Presidential Address:

**COMPETENCE, SAFETY, QUALITY:**

The path of the 21st century
FEATURES

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Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director

Dateline: Washington
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Future meetings

Clinical Congress
2008 San Francisco, CA, October 12-16
2009 Chicago, IL, October 11-15
2010 Washington, DC, October 3-7

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On the cover: In his Presidential Address, Gerald B. Healy, MD, FACS, talks about the qualities and competencies involved in creating a legacy as a caring surgeon. (Photo courtesy of Punchstock.)
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
From my perspective

Anyone who is involved with any aspect of the College’s Clinical Congress understands the positive effects of this annual event. The 2007 conference, which took place October 7–11 in New Orleans, LA, was no exception. Indeed, this year’s meeting provided positive reinforcement for the indomitable people of New Orleans as they continue efforts to improve their city, for surgeons to engage in cutting-edge educational programs, and for the College’s leadership to learn what we could be doing more effectively.

Rebuilding New Orleans
It is always gratifying to see so many surgeons, residents, medical students, exhibitors, and College personnel come together in one location. Approximately 11,170 individuals gathered for this year’s Clinical Congress, and more than 6,670 of them were physicians.

The people of New Orleans, who are still working to rebuild their lives more than two years after Hurricane Katrina, undoubtedly found the attendance figures gratifying. The Clinical Congress was the first major convention to take place in the city since May, and many of the local businesspeople and service workers expressed how pleased they were to have us there.

Furthermore, a number of Clinical Congress attendees and ACS staff participated in Project New Orleans, which was organized through the American College of Surgeons’ Operation Giving Back program and Habitat for Humanity. Participants in this project assisted in transforming an abandoned school into the Daughters of Charity–St. Cecilia Clinic, which will restore access to health care services in the flood-ravaged, economically disadvantaged Ninth Ward. This successful venture was featured in USA Today (http://www.usatoday.com/news/nation/2007-10-11-tourism_N.htm?csp=34&loc=interstitialskip), giving us a chance to demonstrate to the general public the service-oriented qualities most surgeons exude.

Educational program
Of course, the primary purpose of the Clinical Congress always has been to expose surgeons and trainees to the latest in surgical thinking and procedures. Under the direction of Barbara L. Bass, MD, FACS, Chair, and Layton F. Rikkers, MD, FACS, Vice-Chair, the College’s Program Committee assembled an outstanding program. Many of the scientific sessions focused on technological innovations and new techniques. Highlights included sessions on natural orifice operations, fertility-sparing procedures, advances in stem cell biology, tissue engineering, neuroscience, accelerative partial breast irradiation, and laparoscopic and endoscopic procedures. Attendees also explored such nonclinical issues as advocacy at the state and federal levels, professionalism, ethical collaboration with industry, and the emergency workforce. Furthermore, the Clinical Congress featured postgraduate courses intended to help surgeons fulfill their practice-based learning Maintenance of Certification requirements. For instance, the Clinical Congress featured postgraduate review courses in general surgery, urology, and cardiac and thoracic surgery for individuals preparing for certification and Maintenance of Certification exams.

“The Clinical Congress also provides a venue for the College’s Regents, Officers, and Executive Staff to take the pulse of the membership and think about the future of the organization as a whole.”
In addition, two new Named Lectures debuted this year. The Committee on Women’s Issues, friends, colleagues, and women surgeons throughout the nation rallied together to establish The Olga M. Jonasson Lecture. Dr. Jonasson, who died in August 2006, was a pioneer and trailblazer in academic surgery, having been appointed the first woman chair of surgery in the U.S. In addition, I had the honor of presenting the inaugural Heran Abcarian Lecture. Dr. Abcarian is the Turi Josefsen Professor of Surgery at the University of Illinois College of Medicine in Chicago and is a leader in the field of colon and rectal surgery. My remarks related to the overall theme of this year’s meeting: the role of mentoring in surgery.

We have already begun reorganizing the program for next year to make it more meaningful for all surgical specialists. For example, under a new approach that we will phase in over the coming years, the Clinical Congress will be composed of “tracks” centered on the specific needs of the various surgical specialties and learner groups. We intend to organize these tracks in a way that will enable attendees to be on-site for only a few consecutive days rather than the entire week.

Charting the future

The Clinical Congress also provides a venue for the College’s Regents, Officers, and Executive Staff to take the pulse of the membership and think about the future of the organization as a whole. During the Board of Regents’ meeting that precedes the annual meeting, the Board of Governors reports on the issues of greatest concern to the Fellows.

To my dismay, in the nearly eight years that I have served as your Executive Director, the Governors have consistently indicated that the surgeons they represent believe the College should be doing more to address three issues: professional liability, physician reimbursement, and health care reform. Working together, the Regents, Officers, and I have really tried to lead the College into new spheres of political influence so that we can work with the government and other stakeholders to correct the problems in these areas. Nonetheless, the reality of dealing with our political system is that we have been able to effect only incremental changes in terms of payment, liability, and health system reforms.

We were pleased that the Children’s Health and Medicare Protection (CHAMP) Act, which the House passed in August, contained many constructive provisions that would have had a positive effect on physician reimbursement. In addition to renewing and expanding the State Children’s Health Insurance Program, that bill would have replaced the 9.9 percent and 5 percent Medicare reimbursement cuts slated for 2008 and 2009, respectively, with 0.5 percent increases. Even more significantly, it also would have supplanted the sustainable growth rate with a new system of six expenditure targets and fee schedule conversion factors for various categories of physician services.

Unfortunately, our political system is in a state of paralysis, and the CHAMP bill was gutted in the Senate. Given the politically divisive state of affairs in Washington, we may not see any real movement in the health policy arena until after the 2008 elections. In the meantime, the College’s leadership is working to develop a more influential presence on Capitol Hill through our new Washington Office and the Health Policy Research Institute.

We also are creating a system that will enable the Regents and other members of the College’s leadership to hear more directly from the Fellowship. We are modifying the way in which the Regents and Governors relate to each other to encourage a more interactive dialogue.

Finally, I believe that the College’s newly elected President, Gerald B. Healy, MD, FACS, has the clear-sighted vision this organization needs at this time in its history. Dr. Healy has chosen to make competence, safety, and quality the theme of his presidential term. He believes, and I agree, that the College can do much to help surgeons become more skilled and safer health care professionals.

Thomas R. Russell, MD, FACS

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

prepared by the Division of Advocacy and Health Policy

HHS to share performance data

U.S. Department of Health and Human Services (HHS) Secretary Mike Leavitt recently announced plans to make physician performance measurement information available at the community level. Under the proposal, the Centers for Medicare & Medicaid Services (CMS) will use Medicare data to generate physician quality performance reports. Performance will be rated using consensus-based metrics adopted by the AQA and endorsed by the National Quality Forum. These data will be shared with charter value exchanges (CVEs), local entities that will be recognized by the Agency for Healthcare Research and Quality (AHRQ). The CVEs will engage providers, consumers, and other key stakeholders in a collaborative effort to gather and release quality measurements both for physicians who participate in government-sponsored programs, such as Medicare, and for physicians who provide their services in the private sector. Working from the theory that “transparency leads to change,” HHS anticipates that the public release of this information will stimulate health system reform through quality improvement and informed consumer decision making. CMS is expected to begin providing the Medicare reports in the summer of 2008.

Quality experts predict that this effort is only one piece of a much larger strategy to begin reporting on physician performance and to accelerate change in the marketplace. The College continues to work with policymakers to ensure that the data used to measure and report on the quality of surgical care are valid and reliable. To learn more about the HHS Secretary’s plans for instituting value-based health care, go to http://www.hhs.gov/valuedriven/.

RWJ Foundation announces quality initiative

The Robert Wood Johnson (RWJ) Foundation recently announced that it will provide $16 million in grants to finance an effort to develop a consistent national approach to measuring and reporting on health care quality and cost. More than half of the funding will be used by the Engelberg Center for Health Care Reform at the Brookings Institution; additional funding will be provided to America’s Health Insurance Plans. Working with provider and consumer groups, business alliances, and other entities, these organizations will attempt to make better information available to the public about the quality and cost of health care. The project will analyze combined data from a variety of health plans and from Medicare in order to more closely scrutinize care provided across physicians’ entire practices. Former CMS Administrator Mark McClellan, MD, PhD, who currently directs the Engelberg Center, will coordinate the initiative. The Quality Alliance Steering Committee, of which the College is a member, will provide strategic guidance, and there will be collaboration with the AHRQ to make the quality and cost measures available to local communities. For further information, visit the RWJ Foundation Web site at http://www.rwjf.org/newsroom/newsreleasesdetail.jsp?productid=22371&typeid=160.
Part B premiums, deductibles announced

CMS recently announced that the standard Medicare Part B monthly premium will be set at $96.40 in 2008, representing an increase of $2.90, or 3.1 percent, from the $93.50 premium for 2007. This rise in cost represents the smallest percentage growth in the Part B premiums since 2001 and is $2.10 less than the increase in the premium for 2007. Part B premiums cover physicians’ services, outpatient hospital services, certain home health services, durable medical equipment, and other items. Several factors account for escalating Part B premiums, including expansion in home health services, physician-administered drugs, ambulatory surgical center services, durable medical equipment, laboratory services, and growth in the Medicare Advantage program. Because physicians are scheduled to receive a 9.9 percent reduction in Medicare payments for 2008 (barring congressional intervention, which had not occurred as of press time), growth in physician services did not contribute substantially to the Part B premium increase.

