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On the cover: The College’s Division of Advocacy and Health Policy is working to ensure that as federal health care policy is crafted, the important issue of patient access to emergency care services is addressed. (Photos courtesy of istockphoto.)
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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.
At press time, Congress and the White House were seriously debating drafts or outlines of three comprehensive health care reform bills. By the time this column is published, many behind-the-scenes negotiations will have been going on for some time. American College of Surgeons’ advocacy staff and their colleagues at the surgical societies have been—and will continue to be—actively involved in these discussions, presenting a unified message about the urgent need for long-term Medicare payment and surgical workforce reforms, as well as other policies at the forefront of the profession’s legislative agenda.

Surgeons and other health care professionals need to become educated about both the positive and negative effects of the various proposals under consideration. It is also our responsibility to then use this knowledge to effectively and intelligently advocate for reforms that will lead to a more sustainable health care system—one that provides high-quality, evidence-based, cost-effective care to all surgical patients.

**Negotiable and nonnegotiable issues**

Some issues warrant an uncompromising response from the surgical profession—long-term Medicare payment reform being the prime example. Without question, surgeons and surgical patients would suffer a fatal blow if Congress fails to pass legislation that creates a better physician reimbursement system. Surgeons simply cannot afford to shoulder a 21.5 percent cut in Medicare reimbursement, and if that happens, many fine members of our profession may be forced to choose another line of work. To ensure that America’s surgical patients continue to have access to the care they need, we must remain steadfast in our commitment to achieving the repeal of the sustainable growth rate (SGR) formula that is used to calculate Medicare payment. We must also be committed to its replacement with a more equitable methodology. As you may recall, the College has specifically sought to supplant the current Medicare payment system with a structure based on type of service, including a category for major surgical procedures.

At press time, the Centers for Medicare & Medicaid Services had just released a 1,200-plus-page rule pertaining to the 2010 Medicare physician fee schedule. ACS regulatory staff are carefully reviewing this proposal to determine how it will affect surgeons. They will then send their analysis to the ACS leadership to craft our comments. Of course, health care reform legislation that includes modifications to the payment system could significantly alter what is included in the final rule. Hence, it is important that surgeons stay informed about what is happening at both the legislative and regulatory levels.

Other potential reforms may need to be approached in a more open-minded manner. For example, it is perfectly reasonable to object to the concept of directing chronically ill individuals to patient-centered medical homes if unbiased, objective research shows that this arrangement will lead to more inefficiencies or rationing of care. Until such evidence emerges, we need to study the issue closely and consider the available information regarding the value to patients enrolling in these highly coordinated health care settings.

**Public plan option**

Perhaps the most contentious concept in the current health care reform debate is the idea of offering a public health insurance plan option. President Barack Obama and most Democrats...
in Congress maintain that this component must be included in health care reform legislation to ensure that all Americans have access to affordable insurance. They also assert that a public plan will force private insurers to better control costs, premiums, and copayments in order to remain competitive.

Conversely, most Republican lawmakers claim that the public option is the first step toward a single-payer system because private insurers simply cannot compete with a government-sponsored plan. They also maintain that a public plan will lead to increased health care spending, noting the inefficiencies of other government-run programs, including Medicare and Medicaid.

A major concern for our community is how the public plan would reimburse surgeons and other physicians. Obviously, any effort to base the government insurance plan on Medicare’s current payment system would be untenable, and the College and other surgical organizations have strongly voiced our opposition to this strategy.

All sides raise legitimate points, and, indeed, public and private plans have unique and inherent strengths and weaknesses. Public health insurance plans offer certain features that private plans generally are unable, or unwilling, to offer, including stability, risk-pooling, transparency, affordable premiums, broad provider access, and the capacity to collect and use patient data on a wide scale to improve care. On the other hand, private plans generally offer patients more flexibility, are more capable of creating integrated provider networks, and typically offer higher compensation rates.

