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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.
Earlier this year, the American College of Surgeons announced the establishment of a new Health Policy and Research Institute, which is currently based at the University of North Carolina (UNC), Chapel Hill. Already this institute is enhancing the College’s capacity for analyzing issues and developing thoughtful position statements, and we anticipate that it will assist this organization in our efforts to become an increasingly prominent presence in the policymaking arena.

Initial steps

Start-up of this important branch of the College is being led under the careful guidance of George F. Sheldon, MD, FACS, Zack D. Owens Distinguished Professor of Surgery at UNC’s School of Medicine. Dr. Sheldon, a Past-President of the College, was selected for this position through a national search process. He is receiving administrative assistance from Thomas J. Ricketts, PhD, deputy director of the UNC Cecil G. Sheps Center for Health Policy Research.

The Cecil G. Sheps Center for Health Policy Research is an institute within the UNC that reports to the vice-chancellor and collaborates with the schools of medicine, dentistry, public health, nursing, and allied health. The center has 140 full-time time researchers, numerous graduate students, and substantial existing grant support from the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the National Institutes of Health.

This collaboration with an existing health policy research center is a new model that allows a professional organization, such as the College, to collaborate with demographers, statisticians, survey experts, and other experts in health services research. The collaboration between the American College of Surgeons and UNC also ensures that the ACS Health Policy and Research Institute has access to the resources and knowledge necessary to cultivate a nationally respected think tank. Drs. Sheldon and Ricketts are both highly regarded authorities on health care issues, and the Sheps Center has a long and distinguished record in conducting health policy research. Basing the institute at UNC during its early stages of growth has allowed us to initiate our efforts much more quickly than if we had attempted to build an entirely new program from scratch.

Exploratory projects under way

For its first project, the ACS Health Policy and Research Institute is studying surgeon workforce issues. More specifically, the researchers at the institute are attempting to answer questions about how many surgeons will be needed to ensure patient access to care in the future, which specialties need to attract more trainees, and the causes of geographic disparities in access to surgical care. Dr. Sheldon and his team at UNC have already conducted considerable research regarding the impending surgical workforce crisis and have started to generate ideas about how the federal government can help to ensure that surgeons are accessible to the patients who need their services.

Based on the institute’s research, the College has arrived at some of the suggestions we
intend to offer to health policymakers to assist them in addressing the workforce issue. These recommendations include the following: (1) encouraging a well-planned expansion of U.S. medical school graduates and residency training programs, (2) providing federal financial support for specialties with lengthy training requirements, (3) eliminating caps on the number of residents eligible for federal support at each training institution, (4) expanding programs that give financial support to rural physicians to include surgical specialists, and (5) providing incentives for surgeons to take call in our nation’s trauma centers and emergency departments.

We anticipate that the ACS Health Policy and Research Institute will continue to play an instrumental role in helping the College to develop specific, scholarly, well-conceived strategies that lawmakers can apply in reforming the nation’s health care delivery system. For example, as Congress and the Centers for Medicare & Medicaid Services strive to create a value-based, patient-driven schematic, surgeons will face mounting pressures to document the effectiveness and efficiency of the work they do. The institute will be useful in generating data that can show what surgeons are doing well and where there is room for improvement.

Furthermore, the institute will serve as a think tank where clinical scholars can examine and discuss the complexities of surgical practice and create a vision for the future of our profession. Currently, the College’s Division of Research and Optimal Patient Care is benefiting from the assistance of three young research fellows, including a Robert Wood Johnson Clinical Scholar and two new Clinical Scholars in Residence (see related story on pages 93–94 of the July Bulletin). We anticipate that the ACS Health Policy and Research Institute also will provide bright, young people who are interested in legislative and regulatory issues with a fertile training ground for exploring fresh, innovative ideas about how we, as a profession and as a nation, can improve patient care through reasoned policy decisions. These programs for young thought leaders ensure that this organization serves as a true “college” for surgeons and is not just another professional association.

Strong, coordinated presence

Because the institute’s staff will be conducting research and helping to write position statements on issues affected by the federal government, the program’s headquarters will ultimately relocate to the building that will house the College’s new Washington Office, which is scheduled for completion in 2010. Having the College’s advocacy and institute staffs in the same location will allow for the timely exchange of information and ensure that all of our policy-focused efforts are well coordinated.

Although the ACS Health Policy and Research Institute will be headquartered in Washington, the institute will maintain a relationship with UNC. The fact of the matter is that our Washington Office will not have nearly the same research capabilities or staff capacity as our collaboration with the Sheps Center affords us.

Establishment of the ACS Health Policy and Research Institute presents an opportunity for the American College of Surgeons to play a true leadership role in the health policy arena. It will enable us to serve as a trailblazer by contributing real and factual data upon which to base solutions to the problems that have beset our health care system.

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
October 2009

SAVE THE DATE!

American College of Surgeons 95th annual
Clinical Congress, October 11-15, 2009
Chicago, IL - McCormick Place West Building

Visit www.facs.org in the coming months for more details regarding the educational programs, registration, housing, and transportation.
House starts looking at payment reform options

On September 11, the House Ways and Means Health Subcommittee held a hearing on Medicare’s physician payment system. Testimony focused on changes Congress should consider next year in order to avert the cut of more than 20 percent in Medicare reimbursement scheduled to take effect in 2010. Witnesses included two former administrators of the agency now known as the Centers for Medicare & Medicaid Services (CMS): Bruce Vladeck, PhD, and Gail Wilensky, PhD. Dr. Vladeck expressed support for reforms similar to those that the American College of Surgeons has proposed, which would replace the current sustainable growth rate (SGR) methodology with a reimbursement formula composed of separate spending targets for specific types of services. This new payment structure would include a distinct category for major surgical procedures and, consequently, spare surgery from the across-the-board, blunt payment cuts caused by the SGR. Dr. Wilensky also expressed interest in this proposal. For more information regarding this hearing, go to http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=645.

ACS comments on fee schedule

On August 29, the College submitted comments to CMS regarding the proposed rule for the 2009 Medicare physician fee schedule. The letter addresses the following provisions of concern to surgeons: a requirement that physicians who furnish diagnostic testing services enroll as independent diagnostic testing facilities, changes to the effective date for Medicare billing privileges for physicians, an incentive payment and shared savings program, and updates to the Physician Quality Reporting Initiative. In addition, the proposal calls for developing means to address potentially “misvalued” services. To view the College’s comments, go to http://www.facs.org/ahp/views/medicare2009.html.

ACS comments on OPPS/ASC proposed rule

The College submitted comments on September 2 regarding the outpatient prospective payment system and ambulatory surgical center (OPPS/ASC) proposed rule. In this letter to CMS, the College addresses the following issues: a plan to extend payment policies for hospital-acquired conditions to outpatient settings, a proposal to add imaging efficiency measures using 2008 Medicare administrative claims data, and suggested changes to the list of covered surgical procedures designated as device intensive. To view this correspondence, go to http://www.facs.org/ahp/views/ambulatory.html.

New code for noncompliance with Stark law

A new CMS claim adjustment reason code (CARC #213) becomes effective January 1, 2009, for use in denying claims that are noncompliant with the Stark self-referral law. This legislation prohibits physicians from referring Medicare patients needing certain designated health services (DHS) to facilities in which the physicians or an immediate family member have a financial relationship. Penalties for violations of the law include denial of payment, refund of amounts collected for DHS payment, and civil monetary fines. CARC #213 is the first specific code to describe claims denials resulting from violation of the Stark law. For more information, go to http://www.cms.hhs.gov/transmittals/downloads/R1578CP.pdf.
Fahad’s journey

by Sylvia D. Campbell, MD, FACS
I found the following message one early morning when I opened my e-mail:

Am a Ugandan mother of three boys, my last born son who is only seven months old was two weeks ago diagnosed with a heart complication. The doctors at Mulago Heart Institute say he has a hole between the two wall chambers of the heart and on top of that one of the pulmonary arteries is so narrow that the amount of blood pumped to the lungs is minimal thereby affecting his breathing. It’s so unfortunate that the condition cannot be rectified here in Uganda. I thought of contacting you in case you can be of help to me so my request to you is to kindly assist me where possible to save the life of my sweet baby. Any kind of assistance is highly appreciated.

And so began Fahad’s journey

Fahad Bukenya had Tetralogy of Fallot. At five months of age, he began to weaken and become less active. He contracted malaria at six months of age and was seen in his local hospital, where his murmur was heard. He was then referred to Kampala, the capital city of Uganda, where at the Mulago Heart Institute the diagnosis was made with an echocardiogram. His aortic override was 40 percent, his parachlorophenylalanine was 9 mm with confluent branch pulmonary arteries. No atrial septic defect, patent ductus arteriosus, or coarctation of the aorta was seen, and there was no VOT obstruction.

I have had the privilege of working with Heidi Hess in Tampa, FL, who coordinates the Gift of Life program here run by Rotary International. It is a program to help children who are unable to have cardiac surgery in their own countries and has served so many with such great need. I knew that this baby must be helped, and I contacted Ms. Hess about him.

It was believed that Fahad would be an excellent candidate for repair, but that it should be done quickly. St. Joseph’s Hospital in Tampa and Paul Chai, MD, an extremely talented cardiac surgeon, reviewed the information and agreed to take his case.

Jeanne Hardin-Gres—a nurse anesthetist and my good friend and mentor—and I were leaving for Uganda in just three weeks to review and discuss the development of a medical complex that was being planned for the village of Papoli. Ideally, Fahad and his mother, Anne, would travel back with us, if details could be worked out.

I contacted a travel agent who, amazingly, was able to get seats for Fahad and his mother on the same airline flight. My friend and minister, Rev. John DeBevoise, at Palma Ceia Presbyterian Church, was able to raise the funds for the tickets for Fahad and Anne. A letter was then sent to Anne from the Gift of Life program to help with obtaining passports and visas for her and her son.

Fahad could barely eat, he could not sit up, and he did not smile, but he looked at people with enormous eyes that had great pain. Each breath was an effort. His nail beds and lips were blue, and he already had clubbing of his fingers. The first time I saw him, on a dark street in Kampala, my heart broke and was rebuilt...and I knew we must make this journey.

Anne was told by the U.S. Embassy that the staff would need to talk to me before visas could be granted. So after a week in the bush, we traveled on Friday morning to the capital to meet with representatives at the Embassy.

I was told at the front gate again and again that visas were not issued on Friday. I then met with a representative at the Embassy, and I was told there would be no problem obtaining the visas the next week. I told him, “You don’t understand—we are leaving tonight. If this baby does not come with us, he will die. If he comes with us, he will have his only chance for life. You must do something.” Four hours later, we walked out of the Embassy with passports and visas. I do not know his name, but this man was truly an angel.

The trip to Tampa

We left Kampala at midnight to begin the 24-hour trip back to Tampa. We stressed to Anne how important it was that Fahad not cry, as we were concerned about a tet spell, and we sedated him with Benadryl as needed. He was so weak...
that he did not have the energy to cry, and the trip was amazingly uneventful.

However, on his preoperative appointment at the hospital, he was noted to have a significant thrombocytopenia, with his platelet count falling to 35,000. He also was noted to desaturate to an oxygen saturation of 19 percent when he cried. These laboratory values necessitated a week in the cardiac intensive care unit to determine that he had idiopathic thrombocytopenic purpura, thought to be secondary to a viral infection he had caught before leaving Uganda. All of his other workup, including a bone marrow analysis, was negative.

Even with the low platelets, it was believed that his surgery was critical, as he continued to desaturate and weaken.

**The operation and recovery**

Fahad was taken to the operating room on March 18, 2008. There, Dr. Chai was able to do an amazing job repairing his heart. His defect was closed and his stenosis resected. The technical skill of Dr. Chai and his team were evident as the surgery progressed. Fahad’s stenosis was just under the valve, and extreme care had to be taken not to cause injury to the valve. His post-repair intraoperative echocardiogram showed excellent normal flow, and his tiny chest was closed. His heart, once purple, was now pink.

Fahad had an unremarkable recovery and was discharged to my home on Good Friday. His platelets remained low but slowly responded to steroids. With the help of my dear friend Iris Alexander, the manager of the cardiac cath laboratory, an outpouring of community support was organized for Fahad and his mother.

He found his appetite and began to eat everything he could, especially mashed potatoes. He and his mother became part of my own family, as well as the extended family of our community where my husband, my children, and all who met him fell in love with his smile. He began to sing and laugh all the time, and when he returned to his home, six weeks later, he was able to stand. He grabbed everything, and was curious about all those who gave their support and who came to visit.

Fahad and Anne have returned to Uganda, where he should have a normal life, a life full of all the wonder and energy of any little boy, for his broken heart is now fixed.

—I do not know why Fahad was put in front of me.
I do not know what the future will hold for him, nor for his family.
I do not know what God’s greater plan may be.
But I do know that in a small village in Africa, a little boy laughs, and sings, and a family has been restored, thanks to the kindness of those in a country far away.
There is much in the world that is wrong.
But there is also much which is right.
And by reaching out to a child in need, a miracle has been shared both by those who have given it, and those who have received it.
And none of us are the same.

—Sylvia D. Campbell, MD, FACS

**Dr. Campbell** is a general surgeon in private practice in Tampa, FL.
ACS Practice Patterns Survey, Part II:

PRESCRIBING HABITS AMONG SURGICAL SPECIALTIES

by Charles M. Balch, MD, FACS;
and Thomas R. Russell, MD, FACS
With the continued advances and widespread availability of safer, more effective drugs and other systemic agents, the surgeon of today is engaged in a much more holistic approach to treat the whole patient. Indeed, surgeons of all surgical specialties prescribe medications frequently as an integral component of their care for the surgical patient.

Until now, there were very little data that showed how frequently surgeons prescribe drugs and which classes of drugs were used within each of the surgical specialties. To address this issue, an electronic survey of ACS members was conducted in fall 2007. The response rate was impressive: 4,207 individuals participated, representing the broad range of practice settings and surgical specialties. Nearly 45 percent of the respondents work in a university/teaching hospital, 39 percent are in private practice, and the remainder provides care in other environments. The largest percentage of respondents (40 percent) classified themselves as general surgeons, and the other 60 percent represented the majority of surgical specialties. The breakdown of surgical subspecialties was very similar to that of the ACS membership overall.

