EMS. The next step is to meet again to develop a more detailed agenda and identify congressional champions in the House and Senate.

The College’s Committee on Trauma Subcommittee on Emergency Services-Prehospital was invited to participate in the Institute of Medicine project, The Future of Emergency Care in the United States Health System. The focus of this project is pediatric and prehospital EMS issues, as well as hospital-based
emergency department issues. The Committee on Trauma (COT) continues to work with other trauma organizations and the Washington office in support of funding for trauma systems. The COT continues to emphasize the importance of trauma systems in our country, especially in response to disaster and mass casualty events.

The College is an active member of One Voice Against Cancer (OVAC), a coalition that continues to lobby Congress to ensure that funding for federal cancer research and programs remains a national priority. OVAC has begun taking steps to position the cancer community at the forefront of the budget and appropriations processes for next year.

Dr. Russell assembled an Emergency Workforce Task Force, with the goal of developing consensus among the surgical specialty societies on solutions to the impending emergency workforce crisis. This Task Force followed up on previous meetings on the issue. At the March 2005 meeting hosted by the College, the specialties discussed the workforce crisis in emergency departments and trauma centers. Creative solutions that were brought to the table for review included regionalization of care, on-call stipends, development of a new “acute care surgeon” subspecialty, providing additional residency training positions, and continued federal efforts to address the liability and physician reimbursement problems.

In 2005, every state saw some type of allied health professional scope of practice bill introduced, and many states were successful in defeating such legislation. The College has joined with several other groups to monitor and fight these attempts. So far, the coalition has been successful in stopping all attempts to restrict a surgeon’s ability to offer such services as magnetic resonance imaging, computed tomography scans, positron emission tomography scans, and ultrasound. Another strategy being employed to restrict surgeons’ ability to offer imaging services is to approach the private sector (health insurers) to implement guidelines developed by radiology. Insurers see this as a way to limit the growth in imaging services.

Also in 2005, several states attempted to introduce a new tax on physician services—specifically on elective cosmetic surgery—in response to the massive budget shortfalls many of them are facing. Although none of the states was successful in passing this type of tax, it is expected that the idea will be back in other states in 2006. The College has joined with other national specialty societies to fight physician taxes, and in late 2005, the coalition unveiled a Web site to help educate and monitor these attempts.

A series of conference calls was held with State Advocacy Representatives (StARs) as a kick-off to the 2006 state legislative season. These calls gave StARs the opportunity to discuss potential state issues, prepare for advocacy efforts in their states, and consider strategies for engaging Fellows in state-level advocacy. State affairs staff members continue to solicit the names of interested surgeons to participate in the program.

The College’s General Surgery Coding and Reimbursement Committee (GSCRC) is engaged in a major multifaceted effort to address the five-year review of relative work value units. The GSCRC is working on two fronts: Reviewing general surgery codes that it considers misvalued, and uniting the surgical specialty societies in the RUC to contest the medical specialists’ claim that the evaluation and management codes are currently undervalued. The surgical coalition that the College is leading continues to provide in-depth analysis of numerous sources of data to demonstrate that the increases being sought are unfounded and threaten the relativity of the entire Medicare fee schedule.

In November 2005, the College’s delegation in the AMA House of Delegates attended the interim meeting of the AMA in Dallas, TX. The ACS delegation represented surgery’s perspective on a host of issues and policy decisions. At the top of the agenda was pay for performance/value-based purchasing. The delegation also took a strong stand on payment for emergency care mandated by the Emergency Medical Treatment and Active Labor Act.
Accreditation
The Board of Regents approved a business plan for the ACS Bariatric Surgery Center Network (ACS BSCN). The mission of the ACS BSCN program is to improve the quality of surgical care for bariatric patients throughout the U.S., through the accreditation of bariatric centers that maintain certain physical resources, human resources, standards of care, and documentation of outcomes.

