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Future meetings

Clinical Congress
2007 New Orleans, LA, October 7-11
2008 San Francisco, CA, October 12-16
2009 Chicago, IL, October 11-15

On the cover: The importance of the collaboration of surgeons and hospitals with the emergency response system in the event of a mass casualty disaster is discussed in the article on pages 16-20. Photo courtesy of Punchstock.
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From my perspective

In order to play a leadership role in health care improvement, surgeons need to bust out of the silos that have bound them to an ideology driven by a narrow focus on their own practices and open their minds to a more collective way of thinking. We need to stop focusing solely on what is best for general, orthopedic, neurological, and urologic surgery and other specific surgical specialties in the short term and start thinking outside ourselves about what we can do to promote long-term improvements to this country’s health care system.

Cost, quality, access

As stated previously in this column, and in just about every recent item written on health system change, the current reform movement centers on three major issues of concern: cost, quality, and access. Most policymakers and other stakeholders are focused on developing methods of reducing health care spending, improving quality, and ensuring that all Americans receive the medical services necessary to be contributing members of society.

Currently the government, insurers, health care networks, employers, and medical and consumer organizations are diligently promulgating data to determine how care is delivered. Their findings highlight the waste, variances, inequities, and other weaknesses in the system. Indeed, it’s almost impossible to scan the headlines in clinical journals—and even the daily newspapers—without running across an article describing the disparities in the health care system and the foibles of health care professionals.

For example, the June 14 issue of The New York Times featured an article regarding a study by the Pennsylvania government of area hospitals where coronary bypass operations are performed. The state found that the best-paid hospital typically received nearly $100,000 for the operation, whereas the least-paid got less than $20,000 for the same procedure. Furthermore, two of the highest-paid facilities had higher-than-anticipated death rates. The hospitals attributed the greater expenses to one or two very complicated cases. Nonetheless, the Pennsylvania study supports a growing national consensus that higher costs do not necessarily translate into better care.

“'We need to break down the walls that separate us and start building connections and relationships with other health care professionals and stakeholders.’”

Information accrued at such institutions as Johns Hopkins University, Dartmouth Medical Schools, and through the College’s own database and printed in publications ranging from the Wall Street Journal to the New England Journal of Medicine points to the following conditions:

- Variability of care across populations, with individuals who live in certain areas of the country having less access to quality care than other Americans—or, in some cases, patients in some states being much more likely to undergo operative care than to be treated with the less invasive techniques physicians use elsewhere
- Unwillingness on the part of some health care professionals to follow and apply accepted standards of care
- A large percentage of hospital readmissions resulting from postoperative or post-procedure complications
- The frequent delivery of ineffective or unproven treatments
- A lack of familiarity with and infrequent application of evidence-based medicine
• Inappropriate or wasteful use of technology
  These conditions are the realities of our current health care system, and although we are all entitled to our own opinions about why these problems exist, we are not entitled to our own facts. We cannot deny these uncomfortable truths when so much evidence supports them.
  It is important to note that all of these failures are systemic. They are not the result of the shortcomings of one individual or even one specific type of health care provider. Likewise, multiple stakeholders—most significantly, our patients—are suffering the consequences of this dysfunction. In other words, these are collective problems that demand collective analysis and collective solutions.

_Tribal mentality_
  For far too long, physicians have had a tribal mentality. We have focused on our respective specialties instead of rallying around the issues that affect us all. Surgeons talk only to other surgeons, primary care physicians bond with other generalists, and so on. Consequently, no one is hearing the other side of the story, and the physician community can rarely agree on how to approach a global issue, let alone develop and offer innovative solutions to system-wide problems.
  The fact of the matter is that health care professionals are no longer able to function in individual silos. Technology is driving us together by providing a wide range of treatment options. It used to be that if someone had breast cancer, for instance, a mastectomy yielded the best chances for survival. Now, however, we are giving breast cancer patients new hope for remission and a higher quality of life through radiation, the use of “cyber knives,” and chemotherapy implants. As a result, medical and surgical training and practice are becoming more organized and integrated. A full spectrum of specialists brings their talents, knowledge, and skills to patient care. We simply must be able to work together to ensure that our patients receive optimal care.
  We need to break down the walls that separate us and start building connections and relationships with other health care professionals and stakeholders to arrive at more valuable and adaptable solutions to the systemic challenges we are facing and to improve quality of care. Working with other physicians, the pharmaceutical and device companies, consumer advocates, hospitals, health plan providers, and so on will not weaken us but us make us stronger, more robust.
  Rest assured, the American College of Surgeons has no intention of caving into any gratuitous demands from other stakeholders who are looking to serve only their self-interests. Rather, we intend to lead a coordinated, cooperative, patient-focused effort to bring about positive change. By keeping the patient at the center of our efforts, we can effectively address the long-term interests of our Fellows and provide the tools they need to succeed.

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

Thomas R. Russell, MD, FACS
Bills target combat and civilian trauma

In Spring 2007, Congress worked on several bills pertaining to trauma services. Examples are as follows:

- Congress passed the fiscal year (FY) 2007 supplemental appropriations bill, which includes $600 million for the U.S. Department of Defense health program for traumatic brain injury (TBI) and post-traumatic stress disorder treatment. It also allocates $331.7 million for research, development, testing, and evaluation. President Bush signed the legislation.
- The House FY 2008 Labor, Health & Human Services, and Education Appropriations bill was reported out of committee with zero funding for the Health Resources and Services Administration’s Trauma-Emergency Medical Services (EMS) program. At press time, the Senate version of this legislation had not been filed, and the College continued advocating for full authorization at $12 million.
- On March 7, Sens. Orrin Hatch (R-UT) and Edward Kennedy (D-MA) introduced S. 793, legislation that reauthorizes the TBI Act, and on March 8, Rep. William Pascrell, Jr. (D-NJ), introduced a House companion bill. At press time, the bills were being reviewed in the Senate Committee on Health, Education, Labor and Pensions and the House Committee on Energy and Commerce, respectively.

GAO testifies on Medicare efficiency

The U.S. Government Accountability Office (GAO) recently presented testimony before the House Ways and Means Health Subcommittee based on their analysis, Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency. Although the GAO study focused on generalist physicians—who described their specialty as being general, internal medicine, or family practice—the office asserts that its methodology would be useful in profiling medical specialists as well. Based on 2003 Medicare claims data, the analysis found that physicians with a disproportionate share of costly cases were more likely to have patients receiving hospital or home health services. The GAO also concluded that outliers were less efficient. According to the GAO, the Centers for Medicare & Medicaid Services (CMS) has the tools to evaluate the efficiency of physicians’ practices, substantial experience in adjusting for differences in patient health status, and a track record in physician education programs. Therefore, the GAO maintains that CMS could lead an educational effort that uses efficiency profiling and provides physicians with reports comparing their efficiency with that of their peers.

In addition, the GAO concludes that CMS’ use of the sustainable growth rate (SGR) system to moderate physician spending growth and to update payments lacks incentives for the efficient use of resources. Copies of the report can be downloaded from the GAO’s Web site at [http://www.gao.gov/new.items/d07862t.pdf](http://www.gao.gov/new.items/d07862t.pdf).
Chapter leaders, young surgeons meet

Approximately 100 chapter leaders and young surgeons participated in the College’s 2007 Leadership Conference, June 3–6, in Washington, DC. A total of eight members of Congress addressed the attendees, providing their insights into where health care reform legislation is heading and how to effectively communicate with policymakers. Congressional participants included the following: Reps. Pete Session (R-TX); Phil Gingrey, MD (R-GA); Charles Boustany, MD, FACS (R-LA); Bart Gordon (D-TN); Tom Price, MD, FACS (R-GA); Earl Pomeroy (D-ND); and Pete Stark (D-CA), Chairman of the House Ways and Means Health Subcommittee. Sen. Jack Reed (D-RI) spoke to participants in a Capitol Hill reception.

Other highlights of the meeting included sessions on how Capitol Hill works, pay for performance, leadership, and generational factors that affect volunteerism. ACS President Edward M. Copeland III, MD, FACS, provided opening remarks that focused on the lessons he has learned throughout his distinguished surgical career.

Subsequent to the meeting, the College awarded the Arthur Ellenberger Award for Excellence in State Advocacy to Andrew L. Warshaw, MD, FACS, of Boston, MA. Dr. Warshaw has spent many years in his surgical career advocating for patients and for the surgical profession.

Debridement billings need more oversight

The Office of the Inspector General (OIG) of the U.S. Department of Health & Human Services issued a report on June 14 recommending that CMS strengthen Medicare safeguards to prevent improper payments for surgical debridement services, either through a new national coverage determination or better carrier policy guidance. According to the OIG, 64 percent of surgical debridement services that Medicare reimbursed in 2004 fell short of program requirements, resulting in approximately $64 million in improper payments. These improperly paid services most often were provided by podiatrists (66%), with general surgeons performing them 10 percent of the time. To view the report, visit http://www.oig.hhs.gov/oei/reports/oei-02-05-00390.pdf.

AHRQ resource designed to improve safety

The Agency for Healthcare Research and Quality (AHRQ) recently released Mistake-Proofing the Design of Health Care Processes, a new resource designed to improve safety in health care environments. The electronic reference contains tips on inexpensive mistake-proofing, the benefits of root-cause analysis, and creative uses for nonmedical products in medical settings. Specific examples include (1) marking floors to delineate quiet zones that reduce interruptions to nurses that could result in medication errors; (2) using a pen, microchip, and wristband to minimize the chances of wrong-site surgery; and (3) attaching chemical light sticks to intravenous tubes for fluid identification. The resource offers 150 examples, most with photographs, and is available online at http://www.ahrq.gov/qual/mistakeproof.
What surgeons should know about…

The Trauma Act of 2007 and the future of surgical emergency care

by Adrienne Roberts, Government Affairs Associate, Division of Advocacy and Health Policy

Since 1990, the Trauma Care Systems Planning and Development Act (Trauma Act), which created Title XII of the Public Health Service Act, has provided $31.4 million to help states and territories develop and implement statewide trauma care systems. The trauma care program was developed in response to the findings of a 1986 Government Accountability Office report (States Assume Leadership Role in Providing Emergency Medical Services, GAO/HRD-86-132) that severely injured individuals in a majority of sampled urban and rural areas of the U.S. were not receiving the benefit of trauma systems despite considerable evidence that these systems improve survival rates. Administered through the U.S. Department of Health and Human Services’ (HHS) Health Resources and Services Administration (HRSA), the Trauma-EMS (Emergency Medical Services) Systems Program has distributed funds to all 50 states and five territories over the past several years.

The Trauma Care Systems Planning and Development Act of 2007 (H.R. 727) was introduced on January 30, 2007, by Reps. Gene Green (D-TX) and Michael Burgess, MD (R-TX). The Senate version (S. 657) was introduced by Sens. Jack Reed (D-RI) and Pat Roberts (R-KS) on February 16.

On March 27, the U.S. House of Representatives passed H.R. 727. The Senate then followed suit on March 29, and the bill was signed by President Bush on May 3. The legislation is now Public Law (PL) 110-23.

How does PL 110-23 change the original Trauma Act?

PL. 110-23 reauthorizes the HRSA’s Trauma-EMS program through fiscal year (FY) 2012 and doubles the authorization level to $12 million for FY 2008, $10 million for FY 2009, and $8 million for FY 2010–2012.

Another change is the creation of a new competitive grant program for states that have already begun the process of establishing a trauma care system using national standards and protocols. PL. 110-23 provides that...

...states, political subdivisions, or consortia of states or political subdivisions for the purpose of improving access to and enhancing the development of trauma care systems...may make a grant...if the applicant agrees to use the grant—(1) to integrate and broaden the reach of a trauma care system, such as by developing innovative protocols to increase access to prehospital care; (2) to strengthen, develop, and improve an existing trauma care system; (3) to expand communications between the trauma care system and emergency medical services through improved equipment or a telemedicine system; (4) to improve data collection and retention; or (5) to increase education, training, and technical assistance opportunities, such as training and continuing education in the management of emergency medical services accessible to emergency medical personnel in rural areas through telehealth, home studies, and other methods.