**Prescribing patterns**

This study, the largest ever published on this subject, clearly indicates that surgeons in a variety of settings and specialties commonly prescribe a wide range of medications. The majority of respondents (80 percent) said that, on average, they or trainees working under their supervision prescribe more than 10 drugs each week; 56 percent prescribe more than 20 drugs per week, and 45 percent prescribe more than 25 in the course of a week. Among the surgical specialties, the top three specialties prescribing 20 or more drugs each week were specialists in trauma/critical care, urology, and otolaryngology–head and neck (see Figure 1, page 13). Following is a list of the percentages of surgeons within specific surgical specialties who issue 20 or more prescriptions per week:

- Trauma/critical care 90%
- Urology 77%
- Otolaryngology–head and neck surgery 71%
- Cardiovascular 66%
- Colon and rectal surgery 62%
- Vascular surgery 62%
- Surgical oncology 61%
- General surgery 58%
- Pediatric surgery 57%
- Plastic and maxillofacial surgery 35%
- Breast surgery 25%

Not surprisingly, most of these prescriptions are for drugs used in perioperative care, such as analgesics, antibiotics, and antiemetics. However, it is interesting to note that surgeons report prescribing a range of medicines for respiratory, cardiovascular, gastrointestinal, critical care, and thrombosis conditions on a weekly basis (see Tables 1-3, page 14). Furthermore, half of the study participants said that, within the past year, they have ordered or prescribed a recently approved therapy or one under investigation. Following are the most common classes of drugs prescribed, on average, for five or more per week by survey respondents:

- Analgesics 78%
- Antibiotics 66%
- Antiemetics 42%
- Antithrombosis agents 33%
- Anti-inflammatory agents 38%
- Gastrointestinal agents 36%
- Anticoagulation agents 26%
- Cardiovascular agents 23%
- Diuretics 16%
- Respiratory 17%
- Hormones 7%
Figure: Drug Orders by Specialty

<table>
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<th>Specialty</th>
<th>0.00%</th>
<th>10.00%</th>
<th>20.00%</th>
<th>30.00%</th>
<th>40.00%</th>
<th>50.00%</th>
<th>60.00%</th>
<th>70.00%</th>
<th>80.00%</th>
<th>90.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>45.34%</td>
<td>13.15%</td>
<td>16.83%</td>
<td>12.27%</td>
<td>7.85%</td>
<td>2.62%</td>
<td>1.21%</td>
<td>0.74%</td>
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<tr>
<td>Otolaryngology – Head and Neck Surgery</td>
<td>60.00%</td>
<td>10.98%</td>
<td>13.73%</td>
<td>9.80%</td>
<td>2.35%</td>
<td>1.18%</td>
<td>0.78%</td>
<td>1.18%</td>
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</tr>
<tr>
<td>Vascular Surgery</td>
<td>49.06%</td>
<td>12.74%</td>
<td>12.26%</td>
<td>13.21%</td>
<td>9.91%</td>
<td>2.36%</td>
<td>0.00%</td>
<td>0.47%</td>
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<tr>
<td>Colon and Rectal Surgery</td>
<td>45.50%</td>
<td>16.93%</td>
<td>17.99%</td>
<td>10.05%</td>
<td>4.76%</td>
<td>3.17%</td>
<td>0.53%</td>
<td>1.06%</td>
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<tr>
<td>Urology</td>
<td>65.12%</td>
<td>12.21%</td>
<td>14.53%</td>
<td>5.23%</td>
<td>2.33%</td>
<td>0.00%</td>
<td>0.58%</td>
<td>0.00%</td>
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<tr>
<td>Trauma/Critical Care</td>
<td>83.53%</td>
<td>6.47%</td>
<td>5.29%</td>
<td>1.76%</td>
<td>1.18%</td>
<td>0.59%</td>
<td>0.00%</td>
<td>1.18%</td>
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</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>55.69%</td>
<td>10.18%</td>
<td>11.98%</td>
<td>10.78%</td>
<td>7.19%</td>
<td>3.59%</td>
<td>0.60%</td>
<td>0.00%</td>
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<tr>
<td>Pediatric Surgery</td>
<td>46.63%</td>
<td>9.82%</td>
<td>15.95%</td>
<td>10.43%</td>
<td>13.50%</td>
<td>3.07%</td>
<td>0.61%</td>
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<tr>
<td>Plastic and Maxillofacial Surgery</td>
<td>18.59%</td>
<td>16.03%</td>
<td>17.31%</td>
<td>24.36%</td>
<td>20.51%</td>
<td>3.21%</td>
<td>0.00%</td>
<td>0.00%</td>
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<td></td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>14.40%</td>
<td>10.40%</td>
<td>15.20%</td>
<td>22.40%</td>
<td>27.20%</td>
<td>10.40%</td>
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<tr>
<td>Surgical Oncology</td>
<td>48.78%</td>
<td>12.20%</td>
<td>13.01%</td>
<td>13.01%</td>
<td>8.94%</td>
<td>2.44%</td>
<td>1.63%</td>
<td>0.00%</td>
<td></td>
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</tr>
</tbody>
</table>
The different classes of drugs were prescribed with different frequency among the surgical specialties. Following is a list of subspecialties with the most common class of drugs prescribed (for average use of more than 10 per week):

- **Analgesics**
  - Trauma/critical care 91%
  - General surgery 66
  - Pediatric surgery 59
  - Colon and rectal surgery 59
  - Cardiothoracic surgery 59
  - Surgical oncology 58
  - Vascular surgery 54

- **Antibiotics**
  - Trauma/critical care 78%
  - Urology 72
  - Otolaryngology 53
  - Cardiovascular 40
  - General surgery 39
  - Pediatric surgery 39

- **Antiemetics**
  - Trauma/critical care 49%
  - General surgery 31
  - Colon and rectal surgery 21
  - Surgical oncology 21

- **Antithrombosis agents**
  - Trauma/critical care 49%
  - Vascular surgery 32

- **Anti-inflammatory agents**
  - Trauma/critical care 37%
  - Otolaryngology 21
  - Cardiothoracic 19
  - Urology 17
  - Pediatric surgery 17
  - Surgical oncology 14
  - General surgery 14

- **Gastrointestinal agents**
  - Trauma/critical care 43%
  - Colon and rectal surgery 24

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**Table 1: Analgesics by Specialty**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>&gt;20</th>
<th>11-20</th>
<th>6-10</th>
<th>1-5</th>
<th>Never</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Surgery</td>
<td>8.00%</td>
<td>22.40%</td>
<td>37.60%</td>
<td>30.40%</td>
<td>1.60%</td>
<td>0.00%</td>
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<tr>
<td>Cardiothoracic Surgery</td>
<td>31.74%</td>
<td>27.54%</td>
<td>25.15%</td>
<td>13.17%</td>
<td>1.20%</td>
<td>1.20%</td>
</tr>
<tr>
<td>Colon and Rectal Surgery</td>
<td>24.34%</td>
<td>34.39%</td>
<td>29.10%</td>
<td>11.11%</td>
<td>1.06%</td>
<td>0.00%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>32.93%</td>
<td>33.74%</td>
<td>23.34%</td>
<td>8.58%</td>
<td>1.14%</td>
<td>0.27%</td>
</tr>
<tr>
<td>Otolaryngology–Head and Neck Surgery</td>
<td>10.20%</td>
<td>20.39%</td>
<td>40.78%</td>
<td>27.06%</td>
<td>1.18%</td>
<td>0.39%</td>
</tr>
<tr>
<td>Pediatric Surgery</td>
<td>33.74%</td>
<td>25.15%</td>
<td>26.99%</td>
<td>13.50%</td>
<td>0.61%</td>
<td>0.00%</td>
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<tr>
<td>Plastic and Maxillofacial Surgery</td>
<td>21.15%</td>
<td>23.08%</td>
<td>39.10%</td>
<td>16.03%</td>
<td>0.64%</td>
<td>0.00%</td>
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<tr>
<td>Surgical Oncology</td>
<td>31.71%</td>
<td>26.02%</td>
<td>25.20%</td>
<td>14.63%</td>
<td>2.44%</td>
<td>0.00%</td>
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<tr>
<td>Trauma/Critical Care</td>
<td>80.59%</td>
<td>10.59%</td>
<td>6.47%</td>
<td>2.35%</td>
<td>0.00%</td>
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<tr>
<td>Urology</td>
<td>17.44%</td>
<td>26.16%</td>
<td>36.63%</td>
<td>18.60%</td>
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<tr>
<td>Vascular Surgery</td>
<td>27.83%</td>
<td>26.89%</td>
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</tbody>
</table>

**Table 2: Antibiotics by Specialty**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>&gt;20</th>
<th>11-20</th>
<th>6-10</th>
<th>1-5</th>
<th>Never</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Surgery</td>
<td>3.20%</td>
<td>6.40%</td>
<td>24.00%</td>
<td>64.00%</td>
<td>0.80%</td>
<td>1.60%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>16.77%</td>
<td>22.75%</td>
<td>30.54%</td>
<td>28.14%</td>
<td>1.80%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Colon and Rectal Surgery</td>
<td>8.99%</td>
<td>17.99%</td>
<td>32.63%</td>
<td>38.10%</td>
<td>1.06%</td>
<td>1.06%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>12.94%</td>
<td>25.96%</td>
<td>33.87%</td>
<td>25.82%</td>
<td>1.01%</td>
<td>0.40%</td>
</tr>
<tr>
<td>Otolaryngology–Head and Neck Surgery</td>
<td>25.88%</td>
<td>27.45%</td>
<td>34.51%</td>
<td>1 1.76%</td>
<td>0.00%</td>
<td>0.39%</td>
</tr>
<tr>
<td>Pediatric Surgery</td>
<td>15.95%</td>
<td>23.31%</td>
<td>34.97%</td>
<td>23.31%</td>
<td>0.00%</td>
<td>2.45%</td>
</tr>
<tr>
<td>Plastic and Maxillofacial Surgery</td>
<td>10.26%</td>
<td>21.15%</td>
<td>38.46%</td>
<td>30.13%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Surgical Oncology</td>
<td>6.50%</td>
<td>21.14%</td>
<td>38.21%</td>
<td>30.08%</td>
<td>3.25%</td>
<td>0.81%</td>
</tr>
<tr>
<td>Trauma/Critical Care</td>
<td>38.82%</td>
<td>38.24%</td>
<td>15.88%</td>
<td>6.47%</td>
<td>0.00%</td>
<td>0.59%</td>
</tr>
<tr>
<td>Urology</td>
<td>36.63%</td>
<td>34.88%</td>
<td>21.51%</td>
<td>6.98%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>8.96%</td>
<td>21.23%</td>
<td>36.32%</td>
<td>32.55%</td>
<td>0.47%</td>
<td>0.47%</td>
</tr>
</tbody>
</table>

**Table 3: Antiemetics by Specialty**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>&gt;20</th>
<th>11-20</th>
<th>6-10</th>
<th>1-5</th>
<th>Never</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>1.60%</td>
<td>3.20%</td>
<td>11.20%</td>
<td>54.40%</td>
<td>28.80%</td>
<td>0.80%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>10.78%</td>
<td>13.77%</td>
<td>23.95%</td>
<td>44.31%</td>
<td>5.99%</td>
<td>1.20%</td>
</tr>
<tr>
<td>Colon and Rectal Surgery</td>
<td>3.70%</td>
<td>16.93%</td>
<td>20.63%</td>
<td>46.03%</td>
<td>11.11%</td>
<td>1.59%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>11.94%</td>
<td>19.25%</td>
<td>26.56%</td>
<td>37.29%</td>
<td>3.76%</td>
<td>1.21%</td>
</tr>
<tr>
<td>Otolaryngology–Head and Neck Surgery</td>
<td>1.57%</td>
<td>3.53%</td>
<td>13.33%</td>
<td>60.78%</td>
<td>1 8.82%</td>
<td>1.96%</td>
</tr>
<tr>
<td>Pediatric Surgery</td>
<td>5.52%</td>
<td>7.98%</td>
<td>18.40%</td>
<td>53.99%</td>
<td>13.50%</td>
<td>0.61%</td>
</tr>
<tr>
<td>Plastic and Maxillofacial Surgery</td>
<td>5.13%</td>
<td>8.97%</td>
<td>19.87%</td>
<td>53.21%</td>
<td>9.62%</td>
<td>3.21%</td>
</tr>
<tr>
<td>Surgical Oncology</td>
<td>8.94%</td>
<td>12.20%</td>
<td>27.64%</td>
<td>41.46%</td>
<td>8.94%</td>
<td>0.81%</td>
</tr>
<tr>
<td>Trauma/Critical Care</td>
<td>21.18%</td>
<td>27.65%</td>
<td>21.18%</td>
<td>26.47%</td>
<td>2.35%</td>
<td>1.18%</td>
</tr>
<tr>
<td>Urology</td>
<td>3.49%</td>
<td>4.65%</td>
<td>9.30%</td>
<td>63.37%</td>
<td>17.44%</td>
<td>1.74%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>3.30%</td>
<td>10.38%</td>
<td>18.87%</td>
<td>48.11%</td>
<td>17.45%</td>
<td>1.89%</td>
</tr>
</tbody>
</table>
Cardiothoracic  21  
General surgery  20  
Otolaryngology  20  
Surgical oncology  15  

**Cardiovascular agents**  
Cardiothoracic  51%  
Trauma/critical care  42  
Vascular  30  
General surgery  12  

**Diuretics**  
Cardiothoracic  39%  
Trauma/critical care  20  

**Respiratory**  
Trauma/critical care  38%  
Cardiothoracic  23  

**Hormones**  
Urology  20%  
Breast surgery  6

Within surgical specialties, there were varying prescribing patterns as well. For example, trauma/critical care specialists prescribed the entire range of drugs classes, but the nature of their patient care caused them to most frequently prescribe analgesics (91 percent prescribe 10 or more/week), antibiotics (78 percent), antiemetics (49 percent), and antithrombosis agents (49 percent). General surgeons most frequently prescribed analgesics (66 percent), antibiotics (39 percent), antiemetics (31 percent), and gastrointestinal agents (20 percent). Urologists most frequently prescribed antibiotics and hormones.

The data in this survey did not present a sufficient sample size to assess the use of systemic cancer agents. However, a similar survey was conducted in 2006 among members of the Society of Surgical Oncology. Within this specialty, the use of systemic agents for cancer management would be prescribed more frequently as a component of the multidisciplinary cancer management. Thus, among the 532 surgical oncology respondents, two-thirds each week either prescribed, recommended, or administered oncology-related hormone agents. In addition, 30 percent did so for chemotherapeutic agents and growth factors, and 21 percent prescribed monoclonal antibodies.*

**Conclusion**  
These data provide new insights into the practice habits of surgeons caring for their patients. There were differences in both the types of drugs used and the frequency of prescribing them among the various surgical specialties. Most notable was the high frequency with which all surgeons prescribed various drugs and systemic agents in the daily care of their patients.

INTO THE THEATER:

Perspectives from a civilian trauma surgeon’s visit to the Combat Support Hospital in Balad, Iraq

by M. Margaret Knudson, MD, FACS
The history of trauma parallels the history of war, and there is no doubt that many of the principles that guide trauma care are being rewritten during the ongoing global war on terrorism currently being waged in Iraq and Afghanistan. In fact, this conflict has the lowest overall case fatality rate of any war in U.S. history. This outcome is truly remarkable, considering that the care given to these wounded troops spans three different continents. In order to better appreciate these advances in military medicine, the leadership of the American College of Surgeons Committee on Trauma (COT) and of the American Association for the Surgery of Trauma, working in conjunction with the U.S. military, developed the Senior Visiting Surgeons (SVS) program.

The global objective of this program is to establish scientific exchange between the leaders in civilian trauma care and our experienced military counterparts. The SVS program is also meant to rapidly forward the lessons learned in the military realm to the civilian sector. To date, the SVS efforts have been centered at the largest U.S. military medical center outside of the country’s borders: Landstuhl Regional Medical Center (LRMC) in Landstuhl, Germany. LRMC is the receiving hospital for all injured troops being evacuated from Iraq and Afghanistan and the last stop for these patients before transfer back to the U.S.

The SVS program, which was initiated in 2006, involves a two- to four-week rotation at LRMC as part of participants’ trauma/critical care service. The civilian surgeons rotating at LRMC have provided scientific seminars, given surgical grand rounds, instigated or mentored scientific research, assisted in preparing for trauma center verification, attended the peer review conferences (which also span three continents), and, most importantly, were privileged to participate in the surgical and critical care being rendered to these wounded troops. Every SVS has described this care as being outstanding.