In addition, the Part B deductible for 2008 will be set at $135; it was $131 in 2007. To view the CMS fact sheet on the 2008 deductibles and premiums, go to http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

General surgery makes strides in Georgia

This past October, Georgia’s Board of Community Health unanimously voted to define general surgery as a single specialty under the state’s certificate of need (CON) rules. For many years, Georgia has defined general surgery as a multispecialty under its CON requirement for ambulatory surgical centers (ASCs). Under the current Georgia statute, single specialties are exempt from the state’s CON requirement for ASCs. Previous legislative, judicial, and regulatory efforts to address this incorrect and discriminatory definition of general surgery have been unsuccessful because of strong opposition from the hospital community. At press time, this amendment to the CON rules was undergoing a public comment period, with a hearing scheduled for November 28 in Atlanta. For more information, contact jsutton@facs.org.

Boost ACS representation in AMA House

Surgeons who are ACS Fellows and members of the American Medical Association (AMA) are eligible to vote for the specialty society they want to have represent them in the AMA House of Delegates (HOD). For every 1,000 votes, a society receives one additional delegate, increasing its ability to advocate for members in the house of medicine. The College currently has four well-respected and influential delegates but could have as many as 20 if all Fellows who are AMA members voted. At least 16,000 eligible Fellows have yet to cast their ballot. To support the College’s representation in the HOD, AMA members should visit the specialty ballot Web page at http://www.amanet.ama-assn.org/ama/priv/category/11232.html. (AMA members who do not have an AMA members-only name and password will need to obtain them before voting.)
Presidential Address:

**COMPETENCE, SAFETY, QUALITY:**
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by Gerald B. Healy, MD, FACS
Editor’s note: Dr. Healy delivered this Presidential Address on October 7 at the Convocation in New Orleans, LA.

Officers and Regents past and present, Honorary Fellows, our treasured College staff, guests, including my friend, Archbishop Hughes, and, most importantly, 2007 Initiates and your families: welcome.

First I would like to offer a special thanks to Dr. Copeland for [his] long and distinguished career in American surgery and for the many leadership roles in which [he] has served our College. [His] vision has changed our face in so many ways. [His] address to this group last year centered on mentorship. [He should] know that he has been an outstanding mentor to all of us but to me especially. [He has] been a guidepost for me to follow in my service to the College and for that I shall always be grateful.

I am deeply honored to become the 88th President of the American College of Surgeons. To be included among names such as Crile, Mayo, Cushing, Martin, Ravdin, Rhodes, Hanlon, and Spencer—as well as the other former Presidents who sit on this stage this evening—is indeed humbling. I should also say that I am especially honored to be the first otolaryngologist—head and neck surgeon to become President of this august body. Many of my colleagues from the specialty, including three of my teachers and mentors—Stuart Strong, Charles Vaughan, and Domenick Sampogna—have come here tonight to be part of this momentous occasion. I want each of you to know that I shall dedicate my year as President to all of you who have worked so hard to have our specialty recognized as an integral part of American surgery. To my colleagues at Children’s Hospital in Boston, a word of gratitude for allowing me the time to devote to the College. To my dear friends who have traveled from long distances to share this night, I say thank you. I only wish that my parents, who taught me the value of education and hard work, could be here to celebrate with us. Finally, to my dear wife Anne, and my daughters Lisa and Laurie, and their husbands John and Mike, thank you for your love, your support, and your wisdom. These are the people who packed my parachute—never forget who packed yours.

As your new President, allow me to welcome you, the Initiates, to the largest and one of the most respected surgical organizations in the world—an association whose mission statement promises that we, as an organization, are dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment. Today you will become an FACS: a Fellow of the American College of Surgeons. You have toiled through much pain, and your families have made many sacrifices, so that you might sit here this evening. However, you have merely walked a short path to a garden gate that you are about to open. That garden is where you will nurture and grow your legacy. That legacy will lie on a foundation that is FACS—not just a Fellow of the American College of Surgeons, but also Forever A Caring Surgeon.

Allow me to share an interesting story with you as we talk about the preparation to create your legacy as a caring surgeon.

On a bright morning in 1888, a gentleman was reading his morning paper in Southern France. The headline read “Le marchand de mort est mort” (“The merchant of death is dead”). Obviously this headline caught his attention. To his shock, he realized he was reading his own obituary, an obituary that told the world that finally “the father of death and destruction,” an individual who had been responsible for the killing of thousands of humans, had passed from this earth. This gentleman was overwhelmed to read what the world thought of his accomplishments, but he was given an opportunity that most of us will not be given: an opportunity to change his legacy. At the conclusion of this presentation, I shall tell you whether he was successful in accomplishing that goal.

In the meantime, let’s take a journey through what, in my opinion, will formulate the legacy of the 21st century surgeon.

Many years from now, you will look back on your career and examine your legacy. That legacy will have been shaped during a career that will have embraced three distinct areas: competence, safety, and quality. The public—your present and future patients—expect to be cared for by a competent surgeon who achieves quality outcomes in a safe environment. The framework for
meeting these expectations is found for the most part in the six general competencies that are now embraced throughout the medical profession and will become part of the professional lives of physicians from medical school through the lifelong process involved in the Maintenance of Certification program of every certifying board.

The first three competencies are fundamental. It is obvious that safe and competent doctors must be skilled and adept in appropriate patient care and have a fundamental and grounded foundation in up-to-date medical knowledge. All of us must continuously evaluate our skills and outcomes through a process of lifelong, practice-based learning that enables us to learn and improve from every patient encounter.

However, it is my firm belief that the major obstacle to the successful practice of safe, quality, and effective surgery will be found in the failure to be proficient with regard to the last three competencies, which encompass interpersonal skills and communication, professionalism, and, lastly, the ability to work effectively within systems. Let us examine each of these in more detail.

Interpersonal skills and the ability to communicate are heavily grounded in your ability to transmit the fact that you are a caring physician who is willing to spend time with your patient even to the point of embracing the age-old tradition of laying on of hands. These skills and the ability to communicate can mean the difference between your patient forgiving you or suing you when he or she has had less than an ideal outcome. Let your patient know that you care by patiently listening, prompting questions and explaining in layman’s language the pros and cons of surgical intervention.

A recent study in the Journal of the American Medical Association (2007;298:993) confirms that poor skills in communication leads to dissatisfaction, higher rates of complaints to regulatory authorities, increased risk of malpractice suits, and poorer outcomes. If you have ever been a patient yourself, you found out very quickly that bedside manner really does count. Remember, patients do not care how much you know until they know how much you care.

Unfortunately, our profession faces serious impediments to the laying on of hands and the giving of ample time for caring and listening. The computer and its embedded electronic medical record pose traps that will seduce you away from direct communication with your patient and ensnare you in a communication scheme involving only a screen and a keyboard. Throughout society, the art of conversation and the verbal sharing of opinions, thoughts, and ideas are quickly being replaced by printed words rapidly scrolling across a computer screen or Blackberry; with these myriad facts that bombard us each day, the ability to effectively communicate with other humans disappears.

Your patients need a hand on the shoulder, that kind word, that reassuring discussion about their illness, so I ask: Are you just going along with the electronic ride that distances you more and more from those who depend on you? It is sometimes far too easy for us to become lost in the technical...
aspects of surgery and leave behind the human qualities, such as meaningful communication, that differentiate us from the surgical robot.

The next serious hurdle in achieving safe and quality care is the breakdown in professionalism by some of our colleagues. Breaches in professional conduct are more common than we would like to admit, but each of us has a responsibility to acknowledge and deal with this problem.

We are all aware that today we work in an environment of uncertainty laced with loss of collegiality, driven by a neverending bottom-line mentality surrounded by falling reimbursements for our professional activity. In addition, our doctor/patient relationship is constantly being invaded by other individuals who are fondly called “providers.” This category encompasses anyone who is willing to step into the doctor/patient relationship to replace the physician at a moment’s notice. Your College is doing all that it can to combat these difficult aspects of practice today. There is no question that this environment naturally leads to significant stress: the stress of an ever-changing scope of practice, the stress of a society with rising expectations, and the stress of fluctuating and unpredictable relationships—physician to physician, physician to patient, physician to payor, physician to hospital, and on, and on, and on.

Unfortunately, this changing environment has been paralleled by a marked increase in disruptive behavior within our profession. This is a serious impediment to patient safety, a fact that has been documented by risk-management groups, physician managers of large group practices, and statewide physician assistance programs across the country. In a survey of more than 1,500 members done by the American College of Physician Executives, a significant percentage reported breaches in professional conduct. Issues such as physical abuse, verbal insults, and refusal to perform tasks and duties were documented (Weber DO. Physician Exec. Sept-Oct 2004). This behavior has a serious impact on patients and staff. It frequently intimidates patients and leads to high staff turnover rates, increased lawsuits, and high costs to practices, whether based in the community or in academic departments.

So what is our solution? I strongly recommend taking the following steps to deal with this troubling problem if it has invaded your community, your hospital or medical center, or your practice:

- Above all, deal with the problem. Show our colleagues that, as a profession, we are willing to stand up and confront these troublesome issues.
- Be proactive and establish a code of conduct that is acceptable within your organization.
- Train individuals around the issues that I have outlined.
- Help the individuals who are creating the problem to understand that this behavior is inappropriate and will significantly impact the safety of their patients.
- Finally, provide follow-up mechanisms to ensure that the culture around this issue is effectively changing.