In order for the public option to work, experts on health care reform generally agree that it should provide a broad set of benefits, improve on the way in which Medicare pays providers, compete on a level playing field with private insurers, and be sponsored (but not run) by the government. Most importantly, it has to be implemented fairly. The May 28, 2009, New England Journal of Medicine includes several interesting commentaries on the public plan option.¹

**Just the beginning**

Whereas the establishment of a public option may be useful in reducing the number of uninsured Americans, it does little to address the other problems associated with our nation’s health care delivery system, including access to surgical and other specialty care, controlling costs, and improving quality. To achieve these goals, we need to address the workforce shortages by providing medical students with incentives to pursue residencies in surgery and other specialties. We need to encourage scientific research that provides the evidence necessary to determine best practices. We must shield physicians who follow professionally established guidelines from liability lawsuits. We must provide patients with more coordinated care in order to reduce the opportunity for error and costly redundancies.

Needless to say, reforming the U.S. health care delivery system is an enormously complicated undertaking. Hence, it is imperative that surgeons stay abreast of the issues so that they may speak intelligently and with authority during their interactions with elected officials and their staffs.

August is traditionally the month when Congress takes its summer recess, making it the best possible time for you to meet with your senators and representatives. There is no better place to confer with lawmakers than in their district offices. I strongly encourage you to brush up on the ongoing developments in health care reform and to take advantage of this opportunity to advocate on behalf of the surgical patient.

Thomas R. Russell, MD, FACS


If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@fac.org.
10,000 OPERATIONS: 
Musings of a General Surgeon

by Jon C. White, MD, FACS
Recently, I tallied my operative cases for the past calendar year as part of the application process for my second recertification exam for the American Board of Surgery (ABS). The list was just shy of 400 operations. It was neither the busiest nor the slowest year of my surgical career, which started with my training in 1980. Over the course of my career, I’ve worked on cases ranging from hemorrhoids to liver transplantation and—although the majority were done at three teaching hospitals—for a few years as a transplant surgeon, I did organ procurement in a variety of hospitals all over the country. For four months, as a Project Hope volunteer, I operated in Grenada, West Indies, in an open-air hospital, which means there were open windows in the operating room. I estimate that my combined operative experience must be around 10,000 operations. I realize that many surgeons have reached, and far surpassed, this point, but it seems to be a good, round number and a good time to reflect on the lessons I’ve learned to date. I have an academic appointment with a university that mandates a 360-degree evaluation of every student and instructor, and I consider these musings to be an important part of my self-evaluation.

**Enhanced Judgment Skills**

It’s often stated that it takes 15 years to become a surgeon—five to learn how to operate, five to learn when to operate, and five to learn when not to operate. I can’t vouch for this precise time frame but the sentiment is, in my estimation, essentially correct. I learned most of the basics such as suturing, handling tissue, traction/counter-traction methods, developing tissue planes, and so forth, as a trainee. I started to focus more on when to operate once I had finished training and was on my own. Early in my career, I was more likely to be unsure of what was wrong with a patient and would operate much more readily. I seemed to live by the flippant, but not entirely facetious, dictum, “never let the skin stand between you and the diagnosis.” It is only with time and experience that I feel secure enough not to go directly to the operating room. Learning when not to operate is an ongoing process for me.

Many of the operations that I perform are ones that I have done countless times before. Nonetheless, I learn something new with every case and I like to think that my surgical judgment is continually improving. It is also said that good judgment comes from experience, which usually comes from bad judgment. Over the years I’ve tried to minimize my poor judgment by continuing my experiential learning through reading or attendance of morbidity and mortality conferences, which often highlight other surgeons’ mistakes. Although I can make an argument that my knowledge increases with every operation performed or conference attended, I can’t say the same about my surgical skills. My eyesight, hand-eye coordination, ability to stand for hours, and ability to go without sleep for long periods of time are not what they used to be. For the present, I am confident that my heightened judgment skills outweigh my decreasing physical abilities. I feel like an aging baseball pitcher who relies more on his experience and knowledge to outsmart batters rather than his power to overwhelm them with fastballs. When my loss of physical ability exceeds my gains in surgical judgment, then I’ll know it’s time to retire from the operating room.