Education
The Clinical Congress program was strengthened further. The 2005 program was designed to address contemporary topics in surgery relating to the core competencies, patient safety, new procedures, emerging technologies, and nonclinical topics related to the practice of surgery. It was very well received by the attendees and was rated excellent or very good by 91.5 percent of the respondents. In addition, 97.6 percent of the respondents said they would use the newly acquired knowledge and skills in their practices.

The 2006 Clinical Congress program will include 110 general sessions, eight multidisciplinary sessions, 29 specialty sessions, 14 didactic postgraduate courses, and 21 skills-oriented postgraduate courses. Major steps have been taken to move the proposal submission process for the Clinical Congress to an electronic platform. Online systems have been developed to accept submissions of abstracts for the paper presentation sessions, scientific exhibits/posters, and video-based education sessions.

Since its release, Surgical Education and Self-Assessment Program (SESAP) 12 has experienced a continuous growth in enrollment. An audio companion for SESAP 12 was also released simultaneously.

The editorial board of the video library has established a model to systematically review videotapes in the ACS video library. An ACS online video journal has been launched and has generated considerable interest.

A new CD-ROM, Professionalism in Surgery: Challenges and Choices, has been released. The program is highly interactive, with 12 video-based scenes demonstrating challenges in professionalism. Background readings are provided, and the program includes a posttest with opportunities to review specific content areas if a wrong answer is selected. Online Category 1 continuing medical education (CME) credits may be earned through participation in this program.

The Personal Digital Assistant and Internet-based Case Log System, designed to support practice-based learning and improvement, was released in October. As of mid-January, more than 6,500 cases had been entered into the system by approximately 100 surgeons.

Evidence-Based Reviews in Surgery, an Internet-based program, was launched in October 2005. The program is designed to enhance skills in critical analyses and evidence-based surgery and offers participants the opportunity to access online clinical and methodologic articles from the current surgical literature. The program was developed by the Canadian Association of General Surgeons. Participants who complete the multiple-choice questions are eligible for maintenance of certification credits from the Royal College of Physicians and Surgeons of Canada and Category 1 CME credits from the ACS.

Surgical M+M and Patient Safety was recently launched. The Internet-based program was developed to highlight new approaches to designing and conducting morbidity and mortality conferences in surgery. The goal of the program is to address patient safety and focus on systems and individuals within the context of adverse events, errors, and near misses.

The College recently released a new publication, Successfully Navigating the First Year of Surgical Residency: Essentials for Medical Students and PGY-1 Residents. The publication includes two sections; the first addresses the areas of knowledge and skills that surgical residents should possess when they enter their first year of residency, and the second lists the areas of knowledge and skills expected of residents at the completion.
of their first year. The publication is geared toward medical students interested in surgery, surgical clerkship directors, surgical residents, and surgical residency program directors.

**JACS**

As of January 17, the *Journal of the American College of Surgeons (JACS)*, had provided Fellows and subscribers with nearly 80,000 CME-1 credits as a benefit of membership. Frank R. Lewis, Jr., MD, FACS, Secretary-Treasurer of the American Board of Surgery (ABS), reviewed the JACS CME program and will promote it as a preferred way for continuous learning activity as part of the ABS maintenance of certification.

**Proposed statement**

The Board of Regents reviewed a statement on sharps safety, prepared by the Committee on Perioperative Care (CPC). The statement was drafted in follow-up to the Statement on Blunt Suture Needles ([http://www.facs.org/fellows_info/statements/st-52.html](http://www.facs.org/fellows_info/statements/st-52.html)), prepared by the CPC, and approved by the Board of Regents at its June 2005 meeting. The CPC subsequently determined that a broader statement on sharps safety was needed and, thus, drafted the statement on sharps safety. After reviewing the proposed statement, the Board of Regents requested that members of the Board of Governors review it. Board of Governors comments will be brought back to the Board of Regents at its meeting in June.
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Deposit the bull’s-eye

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

Each month we have written articles based on the accumulation of records in the National Trauma Data Bank®. We would like to stress the word “bank.” The NTDB acts like a bank and houses data deposited by trauma centers and states. These data are available to be loaned out to researchers for scientific study. In addition, the individual depositing trauma centers are able to get a statement from the bank—the NTDB—bench-marking their data.