Lastly comes our biggest challenge in changing our surgical culture: 21st century surgery will be embedded in systems-based care rendered by effective teams. You, the surgeon, will struggle to remain at the center of this team. Many of us were trained in the 20th century in an atmosphere sometimes ruled by icons who led in a monolithic fashion and who, unfortunately, in some cases, led by fear. This will not be the pathway to success going forward. Simply said, the ability to function in systems will be entrenched in two words: team and communication. Why? Because poor care is inevitable when a complicated patient is cared for by myriad individuals who have not been trained to communicate effectively as a team.

The poor fellow pictured in Figure 1 (page 10), a victim of multiple trauma, is currently being treated by a trauma surgeon, a neurosurgeon, an orthopaedic surgeon, an intensivist, an anesthesiologist, a pulmonologist, an infectious disease specialist, and a host of other individuals including nurses, a respiratory therapist, and so on. The days when a surgeon who is technically superb but who is not an efficient communicator and team leader can effectively manage this patient alone are gone. Therefore, we must embark on a major educational program in team training throughout all of medicine. Unfortunately, this is not how most of us were trained, but it is how we now care for patients. Team training has been proven to be very effective in the airline industry.
and in the military, and we need to learn from that success.

Sometimes we humans need a wake-up call. This was the airline industry’s wake up call: 582 deaths at Tenerife in 1977 because a captain, who could have been a surgeon in any operating room, refused to listen to a co-pilot who was too intimidated to abort a take-off (Figure 2, this page). The airline industry changed.

So what is our wake-up call? Certainly we are all aware of the report from the Institute of Medicine entitled, To Err Is Human: Building a Safer Health Care System. This startling revelation exposed the fact that avoidable errors occur every day in the health care world. Embedded within that document is the comment that health care organizations like the College must establish interdisciplinary team-training programs for our providers. Perhaps we can learn from the airline industry how we might embrace this new culture in surgery.

There is no question that this is the challenge of the 21st century surgeon. You can no longer be only surgeons, but you must become leaders of high-performance teams. As a leader, you will get what you tolerate and what you promote.

I ask you to leave here today committed to becoming a leader as a fundamental part of your legacy. Leadership is a process through which a person influences others to accomplish an objective and directs an organization so it becomes more cohesive and more coherent. Leaders determine the ultimate effectiveness of the organization as their character and skills determine the way in which problems are solved and tasks are accomplished. Never forget that Martin Luther King, Jr., in his profound declaration to the world, said, “I have a dream.” He did not say, “I have a very good plan.” Leaders provide passion and a strong sense of purpose for change. Leaders communicate a vision to their organization and endeavor to build excellence rather than command it. As you are about to enter the leadership phase of your careers, I ask you to remember what I shall call the 7 Cs of leadership (Figure 3, this page).

- **Courage:** Courageous leaders are decisive and display endurance, a strong will, and assertiveness.
- **Confidence:** Confident leaders exercise self-discipline and demonstrate a high level of maturity.
- **Creativity:** It is truly critical for leaders to be visionary and imaginative. These qualities invigorate the organization and stimulate others to move to the next level.
- **Communication:** Communication is perhaps one of the most important attributes of leadership. Learn to listen but also learn to be frank and forthright.
Caring: Perhaps the most profound trait of a leader is that of caring. This is a simple yet fundamental characteristic of great leaders: the willingness to empathize and provide a “shoulder” for other individuals to lean on in times of crisis, whether that crisis is professional or personal in nature.

Charisma: This is the ability to inspire with a passion and a commitment of purpose. Charismatic individuals are those whom you clearly recognize as people who are willing to try to make a difference.

Character: Lastly, and perhaps most importantly, is character; including the traits of integrity, humility, trust, profound beliefs, values, and, most important of all, honesty.

From a global standpoint, the most effective leaders are those who have taken the time to understand the community that they guide. You must study the organization you lead and understand its history and culture, for if you fail to understand where it has been and the process that has driven it to the foundation it now stands upon, you will fail in your ability to effectively structure its future.

Take this opportunity to move your career forward and become a leader—a leader in your family, a leader in your office, a leader in your hospital or medical center, a leader in your community, a leader in your medical organization. It really isn’t necessary to have the title “President” after your name to be a truly effective leader.

Wherever it is you choose to exercise leadership, challenge the process, inspire a vision, enable others, be a role model, and encourage the heart of the organization to be better. I beg each and every one of you to become a leader in our effort to advocate for our patients and become a leader through participation. Do not abdicate your responsibility to the people on this stage. Every one of us has been given an enormous opportunity to leave a legacy in a profession dedicated to serving our fellow beings. Savor, nourish, and cherish it!

Most of us will not be given a chance to reshape that legacy, as was the case with the gentleman in France on that morning in 1888. Alfred Nobel, the father of dynamite, decided after reading his own premature obituary on that fateful morning that he would dedicate the rest of his life to promoting the peaceful welfare of mankind (Figure 4, this page). Upon his death in 1895, his legacy was what we know today as the Nobel Prize.

Our legacy will follow our names forever. Hopefully it will be said about you that this was your legacy: Forever A Caring Surgeon.

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Figure 4

Dr. Healy is the Healy Chair in Pediatric Otolaryngology and professor of otology and laryngology at Harvard Medical School and otolaryngologist-in-chief at Children’s Hospital, Boston, MA. He is the 88th President of the American College of Surgeons.
It’s become increasingly difficult for practicing surgeons to ignore the relentless push in the health care marketplace for physician-level performance measures. Rapidly escalating costs, increasing public awareness of gaps in quality and medical errors, and benefit plan designs that emphasize consumer choice have led to heightened efforts to publicly report on the level of services delivered through our nation’s health care system.

Although efforts to measure the outcomes of medical and surgical care have been around since the early 1900s, the emphasis on performance measurement for health care professionals and other providers has increased dramatically in the last 10 years. Providers, professional associations, payors, regulators, accrediting organizations, and consumer advocates have begun to make significant changes in their views about monitoring and improving the quality of health care.

**Approaches to quality measurement**

Generally, quality-improvement strategies follow a combination of three strategies: public reporting of performance information, payments that are linked to quality of care (pay for performance), and structured quality-improvement processes. Each approach provides powerful incentives for health care professionals, facilities, and patients to do their part to improve the quality of care. However, each strategy depends on the availability of accurate, reliable, and valid performance measures, and such measures are not uniformly available across the spectrum of care.

Well-designed performance measures create an objective assessment of how well health care professionals and other providers adhere to evidence-based standards of care to achieve desired outcomes. Measures may be used to evaluate the structure, process, and outcome of care. Examples of structural quality measures include staff certifications, accreditation, and whether a practice or facility has the information technology in place to easily and accurately monitor and report on patient care. Structural measures are often thought of as minimum standards—necessities rather than quality assurance or improvement devices.

Measures that look at processes of care provide more direct evidence of quality of care because they document whether key activities were carried out during the patient’s care. Immunization rates and administration of prophylactic antibiotics to prevent surgical wound infections are examples
of process measures, as are most measures of a patient’s experience, such as whether a physician explains tests and treatments in an understandable way.

The ultimate measures of quality examine whether the outcomes for a population of patients are better, the same, or worse than expected for other patients with comparable conditions. Commonly tracked outcomes measures include rates of surgical site infection, mortality, and hospital readmission within a defined period of time. Outcomes measures better reflect the totality of care provided, not just component processes and procedures.

**Status of surgical measures**

To date, most quality measures have centered on preventive and chronic care. Quality measures for surgery are more difficult to develop because of some key distinctions in the way surgical care is delivered. Surgery is more episodic, and the outcome of a surgical intervention is more immediate and clear than with disease management, prevention, and screening activities that may span many years. As a result, surgical care lends itself much more readily to rigorous clinical outcome measurement than primary care. Furthermore, surgeons tend to have more focused areas of practice that make it difficult to apply broad quality measurement sets. Although some measures may apply across surgical specialties, measurement sets that are specific to each surgical specialty also are needed.

With such a variety of metrics in use throughout the health care system, how can a practicing surgeon know whether the methods proposed to evaluate surgical performance are useful in measuring quality? One way to assess usefulness is to find out if the measure has been developed through a rigorous research-based process, such as the one that is used in the American Medical Association’s (AMA) Physician Consortium for Performance Improvement. This panel comprises representatives of more than 50 specialty societies and methodological experts in measure development. They accept proposals for measures from member societies and other groups, then evaluate and test the proposed metrics to determine whether they are actionable, whether they are based on established clinical recommendations and evidence, and whether it is feasible to collect the supporting data.

The National Quality Forum (NQF)† is another organization working to create a standardized national set of measures that can be used to evaluate the entire spectrum of care. The NQF has a broad membership of providers, payors, and health plans. The NQF sets priorities for measure development and endorses national standards for measurement and public reporting of health care performance data that provide meaningful information about quality of care based on consensus from the broad spectrum of their membership. Thus, the NQF has endorsed quality measures developed by the AMA’s Consortium, which have then been adopted for use by the Centers for Medicare and Medicaid Services and private-sector payors and purchasers.

The College is a member of the AMA’s consortium, has a seat on the NQF, and is active in a number of other efforts to create performance measures for surgery that are evidence based and represent priority areas for surgical care. The College also continues to make progress in bringing the ACS National Surgical Quality Improvement Program into the private sector and is working with other surgical specialty societies to create performance measures that are common to all surgical specialties. Finally, the ACS is working to aggregate the demand across all of the entities (health plans, purchasers, and the government) that are using measures for quality improvement and pay for performance. The purpose of these efforts is to promote agreement on common measurement sets and protect our members from having to report multiple different performance measures for different audiences and purposes.