**Consider the Costs**

During my medical education, I was encouraged to keep an open mind and consider all etiologies for every set of symptoms. The brightest and most compulsive students in my class came up with the longest and most esoteric lists of differential diagnoses. This is an approach that is still celebrated by the currently popular Fox Network series *House*, which presents a patient with an unusual diagnosis each week, motivating a whole team of physicians and researchers to order every diagnostic modality at their disposal to determine the final diagnosis. The message here seems to be that every workup should be exhaustive. For example, these days even mundane diagnoses undergoing radiographic evaluation seem to progress rapidly from plain X rays, to computerized axial tomography (CAT) scans, to magnetic resonance imaging scans, to positron emission tomography scans, and, finally, to interventional radiology.

There is no doubt that this approach is appropriate in some circumstances, but I would submit that usually it is not. It is rarely mentioned that these diagnoses are made at great expense. There are, of course, complications to the patients that must be considered, too, and there is also an enor-
mous drain on resources. Many of us who were schooled during the halcyon days of unlimited resources are now the teachers. We have to train younger doctors to do something that we were never taught to do, and that is, to consider the expense of everything that we order. It seems I am constantly telling the residents not to get an abdominal CAT scan on a patient who develops a fever two days after an exploratory laparotomy, and most likely has atelectasis. Unfortunately, our system of medical insurance has uncoupled the mounting cost of medical care from the consumers’ desire to purchase cost-effective treatment. It is left to us as providers to watch what we spend. We should teach our students to use the most economical diagnostic tests, to order the least expensive (but effective) therapies, and to try and imagine the costs for the care that they order.

Balancing career and personal life

I often say that I have been able to define my career so that it fits comfortably into my life. It’s more likely that my career has changed my life so that it fits within the profession’s somewhat demanding parameters. Over the years I have missed countless dinners, performances, parties, and visits from out-of-town friends due to my work, and as a result, many of my life experiences are actually linked to my job. Not only do I remember the small pleasant episodes like the birthday cake that my wife brought to the hospital cafeteria on a night when I was in the operating room, I have memories of events such as being an intern in the emergency room at George Washington University Hospital when President Reagan came in after being shot in the chest. I also remember 20 years later, when I was an associate examiner for the American Board of Surgery and one of the applicants came in the room and asked us to turn on the television. The ABS board member and I sat speechless as we watched planes flying into the World Trade Center.

Medical students and residents can have different values than ours and may seem more dedicated to pursuits outside of their careers. I would guess that not as many of their memories will be linked to their lives as physicians and surgeons. Sometimes I find myself being critical of what they do or, more often, what they don’t do. I have to remind myself of stories I heard as a resident from those surgeons who came before us. They were mainly white males who lived in quarters next to the hospitals and sometimes were not even allowed to marry as house officers. These older surgeons may have looked upon us as slackers because we went home to our families every other night or, in especially deplorable cases, two nights out of three. Values are changing and we don’t have to like them, but we can’t resist them. If we do, we will create a profession which nobody will choose to pursue and, rather than attracting the best and the brightest, we may end up with what’s left over.

The changing business of medicine

As a resident, I always found it interesting to hang around the surgeon’s lounge in one of the local private hospitals. The private surgeons were all fee-for-service practitioners and would talk about the changing business of medicine. At the time of my residency, they were wrestling with the new concept of managed care and the new terminology of health maintenance organizations, preferred provider organizations, and independent provider organizations. Many of the surgeons had been practicing before Medicare and Medicaid were established and few of the older ones even remembered practicing before private health insurance had become widespread. It was clear to me in the early 1980s that times were changing and nobody knew exactly how things would develop. As it has turned out, the surgeons at that particular hospital were making more money 20 years ago than their replacements do today, and this amount is not adjusted for inflation. I’m not sure that this is as true all over the country, but many physicians, and especially surgeons, find that their incomes have been in decline for several decades.