The law also states that preference will be given to grant applicants who have already established a process for developing trauma care systems, evaluating the performance of a system, and designating trauma centers using nationally recognized standards.

How has the Trauma-EMS program been funded in the past?

Funding of the program has included $4.8 million in FY 1992, 1993, and 1994; $3 million in 2001; and $3.5 million in FY 2002, 2003, 2004, and 2005. Unfortunately, the program received no funding for FY 2006 and 2007, but efforts are under way to secure funding for FY 2008.
How do I apply for a Trauma-EMS Program grant?

If funding is restored for FY 2008 (at the time this article was written, appropriations legislation was pending), then the Secretary of the HHS will have to reestablish the HRSA Trauma-EMS office with new staff or assign the program to another office. Once this office has been reinstated, a notice will appear in the Federal Register announcing the availability of grant funding with detailed directions and a grant guidance document. The College will also notify Fellows that the notice has been published.

How does this effort coincide with the IOM report, The Future of Emergency Care in the United States Health System?*

To provide some background on this comprehensive report, in June 2006, the Institute of Medicine (IOM) published an account of the current tragic situation confronting injured and ill Americans across the country. Hospital emergency departments and trauma centers are severely overcrowded and often physician specialists are unavailable to provide emergency and trauma care. To alleviate this situation, the IOM called for a complete overhaul of our nation’s emergency and trauma care by creating a coordinated and regionalized system of care modeled after the HRSA Trauma-EMS program. According to the report, “The objective of regionalization is to improve patient outcomes by directing patients to facilities with optimal capabilities of any given type of illness or injury.” The report further states, “Trauma systems provide a valuable model for how such coordination could and should operate.”

Concurrent with the release of the IOM report, the College released its own report, A Growing Crisis in Patient Access to Emergency Surgical Care (www.facs.org/ahp/emergcarecrisis.pdf), which reached similar conclusions to those of the IOM with respect to patients’ declining access to critical emergency surgical care, detailing fully the emergency care surgical care shortage and providing recommendations for facing the crisis. In 2006, the College continued its commitment to bring national attention to this issue by sponsoring a series of IOM report dissemination workshops throughout the U.S., which brought together the media, stakeholders, and leading federal health care policymakers.

What other efforts is the College working on in regard to emergency services?

The IOM and the College have worked hard to develop concrete recommendations to reverse the emergency care crisis. The College has brought together representatives of the surgical specialties that work daily to provide the life-saving emergency surgical care for our citizens in order to develop a concrete set of recommendations for reforming the nation’s emergency departments with the hope that these proposals will eventually be presented and then adopted by Congress. The College, along with the American Association of Neurological Surgeons and the American Academy of Orthopaedic Surgeons, has worked to develop a legislative agenda to address the ongoing surgical workforce crisis in emergency departments across the nation.

What would this emergency surgical care legislation entail?

The following priority issues were identified: liability protections, reimbursement for treatment of the uninsured, loan deferment extension, and the regionalization of emergency care. We are now approaching other surgical specialty societies for input and support and will then enlist a member of Congress to sponsor this agenda. These reforms include the following:

- **Regionalization.** As recommended by the IOM reports, HHS should create a demonstration project to develop interconnected systems of emergency care across geographic areas so that our nation’s injured citizens receive the emergency care they require regardless of their geographic location.
- **Ensuring an adequate emergency care workforce.** Enhancing the viability of this workforce through incentives such as extension of medical school loan deferment and expansion of the National Health Service Corps to include the emergency surgical care workforce.

*Institute of Medicine, National Academy of Sciences, July 2006.
21 years of reinvention:

Dennis O’Leary, MD, discusses the past and future of The Joint Commission

by Diane S. Schneidman, Manager, Special Projects, Communications

Author’s note: Last year, Dennis O’Leary, MD, announced that after 20 years of serving as president of The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO), he intends to retire. The search for his replacement was continuing at press time.

Since Dr. O’Leary assumed The Joint Commission presidency in 1986, the organization has evolved, shifting its focus from inspection to patient-centered evaluation, quality improvement, and increased patient safety. In this interview, Dr. O’Leary explains how and why The Joint Commission has undergone its transformation; offers his insights into ongoing policymaking efforts that relate to performance measurement, public policy, and quality; and talks about the future.
What do you consider to be the most significant change that has occurred in health care accreditation since you assumed leadership at The Joint Commission in 1986?

We have gone through several changes to make the accreditation process more relevant to hospitals, to other health care organizations, and to patients. For example, when I first started at The Joint Commission, we had 2,600 accreditation standards for hospitals. We have shrunk that number by 90 percent to arrive at a set of requirements that focus on the health care organizations’ actual ability to provide safe, high-quality care.

We also have refined the on-site inspection process. When I started, the on-site survey process was like a hit-or-miss fishing expedition that might or might not find existing problems. We now use data-based algorithms to tell the survey team what aspects of organization performance need to be examined most closely. The surveyors also track the routes for selected patients through their actual care experiences in the organization. Tracking actual patient care made the process come to life for the surveyed organizations and the clinicians who care for patients. They can now see how standards relate to patient care, and it has made Joint Commission accreditation more clinically relevant in their eyes.

These changes had their origins in our Agenda for Change. This initiative was launched in 1986 as a major developmental project to improve the ability of The Joint Commission to evaluate health care organizations in a more meaningful fashion. By 1994, we had succeeded in shifting the focus of our accreditation standards and survey process to the actual provision of care to patients and how health care organization management supports that effort. The Agenda for Change also codified the emphasis of the standards on patient safety and established an expectation that all standards relate directly or indirectly to patient outcomes. That was our first reinvention.

The Joint Commission’s second reinvention was our Shared Visions/New Pathways project, which was implemented in 2004. This set of changes was designed to make the accreditation process more continuous and to encourage hospitals to develop a framework that supports ongoing improvements in patient safety and health care quality. So, we’ve moved from being seen as an inspection group to being seen as a body that evaluates and seeks to help improve the safety and quality of care.

What were your main goals when you assumed your leadership position? What new goals emerged over the years, and how did they develop?

The accreditation process was badly broken when I came to The Joint Commission. Surveyors received minimal training and supervision and were pretty much on their own out in the field. It was like Dodge City before the marshals came. We have since made a huge investment in improving and tightening the surveyor selection, training, testing, and oversight processes.

For many years, many physicians and health care organization administrators had viewed The Joint Commission as an annoyance and sometimes as a problem. And, those who had a stake in how well we did our job, such as patients, saw us as irrelevant, if they saw as at all. To change that image, we both revolutionized the accreditation process and expanded its dimensions. It would seem that the intent of the American College of Surgeons when it created the forerunner of The Joint Commission—the Hospital Standardization Program—in 1917 was performance improvement, and that’s what our goal is today. But to achieve this goal requires more than an accreditation process. It requires investment in performance measurement, patient safety, information dissemination, and the pursuit of public policy initiatives. We call these strategies, along with accreditation, our “five pillars.”

After accreditation, how would you describe the remaining four “pillars”? Which Joint Commission activities are related to each of them?

Performance measurement is the logical extension of accreditation and is the basis for all of our quality improvement activities. As part of the Agenda for Change, we created the Indicator Measurement System, but hospitals weren’t ready for it. Nonetheless, we have persisted and, in so doing, have engaged clinicians and hospitals
in the priority setting and development processes for performance measures. The measure development process—originally created through the Agenda for Change—has also proven its worth and has been widely imitated. Today, three of the four measure sets developed through this process—those for acute myocardial infarction, heart failure, and pneumonia—have become key components of the voluntary reporting programs that the Hospital Quality Alliance and the Centers for Medicare & Medicaid Services (CMS) have initiated.

Patient safety is at the core of who we are because accreditation is fundamentally a risk-reduction process. It assumes that by setting standards and leveraging compliance with those standards, we improve safety. Although that assumption is probably true, we have recognized that much more needs to be done to improve patient safety, and we have aggressively pursued these efforts. For starters, we established a sentinel event policy to encourage voluntary reporting of serious, preventable, adverse events and analysis of their root causes. This effort culminated several years ago with the creation of The Joint Commission’s National Patient Safety Goals, which have now been integrated into the accreditation process. Today, more than 50 percent of Joint Commission standards relate to patient safety.

Information dissemination essentially means public reporting. This activity is about public accountability and about providing patients with information they can use in making decisions about their health care. We now host an information-rich, very active Quality Check Web site. Quality Check provides organization-specific information on the facility’s accreditation status, comparative performance with respect to quality measures, National Patient Safety Goal compliance, and distinctive quality-related achievements.

Our public policy initiatives center on developing positions and recommendations about major issues that affect health care quality and patient safety. The first subject we examined was the nursing shortage and its quality and safety implications. That white paper has now been downloaded from our Web site more than 1.3 million times. Most recently, we have issued a white paper on low health literacy and the attendant safety and quality risks of this problem. We’ve also issued white papers on emergency preparedness, organ donation, and medical liability reform. Projects currently on the drawing board include development of a national data-management strategy, reduction of waste in health care organizations, and linkages between health information technology and opportunities for safety and quality improvement.

**What process is used to develop these public policy white papers?**

We first decided to launch the public policy initiative because resolution of the issues at hand was beyond the reach of The Joint Commission alone. So, we start by identifying the major players who are leaders in addressing the issue or who are affected by it. Then we invite representatives of these groups to participate in a series of roundtable sessions, first to frame and analyze the issues and then to develop recommendations and identify accountabilities for their implementation. The success of these efforts depends on getting all of the key players at the table, but The Joint Commission has long been blessed as an effective convener. The roundtable discussions lead to the framing of the white paper, which is then vetted at a national summit and eventually approved by the Board of Commissioners. It’s a process that typically takes 18 months. These are not easy to get out the door because they center on controversial issues, and we don’t put out anything that’s vanilla.

In reading your 1988 interview in the *Bulletin* (Gere M. Meeting standards for high-quality care: An interview with Dennis S. O’Leary. 1988;73[4]:7-10), one can’t help but note that nearly 20 years ago, you were already talking about concepts that are really at the forefront of health system reform efforts today. For example, you speak of the need to establish risk-adjusted clinical indicators. In recent years, policymakers have shown increasing interest in outcomes measurement. What factors do you think spurred this change in direction?

The 1999 Institute of Medicine report on patient safety and medical errors, *To Err Is Human,*

and its successors on quality and access to care certainly spurred more stakeholders to get involved in quality measurement. All of these reports have created greater visibility for quality and patient safety issues and make it hard for policymakers to ignore them. These reports and other efforts have also stimulated the public to “get some skin in the game.” People today increasingly want to have access to information about quality at the practitioner and health care organization levels so that they can make informed decisions in seeking care.

What federal programs do you think are contributing to the quality improvement movement?

The Agency for Healthcare Research and Quality (AHRQ) has developed quality and safety-related measures, funded major quality and safety research studies, and now issues annual reports on quality and disparities in health care. AHRQ has been a major player in this arena.

The CMS Quality Improvement Organizations also have provided intellectual leadership for performance measure development, implementation, and application.

What do you consider to be the most difficult aspect of implementing quality assurance and improvement programs?

Most of the challenges relate to impressing upon physicians that they need to be involved, to start applying best practices at the clinical level, and to be part of and even lead efforts to redesign patient care processes to make them safer. If you went to medical school and weren’t taught anything about this—about the use of data to drive improvements in outcomes and how engineering principles of systems design apply to patient safety—you’re going to wonder why you need to learn about this now. But in most health care organizations today, the blind are leading the blind, especially in hospitals.

The reality is that we are having difficulty getting people to implement even the most basic safety protocols. For example, we have found an 18 percent noncompliance rate for readback of verbal orders and a 25 percent noncompliance rate for reporting critical test results. These are not frivolous issues. They are simple cornerstones of patient safety.

