The surgical hospitalist:

A new solution for emergency surgical care?
The surgical hospitalist: A new solution for emergency surgical care?
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Dateline: Washington
Division of Advocacy and Health Policy

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From my perspective

The fragmented and labyrinthine schematics that define our current health care system regularly frustrate surgeons’ efforts to deliver, and patients’ attempts to receive, optimal care. Consumers, surgeons, other physicians, health care professionals, policymakers, and other stakeholders all recognize the need for patients to receive care that is more coordinated than our current system allows. However, as is often the case whenever individual interest groups devise plans for change, the results are rarely satisfactory to the people who were omitted from the brainstorming process.

Effects of uncoordinated care

In its multiple reports on quality, the Institute of Medicine (IOM) has attributed variations and defects in care to a poorly organized system rife with complex and uncoordinated procedures. The IOM has asserted that these cumbersome processes lead to wasted resources, unaccountable voids in coverage, loss of information, and a failure to build on the strengths of all health care professionals.

Other studies indicate that approximately 125 million Americans have chronic illnesses, disabilities, or functional limitations that would benefit from coordination of care; they also point to a “black hole” in patient-physician and physician-physician communication. For instance, it has been documented that approximately half of patients leave an office visit not understanding what the physician said. In addition, primary care physicians claim that 25 percent of the time they do not receive specialty consult reports within four weeks of a visit.

New approaches

Because continuous, comprehensive medical services are likely to boost patient satisfaction, reduce costs, improve access, and yield better quality, most stakeholders agree that harmonized health care delivery should be encouraged. As we strive for more orchestrated patient care, solo and single-specialty practices ultimately will become increasingly rare, supplanted by multispecialty practices in which surgeons will lead teams of other highly trained health care professionals working together to promote the best interests of their patients. Good models of these types of mature health systems already exist within the Mayo Clinic, the Marshfield Clinic, and Kaiser Permanente, to name a few.

Teams formed within these mature health systems deliver care in multidisciplinary centers that bring the broad spectrum of health care professionals together to provide the best possible, most comprehensive, and most consistent care to each patient. The specialists at the centers receive integrated training and credentialing and are subject to common quality controls in order to maintain the same high standard of care throughout the facility.

Medical home concept

As I mentioned in this column in the July 2007 issue of the Bulletin (pages 4–5), the medical home concept is gaining considerable attention. Early proponents of this model include the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association. During its summer forum on care coordination in August, the American Board of Internal Medicine Foundation also considered proposals for establishing an advanced, or patient-centered, medical home.
Under this model, each patient would be expected to select a personal physician. This medical professional would have overall responsibility for a patient’s care and would lead a team of professionals charged with ensuring access to care and providing a plan for integrated treatment. The rationale behind this concept is that patients, particularly older patients with multiple chronic conditions, who will account for a large share of the caseloads in the near future, need a single point of contact to help them navigate the health care system. Although there is limited evidence on the cost-effectiveness of this model to date, there have been some indications that the medical home reduces racial and ethnic disparities in access to care and ensures that elderly patients more frequently receive the preventive care and disease management services they need to remain healthy.

To many surgeons and other specialists, the medical home plan smacks of the gatekeeper system that health maintenance organizations used in the 1980s and 1990s to limit access to certain specialty treatment options. However, if properly crafted using input from all health care professionals, the advanced medical home could offer some patients a more direct pathway from generalist services to specialty care. In essence, generalists would move from being gatekeepers to serving as gateways to more coordinated care. If I was still in practice, I would want to be a part of the system, to ensure that I was the surgeon to whom patients are referred.

Unquestionably, the medical home prototype has strengths and weaknesses. However, what makes the plan valuable at this point in the negotiation process is that it lays out a clear vision for the future of health care and brings some intriguing ideas to the table. It is time for surgeons and other specialists to do the same.

Any better ideas?

The American College of Surgeons continues to negotiate with the full spectrum of stakeholders in the expanding effort to develop a better health care system—one that accounts for the unique nature and contributions of all specialties and ensures that patients receive safe, high-quality, effective care. We also present a range of educational programs to help surgeons build the team leadership and communication skills they will need to function as integral members and leaders of integrated groups.

In order to play a more proactive role in developing a safer health care system, the College also is developing plans for an ACS Health Policy Research Institute. This “think tank” will function under the direction of a surgeon, will be headquartered in Washington, DC, and will arm us with the hard facts we need to bring to the table during our negotiations with health care policymakers and other health system stakeholders.

The reality is that groups like those representing primary care physicians are already engaging in these activities, and if we don’t step up to the plate very soon, their plans will be the only ones available for consideration. Therefore, I challenge surgeons to offer any suggestions they might have for creating a more coordinated system of care to the College’s Health Policy Steering Committee or directly to me. I know that by working together and harnessing our collective strength, we can create a blueprint that is designed to meet the needs of modern surgical patients.
On August 27, the Centers for Medicare & Medicaid Services (CMS) issued final regulations prohibiting physicians from referring Medicare patients for certain items, services, and tests provided by businesses in which they or their immediate family members have a financial interest. This regulation represents the third phase of rulemaking to implement the physician self-referral prohibition commonly referred to as the Stark Law. This third phase of rulemaking responds to public comments on the interim final rule published in March 2004, which served as the second stage of regulation development. The final rule does not establish any new exceptions to the self-referral prohibition but makes refinements that could permit or, in some cases, require restructuring of some existing arrangements. Based on public comments on the 2004 rule, this final regulation includes the following actions:

- It provides enhanced flexibility in structuring nonabusive compensation arrangements. For example, rules regarding physician recruitment and retention payments are expanded to permit recruitment of more physicians into extended areas when needed.
- It provides relief for inadvertent violations of the self-referral prohibition under certain circumstances.
- It reduces the regulatory burden for compliance with certain exceptions. For example, the phase III final rule eliminates the requirement that entities providing professional courtesy give written notice to an insurer of a reduction of any coinsurance obligation.
- It clarifies the agency’s interpretation of existing regulations.

The final rule was published in the September 5 Federal Register. For more information, visit the CMS Web site at http://www.cms.hhs.gov/PhysicianSelfReferral/.

CMS recently issued a proposal to revise the requirements that ambulatory surgical centers (ASCs) must meet in order to bill Medicare. This proposed rule would update the existing ASC conditions for coverage to reflect contemporary standards of practice in the ASC community, as well as recommendations from the U.S. Department of Health and Human Services’ Inspector General.

The procedures most commonly performed at ASCs currently include cataract removal and lens replacement, other eye procedures, and colonoscopy. However, the specific types of procedures that will be covered when performed in an ASC and the reimbursement rates that will apply have changed dramatically as a result of the final ASC rule that CMS issued July 16. That regulation provides ASC payment for additional surgical procedures and creates a more balanced relationship between reimbursement levels for services furnished in ASCs and the same services performed in either a hospital outpatient department or a physician’s office. As a result, CMS anticipates that some of the new ASC procedures currently performed in the hospital outpatient department and the physician’s office will move to the ASC setting. Also on July 16, CMS issued a proposed rule setting payment rates and adding procedures to the ASC-covered list, effective for ASC services performed on or after January 1, 2008.

The most recent proposed rule changes include the following:
(1) a quality assessment and performance improvement condition that enables ASCs to take steps to ensure quality care; (2) a new disaster preparedness plan standard; (3) requirements for radiologic services provided in an ASC to ensure they are parallel to those for laboratory services; (4) a new patients’ rights condition to address disclosure of physician financial interests in the ASC, advance directives, the grievance process, and confidentiality of clinical records; (5) expansion of the infection control requirement to the condition level; and (6) a comprehensive patient assessment requirement to ensure that accurate and thorough assessments are conducted to ensure appropriate and safe operative care.

The proposed rule is posted at http://www.cms.hhs.gov/CFCsAndCoPs/Downloads/amb surgreg.pdf.

The Congressional Budget Office (CBO) recently projected that Medicare spending will increase 16.9 percent in fiscal year (FY) 2007, which is much higher than the anticipated 6.9 percent growth in Social Security costs. One explanation for the extraordinary increase in Medicare spending is the fact that FY 2007 is the first full year in which the new prescription drug program will be in effect; accelerated enrollment in the Medicare Advantage program also is cited. Furthermore, despite reductions in Medicare physician payments scheduled to occur in the coming years, spending growth for physician services is projected to rise from 6 percent in 2008 to nearly 9 percent in 2017. To view The Budget and Economic Outlook: An Update, go to http://www.cbo.gov/ftpdocs/85xx/doc8565/08-23-Update07.pdf.

On October 3, President Bush vetoed the $35 billion, five-year expansion of the State Children’s Health Insurance Program (SCHIP). The President had said he would veto the legislation because he believed it set funding for the program too high and that offering the program to more children would lead to the “federalization” of health care. President Bush’s veto means that SCHIP, which provides health insurance to children in low-income families with working parents, will be financed by a continuing resolution that maintains funding at current levels.

Before the veto, the College sent letters relevant to the legislation, which omitted provisions pertaining to Medicare physician payment that were included in the original House bill. One letter was addressed to President Bush and urged him not to veto the SCHIP bill because of its importance in preserving access to care for low-income children. A copy of this letter is posted at http://www.facs.org/ahp/views/schip.html. In anticipation of the probability that the Medicare-related provisions would be excluded from compromise legislation, the College and a number of surgical specialty societies wrote to all members of the Senate, urging them to halt physician payment cuts scheduled for 2008 and 2009 and to establish a system of separate spending targets and conversion factors as a step toward enacting true Medicare payment reforms. The College and the surgical societies also wrote to the House Ways and Means Committee about a technical issue raised by the original SCHIP reauthorization bill. Copies of these letters are available at http://www.facs.org/ahp/views/medicare2008.html.
The surgical hospitalist: A new solution for emergency surgical care?
We introduced the University of California–San Francisco (UCSF) surgical hospitalist program in July 2005 with the primary intent of improving patient access to high-quality and timely hospital-based emergency surgical care. Since its inception, the surgical hospitalist program has sought to propose new solutions to the national challenges of inadequate surgical coverage for a growing patient population. We now describe this new innovation in access to emergency general surgery that redefines and strengthens the commitment to delivering safe and optimal patient-centered care while fulfilling the traditional academic mission to educate medical students and residents.

Emergency care system in crisis

The care of hospitalized patients has evolved rapidly over the last decade, as shifts in surgical and medical care to outpatient settings and the pressure to reduce costs have increased the disease acuity of hospitalized patients as well as the need for improved clinical efficiency and care quality. The unscheduled nature of emergency care challenges health care providers and medical centers relentlessly and underscores the need to enhance organizational methods to improve perioperative patient safety. Between 1993 and 2003, demand for emergency care increased rapidly as emergency department (ED) visits grew nationally by 26 percent. However, over the same period, the number of EDs across the nation declined by 425, and the number of hospital beds declined by 198,000. Ambulances are frequently diverted from overcrowded emergency rooms to other hospitals that may be farther away and may have inferior services. In 2003, ambulances were diverted 501,000 times, an average of once every minute. Overcrowding is another challenge, forcing hospitals to “board” patients for 48 hours or more until a hospital bed becomes available. Increasing patient volume in an era of declining...
resources has challenged the timely delivery of hospital-based ED care nationally.

**Crisis in surgical care and call coverage**

Concurrent with the challenges to the emergency care system, the availability of timely, high-quality, and cost-effective acute surgical care in the U.S. is adversely affected by a mismatch in supply and demand. The availability of key on-call specialists willing to take emergency call (especially neurosurgeons, orthopaedic surgeons, and general surgeons) is threatened by the rising costs of uncompensated care, escalating malpractice premiums, decreasing reimbursement, and lifestyle considerations. A staggering three-quarters of hospitals report difficulty finding specialists to take emergency and trauma calls.³

In July 2006, the Institute of Medicine pronounced in its report, *Hospital-Based Emergency Care: At the Breaking Point*, that, “Emergency medical care in the United States is on the verge of collapse,” citing dangerous overcrowding and an inability to treat patients in a safe, timely, and efficient manner as the main reasons for this dire outlook.⁴ Hospitals in several states across America have closed their EDs because of inadequate surgical coverage, a trend with devastating consequences for critically injured or uninsured patients. In 2006, the American College of Surgeons concluded that, “the single most important factor shaping the surgical workforce issue today is declining reimbursement.”⁵

**ACS statement on access to emergency care**

In response to these challenges, the American College of Surgeons’ Advisory Council for General Surgery issued a Statement on Emergency Surgical Care approved by the Board of Regents
the provision of high-quality care. The growing popularity of specialization has added to the problem by fragmenting the practice of general surgery. The care of emergency surgical patients is time-intensive and associated with prolonged lengths of stay, and it often requires that specialized procedures be performed in the middle of the night or on weekends. Because teaching hospitals have historically been dependent on house staff, the Accreditation Council for Graduate Medical Education (ACGME) workweek restrictions have further challenged the delivery of acute surgical consultation services. Given the critical shortage of surgeons available and willing to take call and provide emergency and trauma consultation, it is clear that new models are necessary to address growing public demand and preserve the availability of timely, high-quality, and cost-effective patient care.

Before July 2005, emergency general surgical
The mission of the UCSF Surgery Hospitalist program is to provide high-quality, timely, and efficient care to patients with emergency surgical conditions at UCSF Medical Center while also educating medical students and residents.

**Vision:**
- To promote evidence-based guidelines for the safe, timely, and comprehensive care of patients with emergency surgery diagnoses
- To provide appropriate medical student and resident teaching and supervision
- To provide the platform for surgical quality improvement research focusing on patient safety and high-quality surgical outcomes, particularly in perioperative processes of care
- To improve communication and professionalism between inpatient services in the coordination of inpatient patient care
- To propose a new solution to the crisis in access to emergency department care and alleviate the crisis of emergency department crowding, boarding, and ambulance diversion
- To enhance the utilization of emergency department, operating room, and medical center resources

Care at UCSF was provided by a diverse faculty spread across two campuses, each surgeon taking call on a 24-hour basis. This system of care was problematic for several reasons. First, daytime consultations disrupted the elective procedures and clinics of on-call surgeons. Patients in the ED or acute care ward might wait hours until the on-call surgeon was available to evaluate them. Second, the diversity of surgical conditions left many surgeons uncomfortable caring for diseases outside their areas of expertise, especially when these conditions presented emergently. Third, the 24-hour structure of the call schedule and separate campuses disrupted continuity of care, particularly for those patients who would need subsequent care but were being treated by a surgeon based at a different hospital. Fourth, surgical house staff provided the only continuity and were further constrained by the 80-hour ACGME workweek. Finally, there was little economic incentive for taking call; the only financial benefit by the surgeon or the department was revenue generated from the minority of consultations that resulted in a surgical procedure.