The medical personnel at LRMC—consisting of members of the U.S. Army, Navy, and Air Force—face challenges unlike those at any other trauma center. First, the injuries being inflicted on our troops are complex and of extremely high acuity. The typical injury pattern follows an explosion and may consist of blast, burn, blunt, and penetrating injuries combined. Not uncommonly, the injured troop has undergone one or two operative procedures before arriving in Germany, including vascular shunting followed by definitive vascular repair, damage control laparotomies, decompressive craniotomies, and stabilization of fractures or the initial phase of fluid resuscitation for burn wounds. Most of these patients leave the combat theater hospital within 24 to 48 hours of their injury, flying eight hours to land at Ramstein Air Force Base in Germany, a short distance from LRMC. The patients arrive together in busloads and are triaged to either surgical wards or the intensive care unit. It is not uncommon to receive five to seven critically injured patients simultaneously at LRMC. Fortunately, via the Web-based Joint Patient Tracking Application, the data on these patients (including operative notes, computed tomography [CT] scans, and so on) can be reviewed long before their arrival.

Once in Germany, the wounded troops undergo a reevaluation of all injuries. Invasive lines are changed and laboratory values rechecked, and many undergo additional surgical procedures such as closure of abdominal wounds, burn or soft tissue wound debridements, muscle compartment releases if needed, and more definitive treatment of fractures. Scanning for deep venous thrombosis (or pulmonary emboli) is a high priority. Steps are taken to identify and control infections and emphasis is placed on the provision of adequate nutrition. Anxious families are contacted and updated as to the condition of their loved ones arriving in Germany. All of these activities are done on a strict timeline, with the goal of transporting stabilized patients to the continental U.S.—to Walter Reed Army Medical Center; National Naval Medical Center in Bethesda, MD; or Brooke Army Medical Center in San Antonio, TX—as soon as feasible (typically 24 to 48 hours later). As this next phase of transport involves
at least 12 hours in flight (18 hours to Brooke), there is no room for error, and adequate preparation of each patient before transport is a dictum. Every laboratory value, line, tube, and monitor must be corrected, secured, and accurate before leaving LRMC.

Despite all of these challenges, the remarkable care rendered at LRMC is delivered with the highest professionalism and with the deepest compassion. Indeed, this was reaffirmed by members of the ACS/COT Verification Review Committee who recently verified that LRMC met (and often exceeded) all of the criteria for a level II trauma center as defined by the COT.* (The observations of some of the SVSs while at Landstuhl have been published in two peer-reviewed articles†). Following the lead of the SVS program, civilian neurosurgeons, orthopaedic surgeons, and vascular surgeons have also volunteered their services at LRMC.

Although the experience at Landstuhl was both educational and fulfilling for the civilian surgeons, many of us felt that we were missing the “front end” of care being delivered in the combat zone. We wanted to understand more fully the challenges of working in combat support hospitals and gain experience in the initial treatment of these often devastating injuries. I was recently offered the incredible opportunity to visit the Air Force’s 332nd Air Expeditionary Wing (AEW) Theater Hospital located at Balad Air Base in Iraq. While I prepared for this adventure, I formulated the following list of my objectives for taking this step:

1. To assist in codifying the important trauma surgical lessons learned during the current conflict in order to preserve them for future conflicts
2. To identify areas that might benefit from collaborative research involving both military and civilian trauma research groups


3. To provide consultation for the continued development of the military trauma system
4. To foster the educational process needed to translate the lessons learned in Operation Iraqi Freedom and Operation Enduring Freedom to civilian trauma care both for daily use and in preparation for mass casualties and disasters
5. To explore the potential development of programs whereby civilian trauma surgeons might provide assistance to our military surgical colleagues

2008 Joint Theater Conference

One of the initial goals of our mission to Iraq was to participate in the Joint Theater Trauma System (JTTS) Chief Conference, The Continuum of Trauma Care in the Matured U.S. Central Command/European Command Areas of Responsibility. I was honored to be accompanied on the entire trip by Col. Donald Jenkins (USAF), MD, FACS, who met me in Germany, assured that I got through all checkpoints en route to Iraq, and attended to my security at every level. We were both invited to present at

Recent publications describing military treatment modalities

this inaugural trauma conference, facilitated by Col. George Costanzo (USAF), who was at that time serving as the director of the JTTS. Surgeons from the various echelons of care, from far forward surgical units to the combat support hospitals throughout Iraq, attended the conference and presented their experience in treating various injuries and the challenges of dealing with the ebb and flow of patient care demands. The formal educational portion of the conference highlighted some of the developments in combat casualty care that are clearly contributing to the low fatality rate in this war. Although a discussion of these treatment modalities is beyond the scope of this article, they are well described in recent publications (see boxed item, page 18) and can be summarized as follows:

- Renewed use and redesign of tourniquets that can be self-applied
- Use of innovative hemostatic dressings for open wounds
- Adoption of a massive transfusion protocol that advocates for more liberal use of freshly frozen plasma and platelets along with packed red cells (so-called damage control resuscitation)
- Use of point-of-care thromboelastogram results to guide transfusion practice
- Recognition of the advantages of using fresh whole blood
- Use of the procoagulant-activated factor VII early in patients requiring massive transfusions
- Aggressive use of vascular shunts for temporary control of vascular injuries
- Development of endovascular capabilities in combat support hospitals
- Guidance of burn resuscitation using a standardized clinical practice guideline algorithm that travels with the patient
- Adoption of damage control strategies for abdominal, vascular, and orthopaedic injuries
- Screening for symptoms of minimal brain injury in all injured troops
- Redesign of personal protective gear

**THE JTTS**

Care of the injured in Iraq and Afghanistan begins at the site of wounding with self-aid and buddy care. Further care in the field may be rendered by the combat medic as dictated by the guidelines promulgated by the Committee for Tactical Combat Casualty Care. When appropriate, or if nearby, the casualty may be moved to a forward operating base and the battalion aid station (Level II), where field medics initiate additional first aid for the wounded. Forward surgical teams are located in many locations throughout the theater and are designated as level IIB facilities, capable of conducting life and limb stabilization in far-forward and austere conditions. The patient is then transferred via helicopter to the combat surgical support hospitals (Balad and Baghdad in Iraq). These facilities are designated as level III facilities and

![Figure](image-url)
have more complete surgical teams, including surgical specialists and intensive care unit (ICU) facilities. The current level III centers in the theater may be roughly equated as civilian level II trauma centers in the U.S. The surgical care at the combat support hospitals is intended to be more definitive. Following stabilization within the theater, the patients are evacuated to the level IV facility at LRMC via the Air Force aeromedical evacuation system. The level V facilities are the military trauma receiving hospitals in the U.S (see Figure, page 19).

This complex trauma system is coordinated by a number of measures. Leadership is provided by the JTTS director, who oversees all echelons of care throughout Iraq and Afghanistan. The second important component is the joint patient tracking application, the Web-based system allowing entry of patient data at each level of care. There are also trauma program managers at various locations in the theater system who supply the initial entries into the joint theater trauma registry, a robust trauma database that now contains data on several thousand injured troops and into which data are entered at each level of care. Research personnel have also been deployed into theater hospitals. The very timely performance improvement process is facilitated by the weekly clinical video teleconference, which connects the medical units in Iraq and Afghanistan by audio to LRMC and Walter Reed and to the U.S. Army facilities in San Antonio (audio and visual) during which individual patients are discussed and their care reviewed at every level. This coordinated process has also resulted in the development of a number of trauma clinical practice guidelines that are considered standards of care within the theater trauma system, including prophylaxis for venous thromboembolic complications, antibiotic use, prevention of hypothermia, and the management of specific injuries such as burns, vascular trauma, and traumatic brain injuries. This highly functional trauma system is truly remarkable when one considers that it was largely developed and refined during the war.


**The trauma experience at Balad**

During the second part of my visit, I was able to integrate myself into the surgical team and participate as much as possible in patient care and in the operating room at the 332nd AEW hospital. This hospital serves not only as a level III combat support facility but also as the primary collection point for casualties requiring evacuation out of theater. The initial configuration of the hospital consisted of more than 30 interlinked tents, but in 2007, the 332nd moved into a new fixed facility (see photos, page 21). The hospital consists of an emergency department, four operating rooms, an ICU, and a large surgical ward (see photos, pages 22-23). There are also limited outpatient facilities, a well-stocked blood bank, advanced imaging capabilities, and a clinical laboratory. The majority of patients arrive by helicopters that land just outside the emergency department. From the desk in the emergency department, one can stand and see the entire room and observe all activities, which is an advantage during mass casuality situations. The week before my arrival, the hospital received 32 casualties during the course of 90 minutes, victims of a suicide bomber in a market. The teams divide themselves efficiently among the casualties, blood and plasma is delivered promptly, laboratory results are back within minutes, and ultrasound units for FAST (Focused Assessment by Sonography in Trauma) exams are readily available. There are two multidetector CT scanners just off the main room and immediately available, as is the radiologist.

The surgical team at the time of my visit consisted of eight general surgeons (two of whom were also vascular surgeons and two trained thoracic surgeons), two orthopaedic surgeons, two oral-maxillofacial surgeons, two neurosurgeons, one ear-nose-throat surgeon, one urologist, and two ophthalmologists. The team is supplemented by emergency physicians, internists, physician assistants, nurses, and anesthesiologists. There are four operating rooms that are fully staffed seven days a week. A “normal” daily schedule consists of somewhere between 12 to 15 semi-elective cases on patients already in the hospital; however, rooms are always ready to provide immediate care to the incoming injured and it
The original 332nd as a series of tents (top), and the newer hospital with Kevlar protective roof over a solid structure.
is not unusual to have two patients being operated upon simultaneously in the same operating room theater.

The ICU is an open unit with beds separated only by curtains. Most of the patients in the ICU are host nationals (Iraqi civilians, Iraqi military, contractors, and so on). The U.S. troops are evacuated to LRMC in Germany usually within 24 hours of their arrival if their condition permits (see photo, page 24). This open ICU presents multiple challenges, including the need to meet the care of men, women, and children alike. The difficulties in maintaining precautions against nosocomial infections are evident when walking through such a busy facility located in the middle of an austere and warm environment. An additional clinical challenge is the state of malnourishment of many Iraqi patients, affecting their ability to heal these large, high-energy combat wounds. Provision of total parenteral nutrition is limited by severe infectious complications and the use of enteral nutrition is often limited by open abdomens, enteric fistulae, or intra-abdominal infections. An additional challenge faced by the military medics is the provision of ongoing care for the patients who are Iraqi nationals. The current state of the medical care in Iraq is very austere and limited even in the most rudimentary components of health care. This became most apparent in the process of discharge planning, as the military medics attempted to return their Iraqi patients into a health care system vastly different than the standards most U.S. physicians are accustomed
to. Sadly, the media have directed little attention to the humanitarian side of the mission in the Middle East, especially by our deployed medical personnel.

On my first day on-call, we received several civilians injured by gunfire. Two were very young children who had sustained gunshot wounds to the head. They were examined, intubated, and had lines established and CT scans performed (and read by the radiologist and the neurosurgeons), and both children were taken to the operating room where two craniotomies were initiated side by side by two neurosurgeons within 20 minutes of arrival. Most U.S. trauma centers would find this scenario very difficult to replicate.

During my short stay in Balad, in addition to a craniotomy, I participated in several wound debridements, abdominal reexplorations, fasciotomies, vascular repairs, amputations, and a thoracotomy. The wounds encountered in this combat environment are significantly different than those common in civilian trauma care. The majority of injuries are related to either high-energy missile wounds (AK-17, M-16) or to blast injuries (improvised explosive device, mortar rounds, explosive formed projectiles, and so on).

The extent and scope of injuries normally include multiple sites, soft tissue as well as orthopaedic injuries, often with concomitant vascular compromise. The appropriate trauma evaluation of these patients includes a thorough examination of all areas of the body and must take into consideration both blunt and penetrating mechanisms of force transmission. The variety and the size of objects removed from wounds as the result of explosive devices are unlike anything seen in our country.

My last day at the 332nd was the hardest. A U.S. soldier was brought in with four tourniquets in place after a devastating explosive injury. He was in profound shock and taken directly to the operating room where four surgical teams assembled around his four limbs as well as his neck, where he had an obvious penetrating injury. Unfortunately, the patient expired (one of the few deaths in this operating room, which is remarkable in itself). Nearly the entire hospital staff immediately assembled for prayers and for the draping of the American flag over his body (Patriot’s Detail). That night, all the surgeons involved in this case met in the “lounge” on the rooftop of the hospital (affectionately referred to as “OR #5”) and discussed the case and what
might have been done differently. This was truly a unique mortality conference and, taken together with the weekly video-teleconference described previously in this article, can serve as an excellent model for civilian trauma centers.

**CCATTs: Critical care in the air**

Another unique experience was my ability to observe the transport of injured troops from Iraq to Landstuhl and then from Landstuhl to Andrews Air Base under the care of the Air Force Critical Care Air Transport Teams (CCATT). The transport of critically ill patients and all the needed equipment—including ventilators, pumps, medications, nutrition, monitors, and so forth—is an art in itself, and loading it all into the back of these huge cargo planes without incident in the dark of night in the middle of the desert is like a well-orchestrated dance. Patients with less severe injuries (typically heading for ward care at LRMC or Walter Reed) are loaded first, to be attended by nurses and medical technicians. (These planes can transport as many as 50 patients at a time.) The back of the plane is reserved for the intensive care patients, each of whom has his or her own CCATT team. Each team consists of a critical care physician (surgeon, emergency physician, anesthesiologist, cardiologist, and so on), an ICU-qualified nurse, and a respiratory therapist. During the flight, blood gases are monitored, as are electrolytes using point-of-care technology; nutritional support is continued; and narcotics and sedatives are administered as needed. The plane is cold and noisy, and the monitor alarms must be visible because they cannot be heard above the background noise of the jet engines. Despite these challenges, this ICU in the air is highly effective and has provided safe transport for stabilized (though not necessarily stable) critically injured troops with the goal of getting them back to the U.S. as soon as possible. It serves as an excellent model of an evacuation process that might be used during a natural or man-made disaster.

**Directives for ACS Fellows**

For the Fellows of the American College of Surgeons who are not current members of the military, what can we do to provide support and
assistance to our deployed military colleagues? I would submit the following directives:

1. We need to critically and scientifically evaluate the lessons learned by the military surgeons during this conflict and be cognizant of situations where we can apply them in civilian trauma care.

2. As many of the senior military surgeons will be separated from their respective military posts before the next conflict, we must assist them in developing a “repository” for these important lessons, so that they can be passed on to the next generation of military medics.

3. We should continue to work with the military toward the goal of developing a worldwide military trauma system, using the ACS COT Verification and Systems Consultation Committees.

4. We should consider innovative programs that would allow civilian surgeons to fill posts now occupied by military physicians. For example, civilian surgeons could work at Veterans Affairs Hospitals, military hospitals in the U.S., or (after proper training) fly CCATT missions from LRMC to Andrews in order to relieve our military colleagues. Perhaps these nondeployable positions could be filled by recent graduates of surgical and specialty residency programs as a method of paying back medical school debt.

