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

Dateline: Washington 7
Division of Advocacy and Health Policy

On the cover: A surgeon serving in Afghanistan does not let an unavoidable mishap derail his career in surgery, and the College does not let it derail his Fellowship (see article, page 15).

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2009 Chicago, IL, October 11-15
2010 Washington, DC, October 3-7

Letters to the Editor should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to sregnier@admin.org, or via mail to Stephen J. 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.
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
On May 9, we will break ground for the American College of Surgeons’ new Washington, DC, office building at 20 F Street, NW. Some Fellows have asked me why the College has chosen to purchase this piece of real estate and to construct a 10-story building on the site at this time. I want to take this opportunity to respond to them and to share that information with all of you.

Access to policymakers

The College leadership believes that construction of this building is absolutely necessary for a number of reasons, the most significant being that a larger structure in close proximity to the halls of Congress will strengthen our presence in Washington. Currently, the College’s Division of Advocacy and Health Policy staff members involved in federal affairs occupy a renovated three-story schoolhouse in the Georgetown section of the District of Columbia. This site, while historically interesting and aesthetically impressive, is several miles from the seat of political power. If we want to influence legislators and regulators, we need to be where they are.

In our politically charged health care environment, our lobbyists and policy analysts need to have easy and rapid access to the people who are determining how physicians will deliver medical services to patients and how we will be paid for our work. Under these circumstances, and given the often rapid pace at which changes occur on Capitol Hill, it is imperative that our advocacy staff be able to quickly travel to congressional hearings, meetings with health policy advisors, and conferences with representatives from other surgical and medical societies. The time our staff devotes to these negotiations will be far better spent than the time they now must spend negotiating the circuitous streets of Washington in order to get to various meetings.

Growth

As the College has sought to play a more active and influential role inside the Beltway, we have continually redefined existing positions in order to add more congressional and regulatory affairs staff. The Washington Office now comprises the Director of Advocacy and Health Policy, Cynthia A. Brown; three administrative, four legislative affairs, and five regulatory affairs staff members; and a political action committee (PAC) manager. However, the strains of expanding responsibilities without increasing the number of staffpeople to share the load is starting to take its toll, and we anticipate more staff will be needed in the coming years to deal with an ever-broadening set of issues. Simply stated, the College’s Washington Office has outgrown its present confines. This new building should allow us to add more experts in congressional and regulatory affairs without physical restriction.

Furthermore, it also will be large enough to hold the College’s burgeoning Health

"The College leadership believes that the construction of this building is absolutely necessary for a number of reasons, the most significant being that a larger structure in close proximity to the halls of Congress will strengthen our presence in Washington."
Policy and Research Institute. Under the direction of George F. Sheldon, MD, FACS, this branch of the ACS is expected to provide us with hard data on workforce issues, quality, and variability in care, which we can then apply in formulating position papers. This institute will cultivate the best thinking available on issues that are very complex and difficult to address with our current resources. Because of current space limitations in Washington, the Institute is now housed in North Carolina at the Cecil B. Sheps Center for Health Services Research. After the new, larger building is complete, we will be able to move this “think tank” into our Washington Office.

Uniting surgery

It is becoming more important that all of surgery come together and speak with one voice about the issues that affect the profession. To ensure that all of surgery is speaking in unison, the College has been reaching out to the specialty societies and forming partnerships with groups that have interests and concerns in common with the College. For example, we have formed the Surgical Quality Alliance to address outcomes-related topics. The ACS also participates in and develops strategies for coalitions that are seeking to achieve passage of legislation regarding Medicare payment, liability, and health system reforms, as well as funding for trauma and National Institutes of Health programs.
Some of these federations have sizable memberships, and the conference room in our current space is too small to accommodate the meetings of these groups. The new building will have meeting areas large enough for us to host these conferences.

In addition, several specialty societies have already agreed to lease space in the structure. Hence, we will be able to easily coordinate our efforts with these groups. We want this new facility to bring the surgical community together as a united presence.

**Investment in the future**

Some Fellows have expressed concern about the cost of buying property and constructing a building in Washington, DC, particularly at a time when surgeons are confronting cuts in reimbursement and increased practice expenses. Without question, this project will be costly. Estimates put total spending at approximately $114 million. Most of the money that we plan to allocate to this endeavor will come out of the College’s endowment fund, which has increased significantly in recent years through investments. Thus, only a small portion of dues income will be directed toward financing the building.

Moreover, the College will occupy just the top floor of the facility. The other nine floors will be rented to other societies and businesses, providing us with a regular source of revenue.

To build better relationships with lawmakers and their advisors, we are planning to turn the rooftop of the facility into a deck area, where we and other occupants can host receptions. Indeed, it is possible that the American College of Surgeons Professional Association-SurgeonsPAC may find this setting appropriate for its fundraising activities.

The College’s leadership anticipates that the most significant payoffs will come in the forms of greater access to lawmakers and an enhanced capacity to promote all of surgery’s agenda on Capitol Hill. We believe that the development of a modernized and ideally situated Washington Office represents an investment in the future of surgery in an era when the government continues to determine how we provide care to patients and how we are paid. Moreover, there is no evidence that the government will be exiting the health care arena. Indeed, some private insurers are now looking to the government plans (which now provide 50% of the health care coverage in this country) for models in redesigning more profitable plans. Surgery needs to play an influential role in determining how patients will receive surgical services.

The building is scheduled for completion in 2010, the same year the College will start periodically hosting the Clinical Congress in Washington, DC. We will keep you posted on any important developments that occur before then, and we welcome your thoughts on how to make our new Washington Office an asset to the profession.

*Thomas R. Russell, MD, FACS*

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
On February 12, the American College of Surgeons submitted a statement to the U.S. Senate Health, Education, Labor, and Pensions Committee regarding the surgical workforce crisis in this nation and its effects on patient care. In its comments, the College detailed the numerous studies at the national and state levels that point to dangerous shortages in the surgical workforce and recommended a course of action for Congress. Sen. Lisa Murkowski (R-AK) noted that the dearth of general surgeons in Alaska has become a matter of public concern. Confirming Senator Murkowski’s claims was Beth Landon, director, Alaska Center for Rural Health. In addition, John E. Maupin, Jr., president of the Morehouse School of Medicine in Atlanta, GA, said the lack of general surgeons is becoming extremely critical in his state. To view the College’s statement, go to http://www.facs.org/ahp/views/workforce.html.

On February 7, the U.S. House of Representatives passed H.R. 4134, the College Opportunity and Affordability Act of 2007, which reauthorizes the Higher Education Act through 2012. This bill contains several provisions pertaining to graduate medical education (GME), that the ACS supports, including a $10,000 loan forgiveness program for physicians in specialties with postgraduate training programs that last more than five years and have fewer U.S. applicants than total training and fellowship positions. Reps. Rob Andrews (D-NJ) and Charles Boustany, Jr., MD, FACS (R-LA), were instrumental in ensuring the inclusion of this provision. The legislation also would increase the annual Perkins loan limit for graduate/professional students from $6,000 to $8,000 and raise the aggregate limit for graduate/professional students from $40,000 to $60,000. In addition, the bill calls on the Government Accountability Office to study the education-related indebtedness of medical school graduates. Reps. Tom Price, MD, FACS (R-GA), and Boustany requested the inclusion of this provision. For more information, contact the Division of Advocacy and Health Policy at ahp@facs.org.

The fiscal year (FY) 2009 budget that President Bush submitted to Congress on February 4 would slash federal spending for health care programs, especially those dealing with emergency and trauma care. For example, the President proposes to eliminate funding entirely for the Trauma Care Systems Planning and Development Act, the Emergency Medical Services (EMS) for Children program, the Preventive Health and Health Services Block Grant that helps fund state EMS programs, and the Traumatic Brain Injury Program. The President’s plan also would eliminate or significantly reduce many health professions’ training support programs and proposes to stop funding GME programs in children’s hospitals. The documents say little about physician payment and offer no solutions to the Medicare fee schedule problems that will produce annual pay cuts absent congressional intervention. For details about the President’s health-related budget proposals, go to http://www.hhs.gov.
The College's Division of Advocacy and Health Policy: An overview

by Cynthia A. Brown, Director, Division of Advocacy and Health Policy
Physicians face many challenges in advocating for their interests among state and federal policymakers. The profession’s division into dozens of specialties and subspecialties, each with their own representative organizations, complicates efforts to present a united front on the many socioeconomic issues confronting surgeons and other physicians today. The dominance of solo and small group practices among all specialties, and legal limits on the ability to act collectively on issues that affect income and patient access, also stand in stark contrast with the high profile and coordination that other health care system stakeholders—like hospitals, manufacturers, and health plans—are able to maintain before policymakers. Even the typical surgeon’s workday, which is scheduled months in advance, inhibits the scheduling flexibility that is sometimes required to participate in a “volunteer army” for advocacy efforts, again in stark contrast with the chief executive officers of health care organizations.

Surgeons are fortunate, however, in that the American College of Surgeons is willing to assume an umbrella role and go to great lengths to provide resources to other specialty societies that it views as constituent organizations. Furthermore, there is camaraderie among surgical specialties that allows for cohesion that eludes the medical specialties. The challenges facing surgery today are significant, but the profession’s influence is steadily growing.

Leadership and staff of the American College of Surgeons understand that Fellows want to improve their awareness of the many activities and programs that the College conducts on their behalf. Some of the programs that are perhaps lesser known but no doubt are of increasing importance to surgeons and their practices fall under the purview of the Division of Advocacy and Health Policy. The following overview of the division and its activities is intended to help improve the Fellows’ familiarity with the College and its socioeconomic programs.

### Division organization

From a structural perspective, the division’s programs are divided among four major areas (see organizational chart on page 10).

#### Federal Legislative Affairs

The College’s congressional lobbying staff is headed by Christian Shalgian, Assistant Director for Legislative Affairs. Three lobbyists divide responsibility with Mr. Shalgian for maintaining relationships with assigned offices in the House of Representatives and the Senate. Each staff member is responsible for communicating surgery’s perspective to his or her assigned legislators on all current issues. Major issues on the College’s federal legislative agenda for 2008 include Medicare physician payment, surgical workforce issues, access to emergency surgical care, children’s health, and quality-related issues such as pay for performance and implementation of health information technology.

Legislative Affairs staff work closely with employees of the American College of Surgeons Professional Association Political Action Committee (ACSPA-SurgeonsPAC). ACSPA staff includes Political Affairs Manager Sara Morse, who will soon be joined by a PAC assistant, which is a newly created position. These staff members, along with the federal legislative affairs staff members who allocate a portion of their time...
to the ACSPA, work together to establish and maintain direct relationships with members of Congress. U.S. members of the ACSPA can access further information about the PAC on the Web at http://www.facs.org/acspa_pac/index.html.