**The solution: Principles and aims of a surgical hospitalist program**

The medical hospitalist model, which was pioneered and instituted at UCSF in the 1990s, was introduced in response to the managed care movement and resulted in improved quality, reduced length of stay, and improved patient safety. This model has gained widespread acceptance, with nearly 20,000 hospitalists now working nationwide. By focusing on continuity and comprehensiveness of care, medical hospitalists have made substantial progress in both quality and efficiency improvement efforts for inpatients. The UCSF surgical hospitalist program was modeled after the medical hospitalist system and the following key principles: (1) dedicated availability of surgeons, (2) extended periods on service, (3) team-based practice, and (4) a platform for research and quality improvement. In 2005, we restructured the delivery of general surgery consultations at UCSF into a surgical hospitalist model with an emphasis on the continuous availability of surgical faculty to improve continuity and timeliness of hospital-based emergency surgical care, promote patient safety, and enhance education (see box, this page).

Three board-certified general surgeons staffed the service on a rotating weekly basis, dedicating 100 percent of their time to ED and inpatient consults. These surgeons had minimal elective procedures or clinics scheduled during their on-call service weeks. Surgical hospitalist attendings rounded daily, providing continuity of care and supervision of house staff. A goal of timely surgical consultation was implemented as a primary measure of performance. In addition to the direct clinical care, hospitalists also managed the majority of surgical transfer requests from referring hospitals throughout Northern California. For those patients possibly requiring
complex surgical intervention, the surgical hospitalist would consult an appropriate surgical specialist for further care after the patient had been stabilized and initially admitted. The key elements of the surgical hospitalist model are listed in Figure 1 (this page).

The program expanded in 2007 and now has seven faculty members. Since the program’s inception, we have tracked several outcomes and measures of the program’s quality of care: patient demographics and diagnoses, operative volume, time to consultation, and revenue generation. A first-year program report was published in the November Journal of the American College of Surgeons.10

Preliminary findings

**Patient and disease characteristics.** Three surgical hospitalists cared for 853 patients in the initial year, averaging 2.3 new consults per day. Patients averaged 53 years of age (range 17 to 100 years) and were racially diverse. Most presented with acute abdominal pain (63%), soft tissue infections (18%), malignancy (6%), or hernia (4%). Most consultations originated from the ED (57%), although general medicine (20%) and medical specialists (7%), including critical care physicians, accounted for significant numbers of consultations. Other surgeons were responsible for 8 percent of the total consult volume; these were generally surgical specialists such as neurosurgeons or urologists. Because our center

Figure 1

**Key elements of the surgical hospitalist model**

- On-call period lasts continuously for one week, not 24 hours, in order to improve continuity of care. During the on-call period, elective clinics or procedures, which might disrupt or conflict with acute surgical care, are minimized.
- A resident or attending should evaluate the patient within 30 minutes of consultation during business hours and within 45 minutes during off-hours.
- If the resident is unavailable, then the on-call attending will be contacted directly to see the patient independently.
- Patients requiring special expertise are initially assessed by the team and then reassigned (triaged) to a higher level of expert care as indicated.
- After the on-call period, the care of inpatients and consults are handed off to the next on-call surgeon in a group-practice model.
- Patient safety is enhanced though increased resident supervision and improved signouts.
- Revenue stems primarily from a per-diem payment from the hospital, procedural fees, and attending documentation of non-operative care.

Figure 2

**Survey of emergency department providers after six months of UCSF surgical hospitalist care**
is a level 2 trauma center, whereby most trauma cases are regionalized to San Francisco General Hospital, trauma accounted for only 3 percent of consultations. Transfers of patients from other institutions accounted for 6 percent.

**Operative volume and triage to subspecialists.** Among consults (n=359), 42 percent resulted in an operation, most commonly appendectomy (29%), incision and drainage of abscess (19%), exploratory laparotomy for intestinal resection or lysis of adhesions (19%), cholecystectomy (11%), and complex liver/spleen/pancreas procedures (7%). We involved surgeons with advanced expertise in 9 percent (37 of 853) of cases. Surgical intervention was necessary in 29 of these cases, while the remaining 92 percent of operations were performed by the surgery hospitalists alone.

**Time-to-consultation and ED provider satisfaction.** The average time-to-consult from request to bedside evaluation averaged 16 minutes, and most patients (85%) were seen within five to 10 minutes. In a confidential survey of ED providers six months after the start of the program (response rate 76%, or 13 of 17), all providers believed that the surgical hospitalist program had improved timeliness of care, supervision of house staff, patient satisfaction, and professionalism of the surgical staff, and reduced ED length of stay (Figure 2, page 13). In addition, 84 percent believed the quality of care was either the same (38%) or better (46%). We also compared the wait time for patients undergoing appendectomy in a six-month period before and after the start of our program and found that it decreased 50 percent, from 16±10 hours to 8±4 hours (P<.05).

**Revenue generation.** Financial data from the division of finance of the UCSF department of surgery demonstrated a 190 percent increase in documented consults from the ED and inpatient wards in the first year of the program. This led to a 415 percent increase in year-over-year billable consult revenue. The greatest increase was observed in the area of subsequent care and follow-up, where a 24-fold increase in revenue was achieved through improved documentation and billing. Among patients treated, 51 percent were insured under capitated care plans, 44 percent had Medicare/Medicaid, and 4 percent were uninsured. Nonprocedural inhospital care accounted for 20 percent of the total revenue for the program. With the financial support of a hospital per diem rate for ED call coverage and the increased revenue (particularly from collections for improved documentation), the program was financially self-sustaining.

**Enhanced efficiency and value of the surgical hospitalist program**

Our preliminary findings suggest that the UCSF surgical hospitalist program is a new and effective way to provide safe and high-quality care in an era of fewer house staff hours, increasing patient volume and disease complexity, and increasing fragmentation of general surgery. Although other medical centers have combined emergency surgical care with trauma care or into “acute care surgery” programs in an effort to improve quality of care and reduce costs,11-13 we believe our system of care is the first true surgical hospitalist model for general surgical care in the U.S. The primary focus of our program is on improving access and the processes of care for general surgical patients, with a lesser emphasis on trauma surgery, and without attempting to extend into the domains of neurosurgical or orthopaedic procedures. We propose this new model as an alternative to the acute care surgery programs being discussed nationally. Though the current model bears greatest relevance to academic teaching hospitals, there is the potential to use this as a foundation to improve the structure of emergency surgical care in every type of practice setting.

The hallmark is the availability and experience of dedicated on-site faculty who are continuously available for a weeklong period to enhance continuity of care, promote timely evaluation of consults, educate house staff and students, triage patients with complex surgical conditions, and implement patient safety measures. The success of the surgical hospitalist program is grounded in the following key principles:

- **Timeliness.** One of our most important findings was that the average waiting time for a patient to be seen by the surgical hospitalist service was 20 minutes. Often this would require that attending surgeons evaluate patients directly, before the house staff could see the
patients themselves. This increased timeliness of care improved relationships with other departments and the operating room, and served as the foundation of other hospital-based quality- and efficiency-improvement efforts.

- **Triage.** Some cases required specialized expertise—surgical hospitalists performed the initial stabilization and assessment, after which patient needs were matched to the appropriate expert among the remainder of the surgical faculty. The triage system provided a way for faculty to become more proficient in the care of patients with complex and challenging surgical diseases, with the assistance of senior-level experienced surgeons as necessary.

- **Documentation.** In an era of declining reimbursement, new strategies to address suboptimal reimbursement rates by maximizing nonoperative revenue are essential. Surgical hospitalists improved documentation for billing purposes, particularly of nonoperative care. Historically, surgeons have not focused on revenue generation from the delivery of care that does not result in an operation. In this study, 58 percent of consultations did not result in a procedure. One of the primary aims of the hospitalist program was to enhance collections from subsequent follow-up care, which had previously been poorly documented and billed. This eventually yielded approximately 20 percent of the overall revenue to support the service. Surgical hospitalist attendings also documented the initial consultation and daily progress notes, resulting in an overall 415 percent increase in revenue generation after the creation of the program.

- **Team-based group practice.** Surgical hospitalists freely shared the care of inpatients from one to another at the end of the on-call week. This required a willingness to share in the care of patients and to adopt a team approach to perioperative care, which represents a major departure from the general surgical tradition of a solo practitioner. Our preliminary data suggest that perhaps the greatest beneficiaries of the surgical hospitalist model were the surgeons themselves. Under the new system, most general surgeons at our center were relieved of emergency call and could therefore focus on elective patient care, research, and teaching. Likewise, the three surgical hospitalists found their one week of continuous call, free from elective clinics and procedures, preferable to the combination of a traditional 24-hour call schedule with an elective practice.

- **Resident supervision and strengthening the department of surgery’s commitment to surgical education.** An important benefit of the new program was that it increased resident supervision on the wards and in the operating room and addressed the challenges in fragmentation and continuity of resident education after the introduction of the 80-hour workweek. Our impression was that house staff valued the real-time contact with faculty surgeons and the role modeling of timely and professional care, and 42 percent of house staff cited teaching as the greatest strength of the hospitalist service.

The generalizability of our pilot study is limited by its being retrospective and descriptive, as well as by its being the experience of a single tertiary academic medical center, where trauma represents a low percentage of patients and the patient population has a relatively favorable payor mix. Our experience highlights the benefits of the regionalization of trauma care to a site of expertise such as San Francisco General Hospital. To maximize patient safety, our program always required a surgeon to be available on back-up call, and it was expanded through 2007 by adding four surgeons.

**Future directions**

*Generating institutional support for surgical hospitalists.* A key task is to convince hospital leaders to support the new surgical hospitalist model of care by demonstrating value through savings and reduced health care costs. Current research explores the effect of surgical hospitalists on length of hospital stay and sets out to determine whether morbidity and mortality are reduced. Length of stay and costs may actually be greater if increasingly complex and ill patients are referred to UCSF from the community. Of importance will be to determine whether an increased value of the quality of care that is delivered offsets the costs to sustain the program. Although our preliminary findings show that substantial resources can be generated by the hospitalist service, we need to determine the level...
of external support appropriate to sustain the surgical hospitalist program. The medical hospitalist field has been nationally supported by medical centers that have recognized the value added by

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the hospitalists and the need for institutional support to make up for shortfalls in clinical revenue generation that occur because of the time spent coordinating care, often for an unfavorable payor mix. In addition, medical centers will perhaps not realize the full benefits of surgical hospitalists until they deploy resources like weekend social workers or a dedicated emergency operating room suite.

**Improving access through collaborations between surgical and medical hospitalists.** Another key task is to develop collaborations between hospitalist programs in surgery and medicine to improve access to emergency care by maximizing hospital efficiencies and achieving hospital-based, patient safety initiatives. The track record of the UCSF medical hospitalist program provides the national visibility and foundation to develop strong and productive collaborations with an emphasis on error reduction, improved signouts, and evidence-based surgery. We intend to research ways that medical and surgical hospitalists can collaborate to alleviate ED overcrowding and boarding by accelerating the admission of ED patients, shortening ED waiting times, and facilitating inpatient discharges. We also intend to apply quality-improvement methods to reduce the morbidity and mortality of emergency surgical care delivered to high-risk patients admitted through the ED. We anticipate that greater coordination of perioperative processes of care will improve surgical outcomes and that increasing expertise in the delivery of care in an emergency setting can lead to improvements in the care of elective patients as well.

**Enhancing patient safety and quality of surgical care nationally.** Our long-term goal is to integrate existing surgical quality-improvement efforts nationally to enhance patient safety and the quality of surgical care. We view the surgical hospitalist program as a stepping-stone toward hospital-based patient-safety initiatives, such as perioperative wound infection prevention, deep venous thrombosis prophylaxis, and myocardial infarction prevention. An unanticipated benefit of our program was that the surgical hospitalists became recognized as institutional leaders in surgical quality-improvement projects, such as the Surgical Care Improvement Project. When onsite surgeons are dedicated to emergency care, they can
better understand and address problems with the institutional health care delivery system that need to be addressed through systems improvements and re-engineering. As has been observed with the medical hospitalists, perhaps today’s surgical hospitalist will become the future hospital directors, chief medical officers, and chief quality officers.

Conclusions

Consistent with the intent of the American College of Surgeons’ Statement on Emergency Surgical Care, the surgical hospitalist model seeks to advance the health of the public by addressing the crisis in access to emergency surgical care in America. The hospitalist model recognizes the evidence that on-site availability is critical to the provision of high-quality, cost-effective care, and that academic centers must provide professional, quality, and prompt care in the face of resident 80-hour workweek restrictions. Implementation of the surgical hospitalist model can improve the quality and efficiency of hospital-based surgical care and provide a foundation for surgical quality-improvement efforts to enhance the structure and processes of emergency surgical care in teaching hospitals.

References

In a noteworthy and timely Bulletin article, C. Suzanne Cutter, MD, urges us to develop a broader perspective and to build “such skills as negotiation, public speaking, coalition building, and the art of persuasion.”* At my state’s recent chapter meeting, Barrett G. Haik, MD, FACS, a Regent of the College, and J. Wayne Meredith, MD, FACS, Medical Director of the Division of Research and Optimal Care and former Chair of the Committee on Trauma, reiterated this concept: caring for our patients is only half of our duty, and the other half is to take care of our profession. Adoption of this view of the profession has never been more imperative than in the current era.

In May 2005, when I was a newly minted State Chair for the Tennessee Committee on Trauma, stakeholders across our state met in beautiful but sparsely populated Bell Buckle, TN, to discuss threats and challenges to the Tennessee trauma system. This stakeholders meeting gave sharp focus to our needs and priorities. A host of issues were debated, but what clearly rose to the top was the dire need for system funding. Over the next year, more and more patients in our state, especially those exposed to trauma, joined the ranks of the uninsured. The difficulties in maintaining top-notch trauma services were compounded by subspecialty call problems. Again, uncompensated care was the predominant driving force.

With this charge from my stakeholders, I began my informal education in the political process. The chair of my department was firmly convinced I was tilting at windmills. Many others were skeptical. I had several factors in my favor: First, both Texas and Florida had recently won this battle for system funding, so I knew it was possible to succeed. Second, our trauma hospitals were willing to mobilize their government relations departments to assist us, both at the legislative and local levels. Third, several legislators were willing champions of our cause. And, lastly, telling me something is impossible is like waving a red flag in front of a bull.

Over the next two years, the stakeholders in our state launched what we knew would be a pitched and cohesive battle. The first year, we made our presence palpable. The second year, we began with a splash, hosting trauma center tours for legislators in Knoxville and Nashville. I have always maintained that “it takes a village” to care for a trauma patient, and never is this more evident than when experiencing a trauma code. Our legislators got to witness this experience firsthand and developed a new appreciation for the tremendous cadre of personnel and resources essential to providing care to the critically injured patient.