As another example, we, with the American College of Surgeons and other health care organizations, introduced the Universal Protocol for Preventing Wrong-Site, Wrong-Procedure, Wrong-Person Surgery in July 2004 to help ensure that the right patients undergo the right surgical procedures. Before that protocol was issued, we were getting five reports of wrong-site surgery per month. Since then, we have averaged eight new reports per month. What this increase in reporting says is that we have to do more at the grassroots level to get institutions and physicians to conform to these expectations and to take them seriously.
So, are you saying that a cultural change needs to occur?

Cultural change and changes in health professional education are both essential. We can and should do more to standardize patient care processes to keep inevitable human errors from reaching patients. But these changes will be most effective if introduced in the right context—an organizational culture of safety, if you will. Introduction of this new environment, if nothing else, requires strong governance, management, and professional leadership in health care organizations. And health care professionals may require some reeducation to learn basic safety and quality principles that were not taught in the professional schools.

How do you see the quality measurement programs developed through other medical organizations, like the College’s National Surgical Quality Improvement Program (ACS-NSQIP), interfacing with The Joint Commission’s accreditation efforts?

Everyone is in a lather about developing quality measures, but most institutions do not know how to translate the data into actionable information. The real quality improvement need is to teach analytic skills to all professionals involved in patient care. This will permit them to engage in actual improvement efforts. So it’s time for hospitals, in particular, to roll up their sleeves and figure out how they’re going to support and make quality improvement happen internally. All that quality measures and databases can do is tell you where the problems are, and all that information does is set the stage for quality improvement. NSQIP worked in the Veterans Affairs system because they knew how to use the data to drive the quality-improvement process.

Which of your original objectives do you believe The Joint Commission has most successfully achieved?

When I came to The Joint Commission, we often were not invited to quality-related policy forums. That, I would presume, is because we were not seen as being relevant. That’s changed now by orders of magnitude. Now we get invited to everything and have trouble keeping up with all of the policy discussions and projects in which we are asked to participate. Policy-makers now often turn to us for answers to their questions. This experience has provided a good object lesson that respect is earned.

Were there any efforts that did not go as expected?

We’ve certainly had our controversies. A number of times when something we proposed didn’t work out, the timing just wasn’t right. People weren’t ready for it yet. For example, a couple of years ago, we contracted with the Blue Cross Blue Shield Association to put out data reports on provider performance. We were pushing the envelope on that one, and there was a strong reaction from provider organizations. Now provider data reports are everywhere. After that misadventure, the Board of Commissioners eventually adopted a new policy that bars The Joint Commission from selling any performance data and provides open public access to our Quality Check Web site. That was actually an even better outcome.

Of course, we’re not going to get everything right the first time, but we’ve learned from our missteps and have tried even harder to get it right the next time around.

Where do you see The Joint Commission headed in the coming years?

Quality and safety will continue to be the top priorities for The Joint Commission and throughout the health care system. In fact, if anything, public interest in these issues will intensify. I expect that The Joint Commission’s five pillars will continue to guide its efforts. Much of the work downstream is going to be an extension of what we’re doing now.

Once called JCAHO, the organization recently changed its name to simply The Joint Commission. What spurred the name change?

We did it primarily for the sake of simplicity. The reality was that no one could say our name in one breath. We decided that a shorter name would help the organization build brand recogni-
tion. There are a few other “joint commissions” out there, including several smaller ones in health care, but most people already refer to us as just The Joint Commission.

How would you describe your legacy as president of The Joint Commission?

I don’t believe in legacies. I would just say that during my presidency, we succeeded in putting The Joint Commission on the map—the organization has developed a clear identity within the health care system.

What advice would offer to your successor?

I would share with him or her the corporate principles that I’ve followed as president of The Joint Commission. I won’t go into all of them right now, but here are six of them:

• Share your intellectual knowledge and work products. Remember that we are trying to spread the use of accreditation standards and performance measures.
• Collaborate with others. It’s almost impossible to achieve anything significant by yourself.
• Be persistent. The last person standing wins.
• Pay attention to process. People want to be involved in your efforts.
• Be a good listener. People are trying to tell you how to succeed.
• Have a sound understanding of who you are. That starts with understanding that you are one among many and that the goal is to make the system work. If it wins, you win too.

What are your plans for the future?

I am the last survivor of two remarkable families that involved several people with real legacies, so I have an estate to manage. That effort will start with a task my father left to me. He wrote book reviews for The Kansas City Star for 60 years, and in the course of his work, accumulated approximately 16,000 books that need to be put into some sort of order. Some of them are quite rare and many are first editions. We have now built a library for them, but the work has only just begun.

Do you have any final thoughts?

I’d just say that it’s been a great trip, and it never would have happened without the remarkable staff we have here. The people who work here believe in what we’re doing. They believe our work is important.
Mass casualty events caused by military operations, terrorist attacks, accidents, and natural disasters are unfortunately ubiquitous events worldwide. Effective professional and institutional responses to such events require forethought and adherence to a predetermined plan. Surgeons and hospitals play key roles but must work collaboratively with the other interdependent components of the emergency response system.
Definitions

A disaster caused by either a natural or man-made event may result in mass casualties as well as a complete loss of social infrastructure. The key issue is provision of security, shelter, food, and water to the populace. (Management of the disaster scene itself is beyond the scope of this article.) A mass casualty event occurs when the number of patients exceeds the ability of the available medical resources to individually manage each patient. In contrast, a multiple casualty event occurs when an institution is able to individually manage each patient by mobilizing additional resources. The goal of the medical response is conversion of a mass casualty event in the field to a multiple casualty event for each hospital. Although the outcome of injured patients is improved by triage and transport to a designated level I trauma center, once a hospital receives a number of severely injured patients which overwhelsm its capacity, it ceases to function as a level I trauma center. Each hospital in a given geographic area must therefore cooperate with the emergency medical system (EMS) and be prepared to receive patients in the event of a mass casualty event.

Management at the scene

Security is the initial priority at the scene of a mass casualty event. The area must be secured. If the event is caused by a terrorist bombing, a careful search for additional terrorists and unexploded ordnance is imperative to prevent a “second hit” aimed at injuring the rescue team. This may result in a delay in transport of the patients to the hospital.

Victims should be concentrated and managed with attention to airway, breathing, and circulation. The simple triage and rapid treatment (START) system uses a protocol consisting of assessment of airway patency, respiratory rate, and pulse to achieve rapid field triage. Airway control, tourniquet application to prevent exsanguination from penetrating extremity injuries, and decompression of tension pneumothorax are the only three life-saving maneuvers that can be performed in the field. Immediate transport of patients with life-threatening injuries to the hospital is essential. Rapidly deteriorating patients should be transported to the closest available hospital. The field commander should distribute critically ill patients among the receiving hospitals to avoid overloading a single hospital. The goal in the field is to create order out of chaos and convert the field mass casualty event to a multiple casualty event for each hospital.

Field management involves a complex interaction between the EMS, the police, the fire department, and, on occasion, the military. Command authority must be established. These relationships should be codified before a mass casualty event occurs to prevent confusion. Attention should be focused on the victims, not the parochial interests of the various responding agencies or the egos of individual commanders.

Hospital management

The emergency room (ER) should be immediately cleared upon notification of a mass casualty event. ER staff should discharge or admit these patients. The initial hospital triage should take place outside of the hospital, preferably in an area adjacent to the ER. The initial triage separates the patients into “walking wounded” and “stretcher” categories. The triage officer might be a surgeon—for example, in 12 of 14 Israeli hospitals recently surveyed, a senior surgeon serves as the triage officer. Walking wounded patients enter the ER by a separate door and are managed by junior physicians and nurses. A surgeon commands the walking wounded area to identify and correct any errors in triage.

Stretcher patients enter the main door of the ER, where they immediately undergo a secondary triage by a senior surgeon. Patients are separated into immediate care and delayed care groups based on cardiorespiratory and neurologic findings. Most of the patients sent to the hospital will have relatively minor injuries. The individuals who have borne the brunt of the explosion usually are dead at the scene. However, hidden within the large number of stable patients are several who are dying. The challenge is to identify these patients and put them in the care of expert teams in the immediate care area.

Each bed in the immediate care area is staffed
by an anesthesiologist, a junior surgeon, two nurses, and a senior surgeon. The role of the anesthesiologist is airway control. The junior surgeon provides vascular access and the senior surgeon makes a decision regarding diagnostic and therapeutic interventions and disposition. The immediate care area is commanded by a senior surgeon who makes triage decisions when immediate care patients compete for limited resources. The goals of therapy in the immediate care area are airway control, vascular access, and control of external hemorrhage.

Each bed in the delayed care area is staffed by a physician (preferably a junior surgeon) and a nurse. A senior surgeon commands the delayed care area to provide advice and identify any triage errors.

The walking wounded area is staffed by nurses and junior physicians. A senior surgeon or physician should command this area to provide advice and effect rapid decisions.

Patients who are dead on arrival to the hospital should be triaged to the morgue. Patients who are dead in the field, in general, should not be transported to the hospital.

Expectant care is a triage category used in mass casualty events. Patients in this category have devastating resource-intensive injuries that would overwhelm the existing medical assets, preventing treatment of other patients with a greater chance for survival. In this situation, patients initially receive minimal comfort care and are treated after the other patients or when additional resources are mobilized. The need for triaging patients to expectant care can be minimized by converting a mass casualty event to a multiple casualty hospital event. This can be achieved by the appropriate distribution of immediate care patients among the different receiving hospitals.

Following airway control, vascular access, and control of external hemorrhage, immediate care patients should be transported to one of three places: the operating room (OR), the computed tomography (CT) scanner, or the intensive care unit (ICU). Most blast injury patients do not require immediate access to the OR unless they have vascular injuries related to traumatic amputations or penetrating shrapnel. The CT scan is a key diagnostic procedure in blast injury patients and is usually the rate-limiting step in the orderly flow of patients through the diagnostic and therapeutic hospital triage cascade.

**Hospital organizational changes**

In order to maintain flexibility and accommodate the surge of patients in a mass casualty event, individual hospitals must shift from standard day-to-day operations to a system that resembles a military hierarchy called the Hospital Incident Command System. This system organizes the emergency response within the hospital and offers a scalable response to incidents of any magnitude. It replaces the normal hospital administrative architecture with a chain of command headed by a predesignated incident commander, a senior surgeon.

The key individuals required for the initial management of the immediate and delayed care patients are surgeons; anesthesiologists; intensivists; ER, ICU, and OR nurses; radiology technicians; and radiologists. Commanders should mobilize these individuals based on pre-arranged phone trees, beeper systems, virtual private networks, and media announcements. Reliance on cellular phone technology is dangerous because the system is either shut down immediately after a terrorist attack to prevent the use of cellular phones to detonate additional bombs or is overloaded by worried relatives calling each other. Management of the surge of volunteer physicians, nurses, and civilians in the clinical arena is an unsolved problem.

The abundance of volunteer and mobilized physicians and nurses has permitted the assignment of physician/nurse teams to each immediate and delayed care patient at the Shaare Zedek Medical Center in Jerusalem, according to Ram Spira, MD, of the department of surgery at that institution. This team accompanies the same patient throughout the diagnostic and therapeutic cascade until the patient has reached the definitive care unit. This system has substantially improved communication with the patient, the family, and the hospital incident commander.

**Hospital security**

Immediately after a mass casualty event, police should be assigned to clear key traffic arteries to facilitate the flow of ambulances to the...
hospital. The hospital area should be secured. Entrance to the hospital grounds should be controlled through one gate. All ambulances should be inspected before admission to the hospital grounds to ensure that they contain neither terrorist operatives nor ordnance. Entrance to the ER should be controlled by armed guards. Relatives should enter the main hospital after passing through security screening.

**Operating room considerations**

All elective surgery should be cancelled until the extent of the mass casualty event is known; however, all operations already in progress should proceed.\(^{10}\) The recovery room should be prepared for function as an extended ICU. Extended ICU capability is important in the initial four to six hours after the event to facilitate resuscitation as well as diagnostic and therapeutic triage.