**Federal Regulatory Affairs**

Elizabeth Hoy, MHA, Assistant Director for Regulatory Affairs and Quality Programs, has four staff members who work with her to accomplish the following: (1) monitor, analyze, and respond to federal regulations; (2) provide support to College representatives on the American Medical Association (AMA)/Specialty Society Resource-Based Relative Value Scale Update Committee and in the AMA’s Current Procedural Terminology process; (3) support College efforts related to quality measurement and improvement alliances; and (4) develop practice-management resource material and educational programs. Major issues on the College’s regulatory agenda for 2008 include refinements to Medicare fee schedule payments and policies, potential regulation of image-guided procedures, patient safety organization rules, and quality measurement and pay for performance.

**State Affairs**

Jon Sutton, Manager of State Affairs, works in the College’s headquarters in Chicago with the assistance of a State Affairs Associate to monitor legislative and regulatory activities in each state
and assist chapters and Fellows in local advocacy efforts. State Affairs staff members also participate in a standing coalition of Chicago-area State Affairs staff for various medical and surgical specialty societies and organize volunteer Fellows into a State Advocacy Representatives (StARs) group—both of which serve as a resource to share information and strategies on common issues of concern across state lines.

Issues on the College’s state advocacy agenda include medical liability reform, trauma system development, repeal of uniform policy provision laws related to insurance coverage for injuries and illnesses resulting from intoxication, uniform emergency volunteer health practitioner protections, patient safety, and taxes on surgery.

The College’s participation in the AMA House of Delegates (HOD) and other AMA organizations like the Scope of Practice Partnership are also conducted through State Affairs. (See box, this page, for a list of College representatives in the AMA HOD.)

Administrative functions

The Division of Advocacy and Health Policy provides staff support to the following committees: Health Policy Steering Committee, General Surgery Coding and Reimbursement Committee, Patient Safety and Quality Improvement Committee, and ACSPA-SurgeonsPAC Board of Directors. In addition, the Washington Office provides all administrative support to the very active Metropolitan Washington DC Chapter of the ACS.

Program area highlights

When considering the College’s advocacy programs, activities that likely come to mind most readily include communicating with legislators and staff, securing opportunities to testify at hearings, preparing official responses to proposed regulations, participating in official expert issue panels, and so forth. However, a broad range of other activities fall within the scope of the Division of Advocacy and Health Policy, including the following.

Practice management tools and programs

Originating from a need to help surgeons comply with billing and regulatory rules and procedures, the College has developed a variety of practice management and coding resources. In addition to regional workshops offered on basic and advanced procedure and diagnosis coding, the division sponsors a free coding hotline that is available to all surgical specialties. We also have a collaborative relationship with Physician Reimbursement Systems Inc., which staffs the hotline, through which discounted subscriptions to a robust online coding tool, ACS CodingToday, are available to all Fellows. ACS CodingToday provides users with procedure-specific information on service bundles, modifier usage, Medicare payment amounts, local carrier coverage rules, and other matters.

With respect to practice management, the College has partnered with Economedix to conduct a broad range of inexpensive webcasts on topics ranging from complying with rules of the Health Insurance Portability and Accountability Act and the Occupational Safety and Health Administration to negotiating better contracts. These teleconferences, which run between 60 and 90 minutes, are held on Wednesdays near the lunch hour to facilitate participation by office staff, and then they are repeated shortly afterward so surgeons can hear the information that was

ACS Representatives to the AMA House of Delegates

Richard Reiling, MD, FACS (general surgery), delegation chair
John Armstrong, MD, FACS (general surgery), delegate
Charles Logan, MD, FACS (urology), delegate
Amilu Stewart, MD, FACS (general surgery), delegate
Chad Rubin, MD, FACS (general surgery), delegate
Hannah Zimmerman, MD, Resident/Fellow Section
Sanjay Parikh, MD, FACS (otolaryngology), Young Physicians Section
Patricia Turner, MD, FACS (general surgery), Liaison with Young Physicians Section and YPS Alternate Delegate to AMA HOD
presented. Economedix principals also provide hands-on practice management consultations each year at Clinical Congress through scheduled appointments at the division’s desk at the Members Resource Center in the exhibit hall.

In addition, College staff work with Fellow volunteers to develop resource material and practical tools to help surgeons and their staff manage their practices. For example, the following ACS-developed material is available on the Web site:

- **CPT and ICD-9 Coding for Surgical Residents and New Surgeons in Practice** provides comprehensive and easily understood information on coding rules and procedures.
- **Physicians As Assistants at Surgery**, developed in collaboration with the surgical specialty societies, is frequently used by surgeons to appeal claims denials for assistants at surgery services.
- **Physicians Quality Reporting Initiative** materials include flow sheets for surgical procedure families, a spreadsheet that allows simple cross-reference for procedure codes and applicable quality measures, and basic instructional information.

For a brief summary of practice management tools and programs, see the box on this page.

**Surgical Quality Alliance**

The College organized the Surgical Quality Alliance (SQA) in late 2005 in response to expanding efforts by private and public sector payors to develop quality measurement, improvement, reporting, and payment incentive programs. (For a list of organizational members of the SQA, see box on page 13). Realizing that the surgical specialties lagged far behind primary care and some medical specialties in the development of performance measures and programs that payors were designing, the College established this forum for the surgical societies to share resources and information, reach consensus, and coordinate responses on behalf of the profession. Among its achievements, the SQA has collaborated on the development of perioperative care process measures and initiated the development of a consumer satisfaction survey for surgical patients.

In addition to the SQA, division staff provides support for Fellows serving on a broad and growing number of regulatory and quasi-regulatory organizations that feed into the quality measurement and reporting movement, all of which have multiple workgroups that meet regularly to consider issues of importance to surgery. Some of the key groups are briefly described in the box on page 14.

**Coalition building**

Recognizing that there is strength in numbers, the division devotes considerable resources toward leading and participating in

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<th>Practice management tools and programs</th>
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<td><strong>Coding workshops</strong></td>
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<td><strong>CPT and ICD-9 Coding for Surgical Residents and New Surgeons in Practice</strong></td>
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<td>Information regarding this coding primer developed by John T. Preskitt, MD, FACS, is available at <a href="http://www.facs.org/ahp/codingmanual.pdf">http://www.facs.org/ahp/codingmanual.pdf</a></td>
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<td><strong>ACS CodingToday</strong></td>
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<td>This online, comprehensive coding resource, for which a subscription is required, can be accessed at <a href="http://www.acscodingtoday.com">http://www.acscodingtoday.com</a></td>
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<td><strong>ACS Coding Hotline</strong></td>
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<td>This hotline, offered as a member benefit, can be reached by calling 800/ACS-7911 (227-7911)</td>
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<tr>
<td><strong>Practice Management Teleconference Series</strong></td>
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<td>These 60- to 90-minute webcasts on practice management topics, which are offered throughout the year, are available at <a href="http://www.facs.org/ahp/workshops/teleconferences.html">http://www.facs.org/ahp/workshops/teleconferences.html</a></td>
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<td><strong>PQRI resources</strong></td>
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<td>This ACS-developed resource material for surgical practices participating in Medicare’s Physician Quality Reporting Initiative can be found at <a href="http://www.facs.org/ahp/pqri">http://www.facs.org/ahp/pqri</a></td>
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standing and ad hoc issue coalitions. Some of the issue-specific groups that involve the Division of Advocacy and Health Policy include the AMA Medicare payment workgroup, Coalition for Patient-Centered Imaging, Stop Medical Taxes Coalition, One Voice Against Cancer Coalition, Health Coalition on Liability and Access, ASC Coalition, Emergency Medical Services for Children Coalition, National Coalition on Health Care, and Physicians Advocating for Patients. Division staff members manage the surgical caucuses of the AMA HOD and its Young Physicians Section and organize annual meetings with leaders of the surgical specialty societies on behalf of Thomas R. Russell, MD, FACS, the College’s Executive Director. In addition, the division hosts frequent meetings of the legislative and regulatory staff of the surgical specialty societies to coordinate and collaborate on advocacy agendas; the groups often work together on sponsoring issue advertisements and other educational efforts aimed at policymakers and the public.

**Communications**

Effective advocacy requires robust communications, and the division is always looking for better ways to communicate with policymakers and with the Fellowship. The division publishes articles and other news items regularly in College communications vehicles like the weekly e-mail newsletter ACS NewsScope; the Bulletin; and Surgery News, the monthly newspaper. In recent months, we have made greater use of Web-based teleconferencing, or “webinars,” to conduct briefings on specific federal programs such as Medicare’s Physicians Quality Reporting Initiative and to regularly update College leaders on federal issues of concern to surgery. Specific division communications vehicles of note include the following.

- *Advocacy in Action* is a new monthly newsletter, sent to Fellows via e-mail, that provides information on advocacy activities conducted by the division and the ACSPA.
- *Bulletin* columns written by division staff members and published monthly include “Date-line: Washington,” “Socioeconomic tips,” “In compliance,” and “What surgeons should know about....” In addition, feature or news articles composed by staff are frequently published.
- *ACS Cross Country* is a Web-based newsletter highlighting state legislative and regulatory issues and trends.
- The Surgery State Legislative Action Center is a Web-based tool jointly sponsored by close to one-dozen surgical specialty societies, and coordinated by the College, allowing surgeons to join forces to affect state legislation throughout the country. It also includes a media guide that provides helpful contact information for newspapers, television and radio stations, and other news agencies in all 50 states.
- The Federal Legislative Action Center allows Fellows to contact their U.S. senators and representatives in response to legislative alerts that are sent by e-mail, as the need arises.


Future programs and activities

College leaders and division staff make a conscientious effort to continuously adjust staffing priorities, update old programs, and adopt new strategies as needs become apparent. Some of the notable changes currently under way include the following.

• **Joint Surgical Advocacy Conference.** On March 9–11, the College cosponsored a Joint Surgical Advocacy Conference with a number of the surgical specialty societies, featuring presentations by key policy leaders in Washington and personal visits for conference participants with their legislators or staff. Plans are under way to make this an annual event, in order to amplify surgery’s presence as a cohesive advocacy force on Capitol Hill.

• **Advocacy Hotline.** Following a successful grassroots telephone campaign last fall on the Medicare physician payment issue, the Board of Regents recently approved establishing a toll-free advocacy hotline that Fellows can use to contact their members of Congress.

• **ACS Institute for Health Policy Research.** Headed by George F. Sheldon, MD, FACS, and housed at the Cecil G. Sheps Center for Health Services Research in Chapel Hill, NC, the new institute will begin collecting data on the surgical workforce and other issues that can be used to augment the College’s policy development and advocacy activities. Its reporting relationship is outside the purview of the division, but there are strong collaborative ties and coordination of activities and information.

• **Nora Institute for Surgical Patient Safety.** This new patient safety initiative is tentatively scheduled to open in June. The Nora Institute will be a premier resource for surgical patient safety information, helping to inform patients and surgeons about the practice and principles of surgical patient safety. The institute’s work will encompass activities that cut across many College divisions, although Advocacy and Health Policy staff will provide general program support.

• **20 F Street.** Scheduled for completion in 2010, the College’s Washington Office will be housed in a new building that is being constructed on F Street on Capitol Hill. This state-of-the-art facility will feature first floor conference facilities and a rooftop terrace for hosting policy briefings and receptions. It will also serve as the Washington home for a number of the surgical specialty societies. (See “From my perspective” on page 4 for further details.)