For almost two and one-half years, several interest groups, along with the Committee on Trauma with funding from the U.S. Health Resources and Services Administration, have collaborated on the National Trauma Registry Standardization Project. These stakeholders set out to devise a uniform set of trauma registry variables along with specific definitions. Before this monumental undertaking, there had been no standardized data set used in the various registries around the country. Many trauma registries started out as home-grown projects, and over the years, several vendors have offered commercial products. However, these programs too suffered from a lack of uniform inclusion criteria, different sets of variables, definitions, and software field specifica-

tions. Liken this challenge to mixing currency from several different countries in one bank vault. In order to aggregate these data, conversion programs and data cleaning are required to make use of only a portion of the data elements found in those various registry products.

This project has yielded a standardized set of trauma registry inclusion criteria along with standardized data elements and definitions. There is consensus among the software developers that provide trauma registries to approximately 90 percent of the market to include these exact data elements and definitions in their software products. In doing so, future data that will be deposited in “the bank” will be uniform in consistency and definition.

The National Trauma Registry (NTR) is a core set of data elements for aggregation at a national level. Looking at the universe of trauma center data elements, it is similar to a bull’s-eye. It is this central blue core that will be deposited by trauma centers and states into the NTDB (see figure on this page). As we move outward from the center, the next ring represents a larger set of data elements that contain additional information useful for aggregation at a state or regional level. The outer-most ring houses the largest
number of data elements. These expanded data elements, which are typically found in a trauma center registry, allow for performance improvement activities and local assessment of trauma care delivery at the institutional level.

To learn more about the National Trauma Registry Standardization Project, there are Webcasts and a downloadable final version of the data dictionary. These are available along with the full 2005 National Trauma Data Bank Report, Version 5.0 on the ACS Web site 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.

A look at the Joint Commission

Periodic performance reviews

Surgeons play an important role in a new requirement from the Joint Commission: the periodic performance review, or PPR.

Under the PPR, health care organizations self-evaluate their standards compliance once a year and implement improvements based on their findings. The Joint Commission designed the PPR to help organizations maintain continuous standards compliance, so there are no penalties when an organization identifies areas for improvement and addresses them.

The Joint Commission encourages surgeons to participate in their organization’s PPR. Many organizations use the tracer methodology to conduct their evaluation, providing a good opportunity for surgeons to get involved. This includes helping to assess compliance with standards addressing informed consent; informing patients of unexpected outcomes; monitoring patients during and after operative procedures, sedation, and anesthesia; implementation of infection control strategies; collection of data to monitor performance; documenting operative procedures and the use of moderate or deep sedation or anesthesia in the medical record; the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™; procurement and donation of organs and other tissues; and clinical practice guidelines. Surgeons may and should assist in the development of plans of action and measures of success for noncompliant standards.

After their organization completes its PPR and submits a plan of action (if necessary) to the Joint Commission, it has the option of participating in a conference call with Joint Commission standards experts to reach final agreement on corrective actions and discuss standards issues. The Joint Commission encourages as many staff at the organization as possible to be listeners on the conference call, and this includes surgeons. It really is a great learning experience.

The next time surveyors come on-site, they will evaluate if improvements were sustained and effective.

The PPR requirement also applies to the Joint Commission’s Ambulatory Care and Office-Based Surgery Accreditation programs.

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.
The future of patient safety just got even brighter.

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

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

Leading the Challenge to Meet the Need

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

by Rhonda Peebles, Division of Member Services

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

Metropolitan Washington Chapter recognizes achievements
At its 2006 annual meeting on February 26, the Metropolitan Washington Chapter presented the LaSalle D. Leffall, Jr., Award to Anton Sidawy, MD, FACS, a longtime leader of the chapter (see photo, this page). The LaSalle D. Leffall, Jr., Award was established to honor the achievements of Dr. Leffall—one of the nation’s finest surgeons. The award is presented regularly, but not necessarily annually, to the active or senior members of this chapter who best exemplify the characteristics and achievements that Dr. Leffall has shared with the Washington, DC, community and with the College throughout his career. Dr. Sidawy is a former officer of the Metropolitan Washington Chapter, and he currently serves as a Governor.