†More information about The National Quality Forum can be found at [http://www.qualityforum.org](http://www.qualityforum.org).
The Verification/Consultation Program of the American College of Surgeons Committee on Trauma (COT), commonly known as the Verification Review Committee (VRC), was developed to assist in improving the care of the injured patient by on-site consultation and verification of trauma center performance as outlined in COT’s *Resources for the Optimal Care of the Injured Patient, 2006*. Through on-site visits that extend over a one- to two-day period, site reviewers of the Verification/Consultation Program review the structure and resources of the trauma program, interview hospital personnel, tour the facilities, and review selected medical records and performance improvement materials in order to evaluate the quality of care provided.

Requirements that have been established by the COT must be met in order for a hospital to be verified as a certain level of trauma center. Areas in need of improvement are identified, as are those areas where special commendations are warranted. During the past year, more than 130 site visits have been conducted and many states use these verification site visits to decide which hospitals should be officially designated as trauma centers. All previous VRC visits have been limited to the U.S. However, this year, the VRC conducted its first official site visit outside of the U.S. at the request of the U.S. Army.

Landstuhl Regional Medical Center (LRMC) in Landstuhl, Germany, is a permanent U.S. military installation and represents the largest American military hospital outside the U.S. The medical center is under the command of the U.S. Army Europe, but it is currently staffed with active and reserve military personnel from the Army, Navy,
and Air Force. The facility was established to provide care for American military personnel and their families throughout the European Theater. However, since 2003, LRMC has served as the primary evacuation site for all combat casualties wounded or experiencing nonbattle injuries and/or medical disease in Afghanistan and Iraq. Over the past year, more than 2,000 injured patients have been admitted to LRMC. Although the initial evaluation and operative care of these trauma patients occurs at forward echelons of military medical care within Afghanistan and Iraq, most of the wounded are evacuated to LRMC within 36 to 48 hours of the time of injury. More than 600 wounded service members required admission to the intensive care unit (ICU) at LRMC in 2006. The wounds experienced by those involved in the current conflict are often extreme, with a combination of blast, burn, and penetrating mechanisms. While at LRMC, the injured undergo additional surgeries as needed with special attention to wound care, nutrition needs, and infection control. Unique to this center is the additional task of preparing these soldiers, sailors, airmen, and marines, including those in the ICU, for a prompt transfer back to the military medical facilities in the continental U.S. (Walter Reed Medical Center, National Naval Medical Center in Bethesda, MD, or the Brooke Army Medical Center in San Antonio, TX).

LRMC was reviewed June 13–14 by the COT VRC, with a two day on-site visit by the following reviewers: Dr. Mitchell, current Chair of the COT VRC; Dr. Knudson, current Vice-Chair of the COT; Donald D. Trunkey, MD, FACS, former COT Chair; and Jorie Klein, RN, Trauma Program Manager (see photo, this page). The hospital was seeking verification as a level II trauma center.

Overall, the review team was extremely impressed with the care being rendered at LRMC and found that all requirements of a level II trauma center were achieved. A level II trauma center provides care for essentially all types of injured patients. Because of the outstanding care that was witnessed, it was the recommendation of the COT for LRMC to pursue a level I verification. The additional requirements needed to achieve this designation would be to formalize the educational curriculum for surgical residents and the research program. In fact, some of the clinical research efforts by LRMC have already advanced the care of severely injured patients and have been implemented in trauma centers in the U.S.

In addition to their excellent patient care, several other special strengths were noted, including the following:

- The commitment to trauma care by the hos-
The leadership of the Director of the Trauma Program (Col. Stephen F. Flaherty, MD, FACS; see photo, this page), the Trauma Medical Director (Col. Warren C. Dorlac, MD, FACS), the Trauma Program Nurse Director (Kathleen D. Martin, MSN, RN), and the ICU Medical Directors (Lt. Col. Gina Dorlac, MD, and Maj. Valerie Pruitt, MD).

- The collaboration among the four military services
- The Joint Patient Tracking Application (JPTA), an outstanding Web-based system for tracking and communicating clinical information between physicians at the various echelons of care, from the combat zones in Iraq and Afghanistan through the medical treatment facilities in the U.S.
- The Joint Theater Trauma Registry, a customized database that is initiated in the combat hospitals “in theater” at the first point of care.
- The interdisciplinary ICU team, including surgeons, pulmonologists, gastroenterologists, infectious disease specialists, nurses, and social workers
- The dedication of surgical specialists (particularly orthopaedic surgeons and neurosurgeons) to trauma care in this unique environment
- The commitment of the operating room staff to being available whenever the injured arrived from the combat zones
In addition to touring the facilities, interacting with hospital personnel, and reviewing medical records, the site visitors had the opportunity to participate in the “VTC,” a unique trauma video-teleconference held weekly that includes simultaneous audio-feed from treatment facilities in Iraq and Afghanistan and audio-video input from LRMC, Walter Reed Medical Center; National Naval Medical Center at Bethesda, Brooke Army Medical Center, and Wilford Hall Air Force Medical Center. The conference begins with a presentation by the physicians who first encountered the injured patient and continues with input from physicians and care providers along the entire spectrum of care. The surgical care provided and any problems identified are discussed openly, thus allowing opportunities to share experience as well as concurrent performance review and loop closure.

Another highlight of this trip was the opportunity to directly observe a Critical Care Air Transport Team (CCATT) mission. The CCATT program was developed by the Air Force to provide continuous en-route care for the injured soldiers. CCATT teams are responsible for the movement of the critically injured soldier from the far-forward echelons of care (combat support hospitals or forward surgical facility in the theater of operation) to a more established, higher level of care (such as LRMC). Each CCATT team is composed of three members: a critical care physician, a critical care qualified nurse, and a respiratory therapist. Each CCATT team is designed to be capable of providing care for three critically injured patients (or six less severely injured) for up to 72 hours. The CCATT equipment set is man-portable, battery operated, and designed to function in austere settings. The equipment set includes a small ventilator, a cardiac/physiologic monitor, intravenous infusion pumps, and laboratory testing devices. These teams are usually joined by other air evacuation teams that care for less-critical patients and together patients and equipment are loaded on large Air Force planes fully equipped for the flights of eight to 12 hours’ duration. During flight, medications and nutrition are administered without interruption and critical cardiopulmonary changes addressed as needed. Despite the complexity of this mission, it appeared to be a seamless process from loading patients in the LRMC critical care unit onto the transport buses, through the transfer to the plane at the Ramstein Air Force Base, to the arrival at Andrews Air Base some 12 hours later, throughout which patient safety and comfort were of highest priority for all involved.

This recent verification of LRMC as a trauma center is of importance for many reasons. First, it recognizes the enormous contributions made by all who have provided care to these wounded soldiers. Second, families may be assured that their sons, daughters, husbands, and wives have received the highest level of trauma care that our nation can provide, as verified by the ACS COT and the VRC. This verification is all the more impressive given the significant challenges of combat conditions, austere environments, and care and transport across thousands of miles and many countries. In addition, this collaborative effort between military and civilian trauma care professionals coordinated by the College reflects the growing recognition of how important it is to work together to improve trauma care worldwide.

But most importantly, the visit to LRMC pays tribute to our soldiers, airmen, sailors, and marines who are willing to give so much of themselves and who deserve the very best in return. The impetus of the LRMC includes the words “Selfless Service”—and this, indeed, was the case.

Dr. Knudson is professor of surgery at the University of California, San Francisco, and Vice-Chair of the ACS COT.

Dr. Mitchell is medical director, trauma and surgical critical care, St. John Medical Center, Tulsa, OK, and Chair of the ACS COT Verification Review Committee.

Dr. Johannigman is a colonel in the U.S. Air Force Reserve, director of the division of trauma/critical care at the University of Cincinnati, OH, and Chief of Region V of the ACS COT.
Like some of my trauma surgical colleagues, I had the opportunity in July 2007 to participate in the American College of Surgeons/American Association for the Surgery of Trauma (AAST), Senior Visiting Surgeon Combat Casualty Program at the Landstuhl Regional Medical Center (LRMC) in Landstuhl, Germany.

This program was initially conceived and inaugurated by the AAST to allow senior civilian trauma surgeons to work with our military surgical colleagues in caring for the combat casualties from the war in Iraq. The concept was that we could help and teach by bringing our years of trauma experience and, in turn, we could learn from them the trauma lessons from this war.

As has been the case for most of the ACS/AAST visiting surgeons who have had the opportunity to visit Landstuhl, it was undoubtedly one of the most rewarding experiences of my surgical career for a variety of reasons. Principally, it was gratifying to have been immediately integrated into the superb LRMC trauma team and to participate in the operative and surgical critical care of the many wounded warriors being evacuated virtually every day from the war in Iraq and from Afghanistan and Africa.

Because of my long-standing interest in trauma systems, I was especially pleased to observe, first-hand, the Joint Services Trauma System (described later in this article).

In addition, I was honored, as a Regent of the College, to deliver a Certificate of Appreciation to the surgical teams at the LRMC.