For more information

For more information about the programs and activities of the Division of Advocacy and Health Policy, visit the College’s Web site at http://www.facs.org/ahp/index.html.
“The best and worst week of my life”: A surgeon at war

by Karen Stein, Associate Editor
Imagine a week when your life changes because of a major professional accomplishment. Imagine a week when your life changes because of a devastating injury that derails your initial career ambitions. Now imagine those two things happening within the same week.

Ross “Rusty” D. Segen, MD, FACS, a member of the 2007 class of American College of Surgeons Initiates, had such a week in 2006.

**The path toward Fellowship**

Dr. Segen hadn’t originally expected to follow the route toward a career in general surgery. In fact, after obtaining his bachelor of science degree in liberal studies, with a concentration in athletic training, from Salisbury (MD) State University—followed by a master of science degree in athletic training from West Virginia University, Morgantown—he had in mind to pursue a medical career in orthopaedics.

But in 1995, while he was pursuing his graduate studies at West Virginia—and after being accepted to medical school at the University of Medicine and Dentistry of New Jersey—Robert W. Johnson Medical School (RWJ), where he ultimately became drawn to surgery during the laparoscopy revolution—Dr. Segen decided to use his impending medical education in service to the U.S. Considering it an honor to care for America’s fighting men and women, Dr. Segen was commissioned as an officer in the U.S. Army; his grandfather, a former Army-Air Corps tail gunner, was influential in spurring his desire to serve.

Beginning his surgical training in 1999, Dr. Segan was an intern at Madigan Army Medical Center in Tacoma, WA, and a resident at Cooper Hospital/University Medical Center at RWJ and at Thomas Jefferson University Hospital in Philadelphia, PA. While serving as clinical instructor in the department of surgery at University of Maryland School of Medicine, Baltimore, he completed a fellowship in advanced laparoscopic and minimally invasive surgery.

Dr. Segan returned to active military duty after completion of his fellowship in June 2005, and was promoted to the rank of major. He served as chief of minimally invasive surgery and acted as associate program director for the general surgery residency in the department of surgery at Tripler Army Medical Center (TAMC) in Honolulu, HI, from 2005 to 2007. During his time at TAMC, the general surgery residency program received approval to expand its categorical positions by one per year and received a favorable review from the Accreditation Council for Graduate Medical Education Residency Review Committee for four years.

While at Tripler, he was granted certification by the American Board of Surgery and was in the process of fulfilling the ACS Fellowship requirement for one year of surgical practice after all formal training is complete when he was deployed to Afghanistan in January 2006. There, while stationed at the 14th Combat Support Hospital at Bagram Air Force Base and responsible for combat specialty care, Dr. Segan accomplished a very important milestone for his career and for the history of surgery.

**The experience of a lifetime**

Practicing medicine while at war was an exhausting and challenging experience. “For my whole time in Afghanistan, I worked every day with little down-time,” Dr. Segan said. “Because I was one of only a few surgeons in the most advanced hospital in Afghanistan, patients tended to accumulate because there is effectively no medical infrastructure. Night after night, we would care for trauma and emergent surgical cases. Doctors rarely had a night off, continuing to provide critical care services to the inpatients. We were all the patients had until [their medical care at Bagram] was over.”

For 12 hours he hand-resuscitated and operated (to stem ongoing shock) on a U.S. soldier who had been impaled by munition and sent to Bagram after initial stabilization at a forward operating base. This soldier survived the procedure and was sent back to the U.S. for convalescence. “If there hadn’t been a general surgeon to treat this soldier,” Dr. Segan said, “he would not have fared as well” as he did.

During his service at Bagram, Dr. Segan also...
cared for Afghan national soldiers involved in Taliban and Al-Qaeda attacks—including a difficult case of a local serviceman who was victim of an improvised explosive device (IED) attack and suffered injuries initially deemed to be lethal but who ultimately survived—and lots of children, some who succumbed to their injuries. “I took care of one kid for two weeks, but unfortunately the constellation of his injuries and sequelae were nonsurvivable,” Dr. Segan explained. “He was at school when the Taliban attacked it because they believed it was teaching western education and didn’t believe it was a good idea for the country. The Taliban rocketed this school, near a U.S. base close to the Pakistani border. A lot of kids died that day just trying to go to school. For me, that senseless death of those children and the child for whom I cared so diligently represented one of my most painful personal and professional experiences.” Dr. Segan described the country’s survival tactics as humbling, saying that bearing witness to the plight of the Afghan people put into perspective the “problems” of the U.S. citizenry. However, without any hesitation, he states that he is a better person for having experienced it.

The experience of a lifetime came on April 28, 2006. As part of the Society of American Gastrointestinal and Endoscopic Surgeons’ (SAGES) annual meeting, Dr. Segan performed minimally invasive gallbladder surgery—the first ever performed in Afghanistan—on a U.S. serviceman. It was broadcast in Dallas, TX, to the 1,700+ SAGES meeting attendees via satellite from the 14th Combat Support Hospital at Bagram (see photo, page 19). It was moderated in Dallas by renowned minimally invasive surgeon, Adrian Park, MD, FACS, FRCSC, the Campbell and Jeanette Plugge Professor and vice-chair in the department of surgery and head of the division of general surgery at the University of Maryland Medical Center and Dr. Segan’s fellowship director and mentor.

“(Performing this procedure) had started out as an initiative to bring this standard of care forward to the operating environment in Afghanistan,” Dr. Segan said. “At that time, if a soldier needed appendectomy, cholecystectomy, or other general emergency procedures, that person would have to undergo open operations, his or
Laparoscopy comes to Afghanistan

Laparoscopic procedures have been included in the standard of surgical care since 1992, soon after the laparoscopic cholecystectomy used today was first performed in the mid-1980s by Philippe Mouret. Since that time, when laparoscopic surgery was mostly used in cholecystectomy and organ removal as well as antireflux, colon, urologic, thoracic, and trauma procedures, its surgical applications have grown exponentially. Today, in the U.S., approximately 700,000 cholecystectomies are performed each year, more than half laparoscopically.

Before laparoscopy’s inauguration in Afghanistan, members of the military stationed in that country who needed gallbladder surgery were sent to other locations with laparoscopic capabilities, and other patients requiring emergency medical care were operated on with open procedures. This system of care contributed to high costs for transport as well as lowered morale caused by lessened troop strength and longer recovery times. Why did laparoscopy take so long to reach Afghanistan, by way of Dr. Segan’s historic first application of the procedure nearly 15 years after its widespread acceptance?

Afghanistan’s long recent history of instability and armed conflict has led to its label as being among the worst countries in terms of health care. With a population of 30 million, average life expectancy is 43 years, and it ranks near the top for newborn mortality (60 deaths per 1,000 births in 2006). Estimates reveal that diarrheal disease and tuberculosis—which have been showing consistently decreasing rates in the U.S.—are frequent contributors to the high mortality rate among children, where approximately 25 percent of children die by the fifth birthday.

But improvements in vaccination programs have not been enough to combat the effects of a country where 80 percent of the populace resides in rural areas that lack access to care (few roads and transportation venues and no system for medical referrals) and a deficiency of skilled medical professionals (approximately eight physicians per 100,000 people). This difficulty is compounded by the frequent targeting of violence toward aid workers based on assumptions regarding their political allegiances and the additional challenge that medical officers servicing rural villages often have a medical educational background both outdated and brief.

Such poor health care is typical in countries with depressed economies. Estimates put the poverty rate at approximately 50 percent, with 40 percent unemployment. The high cost of obtaining equipment and training medical and allied health personnel for performing such advanced procedures is essentially prohibitive in such a climate.

Fortunately, however, Dr. Segan had begun to coordinate and assist in the sustainable introduction of laparoscopic procedures while still in Afghanistan. “The equipment is still there,” Dr. Segan said. “It was a gift to the hospital from industry partners who were paying respects to the men and women of the U.S. Armed Forces. The country of Afghanistan now has the capability to perform laparoscopic surgery.”

References

her convalescence often mandating evacuation [to a facility outside of Afghanistan] at great risk and cost.” To bring laparoscopic procedures to Afghanistan would potentially result in U.S. government savings of $1.5 to $2 million each year (based on historical surgical volumes and diagnoses) and faster recovery and faster return of soldiers to their units (see sidebar, page 18).

Dr. Segan discussed the idea with the leadership of SAGES for the organization to support the arrival of laparoscopy to Afghanistan and the potential training of local surgeons. Given the fortunate timing and magnitude of this event, it became possible to broadcast this significant moment in surgical history to the industry floor at the SAGES’ annual meeting.

Working with U.S. Surgical (now Covidien) and Stryker, the Combat Support Hospital was sent machinery and 20 cases worth of disposable equipment to help make laparoscopy not a novelty but a day-to-day reality for the country. Dr. Segan had been coordinating efforts to establish laparoscopic surgical care and training at a Kabul hospital intending to teach the procedure to medical personnel, including a multinational group of surgeons.

But just as soon as Dr. Segan had started to change the face of medicine in a war-torn country, a devastating injury changed the outlook of his career as a surgeon.

**Fellowship interrupted**

A week after the laparoscopic cholecystectomy was broadcast live to SAGES, while on a medevac mission transporting a patient from Afghanistan to Landstuhl Regional Medical Center in Germany, Dr. Segan’s life and professional career were forever changed. While caring for a patient in the cargo hold of a C17, an unavoidable mishap turned the provider into a patient. The litter slipped, and as Dr. Segan reached out quickly to catch it, the patient landed on Dr. Segan’s head. Dr. Segan suffered a cervical spinal cord injury, multilevel disc herniation, and upper extremity radiculopathy.

Dr. Segan suffered a cervical spinal cord injury, multilevel disc herniation, and upper extremity radiculopathy. Despite physical therapy administered at a military medical facility, months passed without significant meaningful improvement. Dr. Segan realized that he was destined for chronic pain, arm weakness, and paresthesias and that his injuries effectively ended his budding career as a practicing surgeon. “I was in service to our country, trying to make a difference,” he said. “One minute [the ability to do so] is there, the next minute it’s not.” Ultimately he was placed on the medical disability retirement list and separated from the Army.

Dr. Segan had been on track to achieve Fellowship in the American College of Surgeons at the time of his injury. He hadn’t yet begun his formal application, as he was planning to assemble his case list when he returned from deployment. But at that time, aside from compiling the list, Dr. Segan had met all obligations on the Fellowship checklist. However, this injury precluded him from satisfying one major requirement for becoming a Fellow: “A current practice that establishes the applicant as a specialist in surgery.”

Even though his disability prevents him from
The Recommendation for Award for Dr. Segan’s Meritorious Service Medal with Oak Leaf Cluster for his efforts in support of Operation Enduring Freedom.
practicing, Dr. Segan obtained an application and sent a letter to the College to ask for an exemption. “I just wanted to be able to apply for this highest honor, to be inducted as a Fellow,” he explained, adding that just being able to apply for Fellowship was a major achievement in his career.