5. Finally, we have an obligation to assist in the humanitarian medical efforts in a stabilized Middle East.

**Honor and Privilege**

It has been a distinct honor and a privilege for me to have been given such an up-close and personal view of this highly organized and successful trauma care system put in place by the U.S. military. For those readers who have loved ones deployed in Iraq or Afghanistan, be assured that, should they be injured, they will receive trauma care that is unsurpassed by any trauma system here in the U.S. My time at LRMC and at the 332nd have been life-changing for me, both personally and professionally, and I look forward to a continued association with my military colleagues as we work together toward establishment of a worldwide military trauma system. For no matter what your views are on this war or any war, we owe our brave soldiers, airmen, sailors, and marines the very best trauma care that we can deliver. In addition, we owe the patients in our trauma centers at home the chance to benefit from the scientific discoveries coming out of this conflict—that is, after all, our obligation as surgeons.

**Acknowledgments**

I owe special thanks to those who facilitated my trip to Iraq, including Col. Bryan Funke; Col. Jay Johannigman, MD, FACS; Col. Donald Jenkins, MD, FACS; Col. Bryan Gamble; Col. George Costanzo; and Col. Lee Payne. I would also like to acknowledge the members of the Balad Association of Doctors Anaconda Surgical Society who are superb surgeons, dedicated physicians, and exemplary individuals.

It was a privilege to work with everyone, including Dr. Johannigman; Joshua Alley, MD; Carl Baker, MD; Nabil Habib, MD, FACS; Solon Hughes, MD, FACS; Todd Rasmussen, MD, FACS; Jay Sampson, MD, FACS; and Scott Davidson, MD.
The State Affairs area of the College’s Division of Advocacy and Health Policy is responsible for monitoring and tracking legislation at the state level. From January to August 2008, more than 85,000 bills had been introduced in state legislatures across the country; this is approximately half the number of bills introduced by this time last year. This difference exists, in large part, because 2008 is an election year. Election years, especially presidential election years, are traditionally “slower,” legislatively speaking.

Because there are so many bills with so many health-related topics introduced in state legislatures, it is important to focus the College’s State Affairs resources. This year, the Health Policy Steering Committee directed State Affairs to focus on the following five primary issues:

- Medical liability reform
- Trauma
- Uniform Accident and Policy Provision Repeal (UPPL)
- The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)
- Scope of practice issues

However, there are issues beyond these categories that are brought to the attention of State Affairs by individual surgeons or chapters of the College. In those cases, staff may provide advice and resources on the best way to deal with the state legislation or regulation under consideration. These issues include health system reform, provider taxes, office-based surgery/ambulatory surgery regulation, imaging restrictions, licensure/maintenance of licensure, and laser surgery regulation, among others.

During 2008, State Affairs monitored more than 145 bills in 35 states through use of an online legislative and regulatory search service. The following bills are a representative sample of the types of legislation that was monitored.

Medical liability reform

Because of a number of factors, the last few years have seen a significant decrease in the number of bills dealing with large-scale reforms related to the Medical Injury Compensation Reform Act. The decrease is largely the result of the cap on noneconomic damages that now exists in more than 30 states and because many states have enacted other significant reforms. The states without reforms have political climates that are unfavorable to this type of legislation or constitutional barriers. Once again this year, most of the legislation related to liability was defensive, with many of these battles taking place not at the statehouse but in the courts.

One state that has continued to fight for a legislative solution to its liability crisis is Tennessee. This year, Tennes-
see passed S.B. 2001/H.B. 1993. These bills were introduced in 2007 and were signed by Gov. Phil Bredesen (D) in May 2008; they will go into effect October 1, 2008.

The bills originally included reforms such as a $250,000 stacked cap on noneconomic damages (maximum $500,000, with $250,000 for physicians and $250,000 for facilities per incident); a sliding scale for attorneys’ fees; affidavit of merit requirements; and periodic payment for damages exceeding $75,000. All of these reforms were deleted from the bill, which was amended and passed to include only the requirement of a Certificate of Good Faith before a claim may be filed (and 60 days notice before the claim is filed) and to provide for sanctions against any attorney found to be violating the notion of a “good faith” case.

Illustrating the role of the judiciary in medical liability reform, the caps on damages established in Illinois and Georgia are being challenged in the courts.

In Georgia, a state court ruled that the $350,000 cap on noneconomic damages (passed in 2005) violates the state’s equal protection principles. The Georgia Supreme Court has agreed to hear the case, although no hearing date had been set at press time (Parks v. Wellstar, Case #2007CV135208).

A case challenging the $500,000 cap in Illinois is currently being heard in the state’s Supreme Court. In this case, a Cook County Circuit Court originally ruled in November 2007 that the cap was unconstitutional because it violated the separation of powers clause. A ruling is not expected in this case until at least the middle of this month (Lebron v. Gottlieb Memorial Hospital).

Although caps are not at issue in this case, a very important battle is being fought in the Florida court system. In November 2004, Florida voters passed several constitutional amendments. Amendment Seven (also known as the “Patient’s Right to Know about Adverse Medical Incidents”) allowed for open medical records and required the release of records related to any adverse incidents that could have led to patient harm. Because of concerns that this amendment might violate the federal Health Insurance Portability and Accountability Act (HIPAA) and adversely affect the peer review process, the Florida legislature passed S.B. 938 in 2005. This bill placed restrictions on who could view the records and what information the records would contain in order to comply with HIPAA, while still allowing for peer review. The legislature also determined that the amendment did not apply to records created or incidents occurring before Amendment Seven was adopted.

The Florida Supreme Court recently issued an opinion on two cases involving Amendment Seven and the subsequent clean-up language included in S.B. 938. The court ruled that Amendment Seven is self-executing and retroactive and its provisions apply to records existing before its passage. Essentially this ruling makes any information—even information documented before the bill’s passage—not only discoverable but also admissible in court.

The Florida Chapter of the College is working with other members of the Florida medical community on this matter. (To read the full court opinion, visit http://www.floridasupremecourt.org/decisions/2008/sc06-688.pdf.)

Trauma

System development

Two more states, Kentucky and South Dakota, passed legislation this year that creates a legislatively recognized “trauma system.”

In mid-March 2008, South Dakota’s Gov. M. Michael Rounds (R) signed S.B. 200, which establishes a statewide trauma network. This legislation directs the Department of Public Health, along with the Department of Public Safety, to develop, implement, and administer a trauma care system. The Department of Public Health is still working on the rules, and public hearings will be held once the draft rules are published. The legislation mandates that the rules include the following:

• Designation of the levels of trauma hospitals and the resources each hospital is required to have concerning personnel, equipment, data collection, and organizational capacity for each level
• Prehospital emergency medical services triage and treatment protocols for trauma patients
• Requirements for collection and release of trauma registry data

The South Dakota legislation does not allocate
any special funds for the development or maintenance of the system; rather, the funds are coming from the Department of Public Health’s budget.

The Kentucky legislature enacted H.B. 371 to establish a statewide trauma system. H.B. 371 creates an advisory committee that will work with the statewide trauma care director to develop and implement a statewide trauma care system. This system must include (but is not limited to) development of guidelines and protocols, voluntary hospital trauma center verification (either by the ACS or the Department of Public Health), and local and regional triage and transport protocols.2

This legislation also creates a trauma care system fund that is a restricted account of state general fund appropriations. Other grants and any money left in the fund at the end of the year will carry over to the following year. The fund shall be used to pay for several things, including “support for uncompensated care...in a verified trauma center.”3

**Funding**

Mississippi passed H.B. 1405, which is expected to generate approximately $32 million for the state’s trauma system. The money generated by H.B. 1405 comes primarily from additional fines on speeding violations. The fines start at $10 and go up to an additional $30 for speeding. The legislation also includes a $4 fee on each set of license plate tags and an additional $10 for each reckless and/or careless driving offense.

The bill also creates an escrow account and mandates that whenever the trauma fund exceeds $25 million, the remaining funds will be transferred to the escrow account and not be returned to the general revenue fund.

**Injury prevention**

A record number of surgeons used the College’s Surgery State Legislative Action Center at the end of July, with more than 200 letters sent to legislators asking them to support S. 2772. This legislation would have provided important and reasonable regulation of all-terrain vehicles (ATVs) operated by minors and would have addressed concerns related to recreational use of ATVs by those in the age range of 14 to 16 years and would have prohibited operation by individuals younger than 14.

The bill was stalled in the Ways and Means Committee and was released on July 31, the last day of the session, with a recommendation for passage. The bill was read at midnight, and two unfriendly amendments were added. (One of the amendments removed the age restriction.) The bill was then pulled by the Speaker before debate could be heard. The session ended without the bill being passed. The Massachusetts Chapter is committed to passing this type of legislation in 2009.

**Repeal of the UPPL**

UPPL is the state law that allows health insurers to deny reimbursement for services provided to patients for injuries incurred when an accident is a result of “the insured’s being intoxicated or under the influence of any narcotic.”4

California had passed UPPL repeal legislation for the last several years, only to have it vetoed by Gov. Arnold Schwarzenegger (R). In 2007, UPPL repeal was included in A.B. 1461, a bill to create a pilot project regarding methamphetamine intervention. In 2008, the bill was amended; the pilot project was stricken, leaving only the UPPL repeal. As of press time, the bill has been agreed upon by both chambers and will be presented to the Governor.

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**States that prohibit insurers from denying coverage**


**States that never enacted UPPL**

(However, courts have ruled that insurance companies can use alcohol/drug exclusions in states that are silent on Alcohol Exclusion Laws)

Massachusetts, Michigan, Minnesota, New Mexico, New Hampshire, Oklahoma, Utah, Vermont (repealed the explicit law but never enacted prohibitions), and Wisconsin
After several years of trying, New York State also passed the UPPLP repeal; unlike standard UPPLP repeal legislation, however, A.B. 10000 only applies to automobile insurance policies, which, in New York, is the primary payor after a crash.

Tennessee, which does not prohibit these exclusions, saw a pair of bills (H.B. 2875/S.B. 3043) introduced in 2008 that would require health care providers to notify law enforcement officers at the hospital if results of tests performed on the driver of a vehicle involved in a collision indicate that the driver had a .08 percent blood alcohol content or was under the influence of drugs. Neither of these bills had any real momentum and both died upon adjournment; this type of legislation is new to the ACS, and the organization will continue to monitor the situation.

The UEVHPA

A new priority for State Affairs is the UEVHPA, which was created in 2006 and modified in 2007 by the Uniform Law Commission; six states have already adopted this legislation: Colorado, Indiana, Kentucky, New Mexico, Tennessee, and Utah.

The Uniform Law Commission (formerly known as the National Conference of Commissioners on Uniform State Laws) is a nonpartisan organization devoted since 1892 to working toward the development and enactment of uniform state laws. The purpose of the UEVHPA is to allow state governments to give reciprocity to other states licenses who are emergency services providers so that covered individuals may provide services without meeting the licensing requirements of state experiencing a disaster. It recognizes a national registration system used to confirm that physicians and health care practitioners are appropriately licensed and in good standing in their respective states, with their licenses recognized in affected states for the duration of emergency declarations.

The term “health care provider” is defined very broadly in this legislation and includes nurses, pharmacists, morticians, and veterinarians, which helps to create a large and diverse coalition of supporters.

In 2007, the model bill was modified to include liability protections. The model legislation includes two options from which a sponsor may choose:

In Alternative ‘A,’ a volunteer health practitioner is not liable… unless the conduct in question rises to the level of willful misconduct, or wanton, grossly negligent, reckless, or criminal conduct…. Alternative ‘B’ utilizes the same basic exclusions, but caps the compensation a volunteer can receive in connection with the emergency (not including reimbursement of reasonable expenses) at $500 per year, and does not include the limitation on vicarious liability.

A third, “unofficial” option is to simply refer to the state’s current Good Samaritan Laws.

In 2008, a dozen states introduced UEVHPA: Hawaii, Illinois, Indiana, Louisiana, Maryland, Minneapolis, Mississippi, New Mexico, Oklahoma, Pennsylvania, Utah, and Vermont. Only Indiana, New Mexico, and Utah passed the legislation. This legislation is expected to be introduced in at least a dozen states in 2009.

Scope of practice

The physician community scored a big win in Texas in 2008—the Texas Third Court of Appeals ruled that the Texas State Board of Podiatric Medical Examiners went outside its scope when it adopted a rule that expanded the definition of the foot to include the bones in the ankle.* The court made this decision, in part, because in the expanded definition,

...many of the soft tissues included in this definition are not part of the foot or even the ankle. For example, various nerves ending in the foot—including

*The definition of the foot as originally proposed by the Texas State Board of Podiatric Medical Examiners:

The foot is the tibia and fibula in their articulation with the talus, and all bones to the toes, inclusive of all soft tissues (muscles, nerves, vascular structures, tendons, ligaments and any other anatomical structures) that insert into the tibia and fibula in their articulation with the talus and all bones to the toes.

Texas Orthopaedic Association, Texas Medical Association and Andrew M. Kant, MD v. Texas State Board of Podiatric Medical Examiners, Texas Podiatric Medical Association, and Bruce A. Scudder, DPM. Source: http://www.3rdcoa.courts.state.tx.us/opinions/HTMLOpinion.asp?OpinionID=16860.
the tibial nerve, the peroneal nerve, and the sural nerve—run along significant portions of the leg before reaching a termination point in the foot.... Similarly, several veins and arteries—including the saphenous vein and the tibial artery and vein—also end in the foot after having traversed significant portions of the leg.... In fact, one of the nerves and one of the veins previously mentioned run along the entire length of the leg.5

In 2007, the College formally joined the Steering Committee of the American Medical Association Scope of Practice Partnership (SOPP). In 2008, the SOPP awarded several grants to both state medical societies and state specialty societies to fight scope battles in their states. In each state where grants have been awarded there have been physician victories.

Provider taxes

The Maryland medical community came together on March 12, to testify in opposition to H.B. 614. This bill would have imposed a 6 percent sales tax on certain elective cosmetic procedures performed in the state unless they are determined to be medically necessary. As introduced, the procedures included gastric bypass surgery, breast reduction or augmentation, teeth whitening, laser eye surgery, rhinoplasty, facelift, liposuction, laser hair removal, tattooing, or body piercing.

Surgeons at the hearing spoke about the failure of New Jersey’s cosmetic surgery tax to raise projected revenues for that state and emphasized the complexity of determining medical necessity for many cosmetic procedures. After much testimony, the bill was held in committee.

Certificate of Need

In April, after years of grassroots advocacy on the legislative, regulatory, and judicial fronts, Georgia surgeons who fought to have general surgery defined as a single specialty finally achieved victory in the General Assembly. A certificate of need (CON) reform bill, S.B. 433, contained language that recognizes general surgery as a single specialty eligible for the exemption from the CON process for ambulatory surgery centers.

The Georgia House passed the bill 138–17, and the Senate quickly followed suit with a 44–7 vote on April 5, the last day of the state’s 2008 legislative session. Gov. Sonny Perdue (R) signed the bill into law on April 9. (For more information about this legislation, go to http://www legis. ga.gov/legis/2007_08/sum/sb433.htm.)

A final reminder

The State Affairs staff in the Division of Advocacy and Health Policy is always available to surgeons and ACS chapters when a legislative or regulatory issue arises. For more information on state legislative issues or to discuss a particular impending state bill or regulation, contact Melinda Baker at 312/202-5363 or mbaker@facs.org.