Connecticut Chapter advocates for trauma reimbursement
With assistance from the College’s State Surgical Legislative Action Center, the members of the Connecticut Chapter, and the Connecticut Committee on Trauma are advocating for legislation to repeal a current state law that allows insurance companies to deny coverage for treatment of injuries if patients were intoxicated at the time of injury. For more information about S.B. 425, or to participate in this advocacy activity, contact Christopher Tasik, the Connecticut Chapter Executive Director, at ctasik@tasik.com, or 203/674-0747.

Metropolitan Chicago Chapter celebrates 50th anniversary
On April 1, the Metropolitan Chicago Chapter observed its 50th anniversary. To commemorate this milestone event, the College presented a 50th anniversary commemorative charter to the chapter’s leaders (see photo, this page). In addition to its annual business meeting, the chapter also presented reports on pay for performance.

Ohio S-PAC seeking changes
The Ohio Chapter’s Surgeons’ Political Action Committee (S-PAC) is promoting its views on improving the health care environment in Ohio. The advocacy issues being addressed include public places free of cigarette smoke, additional medical liability reforms, scope of practice issues...
**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.

<table>
<thead>
<tr>
<th>June 2006</th>
<th>Date/time</th>
<th>Event</th>
<th>Location/contact information</th>
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</thead>
<tbody>
<tr>
<td>June 8–10</td>
<td>Indiana (CS)</td>
<td>Location: Sanibel Harbour Resort, Ft. Meyers, FL Contact: Carolyn Downing, 800/257-4762</td>
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<tr>
<td>June 8–11</td>
<td>Missouri (CS)</td>
<td>Location: Lodge of the Four Seasons, Lake Ozark, MO Contact: John Adams, Jr., MD, FACS, 573/443-8773</td>
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<tr>
<td>June 15–17</td>
<td>Alabama</td>
<td>Location: Marriott Grand Hotel, Point Clear, AL Contact: John Hooton, 205/776-2106</td>
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<tr>
<td>June 16–17</td>
<td>Colorado (CS)</td>
<td>Location: Doubletree Hotel, Grand Junction, CO Contact: Carol Goddard, 303/770-6048</td>
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<tr>
<td>June 18–21</td>
<td>Oregon &amp; Washington State (CS)</td>
<td>Location: Sunriver Resort, Sunriver, OR Contact: Kelly Smith, 503/494-5300</td>
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<td>July 7–9</td>
<td>North Carolina (CS)</td>
<td>Location: Kingston Plantation, Myrtle Beach, SC Contact: Carol Russell, 919/467-3818</td>
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<td>July 28–30</td>
<td>Tennessee (CS)</td>
<td>Location: Fall Creek Falls State Park, Pikeville, TN Contact: Wanda Johnson, 931/967-4700</td>
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<tr>
<td>August 10–12</td>
<td>Montana-Wyoming (CS)</td>
<td>Location: Big Sky, MT Contact: Andrew Grace, MD, 406/587-0704</td>
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<tr>
<td>August 11–12</td>
<td>Hawaii</td>
<td>Location: JW Marriott Ihilani Resort &amp; Spa at Ko Olina, Oahu, HI Contact: Gary Belcher, 808/586-7446</td>
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<td>August 25</td>
<td>Oklahoma</td>
<td>Location: Doubletree Warren Place, Tulsa, OK Contact: William Jennings, MD, FACS, 918/744-3650</td>
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<th>September 2006</th>
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<tbody>
<tr>
<td>September 6–8</td>
<td>New Mexico</td>
<td>Location: Albuquerque Hilton, Albuquerque, NM Contact: Sharon Wehrle, 505/272-4152</td>
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<td>September 9–10</td>
<td>Kansas (CS)</td>
<td>Location: Hyatt Hotel, Wichita, KS Contact: Chip Wheelan, 785/234-3319</td>
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<tr>
<td>September 14–17</td>
<td>Georgia (CS)</td>
<td>Location: The Cloister, Sea Island, GA Contact: Lois Shinall, 912/925-8969</td>
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</tbody>
</table>
related to physician assistants, state-mandated health insurance requirements, and insurance companies’ procedures that send reimbursements to patients rather than physicians. For more information on these issues, or to support the S-PAC in Ohio, contact Brad Feldman, the chapter’s Executive Director, at ocacs_exec@ohiofac.org, or 614/221-9814.