Fellowship granted
The College did, in fact, waive the current practice requirement for Dr. Segan, and he was inducted into Fellowship at Clinical Congress in New Orleans, LA, in October 2007.

Petitioning the College on his behalf were Dr. Park; Thomas V. Whalen, MD, FACS, chairman of the department of surgery at Lehigh Valley Hospital in Allentown, PA, a Regent of the College, and Dr. Segan’s medical school program director and mentor; and Carlos A. Pellegrini, MD, FACS, the Henry N. Harkins Professor and chairman in the department of surgery at University of Washington in Seattle and a Regent of the College.

In his letter written on Dr. Segan’s behalf, Dr. Pellegrini had this to say: “…I believe his application and his extraordinary interest in Fellowship in the College gives us a unique opportunity to also waive the ordinary process of Fellowship, and bestow this Fellowship, which he considers an extraordinary honor, upon a decorated war hero.” (Dr. Segan received the Meritorious Service Medal with Oak Leaf Cluster for his efforts in support of Operation Enduring Freedom. See opposite page.)

“I was absolutely humbled, amazed, taken aback, and choked up that [Dr. Pellegrini], who has made such great contributions to the field of surgery, was saying it was an honor to speak with me,” Dr. Segan said.

On the Friday before Clinical Congress was to convene, Dr. Segan got the phone call telling him to be in New Orleans that Sunday for Convocation, where he was to be initiated as a Fellow.

A career reinvented
After retiring from the Army, Dr. Segan accepted a position in the private sector. He is now the global medical director at Covidien in North Haven, CT, where he is responsible for supervising global clinical trials, providing oversight and management; coordinating all clinical advisory boards; providing support for regulatory admissions worldwide; participating in content creation for medical education programs; and participating in other activities for bringing products to market, including risk-management reporting and reviewing monthly safety reports.

Although actively practicing surgery is what Dr. Segan would prefer to be doing, he says he is positive and trying to make a difference in his current role—being active in surgery even if not performing operations. “Despite my injuries, I have no regrets about my service to our country and would still be doing that today had my injury not occurred,” he said.

And he maintains much gratitude toward the American College of Surgeons for his Fellowship. “I am very grateful and humbled to be given the opportunity to be a Fellow, and I am extremely grateful to the College,” he said. “This went beyond my expectations, as I just wanted to be able to apply. I didn’t expect immediate granting of Fellowship. I appreciate it and consider it an honor of the highest order.”

APRIL 2008 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
Advances in research and technology over the last few decades have altered how health care services are delivered, how many services are provided, and the cost. At the same time, surgeons and other health care professionals are functioning in a new environment where other stakeholders have an intense interest in increasing the transparency, the efficiency, and the quality of care provided. In an effort to achieve these goals, a number of initiatives, including public reporting of health care quality indicators, have been introduced in recent years.

As a signal of the increasing focus multiple stakeholders now place on transparency, the Agency for Healthcare Research and Quality (AHRQ) provides Web links to 221 health care reports available to the public via http://www.talkingquality.gov/compendium/. Audiences with particular interest in this information include payors, purchasers, patients (that is, organizations focused on patients’ needs and interests), and policymakers.

As the name suggests, public reporting refers to any report that includes health care data made available to the public. The concept of public reporting is now embedded in the current health care culture of accountability and transparency. The debate over who, what, where, and how the data are best reported is still in progress.

To be truly meaningful, reports must give an accurate and complete depiction of the health care provider. Many factors may be examined to evaluate a provider, including the following:

- Structural indicators: accreditation, certification, and staffing ratios
- Volume: number of procedures performed by a provider
- Process: clinical quality indicators measured during the treatment process
- Outcome: risk-adjusted short-term, intermediate, and long-term
- Spending: cost of care provided, price, or resources used to provide care
- Efficiency/value: combination of cost and quality metrics
- Patient experience: patients’ perception of the provider and care provided
Although it is unnecessary to make each of these factors visible to the public, provider ratings and rankings should take all of these factors into account. This goal can be achieved through provider report cards or composite scoring. Reports should also include data on all patients in a physician’s practice or a representative sample of the practice. For instance, a report from “Insurance Company X” will not include data on the provider’s patients insured by other payors or plans. The skewed sample can cause a misleading representation of the provider. This hurdle can be especially important to surgeons, who have a relatively small range of services or procedures to sample.

**Limitations**

Most public reports are still in their infancy, as is our understanding of what a meaningful public report should include and how it should be displayed. Many current reports are limited by the population included or by the type of information collected. Reports are often representative of small populations characterized by a specific disease or condition, geographic area, or single-insurer data. In addition, many reports provide only one aspect of health care decision making, such as cost, volume, or limited clinical quality metrics.

Surgeon-specific data are limited in current public reports, perhaps because much of the current focus is on chronic disease management or because the data are more difficult to collect from billing systems. Most meaningful surgical data reflect the system in which care is delivered. Data available on individual surgeons are often limited to education, liability claims, and structural measures, such as procedure volume and board certification.

It is important to note that many influential health care reports are unavailable to the public. Health insurers often provide data to their enrollees through a password-protected Web site, as do some nonprofit member organizations. In addition, many reports are strictly used for internal quality improvement and available only to the provider being measured.

Surgical specialty societies have some of the most sophisticated data available through programs like the American College of Surgeons National Surgical Quality Improvement Program and the Society of Thoracic Surgeons National Cardiac Database. Both databases collect process and risk-adjusted outcomes data for a hospital or practice. Currently, the vast majority of the data collected in these programs consist of system-level measures, are used for internal quality improvement, and are only available to the participating hospital or practice. There is a strong push from other stakeholders to use these robust databases to enhance the quality of data available to the public.

**Pros and cons**

The concept of public reporting has enthusiastic opponents and proponents. Advocates of public reporting believe that the practice will create a more informed and accountable health care system by promoting competition and increasing incentives for physicians to comply with evidence-based guidelines. With quality and cost data available to the public, insurers could make better decisions about preferred provider networks and benefit plan structure, purchasers could choose health plans for their employees more wisely, and consumers could use the information to make informed decisions about their health care.

Challengers of public reporting cite the limited ability to collect accurate information as a major barrier to success. The release of superficial or poor information could have significant consequences. Inappropriately categorizing providers could lead to adverse health care decisions by other stakeholders. The narrow ability of many organizations to accurately adjust for patient risk factors can lead to some physicians avoiding performing procedures on the sickest patients. In addition, the method used to evaluate health care professionals is a concern. The top 10 percent cannot care for the entire population. The demand for medical and surgical services must be taken into account, as well as quality improvement strategies to improve performance among lower-scoring professionals.

**Standards**

Concerns about public reporting are valid and must be considered in designing a meaningful program. Many organizations have developed
principles to guide organizations interested in publicly reporting health care data. The AQA (formerly known as the Ambulatory Care Quality Alliance) has developed a set of principles for public reports, including the following:

- Standardized measures should be used when available
- A contextual framework should accompany the report
- Measures, methods, and performance targets should be transparent
- Reports should be timely and constantly evaluated

In addition, the Commonwealth Fund’s Commission on a High Performance Health System studied public reporting efforts and cited the following lessons learned:

- Public reporting adds value
- Reports must be carefully designed
- Collaboration is essential
- Regional efforts are successful
- Active research and evaluation are critical
- Automated data collection is necessary

The current state of reporting

The medical and surgical communities continue to educate themselves on successful public reporting efforts. Public reports are continually being improved and refined, but it is important to understand the current state of reporting. The reports come in many shapes and sizes and can be roughly categorized by the type of organization releasing the report. Examples of these organizations and reports are as follows.*

For-profit businesses. The publication of health care data has become a profitable business. Companies such as HealthGrades (www.healthgrades.com) and Consumers’ Checkbook (www.checkbook.com) offer information on providers. HealthGrades charges approximately $20 to $50 for a quality report and, for an additional fee, offers its customers the opportunity to perform a liability search and receive information about what physicians are paid. Consumers’ Checkbook uses a slightly different strategy and charges customers $24.95 for two years of unlimited access. HealthGrades has become a popular site with many providers publicly advertising their “grade” and consequently providing HealthGrades with free advertising. Both Web sites include data on surgeons.

Federal government. Over the last few years, the U.S. Department of Health and Human Services (HHS) has increased the amount of data publicly available. Through the HHS Web site, beneficiaries can access a variety of tools, including Nursing Home Compare and Hospital Compare, to search for providers and make decisions about their care. Hospital Compare includes performance measures on surgical site infection, acute myocardial infarction, heart failure, and pneumonia. The measures used in the surgical site infection module have strong multistakeholder support. The measures are included in the Surgical Care Improvement Project, approved by the National Quality Forum, and adopted by the Hospital Quality Alliance.

In 2007, the Centers for Medicare and Medicaid Services (CMS) launched the Physician Quality Reporting Initiative (PQRI), which allows individual providers to submit quality data to CMS
and receive a 1.5 percent bonus payment. The PQRI has a design similar to the Hospital Compare program, but CMS has stated that provider-specific data will not be publicly reported.

State governments. There is a wide spectrum of involvement by state governments in health care data transparency initiatives. Some states, such as Florida and California, have been particularly active and have developed Web sites for health care consumers. However, most states make no or limited data available to the public.

Business groups on health and purchaser coalitions. As the cost of health care services and insurance has risen, so has the purchasers’ interest in obtaining information about the quality and cost of care. Many purchasers have formed city, state, or regional coalitions to address their concerns regarding health care costs. Groups in California and Colorado have made data publicly available, whereas initiatives like QualityCounts in Wisconsin make data available to member organizations only.

For-profit companies, free reports. About.com’s UCompare is an example of a company providing free health care information to consumers. The site includes data on both individual physicians and hospitals and allows patients to view providers’ ratings on designated performance metrics. Physician data are limited to structural measures, such as education, board certification, and disciplinary action. These Web pages appear to be financially supported by a plethora of sponsors whose advertisements appear throughout the sites. Established Internet-based companies have the benefit of understanding Web design, and the information is often displayed in an easily understandable manner.

Health insurance companies. As discussed previously, some health insurance companies keep quality and cost information in password-protected Web sites and release the information to enrollees only. Some insurers, such as Blue Cross and Blue Shield of Louisiana and Blue Cross and Blue Shield of Tennessee, post their reports on publicly available Web pages. Much of the data are limited to hospital structural measures such as staff ratios and volume, as well as cost information.

Consumer-oriented not-for-profit organizations. With a specific focus on the consumer, many not-for-profit organizations publicly report health care data. These organizations, however, often have financial constraints. As a result, the information provided is extremely limited and the Web sites are basic and difficult to navigate. Sites that include information on surgical care often must use volume as a proxy for quality and do not include specific information on quality or cost metrics.