While money spent on health care nationally seems to be spinning out of control, more consumers are underinsured or uninsured and health care professionals are seeing a decline in income. It’s a difficult situation that is often attributed to capitalism run amok. Many of the commonly suggested solutions suggest adopting—or at least adding—elements of socialism to the health care system. The issue is extremely complex and does not lend itself to a one-paragraph solution, but I must say that I have spent most of my career at a Veterans Affairs (VA) hospital, which is pure socialized medicine, and I love many aspects of
it. My hospital is a wonderful teaching facility that provides instruction for three university and two military programs, produces high-quality research, and provides superb care to its veterans. However, I am also close enough to see the warts in the system. Although we are quick to judge the failure of the market to control costs in private practice, at the VA I see inefficiencies and misplaced incentives due to the lack of these same market forces. When the profit motive is gone, there is little incentive for providers to work at peak efficiency and, when the patients don’t share the cost of treatment, there is little incentive to consume health care responsibly. I’m not a medical economist so I don’t know what combination of capitalism, socialism, managed care, value-based purchasing, or government regulation or deregulation is necessary to rein in expenses, but I hope we come up with a plan soon. The precipice yawns before us.

The future is now

I have been chastened by an experience I had approximately 20 years ago. At the time, some of the forward-thinking people in my department started talking about investing in laparoscopic equipment. I confidently predicted that there was no future in minimally invasive surgery and announced that I would remain a maximally invasive surgeon for the remainder of my career. Of course, within two years I was doing laparoscopic cholecystectomies, and in the intervening years have continued to add to my laparoscopic arsenal. Now, I am having a déjà vu experience and find myself making the same confidently negative predictions about robotic surgery. Only this time I am keeping my opinions to myself.

I asked one of our urologists, who has a private practice outside of our department, about his experience with the robot. He told me that he could perform an open prostatectomy twice as fast as he could do with the robot. He also said that the robot his hospital had purchased cost $1.5 million dollars, with an additional $100,000 more each year in maintenance and consumables. The operative skills required to utilize the robot have a steep learning curve and the oncologic cure rates and retention of sexual function were similar, in his hands, to an open repair. The one advantage with the robot was that his patients spend, on average, one day less in the hospital. When I asked him why he was doing robotic surgery he said simply, “Market forces. The robot is being aggressively marketed and I have to use it to maintain my practice.” I wonder how this aspect of the market forces is going to fit into a new health care paradigm, which might adopt some elements of socialized financing. This time, I really will keep my opinion to myself.

An extraordinary profession

The other morning, as I was backing out of my driveway, I saw a neighbor leaving his house for an early morning walk. When I put down my window to exchange pleasantries with him, he told me about an unusual experience he had only one week earlier. He had been out jogging with his daughter, experienced chest pain, and decided to go to the local hospital. His electrocardiogram in the emergency room suggested ischemia and he was sent for a cardiac catheterization. Twenty-four hours later he was in the surgical intensive care unit recovering from quadruple bypass. He was now starting his exercise program and looked almost the same as he had the last time I saw him. The only scar visible to me was on his leg where a saphenous vein had been removed through several 1 cm incisions. He spent the next 15 minutes telling me what an extraordinary profession I had chosen. He didn’t have to tell me. It’s something I’ve been telling myself for the last 28 years.

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ACS works to ensure
PATIENT ACCESS
TO EMERGENCY CARE

by
Kristin McDonald,
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When the current health care reform debate began, a key component of patient care and system reform was largely absent from the initial congressional discussions: the emergency and trauma care delivered in our nation’s hospitals and trauma centers. Congress primarily focused on increasing preventive care and “unclogging” our nation’s emergency rooms. However, thanks to key House and Senate champions and the persistence of the trauma and emergency advocacy community, Congress now has a better understanding of the issues facing trauma and emergency patients. Universal coverage does not equal access to care, especially in our nation’s emergency rooms and trauma centers.

While legislative language seems to change daily as the health care reform debate in Congress continues, and the overall outlook for the completion of health care reform remains uncertain, the outlook for legislative language that would strengthen our nation’s trauma and emergency care system is positive and, if nothing else, the efforts to gain inclusion of legislative language pertaining to trauma and emergency care have set a new Congressional priority for these critical aspects of patient care.