Following is an edited version of the “Dispatch from Landstuhl” I sent to the leadership of the ACS: Edward M. Copeland III, MD, FACS, Immediate Past-President; Gerald B. Healy, MD, FACS, President; Josef E. Fischer, MD, FACS, Chair of the Board of Regents; and Thomas R. Russell, MD, FACS, Executive Director.
I have completed my tour at the Landstuhl Regional Medical Center (LRMC), as a participant in the ACS/AAST Senior Visiting Surgeon Combat Casualty Program. It has been one of the most rewarding experiences of my surgical career.

It is important to note that LRMC was, just last month, verified by our ACS verification program as a level II trauma center. It is the only military hospital outside the continental U.S. to achieve ACS Trauma Center Verification status. This is an incredible achievement, because they prepared, had a successful site visit, and met all of our rigorous criteria for level II trauma center verification—all accomplished while caring for the large number of critically injured “wounded warriors” they receive on a daily basis.

There have been a number of trauma surgeons who have preceded me in this program and others who will follow. I fortuitously overlapped with my friend and colleague Norman McSwain, MD, FACS, from Charity Hospital, Tulane. I believe all of my predecessors have been Fellows of the ACS.

I, with your endorsement, was privileged to go as a Regent representing the ACS and to deliver an ACS Certificate of Appreciation. Dr. Russell and the staff in Chicago prepared an official ACS document, which read as follows:

Certificate of Appreciation

The American College of Surgeons honors and applauds the dedicated surgical teams of Landstuhl Regional Medical Center for their care of our servicemen and women wounded in Iraq.

I presented this certificate to Col. Brian C. Lein, MD, FACS, Commanding Officer of the LRMC, and Col. Stephen Flaherty, MD, FACS, chief of surgery/trauma and critical care, in a ceremony attended by most of the surgical staff at the hospital. It was graciously received, and Colonel Lein, a general surgeon, expressed his extreme gratitude and pride at receiving this acknowledgment from the ACS. He and Colonel Flaherty told me how much this meant to the morale of their entire surgical team.

One of the highlights of my experience was working with and witnessing the superb leadership of Colonel Flaherty, a talented, committed, and compassionate trauma surgeon. These surgical teams at LRMC are an integral part of the remarkable Joint Theater Trauma System (JTTS), serving our injured warriors from Iraq, Afghanistan, and beyond. Colonel Flaherty is one of the architects of the JTTS.

The JTTS spans all of the military “echelons of care” (that is, continuum of care) as follows:

- **Echelon 1:** Medic care in the battle zone for life-saving care including the control of hemorrhage (often with tourniquets).
- **Echelon 2:** Division-level health service support, which includes evacuating patients from the unit-level aid stations and providing initial resuscitative treatment in division-level medical facilities. These are our forward surgical teams operating in mobile field hospitals. They may remove tourniquets, treat shock with intravenous fluids, perform emergent lifesaving amputations for improved explosive device blast mangled extremities (frequent procedure), place temporary silastic vascular shunts for arterial injuries, stabilize fractures, give pain medications, and so on.
- **Echelon 3:** Includes combat support hospitals such as the one in Balad, Iraq, from which most of the LRMC patients are transferred. Here they do “damage control” surgery, including vascular repairs with interposition vein grafts, external fixators, fasciotomies, laparotomies, splenectomies, and so on. They usually leave the abdomen open, apply a wound vac, and transfer by critical care air transport team (CCATT) (described later in this article).
• **Echelon 4:** Definitive care hospitals such as the LRMC, where patients are reoperated if necessary, wounds washed out, debrided, burn wounds dressed, escharotomies done or extended as needed, wounds including fasciotomies closed when appropriate, critical care provided (such as dialysis and other procedures). Patients are seen by all specialties as indicated. Transfers by CCATT to the U.S. are arranged. The average length of stay at LRMC is only about three to four days.

• **Echelon 5:** Tertiary care hospitals such as Walter Reed, the U.S. Naval Center in Bethesda, and Brooke Army Medical Center (all burns) in San Antonio, TX, and San Diego (CA) Naval Hospital. CONUS (Continental U.S.) is where the ultimate treatment capability for patients from the theater resides, including full rehabilitative care and tertiary-level care.

   (At the invitation of Admiral Christine Hunter, Commander, San Diego Naval Hospital, I was actually able to visit one of the marines I cared for at the LRMC in July. At the Naval Hospital, he is undergoing rehabilitation following an above-the-knee amputation. The people, the facility, and the care he and many other wounded warriors are receiving are truly magnificent.)

   Integral to the JTTS is the U.S. Air Force’s CCATT. CCATT transfers are accomplished in a C17 transport plane that has been converted to a “flying intensive care unit (ICU).” They can carry up to 40 wounded soldiers. The most critical, such as the patient I have described, are accompanied by a doctor, nurse, and respiratory therapist, and they are equipped to do virtually all modes of critical care. Other less critical patients are cared for by nursing teams. They fly at 35,000 feet. It is about an eight-hour flight to the U.S. There is some element of high altitude physiology since the plane interior is at about 1 atmosphere.

   At LRMC, we received flights from “down range” (Iraq and Afghanistan) every day, and had outgoing flights to the U.S. (“up range”) three days a week (Tuesday, Friday, and Sunday).

   It is an amazing process to watch these CCATTs move in to the LRMC ICU, “package” the patients, move them by converted bus to the Ramstein Air Base (a 15-minute drive), and load them on the C17.

   I was allowed to accompany one of my patients on this trip to Ramstein Air Base. They also allowed me to go aboard the C17 and see the interior, which is configured as an ICU. I was able to wish my patient safe travel home. Like most of the Marines I cared for, he said he would rather be going back to the war with his platoon.

   Some of the most remarkable things about the JTTS they have created are as follows:
   - The commitment, courage, passion, and expertise of the surgical teams, particularly those surgeons operating in or near the combat zone (“one terrain feature from the battle line”), with constant threat of mortar and sniper fire. Colonel Flaherty told me that one of his trauma surgeons who had been deployed down range was killed by mortar fire. On rounds one day, Colonel Flaherty commented on the need to carefully reexplore a patient because this would be the first operation he has had where the surgeons weren’t under mortar fire. There is one medical facility that has been nicknamed “Mortaritaville.”
   - The incredibly rapid movement of critically injured soldiers from the battle line of the combat zone to definitive/tertiary care, usually over only several days, which is made possible by the CCATT operation.
   - System performance improvement over the continuum of care. Once a week, they have a video trauma conference with participation from surgeons down range (Iraq), LRMC, and Walter Reed, Bethesda, and Brooke Army Medical Center. They discuss all patients from the past week and we hear what happened in the combat zone, what we did at LRMC, and what they have done and are doing at the echelon 5 hospitals in the U.S.

   I have some initial thoughts about where we, the ACS, can help in this effort to care for combat casualties:
   - **Verification of military trauma hospitals.** We can begin by helping to celebrate the major accomplishment of level II verification at LRMC.

   I have discussed this issue with Dr. Russell, who will help facilitate someone from ACS attending their celebration ceremony. There are only a few verified military trauma centers in the U.S. (such as Brooke Army Medical Center).

   We should also help facilitate the verification of the military’s echelon 3 combat support hospitals such as the one in Balad. This would help ensure the delivery of optimal care at that level. This next step is critical.
In summary, there is much that the ACS can do to support our surgeons (many of whom are Fellows) and surgical teams who are caring for the injured men and women of this war. I did have the opportunity to meet with Brig. Gen. David Rubenstein, Deputy Commanding General, 3rd Medical Command, and he is interested in pursuing how we can work together.

It is clear to me that the support of the ACS is profoundly important to our surgical teams. This appreciation was demonstrated by the surgeons at LRMC, and Brigadeer General Rubenstein, in response to receiving our ACS Certificate of Appreciation.

When we talk about what we can do for our Fellows, this is a prime example, and I think our efforts would also be appreciated by our Fellows at home.

General Rubenstein shared a wonderful quote from the Mayo brothers during WW II: “The only victor in war is medicine.”

Ultimately, injured patients cared for in our trauma centers in the U.S. and Canada will benefit from the new knowledge being learned from this war, just as military medicine has advanced trauma care throughout history.

• Dr. Healy’s idea of involving our surgical specialties. The orthopaedic surgeons play an absolutely critical role, especially down range. I did meet one orthopaedic surgeon from Denver, CO, who is part of the visiting surgeon program.

I discussed the neurosurgeon situation with the only neurosurgeon at LRMC, and clearly they are stressed to the limit. There are, I understand, currently only two neurosurgeons in Iraq, and they do all of the urgent cases before transfer to LRMC.

We could lead discussions with these critical specialties, as Dr. Healy has suggested.

• Research. There are opportunities to help facilitate clinical research. They are putting together a trauma registry database. It will be extremely valuable, especially in the treatment of hemorrhagic shock and blast injuries of the extremities, head, and neck. I would like to consider adding a military surgical scientist (such as John Holcomb, MD, FACS, Director of Research Unit at Brooke Army Medical Center) to the Regent’s Scholarship Committee, of which I am Chair. We could explore how we might direct some of our research grant money to military surgeons doing clinical research in one of these areas.

• Trauma system development. There is opportunity to involve the surgeons who have developed the JTTS I have described. They could teach us a great deal about what they have done with triage and transport. Also, I think we could put together a trauma system consultation team that could help them. The military surgeons would define the questions and describe the expertise they would want on the ACS team. That’s the way we are doing it in the U.S. The ACS Trauma System Consultation Program has the processes and access to surgical expertise to make this happen.