Regional value exchanges. Formal collaborations among health care stakeholders by geographic area are a relatively new phenomenon. In 2006, the AQA chose six of these sites as pilots for collection of physician quality data. The Quality Alliance Steering Committee—a collaborative effort involving the AQA, Hospital Quality Alliance, and HHS—will be certifying community value exchanges in the coming months. The commonality of these initiatives is in their multistakeholder approach, their regional focus on quality, and cost improvement through public transparency. These value exchanges will focus on providing regional improvements with their reports to the public and an educational program for patients and the purchasers of health care. The Wisconsin Collaborative for Healthcare Quality, California Cooperative Healthcare Reporting Initiative, and Massachusetts Health Quality Partners are examples of these collaborative efforts that make health care data available on their Web sites. Most of the information is currently limited to chronic disease management and primary care physicians.

Conclusion
Most reports are still in early stages of development and will require additional research. Public reporting will continue to be enhanced and expanded as stakeholders learn more about which reports are successful. Only through active collaboration can all stakeholders ensure that meaningful, accurate information is available to patients for health care decision making.
A humanitarian effort by the department of surgery of the USUHS to a third-world country: THE PHILIPPINES

by David C. Wherry, MD, FACS, FRCS, DMCC; Norman M. Rich, MD, FACS, DMCC; and David G. Burris, MD (COL MC USA), FACS, DMCC
In 1899, during the start of the U.S. occupation of the Philippines, an American military hospital, the Philippine Civil Hospital, was opened. Maj. John McDill, a U.S. Army surgeon serving in the Philippines, subsequently made a recommendation for a general hospital. In 1906, plans were made for a 120-bed pavilion type of hospital patterned after the Eppendorf Hospital in Hamburg, Germany. The Philippine General Hospital (PGH) opened in 1910, with Major McDill the first head of the department of surgery.

Since that time, PGH has developed into a 1,500-bed hospital for the indigent and has become the premier teaching hospital of the Philippines. It is funded by the Philippine government via the University of the Philippines (UP) and, along with the medical school, is located on the university’s Manila campus. As of World War II, the department of surgery has developed the same divisions that exist in American surgical departments and has in-training for 80 to 90 surgical residents. To have a faculty appointment in the department is considered a high honor.

**Creation of a humanitarian program**

In 1996, two of the authors (DW and NR) traveled to the Philippines as representatives of the Uniformed Services University of the Health Sciences (USUHS) to meet with officers of the Philippine College of Surgeons regarding development of a humanitarian support program. Several of the officers were from PGH, and it soon became apparent that because it was a hospital for the indigent—and, like USUHS, a government-funded university—our efforts should be directed toward PGH.

In subsequent meetings with the then-chairman of the department of surgery, Romeo Gutierrez, MD, FPCS, the dean of the medical school and the chancellor of the University of the Philippines, we learned that many of the staff had trained in the U.S. and their clinical skills were excellent but there was a lack of surgeons trained in research.

After the development of a memorandum of understanding between the USUHS and PGH departments of surgery, the universities, and the governments, USUHS began with a humanitarian effort of having either a PGH junior staff member, or a surgeon just completing his or her residency or fellowship, spend one year in the USUHS department of surgery as a research scientist working in the laboratory only, as a team member on ongoing research projects.

The PGH surgeon selected for this program was competitively chosen by members of the department of surgery of both universities and by the U.S. State Department regional medical officer stationed in the Philippines. It is understood by verbal agreement that the PGH surgeon will return to the Philippines after completion of the year of research, or if he or she remains in the U.S. for a fellowship, he or she is to return after the fellowship is completed.

**Program participants**

Since the beginning of this humanitarian program in 1998, the following 10 surgeons have completed or will complete the program (see photos, page 28):

- **Eric Talens, MD**, came to USUHS when he was a junior consultant in the department of surgery of PGH. He returned to PGH and is now the head of the division of trauma and editor of the *Philippine Journal of Trauma*.
- **May Punzalan, MD**, came to USUHS after completing her residency in general surgery. After her year at USUHS, she returned to PGH, completed a fellowship in colorectal surgery, and became the first female colorectal surgeon in the Philippines.
- **Leoncio Kaw, Jr., MD**, completed general surgery residency at PGH, then after the year at USUHS did a fellowship in critical care with David Hoyt, MD, FACS, in California and one year of vascular training at the Scripps Clinic. He then returned to PGH and is now a clinical associate professor of surgery at UP College of Medicine and an attending surgeon at the UP–Philippine General Hospital.
- **Gemma Uy, MD**, completed general surgery residency at PGH; after the year at USUHS, she returned to PGH, completed a fellowship in surgical oncology, and is now a staff surgeon in surgical oncology at PGH.
- **Racel Ireneo Querol, MD**, completed gen-
eral surgery residency at PGH and then after the year at USUHS, he returned to PGH and completed a fellowship in cardiothoracic surgery. He is now working on a fellowship in thoracic surgery at the Mayo Clinic in Rochester, MN. He will return to PGH as a cardiothoracic surgeon.

- Eduardo Ayuste, MD, who came to USUHS as a junior faculty at PGH, is back at PGH in the division of trauma. He was honored in 2007 as one of 10 Outstanding Young Scientists in the Philippines.
- Earl Gonzales, MD, completed general surgery residency at PGH and after two years at USUHS, because of a multiplicity of reasons from all parties involved, remains in the U.S. and has just restarted a second full residency in a general surgery program.
- Babie Normita Talip, MD, completed general surgery residency at PGH and after the year at USUHS, she returned to the Philippines and plans to start her fellowship in pediatric surgery in January 2009 at PGH. After completion, she will practice in northern Mindanao.
- Mariam Grace Delima, MD, completed her general surgery residency and a fellowship in cardiothoracic surgery before coming to USUHS. She returned to the Philippines in February 2008, hoping to complete a further fellowship in pediatric cardiac surgery in Beijing or a thoracic oncology fellowship in Japan and then return to the Philippines.
- Dione Parreno-Sacdan, MD, completed her residency at PGH in December 2007 and started at USUHS in January of this year. (The PGH residency rotations are from January 1 to December 31 of each year). When the USUHS program is complete, she plans to return to PGH and complete a subspecialty fellowship.

The 10 research scientists have been first authors on four publications (see box on this page) and co-authors on 15 publications.

**Program success**

Support and funding have come from a wide variety of sources, including the USU Surgical Associates, which initiated the Ramon De Jesus and David Wherry Mabuhay Endowment that is now located at the Henry M. Jackson...
Foundation; the Department of Surgery International Relations Committee; and the PGH department of surgery. Other resources remain potential options for the future to continue these important exchanges. The Ramon De Jesus and David Wherry Mabuhay Endowment has recently started supporting USUHS medical students doing an elective surgery rotation at the PGH.

The Diploma in the Medical Care of Catastrophes (DMCC), under the auspices of the Apothecaries of London, has been extremely important in the exchange between the USUHS department of surgery and PGH because it has been mutually supportive. An oral examination and written dissertation are required, and many natural disasters, ranging from typhoons to volcanic eruptions, in the Philippines have been addressed in the written dissertations. All surgeons participating in our exchange program have been successful in securing their DMCC. Based on their success there has also been an independent examination for the DMCC in Manila in November 2006 with successful completion to date by eight of nine candidates. Diplomates holding DMCC in the Philippines are fourth in the world in number behind the U.K., the U.S., and The Netherlands. This provides additional international exchange opportunities for the UP-PGH.

Since returning to PGH, these research scientists who have completed the year at USUHS are not only progressing academically but will one day be among the leaders of surgery in the Philippines. Most are involved in clinical research and are meeting the need of PGH for young surgeons trained in research.

This long-term humanitarian effort has proven to all concerned that it is one of the best ways to help developing countries and their hospitals and universities in not only elevating the academic abilities of their faculty but also enhancing research-oriented patient care.

Acknowledgment

The authors would like to acknowledge the efforts of Dr. Delima for her help in completing this article.

Disclaimer

The opinions in this article are those of the authors, and not of the U.S. government/Department of Defense.

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I arrived a day early in New Orleans, LA, on October 6, 2007, for the American College of Surgeons’ Clinical Congress. I flew from San Francisco, CA, via Denver, CO, and we picked up several surgeons along the way. Although I didn’t know any of them personally, they were still recognizable—by their manner, dress, or lively chatter—and I would get to know a few of the surgeons over the course of the week. No sooner had we arrived at the baggage carousel at the Louis Armstrong Airport than did a four-man jazz band break out into “When the Saints Go Marching In.” This performance put the crowd of new arrivals in the mood as we started swaying to the rhythms while awaiting our luggage.

I have to admit, however, that for as long as I had been looking forward to attending the ACS meeting for the first time, part of my excitement was derived from my desire to see New Orleans in the aftermath of Hurricane Katrina, as televised scenes of the stranded being plucked from rooftops by helicopters and Charity Hospital awash in flood waters lingered in my memory. The shuttle bus to downtown and the convention center were packed with attendees. I sat next to a surgeon from New Haven, MA, who was attending her fourth Clinical Congress and was happy to be in warmer weather. We exchanged notes on our practices and initial impressions of New Orleans as we drove past the Superdome—now refurbished—that seems emblematic of Katrina. I felt like we were retracing the steps, in the opposite direction, of so many who were trying to escape during the 2005 hurricane season.

After checking into the hotel, I couldn’t help but go out to explore the city by foot. I met up with a good friend from residency and we ventured due north to Poydras Street, passed Harrah’s Casino, and cut over to Canal Street, the heart of the French Quarter. Passing innumerable bars, restaurants, art galleries, and tourist trinkets, we came upon Bourbon Street. It was quite a spectacle on a Saturday night, especially with the Louisiana State University (LSU)/Florida college football game in progress. We hopped in and out of the establishments on Bourbon Street as the crowds, fired up by the LSU faithful, spilled onto the street to celebrate their victory. While it was a site we had to get out of our system, we didn’t linger long and made our way back to our hotels, returning along the Riverwalk.

It would turn out that Sunday—the first official day of the Congress—was my hardest day. I started feeling ill the night before but attributed it to the long flight. I was sick the entire day. My greatest regret that day was missing the Scholarship Selection Committee luncheon. By the end of the day, however, I realized I needed the rest to get over the bayou flu and make the most of the week.

I awoke early Monday, refreshed and determined not
to miss another event. I made my first venture to the convention center for registration. Having plotted out my week with the program planner, after perusing the exhibit hall, familiarizing myself with recording continuing medical education credits and the offerings on the ACS Web portal, I attended the annual recognition luncheon atop the New Orleans World Trade Center. It was fascinating to mingle with many surgeons whose names I had only read about and to meet my fellow awardees. Although the day was rainy and overcast, I did catch an occasional spectacular glimpse of the mighty Mississippi River snaking through New Orleans.

I was then off to my first clinical session: Treatment of Gastroesophageal Reflux Disease: Pharmacologic, Endoscopic, or Surgical. I entered the cavernous hall, nearly half-full with three enormous flat-screen TVs, as the presentation had just begun. I sat through a treatise on the current state of reflux disease, with the leading authorities commenting on what the literature says, including what works and what’s on the horizon. This presentation was mixed with great pearls on everything from why proton pump inhibitors can be ineffective to the subtleties of a well-done Nissen fundoplication.