The U.S. emergency care system is in crisis. According to the Centers for Disease Control and Prevention (CDC), traumatic injury is the leading cause of mortality for U.S. citizens younger than 44 years of age, and is the number one cause of mortality of children younger than age 15. As supported by medical evidence, the care and treatment delivered within the first hour of a severe injury, known as the “golden hour,” are likely to mean the difference between temporary and permanent disability, and the difference between life and death. According to studies of conventional trauma care, as many as 25 percent of trauma patient deaths could have been prevented if optimal acute care had been available. Unfortunately, only one in four Americans lives in an area with a trauma care system.

In addition to saving lives, restoring functionality, and preventing disabilities, appropriate trauma care also plays an important part in containing rising health care costs. The CDC estimates that approximately $400 billion is lost each year due to medical costs and lost productivity. According to a report from the Agency for Healthcare Research and Quality (AHRQ), trauma injuries were the second most expensive health care condition in 2006, costing approximately $68 billion. This total includes spending for physician visits, clinics, emergency room visits, hospital room stays, home health care, and prescription drugs. The cost of trauma-related emergency room visits was $9.3 billion in 2006. The National Safety Council’s 2005–2006 edition of Injury Facts found that the total cost of unintentional injuries to society for 2007 was $684.4 billion.

Trauma systems allow for the effective and efficient use of scarce and costly community resources. Both the Institute of Medicine’s (IOM) series on the Future of Emergency Care in the United States Health System and the final report of the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group documented significant gaps in our trauma and emergency health care delivery systems, indicating that hospital emergency departments and trauma centers across the country are severely overcrowded, emergency care is highly fractured, and critical surgical specialists are often unavailable to take emergency call. The IOM found that a coordinated, regionalized, accountable system based on the current trauma care system model must be created. Unfortunately, there is a lack of uniformity regarding system development. As a result, the quality of care that a trauma patient receives largely depends on where the patient incurs his or her trauma injury.

The American College of Surgeons’ Division of Advocacy and Health Policy (DAHP) worked diligently, along with colleagues from the trauma and emergency advocacy community, to ensure that modified language from past legislation—such as the Improving Emergency Care and Response Act, the Trauma Care Systems and Development Act, and the National Trauma Center Stabilization Act—is included in health care reform legislation. In addition, the ACS assisted in drafting new language on pediatric emergency care and the authorization of the Emergency Care Coordination Center (ECCC) that would complement the aforementioned language. The ACS is especially appreciative of the work of Sen. Patty Murray (D-WA) and her staff for their ef-
forts to ensure the inclusion of these provisions in the Senate Health, Education, Labor, and Pensions (HELP) Committee’s health care reform bill. The related bills and their provisions can be described as follows.

**The Improving Emergency Care and Response Act**

The 2006 IOM reports requested a complete overhaul of emergency and trauma care through the creation of coordinated and regionalized systems of care, modeled on the Health Resources and Services Administration (HRSA) Trauma-EMS program. According to the reports, the “objective of regionalization is to improve patient outcomes by directing patients to facilities with optimal capabilities for any given type of illness or injury.” The reports further state, “Trauma systems provide a valuable model for how such coordination could and should operate.”

At press time, the Senate HELP Committee’s proposed health care reform legislation included provisions to regionalize emergency care, based on language previously introduced by then-Sen. Barack Obama (D-IL) and Rep. Henry Waxman (D-CA) in the 110th Congress—the Improving Emergency Care and Response Act. The language as included in the Senate HELP bill would authorize the Secretary of Health and Human Services (HHS) to award no fewer than four multi-year grants to support pilot projects aimed at designing, implementing, and evaluating regionalized, accountable emergency care systems. Within a defined region, these systems would:

- Coordinate public health, safety, emergency services, and trauma centers to facilitate access to the emergency medical system
- Establish a communication mechanism for ensuring a patient is directed to the proper medical facility in a timely fashion
- Track prehospital and hospital resources in real time
- Coordinate standardized data management for prehospital, hospital, and inter-facility transport, specifically ensuring compatibility with the ACS National Trauma Data Bank

The language requires the Secretary to give priority to medically underserved areas, and entities eligible for the grants must meet a state matching requirement. A report would follow the completion of each pilot project to identify the effectiveness of the system, strategies to ensure long-term financial sustainability, and barriers and proposed solutions to those barriers. The pilot projects are authorized for $12 million per year through 2014.