• Education. Better integrate them into our various education programs, including the Clinical Congress, specialty meetings, and so on. I did hear from the surgeon at Walter Reed, during our video trauma conference this week (while discussing one of our patients with a penetrating wound to the neck) that they will present a paper at the Surgical Forum at this year’s Clinical Congress. They are presenting 200 penetrating wounds of the neck. This is a prime example of the wealth of information they have to share with us. This is information that will save lives in the U.S.
Physicians understand that they have an obligation to testify in court as expert witnesses on behalf of the plaintiff or defendant as appropriate. The physician who acts as an expert witness is one of the most important figures in malpractice litigation. In response to the need to define the recommended qualifications for the physician expert witness and the guidelines for his or her behavior, the Patient Safety and Professional Liability Committee of the American College of Surgeons has issued the following statement. The statement is an adaptation of guidelines developed by the Council of Medical Specialty Societies and several other medical groups.

**Recommended qualifications for the physician who acts as an expert witness:**

- The physician expert witness must have had a current, valid, and unrestricted state license to practice medicine at the time of the alleged occurrence.
- The physician expert witness should have been a diplomate of a specialty board recognized by the American Board of Medical Specialties at the time of the alleged occurrence and should be qualified by experience or demonstrated competence in the subject of the case.
- The specialty of the physician expert witness should be appropriate to the subject matter in the case.
- The physician expert witness who provides testimony for a plaintiff or a defendant in a case involving a specific surgical procedure (or procedures) should have held, at the time of the alleged occurrence, privileges to perform those same or similar procedures in a hospital accredited by The Joint Commission or the American Osteopathic Association.
- The physician expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should have been actively involved in the clinical practice of the specialty or the subject matter of the case at the time of the alleged occurrence.
- The physician expert witness should be able to demonstrate evidence of continuing medical education.
relevant to the specialty or the subject matter of the case.

- The physician expert witness should be prepared to document the percentage of time that is involved in serving as an expert witness. In addition, the physician expert witness should be willing to disclose the amount of fees or compensation obtained for such activities and the total number of times he or she has testified for the plaintiff or defendant.

**Recommended guidelines for behavior of the physician acting as an expert witness:**

- Physicians have an obligation to testify in court as expert witnesses when appropriate. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.
- The physician expert witness should review all the relevant medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.
- The physician expert witness should be prepared to distinguish between actual negligence (substandard medical care that results in harm) and an unfortunate medical outcome (recognized complications occurring as a result of medical uncertainty).
- The physician expert witness should review the standards of practice prevailing at the time and under the circumstances of the alleged occurrence.

- The physician expert witness should be prepared to state the basis of his or her testimony or opinion and whether it is based on personal experience, specific clinical references, evidence-based guidelines, or a generally accepted opinion in the specialty. The physician expert witness should be prepared to discuss important alternate methods and views.
- Compensation of the physician expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a physician expert witness to link compensation to the outcome of a case.
- The physician expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records and subject to independent peer reviews. Moreover, the physician expert witness should willingly provide transcripts and other documents pertaining to the expert testimony to independent peer review if requested by his or her professional organization. The physician expert witness should be aware that failure to provide truthful testimony exposes the physician expert witness to criminal prosecution for perjury, civil suits for negligence, and revocation or suspension of his or her professional license.
Call for nominations for the ACS Board of Regents

The 2008 Nominating Committee of the Board of Governors has the task of selecting a nominee for a pending vacancy on the Board of Regents to be filled during the 2008 Clinical Congress.* The following guidelines are used by the Nominating Committee when reviewing the names of candidates for potential nomination to the Board of Regents:

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
- Recognition of the importance of representing all who practice surgery

Also to be taken into consideration are geography, surgical specialty balance, and academic or community practice. The College encourages consideration of women and other underrepresented minorities.

Individuals who are no longer in active surgical practice should not be nominated for election or reelection to the Board of Regents. Priority consideration should be given to representatives of thoracic surgery.

Nominations should include one or two paragraphs regarding the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org. The deadline for nominations is February 29, 2008.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Board of Governors, at psprecksel@facs.org.

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Call for nominations for ACS Officers-Elect

The 2008 Nominating Committee of the Fellows has the task of selecting nominees for the three Officer-Elect positions of the American College of Surgeons: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The following guidelines are used by the Nominating Committee when reviewing the names of potential candidates for nomination as Officers of the College.

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
- Recognition of the importance of representing all who practice surgery

The College encourages consideration of women and other underrepresented minorities.

Nominations should include one or two paragraphs on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org. The deadline for submitting nominations is February 29, 2008.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Fellows, at psprecksel@facs.org.
Japan and Germany Exchange Travelers for 2008 announced

The International Relations Committee (IRC) of the American College of Surgeons has established exchange programs with several national surgical societies and their corresponding national ACS chapter. Earlier this year, John F. Renz, MD, FACS, director of surgery for Columbia University’s Center for Liver Disease and Transplantation, New York, NY, was selected to go to the German Surgical Society’s 2008 meeting in Berlin. At this conference in April, Dr. Renz will give a presentation and then tour several German surgical institutions to interact with colleagues.

In addition, members of the IRC’s Scholar Selection Subcommittee chose the 2008 Japan Traveling Fellow, Sam Wiseman, MD, FACS, FRCSC, a general surgeon from the University of British Columbia in Vancouver, will attend the Japan Surgical Society’s annual meeting in Nagasaki in May and visit fellow surgical oncologists in Japan for several weeks.

In Spring 2008, the surgical societies of Japan and Germany will announce the names of their Exchange Fellows who will visit the ACS 2008 Clinical Congress in San Francisco, CA, and create an itinerary of tours tailored to their interests.

Visit the Web portal of The American College of Surgeons:

e-facs.org

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Membership in the American College of Surgeons?

HERE’S WHY IT’S IMPORTANT:

AS A BODY REPRESENTING ALL OF SURGERY, THE COLLEGE:

• Provides a cohesive voice addressing societal issues related to surgery.
• Is working toward having an increasingly proactive and timely voice in setting a national tone and agenda with regard to health care.
• Is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients.
• Serves as a national forum through which surgeons can reinforce the values and ethics that traditionally have characterized the surgical profession.

THERE IS STRENGTH IN NUMBERS.

Our members represent every specialty, practice setting, and stage of practice. Their views and concerns are helping to shape the College’s agenda for the future.

If you aren’t a member of the American College of Surgeons, apply for Fellowship today. If you are already a member, maintain that status and consider getting involved in the work of the College.

Only by banding together and using our collective strength can we bring about positive change for our patients and ourselves—and for surgeons of the future.

HERE ARE SOME OF THE MANY BENEFITS BEING A MEMBER OF THE COLLEGE AFFORDS YOU:

• Free registration at the Clinical Congress
• Access to the College’s free coding consultation hotline
• Subscription to ACS NewsScope, the College’s weekly electronic newsletter
• Subscription to the Bulletin of the American College of Surgeons
• Subscription to the Journal of the American College of Surgeons
• Access to all College-sponsored insurance, credit card, and other helpful programs
• Free posting of resume on ACS Career Opportunities
• Access to Surgeons Diversified Investment Fund

Information on becoming a member of the College and an application form are available online at www.facs.org/dept/fellowship/index.html or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 800/293-9623, or via e-mail at chicks@facs.org.
Scholarships in health policy and management available for 2008

The American College of Surgeons is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management at Brandeis University (http://heller.brandeis.edu/academic/elp.html). The 2008 course takes place June 22–27. The award is in the amount of $8,000, to be used toward the cost of tuition, travel, housing, and subsistence during the period of the course.

One of the scholarships is reserved for general surgeons and is fully funded by the College. The College is pleased that many of the surgical specialty societies have partnered with the organization to cosponsor a scholarship for a member in good standing within the College and his or her specialty society to attend this intensive program. The participating societies supporting scholarships are the American Academy of Ophthalmology, the American Academy of Otolaryngology–Head & Neck Surgery Foundation, the American Association for the Surgery of Trauma, the American Pediatric Surgical Association, the American Society of Colon and Rectal Surgeons, the American Society of Plastic Surgeons, the American Surgical Association, the American Urogynecologic Society, the Society of Thoracic Surgeons, and the Society for Vascular Surgery.

In addition to the requirement of good standing in the College and the applicant’s respective surgical society among those listed, general policies covering the granting of the scholarships are as follows:

- Applicants must be at least 30 years of age, but younger than 55, on the date that the completed application is filed.
- The award is to be used to support the recipient during the period of the course. Indirect costs are not paid to the recipient or to the recipient’s institution.
- Applications for this scholarship consist of one copy of the applicant’s current curriculum vitae and one copy of a one-page essay that discusses why the applicant hopes to receive the scholarship.
- Application for this award may be submitted even if comparable application to other organizations has been made. If the recipient accepts a similar scholarship from another agency or organization, the scholarship will be withdrawn. It is the responsibility of the recipient to notify the Scholarships Section of the ACS, which administers this program, of competing awards.
- The scholar must be used in the year for which it is designated. It cannot be postponed.
- The scholar is required to provide one year’s health policy-related assistance to the ACS and the cosponsoring society, including attending meetings, reviewing applications, participating as a pro tem member of the health policy committee, and so on, as requested by either organization.
- A brief report of the scholar’s experiences and activities is due at the conclusion of the course and again at the end of scholarship period. A simple accounting is also required.

The closing date for receipt of applications is February 1, 2008. All applicants will be notified of the outcome of the selection process by March 31, 2008.