From there it only got better. Over the next three days, I attended a fascinating variety of general sessions, lectures, and courses, including Current Approaches to Hyperparathyroidism, Clinical Workshops Through Video, the Olga Jonasson Lecture (The Ultimate in Surgical Translation: Transplantation), From Napkin Scribbles to Improvements in Patient Care, and Optimizing Outcomes in Rectal Cancer, among many others. The sheer enormity of discourse was amazing and the quality was unparalleled.

The highlight of my week at the College meeting was, without question, the Rural Surgeons Forum. I had been in correspondence with the moderator, Stephen Olsen, MD, FACS, before the Congress and finally met him for lunch before the forum. It was a true pleasure to get to know Dr. Olsen, who had a great appreciation of the issues at hand for the modern rural surgeon. The forum was exceptional. A distinguished panel led by Thomas R. Russell, MD, FACS, Executive Director of the College, carefully listened to and constructively answered pointed questions from the forum’s surgeons, on everything from qualifying as a Center of Excellence for bariatric surgery in a rural setting to reimbursement issues for emergency room call. I was both honored and humbled to be a participant in the forum.

I returned home invigorated with the feeling that I had just experienced one of the most educational and entertaining weeks of my year. I met new colleagues from throughout the country, reconnected with the people who I trained with and those who trained me, and even tried my hand at some games in Harrah’s. I would like to offer my sincerest appreciation to the committee for the privilege and opportunity to attend as the Oweida Scholar. Next year the Congress is closer to home and I am already looking forward to once again bringing the benefit of that conference to my patients, residents, and hospital.

The Nizar N. Oweida, MD, FACS, Scholarship

The Nizar N. Oweida, MD, FACS, Scholarship provides an award of $5,000 to subsidize the participation of a young rural-based Fellow or Associate Fellow in attendance at the annual Clinical Congress of the American College of Surgeons. It is available to any Fellow or Associate Fellow of the College in any of the surgical specialties who is in good membership standing, serves a rural community in the U.S. or Canada, and is younger than 45 years on the date the application is filed. More information about this scholarship is available on the College’s Web site, at http://www.facs.org/memberservices/oweida.html.

Dr. Gynn is a general surgeon living in Dublin, CA.
In memoriam

Robert Wayne Hobson II, MD, FACS (1939–2008)

After a long illness, Robert Wayne Hobson II, MD, FACS—recipient of the College’s 2005 Distinguished Philanthropist Award—died at the age of 68 in January in Summit, NJ.

He had recently accepted the position of director of the Vascular Institute at Morris-town (NJ) Memorial Hospital and professor of surgery at Mount Sinai School of Medicine.

Dr. Hobson was born December 21, 1939, in Illinois. He earned his bachelor of science in chemistry and his medical degree (1963) from The George Washington University School of Medicine in Washington, DC, and pursued a postdoctoral internship at Tripler U.S. Army General Hospital in Honolulu, HI, and a residency in general surgery and fellowship in vascular surgery at Walter Reed Medical Center in Washington, DC.

Dr. Hobson also served during the Viet Nam War as group surgeon for the 3rd Special Forces Group at Ft. Bragg, NC, and the Special Forces Group in the Republic of Viet Nam. By the time he retired from the U.S. Army Medical Reserve in 1995, he had reached the rank of colonel.

He became a Fellow of the College in 1974.

At the University of Medicine and Dentistry of New Jersey (UMD), Dr. Hobson had played many roles: He was director of the Center for Vascular Disease, designated by the National Institutes of Health at UMD; professor of surgery and physiology; chief of the division of vascular surgery; director of the vascular fellowships program; faculty member of the graduate school of biomedical sciences; and associate director of the vascular biology program.

Dr. Hobson participated in College governance, serving as Secretary, Vice-President, President-Elect, and President of the New Jersey Chapter; a New Jersey Governor-at-Large; and Chair of the ACS Advisory Council for Vascular Surgery.

He was also the vice-president and president-elect for the International Society for Vascular Surgery.

Dr. Hobson and his wife, Joan, were honored with the Distinguished Philanthropist Award by the Fellows Leadership Society in 2005 because of their generosity in establishing the Robert W. Hobson II and Joan P. Hobson Charitable Remainder Unitrust. Unfortunately, because of his illness, Dr. Hobson was unable to attend the Clinical Congress in San Francisco, CA, to receive his award.

Dr. Hobson is survived by his wife, Joan; his step-children, Anne Marie Gesualdo and Patrick Gesualdo; and two grandchildren.
"Research shows that people who are well informed about their treatment options enjoy better surgical outcomes and are more satisfied with their results."

To order or for further information, visit http://www.facs.org/public_info/patientguidebook.html or call 312/202-5474
Selected Readings becomes a College publication

After being published for more than 30 years at the University of Texas Southwestern Medical Center in Dallas, Selected Readings in General Surgery will now be produced by the College’s Division of Education, headquartered in Chicago, IL. “It is both a great honor and exciting challenge to lead the transformation of Selected Readings,” editor-in-chief Lewis Flint, MD, FACS, said. “The journal has a long-standing reputation as an invaluable resource for practicing and resident surgeons. It is my goal to sustain its quality of information and make accessibility improvements by offering enhanced Web capabilities.”

“We are enthusiastic about adding Selected Readings in General Surgery to our lineup of continuing medical education (CME) vehicles,” Thomas R. Russell, MD, FACS, ACS Executive Director, said. “It is a valuable tool to help our members stay up-to-date in the field and assist them with their Maintenance of Certification. We welcome the full range of expertise that Dr. Flint and his editorial staff bring to the College for this endeavor. Selected Readings — along with our Evidence-Based Reviews in Surgery and our Surgical Index — enables us to further enhance our strong efforts to help busy practicing surgeons and residents stay abreast of current developments in surgery.”

The March issue of Selected Readings, which addresses the spleen, features an overview as well as articles selected by Dr. Flint. Dr. Flint said that subscribers can look forward to new changes in upcoming issues including an editorial review board composed of leading surgeons, improved CME test questions, and a more user-friendly online experience. Topics addressing core competencies, evidence-based surgery, and outcomes will also be added to the publication. In addition, there are plans under way to increase readership through marketing and promotional initiatives.

According to Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the Division of Education, “We are delighted to include Selected Readings in General Surgery to the repertoire of offerings of the American College of Surgeons, which is especially designed to meet the current and future educational needs of practicing surgeons and surgical residents. This exceptional resource should help individuals deliver state-of-the-art, evidence-based surgical care and support efforts directed at maintaining certification in surgery.”

Selected Readings in General Surgery is published 11 times per year, offering a comprehensive surgical education for surgeons and residency programs worldwide. The journal provides a thorough review of topics in the field of general surgery in a three-year cycle by reviewing more than 150 articles. Each issue includes 10 to 15 complete article reprints, overview, bibliography, and a self-assessment quiz.

For more information, contact Kimberly Cambric at 312/202-5227 or kcambric@facs.org. To subscribe, call 800/631-0033 or visit http://www.srgs.us.
Join us in San Francisco for the 94th annual Clinical Congress. As always, it will be an educational opportunity you won’t want to miss!

Please be sure to visit WWW.FACS.ORG in the coming months for more details regarding the educational program, registration, housing, and transportation.
College offers new wound care management award

The American College of Surgeons, through the generosity of KCI USA, is offering a two-year faculty research award to a general surgeon engaged in a research project addressing wound care management. The purpose of this fellowship will be to acquire knowledge leading to new clinical applications or projects that will provide the medical community with a better understanding of the use of advanced wound healing therapies. The fellowship award is $85,000 per year with the possibility of an extension for a second year if satisfactory progress is made.

Research endeavors specifically sought are translational projects, such as new methods to mechanically stimulate wound healing, design of clinically applicable skin substitutes, methods to enhance specific, difficult-to-heal wounds related to general or extremity trauma, various soft-tissue injuries, quality limb salvage, or methods to reduce surgical intervention to heal a variety of wounds.

General policies for granting the Wound Care Management Award are as follows:

• The fellowship is open to a Fellow or Associate Fellow of the College who has completed the chief residency year or accredited fellowship training within the preceding 10 years and received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

• This award may be used by the recipient for support of his or her research or academic enrichment in any fashion that the recipient deems maximally supportive of his or her investigations. This may include faculty salary replacement, support for clinical research personnel, supplies directly related to the research activity, consumable equipment, and research-related travel costs up to $2,000 per year.

• Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health, Canadian Institutes of Health Research, or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award.

• Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research.

• The applicant must submit a research plan and budget for the two-year period of fellowship, even though continuation of the award for the second year is contingent on approval by the Scholarships Committee of the College. A final narrative and financial report is also required.

• A minimum of 25 percent of the fellow’s time must be spent in the research proposed in the application.

• The fellow is expected to attend the Clinical Congress of the American College of Surgeons in 2010 to meet with the Scholarships Committee and to present a report to the Surgical Forum.

The closing date for receipt of applications is May 1, 2008. Application forms may be obtained upon request from: Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or the College’s Web site, www.facs.org/member services/research.html.
Recognizing the goal of offering members of the American College of Surgeons and affiliated organizations a reasonably priced investment product, the expense ratio of the College’s Surgeons Diversified Investment Fund (SDIF) has been lowered to just over 1%. The lower expense ratio will have an immediate positive impact on our shareholders, and, over time, will positively impact the performance returns for prospective and current shareholders. The new expense ratio, including ETF costs, is 1.08%.

Moving forward, all current and prospective investors will have the ability to invest at a lower cost in a no-load, open-end, diversified, actively managed mutual fund. SDIF is broadly modeled after the ACS’s endowment utilizing the same investing principles of asset allocation, diversification and rebalancing.

For more information or for a free copy of the prospectus, please download a copy at www.surgeonsfund.com or call 1-800-208-6070 and a copy will be mailed to you.

An investor should consider the charges, risks, expenses and investment objective carefully before investing. Read the prospectus carefully before you invest or send money.

SDIF is distributed by Ultimus Fund Distributors, LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246. The phone number is 513-587-3400.
CDC study: Adopting BTF guidelines could lead to fewer deaths

The December issue of the Journal of Trauma: Injury, Infection, and Critical Care features a study conducted by the Centers for Disease Control and Prevention (CDC) on the effectiveness of adopting the Brain Trauma Foundation’s (BTF) inhospital guidelines for the treatment of adults with severe traumatic brain injury (TBI). The findings presented in this article demonstrate that widespread adoption of the BTF inhospital guidelines could result in a 50 percent decrease in deaths and a savings of $288 million in medical and rehabilitation costs. In addition, the study found that with treatment adoption, the projected lifelong savings in societal costs are $3.8 billion each year.

According to Richard C. Hunt, MD, FACEP, director of CDC Injury Center’s Division of Injury Response, “The BTF guidelines were put forth to improve the quality of care of TBI patients. This study demonstrates that more routine use of these guidelines could result in a substantial reduction in deaths and a simultaneous reduction in medical, rehabilitation, and societal costs.”

The BTF guidelines for in-hospital care were developed in collaboration with the American Association of Neurological Surgeons. More than 10 years ago, Companion guidelines for prehospital care were prepared with the support of the National Highway Traffic Safety Administration and issued later. Although disseminated widely, these guidelines need far greater implementation.