References

5. Frank H. Netter, MD, Atlas of Human Anatomy 482, 483, 485, 504 (2nd ed. 1997) as cited by: Texas Orthopaedic Association, Texas Medical Association and Andrew M Kant, MD v. Texas State Board of Podiatric Medical Examiners, Texas Podiatric Medical Association, and Bruce A. Scuddy, DPM.
Socioeconomic tips

ACS Coding Hotline: Cholecystectomy questions
by Linda Barney, MD, FACS; Albert Bothe, Jr., MD, FACS; and Debra Mariani, CPC, Practice Affairs Associate, Division of Advocacy and Health Policy

This column lists some frequently asked questions regarding Current Procedural Terminology (CPT)* recently posed to the ACS Coding Hotline and the responses. As a benefit of membership in the College, ACS members and their staff may consult the hotline 10 times annually without charge. If your office has coding questions, contact the Coding Hotline at 800/227-7911 between 8:00 am and 6:00 pm Mountain Time, holidays excluded.

The surgeon performed an open cholecystectomy with cholangiography. When the procedure was done, there was a fistula into the colon, so he repaired the colon. We are coding this surgery with code 47605, Cholecystectomy; with cholangiography, and code 44604, Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy. The diagnosis for the cholecystectomy was stones. Should the surgeon give the diagnosis of fistula in gallbladder?

The use of the two CPT codes is correct. The International Classification of Diseases, Ninth Revision (ICD-9), diagnosis for the gallbladder problem is 574.00. The fistula should have a diagnosis of 575.5.

The surgeon performed a laparoscopic cholecystectomy with removal of a common bile duct lymph node. Do I also code 38747, Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (list separately in addition to code for primary procedure)?

Code for the cholecystectomy using 47652, Laparoscopy, surgical; cholecystectomy. There is no extra coding for removal of the common bile duct lymph node.

The procedures dictated in the operative note are cholecystectomy with choledochoenterostomy and a gastrojejunostomy. In the note, the surgeon stated that the gastrojejunostomy was performed 30 cm away from where the choledochoenterostomy was completed. Which codes should be used?

The codes for this surgery would be 47612, Cholecystectomy with exploration of common duct; with choledochoenterostomy, and 43820, Gastrojejunostomy; without vagotomy.

The surgeon planned a laparoscopic cholecystectomy but encountered problems that necessitated switching to an open procedure. The surgeon also did a partial...
should report the open procedure code only. You can use the code V64.41, Laparoscopic surgical procedure converted to open procedure, to show the conversion to open procedure.

The patient underwent a laparoscopic cholecystectomy, but the surgeon also did an open cholangiogram. How would I code these two procedures?

The cholecystectomy code that includes the cholangiogram is 47563. Code the laparoscopic code, 47563, Laparoscopy, surgical; cholecystectomy with cholangiography, with the –22 modifier (Increased Procedural Services) to indicate that the cholangiography was done as an open procedure and include a detailed description of the situation in the operative note.

The patient had a laparoscopic cholecystectomy, 47563, and within the global period (90 days) of this procedure was taken back to the operating room for a Whipple procedure, 48150. The surgeon is also coding the +44015, Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (list separately in addition to primary procedure), and placed the –79 modifier on both of these codes. Is this the correct coding?

Coding the 48150, Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatic-jejunostomy, with the –79 modifier (Unrelated procedure or service by the same physician during the postoperative period) is correct. Add-on codes are exempt from modifiers so the –79 modifier is not necessary with +44015. Guidelines for add-on codes can be found in the Introduction of the Professional Edition of the CPT.

Dr. Barney is associate professor and associate program director for general surgery, department of surgery, Wright State University Boonshoft School of Medicine, and member, Wright State Surgeons, Miami Valley Hospital, Dayton, OH.

Dr. Bothe is chief quality officer, Geisinger Health System, Danville, PA.

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PEG tube coding tips

- If the surgeon replaces the percutaneous endoscopic gastrostomy (PEG) tube because of clogging or other factors, code 43760, Change of gastrostomy tube, if there is no image guidance.
- If the surgeon performs a replacement of gastrostomy or jejunostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injections(s), image documentation and report, use 49450.
- If the surgeon encounters a problem replacing the PEG tube and uses endoscopy to determine the problem and assist in the tube removal, it would be appropriate to code a diagnostic endoscopy code and 43760, Change of gastrostomy tube.
- You cannot report a separate code for simple PEG tube removal. Use the appropriate evaluation and management codes. Removing a PEG does not qualify as foreign body removal, so 43247, Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body would not be appropriate. Only use code 43247 if a scope is used to retrieve a broken portion of a PEG tube that remains in the stomach.
John L. Cameron, MD, FACS, a general and thoracic surgeon who specializes in treatment of alimentary diseases, was installed as the 89th President of the American College of Surgeons during Convocation ceremonies that preceded the official opening of the College’s 94th annual Clinical Congress in San Francisco, CA, in October. Dr. Cameron is the Alfred Blalock Distinguished Service Professor of Surgery at The Johns Hopkins University School of Medicine, Baltimore, MD.

Dr. Cameron received a bachelor of arts degree from Harvard University, Cambridge, MA (1958), and earned a medical degree from Johns Hopkins University School of Medicine (1962). He served a surgical internship at Johns Hopkins (1962–1963) before he began service in the U.S. Army as a research surgeon in the department of surgical metabolism at Walter Reed Army Institute of Research (1963–1965). He returned to Johns Hopkins in 1965, where he completed a surgical residency (1965–1970) and then a clinical and research fellowship (1970–1971) at the Johns Hopkins Hospital.

A Fellow of the American College of Surgeons since 1975, Dr. Cameron has been actively involved in the governance of the College, including serving as Treasurer from 1998 to 2007. Dr. Cameron has also served as a member of the Executive Committee (2006–2007), Board of Regents Honors Committee (2005–present), Investment Subcommittee of the Finance Committee (2002–present), and Finance Committee (1998 to present). In addition, Dr. Cameron served as a senior member of the College’s Committee on Video-Based Education (1980–1990).


Trained in both general and thoracic surgery, Dr. Cameron has devoted his professional life to several significant clinical and research endeavors in alimentary tract diseases, specifically in pancreatic cancer. A leader in alimentary tract surgery, he has operated on more patients with pancreatic cancer and done more Whipple resections than any other surgeon in the world.

His research interests have included randomized clinical trials and clinical outcomes in pancreas surgery as well as basic laboratory research of pancreatic diseases, for which he has received grant support from the National Institutes of Health.

Throughout his distinguished career, Dr. Cameron has exemplified a strong commitment to the dissemination of surgical knowledge. He is the author of several internationally recognized surgical textbooks, including Atlas of Surgery I and II, Atlas of Biliary Tract Surgery, Atlas of Clinical Oncology, and nine editions of Current Surgical Therapy, and the coauthor of Evidence Based Surgery, written with Toby A. Gordon, ScD. Moreover, Dr. Cameron has served as the author or coauthor of 99 chapters in surgical textbooks and 384
clinical and research articles published in the medical literature. He has also contributed to the surgical profession through his work as a member of the editorial boards of the following journals: Journal of the American College of Surgeons, Surgery, Journal of Hepato-Biliary-Pancreatic Surgery, Digestive Diseases and Sciences, Asian Journal of Surgery, and The American Surgeon. He currently is the editor-in-chief of the Journal of Gastrointestinal Surgery and Advances in Surgery.

Dr. Cameron currently resides in Ruxton, MD, with his wife Doris Mae. They have two daughters, Heather and Shannon, and two sons, Duncan and Andrew.

Honorary Fellowships presented to five prominent surgeons

Honorary Fellowship in the American College of Surgeons was awarded to the following five prominent surgeons from Belgium, Brazil, Ireland, United Kingdom, and Australia during Convocation ceremonies at this year’s Clinical Congress in San Francisco, CA:

• Jacques Brotchi, MD, PhD. Dr. Brotchi is president of the World Federation of Neurosurgical Societies and emeritus professor and honorary chairman, department of neurosurgery, Erasme Hospital, University of Brussels, Brussels, Belgium.

• Joaquim Gama-Rodrigues, MD, FACS. Dr. Gama-Rodrigues is director of gastrointestinal surgery and gastroenterology, Hospital Alemão Oswaldo Cruz and Hospital da Beneficência Portuguesa, Sao Paulo, Brazil.

• Gerald C. O’Sullivan, MB, BCh, FACS, FRCSGlas, FRCSI. Dr. O’Sullivan is the immediate past-president, Royal College of Surgeons of Ireland (Dublin); lecturer and professor of surgery, University College, Cork; director, Cork Cancer Research Centre, Cork; and consultant surgeon, Mercy University Hospital, Cork, Ireland.

• Bernard F. Ribeiro, CBE, FRCSEng, FRCPEng. Mr. Ribeiro is a past-president of the Royal College of Surgeons of England; senior lecturer, Middlesex Hospital, London; and director, undergraduate teaching for surgery, University College, London, United Kingdom.

• Russell W. Strong, MB, BCh, FACS, FRCSEd(Hon), F R A C S , F R C S E n g , FRACDS. Dr. Strong is emeritus professor, surgical specialties, Princess Alexandria Hospital, Brisbane, Australia.

Presenting the Honorary Fellowships on behalf of the College were Fernando G. Diaz, MD, FACS, Southfield, MI; Carlos A. Pellegrini, MD, FACS, Seattle, WA; Tom R. DeMeester, MD, FACS, Los Angeles, CA; George F. Shelden, MD, FACS, FRCSEd(Hon), FRCSEng(Hon), Chapel Hill, NC; and L. D. Britt, MD, FACS, Norfolk, VA.

This year, 1,189 surgeons from around the world were admitted into Fellowship during the College’s Convocation ceremonies.

Sir Rickman Godlee, President of the Royal College of Surgeons of England, was awarded the first Honorary Fellowship in the College during the College’s first Convocation in 1913. Since then, 413 internationally prominent surgeons, including the five chosen this year, have been named Honorary Fellows of the American College of Surgeons.

Following are the citations presented during the Convocation.
Mr. President, it is my honor to introduce Prof. Jacques Brotchi of Brussels, Belgium, for Honorary Fellowship in the American College of Surgeons.

Professor Brotchi was born in Liège in 1942 during the Second World War. After graduating in medicine (MD) from the State University of Liège in 1967, Professor Brotchi completed his training in neurosurgery with Prof. J. Bonnal in the same university, where he also invested in basic research in the Neuroanatomy Laboratory (under Prof. M.A. Gerebtzoff). Then, in 1982, he moved from Liège to Brussels, where he created the department of neurosurgery at Erasme University Hospital.

Head of the department since 1982, full professor and chairman at the Free University of Brussels (ULB) since 1984, he was also director of the ULB laboratory of experimental neurosurgery until September 1 of this year, when he became honorary chairman and emeritus professor. He continues his surgical activity as a consultant-neurosurgeon in the department.

Professor Brotchi has published more than 350 papers in international journals, with special emphasis on meningiomas and surgical approaches of pineal lesions and almost intraspinal cord tumors. He has stimulated many works in his department with a special interest on the use of positron emission tomography (PET) scan combined with neurosurgery—PET-guided stereotactic biopsies; PET-guided neuronavigation; and, thereafter, PET-guided gamma knife treatment. He has also equipped his department with magnetic resonance imaging and, before retiring, with a magnetoencephalography.

Deeply involved in educational programs of the World Federation of Neurosurgical Societies (WFNS) since 1991, he is currently president of the WFNS. He has held that position since 2005 and will complete it in 2009.

In 1998, his department was distinguished by the World Health Organization (WHO) and nominated “First Worldwide WHO Collaborating Center for Research and Training in Neurosurgery.” In 2000, he received one of the most prestigious Belgian medical prizes—Scientific Prize, Joseph Maisin-Clinical Biomedical Sciences—within the scientific quinquennial prizes of the National Research Foundation of the period 1996–2000.

A member of the Royal Academy of Medicine of Belgium and of the French Academy of Surgery, Professor Brotchi has been awarded Commandeur de l’Ordre de Leopold of Belgium, Chevalier de la Légion d’Honneur of France, Chevalier of Danneborg Order of Denmark, and Great Commandeur of the Merit Order of Spain.

In 1988, King Baudouin of Belgium ennobled him as knight for his contributions to neurosurgery and Belgium. In 2007, King Albert II of Belgium upgraded him to the rank of baron.

Finally, since 2004, he has been senator of the Royal Kingdom of Belgium and was re-elected in June 2007. His fields of interest are health, medical research, and bioethics. He also has created in the Belgium Senate a Brainstorming Group for Peace in the Middle East that he is chairing.

Jacques Brotchi and his wife Rachel have one daughter, Nathalie, and two grandchildren, Nina and Dylan.
Citation for Prof. Joaquim Gama-Rodrigues

by Carlos A. Pellegrini, MD, FACS

Mr. President, ladies, and gentlemen, thank you for the privilege of introducing Prof. Joaquim Gama-Rodrigues of São Paulo, Brazil, for Honorary Fellowship in the American College of Surgeons.

Gama, as he is known among his friends and colleagues, was born in Cruzeiro, São Paulo, Brazil, and completed his medical studies at the prestigious School of Medicine of the University of São Paulo. It was during his medical school training that he met Renato Locchi—a teacher known for his inspiring intellectual character and discipline—who introduced him to surgical anatomy and awakened in young Gama a desire to become a surgeon. Having emulated the discipline of his teacher and using his own drive, he was quickly singled out by some famous surgeons of the time, such as Arrigo Raia and Correa Neto, who adopted this young student and got him into a surgical residency at the Hospital Das Clinicas of the University of São Paulo. After he completed his training, Gama joined the faculty of his school, where he quickly moved through the ranks to become a full professor of surgery.

Professor Gama-Rodrigues focused his career on surgery of the alimentary tract, with a particular interest in cancer of the digestive tract, eventually becoming director of gastrointestinal surgery and gastroenterology at the Hospital Alemão Oswaldo Cruz, São Paulo. His research focus has been the oncogenesis and oncogenomics and treatment of gastric and colonic cancer. Gama is the principal investigator of the Brazilian Clinical Cancer Genome Project, which was initiated in 2000. The project includes seven collaborating institutions and hospitals throughout the state of São Paulo and the Ludwig Institute for Cancer Research and has developed the largest national cancer genome database.

Professor Gama-Rodrigues’ fascination for molecular biology and his understanding of the genetic mechanisms involved in the carcinogenesis of tumors of the alimentary tract led him to search for new alternatives for screening, diagnosing, staging, and treating cancer. His ability to convince the medical community, hospital administration, and fundraisers of the importance of this effort led to the formation of a state-of-the-art tumor tissue bank.

Gama has a particular passion for education and educational systems. As a member of many local, regional, and national committees and through the role he played in the Postgraduate Commission in Brazil, he has been able to set in place modern systems of education, consolidating graduate and postgraduate education and emphasizing the need for lifelong learning and teamwork. As an educator, he has repeatedly been honored by graduating classes as the Teacher of the Year and has actively participated in formal mentoring of postgraduate students and fellows in the area of gastrointestinal cancer, many of whom now populate the hospitals of Brazil. Because he embraces change and innovation easily, he was instrumental in the adoption of laparoscopy—and, more recently, robotics—in his country and was recognized by the Brazilian Society of Laparoscopic Surgery with its Medal of Honor.