On the House side, congressional staff has repeatedly assured ACS advocacy staff that language relating to the regionalization of emergency care would be included in the next version of the House health care reform legislation. As the champion of regionalization on the House side, Representative Waxman is in a unique position as Chairman of the House Energy and Commerce Committee to include such language. At press time, language had yet to be released by the House. The ACS will continue to seek inclusion of this important language on the House side.

**Reauthorization of the Trauma-EMS program**

The ACS also made a significant legislative push to ensure the longevity of trauma systems in health care reform. Since 1990, the Trauma Care Systems Planning and Development Act (Title XII of the Public Health Service Act) has provided $31.4 million to help states and territories develop and implement statewide trauma care systems. The trauma care program was developed in response to a 1986 Government Accountability Office report (GAO/HRD-86-132), which indicated that severely injured individuals in a majority of both urban and rural areas of the U.S. did not have access to trauma systems despite considerable evidence that these systems improve survival rates.

In 2007, former President George W. Bush signed the Trauma Care Systems Planning and Development Act (P.L. 110-23) into law. Championed by Reps. Gene Green (D-TX) and Mike Burgess, MD (R-TX), and Sens. Jack Reed (D-RI) and Pat Roberts (R-KS), the legislation reauthorized the Trauma-EMS program through fiscal year (FY) 2012. The law also created a new competitive grant program for states that have already begun the process of establishing a trauma care system using national standards and protocols.

Currently operating under the auspices of HRSA, securing funding for the Trauma-EMS program has proven difficult. Although the ACS
began advocating earlier this year for funding through the FY 2010 Labor, HHS, and Education appropriations bill, health care reform presents a good opportunity to consider ways to better ensure financing for this crucial program. To that end, the ACS worked with congressional staff, including the champions of the previous reauthorization of the program, to ensure reauthorization of the Trauma-EMS program in health care reform through 2014. At press time, the Senate HELP bill included language reauthorizing the Trauma-EMS program as part of the regionalization language mentioned previously, with funding for the program set at $12 million per fiscal year. The ACS supports inclusion of both the reauthorization of trauma systems and regionalization of emergency care language as included in the Senate HELP bill in the House health care reform legislation. If the House simply uses the Improving Emergency Care and Response Act as written in the 110th Congress, which does not contain reauthorization language for the Trauma-EMS program, the ACS will work to seek inclusion of language that will reauthorize trauma systems.

**Pediatric research**

Efforts to improve access to emergency and trauma care through health care reform must improve upon current systems and must include all members of society, especially our nation’s children. To that end, in addition to including references to pediatric emergency care throughout the regionalization language as written in the Senate HELP bill, the ACS sought inclusion of new language to address the unique nature of pediatric emergencies. Specifically, the language includes a study based on the recommendations of the IOM that would examine the following:

- Integrating pediatric emergency services into the overall health system
- System-wide pediatric emergency care planning, preparedness, coordination, and funding
- Pediatric training in professional education
- Research in pediatric emergency care, especially as it pertains to prescriptions for infants, children, and adolescents

As previously noted, securing inclusion of the Senate HELP language on the regionalization of emergency care is crucial to ensuring the success of this new language on pediatric emergency care, should Congress ultimately enact health care reform legislation this year. However, should the House include an alternate version, the ACS will work to secure language on pediatric emergency care.

**Authorizing the Emergency Care Coordination Center (ECCC)**

In February, the Office of Management and Budget (OMB) presented the ACS with the idea of moving the Trauma-EMS program from HRSA over to the Office of the Assistant Secretary for Preparedness and Response (ASPR). In light of the connection between well-functioning trauma and emergency systems and the ability to quickly respond to a disaster by elevating those systems, OMB thought that the Trauma-EMS program might have a better chance of receiving money in the President’s budget under ASPR.