These visits were followed by a publication by the Tennessee Trauma Alliance (www.tntrauma.org), Pending Crisis for Tennessee’s Trauma Network: A Report to the General Assembly—2007. By mid to late session, I began weekly trips to Nashville, to talk to our legislators, to give testimony in a multitude of committees, and generally to provide additional presence as a constituent rather than relying solely on the presence of our lobbyists. My ability to make meaningful contacts was made possible by our knowledgeable hospital government relations members. While busy in Nashville, trauma surgeons, program managers, and other stakeholders across the state maintained a steady stream of letter writing, visits, and educational efforts in their own regions. It had to be crystal clear that this was a statewide endeavor.

Key points were driven home to the General Assembly. First, although on many, many occasions, Tennessee holds the dubious distinction of being near the bottom in many categories—health, education, and income—in terms of trauma quality of care, we excelled. As a representative of the state on a national level, I have come to appreciate that, because of the hard work of my predecessors, trauma surgeons who helped build the current system—Tim Fabian, MD, FACS; John Morris, MD, FACS; Phil Burns, MD, FACS; Don Barker, MD, FACS; Blaine Enderson, MD, FACS; and Martin Croce, MD, FACS—Tennessee has a level of trauma care that meets or exceeds any other state in the country. Also, regardless of the day, the hour, or the need, trauma services remained at the ready to meet the needs of the injured patient. The crowning information provided to the General Assembly was in the form of a statewide map of Tennessee, used on the House floor during the final voting hours, that showed that every single county in the state of Tennessee used the services of a trauma center in the past year. Our rural legislators came to understand that it was in the best interests of their communities and hospitals to keep this vital safety net alive and viable.

Lessons learned

I learned many critical lessons over the last two years. Our sponsor, Sen. Tim Burchett (R-Knoxville), advised me to “trust my quarter-back”: I learned to test all my messages on my government relations contacts, as they far better understood the legislators’ mood of the day (and sometimes the mood of the minute). I learned that a simple message was best, and that message must be predicated on what was absolutely best for our patients and, hence, our elected officials’ constituents. I learned that working at the political level was like walking on a mossy rock—it takes only a fraction of second to lose your footing.
And, finally, I learned and was fortunate to have a legislator on our side with great political acumen and intestinal fortitude.

The process was difficult, tedious, and frustrating but sometimes fun and definitely educational. It is a process confounded by the fact that, comparing surgeons and politicians, we dance a different dance and our approaches to our daily issues are diametrically opposed: At the end of the day in the operating room, the offending organ will be in the bucket. At the end of the day at the legislature, the issue will have four addenda. At the end of the day in the trauma bay, a life will be saved...or a life will be lost. At the end of the day at the legislature, a slightly different deal will be brokered than was originally intended. Surgeons deal with one life at a time. Legislators deal with hundreds of (often competing) issues at a time. For both of us, the balance is quite delicate.

As our bill moved through committees, it was clear that almost all legislators supported the idea of a trauma fund, but few could really agree on a source of funding. Should the funding come from fees? Fines? What would their constituents say? In May, Sen. Rosalind Kurita (D-Clarksville) suggested what she called a “friendly amendment” to add a 2-cent tax on cigarettes. Frankly, I was stunned and I thought our bill would be dead. This occurred during a year of budget surpluses, and the Republicans were not keen on the cigarette tax or any raise in taxes for that matter, even if they were in support of trauma funding itself. In addition, there was no obvious connection between smoking cigarettes and being involved in trauma. And then our bill seemed to take on a life of its own.

In late May, our bill passed in the Senate, albeit narrowly. The amendment for a 2-cent tax increase on cigarettes, explicitly for the trauma fund, passed the Senate by one vote.

I made my final trip to Nashville the second week of June. I knew the time for talking was done, the time to meet with legislators passed, but I retained the outside hope that the issue would come up during the House session and my testimony might be of worth. So I went, and the day went by, and at 7:00 pm, we began to leave the capitol, downcast, only to find out the House had reconvened and were debating the cigarette tax. Two-and-a-half hours and 22 attempted amendments later, the bill passed unmolested, 59-35.

I must admit, I haven’t always enjoyed the process and I can’t say I even completely understand it. But I am deeply appreciative of the fact that we do have a process. It is by no means perfect, and by no means do we always get it right, but there is a process—and for that the citizens of this country need to be deeply grateful.

As Dr. Cutter so aptly states in her article, “It profits none of us to allow the challenges we face to become paralyzing.” Take heart, value and use the boldness that was inculcated into us during our rigorous training, even though the arena may be different, and charge ahead with the zeal we undertake daily as though a life depended on it—because, in fact, it does.

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**Dr. Dunn** is director of trauma at East Tennessee State University in Johnson City, and Chair of the Tennessee Committee on Trauma.
The State Affairs area of the College’s Division of Advocacy and Health Policy is responsible for identifying and tracking legislation at the state level. From January to August 2007, more than 150,000 bills had been introduced in state legislatures across the country. States provide a good barometer for the federal government as they are an ideal “laboratory” for implementing innovative reforms.

Because there are so many bills introduced in state legislatures, it is important to focus the College’s state affairs resources. In order to do this, the Health Policy Steering Committee has directed State Affairs to focus on the following five broad categories:

- Medical liability reform
- Provider taxes
- Scope of practice
- Trauma system funding and development
- Regulation of anesthesia in office-based surgery

However, there are issues beyond these categories that are brought to the attention of State Affairs by individual surgeons or College chapters. In those cases, staff may provide advice and resources on the best way to address the state legislation or regulation under consideration.

To date in 2007, State Affairs monitored more than 250 bills in 45 states through use of an online legislative and regulatory search service. Following is a representative sample of the types of bills that were monitored.

**Medical liability reform**

The number of bills dealing with comprehensive liability reforms in the style of the Medical Injury Compensation Reform Act, including caps on noneconomic damages, has dropped off in recent years. This outcome can be attributed to the fact that more than 30 states now have some type of cap on noneconomic damages and many others have enacted other significant reforms. In those few states left without reforms, the political climates are not favorable to this type of legislation, or constitutional barriers exist. Still, medical liability reforms made up more than one-quarter of the bills tracked by the College. At press time, there were pending medical liability reform proposals in the following states: California, Colorado, Connecticut, Illinois, Indiana, Minnesota, Michigan, Oregon, Pennsylvania, Washington, and Wisconsin. At this time, most significant liability battles are taking place in the courts.

In February, Louisiana’s Supreme Court overturned two lower court rulings that struck down the state cap on noneconomic damages. In its ruling, the Court noted that the constitutional challenges (first raised in the appeals process) should have been heard in trial court instead of in the appeals process.
This issue originally got started in late September 2006, when the Louisiana Court of Appeals struck down the state’s 20-year cap on noneconomic damages. The Appeals Court ruled that because the cap was originally enacted in 1975, and considering the devaluation of the dollar, the $500,000 cap is worth much less today than it was originally intended and no longer constituted an “adequate remedy” under Louisiana law. To read the court’s full opinion, visit http://www.la3circuit.org/opinions/2006/09/092706/04-1069opi.pdf.

Tennessee is one of the few states still campaigning for serious liability reforms. A coalition was organized by the Tennessee Medical Association and currently has more than 50 partners, including the Tennessee Chapter of the American College of Surgeons. For more information, go to Medical Liability Reform Now or Pay Later? at http://www.mlrnw.org.

In February 2007, comprehensive liability reforms were introduced in H.B. 1993/S.B. 2001. The bill originally included reforms such as a $250,000 stacked cap on noneconomic damages (maximum $500,000: $250,000 for physicians and $250,000 for facilities per incident), a sliding scale for attorneys’ fees, affidavit of merit requirements, and periodic payment for damages exceeding $75,000.

The Senate bill was amended to address only the issue of lawsuits without merit and was passed unanimously by the State Senate; the House bill, however, was ultimately amended further to weaken the Senate provisions and overturn the existing locality rule. The Tennessee Medical Association and its coalition partners, including the ACS Tennessee Chapter, ultimately opposed the amended bill, which was defeated in the House.

In Colorado, the governor signed S.B. 129, a bill that would adjust for inflation the cap on noneconomic damages on January 1, 2008. The bill also included language that this provision will be reviewed in two years.

Kentucky’s H.B. 505, which died in committee, would have created a ballot initiative to authorize the General Assembly to enact liability reforms such as pretrial screening panels, statute of limitations, collateral source reform, expert witness qualifications, certificate of merit, and confidentiality of peer review. As it is a long-term initiative, it will likely be reintroduced in 2008.

**Provider taxes**

Provider taxes were in the news quite a bit during the 2007 legislative season. With many states looking for unique ways to fund their health care reform proposals, provider and cosmetic surgery taxes were seen as an easy revenue source. Although many agree on the problem, funding the solution is not as easy.

The proposal by Gov. Arnold Schwarzenegger (R) for such taxes in California made big news, although it was never formally introduced into the legislature. However, the threat was much more real in Connecticut with the introduction of H.B. 6652, An Act Establishing the Connecticut Healthy Steps Program, which included a number of taxes on physician and surgical services. One particularly onerous tax, the health care service tax, would have assessed a 3 percent tax on revenue derived from delivering health care services in the state and applied to all providers of medical services, including physicians, hospitals, nursing homes, and other facilities.

The ACS Connecticut Chapter, the Connecticut State Medical Society, and other major physician organizations joined together to testify against this tax and other provisions of H.B. 6652. This tax, as well as a 6 percent sales tax on cosmetic surgery services and a cap that prevents physicians from charging more than 200 percent of the Medicare fee for any service, was ultimately removed.

As press time, H.B. 6652 had not passed, although the Connecticut legislature was in special session to discuss access to health care and the state’s budget.

Cosmetic surgery taxes have not fared well in state legislatures, even though they are seen as quick ways to raise some revenue. In fact, the only tax on cosmetic surgery in the country was passed in New Jersey in 2004, and though original projections had the tax bringing in $24 million in the first year, only $7.8 million was actually collected.

In March 2006, New Jersey State Assemblyman Joseph Cryan (D), the same legislator who sponsored the tax in 2004, introduced a bill to repeal the tax, calling it “an untested revenue stream that ultimately hasn’t delivered.” In December 2006, the repeal passed the Assembly 79-0-1 and the Senate 39-0. However, the bill to
repeal was vetoed in January 2007 by Gov. John D. Corzine (D).

In his veto message, Governor Corzine wrote, “The revenues generated by the cosmetic medical procedure tax, while somewhat less than the original revenue forecast in 2004, are nevertheless recurring and dependable.... In this context, I cannot support repealing this tax, midway through the fiscal year, without establishing an alternative revenue stream to support charity care.”

Scope of practice

Only approximately 13 percent of the bills tracked by State Affairs in 2007 dealt with non-physician scope of practice issues.

New York saw several significant scope battles in 2007. A coalition was formed to help defeat A.B. 7044, which would have expanded the scope of single degree oral surgeons (DDS only) to include elective cosmetic procedures. Under this proposal, dentists would have been allowed to perform cosmetic or reconstructive surgery unrelated to dental care in any health care environment, including office-based practices. Thanks to the work of the coalition (including the New York Chapter of the ACS), this bill died upon its introduction.

Another bill in New York, A.B. 3168/S.B. 1443, would have expanded the scope of podiatry to include conditions of the ankle and all soft tissue structures below the knee anatomically affecting the foot and ankle. This bill died in committee, once again thanks, in part, to the hard work of the New York Chapter.

The outcome was not as successful in Louisiana. Upon signature of the governor in June 2007, podiatry’s scope was expanded to include “...treatment of the ankle, muscles, or the tendons of the lower leg governing the functions of the foot and ankle.”

As further support for addressing scope of practice issues, the College formally joined the Steering Committee of the American Medical Association (AMA) Scope of Practice Partnership. This group is a cooperative advocacy effort between the AMA, state medical associations, and national medical specialty societies and is involved in a wide range of activities, including a combination of legislative, regulatory, and judicial advocacy, as well as programs of information, research, and education.

Trauma

Helping state committees on trauma (COT) implement grassroots advocacy activities related to trauma-focused legislation is an important part of State Affairs’ responsibilities. Approximately 23 percent of the bills tracked during 2007 were trauma-related and were focused on the following four categories:

- Injury prevention
- Trauma system funding and development
- Repeal of the Uniform Accident Sickness and Policy Provisions (UPPL)
- General trauma issues

In May 2007, Indiana’s governor signed H.B. 1237, a bill that amends the requirement for seat belt usage from occupants of the front seat to all occupants in a motor vehicle equipped with safety restraints. Maine also passed L.D. 24, which made a driver’s failure to wear a seat belt a primary offense.

Tennessee’s trauma community was successful in stopping H.B. 1283, a bill that would have repealed the helmet law for motorcyclists. The bill’s original sponsor was a family physician, Rep. Joey Hensley (R), but he withdrew his sponsorship in May; it was then taken up by Representative Todd (R), but after this change in sponsorship, the bill saw no more activity.

Tennessee also passed legislation that created the Tennessee Trauma Center Funding Law of 2007, which will be funded partially from an increase in the state cigarette tax, providing approximately $10 million annually. Julie Dunn, MD, FACS, Chair of the Tennessee COT, testified in support of the funding law and worked very hard to see this legislation pass. (See related story, page 18.)

Arkansas’ H.B. 1575 would have created a trauma fund by increasing the fine on driving under the influence by $50 and increasing fines on certain moving violations by $25, but this bill died upon adjournment.

Georgia had several funding bills introduced in 2007. However, by early April, only two bills—H.B. 77 and S.B. 125—were still alive. The combined revenue of these bills was estimated to generate less than half of the $80 to $85 million recommended by the Joint Comprehensive Trauma Services Study Committee in its final report. Ultimately, neither bill passed. However,
S.B. 60, which created the Georgia Trauma Care Network Commission and the Georgia Trauma Trust Fund, was signed by the governor in May and went into effect July 1.

One of the duties of the trauma commission will be to distribute the money from the trust fund. The distribution formula will be determined and reviewed by the commission with special emphasis on the following:

- Uncompensated physician trauma care services provided in designated trauma centers
- Uncompensated trauma care services provided by emergency medical service to patients transported to designated trauma centers
- Uncompensated trauma care services of designated trauma centers
- Trauma care readiness costs for designated or certified trauma care service providers
- Trauma care service start-up costs for providers seeking a trauma care designation or certification.

In May 2006, after Arizona’s Gov. Janet Napolitano (D) vetoed H.B. 2315, which would have raised the burden of proof from “a preponderance of evidence” to “clear and convincing evidence” in order to win a lawsuit against emergency-room personnel, she appointed a task force to consider this issue. In 2007, the task force recommended passage of S.B. 2315. However, political maneuvering caused this bill to fail passage in the House on third reading by a very slim margin.

In 2007, half a dozen states introduced legislation to repeal the UPPL—the law that allows health insurers to not be required to reimburse patients for costs incurred when an accident is a result of “the insured’s being intoxicated or under the influence of any narcotic.” Such efforts to repeal were often successful.