Chapter anniversaries

<table>
<thead>
<tr>
<th>Month</th>
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<td>Arkansas</td>
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<td>Connecticut</td>
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<td>Metropolitan Washington (DC)</td>
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<td>Ecuador</td>
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<td>Idaho</td>
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<td>Ireland</td>
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<td>Maine</td>
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<td>Mexico—Northeast</td>
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<td>Mexico—Nor-Occidental</td>
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<td>North Dakota</td>
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<td></td>
<td>Wisconsin</td>
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</table>

Brooklyn–Long Island Chapter, left to right: Michael O. Bernstein, MD, FACS, President; Michael Setzen, MD, FACS, Program Chair; Mrs. Setzen; and Paul Weiss, MD, FACS, member of the ACS SurgeonsPAC.

Brooklyn–Long Island Chapter cohosts Annual Clinic Day

In conjunction with the Nassau Surgical Society, the College’s Brooklyn–Long Island (NY) Chapter cohosted the Annual Clinic Day in December 2005. The all-day event presented updates on surgical procedures for a variety of specialties. In addition, Marcie Fraser, a medical reporter who spoke on “Extreme Makeover and the Media Frenzy,” presented the luncheon’s keynote address. (See photo, this page.)

The 2006 Annual Clinic Day will be held on December 6; for more information, contact Teresa Barzyz at Acsteresa@aol.com, or 516/741-3887.

Visit the College’s Web portal!

View surgical news, interact with surgical communities, update CME credits, enter case log information, track resident hours, and more—all at e-facs.org
PATIENT EDUCATION, from page 19


COMMITTEE ON CHAPTER ACTIVITIES, from page 35

individual reports to each chapter for the purpose of performance benchmarking.

Membership and diversity

In 2005, the Subcommittee on Membership and Diversity was charged with contacting chairs of regional Committees on Applicants. The purpose of this communication—a letter, which included the College’s Statement on Diversity—was to encourage the chairs of the Committees on Applicants to consider diversity when selecting new members.

International activities

The Subcommittee on International Activities is currently examining the pricing structures for various College programs and activities. Dues and charges for educational programs and services for International Members are under review.

At the 2005 Clinical Congress in San Francisco, CA, the newest chapter—Iran—received its charter. The subcommittee has also received requests to establish chapters in Egypt, West Africa (Nigeria), and Pakistan. A Pan-Africa chapter (to include all Fellows in Africa) has also been proposed.

Leadership conference

The 2006 Leadership Conference will be held June 11–13 in Washington, DC. This educational program will include an update on current health policy issues, an expanded educational program on leadership development topics for Young Surgeons and Residents, and management topics for Chapter Administrators and Executive Directors.

Acknowledgments

I would like to thank all the members of the committee for their continued efforts. (See box on page 35 for the GCCA roster.) In addition, on behalf of the GCCA, I would like to extend thanks to Thomas R. Russell, MD, FACS, Executive Director of the College; Paul E. Collicott, MD, FACS, Director of the Division of Member Services; Mark A. Malagoni, MD, FACS, Chair of the Board of Governors; Rhonda Peebles; and Patricia A. Sprecksel, in recognition of their assistance.