Requirements for scholarships are posted on the ACS Web Site at http://www.facs.org/memberservices/research.html. Additional questions may be directed to the ACS Scholarships Administrator at 312/202-5281. Send applications to Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
The American College of Surgeons and the National Ultrasound Faculty have developed “Ultrasound for Surgeons: The Basic Course” for surgeons and surgical residents on CD-ROM.

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

Replaces the basic course offered by the American College of Surgeons.

A printable CME certificate is available upon successful completion.

CD will install the necessary software (PC or Mac).

The learner is offered two attempts to pass a multiple-choice exam with a minimum score of 80% at the completion of the program.

Residents must submit a letter from their director/chair to document residency status.

Only one user per CD is allowed. Online access is needed to register the CD and to take the exam.

$300 for nonmembers

$225 for Fellows of the American College of Surgeons

$125 for residents with letter proving status*

$90 for Resident and Associate Society (RAS) members (Additional $16 for shipping and handling of international orders)

*Non-RAS residents must supply a letter confirming status as a resident from a program director or administrator and are limited to one CD-ROM.

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

For additional information, contact Olivier Petinaux, MS, tel. 866/475-4696, e-mail elearning@facs.org

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

John M. Eisenberg Patient Safety and Quality Award recipients announced

The National Quality Forum (NQF) and The Joint Commission presented the 2007 John M. Eisenberg Patient Safety and Quality Awards in late September at NQF’s Annual Policy Conference on Quality in Washington, DC. One of the two recipients in the individual achievement category was Darrell A. Campbell, Jr., MD, FACS, of University of Michigan Hospitals and Health Centers, Ann Arbor, MI.

Dr. Campbell was recognized for advancing quality-improvement initiatives at the national, regional, and local levels. He led the expansion of the National Surgical Quality Improvement Program (NSQIP) from the Veterans Administration to the private sector and then used that experience to design and develop the Michigan Surgical Quality Collaborative (MSQC), a quality collaborative based on NSQIP.

Today the MSQC is a partnership involving 34 Michigan hospitals, the American College of Surgeons, and Blue Cross Blue Shield of Michigan. At the local level, Dr. Campbell has distinguished himself as chief of staff at the University of Michigan Health System, where he has implemented multiple patient safety and quality-improvement initiatives. These include a hospital-wide rapid response team, regular patient safety rounds, establishment of a “full disclosure” policy for medical errors, provision for annual patient safety training for all employees, and a patient safety certification program for house officers.

The patient safety awards program, launched in 2002 by NQF and The Joint Commission, honors John M. Eisenberg, MD, MBA, former administrator of the Agency for Healthcare Research and Quality (AHRQ). Dr. Eisenberg was one of the founding leaders of the NQF and sat on its board of directors. In his roles both as AHRQ administrator and chair of the federal government’s Quality Inter-Agency Coordination Task Force, he was a passionate advocate for patient safety and healthcare quality and personally led AHRQ’s grant program to support patient safety research.

The December issue of The Joint Commission Journal on Quality and Patient Safety features the achievements of each of the award recipients.

Joining Dr. Campbell, the honorees, by award category, are as follows: Individual achievement: Flaura Koplin Winston, MD, PhD, Center for Injury Research and Prevention at The Children’s Hospital of Philadelphia and the University of Pennsylvania. Dr. Winston is being recognized for her lifelong professional commitment to combining public health, biomechanical engineering, and psychologic methodologies to promote safety and prevent injury among children from motor vehicle crashes.

Research: Eric J. Thomas, MD, MPH, The University of Texas Health Science Center at Houston. Dr. Thomas’ broad-based patient safety and quality research activities have focused on the epidemiology of errors and adverse events, teamwork, incident reporting, measuring and improving cultures of safety, claims file analysis, pediatric patient safety, geriatric patient safety, and organizational learning.

Innovation in patient safety and quality at the national level: Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA. This organization is being recognized for the adaptation and application of the military and commercial aviation crew resource management principles to the field of obstetrics.

Innovation in patient safety and quality at the local level: Evanston Northwestern Healthcare, Evanston, IL. This organization is being recognized for its development and deployment of the first universal admission surveillance program for methicillin-resistant staphylococcus aureus.
The online resource, So, You Want to Be a Surgeon... A Medical Student Guide to Finding and Matching with the Best Possible Surgery Residency, is now available on the American College of Surgeons Web site at:

http://www.facs.org/residencysearch

This online, contemporary version of the popular “Little Red Book” has proved to be an invaluable resource for medical students seeking opportunities in graduate medical education. The revised online version of this helpful reference includes a searchable database containing a complete list of accredited surgical specialty residency programs, as well as a section devoted to assisting students in choosing a residency program that is their best match.

For further information, contact Elisabeth Davis, MA, Education Research Associate, Division of Education, at 312/202-5192, or via e-mail at edavis@facs.org.
ACOSOG news

How a surgeon in the boonies becomes a researcher and regional expert

by Gary Unzeitig, MD, FACS

After a few decades in practice, many surgeons feel secure in their skills and calm under pressure but may question if the pinnacle has been reached and if the next wave of medical advances will render their clinical experience obsolete. We also have witnessed sub-optimal care given to patients and their subsequent flight to distant medical centers, and it makes us want to improve what we have to offer. For me, involvement in clinical trials has been the means to stay on the cutting edge academically; to give the community access to services that individuals previously had to travel great distances to receive; and, in the process, to become acknowledged as a regional expert in my field—and it was not that hard to do.

The use of clinical trials as the means to achieve a standard for evidence-based medicine was in its infancy in the 1970s. Trials that compare time-honored surgical techniques with novel techniques have rapidly changed how all physicians practice, including surgeons. In my case, research during general surgery residency, on surgical options for breast masses, sparked an interest in the field that now is my specialty. My solo practice began in general surgery in a small South Texas border city. Staying at the top of this field in skill and knowledge and offering comprehensive care to the community presented challenges. Though we all have access to the same journals, it seems that keeping current requires more effort in a smaller city than it would in a large city with an academic center. Reading journals and e-mail updates and attending conferences became an increasing part of my practice. It is true that we often do not know just how much we do not know until we make the time for continued study.

As in many small cities, physicians in Laredo are frequently concerned that patients are transferred to larger cities for care that could probably be given in our own community. Some cases truly needed a tertiary care center service, but many patients whose condition could well be managed in our community sought services at a medical center because of a perception that it would be more advanced. Patients, physicians, and hospitals alike lost in this high-cost scenario, and it was not a feasible option for many of the poorer patients.

My continuing interest in breast cancer triggered a desire to improve the treatment options available to all of our patients. Bringing up the level of care in the community clearly required a multidisciplinary approach with strong support of the hospital and involvement in multicenter, cooperative group trials. Several factors converged to make this reality for us. Our first step was the realization that we already had laid the groundwork of a great community hospital cancer program.

Connecting with one medical oncologist, an enthusiastic clinician, was the next step. His clinical trials experience during an oncology fellowship made us understand that when the correct team is assembled, good research can be done. We consulted and enlisted the support of a dynamic pathologist, the hospital’s part-time tumor registrar, and the hospital administration, thus creating an effective and quite motivated alliance. We obtained the criteria needed to become an affiliate of Southwest Oncology Group (SWOG) and set about to fulfill them.

It is more accurate to consider us a research program without walls and both the medical oncologist and I are in solo private practice. The hospital provides us with a
part-time data manager. I had to learn what an Institutional Review Board (IRB) was and have served as our IRB co-chair since the beginning. Our IRB board meets regularly and the members are great ambassadors to the community to advertise the importance of clinical trials as well as the quality of medical care available locally. Other physicians were interested but cited time constraints for their inability to participate. So, between the medical oncologist and me, we serve as IRB co-chairs, cancer committee chairs, liaison physicians to the Commission on Cancer, and principal investigators for our respective clinical trial interests.

The learning curve in the various documentation requirements—including study notes, shadow charts, and drug accountability logs—was steep but facilitated graciously by the support staffs at SWOG and especially at the American College of Surgeons Oncology Group (ACOSOG). We keep abreast of opening trials and assess whether or not they are studies appropriate for our patients. For surgeons, ACOSOG, in particular, has excellent trials.

The key to successfully enrolling patients is to keep in mind the eligibility requirements. Post-It notes above my desk remind me with brief eligibility notations on the breast cancer trials that are currently open. All eligible patients are offered enrollment as part of my diagnosis discussion. Our enrollment rate of approximately 90 percent is likely because of the time we spend personally in discussion of the meaning of clinical trials and the consent form.

The first patient enrolled in each trial takes more time in order to correctly navigate the protocol, but subsequent enrollment gets easier. Clinical dictations have always been my routine, and it takes little extra time to personally complete the case report forms. The clinical research associate then enters the data and verifies that the forms are complete and correct.

What has all this effort done for me, my patients, and my practice? First of all, the patients benefit because they are offered participation in a trial that offers what looks to be treatment superior to what is the current standard of care. They realize that they can be a part of cancer research that will help future cancer patients, perhaps even their own children. As for my practice, having become the local and regional expert in breast cancer care has kept my practice busy and rewarding. For the hospital, the reputation as the provider of choice for cancer care has improved its standing in the community and reduced the flight of patients and revenues northward.

For me personally, involvement in research has given me wonderful confidence that what I am doing is exciting, and worthwhile.