Illinois, Indiana, Oregon, and the District of Columbia all passed UPPL repeal in 2007, joining the following states that had already prohibited such denial of coverage: Colorado, Connecticut, Iowa, Maryland, Nebraska, North Carolina, Rhode Island, South Dakota, and Washington State. Tennessee passed a joint resolution to direct the state’s comptroller to study current drug laws, including repeal of UPPL. In Texas, however, the repeal bill (H.B. 634) was heard in committee in April but was left pending and died upon adjournment. California has passed UPPL repeal for the last several years only to have it vetoed by the governor. This year, UPPL repeal was included in A.B. 1461, a bill to create “a two-year pilot project to demonstrate the efficacy and cost-effectiveness of a specified early methamphetamine intervention model in identifying and diverting methamphetamine addicts.” The bill was moving forward at press time.

The following states have never enacted UPPL: Massachusetts, Michigan, Minnesota, New Mexico, New Hampshire, Oklahoma, Utah, Vermont, and Wisconsin (however, courts have ruled that insurance companies can use alcohol/drug exclusions in states that are silent on alcohol exclusion laws).

In September 2006, the College adopted a formal statement calling for the repeal of UPPL. The Statement on Insurance, Alcohol-Related Injuries, and Trauma Centers, a useful document for educating legislators and policymakers on repealing UPPL, can be found online at http://www.facs.org/fellows_info/statements/st-55.html.

**Regulation of office-based surgery**

A few states implemented standards for office-based surgery. New York Gov. Eliot Spitzer (D) signed legislation in July that reflects the standards for in-office procedures set forth in the ACS patient safety principles for office-based surgery. Under this new law, surgeons who perform in-office procedures using moderate sedation, deep sedation, or general anesthesia must have their offices accredited by a nationally recognized agency by July 2009, and adverse events must be reported to the New York Department of Health’s Patient Safety Center.

Meanwhile, other state medical boards have advanced patient safety for office-based surgery through the regulatory process. The South Carolina Board of Medical Examiners expanded the state’s patient safety guidelines for office-based procedures by adopting formal regulations based on the type of anesthesia used. The new requirements focus on the following issues: accreditation from one of the major accrediting organizations, certification in advanced resuscitative techniques, staffing levels and training requirements, emergency transfer agreements with local hospitals or admitting privileges by the surgeon, and various performance improvement and facility standards.

In Tennessee, the Board of Medical Examiners...
finalized similar regulations, and the Arizona Medical Board continued efforts to draft its own set of office-surgery rules.

**Miscellaneous legislation**

Of the bills that fall in the “miscellaneous” category, the majority pertained to patient safety (which includes hospital-acquired infection reporting requirements and informed consent issues). As mentioned earlier, 2007 also saw a large percentage of bills dealing with insurance coverage of both the uninsured and the underinsured.

**New state advocacy programs**

State Affairs unveiled several new resources for ACS chapters and members in 2007. An Advocacy Handbook and a resource list of more than 60 useful Web sites is now available online on the Advocacy home page on the Web portal and the College Web site.

Another resource, The Advocacy Forum, was added to the Web portal. This forum is an electronic bulletin board for members to discuss current advocacy issues and ask questions on a variety of issues. Other information, including bill tracking reports and notices of headlines in new issues of *Cross Country*—a monthly newsletter dedicated to state legislative efforts—will also be posted on the board.

**Ongoing state advocacy**

Identifying and tracking state legislation is just one component of the College’s State Affairs program. In 2007, the College continued to publish *ACS Cross Country*, and participated in several issue-based coalitions. In addition, staff worked with ACS chapters to address issues in their states and helped them use the Surgery State Legislative Action Center (SSLAC), a Web-based advocacy tool (http://www.facs.org/sslac/index.html). Co-sponsored by 12 surgical specialty societies, the SSLAC provides surgeons a quick and easy way to send prewritten letters to their state legislators or other elected officials.

The StAR (state advocacy representative) program continues to provide an opportunity for surgeons throughout the country to discuss state legislative concerns. StARs act as liaisons between the College and their state legislatures. Quarterly conference calls are held to discuss ACS state legislative activities and to provide an opportunity for StARs to share state legislative information regarding their own state with both the College and their colleagues in surrounding states. Because many legislative concepts often cross state borders, the calls can serve as an early warning system for contiguous states.

**A final reminder**

Now is the time for chapters and other groups to begin preparing for next year. State Affairs staff can assist with planning a Day at the Capitol, address advocacy planning/strategy issues (including development of a Chapter Advocacy and Health Policy Committee), and help develop testimony for presentation at state legislative committee hearings. In addition, staff is willing to participate as speakers for any chapter event or other stakeholder group.

For more information on state legislative issues or to become a StAR, contact Melinda Baker at 312/202-5363 or mbaker@facs.org.

**References**

Next month, Evidence-Based Reviews in Surgery (EBRS) will begin its seventh year of existence, three of which were under the joint auspices of the Canadian Association of General Surgeons (CAGS) and the American College of Surgeons. EBRS is now used by most of the general surgery programs in Canada, and we estimate that approximately 50 programs in the U.S. use EBRS in their general surgery curriculum as well. We have published more than 20 reviews in the Canadian Journal of Surgery and the Journal of the American College of Surgeons. In addition, we have received terrific feedback from members of both organizations with regards to the relevance of the program to their practice. Some of the comments include the following:

- EBRS is excellent. The timely choice of subjects, the informative discussions, the detailed comments that inform and stimulate further thought and searches, the expert selection of references, the availability of this excellent archived source at any time and from any place makes this a unique place to visit first and always.

- I just wanted to write and let you know how much I have appreciated the EBRS program this year. I am constantly looking for educational formats that work well with my time constraints and with my learning abilities. I love the combination of relevant articles, critical reviews, methodological reviews, and discussion. I feel like I’ve gained quite a lot from the articles themselves and the input of the other participants regarding the topics, but more importantly, I believe I am growing in my abilities to critically review other articles. So thank you, and I look forward to participating in the next series of articles.

- Be assured that the online “study group” on evidence-based surgery has been for me informative, instructional, and, at times, downright useful. Observing the discussion and from time to time throwing in my two bits has reinforced my belief that there is usually more than one way to skin the cat. But the program allows me to consider that my way, good old Sinatra, may not be most effective. Perhaps one of the most interesting features of the course has been those seeds of doubt induced and thus the need to read the data carefully and openly. The analysis can then be compared to one’s own surgical beliefs and practice. Rational choice and change may then be considered.
“Evidence-based surgery,” as you have so adequately presented, is much appreciated.

EBRS continues to expand. Beginning this fall, we will introduce a set of six packages focused on topics in colorectal surgery. These packages are available to all members of CAGS and the College and can be accessed through the College’s Web site at http://www.facs.org/education/ebrs.html. There will be a separate listserv discussion, however, so if you wish to participate in this discussion and receive Maintenance of Certification credits for completion of these packages, e-mail Marg McKenzie at mmckenzie@mtsinai.on.ca so she can add you to the list. The topics will include the following:

- Preoperative staging of rectal cancer with magnetic resonance imaging
- Need for initial surgery because of stricture disease in Crohn’s disease patients carrying the Nod2/CARD15 genotype
- Use of sacral nerve stimulation for fecal incontinence
- American Society of Clinical Oncology guidelines for colorectal cancer surveillance

Nancy Baxter, MD, FACS (University of Toronto), Carl Brown (University of British Columbia), Arden Morris, MD, FACS (University of Michigan), and Larissa Temple, MD, FACS (Memorial Sloan-Kettering) serve on the Colorectal Surgery Steering Committee.

EBRS will also continue to produce general surgery packages. Beginning in October, the following topics will be discussed during the course of the academic year:

- Factor VII as adjuvant therapy for bleeding in trauma patients
- Hernia surgery versus watchful waiting in minimally symptomatic men
- Perioperative chemotherapy versus surgery alone for resectable gastric cancer
- Fast-track colonic surgery
- Evaluation of rectal bleeding in adults
- Simple scoring system for prediction of prognosis of acute pancreatitis
- ALMANAC trial: Sentinel node biopsy versus standard axillary treatment in operable breast cancer
- Urban versus rural inpatients case mix differences

In addition, we want to remind members that our “old” packages of reviews are available in the Archives section of the EBRS Web site (http://www.facs.org/education/ebrs.html), and many surgeons have told us that they are a valuable resource. In addition, members can access the journals that EBRS subscribes to at any time for their own use.

I would like to acknowledge the members of the steering committee: Jeffrey Barkun, MD, FACS (University of McGill); Karen Brasel, MD, FACS (Medical College of Wisconsin); Suzanne Cutter, MD (ACS resident representative); Thomas Cogbill, MD, FACS (Gunderson Lutheran Medical Center); Bill Fitzgerald, MD (St. Anthony, NL); Harry Henteleff, MD, FACS (Dalhousie University); Andrew Kirkpatrick, MD, FACS (University of Calgary); Steve Latosinsky, MD (University of Manitoba); Anthony MacLean, MD, FACS (University of Calgary); Tara Mastracci, MD (McMaster University); Leigh Neumayer, MD, FACS (University of Utah); Shona Smith, MD (CAGS resident representative); Mark Taylor, MD, FACS (Lakeridge Health Corporation); and Dr. Temple (Memorial Sloan-Kettering). Thanks also go to Marg McKenzie, our administrative coordinator who keeps things going, as well as to the many clinical reviewers and listserv discussants who willingly assist us. Finally, EBRS continues to be funded by Ethicon and Ethicon Endo-Surgery Canada as well as Ethicon Inc. and Ethicon Endo-Surgery Inc. in the U.S., and we are grateful to them.

EBRS is flourishing, and we hope that you will participate. If you have any comments, e-mail us at mmckenzie@mtsinai.on.ca

Dr. McLeod is professor of surgery and health policy, management and evaluation, University of Toronto; head, division of general surgery, Mt. Sinai Hospital, Toronto, ON; and a Regent of the College.
A roadmap to safe surgical care:

A view from Pennsylvania

by John R. Clarke, MD, FACS
Safe operations and patient care should be a precondition for all clinical surgical activities. To achieve safe surgery, surgeons should take a number of steps.

**Commit to safety as a precondition**

The most important component of patient safety during surgical care is the will of the surgeon to make a commitment to safe operations and patient care. This commitment will take many forms. Most importantly, it will require surgeons to accept the responsibility of doing whatever they can to make surgery safe. Safe surgery should be a precondition for surgical care and not a goal in competition with efficiency, productivity, or profitability. The long-term effects of safe surgery should be fewer complications, less care per patient, lower costs, and less liability.

**View safety as a system responsibility**

Surgeons have been taught individual responsibility: mistakes are the result of personal cognitive or technical failures and if shame does not immunize against error, remediation is needed. Safety experts see health care as a complex system of services. Safety is a product of the way the system is organized as well as the way providers in the system behave. Individual providers must act safely, but the system must not be dependent on the safe practices of individual providers to make the entire system safe. Systems also need such properties as forcing functions, resiliency, redundancy, and standards to be safe. Although providers are not individually responsible for the inherent safety of a system, they must be jointly responsible for making a system as safe as it can be. In particular, they must not only help each other recover from errors before patient harm occurs, they must pursue improvements in the system so that ad hoc workarounds are not needed to make the system work as intended.

**Provide leadership**

Surgeons cannot make the health care delivery system safe by themselves. They can provide leadership that will help, rather than hinder, the organization’s efforts. They can show commitment, be good role models, and give direction. Many opportunities for leadership can be cited. Surgeons are particularly well-positioned to identify those options leading to safe operations.

**Practice according to an evidence-based system of medical care**

A bazaar provides a variety of ideas and opinions about what is desirable, and the craft of cooperative feeding a bazaar is a group of individualists, all trying to meet their own needs in a collective setting for increased individual efficiency. In contrast, a hospital provides the best scientifically based medical care to a variety of patients with specific problems and comorbidities. In a hospital, it is the patient, not the science, that varies. The best management for a problem varies commonly with the patient’s comorbidities but only occasionally with the technical competencies of the provider.

In general, the best clinical care is the care best supported by the scientific or clinical evidence; the number of optimal ways to manage the patient does not equal the number of provider preferences. Best practice guidelines and standards of care are available for many clinical situations, including patient safety situations. They should be followed where appropriate. Sources include the American College of Surgeons’ Evidence-Based Reviews in Surgery (EBRS), the National Guideline Clearinghouse (http://www.guideline.gov), and the report published by the Agency for Healthcare Research and Quality, Making Health Care Safer: A Critical Analysis of Patient Safety Practices (available at http://www.ahrq.gov/CLINIC/PTSAFETY/). For other common clinical situations, an institution-specific protocol can be developed by those most expert, then critiqued, defended, modified by consensus, and used as a uniform approach to the problem. When an organization has one way of doing something, variation is obvious and can be efficiently double-checked for appropriateness.

**Practice only at the highest level of intellectual and technical competency**

If you know you could do better, why not learn? If you know someone else could do a better job, how can you justify doing it yourself? Not every-
Focus on safe operations

Many patient-safety initiatives focus on medications, falls, and other aspects of care that could affect anyone receiving health care. Surgery invariably involves a specific procedure in a specific place by a specially trained team. Procedures are a major source of iatrogenic morbidity. The operating room is the focal point of surgical care. A safe operation is a logical primary objective for any surgical patient-safety initiative. It is of great interest to all concerned. Achieving safe operations will involve a finite number of providers in a limited setting. Progress is measurable, and results may be generalizable.

Encourage teamwork characterized by mutual respect

The surgeon has the responsibility to perform a safe operation, but every member of the operating team shares that responsibility. Teamwork is an essential part of modern clinical care. Good teamwork requires additional skills and training. Teamwork involves not only meeting your own responsibilities but helping the patient care team achieve the most successful outcome possible. Teamwork in the operating room involves surgeons, anesthesia personnel, and nurses. Each has expertise that should be valued for its contribution to the coordinated care of the patient. The “captain of the ship” has been replaced by a flattened hierarchy of the “first among equals.” Good teamwork is an essential asset for good patient care and safe surgery.

Be open to sharing

No one likes mistakes pointed out after the fact (although most professionals would like someone to point them out before they are acted on). On the other hand, everyone would like to learn from the mistakes of others, rather than their own. Sharing mistakes is justified both ethically and practically.

Surgeons are known for their confidence. Confidence means not only belief in yourself but trust in others. Confidentiality should not mean secrecy—it should refer to discretion and confiding in a supportive, learning environment. The National Patient Safety and Quality Improvement Act of 2005 recognized the need for confidential sharing of information for learning purposes by establishing a system for confidential reporting to patient safety organizations.

Sharing also means communicating and accepting responsibility to patients. Sharing has been shown to engender, rather than endanger, trust. Patients do not expect perfection. They expect providers to do their best, accept responsibility for and express regret about mistakes, and demonstrate responsibility for correcting these mistakes for the patient injured and for future patients. Disclosure of errors to patients facilitates objective analysis of the causes and increases the probability of effective solutions. It has also been shown to decrease malpractice claims.