**Intrahospital and interhospital transfer**

It may be necessary to transfer patients from surgical to medical wards in order to free up surgical beds to receive casualties. If a particular patient requires treatment beyond the capability of the receiving hospital (for example, a patient with head injury arriving at a hospital without neurosurgical capability), timely transfer of the patient following initial resuscitation is necessary. Alternatively, in a military situation, receiving hospitals may need to transfer stable ICU patients to other institutions farther from the front in order to have adequate bed capacity to receive the next wave of casualties. A predetermined interhospital transfer plan should be established with the help of the EMS.

**Patient tracking**

A mass casualty documentation system should exist. An example of a good nationwide patient-tracking system exists in Israel, where specially numbered medical folders, wristbands, and nylon sacks (for personal possessions) are prepared in advance. These items accompany the patient at all times. The location of each casualty is documented in a computer database continuously. A computerized list of patient location and injury severity is provided to the incident commander every 15 minutes. Digital photographs are taken of all unidentified patients and placed on a secure, national Web site to help families identify missing relatives, regardless of their location.

**Injury patterns**

The most common form of terrorist-related, mass casualty event is a bomb explosion. The patterns of blast injury can be divided into primary (injury caused by the blast wave), secondary (penetrating trauma caused by shrapnel), tertiary (blunt trauma caused by striking solid objects), or quaternary (a wastebasket category including burn, crush, or inhalation injury).\(^{11}\)

One form of primary blast injury that can complicate management of the patient’s other injuries is “blast lung” injury. This injury is a pulmonary contusion caused by the impact of the blast wave. It can be associated with significant hypoxemia and require intensive ventilator support.\(^{11}\)
Conclusion

An effective medical response to a mass casualty event seeks to convert a mass casualty event in the field to a multiple casualty event for each hospital by appropriate distribution of immediate care patients to the various receiving hospitals. The hospital response involves establishing security, mobilizing additional resources, and conversion to the hospital incident command system. An intrahospital triage cascade occurs that prioritizes diagnostic and therapeutic procedures with the goal of saving the maximum number of lives possible.

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Dr. Staudenmayer is a fellow in trauma and critical care surgery, San Francisco General Hospital, San Francisco, CA.

Dr. Schecter is professor of clinical surgery and vice-chair of surgery, University of California, San Francisco; and chief of surgery, San Francisco General Hospital. In 2004, Dr. Schecter spent a sabbatical at the Shaare Zedek Medical Center in Jerusalem, Israel, studying civilian hospital response to mass casualty events. In 2006, Dr. Schecter served in the Rebecca Sieff Hospital in Safed, Israel, caring for casualties from the Lebanon war.
Patient demand for bariatric surgical services has been exponential, but meeting that demand has not kept pace with the epidemic of obesity (see Figure 1, page 22). Obesity is defined as a body mass index (BMI) greater than 30 kg/m², and weight-loss surgery is reserved for patients with comorbid conditions and a BMI greater than 35 or a BMI of 40 alone. Severe obesity is defined as having a BMI ≥ 40. In 2003, more than 110,000 bariatric operations were performed in the U.S. With estimates of 11.5 million patients meeting medical necessity for weight-loss surgery, millions of potential patients may not have access to care. Without weight-loss surgery, severe obesity treated by diet and exercise carries its own high mortality.

In response to the epidemic of obesity, many surgeons are adding weight-loss surgery (see Figures 2 and 3, page 23) to their practices and bariatric centers are emerging to meet the demand for this operation, for which there are long waiting lists. Societies, licensing boards, and governmental agencies have published guidelines to standardize care and encourage hospital investment in its infrastructure for their patients of size. The Betsy Lehman Center for Patient Safety and Medical Error Reduction convened an expert panel in Massachusetts to establish best practices for weight loss surgery (www.mass.gov/dph/betsylehman/panel_summary.htm). The American Society for Bariatric Surgery (ASBS) recognized the importance of establishing “centers of excellence” and established a program for accreditation of surgeons and facilities based on volumes, personnel, and infrastructure. The ASBS endorsed a not-for-profit corporation with a board representing surgeons, industry, and insurance providers to oversee the new corporation. Site visits are conducted by nurses. The best programs would be recognized based on initial criteria of hospital volume and surgeon...
experience. Lower-volume hospitals could not meet the centers of excellence criteria.

The American College of Surgeons had already recognized the importance of surgeons accrediting surgeons. The ACS had established the Hospital Standards Committee, which became the Joint Commission on Accreditation of Healthcare Organizations (now called The Joint Commission) in 1951. Later the ACS established the accreditation of trauma centers and cancer centers. The ACS established a Bariatric Surgery Center Network (BSCN) Advisory Committee in 2003 to set criteria for accreditation of bariatric surgery centers using the already existing programs for trauma and cancer centers as suggested templates. Key concepts were that surgeons alone, and not industry or nonsurgeons, needed to have oversight of the accreditation process; the professional society—not a separate corporation—should oversee the process; and although institutions, facilities, and programs needed rigorous accreditation, surgeon expertise would be better assessed by local hospital credentialing systems already in existence. The goal was to be inclusive and to use best-practice guidelines to improve patient safety across programs. Central to the goal of the ACS was a database that could be verified, to ensure patient outcomes did not deviate from risk-adjusted benchmarks. Maintenance of accreditation would be based on meeting these benchmarks.

The American College of Surgeons Board of Regents formally approved the BSCN to accredit hospitals in 2005. The standards established for the American College of Surgeons BSCN Accreditation Program delineate four levels for accreditation of inpatient facilities—identified as levels 1a, 1b, 2a, and 2b—and outpatient surgical care facilities, identified as “outpatient.”

High-quality surgical care requires documentation of reliable outcome measurements. Level 1a and 2a centers will use the ACS National Surgical Quality Improvement Program (ACS NSQIP) adapted for bariatric surgery, requiring a trained surgical clinical nurse reviewer to collect and submit the required ACS NSQIP data. These centers will have access to benchmark reports containing national aggregate data and individual facility data to assess patterns of care and outcomes relative to national norms. Level 1b, 2b, 2-new, outpatient facilities, and outpatient-new will report outcomes data to the ACS bariatric surgery database for accreditation purposes only. A designated and trained nonsurgeon of the bariatric surgery team will enter the data using the ACS’ established protocol. All centers must capture 100 percent of bariatric cases in their data collection.

**Level 1a and 1b centers**

Level 1 centers will provide complete care, with resources devoted to bariatric surgery. These hospitals can manage the most challenging and complex patients with optimal opportunity for safe and effective outcomes. These centers will engage all levels of obesity and standards of care for weight loss operations, ages, comorbid conditions, and reoperations. They will have high-volume practices of 125 or more weight-loss operations annually, with at least two credentialed and experienced bariatric surgeons, each performing a minimum of 100 weight-loss operations in the previous 24 months. These centers may apply for level 1 accreditation after providing bariatric surgery services for more than one year.
Recognizing that high-quality surgical care occurs in centers that don’t have a high volume of cases, the ACS will designate certain facilities as level 2 centers. These centers will provide high-quality care to a lower volume of patients—25 or more weight-loss operations annually, with one or more credentialed and experienced bariatric surgeon performing a minimum of 50 weight-loss operations in the previous 24 months. Level 2 bariatric surgery centers are not approved for operations on high-risk patients, such as men with a BMI of 55 or higher, women with a BMI of 60 or greater, or any nonambulatory patients or elective revisional operations. These centers may apply for level 2 accreditation after providing bariatric surgery services for more than one year.

In February 2006, the Centers for Medicare & Medicaid Services (CMS) tied reimbursement for bariatric surgery to already-existing patient-qualification criteria in addition to the requirement that the center be approved as a level 1 ACS center or ASBS-accredited program. In Massachusetts, Blue Cross Blue Shield broadened reimbursement to include ACS level 2a centers reporting excellent patient outcomes. It is hoped that CMS will eventually amend its decision and provide reimbursement for level 2 centers as well.

**Outpatient centers**

Outpatient centers will provide the application and adjustment of laparoscopic gastric bands. These centers will perform 50 or more weight-loss operations annually, with at least one

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**Figure 2.** Laparoscopic gastric bypass.

**Figure 3.** Laparoscopic adjustable gastric band.

ACS-accredited bariatric centers

Level 1 centers

Alabama
University of Alabama at Birmingham Hospital, Birmingham, AL (Level 1a)
Effective 12/7/06–12/7/09

California
Community Medical Center–Clovis, Clovis (Level 1b)
Effective 6/26/06–6/26/09
Cedars-Sinai Medical Center, Los Angeles (Level 1a)
Effective 6/20/06–6/20/09

Connecticut
Danbury Hospital, Danbury (Level 1a)
Effective 5/5/06–5/5/09

Florida
Cleveland Clinic Florida, Weston (Level 1a)
Effective 10/19/06–10/19/09

Illinois
Evanston Northwestern Hospital, Evanston (Level 1b)
Effective 1/26/06–1/26/09

Iowa
Grinnell Regional Medical Center, Grinnell (Level 1a)
Effective 10/19/06–10/19/09

Michigan
Hurley Medical Center, Flint (Level 1b)
Effective 4/14/06–4/14/09

Minnesota
Mayo Clinic–St. Mary’s Hospital, Rochester (Level 1a)
Effective 10/23/06–10/23/09

Massachusetts
Beth Israel Deaconess Medical Center, Boston (Level 1a)
Effective 2/17/06–2/17/09
Brigham and Women’s Hospital, Boston (Level 1a)
Effective 8/14/06–8/14/09

New Jersey
Hackensack University Medical Center, Hackensack (Level 1a)
Effective 12/8/06–12/8/09
Morristown Memorial Hospital, Morristown (Level 1a)
Effective 1/25/07–1/25/10

New York
Albany Medical Center, Albany (Level 1b)
Effective 6/2/06–6/2/09
Lutheran Medical Center, Brooklyn (Level 1b)
Effective 11/8/05–11/8/08
New York-Presbyterian Hospital/Columbia University Medical Center, New York (Level 1a)
Effective 6/14/06–6/14/09
New York-Presbyterian Hospital/Weill Cornell Medical Center, New York (Level 1a)
Effective 8/4/06–8/4/09
St. Luke’s-Roosevelt Hospital Center, New York (Level 1b)
Effective 10/11/06–10/11/09
Highland Hospital, Rochester (Level 1b)
Effective 8/30/06–8/30/09

Ohio
Cleveland Clinic, Cleveland (Level 1a)
Effective 12/1/06–12/1/09

Oklahoma
Saint Francis Hospital, Tulsa (Level 1b)
Effective 10/23/06–10/23/09
Oregon
Oregon Health & Science University, Portland (Level 1a)
Effective 6/27/06–6/27/09

Pennsylvania
Geisinger Medical Center, Danville (Level 1a)
Effective 1/26/07–1/26/10

Western Pennsylvania Hospital, Pittsburgh (Level 1b)
Effective 10/16/06–10/16/09

Vermont
Fletcher Allen Health Care, Burlington (Level 1b)
Effective 6/9/06–6/9/09

Virginia
University of Virginia Health System, Charlottesville (Level 1a)
Effective 7/12/06–7/12/09

Sentara Norfolk General Hospital, Norfolk (Level 1a)
Effective 9/29/06–9/29/09

Washington
University of Washington Medical Center, Seattle (Level 1a)
Effective 12/5/06–12/5/09

Wisconsin
Theda Clark Medical Center, Neenah (Level 1b)
Effective 1/27/06–1/27/09

Level 2 centers

Maryland
Harford Memorial Hospital, Havre de Grace (Level 2b)
Effective 12/21/06–12/21/09

Outpatient centers

Texas
Surgery Center of Richardson, Richardson
Effective 6/21/06–6/21/09

ACS Bariatric Surgery Center Network Advisory Committee

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credentialed and experienced bariatric surgeon performing a minimum of 50 primary weight-loss operations annually. These facilities must provide bariatric surgery services for more than one year before applying for outpatient accreditation.