During his long career as a surgeon, he has been particularly concerned about the fate and lack of access to care of the poor and has devoted countless hours to working with groups in safety-net hospitals to improve access to care for these individuals. As his interest in the social aspects of medicine...
and surgery grew, he took additional courses to become a specialist in tropical medicine, a discipline that deals with diseases prevalent in Brazil and thus directly affecting his community. Gama’s interest in public health led him to develop and participate extensively in public health campaigns like anti-smoking and early detection and prevention of gastrointestinal cancer programs. One of those programs, the Colorectal Cancer Screening program, first piloted in the small community of Santa Cruz das Palmeiras, has been so successful that it is now ready for implementation throughout São Paulo, one of the world’s largest metropolises with an estimated population of 20 million. This interest in the health of his community led him to join the Curator Council of the Oncological Center Foundation in São Paulo. Today he holds the position of chairman of the council, which is a state agency for policies in prevention, early detection, and education for cancer management.

Mr. President, it is with great honor that I present to you Prof. Joaquim Gama-Rodrigues—a great surgeon-scientist, a respected teacher, a community leader, and a formidable human being—for Honorary Fellowship in the American College of Surgeons. And may I add, sir, that this is a historic moment for our institution, as Gama is married to Angelita Habr-Gama, who became an Honorary Fellow a few years ago. Thus, this is the first wife/husband team of Honorary Fellows of the American College of Surgeons.

Citation for Prof. Gerald C. O’Sullivan

by Tom R. DeMeester, MD, FACS

Mr. President, it is my privilege and honor to present to you the distinguished Irish surgeon Gerald Christopher O’Sullivan, currently professor of surgery at University College Cork, director-in-chief of the Cork Cancer Research Center, and consultant surgeon at Mercy University Hospital, University College Cork, Cork, Ireland.

Professor O’Sullivan was born in Cork in 1946 where he received his undergraduate and graduate medical education. He was elected into fellowship of the Royal College of Surgeons of Ireland in 1974 and became its president in 2006. In 1975, he traveled to Edmonton, AB, where he received his master of science degree in experimental medicine from the University of Alberta. In 1999, he became a Fellow of the American College of Surgeons.

At the University of Chicago, the late Dr. David Skinner and I had the distinct pleasure of having Dr. O’Sullivan work with us for two years as a research associate, from 1979 to 1981. During that time, Dr. O’Sullivan’s creativity as an investigator and his genetic capacity as a storyteller became known and appreciated by all. Gerry impressed on us the Irish principle that “no good story should remain untold for the lack of a few facts.” The Chicago experience accounted for eight of his first 15 papers—only the beginning of his current voluminous bibliography.

It comes as no surprise that Professor O’Sullivan became the founder and director of the Cork Cancer Research Center, which currently has a staff of 32 people. The center has been fully active for nine years and boasts of activities that focus on the gene therapy of cancer, creative ways to facilitate drug delivery to solid tumors, immune control of cancer, prevention of colon cancer, identification and therapy of bone marrow micrometastasis, and...
the biological behavior of upper gastrointestinal cancers.

Professor O’Sullivan’s clinical interests, as expected, are in surgical oncology with a focus on upper gastrointestinal surgery for benign and malignant disease. Through his research, lectures, writing, and practice, patients and surgeons throughout the world have benefited from his knowledge, expertise, and compassion. For his work, he has been widely recognized nationally and internationally as an outstanding communicator and has delivered more than 11 named lectures. Professor O’Sullivan is president-elect of the European Surgical Association, and he has served with distinction as president of the Royal College of Surgeons in Ireland and the Irish Society of Gastroenterology.

While president of the Royal College of Surgeons in Ireland, Professor O’Sullivan established a surgical training program in 10 countries in East and Central Africa through collaboration with the College of Surgeons of East, Central, and Southern Africa. The development of an intercollegiate structure has provided high-quality surgical training in those countries. He also developed a strategy to enable surgical research by all surgeons in Ireland irrespective of their hospital type or surgical specialty. This strategy involved creation of a network to facilitate collaboration, create an opportunity for intercalated doctoral programs for suitable candidates, and organize a structure to provide, manage, and coordinate generic support.

During his outstanding career, Professor O’Sullivan has been fortunate to have the loving support of his wife, Breda, for 36 years. They have three children—Orla, Gearoid, and Eoghan. It is difficult to fathom that with all he has done he would have spare time, but he does find and cherish time to read extensively and practice armchair philosophy with ever-present guests.

Mr. President, Prof. Gerald O’Sullivan is known and loved by many surgeons and physicians. His investigative studies, creative thinking, and provocative lectures have had a profound impact on Irish, European, and American surgery. He has achieved his objectives with indefatigable energy, innovative thinking, and collaboration with colleagues. He is a most worthy recipient of Honorary Fellowship in the American College of Surgeons.

Citation for Mr. Bernard Ribeiro

by George F. Sheldon, MD, FACS, FRCSEd(Hon), FRCSEng(Hon)

Mr. President, it is my honor to present Mr. Bernard Ribeiro of Hampshire, England, for Honorary Fellowship in the American College of Surgeons.

Mr. Ribeiro is an accomplished international surgeon and is the immediate past-president of the Royal College of Surgeons of England. He follows many previous Royal College presidents in becoming an Honorary Fellow of this College, including our first Honorary Fellow at the founding of the American College of Surgeons in 1913, Sir Rickman Godlee.

Mr. Ribeiro is of British/Ghanaian nationality. His education was at the Dean Close School in Cheltenham (1957–1962) and Middlesex Hospital Medical School (1962–1967). After concluding training, he was appointed consultant surgeon to Basildon Hospital, Essex, where he introduced laparoscopic surgery to the Trust and established an advanced laparoscopic unit that has performed more than 1,000 chole...
cystectomies. His involvement in undergraduate and graduate education was instrumental in forging links with University College London, which contributed to the Trust achieving university status in 2002.

Mr. Ribeiro’s leadership skills were recognized early in his career. He became secretary and then president of the Association of Surgeons of Great Britain and Ireland (ASGBI) in 1991 through 2000. He represented the ASGBI on the Senate of Surgery, an organization of the four surgical colleges and nine specialist associations in Great Britain and Ireland. He was elected to the Council of the Royal College of Surgeons of England in 1998, and he received a fellowship from the Royal College of Surgeons of Edinburgh ad hominem in 2000. In 2004, he was appointed Commander of the Order of the British Empire for services to medicine.

The crowning organizational achievement of Mr. Ribeiro’s career was election in July 2005 to a three-year term as president of The Royal College of Surgeons of England. Continuing the work of his predecessors, he presided over the expansion of the Royal College’s leading historical role in surgical education. The facilities of the Royal College of Surgeons have been expanded, the Hunterian Museum has been remodeled, the education and training facilities have been upgraded, and a policy unit has been established at the headquarters at Lincoln’s Inn Fields. His presidency saw the commencement of the successful Eagle Project, for which the first completed stage is the Wolfson Surgical Skills Laboratory that has bench top clinical skills areas and minimally invasive surgery simulation tools. He also initiated an independent external review of the structure and activities of the Raven Department of Education.

Mr. Ribeiro’s presidency came as the National Health Service (NHS) was undergoing extensive reorganization, which included changes with negative implications for physicians and surgeons in training. The sea change in the format of British education occurred within the context of the NHS program Modernising Medical Careers (MMC). Part of the reorganization included the Medical Training Application Service as a cornerstone of the MMC initiative. Unfortunately, the implementation of the program produced many problems, which included insufficient numbers of advanced training positions. Mr. Ribeiro led the United Kingdom in working constructively but firmly to ensure that patient care would be unaffected and that the flawed recruitment process would not mar the careers of a generation of committed trainees. He successfully secured a significant temporary expansion of ST3 surgical training posts. While so doing, he shared his experience with the international community. The experience of dealing with a shortage of funded training positions in surgery is also occurring in the U.S.

Mr. Ribeiro has led the international community in addressing the problems raised by the European Working Time Directive (EWTD), the equivalent of the Accreditation Council on Graduate Education’s 80 hour workweek requirement. In 2008, he joined the leadership of the American College of Surgeons in presenting testimony on work hours to the Institute of Medicine of the National Academy of Sciences’ Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety panel. He described the impact on surgical education in England and elsewhere in the European Union under the EWTD. The American College of Surgeons has been a beneficiary of his participation in postgraduate programs at the Clinical Congress.

Bernie, as he is known, is a devoted family man. He and his wife, Liz, have one son and three daughters, two of whom are twins. His son Richard and his wife Joanne have given Bernie and Liz their first grandchild. Bernie and Liz have moved recently from Essex to Hampshire, where Liz is overseeing extensive building and renovation. They have a stretch of the River Itchen, where Bernie enjoys his passion for fishing. Another member of the family is a black dog named Meg that Bernie claims is a good retriever, but in reality is a pet.

As president of The Royal College of Surgeons of England, Mr. Bernie Ribeiro will be remembered as the trainees’ advocate, much as his close friend, Claude Organ, MD, FACS (deceased), is remembered as the residents’ president of the American College of Surgeons.
Citation for Prof. Russell W. Strong

by L. D. Britt, MD, FACS

Mr. President, it is my honor to present to you Prof. Russell Walker Strong of Brisbane, Australia, for Honorary Fellowship in the American College of Surgeons.

Professor Strong was born in Lismore, New South Wales. He is currently professor of surgery at the University of Queensland in Brisbane and director of surgery at the Princess Alexandra Hospital. Professor Strong completed his undergraduate medical education at the University of London. He remained in England for his graduate medical training, where he was the senior house surgeon at the Birmingham Accident Hospital, the surgical registrar at the Charing Cross Hospital in London, and the senior surgeon registrar at the Whittington Hospital, London.

Professor Strong moved south to Brisbane to launch his academic career. Starting as a surgical supervisor at the Princess Alexandra Hospital, his rapid ascent in academic surgery was remarkable. Professor Strong was selected to be the James IV Travelling Fellow, which afforded him the opportunity to have intellectual exchange and share his technical expertise with many of his international colleagues.

The recipient of an almost endless list of academic awards and honorary fellowships, Professor Strong is acknowledged by experts in the field as one of the top liver surgeons in the world. He has more than 260 scientific publications to his credit, including 14 book chapters. His landmark contributions to the medical literature have paved the way for the definitive management of some of our most challenging hepatic injuries and diseases. He developed and pioneered the “Brisbane technique” of reduced-size liver transplant for children. Professor Strong performed the first successful living related liver transplant in the world in 1989, when a portion of a mother’s liver was transplanted into her son; both are alive and well 19 years later. He now has an impressive personal series, which is considered by many to be unparalleled with respect to both numbers and outcomes.

It is a certainty that Professor Strong’s legacy will continue for generations, for he has been very active in training young surgeons, particularly in Southeast Asia. He has trained more than 80 surgeons from overseas in hepatobiliary and liver transplant surgery. Many of his fellows have returned to Indonesia, Japan, Malaysia, and several other countries to become leaders in hepatic surgery and liver transplantation.

In addition to his innumerable academic accolades, Professor Strong is a highly decorated civilian. He was honored as the Queenslander of the Year in 1986 and was the recipient of the Companion of the Distinguished Order of St. Michael and St. George presented by Her Majesty, Queen Elizabeth, at Buckingham Palace. He also received Australia’s highest civilian honor, the Companion of the Order of Australia.

Professor Strong, the consummate clinician/surgeon, educator, investigator, and humanitarian, embodies all the laudable tenets of an honorary fellowship.

Mr. President, it is my distinct privilege to present this world-renowned surgeon, Prof. Russell Strong, for Honorary Fellowship in the American College of Surgeons.
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Edited by Mary H. McGrath, MD, MPH, FACS  

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**American College of Surgeons • Division of Education**
In memoriam

James C. Thompson, MD, FACS, 1928–2008

by Marshall J. Orloff, MD, FACS

James C. Thompson, MD, FACS, one of the leading surgical scientists, educators, and statesmen of the past half-century, died at age 79 in his home in Galveston, TX, on May 9, of prostate cancer. From 1970 to 1995, he was chairman of the department of surgery at the University of Texas Medical Branch (UTMB) in Galveston, where he also served as the Ashbel Smith Professor of Surgery and as professor in the department of physiology and biophysics. He is widely credited with building one of the leading surgical scientific programs in the U.S. and with bringing about a sea change throughout UTMB in education and research.

Jim Thompson was not born with a silver spoon in his mouth. He grew up in the little cow town of Hebbronville in Jim Hogg County in south Texas, population 3,000. His father owned the town hardware store and died while on a hunting trip on horseback, when Jim was 14 years of age. At best, the economic condition of the family was modest. Jim attended grade school and high school in the single, little Hebbronville public school. In 1944, when he had just turned age 16, he entered the Agricultural and Mechanical College of Texas, now Texas A&M University, graduating with a bachelor of science degree in just two years. In 1946, when he had just turned 18 years, he entered medical school at UTMB. His family was dirt-poor and even though the tuition was small, he dropped out after his freshman year to earn sufficient funds to continue his medical education. He worked as a paid laboratory assistant to Dr. Raymond Blount, professor of anatomy, ultimately earning a master’s degree in anatomy and endocrinology some years later. He returned to medical school at UTMB in 1948 and went on to serve a rotating internship at UTMB from 1951 to 1952.

Toward the end of his internship, he applied all over the country for a residency in surgery and was turned down by every institution except one, and that was a fluke. The one program that accepted him tentatively was at the University of Pennsylvania, headed by I. S. Ravdin, MD, FACS, who sent him a telegram that read, “We are of course full, but any descendant of the famous James E. Thompson of Galveston is welcome into my program. We will put you into the Harrison Department of Surgical Research for a year, and then you can come into the clinic.” Jim Thompson didn’t have a clue as to who James E. Thompson was. In fact, James E. Thompson was the founder many years earlier of the department of surgery at UTMB. It was a clear case of mistaken identity, which Jim Thompson let pass, given his desperate circumstances.

After a year in the research lab, Jim Thompson entered the clinical surgery residency at Penn in 1953 and completed residency in 1959. His training was interrupted during the Korean War by the “doctors draft,” which resulted in a two-year stint in the U.S. Army Medical Corps in Germany, where he...
achieved a modicum of fame in Army circles. The Army classified him as a physician, general duty, not a surgeon, and assigned him to a small battalion clinic in Munich, where he took daily sick call. In that capacity, he saw soldier after soldier with the unfortunate socially transmitted disease of gonorrhea. The soldiers were very upset by the knowledge that they had gonorrhea, mainly because they feared demotion or even expulsion from the Army. So, kindly, Lt. James Thompson, MD, recorded in the medical record a diagnosis of laryngitis for each of these soldiers with gonorrhea. Army medical headquarters in Washington, DC, was alarmed by the unusual outbreak of laryngitis in Munich and sent a team of senior infectious disease specialists and epidemiologists there to investigate. Needless to say, interrogation of Lieutenant Thompson uncovered the truth of the matter, but the inspectors were so impressed by his kindness and ingenuity that they covered up the reported epidemic of laryngitis.

I first met Jim Thompson late at night in October 1952 in the research laboratories of the Harrison Department of Surgical Research at Penn. We liked each other from the start and we saw each other regularly from then on, and throughout the next 56 years. I recognized his enormous talent and engaging personality, but I do not believe the senior surgical faculty at Penn fully appreciated his potential, a fact that only served to increase his determination to succeed as an academic surgical scientist. When he completed the surgical residency at Penn, he was shunted off to the old Pennsylvania Hospital, a Penn affiliate, to fend for himself. What he accomplished on his own at the Pennsylvania Hospital from 1959 to 1963 was remarkable and a tribute to his determination, tenacity, and ability. He established a first-rate surgical research laboratory on his own; obtained research grants from major agencies, including the National Institutes of Health, on his own; published paper after paper on gastrointestinal physiology and disease on his own; and attracted the attention of leading gastrointestinal (GI) scientists from the U.S. and abroad, such as Lester Dragstedt, Roderick Gregory, and Morton Grossman.