Make safety a legitimate area of academic inquiry

If safety is a systems science, research is needed to solve intractable problems. Clinical complications like retained foreign bodies and wrong site surgery have not disappeared with scrutiny alone. Clinicians lack expertise in safety and safety experts lack domain knowledge. Partnerships, available in large universities, are needed to provide centers for useful and effective insights. Observational and epidemiological data are needed. Champions, mentors, salary support, project funding, reviewers, forums for presentations and publications, prizes, and other research infrastructure are needed. Reducing mortality and morbidity through new treatments has value. Reducing mortality and morbidity through reli-

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able application of the treatments we currently know to be effective should have similar value.

Collect data

Problems cannot be identified without information. Progress cannot be determined without measures of process and outcome. Factors affecting successful outcomes include patient factors such as comorbidities and provider factors such as competencies. Factors involving safe outcomes also include institutional and team factors. All need to be measured to understand the relationship between process and outcome. As with any other clinical problems, some patient safety problems will be identified by monitoring key measures. Others will require in-depth analyses. Currently, most patient safety reporting systems are not linked to broad-based outcomes databases. NSQIP is an outcomes database that could help provide information to improve patient safety.

Identify high-risk situations

Errors in the delivery of medical care may be influenced by predetermined patient factors (such as a higher risk of retained foreign bodies in obese patients), provider factors (such as hours worked), institutional factors (such as computerized provider order systems), and team factors (such as new team members). Data on the relationship between process, outcomes, and the characteristics of the patient, provider, institution, and team can reveal attributes that are associated with high- and low-risk situations. Identification of high-risk situations could trigger extra safety precautions, such as double-checking the programming of infusion pumps delivering high-alert drugs.

Identify safest practices

Errors in the delivery of medical care are also influenced by the choices and actions of providers, both individually and within a team. Some decisions, techniques, and behaviors will produce fewer errors (and better outcomes) than others. Again, data on the relationship between process, outcomes, and those plans and actions can reveal strategies that are associated with better and worse outcomes. Identification of safest practices can be evaluated for best-practice designation.

Summary

An effort to make operations safe is realistic if surgeons are committed. Such an effort involves educating surgeons about safe practices based on current knowledge of best practices, including team training and talking to patients. It involves identifying leaders and developing appropriate infrastructure for academic activities. It also involves the collection of information needed to identify safe and unsafe situations. The potential advantages of a drive for safe surgery should be fewer complications, less care per patient, lower costs, and less liability.

Dr. Clarke is professor of surgery at Drexel University in Philadelphia, PA, clinical director of the Pennsylvania Patient Safety Reporting System, and a member of the ACS Patient Safety and Quality Improvement Committee.
The Board of Governors’ Committee on Blood-Borne Infection and Environmental Risk was established in 1989, when human immunodeficiency virus (HIV) and acquired immune deficiency syndrome were a new major health concern. Since then, concern about safety in the surgical environment is appropriately increasing. As a result, multiple regulatory bodies have become increasingly involved in regulating control over spread of blood-borne pathogens and new environmental risks.

To adequately address these issues, the committee decided to separate into two subcommittees that have been active: The first one is specifically involved with blood-borne infections and the second is focused on new problems and risks in the surgical environment. The committee will continue to have a consultant panel of Donald E. Fry, MD, FACS; Edward J. Quebbeman, MD, FACS; and Leonard M. Randolph, Jr., MD, FACS.

Earlier this year, the Board of Regents approved a broader Statement on Sharps Safety; it was published in the October issue of the Bulletin (pages 34–37) and will be posted on the ACS Web site. Sharps injuries and surgical glove tears continue to expose surgeons and operating room (OR) personnel to the risk of HIV, hepatitis B and C viruses, and bacterial infection from patients. Patients’ blood makes contact with the skin or mucous membranes of OR personnel in as many as 50 percent of operations.

To further assess these risks, our committee has developed a survey for ACS Fellows to assess their risk of blood-borne infections and their use of recommended preventive measures, such as double-gloving and use of blunt needles to close the fascia. The questionnaire also addresses a fellow’s ability to respond to toxic and nuclear hazards at a local or a national disaster site. A summary of this survey was presented at the annual Board of Governors meeting in October at the Clinical Congress in New Orleans, LA.
Members of the Governors’ Committee on Blood-Borne Infection and Environmental Risk

Vijay K. Maker, MD, FACS, Chair;  
Chair, Subcommittee on Blood-Borne Pathogens  
Michael A. West, MD, FACS, Vice-Chair;  
Chair, Subcommittee on Environmental Risks  
Maria Allo, MD, FACS  
Marianne E. Cinat, MD, FACS  
Abilio Armando Coello, MD, FACS  
John Fildes, MD, FACS  
Henri R. Ford, MD, FACS  
Donald E. Fry, MD, FACS  
John C. Hendricks, MD, FACS  
Burton L. Herz, MD, FACS  
Jan K. Horn, MD, FACS  
M. Margaret Knudson, MD, FACS  
Lawrence Lottenberg, MD, FACS  
Stephen P. Moenning, MD, FACS  
Arthur L. Ney, MD, FACS  
Edward J. Quebbeman, MD, FACS  
Leonard M. Randolph, Jr., MD, FACS  
Andrew W. Saxe, MD, FACS  
Francis J. Scarpa, MD, FACS  
Glenn D. Warden, MD, FACS  
Stephen Michael Warren, MD  
Michael J. Zinner, MD, FACS

The committee has also submitted proposals for two symposia at the 2008 annual Clinical Congress that will incorporate findings from the questionnaire. The first proposed symposium, Accepting the Evidence: Enhancing Sharps Safety in the OR, will reinforce the ACS Statement on Sharps Safety and will present all the available evidence. The issues of products that may enhance protection from sharps injuries but are clumsy, difficult to handle, and at times traumatic to the patient will also be discussed. The role of ACS Fellows to objectively evaluate the evidence and set an example for residents, other medical personnel, and patients will be reinforced.

The second proposed symposium will be co-moderated with the Committee on Trauma. This symposium will address issues of radioactive/toxic hazards in the OR environment and the surgeon’s role. In an era of increasing terrorism, radioactive/toxic material, mass exposures, and nuclear terrorism are very real possibilities. This session will focus on the unique aspects of patient triage, faculty preparedness, containment techniques, and decontamination. OR preparedness for patients with toxic or radioactive exposures with injury and workforce preparation drills will be considered. Moral and ethical issues facing an ACS Fellow in this contaminated setting will be discussed.

All surgeons are encouraged to share their thoughts by contacting me or their local Governors who serve on the committee.

Dr. Maker is program director in surgery, University of Illinois, Metropolitan Group Hospitals Residency in General Surgery; chairman, department of surgery at Advocate Illinois Masonic Medical Center, Chicago, and Chair of the Governors’ Committee on Blood-Borne Pathogens and Environmental Risk.
Governors’ Committee on Physician Competency and Health: An update

by Gerald J. Bechamps, MD, FACS

The Board of Governors’ Committee on Physician Competency and Health is a consolidation of two older committees. The new committee has recently adopted a revised mission statement that reads as follows:

To examine issues related to surgical competency, emphasizing credentialing and practice within expected community standards, and to promote maintenance of physical and mental wellness in the Fellows.

To these ends, the committee distributed a draft survey to the Governors attending the 2006 Clinical Congress on issues of professional satisfaction, work hours, work-related stress, sleep deprivation, and safety concerns. A compilation of these data will be reported to the Executive Committee of the Board of Governors and ultimately to the Fellows. In addition, the committee will consider expanding the survey to all Fellows utilizing the College’s Web site. The committee will then develop educational sessions for future Clinical Congresses addressing issues brought out by the survey.

Committee issues
For the impaired physician—whether the issue is mental, physical, or substance abuse—the state medical/licensing boards have the legal authority (through issuance and maintenance of licensure) to initiate behavioral changes and restricted practices. However, as advocates for our colleagues, listing programs for measuring disability and rehabilitating impaired physicians may be posted on the Web site.

Health issues ultimately affect competence, particularly surgical disciplines that demand mental and physical skills to be paramount. In the 21st century, competency has become a buzzword for health care performance. The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) have stressed the six core competencies. The public, legislators, payors, hospital adminis-
Dr. Bechamps has been president of the Federation of State Medical Boards and currently serves on the Composite Committee of the U.S. Medical Licensing Examination. He is in private practice in Winchester, VA, and is Chair of the Governors’ Committee on Competency and Health.

The ACS, through this committee, will be engaged in this process by continuing to provide educational sessions, informing its members of current trends and developments on competency issues, and providing resources on these issues through the ACS Web site.

Any Fellows interested in contributing to this subject matter should contact the chair or any of the committee members so that we may develop this further for the benefit of our members.
Gerald B. Healy, MD, FACS, an otolaryngologist from Boston, MA, was installed as the 88th President of the American College of Surgeons during Convocation ceremonies that preceded the official opening of the College’s 93rd annual Clinical Congress in New Orleans, LA, in October. Dr. Healy is the Healy Chair in Pediatric Otolaryngology and professor of otology and laryngology at Harvard Medical School, Boston, and otolaryngologist-in-chief at Children’s Hospital, Boston, MA.

A native of Boston, Dr. Healy received a bachelor of arts degree from Boston College in Chestnut Hill, MA, in 1963 and earned a medical degree from Boston University School of Medicine in 1967. He completed a surgical internship (1967–1968), surgical residency (1968–1969), and residency in otolaryngology (1969–1972) at Boston University Medical Center. Dr. Healy became a diplomate of the American Board of Otolaryngology in 1972.

A Fellow of the American College of Surgeons since 1977, Dr. Healy has been actively involved in the governance of the College, including serving as a member of the College’s Board of Regents since 1997 and as Chair from 2005 to 2006—the first otolaryngologist to serve in that capacity. Dr. Healy has also served as a member (1999 to present) and Chair (2000–2004) of the Regents’ Central Judiciary Committee, a member of the Honors Committee (1999 to present), and Chair of the ACS Advisory Council for Otorhinolaryngology (1995–1998). In addition, Dr. Healy served as President of the Massachusetts Chapter of the American College of Surgeons from 1997 to 1998.


Beyond his service to surgical societies, Dr. Healy has also devoted his professional life to several significant clinical and research endeavors in children. As an internationally recognized clinician, he pioneered the use of laser surgery in the pediatric airway. His research interests have included diseases of the pediatric airway and ear, for which he has received support from the National Institutes of Health.

Dr. Healy’s contributions to the surgical profession also include his work as a member of the following editorial boards: International Journal of Pediatric Otolaryngology; The Laryngoscope; Annals of Otolaryngology, Rhinology and Laryngology;and Diagnostic and Therapeutic Endoscopy. He is also a reviewer for the Journal of Pediatrics, Pediatrics, and New England Journal of Medicine.

Dr. Healy currently resides in Wellesley and Centerville, MA, with his wife, Anne. They have two daughters: Lisa Healy Lacey, a professor at Suffolk Law School in Boston, and Laurie Healy Ewald of Newton, MA.
David B. Hoyt is recipient of 2007 Distinguished Service Award

The Board of Regents presented David B. Hoyt, MD, FACS, of Orange, CA, with the College’s highest honor—the 2007 Distinguished Service Award—on October 11 during its 93rd annual Clinical Congress in New Orleans, LA. The award was presented at the College’s Annual Business Meeting of Members.

The Board honored Dr. Hoyt for his devoted service as Chair of the College’s trauma registry, National Trauma Data Bank (NTDB), and Committee on Trauma (COT), and as Medical Director of the American College of Surgeons Trauma Programs. The award also recognizes Dr. Hoyt’s distinctive scientific contributions in shock physiology, trauma resuscitation, immunomodulation, and trauma systems; his leadership as president of the American Association for the Surgery of Trauma (AAST), president of the Shock Society, and as an architect and sustaining force of the San Diego Trauma System; and his natural leadership, integrity, vision, and service as a role model to surgeons everywhere.

Dr. Hoyt is chairman of the department of surgery at the University of California–Irvine (UCI) Medical Center. At UCI, Dr. Hoyt oversees all surgical services and training provided through the department of surgery, which encompasses 10 surgical divisions and the highly acclaimed UCI Regional Burn Center and Beckman Laser Institute. He also serves as the John E. Connolly Professor of Surgery at the UCI School of Medicine.

Dr. Hoyt received his medical degree from Case Western Reserve University in Cleveland, OH, in 1976. He studied as a surgical intern (1976–1977) and completed his residency in general surgery (1977–1984) at the University of California San Diego (UCSD) School of Medicine, where he served as senior and chief resident from 1982 to 1984. From 1979 to 1982, Dr. Hoyt served as a research fellow in the department of surgery and the department of immunopathology at UCSD School of Medicine and Scripps Clinic and Research Foundation, respectively.

After completing postgraduate training, Dr. Hoyt began his tenure at UCSD School of Medicine and UCSD Medical Center, where he served in several surgical and teaching capacities. He was director of the general surgical intensive care unit (ICU) (1984–1988); associate director, regional trauma center (1984–1989); director, ICU critical care team (1985–present); director, intermediate care unit (1985–2006); director, surgical ICU (1988–2006); chief, division of trauma, burns, surgical critical care (1989–2006); director, acute surgical service, White General Surgery Service (1989–2006); and medical director, life-sharing tissue services (2001–2006).

At UCSD School of Medicine, Dr. Hoyt served as assistant professor of surgery (1984–1989); associate professor of surgery (1989–1995); professor of surgery (1995–2006); clinical professor of pediatrics (1996–2002); the Monroe E. Trout Professor of Surgery (1996–2006); vice-chairman, department of surgery (1997–2006); and interim chairman, department of surgery (2003–2006). In 2006, he was appointed to his current position as chair of the department of surgery at UCI.

Since Dr. Hoyt became a Fellow of the College in 1987, he has made outstanding contri-
butions to and on behalf of the College. From 2002 to 2006, he was Medical Director of Trauma Programs in the Division of Research and Optimal Patient Care.

Furthermore, Dr. Hoyt has distinguished himself as an advocate for the care of the injured patient through his work on the COT, having served as Chair from 1998 to 2002 and as a member of the Executive Committee from 1994 to present; Chair, Trauma Registry Subcommittee, National TRACS®, and NTDB from 1994 to 1997; Chair (1989–1992) and member (1985 to present) of the COT, San Diego/Imperial County; member of the Program Committee of the ACS Western States COT (1994 to present); member of the ACS COT and AAST Health and Finance Committee (1993–1997); National Quality Improvement Subcommittee (1990–1995); Verification Program-Senior Reviewers (1993 to present); Advanced Trauma Life Support® (ATLS®) National Faculty (1992 to present); Region Chief, COT Region IX (1992–1998); Judge, ACS COT Resident Paper Competition (1992 and 1994); and Coordinator, Instructor, and Director of Training, ATLS Course (1980 to present).