For more information or to view the press release, visit www.braintrauma.org. For more information on CDC’s TBI-related activities and resources, visit http://www.cdc.gov/ncipc/tbi/TBI.htm.
The Executive Committee on Video-Based Education and Ciné-Med have developed the interactive Multimedia Atlas of Surgery. Each volume presents a comprehensive list of surgical procedures, featuring:

- Narrated surgical video
- Didactic presentations
- Medical illustrations
- Expert commentary
- Foreword by Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, American College of Surgeons

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American College of Surgeons • Division of Education: “Improving the Quality of Surgical Care through Education”
A look at The Joint Commission

Task force examines implementation of MS.1.20

The Joint Commission has established a special fact-finding task force that will examine implementation issues related to revised hospital medical staff standard MS.1.20 and address issues of concern that have been raised by the health care community.

The revised standard MS.1.20 was approved by The Joint Commission’s Board of Commissioners in June 2007 and will become effective in July 2009. The 16-member task force will analyze the potential impact of implementing the revised standard through the examination of case examples and factual information and will suggest mitigating remedies that will support achievement of the objectives of the standard revision.

The intent of the revised standard is to support and reinforce a productive working relationship between the medical staff and the governing body while minimizing disruptions to the hospital, including its medical staff. The revised standard calls for the medical staff and the governing body to work together, reflecting clearly recognized roles, responsibilities, and accountabilities, to enhance the quality and safety of care provided to patients.

The MS.1.20 implementation task force will focus on gaining a better understanding of the practical implementation issues related to hospital compliance with the following four concepts contained within the revised standard: (1) the flexibility allowed the organized medical staff and the governing body on the placement of documents in or outside of the medical staff bylaws; (2) the expectation that the decisions of the medical executive committee reflect the wishes of the organized medical staff; (3) the expectation that organizations with productive working relationships among leadership will find the voting requirements of the organized medical staff reasonable to implement; and (4) the method to limit items requiring joint approval, thus not burdening the hospital.

An additional aim of the task force is to allay concerns related to the amount of time and money required to meet the mandates of the revised standard within a well-functioning organization.

Organizations proceeding with any medical staff bylaws revisions are advised that The Joint Commission will act as expeditiously as possible on recommendations from the task force. It is anticipated that the task force’s report will be available later in the first quarter of this year.

AWS Foundation announces call for research fellowships

The Association of Women Surgeons (AWS) Foundation, together with Ethicon Endo-Surgery Inc. and Genomic Health Inc., has announced a call for two fellowships of $25,000 each. The two grants will be awarded to two qualified and approved grant applicants who submit a grant request addressing the following research topic areas:

• Breast cancer
• Bariatrics
• New, innovative, minimally invasive surgery
• Surgical education

The deadline date for grant submissions is May 15. For a detailed schedule and application information, go to www.WomenSurgeons.org.
2008 Coding Workshops
American College of Surgeons
2008 Coding Workshop Series for Surgeons and Their Staff

DENVER, CO
FEBRUARY 28
2008 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding
FEBRUARY 29
2008 Surgical and Office-Based Coding and Reimbursement (Advanced)

LAS VEGAS, NV
APRIL 10
2008 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding
APRIL 11
2008 Surgical and Office-Based Coding and Reimbursement (Advanced)

DALLAS, TX
AUGUST 7
2008 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding
AUGUST 8
2008 Surgical and Office-Based Coding and Reimbursement (Advanced)

CHICAGO, IL
SEPTEMBER 18
2008 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding
SEPTEMBER 19
2008 Surgical and Office-Based Coding and Reimbursement (Advanced)

For more information and to register, go to
http://www.facs.org/ahp/workshops/index.html
or contact
Debra Mariani,
Practice Affairs Associate,
tel. 202/672-1506,
e-mail dmariani@facs.org
**Fellows in the news**

Giorgio Di Matteo, MD, FACS, of Rome, Italy—president emeritus of the Italian Surgical Society and professor emeritus in the department of surgery at University La Sapienza in Rome—has been awarded the medaglia d’oro al merito della Sanità Pubblica (the gold medal of merit for public health), the highest honor for Italian physicians, by the Italian Minister of Health.

Douglas B. Dorner, MD, FACS, a designated institutional official (DIO) and director of medical education at Central Iowa Health System, was one of three recipients of the 2008 Parker J. Palmer Courage to Lead Award, bestowed by the Accreditation Council for Graduate Medical Education. This award honors DIOs for exemplary leadership in resident teaching and institutional accreditation.

Rafael Espada, MD, FACS, a heart surgeon from Houston, TX, was inaugurated as the vice-president of Guatemala in January. Among Dr. Espada’s ambitions during his leadership tenure is to improve the country’s health care and education: “A healthier, safer, and better educated country is the key to improving Guatemala’s image throughout the world,” he has said.

Walter J. Kahn, MD, FACS, an ophthalmologist in private practice in Red Bank, NJ, and ophthalmology department director at Riverview Medical Center, has been awarded the Edward J. Ill Physician’s Award, which is presented each year to recognize a New Jersey physician’s distinguished service as a leader in the medical profession and the community.

France’s highest honor, the Légion d’Honneur, was awarded to John Kerner, MD, FACS, of San Francisco, CA, by President Nicolas Sarkozy in November 2007. This award to Dr. Kerner and six other World War II veterans was given as recognition of gratitude to individuals who liberated France from oppression in the mid-1940s. Dr. Kerner, who served as a combat medic in Normandy after D-Day, was the recipient of a Combat Medic Award, two Bronze Stars, five Battle Stars, and a Presidential Unit Citation during his service.

In June 2007, Eugene N. Myers, MD, FACS, FRCS(Hon)Edin, was presented the Grand Gold Medal of the Comenius University. Dr. Myers received this award at the Second Joint Meeting of the Slovak Society of Otolaryngology, the Czech Society of Otolaryngology, and the American Academy of Otolaryngology—Head and Neck Surgery, in honor of his achievements in head and neck cancer and his personal contributions to Slovakian otolaryngology. He was also granted honorary membership in the Czech Society of Otolaryngology.

Two Fellows—Donald Trunkey, MD, FACS, professor of surgery at Oregon Health and Science University in Portland, and Basil Pruitt, Jr., MD, FACS, professor of surgery at University of Texas Health Science Center, San Antonio—have been awarded the 2008 King Faisal International Prize for Medicine. This award, presented by Saudi Arabia’s King Faisal Foundation, honors Dr. Trunkey for the mobile surgical units he helped develop for trauma victims and Dr. Pruitt for his work in improving the medical care for burn patients. In addition to a gold medallion for both surgeons, each will receive half of the $200,000 prize.

In June 2007, Eugene N. Myers, MD, FACS, FRCS(Hon)Edin, was presented the Grand Gold Medal of the Comenius University. Dr. Myers received this award at the Second Joint Meeting of the Slovak Society of Otolaryngology, the Czech Society of Otolaryngology, and the American Academy of Otolaryngology—Head and Neck Surgery, in honor of his achievements in head and neck cancer and his personal contributions to Slovakian otolaryngology. He was also granted honorary membership in the Czech Society of Otolaryngology.
Operation Giving Back

Volunteer opportunities available

Operation Giving Back frequently receives inquiries from medical students who are interested in a surgical career and would like to explore volunteer opportunities with a surgical component. In addition to this early introduction to surgery, these experiences provide some unique opportunities through exposure to different cultures and pathologies and insights into policy and economic influences on health care decisions. The following is a sampling of resources available in the Resource Center for medical students, which provides opportunities and information for students interested in global health.

• Child Family Health International (CFHI) works at a grassroots level with committed professionals and students to promote the health of the global community. Since 1993, CFHI has coordinated international health service learning electives for more than 2,700 premedical and medical students and other students of the health professions. Students travel to Bolivia, Ecuador, India, Mexico, Nicaragua, and South Africa to immerse themselves in new cultural contexts and to learn about the way health care is practiced and experienced worldwide.

• Mission Finder, Missions for Medical Students provides information on short-term medical outreach opportunities for students. Information is available on elective rotations, specialty medical training, and other trips.

• Through its focus on education, the Global Health Education Consortium provides dedicated global health leadership to educate, train, and mentor health care students, faculty, professionals, and practitioners to address global health challenges.

You can learn more about these and other opportunities for medical students on the Operation Giving Back Web site, www.operationgivingback.facs.org. From the Venn diagram on the homepage, specify search parameters and click the yellow “Search” button. The “Search Results” page will display all relevant matches, and clicking on each title will provide a detailed description with appropriate contact information and links to a country-specific toolkit of other resources. In addition, there is a “Resource Center for Medical Students” available from the main menu. The information on the site is always changing, and we encourage those interested in volunteering to revisit the site often to research available opportunities.

Visit the Web portal of The American College of Surgeons:

View surgical news
Interact with surgical communities
Update CME credits
Enter case log information
Track resident hours
and more—all at:

e-facs.org
Surgeons Diversified Investment Fund’s fourth quarter 2007 performance report
If you have any questions, contact Savi 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 www.surgeonsfund.com or contact SDIF directly at 800/208-6070 for more information.
When asking for the definition of “rural,” one may get many diverse and sometimes interesting replies. For some, rural is a subjective state of mind, such as rural is when you hit “seek” on your FM car radio and nothing tunes in, or when you can’t get enough bars on your Blackberry to receive an e-mail. For others, rural is a quantitative objective measure. One thing is for certain: seldom are these definitions of rural in agreement.

There is no single, universally preferred definition of rural and there is not a single definition of rural that can serve all purposes. There are currently 15 definitions of rural used by federal programs. Two of the most commonly used classification systems are the U.S. Census Bureau’s definition of rural—open areas of country and settlements that have fewer than 2,500 residents—and the Office of Management and Budget classification system definitions of metropolitan and nonmetropolitan divisions. The Economic Research Service of the U.S. Department of Agriculture developed a set of county-level urban influence categories and in 2003 used these codes to divide the 3,141 counties, county equivalents, and independent cities in the U.S. into 12 groups (http://www.ers.usda.gov/briefing/rurality/urbaninfl/). These urban influence codes can then be grouped into urban, suburban, rural, and wilderness.

There were 798,439 records with injury sites that could be matched up with urban influence codes for examining the occurrence of rural injuries in the National Trauma Data Bank® Dataset 7.0. Using the urban influence codes grouping, 67,632 of the injuries were classified as rural; 25,796 as wilderness; and the remaining were classified as urban.
and suburban. Of the 62,896 rural records with discharge status, 43,567 were discharged to home, 9,603 to acute care/rehabilitation, and 6,955 to nursing homes; 2,771 died. Victims were 63 percent male and on average 40.2 years of age; they had an average length of stay of 5.4 days, an intensive care unit stay of 2.3 days, and an average injury severity score of 11.1 (see Figures on page 47).