**Level 2-new centers**

At an ACS BSCN Advisory Committee meeting in November 2006, committee members approved an additional level of accreditation, level 2-new, for more recently established centers. New programs can apply for accreditation as a level 2-new center without having to provide bariatric services for more than one year, but 25 weight-loss operations within the last 24 months are required. New centers submit outcomes quarterly and can apply for level 1 status after one year with adequate facility and surgeon volumes and all other level 1 standards having been met.

**Outpatient-new centers**

At its meeting in April 2007, the committee approved an additional level of accreditation for newly established outpatient facilities. An outpatient-new center may apply for accreditation after performing a minimum of 25 laparoscopic gastric bands. The program must meet all standards for outpatient facilities with the exception of time and volume requirements. After one year of accreditation, these centers may convert to outpatient center status.

**Grandfather clause**

The ACS BSCN program understands that established bariatric surgeons will relocate, and as such, surgeons with 300 lifetime cases will be considered bariatric surgeons for accreditation purposes. Moreover, fellows completing a formal minimally invasive surgery/bariatric fellowship should be credited for cases performed during fellowship training upon entering practice. However, such cases are not applicable to an institution other than the training center. Certification in fundamentals of laparoscopic surgery is recommended for newly trained laparoscopic surgeons.

**The ACS bariatric surgery database**

Level 1b, level 2b, and outpatient bariatric surgery centers will report their outcomes data to the ACS bariatric surgery database using a Web-based data-entry system. A designated trained nurse or other nonsurgeon of the bariatric surgery service will enter the data using the established protocol. The entered data will be subjected to quality control. The data will be entered into the database encrypted and deidentified to protect the confidentiality of the patients, the hospital, the outpatient facility, and the surgeons. When the hospital or outpatient facility receives the data reports, staff can identify the patients and surgeons. The hospitals and outpatient facilities will receive annual data reports. Center verification visits will include audits of the data, which include chart reviews. These data do not have the same rigor as ACS NSQIP and are not risk-adjusted; furthermore, they will not be used to make comparisons or for research because of the lack of rigor. These data will only provide a center’s outcomes to the ACS for accreditation.

**Data monitoring**

- **Level 1a and 2a centers**
  
  Level 1a and 2a centers, which are ACS NSQIP participants, can monitor their data on a 24/7/365 basis using the ACS NSQIP Web site. They can compare their data with the average of the other centers in the program. These centers will receive a semi-annual report of their risk-adjusted outcomes in confidential ranking with other center programs. These data will also undergo confidential review by the ACS NSQIP Advisory Committee and the ACS BSCN Advisory Committee. If these reviews reveal trends or variances of concern, the concerns will be communicated to the hospital chief executive officer (CEO), the surgeon director, and the program coordinator. Each ACS NSQIP Center will have interrater reliability visits from a trained, experienced surgical clinical nurse reviewer. This process involves a medical record review to assess the reliability of the submitted data and the variability of data collection and submission.

- **Level 1b, 2b, and outpatient facilities**
  
  Level 1b, 2b, and outpatient facilities are participants in the ACS BSCN database. The hospital CEO, the bariatric surgery director, and the bariatric surgery coordinator will receive a report of their non-risk-adjusted outcome data annually. The ACS BSCN Advisory Committee will review
each hospital’s deidentified data annually. If these reviews reveal trends or variances of concern, the concerns will be communicated in a special report to the hospital CEO, the bariatric surgery director, and the bariatric surgery coordinator.

**Finding out more**

To learn more about the necessary physical resources, human resources, clinical standards, surgeon standards, data-reporting standards, and verification/approvals processes required for the designation of American College of Surgeons bariatric surgery centers, log on to the ACS Web site, www.facs.org, and click on the link to the program in the left-hand column of the home page. Applications can be downloaded. At the time of application submission, established centers that have been in operation for more than two years will be asked to provide data for the previous two years. Facilities that have been in operation for less than two years will be asked to provide all their data. The applying center’s outcomes data are to be reported at 30 days postoperatively or in-house acute care. After successful review of an application, a site visit is scheduled. The committee reviews findings and accreditation is posted. For further inquires, contact the ACS BSCN directly at BSCN@facs.org.

Recognition as an accredited member of the ACS BSCN demonstrates a program’s commitment to the highest standards of care by the bariatric surgeons, allied health team, and hospital. Obesity remains a major health problem, and society needs to do more to prevent and treat the disease. The ACS BSCN establishes guidelines to ensure an infrastructure, multidisciplinary program, and patient preparation process to promote best practices and patient safety.

**References**


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Surgical lifestyles

The singing surgeon

by Karen Stein, Associate Editor
How does a person skilled in more than one craft pick the one that will be his future? When faced with the decision of becoming a physician or a musician, Gregory J. Gallivan, MD, FACS, of Springfield, MA—chief of thoracic surgery at Mercy Medical Center and Wing Memorial Hospital and an assistant professor of clinical surgery at University of Massachusetts Medical Center—decided to be both.

Choosing a future
He chose medicine as his main vocation. “I would have been good, but not world-class, as a pianist,” he says, considering the alternative of a primary career in music. “As my singing voice developed, my musical abilities entered the world-class realm. In medicine, you are measured by training, experience, and outcomes,” he explains. “But in music, you can be the greatest voice that ever lived, but without the right contacts, agents, or managers, you don’t necessarily make it to the big time.” So he set out to find a way to manage two demanding careers and became known as “The Singing Surgeon.”

But he was told early in his medical career—as a student attending Tufts Medical School in Boston, MA—that if he wanted to be a surgeon, he’d have to give up any aspirations of also singing opera. This scolding began when “A professor asked all of our class, most of whom had failed a parasitology exam miserably, what our medical intentions were,” Dr. Gallivan explains. “When I told him that I planned to merge music and medicine into a dual career, I was given a stern lecture that this was impossible. He further told me that I should not even consider marrying and having a family if I were to become a good surgeon but was to dedicate my life totally to surgery.”

Of course, Dr. Gallivan did not agree and has spent his career in surgery proving that assertion to be wrong, as he has managed to maintain two fulfilling careers. It would not have been easy for Dr. Gallivan to walk away from music, had he followed the directive to give it up. Having begun his classical piano training at age seven, Dr. Gallivan eventually studied piano, organ, voice, harmony, and theory at the Hartt College of Music while he was attending Tufts for his undergraduate and medical degrees.

Starring as the doctor
Major operatic roles for Dr. Gallivan, who is a dramatic baritone, include Die Zauberflöte (The Magic Flute, Mozart, 1791), Faust (Gounod, 1859), Mefistofele (Boito, 1868), Aida (Verdi, 1871), La Gioconda (Ponchielli, 1876), I Pagliacci (Leoncavallo, 1892), Hansel and Gretel (Humperdink, 1893), Amahl and the Night Visitors (Menotti, 1951), and The Phantom Tollbooth (Black, 1995).

But Dr. Gallivan has also played the role of the physician in many different operas. He has played Dr. Bartolo—in Mozart’s Le Nozze di Figaro (The Marriage of Figaro, 1786)—a stupid and funny doctor that he concedes is not a very flattering portrayal of physicians. In Strauss’ 1874 operetta Die Fledermaus (The Bat), he played Dr. Falke, an aristocratic type seeking revenge against a friend who got him into trouble (though as is the case with all operettas, the story ends on a happy note). He also played the
The association between divas and obesity is so common that when discussing the weight-related health concerns of operatic performers, the popular saying “It ain’t over ’til the fat lady sings” is often invoked. But when soprano Deborah Voigt announced in 2005 that she had undergone gastric bypass surgery for obesity, there was renewed examination of whether the singing lady need be fat at all. The debate had been sparked previously, for example, when Maria Callas lost a substantial number of pounds; many said that she subsequently lost some of her vocal talent.

But according to Dr. Gallivan, who shares a voice coach with Ms. Voigt and knows her personally, being fat, in fact, is not a necessity for singing well. Dr. Gallivan noted that the demands of a life of multiple performances and always traveling the globe are very difficult and that some people who have a compulsion to sing also have a compulsion to eat.

Though Ms. Voigt had previously made headlines for being fired from a production of Ariadne auf Naxos—the director thought the costume for her role, a sleek black dress, would not look right on her—her decision to undergo this procedure had exceeded this unceremonious dismissal, which she described as humiliating.

After previous attempts at weight loss had achieved only short-term results or had failed, Ms. Voigt reconsidered gastric bypass. She had contemplated having the procedure when it was new but had decided against it based on its associated mortality rate. When she opted to go ahead with the procedure 20 years later, she was experiencing knee weakness and had concerns about comorbidities associated with obesity (namely, diabetes and high blood pressure). That same year, the American College of Physicians, based on a report from the Agency for Healthcare Research and Quality, had issued guidelines recommending bariatric surgery for patients with a body mass index of 40 or greater and obesity comorbidities. At that time, 75 percent of the 150,000 obesity surgeries occurring annually were the same type of gastric bypass surgery Ms. Voigt had undergone. Through the gastric bypass, she lost 100 pounds.

To alleviate her concerns about risks of how the endotracheal tube might affect her livelihood, her physician inserted the smallest tube possible. And since the operation, she admits, the lost weight has affected the automatic engagement of the abdominal muscles, and as a result she has had to tweak her technique and put more thought into how she performs.

As a relief to any opera fans and theater principals who were concerned that she would also lose her voice talent, Ms. Voigt’s postsurgical performances have earned her great acclaim. Dr. Gallivan saw Ms. Voigt’s March 2007 performance in Die Ägyptische Helena (Egyptian Helen), and he says her performance was astounding. “There are voices and then there are miracles,” he said of her, adding, “All she has lost is her weight.”

Bibliography


Playing favorites

Musically speaking, Dr. Gallivan’s identifies his best performance as when he played Giorgio Germont in Verdi’s *La Traviata* (1853). “This composition is beautifully built for a baritone with high extension. It’s a powerful but melodic legato (long, drawn-out musical lines), and it’s probably the best singing I’ve ever done.”

But in terms of fun, Dr. Gallivan mentions his role as Figaro in Rossini’s *The Barber of Seville* (*Il Barbiere di Siviglia*, 1816). “Figaro is a factotum who does everything and knows everybody. He’s not just a barber—he fixes people’s lives and love lives, and everything in town goes through him. It’s a fun and different role to play this cavalier guy.”

The role of Figaro is not just fun for Dr. Gallivan, however; the character’s well-known aria is Dr. Gallivan’s signature solo. In 2002, he participated with 17 other performers in an Austrian exposition where all contributors came dressed in lederhosen and multicolored coats with fancy buttons but with no advance knowledge of what they would be asked to sing. Dr. Gallivan, chosen by audition to perform last, was assigned the aria of Figaro. Though he says he felt like he was stepping in front of a firing squad when it was his turn, “It went tremendously well. In Europe, if you’ve done your singing well, they reward you with rhythmic applause, where the whole audience together claps in a cadence.” Dr. Gallivan was the only performer at this event to receive this type of praise.

However, Dr. Gallivan’s performances have not been without disaster. At the end of Dr. Gallivan’s aria as the toreador Escamillo in a staging of *Carmen* (Bizet, 1875), when he sang “L’amour”—and Carmen, Mercedes, and Frasquita were supposed to echo it—the woman playing Frasquita missed her cue, and the opera came to a dead halt. But Dr. Gallivan did not relate this story with complaint. “Things happen,” he says.

Perfecting the craft

Though he did not attend the Juilliard School of Music (New York, New York), Dr. Gallivan was once a pupil of Oren Brown, former Juilliard faculty member and pioneer in voice therapy, and of Anna Moffo, operatic soprano who was the star performer at the Metropolitan Opera in New York for decades. In voice lessons, Dr. Gallivan...
Physicians in opera

The prevailing public opinion of physicians in 18th, 19th, and 20th century Europe can be inferred from the text and music that accompanied their portrayal in operas. Prominent characters in operatic literature of that era, physicians were sometimes depicted as incompetent and clownish, sometimes as self-serving and deceitful, eventually as healers.