In addition to Dr. Hoyt’s involvement with the College, he has also been a leader of numerous organizations within the surgical community, including serving as president (2002–2003) and president-elect (2000–2002) of the AAST, president (2003–2004) and president-elect (2002) of the Shock Society, and associate examiner of the American Board of Surgery. He is also a member of numerous surgical organizations, including the American Surgical Association, Western Surgical Association, Southwestern Surgical Congress, Society of University Surgeons, International Society of Surgery, the AAST, Society for Surgery of the Alimentary Tract, Association for Academic Surgery, Surgical Infection Society, and Association for Surgical Education.

Dr. Hoyt has been active in the dissemination of surgical knowledge through his work as an advisor to graduate students, undertaking numerous visiting professorships, giving guest lectures, and making scientific presentations.

In recognition of Dr. Hoyt’s continued and dedicated service to and on behalf of the College and the surgical community, the Board of Regents is pleased to present him with the College’s highest honor, the 2007 Distinguished Service Award.

Five international surgeons awarded Honorary Fellowships

Honorary Fellowship in the American College of Surgeons were awarded to the following five prominent surgeons from Argentina, Germany, Poland, Italy, and Austria during Convocation ceremonies at this year’s Clinical Congress:

• **Juan M. Acosta, MD, PhD, FACS.** Professor Acosta is a former professor and chairman in the department of surgery, School of Medical Sciences, at Rosario National University, Rosario, Argentina, and a former professor of clinical surgery in the department of surgery at Keck School of Medicine, University of Southern California, Los Angeles.

• **Hans G. Beger, MD, FACS.** Dr. Beger is a professor of surgery in the department of general surgery at University of Ulm, Ulm, Germany.

• **Adam Dziki, MD, PhD.** Dr. Dziki is professor and chairman of the department of general and colorectal surgery at Medical University of Lodz in Lodz, Poland.

• **Nicola Scopinaro, MD.** Dr. Scopinaro is the head of the surgical unit at San Martino University Hospital and director of residency in the school of general surgery, University of Genoa Medical School, in Genoa, Italy.

• **Heinz R. Stammerberger, MD, FRCSEd(Hon).**
Dr. Stammberger is professor and head, department of general ENT, head and neck surgery, at University Ear, Nose and Throat Hospital, in Graz, Austria.

Presenting the Honorary Fellowships on behalf of the College were the following: Carlos A. Pellegrini, MD, FACS, Seattle, WA; Andrew L. Warshaw, MD, FACS, Boston, MA; John W. Harmon, MD, FACS, Baltimore, MD; J. Patrick O’Leary, MD, FACS, Miami, FL; and David W. Kennedy, MD, FACS, Philadelphia, PA.

This year, 1,290 surgeons from around the world were admitted into Fellowship during the College’s Convocation ceremonies.

Sir Rickman Godlee, President of the Royal College of Surgeons (England), was awarded the first Honorary Fellowship in the College during the College’s first Convocation in 1913. Since then, 407 internationally prominent surgeons, including the five chosen this year, have been named Honorary Fellows of the American College of Surgeons.

Citation for Prof. Juan Miguel Acosta

by Carlos A. Pellegrini, MD, FACS

Mr. President, ladies, and gentlemen, it is with great pleasure that I introduce Dr. Juan Miguel Acosta, professor of surgery and immediate past-chair of the department of surgery at the National University of Rosario, Argentina.

Professor Acosta received his undergraduate degree from the Colegio Nacional Simón de Iriondo in Santa Fé, Argentina, and a medical degree (MD) from the then National University of Litoral (now Universidad Nacional de Rosario) School of Medicine in Argentina. He was appointed to the faculty of this school in 1956 and embarked on a career in research on pancreatic physiology and pathology. In the early 1960s, his research interests brought him to the Massachusetts General Hospital where, under the tutelage of George Nardi, MD, FACS, and Benjamin Castleman, MD, he studied the role of ampullary occlusion in the etiology of acute pancreatitis.

This unique experience had a profound impact on his personal and professional life and established ties with this country that would grow stronger over the years.

Indeed, exposure to the surgical education system in this country led Professor Acosta to create a residency in surgery at the University of Rosario modeled after the U.S. system. Under his leadership, that program became one of the most sought after by graduates from Argentinian medical schools. As one of the few who were chosen to train there, I witnessed firsthand his devotion to the pursuit of excellence.

Professor Acosta also continued to pursue his research vigorously, this time focusing on the etiology and pathogenesis of acute pancreatitis. Most importantly, he integrated his residents into his research and encouraged many of them to enter academic careers. His work culminated with the discovery that acute biliary pancreatitis is caused by the temporary obstruction of the Ampulla of Vater by a stone, as the stone migrated through it into the duodenum. The publication of this landmark research in the New England Journal of Medicine in 1974 laid the foundation for the modern treatment...


of acute biliary pancreatitis. Namely, it explained the reason why early cholecystectomy prevented recurrent attacks, and it proposed early sphincterotomy to alleviate the ill effects of prolonged ampullary obstruction. This work stands as testimony that lack of resources can be overcome with intelligence, wit, and dedication. Indeed, this entire study, which proved that the offending stone could be found in the feces of patients who had suffered an attack of pancreatitis, was performed with a simple strainer, a glass rod, and the sweat of a few residents!

In appreciation of Professor Acosta’s many contributions to surgical education and to the discovery of new knowledge, he was awarded honorary membership by the Society for Surgery of the Alimentary Tract and by the American Surgical Association.

Mr. President, it is with great pleasure that I present to you Prof. Juan Miguel Acosta from Rosario, Argentina, a superb hepatobiliary and pancreatic surgeon, a mentor of many, a brilliant clinician-scientist, and a fantastic teacher, to receive Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Hans Günther Beger

by Andrew L. Warshaw, MD, FACS

Mr. President, it is my honor to present Prof. Hans Günther Beger of Ulm, Germany, for Honorary Fellowship in the American College of Surgeons. Professor Beger, one of the world’s preeminent pancreatic surgeons, has contributed as much to this field as any other surgeon in the last 50 years.

Born in Dresden, East Germany, he was forced by political circumstances to move to the West to obtain his medical education at the University of Bonn in 1956. Professor Beger completed his surgical training in Berlin and began his academic career there. His early investigations on gastric physiology ultimately led to development of the “Ulm pouch” after total gastrectomy, an example of his continuing focus on preservation of normal function after surgical resections. While in Berlin, he also began his seminal work on duodenum-preserving resection of the pancreatic head for the complications of chronic pancreatitis and on necrosectomy with lesser-sac lavage for acute necrotizing pancreatitis. Both of these operations, which are associated with his name, are now used worldwide.

In 1982, Hans moved to the university in Ulm as chair of the surgical department. Under his leadership, that department grew to more than 100 doctoral students engaged in more than 100 clinical and experimental research projects with collaborators at dozens of institutions. The “Ulm School of Surgeons” annually produced 80 to 100 publications and made 190 to 200 presentations at national and international congresses. Prominent among these contributions were major observations on the pathophysiology and hemodynamics of acute pancreatitis, the role of bacterial infection and the importance of multiple organ failure in determining surgical treatment of necrotizing pancreatitis, the recognition of the immune system in the inflammation of nerves that cause pain in chronic pancreatitis, and ongoing investigations of the molecular biology of pancreatic inflammation and neoplasms.

An active surgeon who has performed thousands of pan-
creative operations, he is known for clear, evidence-based principles aimed at the optimal care of patients. Among Dr. Beger’s trainees and disciples, 27 have themselves gone on to become university chairs and chairs of surgical departments, in Germany, Turkey, Mexico, Japan, Uruguay, and China.

Hans Günther Beger, who was founder and chairman of the German Pancreatic Cancer Foundation, secretary-general of the German Society of Visceral Surgery, and president of the German Society of Gastroenterology, has also had an international impact as president of both the European Pancreatic Club and the International Association of Pancreatology. He is the only non-American to have been elected an officer of the Society for Surgery of the Alimentary Tract. He is an honorary member of seven national societies, including the American Surgical Association, and has received major awards from France, Thailand, Spain, the U.S., and, of course, Germany.

In retirement from his chair at the University of Ulm, he remains an active surgeon, leading a group of clinicians and investigators in the city hospital of Neu-Ulm, and continues as the editor-in-chief of *Langenbecks Archives of Surgery*, a venerable journal that he converted to an English-language publication and guided to a significant increase in impact factor. His worldwide travel schedule as a visiting professor continues at a breathtaking pace, including an active clinical appointment as professor of surgery at the Medical University of Beijing, China.

Hans and his wife Irmela, a physician of occupational medicine, have three children—Carmela, Mira, and Frank-Michael. He and his two daughters, both physicians, also formed a family chamber music group with Hans Günther as the pianist, Carmela as the flutist, and Mira as the cellist. In his other free time, he enjoys golf and filling his house with his own paintings. True to his fascination with molecular biology, his current theme is “dancing genes.”

Mr. President, it is my great pleasure to present my colleague and friend, Hans Günther Beger of Ulm, Germany, for Honorary Fellowship in the American College of Surgeons.

**Citation for Prof. Adam Dziki**

*by John W. Harmon, MD, FACS*

Mr. President, it is my honor to introduce Prof. Adam Dziki for Honorary Fellowship in the American College of Surgeons. Dr. Dziki is professor and chairman of the department of general and colorectal surgery at the Medical University of Lodz, Poland, and vice-rector of the Medical University of Lodz, as well as consultant surgeon for the Lodz District in Poland.

Professor Dziki has a special interest in colorectal surgery and has developed a program that is ranked as the number-one colorectal program by the Polish equivalent of *U.S. News & World Report*. In addition to his busy clinical practice, he is editor of *Proktologia*, the Polish counterpart to the *Journal of Colorectal Surgery*. He is also the organizer of the Polish Biennial Colorectal Symposium, which draws faculty from the most distinguished centers of colorectal surgery in the world, including the Cleveland Clinic in the U.S. and St. Mark’s Hospital in London, among others.

Adam’s talent came to my attention when we met and jointly applied for a Fulbright fellowship, which he was awarded.
and he spent time with me in Washington, DC.

When one meets Adam, it is immediately apparent that he is a man of rare energy, intelligence, and good humor, who has a charming wife and two exceptional children. It is not surprising to me that since the collapse of communism in Poland, his career has risen like a rocket ship: Adam’s career was being crushed because he did not accept communistic politics, but when the regime collapsed, his career took off.

In the post-communist era, he has become surgeon-in-chief and department chair in Lodz, chief surgeon of his geographic district, president of the Polish Colorectal Club, and now, most remarkably, president of the European Society of Colo-

Citation for Prof. Nicola Scopinaro

by J. Patrick O’Leary, MD, FACS

Mr. President, it is my pleasure to present to this convocation Prof. Nicola Scopinaro, a distinguished gastrointestinal surgeon from Genoa, Italy, for Honorary Fellowship in the American College of Surgeons. Dr. Scopinaro stands before you tonight a broken man, but more about that to come later. Professor Scopinaro’s entire career has been centered in his lovely hometown nestled in the upper northwest coast of Italy, a town until now perhaps best known as the birthplace of Christopher Columbus.

Nicola was born in the region of Castagneto Carducci. However, all of his schooling from elementary school to graduation from the Universidad de Genoa College of Medicine and its surgical residency program occurred in this remarkable city that is perched on the bluffs overlooking the Mediterranean. His postgraduate education included studies in angiology, then in vascular surgery, and finally in general surgery. Upon receiving his certificate, he joined the faculty of his home institution and rose through the academic ranks, ultimately being appointed full professor in the department of surgery in August 1992. Today Dr. Scopinaro serves as head of surgery and program director for surgical education at San Martino Hospital, the major teaching facility in the area.

Although there have been a few notable distractions during his career, Professor Scopinaro has primarily focused his work on the various aspects of surgical intervention for morbid obesity. Early in his career, he became disenchanted with the surgical approach to the disease and developed a new operation based on his investigative work in the laboratory. Rarely do you meet a surgeon who has a procedure named after him. Nicola developed the biliopancreatic diversion, now known as the Scopinaro procedure. He first performed this operation in a human in May 1976, and the weight loss produced was substantial. Since that time, Dr. Scopinaro has been, without question, the strongest propo-

Citation for Prof. Nicola Scopinaro

by J. Patrick O’Leary, MD, FACS

Mr. President, it is my pleasure to present to this convocation Prof. Nicola Scopinaro, a distinguished gastrointestinal surgeon from Genoa, Italy, for Honorary Fellowship in the American College of Surgeons. Dr. Scopinaro stands before you tonight a broken man, but more about that to come later. Professor Scopinaro’s entire career has been centered in his lovely hometown nestled in the upper northwest coast of Italy, a town until now perhaps best known as the birthplace of Christopher Columbus.

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follow-up for many of his patients has exceeded 30 years.

Professor Scopinaro is also a leader in organizations promoting a better understanding of obesity. He has served as chairman or president of various organizations in this arena, including the chairmanship of the First International Symposium on Obesity Surgery. He also organized the First International Symposium on Laparoscopic Obesity Surgery and was elected the first president of the International Federation for Surgery of Obesity when it was created in 1995. When he left office, Dr. Scopinaro was elected honorary president of the federation and continues to serve on its executive board. He was president of the Fifth Congress in Genoa and has been elected chair of the European chapter.

Professor Scopinaro has been elected as the first honorary member of the American Society for Bariatric Surgery and the Greek, German, South African, Italian, and Brazil Societies of Obesity Surgery. Dr. Scopinaro is founding co-editor of *Obesity Surgery* and has 464 publications, 38 book chapters, and 277 invited lectures to his credit.

But now back to the broken man. Dr. Scopinaro has had a propensity for high-risk activities. One of his accomplishments was serving as a competitive member of the Italian National Senior Parachute Team. Not too many years ago, Nicola chose to jump out of a perfectly good airplane during practice for international competition and noted, with some degree of concern, that his parachute fouled upon deployment. Rushing toward the earth at speed greater than 100 mph, Nicola understood that if he attempted to deploy his back-up parachute, it too would foul in the cords of his primary chute. His only chance was to wait until just before impact and then to pull the ripcord for the secondary parachute—a situation that points out the extreme discipline inherent in Dr. Scopinaro. At impact, Dr. Scopinaro broke almost every major bone in his body. He was nursed back to health by many physicians in his community, but most notably by Dr. Enzo Ginnatta. He stands today before us, a broken man who has mended well.

Dr. Copeland, I present to you Dr. Nicola Scopinaro for Honorary Fellowship in the American College of Surgeons.

**Citation for Prof. Heinz Stammberger**

*by David W. Kennedy, MD, FACS, FRCSI*

Mr. President, it is a great pleasure to present Prof. Heinz Stammberger, renowned throughout the world for his teaching within the field of endoscopic sinus surgery, to this esteemed body for Honorary Fellowship in the American College of Surgeons. Actually, I suspect that Professor Stammberger requires little introduction either to this body, or to almost any commercial airline in the world, because of his longstanding commitment to international teaching in the field of sinus disease and minimally invasive surgery.