In 1963, knowing that his talent was not fully appreciated and recognized at Penn, I was able to recruit him to University of California–Los Angeles Harbor General Hospital, where I was chief of surgery. In 1967, he succeeded me as professor and chief of surgery. At Harbor General Hospital, he continued his remarkably productive career as an academic surgical scientist, so much so that in 1970, he was recruited by his alma mater, UTMB, to return as professor and chair of surgery for the next 25 years.

Scientific contributions

The research laboratory that Jim Thompson established was involved continuously in the investigation of basic and applied principles of GI physiology and endocrinology. The numerous original and far-reaching studies undertaken by the Thompson laboratory focused particularly on identification and function of GI hormones in health and disease. The work was made possible by research grants that Jim Thompson obtained continuously for 41 years from the NIH under highly competitive circumstances. The laboratory and clinical research accomplished by the Thompson group resulted in 616 publications in peer-reviewed journals, 120 book chapters, and 588 scientific abstracts in the 54 years from 1953 to 2007, a remarkable record of productivity that few academic surgeons have equaled.

Service to surgery and society

Jim Thompson’s record of service to surgery and to society is unsurpassed. He was elected to the presidency of six major national surgical organizations, including the American College of Surgeons, the American Surgical Association, the Southern Surgical Association, the Society for Surgery of the Alimentary Tract, the Society of Surgical Chairs, and the James IV Association of Surgeons. He also served as president of the Texas Surgical Society and the South Texas Chapter of the American College of Surgeons. He was heavily involved in service to the American College of Surgeons, having served as Chairman of the Committee for the Forum on Fundamental Surgical Problems, a member of the Board of Governors for six years, a member of the Program Committee for 10
years, Chairman of the Surgical Research and Education Committee, and a member of the Scholarship Committee. He also served as chairman of the Merit Review Board for Surgery of the U.S. Veterans Administration, a director for six years of the American Board of Surgery, an associate editor of the Yearbook of Surgery, and a member of the editorial board of the Journal of the American College of Surgeons.

Contributions to education
Arguably, Jim Thompson’s most lasting contributions were in education. He trained 131 research fellows from the U.S. and 18 foreign countries in the fundamentals of scientific research. Along with his faculty colleagues, he trained more than 200 residents in clinical surgery. Twelve of his students advanced to the position of chairman of the department of surgery and/or full professor at major universities. During the course of his career, he was invited 265 times to serve as a visiting professor at universities in the U.S., Europe, the Far East, India, Africa, South America, and Central America. His influence on the education of surgeons was worldwide.

Honors
Among his many honors, the two that he prized most highly were his elections to the Institute of Medicine of the National Academy of Sciences and to the American Philosophical Society. In addition, he was elected to membership in 56 national professional and scientific organizations. Ten foreign surgical societies selected him as honorary member, and the University of Beijing made him an “honorary professor for life.” In 1993, the 44th volume of the Surgical Forum was dedicated to Jim, and in 1996 the American College of Surgeons selected him for the Distinguished Service Award. He received a similar award from the National Medical Association and a Lifetime Achievement Award from the Society of University Surgeons.

Qualities of character and personality
The most important and lasting attributes of a man are the qualities of his character and personality. In regard to Jim Thompson, those qualities were his essence. The first quality was his incredible tenacity and determination. His background is a story of “we shall overcome”. He overcame a background of near poverty in a small Texas town; he overcame poverty that forced him to interrupt his medical education; he overcame lack of recognition in his residency at Penn; and he overcame being shunted to a backstreet hospital at the start of his academic career. With determination and tenacity and no athletic experience, at the age of 60, he took up snow skiing and gave it up some years later only after he sustained a hip fracture on the slopes. Importantly, as a result of determination, tenacity, and ability, he changed UTMB and built one of the leading surgical scientific programs in the U.S., where nothing like it existed when he arrived in Galveston.

The second Thompson attribute that deserves comment was his unflagging support of the young people in his program and of his coworkers. He learned early in life that the main responsibility of an academic leader is to help and nurture and mentor those under him, and that the accomplishments of the troops ultimately reflect glory, not only on themselves but also on the leader. He strongly believed that their success was his success. During many of our conversations over the years, often with obvious pleasure, he eulogized the abilities and virtues of his people. In preparing this memorial tribute, I carefully examined his curriculum vitae. As a reflection of his nurturing—and it is only a sample—of his 616 peer-reviewed publications, Courtney Townsend, MD, FACS, was a co-author in 245; Mark Evers, MD, FACS, in 51; Dan Beauchamp, MD, FACS, in 43; Gerald Fried, MD, FACS, in 15; David Herndon, MD, FACS, in 14; Bill Nealon, MD, FACS, in 12; and Hugo Villar, MD, FACS, in 9. Jim Thompson was and will remain a model of effective leadership.

The third Thompson attribute, and one that few surgeons possess, is in the area of non-medical culture. Jim Thompson was truly a cultured man, with serious interests and knowledge in literature, art, and music. Many of his colleagues considered him to be the most cultured person in the city of Galveston, a most unusual accolade for a surgeon. One had only to visit the large Thompson home on Bayou Shore Drive
to experience striking confirmation of these cultural interests. The walls in every room were lined by bookcases filled with a wide array of books, both non-fiction and fiction. Jim was the most avid reader whom I have known. The walls and ceilings of every room, including the kitchen, were papered with original artwork from all over the world. And the collection of classical and modern music CDs and tapes was staggering. You might ask, “What did these interests have to do with his job as a chair of the department of surgery?” They enhanced his understanding of his patients and of the human condition. Moreover, his cultural interests made him a most interesting colleague and friend—far out of the ordinary.

The fourth attribute that deserves comment is a quality that many find wanting when they face difficult choices (as they say, when the chips are down)—that is, the quality of loyalty. Jim Thompson was intensely loyal to his friends, to his colleagues, to his department, to his institution UTMB, and to Texas. I sometimes asked myself, if I were in the trenches with the Viet Cong or North Koreans coming at me with guns blazing, who would I want in the trenches with me? The answer was, without doubt, Jim Thompson.

The final attribute that deserves comment is his warmth of personality. Words that characterize his personality include colorful, irreverent, sometimes outrageous, funny, bombastic, eloquent, occasionally offensively vulgar, charming, and engaging. He was never dull. Above all, he was fun to be with in social situations and an unforgettable friend. I doubt that there will ever be another professor of surgery like him. Jim Thompson will be remembered forever by his students, residents, research fellows, and coworkers—young and mature alike—as an inspirational teacher and role model of what a university professor should be. He will be remembered by his colleagues and the surgical profession as a leader who influenced the course of a great university. He will be remembered by his many, many friends as a warm, thoughtful, generous, loyal, and engaging man who enriched the lives of all who had the good fortune of coming to know him. And, of course, he will be sorely missed by his six children, five grandchildren, longtime companion Bebe Jensen, and the entire Orloff family who knew him as Uncle Jim.

Dr. Orloff is Distinguished Professor of Surgery, Emeritus, in the department of surgery at University of California–San Diego.
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Germany Traveling Fellow selected for 2009

Richard A. Santucci, MD, FACS, professor of urology in the College of Osteopathic Medicine at Michigan State University, East Lansing, has been selected as the 2009 ACS Traveling Fellow to Germany.

Dr. Santucci has researched and written extensively on genitourinary trauma and reconstruction, as well as on more customary urological topics.

As the Germany Traveling Fellow, Dr. Santucci will participate in the annual meeting of the German Surgical Society in Munich, Germany, April 28–May 1, 2009. He will attend and participate in the ACS’ Germany Chapter meeting during that event. Dr. Santucci will also travel to several surgical centers in Germany, with assistance from mentors provided by the German Surgical Society and the Germany Chapter.

The application deadline for the 2010 Traveling Fellowship to Germany is April 1, 2009. The requirements will be published in a future edition of the Bulletin and have been posted to the College’s Web site at http://www.facs.org/memberservices/acsgermany.html.

Dr. Eastman appointed to national injury prevention advisory board

The Board of Scientific Counselors, National Center for Injury Prevention and Control, has appointed A. Brent Eastman, MD, FACS, to serve on the 13-member board that advises the Secretary of the U.S. Department of Health and Human Services and the Director of the Centers for Disease Control and Prevention.

The board will examine strategies and goals for programs and research within the national center, conduct peer review of scientific programs, and monitor the overall strategic direction and focus of the national center. The board also performs second-level peer review of applications for grants-in-aid for research and research training activities, cooperative agreements, and research contract proposals related to the broad areas within the national center.

A Fellow of the College since 1976, Dr. Eastman has served on the Board of Regents since 2001 and has been an active participant in its trauma programs and activities. He is currently the chief medical officer at Scripps Health and N. Paul Whittier Chair of Trauma, Scripps Memorial Hospital, La Jolla, CA.
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The objectives of my visit to Japan were to attend the 108th Congress of the Japan Surgical Society (JSS) in Nagasaki, stimulate scientific exchange, and develop new friendships and research collaborations. I was readily able to accomplish these objectives during the Japan Traveling Fellowship, with my wife Natalie eagerly accompanying me, and I am already planning a future visit.

**Tokyo**

I arrived in Tokyo before the JSS meeting to visit the Nippon Medical School where I was hosted by Prof. Kazuo Shimizu, MD, PhD, chairman of the department of surgery (see photo, this page). The first day of my visit was spent in the operating room (OR) with Professor Shimizu, where I had the opportunity to watch him carry out a thyroidectomy and neck dissection for cancer. I was very impressed with the intraoperative teaching and mentorship he gave to junior surgical staff, surgical residents, and medical students. It was in the OR with Professor Shimizu that I had my first opportunity to observe a lateral neck dissection in Japan. We also spoke at length about the extent of lymphadenectomy for thyroid cancer.

Over lunch with junior staff, residents, and students, we had in-depth discussions on many interesting topics. I especially enjoyed learning about the use of adjuvant therapy for thyroid cancer in Japan. We also had the opportunity to discuss the video-assisted neck surgery approach to thyroid and parathyroid surgery, a technique that Professor Shimizu has pioneered.

I had the opportunity to tour the Nippon Medical School and visit the outpatient clinic, inpatient wards, radiology, and the laboratory. Kiyomi Yamada Hames, MD, PhD, a clinical fellow in endocrine surgery who had recently returned from completing her research training in Boston, MA, was an excellent tour guide and taught me much about the medical system in Japan. It was thrilling to visit the beautiful Shinto shrine located just across the street from the medical school.

I also had the opportunity to meet and speak with many
endocrine surgeons and trainees at the school, including associate professors Haruki Akasu, MD, PhD, and Takehito Igarashi, MD, PhD; assistant professor Ritsuko Okamura, MD, PhD; and clinical fellow Tomoo Jikuzono, MD. Everyone was very friendly and welcoming and I was able to answer many questions for them regarding thyroid and parathyroid surgical surgery in Canada. I also had the pleasure of meeting and speaking with Koji Yamashita, MD, PhD, about his experience using a transaxillary retromammary, video-assisted breast surgery (VABS) approach for breast conservation surgery.

The weekend was spent sightseeing with Natalie in Tokyo, an incredibly large and diverse city with a very efficient and user-friendly mass transit system. Sightseeing highlights from the weekend included attending sumo wrestling matches in the Kokugikan arena, visiting the Asakusa Shrine and Tsukiji Fish Market, and exploring the Shinjuku, Ginza, and Shibuya areas. The Akihabara “Electric Town” was overwhelming, with more electronics on display and for sale than I could have ever imagined was possible.

The highlight of the weekend was an authentic Japanese meal hosted by Professor Shimizu in a beautiful venue located in a lush park in Tokyo. Many interesting discussions over dinner included the current surgical approach to parathyroid disease in Japan and minimally invasive surgical management of adrenal tumors.

The following morning, I was warmly received at the Nippon Medical School surgical rounds and report. At rounds, I heard a very interesting presentation on VABS for in situ breast cancer and delivered a presentation on my research of molecular diagnostic markers for thyroid cancer. There were many interesting comments and questions and the discussion that followed was stimulating. Before my departure, I spoke with Professor Shimizu and Dr. Hames about several future collaborative research projects. After rounds, we were off to Kobe on the shinkansen (bullet train) that we found to be a fast and pleasant way to travel the country.

**Kobe**

The next stop was Kobe, where I visited the Kuma Hospital and was hosted by Prof. Akira Miyauchi, MD, PhD, director of the thyroid disease-focused medical center (see photo, this page). I attended the hospital’s morning conference where I very much enjoyed presentations on several topics that included musculoskeletal complaints experienced in patients with Graves disease and controversies related to poorly differentiated thyroid cancer.

Professor Miyauchi gave me a tour of the hospital, an impressive facility that provides multidisciplinary care for individuals diagnosed with thyroid disease. I spent the morning with Professor Miyauchi in his outpatient clinic, reviewing a
large number of patients with thyroid and parathyroid disease. The topics of discussion ranged from surgical management of medullary carcinoma to the unique experience at the Kuma Hospital of long-term surveillance for individuals diagnosed with papillary microcarcinoma.

The afternoon was spent in the OR observing several of the skilled surgeons at Kuma performing thyroid and parathyroid operations. This experience was interesting and very different from my experience in North America, as there were two operations going on simultaneously in each surgical theater, and doors between ORs allowed me to see several other thyroid operations occurring simultaneously. I observed several thyroidectomies for thyroid cancer, including several lymph node dissections, several thyroidectomies for goiter, and resection of a parathyroid carcinoma. All the endocrine surgeons were friendly and we had many discussions focused on technical aspects of their thyroid operations.

In the evening, there was a research mini-symposium at which several of the Kuma staff gave presentations of their work that would be presented at upcoming meetings. The presentation topics included poorly differentiated thyroid cancer and intrathyroid epithelial thymoma/carcinoma showing thymus-like differentiation lesions (an uncommon thyroid tumor originally described by Professor Miyauchi at Kuma Hospital).

I gave a presentation on molecular markers for improving thyroid cancer diagnosis at this symposium. The discussion was terrific and I answered several questions on my research that has focused on anaplastic thyroid cancer. It was a pleasure to meet and chat with Yasuhiro Ito, MD, an endocrine surgeon at Kuma who, like myself, has a research interest in thyroid cancer molecular biology.

Before my departure, I had the opportunity to speak further with Professor Miyauchi on several other topics, including a review of his technique of lateral mobilization of the recurrent laryngeal nerve to facilitate tracheal resection in patients with thyroid cancer invading the trachea near the ligament of Berry.

Kobe was a beautiful city and before Natalie and I left, we took a ride on the Shin-Kobe cable car to the top of a mountain that had a beautiful view of both the city and the sea.

**Nagasaki**

I then took the shinkansen and train to Nagasaki for the 108th annual congress of the JSS. The meeting began with the council dinner, where Natalie and I were warmly welcomed by the president, Prof. Takashi Kanematsu, MD, and Ms. Kanematsu. At this dinner, we were seated with several members of the society, including Prof. Koichi Tabayashi, MD, Prof. Hiroshi Takami, Prof. Akira Kawaguchi, and visiting pioneering cardiac surgeon/conference speaker Randas J.V. Batista, MD, of Brazil. I was introduced to the members of the society as the representative of the American College of Surgeons. I was very proud and honored to represent the ACS at this event. I also met Thomas R. Russell, MD, FACS, ACS Executive Director, who was giving a lecture at the JSS congress, and Susumu Eguchi, MD, PhD, FACS, who had assisted me with planning my visit. After dinner, I was honored to be congratulated by many members of the society for being selected as the Travelling Fellow.