The definition of rural is not the only difference in rural trauma. Even though the trauma victim may sustain the same physiologic insult, rural hospitals have fewer resources, staffing, and available personnel than their urban or suburban counterparts. To improve the level of care provided to the injured patient in areas where geography, population density, weather, distance, or availability of professional or institutional resources combine to isolate the victim of trauma, the Ad Hoc Subcommittee on Rural Trauma of the American College of Surgeons Committee on Trauma created the Rural Trauma Team Development Course (RTTDC©). No matter what definition one chooses for rural trauma, through the educational efforts of RTTDC, rural hospitals’ ability to handle victims of trauma will improve. You can find more information on this course at http://www.facs.org/trauma/rttdc/rttdcinfo.html. Then, if you happen to be injured while traveling through remote parts of the country, you won’t have to ask, “How rural is it?” when it comes to trauma care.

The full NTDB Annual Report Version 7.0 is available on the ACS Web site as a PDF and a PowerPoint presentation at http://www.ntdb.org.

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

Acknowledgment

Statistical support for this article has been provided by Sandra M. Goble, MS.

Dr. Fantus is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago, IL. He is Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.

Dr. Foley is trauma director at Marshalltown Medical and Surgical Center, Marshalltown, IA.
Chapter news

by Rhonda Peebles, Division of Member Services

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

Philippine Chapter hosts ACS First Vice-President

The Philippine Chapter, led by Chapter President and Governor Bienvenido Gaddi, MD, FACS, hosted the College’s First Vice-President, Mary H. McGrath, MD, FACS, during the 2008 annual meeting of the Philippine College of Surgeons, December 2–5, 2007, in Quezon City (see photos, this page). During her visit, Dr. McGrath addressed members of the College’s Philippine Chapter, the Philippine College of Surgeons, and Society of Philippine Surgeons in America. Dr. McGrath’s presentations included The Surgical Workforce Crisis, Evolving Experience with Post-Bariatric Body Contouring Surgery, and An Update on ACS Activities.

Southern California Chapter awards young surgeons

Last January, at its annual meeting, the Southern California Chapter awarded $3,000...
**Chapter meetings**

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

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

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<tr>
<th>Date</th>
<th>Chapter</th>
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<td><strong>April 2008</strong></td>
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<td>April 5</td>
<td>Metropolitan Washington (CS)</td>
<td>Location: Georgetown University Conference Center, Washington, DC</td>
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<td>Contact: Tavia Dixon, 202/337-2701, <a href="mailto:tdixon@facs.org">tdixon@facs.org</a></td>
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<td>April 11–12</td>
<td>North and South Dakota (CS)</td>
<td>Location: Watertown Event Center, Watertown, SD</td>
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<td>Contact: Terry Marks, 605/336-1965, <a href="mailto:tmarks@sdsma.org">tmarks@sdsma.org</a></td>
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<td>ACS representative: David A. Krusch, MD, FACS</td>
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<tr>
<td>April 25–26</td>
<td>Indiana (CS)</td>
<td>Location: University Place Conference Center, Indianapolis, IN</td>
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<td>Contact: Carolyn Downing, 317/261-2060, <a href="mailto:edowning@ismanet.org">edowning@ismanet.org</a></td>
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<td>ACS representative: Frank G. Opelka, MD, FACS</td>
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<td>April 26</td>
<td>New York (CS)</td>
<td>Location: Otesaga Resort, Cooperstown, NY</td>
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<td>Contact: Amy Clinton, 518/283-1601, <a href="mailto:NYcofACS@yahoo.com">NYcofACS@yahoo.com</a></td>
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<td>ACS representative: Gerald B. Healy, MD, FACS</td>
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<td><strong>May 2008</strong></td>
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<td>May 2–4</td>
<td>Virginia (CS)</td>
<td>Location: Inova Fairfax Hospital, Falls Church, VA</td>
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<td>Contact: Susan McConnell, 804/643-6631, <a href="mailto:smcconnell@ramdocs.org">smcconnell@ramdocs.org</a></td>
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<td>May 3–5</td>
<td>Iran</td>
<td>Location: TBA, Tehran, Iran</td>
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<td>Contact: Heshmatollah Kalbasi, MD, FACS, 0098-21-88081469, <a href="mailto:h_kalbasi@yahoo.com">h_kalbasi@yahoo.com</a></td>
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<td>May 7–10</td>
<td>Chile</td>
<td>Location: Hotel Sheraton, Santiago, Chile</td>
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<td>Contact: Xabier De Aretxabala, MD, FACS, 56-2-264-1878</td>
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<td>May 8–10</td>
<td>West Virginia (CS)</td>
<td>Location: The Greenbrier, White Sulphur Springs, WV</td>
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<td>Contact: Sharon Bartholomew, 304/293-1258, <a href="mailto:wvacs@labyrinth.net">wvacs@labyrinth.net</a></td>
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<td>ACS representative: Raymond F. Morgan, MD, FACS</td>
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<td>May 9–10</td>
<td>Ohio (CS)</td>
<td>Location: Hyatt Regency Columbus, Columbus, OH</td>
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<td>Contact: Brad Feldman, 877/677-3227, <a href="mailto:ocacs_exec@ohiofacs.org">ocacs_exec@ohiofacs.org</a></td>
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<td>ACS representative: Charles D. Mabry, MD, FACS</td>
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<td>May 9–11</td>
<td>Southwestern Pennsylvania</td>
<td>Location: Nemacolin Woodlands Resort, Farmington, PA</td>
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<td>Contact: Dianne Meister, RN, 412/321-5030, <a href="mailto:demister@acms.org">demister@acms.org</a></td>
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<td>May 12</td>
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<td>Contact: Danielle Spriggs, 717/558-7850, <a href="mailto:dspriggs@pamedsoc.org">dspriggs@pamedsoc.org</a></td>
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<td>ACS representative: David R. Hunt, MD, FACS</td>
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<td>May 15–16</td>
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<td>Contact: Angie Kemppainen, 517/336-7586, <a href="mailto:akemppainen@msms.org">akemppainen@msms.org</a></td>
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</table>
stipends each to three young surgeons to enable them to attend national or local College-sponsored education programs. The awards are effective for 18 months. This year’s awardees included Steven L. Lee, MD, FACS, of Kaiser-Permanente; Brian Randall Smith, MD,* of the University of California–Irvine; and Farin Amersi, MD,* of Cedars Sinai Medical Center.

In addition, the chapter conducted its annual residents’ competition. This year’s winners included Jessica Rayhanabad, MD, Kaiser-Permanente, first place ($500); Caitlyn Truong, MD, Loma Linda University, second place ($300); and Joyce Ho, MD, Harbor–University of California, Los Angeles, third place ($200).

*Denotes Associate Fellow or Resident membership in the College.

<table>
<thead>
<tr>
<th>Date</th>
<th>Chapter</th>
<th>Location/contact information</th>
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<tbody>
<tr>
<td><strong>May 2008 (continued)</strong></td>
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<tr>
<td>May 17</td>
<td>Northern California (S)</td>
<td>Location: Marines Memorial Hotel, San Francisco, CA Contact: Annette Bronstein (650) 992-1387, <a href="mailto:ABronst230@aol.com">ABronst230@aol.com</a> ACS Representative: Mary H. McGrath, MD, FACS</td>
</tr>
<tr>
<td>May 22–25</td>
<td>Florida (CS)</td>
<td>Location: The Breakers, Palm Beach, FL Contact: Bob Harvey, 904/637-0943, <a href="mailto:bharvey@hgmnet.com">bharvey@hgmnet.com</a> ACS representatives: Thomas Russell, MD, FACS; Gerald Healy, MD, FACS; and David Ota, MD, FACS</td>
</tr>
<tr>
<td>May 22–29</td>
<td>New Jersey</td>
<td>Location: Barcelona, Spain Contact: Art Ellenberger, 973/239-2826, <a href="mailto:njacschapter@yahoo.com">njacschapter@yahoo.com</a></td>
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<tr>
<td><strong>June 2008</strong></td>
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<tr>
<td>June 5</td>
<td>Brooklyn &amp; Long Island (CS)</td>
<td>Location: Garden City Hotel, Garden City, NY Contact: Teresa Barzyz, 516/741-3887, <a href="mailto:Acestera@aol.com">Acestera@aol.com</a> ACS representative: Susan Kaiser, MD, FACS</td>
</tr>
<tr>
<td>June 6–8</td>
<td>Maine (CS)</td>
<td>Location: Harborside Hotel, Bar Harbor, ME Contact: Joel Lafleur, MD, FACS, 207/593-5723, <a href="mailto:jlaflurmd@gmail.com">jlaflurmd@gmail.com</a></td>
</tr>
<tr>
<td>June 12–14</td>
<td>Alabama</td>
<td>Location: Marriott’s Grand Hotel, Point Clear, AL Contact: John Hooton, 205/930-8010, <a href="mailto:jh@surgicalassociates.com">jh@surgicalassociates.com</a> ACS representative: Frank G. Opelka, MD, FACS</td>
</tr>
<tr>
<td>June 15–18</td>
<td>Oregon &amp; Washington (CS)</td>
<td>Location: Skamania Lodge, Stevenson, WA Contact: Sue Lentz, 206/794-7022, sc <a href="mailto:lentz@aol.com">lentz@aol.com</a></td>
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**Brooklyn-Long Island Chapter cosponsors clinic day**

In conjunction with the Nassau Surgical Society, the Brooklyn–Long Island Chapter held its annual Clinic Day in December 2007. The keynote address was presented by Martin Bashir, an anchorman for ABC News in New York, NY (see photo, page 52).

**Uruguay Chapter conducts annual meeting**

The College’s Uruguay Chapter conducted its annual education program in November 2007 in conjunction with the 58th annual Uruguay Congress of Surgery in Montevideo (see photo, page 52).

**Ohio Chapter Executive Director achieves certification**

Last January, Brad Feldman, Executive Di-
rector of the Ohio Chapter, earned the certified association executive (CAE) credential, the highest professional credential in the association industry. To be designated as a CAE, applicants must have at least three years’ experience in nonprofit organization management, complete 75 hours of association-related education and/or coursework, successfully pass the CAE examination, and pledge to uphold a code of ethics.

Chapter anniversaries

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<thead>
<tr>
<th>Month</th>
<th>Chapter</th>
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<tbody>
<tr>
<td>March</td>
<td>Brazil</td>
<td>56</td>
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<tr>
<td></td>
<td>Southern California</td>
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<td></td>
<td>Massachusetts</td>
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<td>Nevada</td>
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<td>New Hampshire</td>
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<td>Puerto Rico</td>
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<tr>
<td></td>
<td>South Dakota</td>
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<tr>
<td>April</td>
<td>Metropolitan Chicago</td>
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<td></td>
<td>Mississippi</td>
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<td></td>
<td>Oklahoma</td>
<td>58</td>
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The Uruguay Chapter officers and members at its November 2007 annual meeting.

Brooklyn–Long Island Chapter, left to right: Stanley Ring, MD, FACS; Frank DiMaio, MD, FACS, president, Nassau Surgical Society; James C. Rucinski, MD, FACS, Section Chair; Mr. Bashir; James W. Turner, MD, FACS, President; Robert D’Esposito, MD, FACS, Governor; and Michael Setzen, MD, FACS, Program Organizer.