In Le Nozze di Figaro (The Marriage of Figaro, Mozart, 1786), Dr. Bartolo is a vengeful character whose status as a physician is merely a detail and not essential to the plot line itself. But although the clash between Dr. Krautmann and his opponent—the pharmacist Stoessel—in Doktor und Apotheker (Doctor and Pharmacist, Ditters von Dittersdorf, 1786) is caused by a romantic relationship between their children, it progresses into a professional quarrel. Both physician and pharmacist reveal doubts about the professional competence of the other and both threaten to take legal action because of it. In this opera, Dr. Krautmann’s opening aria is full of self-admiration.

As a reflection of the status of medical practice in the early 19th century, in L’Elisir d’Amore (The Love Potion, Donizetti, 1832), Dr. Dulcamara, a traveling physician, is introduced in an aria as a quack like those who often passed themselves off as physicians in that era—in his lyrics he claims to have a tonic that can cure any and every malady “immediately and unfailing,” including rheumatic pain, cough, muscle strain, chickenpox, hysteria, flatness, and thinness. He sells a bottle of wine to a peasant who had asked for a love potion to help him win the heart of a specific woman. The peasant does gain popularity and eventually wins the object of his desire after losing inhibitions from the wine, but the physician exploits this outcome to sell more bottles of wine as medication.

As medicine advanced, so too did the skill and knowledge of physician characters in opera. Surgery, for example, emerged in the operatic literature after it became added to the practice of medicine in the 19th century, and a surgeon appears in La Forza del Destino (The Force of Destiny, Verdi, 1862) to remove a bullet from the body of a main character.

Dr. Grenvil, the physician in La Traviata (Verdi, 1853), is depicted as sympathetic, reassuring, and humble as he stays with a dying patient whom he supported throughout, though he knew he could not help her recover from her illness, and admits that he and science are limited in what can be done to help the patient. The newly emerging theories of heredity affecting one’s health are factored into Les Contes d’Hoffman (Tales of Hoffman, Offenbach, 1881). But Dr. Miracle is portrayed as a villain, as one who causes death, because he asks a character to sing even though she has many symptoms that suggest mitral valve prolapse. The illnesses in Offenbach’s family at the time he composed this opera (he had gout and his son, tuberculosis) might have informed his characterization of the physician and his ultimate deflection of blame for that character’s death.

By the 20th century, physicians were shown as researchers, though not necessarily in a flattering way. In Wozzeck (Berg, 1925)—which debuted in Germany at a time that people were losing faith in conventional medicine and were seeking out alternatives—the title character, to earn extra money, signs on to work with a physician. In turn, this physician—who is given no name and is called, simply, The Doctor—conducts experiments on Wozzeck, such as testing various diet prescriptions, and uses him as an educational aid for teaching medical students (such human experimentation and misuse of science to further one’s career goals, rather than to help patients heal, was an issue at that time, according to some historians). But 20th century opera also showed the functional role of the profession, such as the physicians consulted about illness and injury in Pelléas et Mélisande (Debussy, 1902) and Der Rosenkavalier (Knight of the Rose, Strauss, 1911).

Bibliography


explains, the voice instructor teaches the singer how to sing and breathe properly to get proper resonance, whereas the voice coach will teach repertoire, diction, and language of the opera (French, German, Italian, Spanish, and Polish). And just as in medicine, continuing education is essential to opera singers. While making the point that anyone serious about singing should never stop training, Dr. Gallivan says, “Even if you’ve been singing for half a century, you can never hear yourself—you can’t hear what they are hearing. That’s why, even now, I continue to study with William Riley in New York.”

Cultural shift in music

Though the classic operas are still performed frequently, composition of new operas is rare. Dr. Gallivan attributes this sea change partly to the perception of opera as an elitist endeavor where “big fat women sing at the top of their lungs.” However, he notes that contemporary musical theater—such as Hair, Rent, Porgy and Bess, Jesus Christ Superstar, and Phantom of the Opera—is merely a modern expression of the same artistic foundations. “Opera was the common classical way of singing for theater before television and radio,” he explains.

The cultural shift toward rap and American Idol in the contemporary music scene has also played a part in the current perception of classical music. Though rap doesn’t appeal to him, he acknowledges it as a commentary on life spoken against a rhythm. But he believes most contestants on American Idol cannot sing. Though a classically trained singer need not sing opera, he says, an opera singer must be classically trained. “If you’re playing the role of the soprano in Phantom, you had better be a coloratura soprano who is classically trained,” Dr. Gallivan says. “This isn’t for someone on American Idol—you have to be able to sing.”

Balancing act

In addition to Dr. Gallivan’s hospital and university appointments, he is also a faculty member of the Voice Foundation, a group of trained singers with scientific backgrounds who combine music and medicine to address voice problems based on science. “At this point, they call me a voice and airway reconstructive surgeon, operating on voice boxes and trachea,” he says, noting that perhaps only a few surgeons perform such procedures.

And in addition to his many performances in operatic productions and his training, Dr. Gallivan was a founding member of Commonwealth Opera in Northampton and participates in concert solos, regional summer performances, and various medical meetings where he is called upon to sing.

Finding the balance between two such highly demanding lines of work was not easy. “At first there was great dismay in the medical community: ‘Who is this idiot who thinks he can sing?’” Dr. Gallivan explains. “It was frowned upon in the mid-1970s by fellow physicians who thought this was just a confounding thing for a doctor to do.” But Dr. Gallivan says he was fortunate in eventually working with two, then three, then several thoracic surgeons who recognized his seriousness about opera. They provided coverage when needed, taking his call for one to two weeks at a time as needed. (Of course, he returned the favor in kind when asked.)

But Dr. Gallivan had another great source of support: his wife Helen, a registered nurse who is also his practice manager and runs his professional and home life. “Without her support and without the support of my colleagues,” Dr. Gallivan says, “I never would have been able to do this.”

But even with all the support he has received, much of what had driven Dr. Gallivan’s determination through medical school and beyond was that professor’s stern lecture at Tufts in the 1960s. “It has been a passion of mine to tell people, ‘You don’t have to be just one thing,’” Dr. Gallivan says. “‘You must use the talents God gave you.’”
Statement on the surgical workforce

The following statement was developed by the ACS Health Policy Steering Committee and was approved by the Board of Regents at its June 2007 meeting.

The American College of Surgeons is concerned that access to surgical care is eroding in many U.S. communities. An aging population, unstable practice environment, geographic differences in the liability climate, changing lifestyle expectations, technological changes, and an increasing tendency toward subspecialization are combining to produce surgical workforce shortages. This problem is most evident and widespread in rural areas and in our nation’s trauma centers and emergency departments, as noted in the Institute of Medicine’s 2006 reports on the future of emergency care. Increasingly, our urban and suburban communities are facing shortages as well.

Much attention has been focused recently on a declining physician-to-population ratio in the U.S. that will accelerate as the baby boom generation ages. Although policymakers have devoted considerable discussion to developing solutions for a predicted shortage of generalists, little attention has been devoted to surgical workforce limitations. Notably, the number of surgeons being produced by our graduate medical education system has remained stable for nearly 30 years. In general surgery, for example, the ratio of surgeons-to-population has been declining steadily since 1985. In other specialties, where the supply is limited to only a few thousand, surgeons are finding that they are unable to meet community demands for their services. Furthermore, there is evidence that many surgeons have narrowed their practices to include only outpatient care, whereas others have subspecialized to the point where they no longer feel qualified to serve on emergency call panels. In addition, relatively few women choose surgery as a career, which is especially troubling now that more than half of medical school enrollees are women.

The American College of Surgeons supports measures to ensure access to surgical specialty care. More specifically, the College believes the federal government should do the following:
• Develop national self-sufficiency in the production of physicians, surgeons, and other health professionals through a well-planned expansion of U.S. medical school graduates and residencies
• Provide full federal support for needed specialties with long training requirements
• Remove the caps that were imposed by the Balanced Budget Act on the number of residents eligible for federal support at each training institution under Medicare
• Expand programs of support for rural physicians to include surgical specialties
• Provide financial support for specialists who provide safety net services for uninsured patients in our nation’s trauma centers and emergency departments
• Take steps to ensure a less hostile practice environment, such as realistically addressing the nation’s liability issues
College news

In memoriam

George Rodgers Dunlop, MD, FACS (1906–2007)

by H. Brownell Wheeler, MD, FACS, Worcester, MA; and C. Rollins Hanlon, MD, FACS, Executive Consultant

George Rodgers Dunlop, MD, FACS, died March 11, in Worcester, MA, shortly before his 101st birthday. Dr. Dunlop was a former President of the American College of Surgeons, a former Vice-Chair of the ACS Board of Regents, past-president of the New England Surgical Society, and past chairman of the board of Massachusetts Blue Shield as well as chairman of the National Board of Blue Shield plans.

Dr. Dunlop was born March 31, 1906, in St. Peter, MN, the son of an Episcopal clergyman. Greatly impressed in childhood by the care and concern of a physician who treated his mother’s tuberculosis, he resolved to become a physician himself. The empathy for patients that so impressed George as a child became the defining characteristic of his practice of surgery.

After completing college at the University of Cincinnati in Ohio, he obtained his medical degree from Harvard Medical School in 1931. After surgical training at New York Hospital–Cornell Medical Center, he began the private practice of surgery in Worcester in 1935. During World War II, he served in the Pacific region as a lieutenant commander in the U.S. Navy Medical Corps from 1942 to 1945. Assigned to the U.S.S. Custer, an attack transport ship involved in five major island landings, he provided surgical care for marines injured in the fierce battles of Guadalcanal and Saipan.

Returning after the war to the private practice of surgery at the Memorial Hospital of Worcester, he served as chief of surgery and developed a strong surgical residency program. Despite the lack of a research-oriented academic health center, he stayed in close touch with latest advances in surgical practice, with special attention to vascular surgery. Consistent with this pattern of following such advances, he was in the operating room at St. Mary’s Hospital in London when H.H.G. “Felix” Eastcott, MD, and Charles Rob, MD, carried out the first carotid arterial reconstruction, taking the only photographs of that historic procedure. He was also among the first to perform newly described vascular procedures such as homograft replacement of an abdominal aortic aneurysm.

Because of his interest in medical education, he was enthusiastic about the new University of Massachusetts Medical School in 1970 and did much to facilitate its good relationships with the medical community. Appointed as its first clinical professor of surgery, he enjoyed the teaching of students and residents. Gifted as a clinical surgeon, his warm rapport with patients made him a great role model for students and staff. In addition, he dealt with the declining level of ward patients by making a teaching video for the American College of Surgeons’
Clinical Congress to promote the use of private patients for surgical teaching.

As a natural leader, he had an unusual breadth of perspective. For complex problems, he was able to devise common-sense solutions and he defused many tense meetings with wit and diplomacy. Because of his leadership ability and his inherent grace and dignity, he served as president or board chair for many important organizations. He received the New England Surgical Society’s Nathan Smith Award for his numerous contributions to surgery. As an ACS representative to the Joint Commission on Accreditation of Hospitals, he served as vice-chairman and in 1985 through 1986 as chairman of its board of commissioners. Throughout his career, he worked steadily to lower health care costs by reduction of unnecessary tests and procedures, and his humanitarian work in end-of-life care was a source of comfort to many.

He was a leader in many civic organizations, serving on the boards of the predecessor of the United Way and the Worcester Boys’ Club and as chair of the Worcester Foundation for Experimental Biology. A trustee of the Bancroft School, he was a vestryman of the All Saints Episcopal Church and was twice awarded the “keys to the city” of Worcester—in 1984 and in 2006, on the occasion of his centennial birthday. In 1982, President Ronald Reagan appointed him to the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Grateful patients established an endowment to support an annual George R. Dunlop Symposium in Medical Ethics at Memorial Hospital.

Dr. Dunlop was a tall, dignified man with the carriage of an athlete or a military officer. Even as a centenarian, he stood erect. He was a lifelong physical fitness advocate. His day usually started with lap swimming at 6:00 am, preceded by calisthenics. He maintained that the most valuable single exercise for the elderly was a half knee-bend to strengthen the quadriceps. He originally advised 100 repetitions, but later reduced the requirement somewhat for those older than 90 years. He urged anyone he met to adopt this exercise, even in the assisted-living facility where he spent his last years, where it became known as the “Dunlop dip.”