I first had the opportunity to meet Professor Stammberger nearly a quarter of century ago in Dubrovnik, Yugoslavia, before the concepts of endoscopic sinus surgery were known to the world. It is in this field that he is now internationally recognized as an innovator and incredibly dedicated and committed teacher.

Professor Stammberger is professor and past-chair of the department of otolaryngology in Graz, Austria. I suspect that he is second only to Governor Schwarzenegger in being recognized internationally as the...
Heinz Stammberger is a major innovator within the field of minimally invasive techniques for surgery on the sinuses and the skull base. He is past-president of the European Rhinologic Society, the International Society of Infection and Allergy of the Nose, and the Austrian Society of Otolaryngology. He is an honorary fellow of several societies and colleges throughout Europe, including the Royal Colleges of Surgeons of Edinburgh and London. He has been honored with the Gunnar Holmgren Prize of the Swedish Society of Otolaryngology and has been a recipient of the Independence Medal from the State of Jordan.

Mr. President, it gives me great pleasure to present Prof. Heinz Stammberger, innovator and teacher, for Honorary Fellowship in the American College of Surgeons.

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So, You Want to Be a Surgeon...

Medical student guide to residency training

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 proven 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.
Following are frequently asked questions received by the Surgeons Diversified Investment Fund (SDIF).

**What is SDIF?**

SDIF is a no-load, actively managed, open-end, diversified asset allocation mutual fund modeled after the American College of Surgeons’ endowment.

**Why did the College start SDIF?**

In 1999, the College altered the manner in which it managed its endowment. The College hired the country’s premier institutional investment consultant, Cambridge Associates, and began the process of adhering to a disciplined program of asset allocation, diversification, and rebalancing. In response to a membership survey, and at the urging of the leadership, the College determined that a similar investment concept should be made available to the membership. The College spent two years developing and refining the delivery of an investment concept for its members and their organizations; hence, SDIF was formed.

**How is SDIF allocated among asset classes?**

SDIF’s current target allocation is as follows:

<table>
<thead>
<tr>
<th>Asset class</th>
<th>Allocation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Equity</td>
<td></td>
</tr>
<tr>
<td>Large cap value stocks</td>
<td>8</td>
</tr>
<tr>
<td>Large cap growth stocks</td>
<td>8</td>
</tr>
<tr>
<td>Large cap index stocks</td>
<td>8</td>
</tr>
<tr>
<td>Small cap value stocks</td>
<td>3.5</td>
</tr>
<tr>
<td>Small cap growth stocks</td>
<td>3.5</td>
</tr>
<tr>
<td>Real estate investment trust stocks</td>
<td>6</td>
</tr>
<tr>
<td>Energy stocks</td>
<td>6</td>
</tr>
<tr>
<td>International equity</td>
<td>23</td>
</tr>
<tr>
<td>Emerging market</td>
<td>4</td>
</tr>
<tr>
<td>U.S. fixed income</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**How has SDIF performed?**

Performance as of June 30, 2007, is reported in the table on this page.


**What types of investments are currently in SDIF?**

Currently, exchange traded funds (ETFs) are the type of investment in SDIF. ETFs are exchange traded investment companies that are registered under the Investment Company Act of 1940 and hold a portfolio of common stocks or other securities designed to track the performance of a particular index. ETFs differ from traditional index funds in that their shares are listed on a securities exchange and can be traded throughout the day.

When SDIF has accumulated at least $100 million in net assets, SDIF may hire additional sub-advisors to manage each of the asset allocation categories in which SDIF invests, in which case the sub-advisors would be responsible for making investment decisions and placing orders to purchase and sell securities other than ETFs for SDIF. Subject to the oversight of the Surgeons Asset Management, LLC (SAM), Board of Directors and the SDIF Board of Trustees, the sub-advisors would have complete discretion as to the purchase and sale of investments for SDIF, consistent with

### Table: SDIF performance

<table>
<thead>
<tr>
<th></th>
<th>Quarter</th>
<th>Year to date (June 30)</th>
<th>Since inception*</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDIF</td>
<td>3.05%</td>
<td>4.89%</td>
<td>12.63%</td>
</tr>
<tr>
<td>S&amp;P 500 Index/Lehman Brothers</td>
<td>4.23%</td>
<td>5.18%</td>
<td>11.73%</td>
</tr>
<tr>
<td>U.S. Aggregate Index</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* SDIF commenced operation on September 22, 2006. Current performance may be lower or higher than the quoted past performance, which cannot guarantee future results. Share price, principal value, and return will vary, and you may have a gain or loss when you sell your shares. For performance information current through the most recent month’s end, call 800/208-60670.
SAM Board of Directors

Dr. Cameron (Chair)  Dr. Bailey  Dr. Finley

Dr. Fischer  Dr. Mabry  Dr. Richardson  Dr. Russell

SAM staff

Left to right: Kelly M. Mason, Business Development Coordinator; Gay L. Vincent, CPA, MBA, Chief Financial Officer; Thomas P. Kiley, Business Development Manager; Savitri P. Pai, Esq., Chief Operating Officer; and Deborah A. Bakazan, Chief Compliance Officer.
SDIF’s investment objective, policies, and restrictions.

Who manages SDIF?

SAM, an investment advisor registered with the Securities and Exchange Commission, serves as the investment advisor to SDIF. SAM is a limited liability company and a wholly owned subsidiary of the American College of Surgeons. SAM consults with Cambridge Associates with respect to asset allocation and employs professional portfolio managers to invest SDIF’s assets. The process for managing SDIF is similar to that used for managing the College’s endowment.

What is Northern Trust’s role as sub-advisor?

Northern Trust Investments N.A. has been retained by SAM to manage SDIF’s investments in the ETFs. Within each asset allocation category determined by SAM, Northern Trust will determine how SDIF’s assets should be invested among the ETFs to best mirror the performance benchmark established for each asset allocation category by SAM.

What is the role of the SAM Board?

The SAM Board is responsible for determining the asset allocation of SDIF, establishing the appropriate benchmarks for performance for each asset allocation category selected by the board and then evaluating and monitoring Northern Trust’s investments in the ETFs. The SAM Board consists of the following directors: John L. Cameron, MD, FACS, Chair; H. Randolph Bailey, MD, FACS; Richard J. Finley, MD, FACS; Josef E. Fischer, MD, FACS; Charles D. Mabry, MD, FACS; J. David Richardson, MD, FACS; and Thomas R. Russell, MD, FACS. (See photos, page 46.)

What is the role of the SDIF Board?

The overall responsibility of the SDIF Board is protecting SDIF’s shareholders. The board is also responsible for overseeing the way the business operates and to ensure that corporate policies are followed by SAM. The SDIF Board consists of the following Trustees: John L. Cameron, MD, FACS, Chair; Michael M. Abecassis, MD, FACS; and James W. Atkinson. (See photos, page 48.)

What is the expense ratio?

The expense ratio for SDIF shareholders is 1.35 percent. Currently, the actual cost of operating SDIF is 1.92 percent. According to the Investment Company Institute’s Fact Book 2007, the average equity mutual fund expense ratio is 1.41 percent. In an effort to offer an investment product to the membership of the ACS at a reasonable cost, SAM has contractually agreed to limit SDIF’s expense ratio to an amount not exceeding 1.35 percent. The contractual arrangement

Disclosure

An investor should consider the investment objectives, risks, and charges and expenses of SDIF carefully before investing. SDIF’s prospectus contains this and other information about SDIF and should be read before investing. SDIF’s prospectus may be obtained by downloading it from SDIF’s Web site at www.surgeonsfund.com or by calling 800/208-6070.

Target allocations are subject to change. As a result of SDIF investing in other funds, an investor will pay proportionate share of the expenses charged by the underlying funds invested in. In addition, SDIF is subject to the same risks as the underlying exchange traded funds that it invests in, including, among others, interest rate risk, credit/default risk, market risk, international investment risk, derivatives risks, management risks, and liquidity risks.

The S&P 500 Index/Lehman Brothers U.S. Aggregate Index is composed of 70 percent S&P 500 Index and 30 percent of Lehman Brothers U.S. Aggregate Index.

SDIF is distributed by Ultimus Fund Distributors LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246; phone 513/587-3400.
is in place through August 31, 2009, although SAM intends to limit SDIF’s expense ratio to an amount not exceeding 1.35 percent indefinitely thereafter.

**Who can invest in SDIF?**

Shares of SDIF are available only to members of the American College of Surgeons, their families and employees, affiliated retirement plans, physician practice plans, and U.S. medical societies and associations with College membership representation. Individuals must be a U.S. citizen or resident of the U.S. with a valid Social Security number to invest in SDIF. Shares of SDIF are no-load, which means you pay no sales charges.

**How do I invest in SDIF?**

An account may be opened by mail or bank wire. By mail, complete and sign either a general account or individual retirement account (IRA) application. Enclose a check payable to the Surgeons Diversified Investment Fund and mail to SDIF’s transfer agent, Ultimus Fund Solutions LLC (the address is provided on the applications). To open a new account by wire, call the transfer agent at 800/208-6070 and a representative will assist you.

**Can I purchase SDIF through my broker or financial institution?**

Shares of SDIF may be purchased through certain brokerage firms and financial institutions that are authorized to accept orders on behalf of SDIF. These organizations may charge you transaction fees on purchases of SDIF shares and may impose other charges or restrictions or account options that differ from those applicable to shareholders who purchase shares directly through SDIF or the transfer agent. Shareholders investing in this manner should look to the organization through which they invest for specific instructions on how to purchase and redeem shares. If your financial institution needs assistance with becoming authorized to accept orders on behalf of SDIF, contact Savitri Pai or Tom Kiley. (See contact information at the end of the article.)

**What is the minimum investment?**

The suggested minimum initial investment in SDIF is $25,000. The minimum investment requirement may be waived or reduced. Call SDIF directly at 800/208-6070 to discuss the waived minimum. The minimum investment has been modified for Medical Student Members ($500), Resident Members ($1,000), and Associate Fellows ($2,500) of the College. The minimum investment for Affiliate Members can be waived. For those who find it appropriate, an automatic investment plan* is also available.

**What type of individual and institutional accounts can be opened with SDIF?**

SDIF is available to be used as an investment vehicle in individual accounts, such as traditional IRAs, Roth IRAs, simplified employee pension IRAs, simple IRAs, rollover IRAs, beneficiary/inherited IRAs, profit-sharing plans, and

* A program of regular investing does not ensure a profit or protect against depreciation in a declining market. Because a consistent investing program involves continuous investment in securities regardless of fluctuating prices, you should consider your financial ability to continue to purchase through periods of various price levels.
regular personal investment accounts. SDIF can also be used as an investment vehicle in institutional accounts, such as associations, foundations, societies, chapters of the College, hospital and university retirement plan platforms, surgical group practice plans, and others.

If you have additional questions, contact Savitri Pai at 312/202-5056 or spai@facs.org or Tom Kiley at 312/202-5019 or tkiley@facs.org. Both individuals are registered representatives available to discuss specific details regarding SDIF. You may also visit the Web site at www.surgeonsfund.com or call 800/208-6070.

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**A look at The Joint Commission**

**Joint Commission clarifies accreditation participation requirement**

Physicians and medical staff members who have concerns about the safety and quality of care at their hospital may report those concerns with the understanding that retaliatory disciplinary action is prohibited, according to explicit new rules announced by The Joint Commission. The accreditation participation requirement previously referred generally to hospital staff, although it has always been intended that physicians and medical staff be included as part of “good faith participation” in the accreditation policy.

The revised requirement, which will become effective January 1, 2008, means that accredited hospitals must educate administrative and medical staff that no disciplinary action will be taken if concerns are shared with The Joint Commission, and hospitals should demonstrate this commitment by refraining from taking action against employees or physicians who report their concerns to The Joint Commission.

“The Joint Commission policy forbids accredited organizations from taking retaliatory actions against those who report quality of care concerns, because it is the obligation of everyone in an organization to make patient well-being the priority,” says William E. Jacott, MD, special advisor for professional relations for The Joint Commission.

Anyone who has concerns about the safety or quality of care at an accredited organization may share those concerns with The Joint Commission office of quality monitoring by telephoning 800/994-6610, or by sending an e-mail to complaint@jointcommission.org.

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**Change your address online!**

Go to the College’s “members only” Web portal at [www.efacs.org](http://www.efacs.org)
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.
The College’s Committee on Trauma, Region 7 (Iowa, Kansas, Missouri, and Nebraska), is sponsoring the 30th annual Advances in Trauma seminar December 7–8 at The Westin Crown Center in Kansas City, MO.

The regional and state chairs have planned a program that will benefit all involved in trauma patient care.

The objective of this continuing medical education course is for national faculty to present timely trauma and critical care issues aimed at improving care of the acutely injured patient. Current trauma diagnostic and therapeutic techniques will provide the audience with the most up-to-date information available. This seminar will offer content valuable to trauma, general, vascular, and orthopaedic surgeons; primary care and emergency physicians; trauma coordinators; trauma and critical care nurses; and surgical residents who care for injured patients.

The Friday program will include a keynote lecture, For the Patient, presented by David V. Feliciano, MD, FACS. Other lectures will include the following: Penetrating Cervical Injury; Penetrating Thoracoabdominal Wounds: A Role for Laparoscopy?; PIPS: The Key to Quality Trauma Care; Optimal Treatment of Hemorrhage Shock; End Points of Resuscitation; Surgical Critical Care: A Discipline at the Crossroads; The Injured Duodenum; Emergency Department Thoracotomy: When and How; Operative Treatment of Lung Injury; and Case Presentations.

Saturday’s program continues with the following lectures: The Tip of the Spear: Advances in Military Trauma Care; Bench Research to Battlefield Care; Hemostatic Resuscitation; Critical Care Air Transport Team: State-of-the-Art Aeromedical Transport; Complex Liver Injury: Operation or Angiography; Thoracic Aortic Rupture: Operate, Stent, or Observe?; Cost-Containment Opportunities in Trauma Care; Clearing the Cervical Spine: The Final Word; The Latest on Local Hemostatics; Acute Lung Injury: Management in the Intensive Care Unit; and Stump the State Chairs.

Faculty members include Juan A. Asensio, MD, FACS; Roxie M. Albrecht, MD, FACS; L. D. Britt, MD, MPH, FACS; David G. Burris, MD, FACS; Reginald A. Burton, MD, FACS; Philip R. Caropreso, MD, FACS; H. Gill Cryer, MD, FACS; Demetrios Demetriades, MD, FACS; Warren Dorlac, MD, FACS; Jonathon M. Dort, MD, FACS; Dr. Feliciano; Eric R. Frykberg, MD, FACS; Ray D. Gaines, MD, FACS; Jeffrey S. Hammond, MD, FACS; Roger E. Huckfeldt, MD, FACS; Fred A. Luchette, MD, FACS; Lee V Ludwig, MD, FACS; Jorie D. Klein, RN; Frank L. Mitchell III, MD, FACS; Peter Rhee, MD, MPH, FACS; Richard A. Sidwell, MD, FACS; R. Stephen Smith, MD, FACS; and Gregory A. Timberlake, MD, FACS.