The JSS congress was held at the Nagasaki Brick Hall, a large conference center, and several meeting sessions were held in surrounding hotels. My personal highlights of the conference included the endocrine surgical session chaired by Shigeto Maeda, MD, PhD. I especially enjoyed a presentation given by Makoto Kamomori, MD, PhD, of Tokyo, that evaluated the diagnostic utility of telomere length in follicular thyroid lesions.

As part of the congress, I also gave a lecture during this session on my research evaluating the molecular phenotype of differentiated thyroid cancer. My lecture generated an interesting discussion and several questions. Overall, it was encouraging for me to see that, like in North America, surgeon-scientists in Japan are carrying out excellent research.

Another highlight of the JSS for me was the minimally invasive thyroid surgery video session. Pioneers in a wide variety of minimally invasive approaches to thyroid surgery...
Dr. Wiseman receiving a certificate commemorating his ACS Traveling Fellowship to Japan from Professor Takami on behalf of the Japan Surgical Society.

presented videos and discussed their operative techniques. I was impressed with the innovation, resourcefulness, and technical expertise evident in these videos. Other lectures and poster sessions I attended at the JSS congress further impressed me with the high level of scholarship maintained by Japanese surgeons. I especially enjoyed meeting several of the international JSS travel grant recipients, and it was a great honor being presented with a certificate from the JSS by Prof. Hiroshi Takami to commemorate my travelling fellowship (see photo, this page).

Natalie and I very much enjoyed the informal dinner hosted by Shigeto Maeda, MD, PhD, and his colleagues from Nagasaki University, that allowed me to chat with many of the endocrine surgeons I had met on my trip, including Prof. Shimizu from Tokyo, Yasuhiro Ito from Kobe, Makoto Kamori from Tokyo, and others. I enjoyed speaking with Dr. Maeda about endocrine surgery in Nagasaki.

While visiting Nagasaki, we had the opportunity to visit several tourist sites and were very moved by the Nagasaki atomic bomb museum and memorial.

Beppu

My next destination was the Noguchi Thyroid Clinic and Hospital in Beppu. Beppu is a quaint town known in Japan for its many natural hot springs. While visiting the Noguchi Hospital, I was hosted by Prof. Shiro Noguchi, MD, PhD, director of this medical center that, like Kuma, is focused on thyroid disease. I was greeted by Hitoshi Noguchi, MD, and Shiro Noguchi upon my arrival (see photos, page 53). Initially I toured around this facility and was shown the inpatient wards, outpatient department, radiology, and laboratory.

Afterward, Hitoshi Noguchi and I spoke at length about multiple issues related to the management of thyroid cancer. I learned that, like me, he had an interest in studying new treatments for anaplastic thyroid cancer and he shared with me the results of some of his recent study. I also gave a presentation of my research evaluating novel treatments for anaplastic thyroid cancer. This generated many questions, stimulated further discussion, and we decided that we would collaborate in the future on anaplastic thyroid cancer-related research projects.

I spent the afternoon observing several thyroid operations carried out by the skilled endocrine surgeons at the hospital. I observed several operations for both benign and malignant thyroid disease, including a locally advanced thyroid cancer, and it
was very exciting for me to see that for some thyroid surgeries, an electrothermal vessel sealing system was used.

At the end of the day, I had an opportunity to speak with Shiro Noguchi on several topics including the management of papillary microcarcinoma, and how he had recently reported that tumors between 6 mm and 10 mm behave in a fashion similar to larger tumors. We also discussed the extent of lymphadenectomy for thyroid cancer.

The multidisciplinary conference that followed reviewed many interesting cases and I was impressed with the high level of scholarship displayed at this meeting. Beppu was a beautiful city and before our departure, we had the opportunity to visit their famous natural hot springs.

**Reflections**

On the way to the airport in Osaka, we visited the atomic bomb memorial in Hiroshima and spent a day touring Kyoto, one of the most beautiful cities I have ever seen. The impressive beauty of the many shrines and gardens in Kyoto really must be seen to be believed. My visit to Japan was a very busy but a wonderful experience for Natalie and me. I found all my Japanese colleagues to be fantastic hosts and their technical expertise, academic focus, and science to be at a very high level. I wholeheartedly thank the American College of Surgeons for the great honor of serving as its representative and giving me the opportunity to visit several excellent Japanese surgical centers, to exchange ideas, to learn, and to develop new academic collaborations and friendships.

**Dr. Wiseman** is a surgical oncologist, head and neck surgeon, general surgeon, and scientist in the Department of Surgery, St. Paul’s Hospital, University of British Columbia, Vancouver.
Programs accredited by the Commission on Cancer (CoC) of the American College of Surgeons make a commitment to their patients to invest their resources in the best available methods for the early detection and treatment of cancer. And the Commission is there—every step of the way—to help each accredited program meet the challenge.

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The term “medical tourism” is gaining recognition in the U.S. as the media increasingly are shining a spotlight on the growing trend of Americans, particularly the uninsured, traveling overseas for low-cost medical care.

As a result of this trend, The Joint Commission’s international accrediting arm, Joint Commission International (JCI), is also garnering a fair amount of attention. JCI is recognized around the world for its rigorous and comprehensive set of international standards. JCI, a division of Joint Commission Resources Inc. (JCR)—a private, not-for-profit affiliate of The Joint Commission—was established in 1997 and began accrediting organizations outside the U.S. in 1999. JCI offers accreditation for hospitals, ambulatory care facilities, clinical laboratories, care continuum services, primary care facilities, and medical transport organizations, as well as certification in disease- or condition-specific care. Today JCI accredits and certifies more than 200 organizations in 33 countries.

For Americans traveling abroad for medical treatment, whether an organization is accredited by JCI is one way to assess the quality and safety of an organization where they are considering undergoing a procedure.

JCI’s standards, training, and processes used during the survey meet the highest international benchmarks for accreditation. The standards and survey process have been adapted for the international community and are designed to be culturally applicable and in compliance with laws and regulations in countries outside the U.S. The standards were developed by international experts and set uniform, achievable expectations for structures, processes, and outcomes for health care organizations. The requirements for accreditation also include international patient safety goals, which highlight problematic areas in health care and describe evidence and expert-based consensus solutions to these problems. The survey process is designed to accommodate specific legal, religious, and cultural factors within a country.

Although some of the organizations accredited by JCI serve medical tourists, the vast majority of the patients served at JCI-accredited organizations are local residents. JCI helps countries educate organizations and staff on how to achieve improved quality and safety. JCI also helps ministries of health to develop their own standards and establish their own accrediting bodies.

JCI is accredited by the International Society for Quality in Health Care and extends The Joint Commission’s mission worldwide by assisting international health care organizations, public health agencies, health ministries, and others to improve the quality and safety of patient care in more than 80 countries. JCI is headquartered in Oakbrook, IL, and has international offices located in Ferney-Voltaire, France; Milan, Italy; Dubai, UAE; and Singapore.

For more information on JCI, visit www.jointcommissioninternational.org or call 630/268-7400.
The famous Shakespearean line (The Tempest) about illusion that is cited in the title of this column seems appropriate to new laparoscopic procedures. These procedures are receiving gradual acceptance in our surgical practice. This incremental acceptance of minimally invasive surgery (MIS) is more pronounced with cancer because there are concerns related to efficacy and safety when compared with standard surgical resection. Local control of primary malignant disease is a priority for surgeons who treat resectable disease. This is of greatest concern when MIS is considered for primary resectable rectal cancer. As with laparoscopic colectomy, laparoscopic approaches to low anterior resection, coloanal resection, and abdominoperineal resection are technically feasible with improved instrumentation and greater surgeon skill.

Although many of us can appreciate the potential patient recovery benefits of performing these procedures, do they achieve the same local cancer control rate of open resection? Only through a prospective, randomized trial design can we answer this question and others.

The American College of Surgeons Oncology Group (ACOSOG) has recently activated protocol Z6051, A Phase III Prospective Randomized Trial Comparing Laparoscopic-Assisted Resection versus Open Resection for Rectal Cancer. The primary objective is to test the hypothesis that laparoscopic-assisted resection for rectal cancer is not inferior to open rectal resection based on pathologic analysis of the resected specimen. This analysis will include a circumferential tumor margin >1 mm, distal resection margin >2 cm (or >1 cm with clear frozen section in the low rectum) and completeness of transmesorectal excision. These are crucial benchmarks in evaluating the quality of surgical resection of primary rectal cancer.

Secondary objectives of the trial include assessment of patient-related benefit of laparoscopic-assisted resection for rectal cancer versus open rectal resection (blood loss, length of stay, pain medicine utilization); assessment of disease-free survival and local pelvic recurrence at two years; and assessment of quality of life, sexual function, and bowel and stoma function at scheduled time points throughout the trial.

Currently, there is no level I evidence that laparoscopic resection of rectal cancer produces the same histopathologic outcome compared with open resection. Potential concerns with laparoscopic resection include less visualization of the pelvis and exposure of the mesorectum and adjacent structures, such as hypogastric nerves. A recent prospective, randomized trial of laparoscopic surgery for either colon or rectal cancer suggested an increased risk of positive circumferential radial margin with the laparoscopic approach,* which did not result in a higher local recurrence, but the trial was not powered to address this issue in rectal cancer.

The patient eligibility criteria for Z6051 include the following:

- Histologic diagnosis of adenocarcinoma of the rectum (<12 cm from the anal verge)
- T3N0M0, TanyN1M0 disease as determined by pretreatment computed tomography scans and pelvic magnetic resonance imaging or transrectal ultrasound; patients with T4 disease extending to circumferential margin of rectum or invading adjacent organs are not eligible

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• Completion of preoperative 5FU-based chemotherapy and/or radiation therapy; capecitabine may be substituted for 5FU
• Age >18 years
• Eastern Cooperative Oncology Group (Zubrod) performance status <2
• Body mass index <34
• No evidence of conditions that would preclude use of a laparoscopic approach (for example, multiple previous major laparotomies, severe adhesions)
• No systemic disease (cardiovascular, renal, hepatic, and so forth) that would preclude surgery; no other severe, incapacitating disease—that is, American Society of Anesthesiologist classification of IV (a patient with severe systemic disease that is a constant threat to life) or V (a moribund patient who is not expected to survive without the operation)
• Nonpregnant and nonlactating, as confirmed by pretreatment pregnancy test for patients of childbearing potential
• No concurrent or previous invasive pelvic malignancy (cervical, uterine, and rectal) within five years before registration
• No history of psychiatric or addictive disorders or other conditions that, in the opinion of the investigator, would preclude the patient from meeting the study requirements

As with all ACOSOG procedure trials, there are surgeon credentialing criteria to participate as an investigator in the trial. Credentialing in laparoscopic colon and rectal surgery are required. Credentialing for laparoscopic colectomy and laparoscopic rectal surgery both require 20 laparoscopic or hand-assisted operations. Laparoscopic cases for benign tumors or non-neoplastic diseases can be included in credentialing cases.

Further details are found in the protocol, which can be accessed on the ACOSOG Web site (www.acosog.org). James Fleshman, MD, FACS, protocol study chair, can be contacted at fleshman@wudosis.wustl.edu.

Z6051 is very much a successor trial to the laparoscopic colectomy trial but with a different primary endpoint. Prospective phase III randomized trials for new procedures in cancer treatment are needed to demonstrate that such technical advances are not inferior to standard procedures and that there is measurable improvement in quality of life.

The National Cancer Institute has designated Z6051 as a high-priority trial. ACOSOG needs your involvement in order for surgeons to establish the validity and safety of the procedure. As a surgeon-oriented cooperative group, ACOSOG will continue to develop and conduct procedure-oriented national trials. To date, ACOSOG has achieved considerable success with such trials and the commitment of the ACOSOG members is very much appreciated.

Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG co-chairs.

2009 Oweida Scholarship availability announced

The Board of Governors of the American College of Surgeons is pleased to announce the availability of the 2009 Nizar N. Oweida Scholarship. The Oweida Scholarship, an annual award administered by the Executive Committee of the Board of Governors, was established in 1998 in memory of Dr. Oweida, a general surgeon who practiced in a small town in western Pennsylvania. The purpose of the Oweida Scholarship is to enable young surgeons practicing in rural communities to attend the Clinical Congress and benefit from the educational experiences it provides. The $5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees.

Applications consist of a curriculum vitae plus a one-page essay describing why the applicant characterizes his or her practice as rural and why he or she would like to receive the scholarship. The deadline for receipt of application materials is December 15, 2008. For the complete requirements for this scholarship, visit http://www.facs.org/member services/oweida.html or contact the Scholarships Administrator at kearly@facs.org.
Let the power of compounding work for you. You have worked hard and spent time and money to be where you are. Now you can put both time and money to work for you by investing $100 per month in an account with SDIF. Starting early on, a regular program of investing can make a tremendous difference over time. The charted hypothetical example illustrates the difference between two investors who invest identical amounts, starting with $100 per month, and increase their contributions by 10% each year. The chart assumes an average annual return of 6%, compounded monthly. The only difference is that one investor starts today, and the other starts 10 years from now. Forty years later, the investor who started early has a portfolio of more than $1 million. The investor who started later has only $400,000.

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It is now the middle of fall, and all-terrain vehicle (ATV) use is in full gear. It is not uncommon in the Midwest to hear of an ATV-related fatality on a regular basis this time of year. According to the U.S. Consumer Product Safety Commission (CPSC), the number of estimated injuries treated in the emergency room has almost tripled over the most recent 10-year period for which data are available, from 53,500 in 1996 to almost 150,000 in 2006. Along with this increased number of injuries has been an estimated threefold increase in deaths from 267 in 1996 to 870 in 2006. In 2006, deaths in children younger than 16 years of age accounted for approximately 20 percent of the fatalities (http://www.atvsafety.gov/stats.html).

The CPSC has stated that ATVs are one of the deadliest products under their jurisdiction. The agency has worked for 20 years trying to make ATVs safer. Aside from a decree in the 1980s to ban the sale of three-wheel models, there has been very little progress in recent years.

In order to examine the potential occurrence of injuries sustained while on an ATV, the National Trauma Data Bank® (NTDB) Dataset 7.1 records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification cause of injury code E 821, accident involving off-road motor vehicles (which include ATVs), and further sorted to identify injury to driver, 821.0, or to passenger, 821.1. This search resulted in 58,235 records, composed of 35,665 drivers, 6,859 passengers, and 15,711 other/unspecified. These records were then divided to assess the ages of victims in these incidents. There was an increase in incidents among younger ATV users. These data are depicted in the graph on this page.

The Specialty Vehicle Institute of America points out that a vast majority of the ATV-related accidents and fatalities involve rider error. There is a chasm between the industry and the protection agency. There are some valuable precautions one can take in order to mitigate potential injury, such as keeping the vehicle off paved roads, avoiding tandem rides, wearing a helmet, not driving under the influence of alcohol, and not allowing children to operate adult-sized ATVs. To take it one step further, the American As-
association of Pediatrics suggests that no children younger than 16 years drive ATVs regardless of the model and whether an automobile driver’s license is required to operate one.

We all make choices in life, and if one of yours puts you on the back of an ATV, be sure to heed the above so your ATV will not stand for “all-terrain victim.”

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.