A skilled and graceful dancer, he was often the first out on the floor at dinner dances. Many a surgeon has heard his wife say, “Why can’t you dance like George Dunlop?” Even at 94, he led the dancing with his granddaughter on her wedding day.

Many anecdotes reflect the personal charm and warmth of George Dunlop. He loved people and related easily to individuals from all walks of life. He had a genuine concern for the welfare of others, whether family, friends, patients, or inner-city children at the Boys’ Club. In his home environment, he became a legend in his own time.

He was fortunate in having a worthy life companion in Barbara, his wife of 67 years. Like George, she was wise, witty, warm, and gracious. They loved and supported each other to a good old age. When George died, Barbara was near death herself. She passed away quietly only five hours after the memorial service celebrating his life was concluded. To family and friends, it seemed almost as though she did not want her own death to interfere in any way with the celebration of his remarkable life. Surviving the Dunlops are two daughters, Susan Roberts (Dr. Reid Roberts) and Madora Howell; two grandchildren; and two great-grandchildren.

George Dunlop’s legacy lives on through the many lives he touched and the contributions he made to his profession and his community. Fortunate are those individuals who had the privilege of knowing him personally, and many without that privilege are nevertheless in his debt in ways beyond measure.

**Dr. Wheeler** is professor, department of surgery, University of Massachusetts Medical School, Worcester.
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New CME training in palliative care offered by NCI

The National Cancer Institute (NCI) estimates that there are more than 10.5 million cancer survivors living in the U.S. and more than 500,000 of these individuals will die from cancer each year. To address the education needs of cancer health care providers, the NCI is releasing a new palliative and end-of-life care self-study curriculum.

The Education in Palliative and End-of-Life Care for Oncology (EPEC™-O) CD-ROM and DVD is a comprehensive multimedia program developed for health professionals, including physicians, physician assistants, nurses and nurse practitioners, therapists, and social workers. The curriculum, featuring slides and case study videos, provides the following:

- Knowledge and skills necessary to provide state-of-the-art palliative interventions for cancer patients
- Educational tools and materials to use in teaching palliative care core competencies
- An opportunity for physicians and nurses to earn continuing education (CE) credits through the American Society of Clinical Oncology and the Hospice and Palliative Nurses Association

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The Hospice and Palliative Nurses Association is approved by the California Board of Registered Nursing (provider number CEP7976) as a provider for continuing education for nurses. This educational activity is approved for a maximum of 31 nursing contact hours.

To order your free copy of the EPEC-O CD-ROM and DVD, please call NCI’s Cancer Information Service toll-free at 800/4-CANCER (800/422-6237) or visit www.cancer.gov/publications.

To access EPEC-O promotional materials, please visit www.nciopoet.org/PromoToolsEPECO.cfm.

The EPEC-O curriculum was developed by the EPEC Project at Northwestern University with major funding from NCI and supplemental funding from the Lance Armstrong Foundation. The American Society of Clinical Oncology and the Oncology Nursing Society are among the professional organizations partnering with NCI to disseminate the EPEC-O curriculum.

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- View surgical news
- Interact with surgical communities
- Update CME credits
- Enter case log information
- Track resident hours
  and more—all at:
  e-facs.org
NCDB report says pancreatic cancer recommendations are outdated

Analysis of data from the largest cancer database in the U.S. has shown that a significant proportion (38.2%) of patients with operable, early-stage pancreatic cancer are not being offered surgical treatment, even though an operation is the only potential cure for this type of cancer. Researchers from the National Cancer Data Base (NCDB) commented on this ground-breaking study in June.

“As surgeons, the message we have been sending for many years is that surgical treatment for early-stage pancreatic cancer can have a positive impact on survival and quality of life,” said Mark S. Talamonti, MD, FACS, chief of the division of surgical oncology, Feinberg School of Medicine, Northwestern University, Chicago, IL, and co-researcher of the study. “This study suggests, however, that the percentage of patients who should have an operation, but don’t get it, is alarmingly high.”

Dr. Talamonti believes patients are not being offered an operation because of nihilism and skepticism on the part of medical professionals, including some surgeons who question whether patients with pancreatic cancer can benefit from any treatment at all.

“For physicians who trained before the 1980s and 1990s, when studies started to show some improvement in survival and quality of life from treatment for pancreatic cancer, the general idea was that there was no effective treatment for the disease,” Dr. Talamonti said. “While this is a very formidable disease with considerable medical challenges, the reality is that not everybody has to die. Many patients do benefit by having the appropriate operation by sufficiently experienced surgeons in high-volume medical centers.”

“The pessimistic attitude toward pancreatic cancer and pancreatic cancer surgery is based on outdated data,” explained Karl Bilimoria, MD, a research fellow (focusing on surgical oncologic outcomes) at the American College of Surgeons and the department of surgery at Feinberg School of Medicine and lead author of the study. “Pancreatic cancer had terrible outcomes in the 1960s. The mortality and complications associated with surgical procedures for pancreatic cancer and the lack of effective systemic therapies made the short-term and long-term outlook for patients rather dismal. But there have been improvements over the last 30 to 40 years, to the point where postoperative mortality is less than 3 percent in many hospitals, and long-term survival rates are now about 30 percent after surgical resection for stage I disease,” Dr. Bilimoria added.

“We need to get the message out to the gatekeepers—the primary care and internal medicine physicians, gastroenterologists, and medical oncologists who see these patients before they are referred to surgeons—that it’s better to operate than not to operate,” Dr. Talamonti said.

Data for the study were obtained from the NCDB, which is maintained by the American College of Surgeons’ Commission on Cancer. The NCDB accounts for more than 75 percent of all cancers treated in the U.S. each year. The database includes information on more than 20 million patients with cancer who have been cared for at 1,440 hospitals in this country.

NCDB researchers examined data on 292,565 patients with pancreatic cancer. From 1995 to 2004, they studied 9,559 patients with stage I disease who were potential candidates for an operation. Stage I pancreatic cancer is confined to the pancreas itself, and it typically occurs in 10 percent to 15 percent of patients initially diagnosed with pancreatic cancer, according to Dr. Bilimoria.

Although overall use of surgical procedures for pancreatic cancer increased during the period of the study by 14 percent, only 28.6 percent of patients actually underwent an operation. Of the remaining patients who did not have an
operation, 51.7 percent did not have a documented or identifiable reason why they did not have the procedure. A total of 38.2 percent of patients were not offered an operation, and 13.5 percent did not undergo a procedure for unknown reasons.

Although the study could not fully explore why patients with operable cancer did not have a surgical procedure, it did at least identify some common underlying factors—advanced age, race, socioeconomic status, and insurance status. Patients who were not offered an operation tended to be approximately six years older than those who had the procedure: 71.7 years versus 65.1 years on average. Patients also were less likely to have an operation if they were African-American, had lower annual incomes or less education, and were covered by Medicare or Medicaid.

A surgical procedure also was not offered to many patients whose tumor was located in the head or the body of the pancreas. “This finding goes back to a previous perception that the Whipple procedure was worse than the disease. But over the last 10 to 15 years, there have been unequivocal data that the operation is associated with improvement in quality of life and survival when done by experienced surgeons. The thought may still exist that the operation is a bad thing to subject patients to, even though the data show that is just not true,” said Dr. Talamonti.

The American College of Surgeons is beginning to explore how it may respond to findings from this study. “The ACS is looking at not just the Whipple procedure but cancer surgery in general to make sure segments of our population are not underserved and that the information that is disseminated about surgical treatment for pancreatic cancer is accurate,” Dr. Talamonti said. “It is imperative to get the information out that patients who need and qualify for this surgical approach are offered the operation.”

“Pancreatic cancer surgeons should continue to give lectures about the efficacy of this type of surgery and treatment for pancreatic cancer to improve the medical community’s opinion of what surgeons can do for patients with pancreatic cancer in 2007,” Dr. Bilimoria said.

Pancreatic cancer is the fourth leading cause of death caused by cancer in this country. The American Cancer Society estimates that in 2007, more than 37,000 individuals will be diagnosed with pancreatic cancer and more than 33,000 will die from the disease.

A complete report of these research findings, entitled “National Failure to Operate on Early-Stage Pancreatic Cancer,” will appear in an upcoming issue of Annals of Surgery. Other authors of the study include David J. Bentrem, MD, FACS (Northwestern University); Clifford Y. Ko, MD, FACS (University of California, Los Angeles, and VA Greater Los Angeles, and the Director of the ACS Division of Research and Optimal Patient Care); Andrew K. Stewart, MA (Senior Manager, NCDB, American College of Surgeons Commission on Cancer); and David P. Winchester, MD, FACS (Medical Director of the ACS’ Cancer Programs).

The study was supported by the American College of Surgeons’ Clinical Scholars in Residence program and a research grant from the Northwestern University Department of Surgery.
The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at the 94th annual Clinical Congress, October 12–16, 2008, San Francisco, CA.

**Oral presentations**
- Surgical Forum
  Program Coordinator: Kathryn L. Matousek, 312/202-5336, kmatousek@facs.org
  (12 $1,000 Excellence in Research Awards were given in 2007)
- Papers Session
  Program Coordinator: Beth Cherry, 312/202-5325, echerry@facs.org

**Poster presentation**
- Scientific Exhibits
  Program Coordinator: Kay Anthony, 312/202-5385, kanthony@facs.org

**Video presentation**
- Video-Based Education
  Program Coordinator: GayLynn Dykman, 312/202-5262, gdykman@facs.org

**Submission information**
- Abstracts are to be submitted online only
- Submission period begins November 1, 2007
- Deadline: 5:00 pm (CST), March 1, 2008
- Late submissions are not permitted
- Abstract specifications and requirements for each individual program will be posted on the ACS Web site at www.facs.org. Review the information carefully prior to submission.
- Duplicate submissions (submitting the same abstract to more than one program) are not allowed.
Japanese and German Exchange Travelers for 2007 announced

The International Relations Committee of the American College of Surgeons has established an exchange program with the Japan Surgical Society and the ACS Japan Chapter. Earlier this year, Luis A. Fernandez, MD, FACS, a transplant surgeon at the University of Wisconsin–Madison Medical School, attended the annual meeting of the Japan Surgical Society and visited various Japanese surgical centers. The Japanese Exchange Traveler, Yuko Kijima, MD, PhD, of Kagoshima University, has been selected to attend the College’s Clinical Congress in New Orleans, LA, in October. She will give a presentation, and will visit several surgical institutions in North America. Dr. Kijima specializes in surgical oncology and reconstruction of the breast.

The German Surgical Society and the ACS Germany Chapter have also developed a similar exchange program with the College. ACS Fellow Mark A. Carlson, MD, FACS, a general surgeon at University of Nebraska, Omaha, attended the German Surgical Society’s annual meeting in Munich in May 2007 then visited surgical sites around Germany. His German counterpart, Robert Gruetzmann, MD, PhD, of the University of Dresden, will attend the ACS Clinical Congress and choose several surgical sites to visit with the guidance of his mentors at home and in the U.S. Dr. Gruetzmann specializes in surgical oncology and researches pancreatic cancer and its genetics.

Trauma meetings calendar

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

• **Advances in Trauma**, December 7–8, Kansas City, MO.
• **Trauma, Critical Care, & Acute Care Surgery–2008**, March 24–26, 2008, Las Vegas, NV.

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

“Never...was so much owed by so many to so few”: An update on Z6041

by David Ota, MD, FACS, Durham, NC; and Heidi Nelson, MD, FACS, Rochester, MN

ACOSOG (American College of Surgeons Oncology Group) Z6041 is a phase II trial of neoadjuvant chemoradiation and local excision for uT2uN0 rectal cancer. Patients receive capecitabine and oxaliplatin concomitantly with 54 Gy external-beam radiotherapy followed by local excision of the primary tumor.