A premeeting course, on Disaster Preparedness and Emergency Management, is scheduled for 7:00 am to 4:15 pm on Thursday, December 6. Registration for this course is limited to 40 participants and requires a separate registration.

For more information, visit the ACS Web site at: http://www.facs.org/trauma/cme/traumtgs.html.
ACOSOG news

Why are clinical trials relevant to surgeons?

by David Ota, MD, FACS; and Heidi Nelson, MD, FACS

For the past two years, we have been providing monthly updates regarding clinical trials conducted by the American College of Surgeons Oncology Group (ACOSOG). These Bulletin articles describe trials that focus on procedures and adjuvant therapies that require a surgeon’s judgment. The articles are also about surgeons who actively participate in ACOSOG trials. However, it seems that the ACOSOG membership of hundreds is small in comparison with the ACS membership of thousands.

So how does ACOSOG relate to the greater members of the College? Perhaps there is a perspective that justifies the clinical trials endeavor within the College. Prospective clinical trials offer the best opportunity to validate new treatments or procedures. These trials prospectively select the patient population, describe the treatment or procedure, and define the surgeon credentialing process. The trial is conducted with a consistent standard of care and the data will determine the evidence that will ultimately establish improved and safer standards of care. Technology and science are always changing and they are affecting our surgical practice. Our role—indeed, our obligation—is to bring those changes to our patients by validating their benefit and by proving that they are safe, clinically efficacious, and cost-effective. This scientific approach is the underpinning of “evidence-based surgery” and is a primary reason for surgeons to participate in clinical trials.

But there must be more reasons. Surgeons hear a lot about measuring results; pay for performance, outcomes research, registries, and clinical trials are about data collection. However, the surgical community is not alone in measuring results. Governmental agencies and payors are generating data banks to catalog our performance and there are emerging search engine technologies that will review our electronic medical records, just as major search engines trawl the Web. This developing software can be used by others to measure and benchmark our clinical outcomes. Clinical research based on outcomes and prospective clinical trials give us an opportunity to take the initiative to create our databases and set new standards of care through measured results. By this approach, we have some measure of control over what new treatment or procedures should become standard of care with specific medical indications. All research approaches give surgeons a chance to develop these databases and interpret the results from a surgical perspective. Although none is likely to argue that medicine remains an art and our humanity figures prominently in medical decisions, we are also taught that science ultimately determines what is standard of care. Surgeons should embrace, and even lead, this scientific approach.

It is not uncommon to hear that clinical research competes for time and effort to generate clinical income. This becomes even more important as clinical revenue continues to decline for many of us. However, there are models to show that industry or government clinical trials can generate an additional revenue stream while we care for our patients. In the near future, ACOSOG will plan educational programs that will focus not only on successfully conducting clinical trials, but also on the financial management and business expertise that will enable a busy surgical practitioner to incorporate clinical trials as a distinguishing part of their practice and to bring the latest innovative care to their patients. More
about these programs will be discussed in future articles.

Clinical trials can also enhance the image of those who participate. Past ACOSOG columns in the Bulletin cite those surgeons who contribute to the success of a clinical trial (such as “Never...was so much owed by so many to so few” in August and “Neoadjuvant aromatase inhibitor trials for breast cancer” in June). ACOSOG will continue to publicize these individuals who enroll patients into trials. Surgeons who are cited in these articles can print these articles for their patient waiting rooms.

With its recent grant renewal, ACOSOG will expand its list of trials for breast, thoracic, and gastrointestinal malignancies. ACOSOG will continue to provide regular updates regarding trials, honor enrolling investigators, and provide educational material on the conduct and management of trials in your practice. Prospective collection of data will set new standards of care for cancer patients. Society will benefit and will value those who participate. For more information about ACOSOG, go to www.acosog.org. We ask that you consider ACOSOG trials for your patients.

Dr. Ota and Dr. Nelson are ACOSOG co-chairs.

Conjoint surgical congress to be held in Hong Kong in 2008

The Royal Australasian College of Surgeons (RACS) and the College of Surgeons of Hong Kong (CSHK) will sponsor a conjoint scientific congress May 12–16, 2008, at the Hong Kong Convention and Exhibition Center.

The overall theme of the congress is Achievement through Collaboration, and the large numbers of combined sessions will emphasize this important aspect of how surgeons apply themselves to the practice of surgery every day. The theme will be further promoted with the participation of the Australian and New Zealand Burn Association and the Australian and New Zealand Society of Craniofacial Surgeons.

All of the scientific program presenters from Melbourne will have a co-presenter in Hong Kong with whom they will work closely to bring the programs together and to ensure that the interests of fellows and trainees of both colleges are addressed. An international faculty of invited surgical leaders from Southeast Asia, China, Europe, and the U.S. will be in attendance.

The congress will commence on the evening of Monday, May 12, with a diploma and convocation ceremony, bringing together the important ceremonial elements of both colleges. The scientific programs will be held over the following four days and will cover contemporary and controversial topics, including the following: Doing More with Less—Improved Bed Utilization, Minimally Invasive Surgery—the Future for All Specialties, Credentialing for New Technology—Who Is Responsible?, and Identifying and Helping the Underperforming Surgeon.

The plenary program will be followed by a named lecture. Scientific sessions will then occupy the remainder of each day and section dinners will be held in the evenings, with a banquet on the final evening.

The call for abstracts for research papers will occur this month. Information will be mailed to fellows and trainees of the RACS and CSHK with instructions on how to submit an abstract. All other health professionals and surgeons from other international colleges should write to casc.abstracts@surgeons.org with any queries.

Registration for the congress will open in December 2007. Additional information and registration may be found online at http://www.surgeons.org/AM/Template.cfm?Section=ASC.
The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the “From my perspective” column written by Executive Director Thomas R. Russell, MD, FACS.

Letters should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to sregnier@facs.org, or via mail to Stephen Regnier, Editor, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.

Spreadsheet to the bed sheet
I just finished reading Dr. Russell’s new editorial in the June issue of the Bulletin and I want to thank him for his continued advocacy for general surgery and for his wise and insightful comments concerning our profession. It has been my feeling for years that if surgeons concentrate on the quality of their practice, the finances will work themselves out. Obviously, in this complex environment of reimbursement, we all need to be educated and aware of how the system functions. But I couldn’t agree more that the joy of practicing comes from the care that we provide for patients and not from worrying about financial matters. Thank you again for your comments, and keep up the good work!

Richard A. Armstrong, MD, FACS
Newberry, MI

I read with interest and appreciation the June “From my perspective.” As a part of a generation of physicians much before those practicing now, I know the warmth and respect that existed between patient and physician then. Even more revered were the physicians of my uncles’ generation, who practiced before I did. They had less to offer but gave freely of caring compassion, more helpful than any prescription they could write.

Many things have changed. The practice of surgery—of medicine in general—seems more a business enterprise than a service-dedicated profession. The introduction of government subsidies and insurance companies and the greater expectations by the public have changed our appearance. The individual practitioner is a rarity. Complaints I hear most often from friends and former patients about their relationship with the medical profession are as follows: Physicians are not as accessible as they once were. There is an impersonal sense when calling a physician office with many roadblocks before the physician can be reached. The patient often has to talk with someone on-call rather than his or her attending physician.

There seems little sympathy for the financial and other troubles of physicians when patients observe their fine homes and expensive automobiles. Yet, surgeons can offer so much now and are more skilled in many more ways than my generation. With changes that have taken place, surgeons’ relationships with and appreciation by patients may never again be what they were. There used to be a Doctor Appreciation Day in this community. I don’t see that occurring now.

I am grateful for the rewards of being a Fellow of the American College of Surgeons and for what the College continues to do to improve the art and science of surgery.

Jacob T. Bradsher, Jr., MD, FACS
Knoxville, TN

Patient education Web site
Congratulations on your new ACS patient education Web site. It is terrific—just what the ACS should be doing. Patients are going to the Web for advice—it should be good advice, and it should be our advice. This will do it. I am very pleased to see you take the leadership in making this happen.

Lucian Leape, MD, FACS
Boston, MA

Economics of managed care
The article in the April issue by Robert DeGroote, MD, FACS, regarding the economics of managed care (pages 28–36) was probably the finest and most important article I have read in the Bulletin in the last 10 years.

He is absolutely correct that the practice of medicine has been hijacked by the insurance industry and the federal government. The only way to fix this problem is to completely withdraw from the system and return to the everyday practice of taking care of our patients as best we can and as only we know how.

R. Anders Rosendahl, MD, FACS
Austin, TX

Economics of medicine
There is no such thing as magic money. What government spends must first be seized. There is a steady drum roll for a single-payor, national health care system, Medicare for us all. At the same time, the Office of Management and Budget warns that changes must be made in our existing Medicare system or the coming wave of unfunded debt will bankrupt our nation. A level head is needed at this time, not pandering demagogues.

If I were to promise to create a health care system in which everyone pays what he or she can afford and is entitled to take out of it whatever he or she needs, I would be laughed at by those who remember those words as the credo of Karl Marx’s communism. There simply is not enough money in the world to provide any premier product for all the people. People do not expect to make monthly payments of $300 and drive a Rolls-Royce. Most Americans, however, have the expectation that they
are entitled to absolutely the best, most perfect medical care possible, spare no expense when it comes to me or my family. The real question that our nation must address as we grapple with runaway health costs is this: How do we say “no” to people who demand unessential or absurdly heroic health care but cannot or will not pay for it? How do we eliminate the absurd concept of egalitarianism when it comes to health care?

Last year, I personally provided more than $130,000 of free emergency surgery for hand trauma. According to the Texas comptroller of public accounts, physicians in Angelina County provided $2.7 million in charity care and had $3.3 million in bad debt in 1997 (reported in March 2001). By my estimate, it must have been at least five times that amount in 2006. Physician charitable care is a substantial sum. As you consider the implementation of a single-payer system, keep in mind that if physicians receive payment for that which is now given free, the budget must be much greater than that estimated upon billing totals for the Centers for Medicare and Medicaid Services and private insurance combined.

At this time, there is a tremendous amount of waste purely because the service is “free.” For example, the true benefit of hyperbaric oxygen is limited and for typical wounds is certainly marginal; yet, hospitals have set up wound clinics across the nation, appointed medical directors who have no surgical experience supervising wound care nurses, and these very expensive treatment modalities are freely applied. It is common for me to see a patient in consultation only after they have received 33 “dives” over three months with a surgical problem, which is then treated with surgery and healed in a week.

Any system created in which the physicians and patients can take what they think they need will quickly exceed budget. Bureaucrats will then impose precertification and draconian rules. Reimbursements will decline until physicians are driven out of medicine. No matter how efficient the system, it cannot approach the efficiency of my system in the cosmetic surgery portion of my practice. My patients shop based on regional prices, my reputation, and the perceived quality of my staff and operating facility. If I am too high-priced, or if the patient perceives higher quality from another physician, he or she will go elsewhere. This is the free market. The bottom line is that the free market in which patients must bear the cost and make difficult decisions is by far the most efficient.

The best a lawmaker can do is provide a government safety-net system in which it is clear that resources are limited. We must deal with end-of-life issues. We cannot afford to place feeding tubes into unaware nursing home residents who are in a vegetative state and have no hope of recovery. We must understand that there comes a time to meet the Lord, without the comfort of a lawsuit against the nursing home. We must understand that if Christopher Reeve—with 24-hour-a-day attendants, the finest equipment, and best medical care—died of sepsis from a pressure ulcer and, as his wife stated on Oprah, that it was inevitable because he was in a state of decline, then we must recognize that people must have the opportunity to die at the end of life.

Unless we first deal with the end-of-life issues and extreme low-birth-weight infant salvage, unless we are willing to limit the government’s exposure to every American’s desire for endless free everything, a single-payer system will fail. There must be severe limits on everything, but a free-market opportunity for people to buy hip replacements if they want, or hyperbaric treatment, or pacemakers beyond the point of reason, if that is how people want to spend their own money. Government money—that money taken from the paycheck of a young widow working two jobs for her own children’s benefit—must have more careful stewardship.

Whenever a problem seems insoluble, the question is often based on false premises. Ask not, “How can we give everything to everyone?” but rather, “What should government not be responsible for, and how can we protect physicians and hospitals who try to prevent the squander of resources?” One must also ask, “Which group is wealthy and should pay for their health care, and which group is poor, struggling, and needs tax relief: the 68-year-old globetrotting pensioner, or his married 32-year-old daughter with two children who is trying to get started?” As I stated earlier, there is no such thing as magic money. If government pays for the pensioner’s health care, it is taking money from his daughter’s pocketbook. If this cause and effect were more clearly apparent to the nation, I suspect that wiser choices regarding health expenditures would be made.

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The National Trauma Data Bank® column in the October Bulletin discussed pedestrians injured as a result of being struck by a bicycle. Anyone working in a busy urban trauma center knows that it is far more common to treat pedestrians because of injuries sustained from a collision with a motor vehicle. According to the National Highway Transportation and Safety Administration’s Traffic Safety Facts 2003, there were 70,000 pedestrians injured in traffic crashes that year. This translates to one injury every 8 minutes, resulting in one fatality every 111 minutes. Most of the fatalities occurred in urban areas (72%), at non-intersection portions of the roadway (79%), in normal weather conditions (89%), and at night (65%); more than two-thirds were male (69%), and one-third (34%) of the fatalities had a blood alcohol level over the legal limit established for driving (http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/TSF2003/809769.pdf).

To examine the occurrence of pedestrians injured by motor vehicles in the NTDB Dataset 6.2, I used the International Classification of Diseases, Ninth Revision, Clinical Modification cause of injury code E814.7, motor vehicle collision with pedestrian where the pedestrian was the injured person. There were 50,617 records with discharge status recorded in the dataset with this E code. Of these individuals, 38,369 were discharged to home, 7,320 to acute care/rehab, and 842 to nursing homes; 4,086 died. Among these records, 65 percent of victims were male and on average 34.2 years of age; there was an average length of hospital stay of 7.1 days and an average injury severity score of 12.6. Among those tested for alcohol, 35 percent tested positive. These data are depicted in the figure on this page.

When walking, there are a few simple steps that you can take to increase your chances of making it safely to your destination. Look both ways when crossing the street, cross the street at the intersection, do not walk out between parked cars, and do not walk around the front of a stopped bus. Last, but not least, if you have consumed alcohol to the point where you are unable to walk the line, take a cab so you do not end up as one of the walking wounded.

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 m Neal@facs.org.

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