Note from the ACOSOG Group Co-Chairs, David Ota, MD, FACS, and Heidi Nelson, MD, FACS: Dr. Unzeitig has a successful breast surgery practice in Laredo, TX, and is a high-enrolling ACOSOG investigator. Dr. Unzeitig was the first investigator to enroll a patient in trial Z1041 and has had outstanding data quality and audits of his site. We are grateful to him for his participation and for this article.
Join us in San Francisco for the 94th annual Clinical Congress. As always, it will be an educational opportunity you won’t want to miss!

Please be sure to visit WWW.FACS.ORG in the coming months for more details regarding the educational program, registration, housing, and transportation.
New Year’s Eve is just around the corner, but it was not always commemorated at this time of the year. The beginning of the new year has been celebrated on different dates throughout history, but in 1752, Great Britain and its colonies in America adopted the Gregorian calendar and January 1 was permanently established as New Year’s Day.

Throughout the world, the new year is celebrated differently according to various customs and religions. In the U.S., we have the “countdown” just before midnight in Times Square in New York. But tradition does not end when the ball hits the bottom. Bright and early this January 1 will mark the 119th Tournament of Roses parade, a tradition first staged in 1890 by the Valley Hunt Club in Pasadena, CA. Former residents of America’s East and Midwest wanted to showcase their new locale’s mild winter weather.

Yet another New Year’s tradition is treating the intoxicated revelers who have managed to become New Year’s statistics. Each year, numerous New Year’s predictions are made, and though many never come to pass, there is one in particular that is unfortunately very reliable: According to the National Institute on Alcohol Abuse and Alcoholism’s 2006 New Year, Old Myths, New Fatalities, significantly more people are likely to die in alcohol-related traffic crashes on New Year’s Eve than on any other mid-week winter evenings (http://pubs.niaaa.nih.gov/publications/NewYearsFactSheet/NewYearsFactSheet.htm).

In order to examine the occurrence of New Year’s Eve-related injuries in the National Trauma Data Bank Dataset 6.2, I searched by emergency department arrival time between 7:00 pm on December 31 to 7:00 am on January 1. There were 2,219 records with discharge status recorded in the data-
set. Among the victims in these records, 1,831 were discharged to home, 250 to acute care/rehabilitation, and 41 to nursing homes; 97 died. Victims were 72 percent male, on average 33.6 years of age, and had an average length of stay of 5.3 days, an intensive care unit stay of 1.9 days, and an average injury severity score of 9.96. Of those tested for alcohol, almost three-fourths had alcohol present. These data, along with the mechanism of injury, are pictured on page 36.

Of note, although motor vehicle-related injury was the largest category similar to the overall 2006 report, penetrating injuries were more prevalent by two and one-half.

When you plan your New Year’s Eve festivities, remember to advise your family and friends to party responsibly. Many cities offer free or inexpensive public transportation; another alternative is to identify a designated driver. After all, you do not want to be ringing in the new year with an ambulance siren.

The full NTDB Annual Report Version 6.0 is available on the ACS Web site as a PDF 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.

Dr. Fantus is Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma, Chicago, IL.

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

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For additional information, contact Olivier Petinaux, MS, tel. 866/475-4696, e-mail elearning@facs.org

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NOW AVAILABLE:

ATLS for Doctors
Student Manual, 7th edition

The ATLS® Program was developed to teach doctors one safe, reliable method for assessing and initially managing the trauma patient. The course teaches an organized approach for evaluation and management of seriously injured patients and offers a foundation of common knowledge for all members of the trauma team. The emphasis is on the critical “first hour” of care, focusing on initial assessment, lifesaving intervention, reevaluation, stabilization, and, when needed, transfer to a trauma center.

This publication, in its 7th edition, was written for use in ATLS Student Courses and is updated approximately every four years.

Price: $80 each

To obtain an ATLS for Doctors Student Course Manual, visit the American College of Surgeons online publication catalog at: https://web2.facs.org/timssnet464/acspub/frontpage.cfm?product_class=trauma
North Carolina Chapter busy with recognitions

During its 2007 annual meeting in July in Asheville, the North Carolina Chapter presented two awards to Rollin S. Burhans, MD, FACS: the Chapter’s Honored Surgeon Award and the inaugural Lowell Furman, MD, FACS, Humanitarian Award (see photo, right). Dr. Burhans has served in all the leadership positions of the North Carolina Chapter, and this year, his chapter recognized his volunteer surgical missions that have occurred in 19 countries, including China, where he provides surgical care in rural villages.

The Lowell Furman Humanitarian Award was created to honor Dr. Furman’s development and devotion to world medical missionaries, which was begun in 1978 and sends approximately 250 surgeons, internists, and family practitioners to hospitals throughout the world.

In addition, during the meeting the College recognized the North Carolina Chapter for its loyal support of the Scholarship Endowment Fund since 1969. Having contributed $25,000, the North Carolina Chapter has attained Life Membership in the Fellows Leadership Society.

Tennessee Chapter honors Kurita

In July, at its annual meeting at Paris Landing State Park, the Tennessee Chapter recognized State Sen. Rosalind Kurita for her sponsorship and support for legislation to fund the state’s 10 trauma centers. Senator Kurita, a nurse by profession, was recognized by Julie Dunn, MD, FACS, the Chapter Secretary and Chair of the Tennessee Committee on Trauma (see photo, right). During the presentation, Senator Kurita explained that the sponsored legislation, which added 2 cents to the cost of a pack of cigarettes, would assist in funding Tennessee’s six level I, one level II, and three level III trauma centers.


## Chapter meetings

For a complete listing of the ACS chapter education programs and meetings, visit the ACS Web site at [http://www.facs.org/about/chapters/index.html](http://www.facs.org/about/chapters/index.html).

(CS) following the chapter name indicates that the ACS is providing *AMA PRA Category 1 Credit™* for this activity.

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| January 17–18   | Southern California (CS) | Location: Santa Barbara Biltmore Hotel, Santa Barbara, CA  
Contact: C. James Dowden, 323/937-5514, cj dowden@pacbell.net  
ACS representative: Thomas R. Russell, MD, FACS |
| January 18–20   | Louisiana (CS)      | Location: The Ritz Carlton–New Orleans, New Orleans, LA  
Contact: Janna Pecquet, 504/733-3275, pecquet@LAACS.org |
| **February 2008**|                     |                                                                             |
| February 2      | Salt Lake City      | Location: The Hotel Monaco, Salt Lake City, UT  
Contact: Teresa Holdaway, 801/747-3500, teresa@utahmed.org |
| February 16     | Alberta             | Location: Rimrock Resort Inn, Banff, AB  
Contact: Philip Mitchell, MD, 403/264-6720, philipmitchell@mac.com |
| February 22     | North Texas (CS)    | Location: TBA, Dallas, TX  
Contact: Marcia McIntyre, 314/579-9707, Marcia@lettuceplanet.com  
ACS representative: Andrew L. Warshaw, MD, FACS |
| February 22–24   | Puerto Rico         | Location: La Concha Hotel, San Juan, PR  
Contact: Aixa Velez-Silva, 787/277-0674, genteinc@prtc.net  
ACS representative: Bruce L. Gewertz, MD, FACS |
| February 28–March 1 | South Texas (CS) | Location: Omni Houston Hotel, Houston, TX  
Contact: Janna Pecquet, 504/733-3275, janna@southtexasacs.org  
ACS representative: Thomas R. Russell, MD, FACS |
| **March 2008**   |                     |                                                                             |
| March 5–7       | Peru                | Location: Los Delfines Hotel, Lima Peru  
Contact: Eduardo Barboza, MD, FACS, 511/219-0051, edbarboza@qnet.com.pe  
ACS representative: H. Randolph Bailey, MD, FACS |
| **April 2008**   |                     |                                                                             |
| April 25–26     | Indiana (CS)        | Location: University Place Conference Center, Indianapolis, IN  
Contact: Carolyn Downing, 317/261-2060, cdowning@ismanet.org |
| April 26        | New York (CS)       | Location: Otesaga Resort, Cooperstown, NY  
Contact: Amy Clinton, 518/283-1601, NYCoFACS@yahoo.com  
ACS representative: Gerald B. Healy, MD, FACS |
Representatives from New York Chapter to serve on task force

In August, the New York State Health Department and the New York State Insurance Department announced the membership that will compose the Medical Malpractice Liability Task Force. In addition to the New York Chapter representatives, other stakeholder groups to be members of the task force include physicians, consumers, businesses, hospitals, health insurance plans, malpractice insurers, attorneys, and several members of the state legislature. According to Amy Clinton, the New York Chapter Executive Director, the task force is charged “with identifying the fundamental causes of high medical malpractice costs and proposing solutions.”

Nebraska Chapter welcomes young surgeons

On September 9, in conjunction with the University of Nebraska Medical Center and Creighton University Medical Center, the Nebraska Chapter hosted young surgeons, residents, and medical students, as well as faculty members. Called the Welcome BBQ, the event was hosted at the home of Debra Sudan, MD, FACS, President of the Nebraska Chapter. The purpose of the BBQ was to welcome the new first-year medical students and to network with the medical students who are planning residency training in Nebraska.

Florida Chapter honors Dr. Copeland

During the Clinical Congress in October in New Orleans, LA, the Florida Chapter presented Edward M. Copeland III, MD, FACS, Immediate-Past-President of the College, with a plaque to honor his service to surgeons in Florida (see photo, this page).

Chapter anniversaries

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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, or contact the Trauma Office at 312/202-5342.
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