Although Z6041 has a neoadjuvant chemoradiation therapy component, it is an example of a procedure-oriented trial. Many T2 distal rectal cancers are treated either with a low anterior resection or coloanal resection and anastomosis or abdominoperineal resection. More surgeons are performing excision for T2 rectal cancer followed by radiation therapy,* but Z6041 describes the role of neoadjuvant chemoradiation therapy followed by transanal local excision. Preservation of sphincter function is an important goal in the ACOSOG rectal cancer portfolio of trials.

In June 2006, ACOSOG published in the Bulletin a call for participation in Z6041. Enrollment of patients into ACOSOG trials was critically important. The response has been excellent and the monthly accrual rate has exceeded expectations. There are 51 surgeons with Institutional Review Board (IRB) approval who have been credentialed by Julio Garcia-Aguilar, MD, FACS, Chair of the study. For this trial, 19 surgeons have enrolled at least one patient. As of April 2007, 35 patients had been enrolled into this trial, which has a target enrollment of 85 patients. The targeted accrual rate was three patients per month. Four patients per month were enrolled in February and March 2007;

Physicians participating in Z6041

H. Randolph Bailey, MD, FACS, Methodist Hospital
Ronald Bleday, MD, FACS, Brigham and Women’s Hospital
Peter A. Cataldo, MD, FACS, Fletcher Allen Healthcare
Jacques Heppell, MD, Mayo Clinic Scottsdale
Alan J. Herline, MD, FACS, Vanderbilt University
Richard Hoefer, DO, Surgical Oncology Associates
Craig S. Johnson, MD, FACS, Natalie W. Bryant Cancer Center
Natalie E. Joseph, MD, FACS, Fox Chase Cancer Center
Kirk Allen Ludwig, MD, FACS, Duke University
Najjia N. Mahmoud, MD, FACS, University of Pennsylvania Cancer Center
Jorge E. Marcet, MD, FACS, Tampa General Hospital
Michael S. McNevin, MD, Holy Family Hospital
David S. Medich, MD, FACS, Allegheny Cancer Center Network
Samuel C. Oommen, MD, FACS, John Muir Medical Center
Alessaio Pigazzi, MD, City of Hope
Roger K. Pons, MD, FACS, United Hospital Center
Miguel A. Rodriguez-Bigas, MD, FACS, M. D. Anderson Cancer Center
Bruce G. Wolff, MD, FACS, Mayo Clinic Rochester
Earl Yeager, MD, FACS, Saint Joseph’s Hospital

in April 2007, seven patients were enrolled. Based on the current accrual rate, this trial could complete enrollment by April 2008. A successor trial design based on the pathologic response rate is already being discussed.

Although we are pleased with the higher-than-expected enrollment rate for this trial, we remain optimistic to engage even more surgeons to participate in the trial. We have reviewed the National Cancer Data Base (NCDB) and have found that there are more than 400 high-volume sites for T2 rectal cancers. When the NCDB high-volume list was compared with the Z6041 enrolling sites, we realized that we have engaged only 1 percent of the potential high-volume sites. We have more work to do in order to recruit more surgeons to participate in this trial.

Patient eligibility and study schema can be found on the ACOSOG Web site at www.acosog.org. A list of IRB investigators for Z6041 can be found at clinicaltrials.gov by doing a search with the trial code. We want to thank those surgeons who have enrolled patients into Z6041 and who have contributed to the success of this trial thus far. (See the sidebar on page 44 for a list of participating surgeons and their institutions.)

These 19 surgeons have contributed to the success of Z6041. Although the number of surgeons participating in Z6041 may seem small on a national scale, these few surgeons have shown that despite the low frequency of distal stage I rectal cancers, ACOSOG surgeons can enroll patients and complete a complex multisite trial that potentially can establish a new treatment paradigm for patients with this diagnosis.

On behalf of patients and surgeons, as Sir Winston Churchill said in 1940, “Never...was so much owed by so many to so few.”

To learn more about becoming an ACOSOG member, go to the ACOSOG Web site or contact Helen Harbett at har011@dcri.duke.edu.

Dr. Ota and Dr. Nelson are ACOSOG Group Co-Chairs.

Papers being accepted for 2008 Resident Trauma Papers Competition

The ACS Committee on Trauma (COT) is now accepting papers for the 2008 Resident Trauma Papers Competition, which will be held during the COT’s annual meeting March 13–15, 2008, in Washington, DC.

The Resident Trauma Papers Competition is open to general surgical residents, surgical specialty residents, and trauma fellows. The papers should describe original research in the area of trauma care and/or prevention, categorized as basic laboratory research or clinical investigation. Papers should be sent to the appropriate ACS state/provincial chair. The list of chairs’ names can be found at http://www.facs.org/trauma/regional.html.

The papers competition has been funded by the Eastern and Western States COTs, Region 7 COTs, Wyeth Pharmaceuticals, and the American College of Surgeons.

Deadline for submission of papers to the region chief is November 14, 2007. Further information can be obtained on the ACS Web site at http://www.facs.org/trauma/traumapapers.html or by calling Bridget Blackwood, ACS Trauma Programs Coordinator, at 312/202-5380 or e-mail bblackwood@facs.org.

A look at The Joint Commission

Web site features keep physicians informed

The Joint Commission’s Web site offers some tailored options for surgeons to stay abreast of new initiatives at The Joint Commission.

A complimentary online newsletter, This Month for Physicians, is published monthly by The Joint Commission. This newsletter covers topics of interest to physicians, including updates about ongoing work at The Joint Commission, notification of upcoming free audio conferences, and updates on the work of the Physician Engagement Advisory Group.

Subscribers can be assured they will never miss the opportunity to comment on proposed standards or National Patient Safety Goals, as the newsletter keeps readers informed of the dates of field review comment periods and provides details about how to submit comments.

An archive of previous issues of the newsletter is posted on The Joint Commission Web site. To access the current and archived issues, go to www.jointcommission.org, click on “Library” and then on “This Month for Physicians” in the left-hand column. To sign up for monthly e-mail delivery of This Month for Physicians, send an e-mail to Caron Wong at cwong@jointcommission.org with “This Month for Physicians” in the subject line.

Another outlet for information on the Web site is the “For Physicians” section. This section includes IN Sight, a monthly publication of developments and potential revisions that can affect accreditation and that tracks proposed changes before they are implemented; Sentinel Event Alert; and newsletters and periodicals from Joint Commission resources that are directed to physicians. In addition, this site includes a schedule of events that include speaking engagements of William E. Jacott, MD, The Joint Commission’s special advisor for professional relations, at physician organizations, conferences, and other venues across the U.S.

To access this section of the Web site, go to www.jointcommission.org and click on “Information For...Physicians,” located near the lower center of the home page, or go to www.jointcommission.org/physicians/.

WHAT SURGEONS SHOULD KNOW ABOUT, from page 9

• Providing resources for emergency care. Creating incentives for on-call emergency surgical coverage and expand Medicare coverage of emergency care at critical access hospitals.

• Supporting coverage of emergency care for the uninsured. Strengthening the emergency care safety net through the expansion of Medicare coverage.

• Liability protections. With a focus on care related to the Emergency Medical Treatment and Active Labor Act, the Federal Tort Claims Act could provide liability protections for on-call physicians.

The College is currently working with other surgical specialty groups and Congress to introduce legislation to tackle this crisis.

For any information regarding the topics discussed in this article, please do not hesitate to contact Adrienne Roberts in the Division of Advocacy and Health Policy at aroberts@facs.org.

Acknowledgment

The author would like to thank Geoff Werth, Government Affairs Associate, for his assistance with this article.
Summer is well under way. It is a time for family gatherings, vacations, outdoor activities, and home improvements. According to the Home Improvement Research Institute (www.hiri.org), chain stores like Home Depot and Lowe’s have proliferated from 96 stores in 1998 to 1,895 stores in 2007. Consumer spending at such stores nearly doubled between 1996 and 2006 to greater than $230 billion per year, and this figure is projected to continue to grow annually by 5.4 percent. There have been sitcoms, public access programs, and entire television channels devoted to home improvements. Along with the exponential growth in do-it-yourself home projects has been the alarming climb in ladder-related injuries. The Underwriters Laboratories (UL) report that one of the most potentially hazardous tools used around the house, accounting for 222,000 emergency room visits in 2005, is an extension ladder or stepstool.* As I was getting ready to ascend my 24-foot fiberglass extension ladder, I thought it would be best to assess the risk-to-benefit ratio of changing those flood light bulbs myself.

In order to examine the occurrence of home improvement injuries in the National Trauma Data Bank® Dataset 6.2, I used the International Classification of Diseases, Ninth Revision, Clinical Modification cause of injury code E 881.0, 881.1, falls from ladder or scaffold; E919.2, 919.3, 919.4, accidents caused by machinery; E920.1, 920.3, 920.4, accidents caused by cutting or piercing instruments (hand tools); and E849.0, for place of injury home. There were 16,084 records found in the dataset for these E codes. The injuries included 10,776 related to ladders, 3,049 related to powered and nonpowered hand tools, 1,595 related to woodworking saws, 522 related to scaffolds, 93 related to hoists, and 49 related to metal working. These data are depicted in the figure on this page. Among victims, 85 percent were male, on average 52 years of age, and with an average length of hospital stay of 4.3 days and an average injury severity score of 7.36; 2 percent died of their injuries.

Ladder-related injuries accounted for two-thirds of the records. UL safety experts have put together guidelines for ladder use, including following the instructions and warning labels, using fiberglass ladders whenever near electric wires, inspecting the ladder before stepping on the first rung, keeping the ladder on a firm surface, using the right height ladder or stepstool, not overextending reach, facing the ladder while climb-

*Available at: www.ul.com/media/newsrel/nr_spr05_fad.html.
When it is time to start your home improvement project—especially when it involves a ladder—please observe the above safety recommendations so we can stop the climb in ladder-related injuries and your home will not turn into the house of pain.

Throughout the year, this column will provide brief monthly reports. The full NTDB Annual Report Version 6.0 is available on the ACS Web site as a PDF file and a PowerPoint presentation at http://www.ntdb.org.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Operation Giving Back

Volunteer opportunities available

Operation Giving Back (OGB) frequently receives inquiries from surgical residents interested in surgical volunteer opportunities and international medical experiences. The education afforded by such unique experiences includes learning different cultures and pathologies as well as insights into policy and economic influences on health care decisions. The following is a sampling of OGB’s partner agencies that provide volunteer opportunities for residents:

• The Community Coalition for Haiti conducts several mission trips a year to Pignon, Haiti, to provide education, training, and medical support at the Hôpital Bienfaisance de Pignon.

• Omni Med organizes five teaching missions a year to Belize from September through May and offers one-week teaching rotations to Georgetown, Guyana.

• The Foundation for International Education in Neurological Surgery has partnerships with 17 sites in Central and South America, Africa, and Asia, offering many unique and valuable experiences for residents in neurosurgery.

• Global ENT Outreach offers two-week opportunities for ear, nose, and throat residents throughout the year at the University of Addis Ababa School of Medicine in Ethiopia, the Hospital de San Juan de Dios in the Santa Ana province, and the Hospital Rosales in San Salvador, El Salvador.

• The Pan-African Academy of Christian Surgeons provides short-term learning opportunities for residents at their training centers in Kumbo and Mbingo in Cameroon and Lebamba, Gabon.

• The World Surgical Foundation conducts two medical missions a year in developing countries. Upcoming missions will be in San Pedro Sula, Honduras, in September and Hyderabad, India, in January 2008.

You can learn more about these and other opportunities for residents on the OGB Web site, www.operationgivingback.facs.org. From the Venn diagram on the home page, specify search parameters and click the yellow Search button. The Search Results page will display all relevant matches, and clicking on each title will provide a detailed description with appropriate contact information and links to a country-specific toolkit of other resources. In addition, there is a Resource Center for Residents available from the main menu. The opportunities included in the OGB database are current, so the information on the site is always changing. We encourage those interested in volunteering to revisit the site often to look for available opportunities.