In April, ACS DAHP staff followed up on this recommendation by meeting with officials at ASPR, specifically individuals at the ECCC, as well as a representative from the White House. Whereas the initial purpose of the meeting was to ascertain whether ASPR was truly interested in taking on and funding the Trauma-EMS program, the conversation quickly grew in scope, and it became clear that the intention of the Administration is for the ECCC to serve as the home for all emergency and trauma care. The ECCC, housed in HHS under ASPR, currently collaborates with the Departments of Homeland Security, HHS, Transportation, Defense, and Veterans Affairs in an effort to build and develop the ECCC as the central office for emergency care—both for daily operations and disaster preparedness. In addition to being supportive of the Trauma-EMS program, the ECCC has begun work on regionalization pilot projects based on the concepts as set forth in the Improving Emergency Care and Response Act. The ECCC also seeks to improve trauma and emergency care through additional efforts, including performance measurement. The ACS provided the ECCC with information about the Committee on Trauma’s (COT) new Trauma Quality Improvement Program.

Since that time, ACS staff arranged for ACS
COT Chair John Fildes, MD, FACS, FCCM, to meet with the ECC. In June, the Director of the ECC, Michael Handrigan, MD, presented the work and goals of the ECC to the ACS COT Executive Committee. The ACS COT is hopeful that it can work regularly with the ECC in the future.

The intentions of the ECC, as well as the determination of the White House to improve emergency care, were highlighted in President Obama’s FY 2010 budget plan. That proposal would allocate $10 million to the Emergency Care Systems program that would support the development of the ECC and two of its main objectives: the regionalization of emergency care services, and the promulgation of national standards on emergency care performance measurement.

In order to ensure the success of the ECC in the years following the Obama Administration, the ACS, along with its colleagues from the trauma and emergency advocacy community, wrote language formally authorizing the ECC. In addition, language was included to formally move the Trauma-EMS program and the regionalization pilot projects over to ASPR, which will now be responsible for including the programs in its annual budget. Authorization of the ECC in health care reform will ensure that the Administration has the necessary resources in place to provide an organized, planned response to emergency and trauma care and disaster management. In addition, these activities will hopefully better ensure funding for both programs in the future.

While the Senate was unable to include the authorization of the ECC in the Senate HELP bill, the House has expressed interest in including the ECC authorization in its version of the bill. The ACS is supportive of the language as written in the Senate HELP bill and will continue to push for its inclusion on the House side.

**Additional efforts**

In addition to these efforts, the ACS is also working hard to have other legislative items on its emergency and trauma agenda included in the health care reform package. Some examples include the following:

- **The Health Care Safety Net Enhancement Act (H.R. 1998).** The College worked closely with Reps. Bart Gordon (D-TN) and Charlie Dent (R-PA) to draft this bill. Introduced on April 21, H.R. 1998 would provide liability protections under the Federal Tort Claims Act for physicians who provide EMTALA-related services. At press time, Representative Gordon was seeking to have H.R. 1998 included in the House health care reform bill as part of a larger medical liability reform provision. Representative Dent also included the legislation in the moderate Republican “Tuesday Group” health care reform proposal. However, it remains unclear whether Congress will truly be willing to tackle the issue of medical liability reform as part of health care reform.

- **The Mitigating the Impact of Uncompensated Service and Time Act (H.R. 1678).** The

The National Trauma Center Stabilization Act

Trauma centers across the country are facing downgrades and closures due to such issues as uncompensated care, workforce shortages, high malpractice costs, and outlays to support the infrastructure. The National Trauma Center Stabilization Act, introduced by Senator Murray and Sen. Johnny Isakson (R-GA), would provide critical funding to centers that are at serious risk of closing, thereby ensuring patient access to the type of care they need, when they need it.

Specifically, the bill authorizes the Secretary of HHS to award grants to trauma centers to help defray the costs of uncompensated care, support the core missions of trauma centers, and provide emergency relief to ensure the long-term success and survival of trauma centers. The language also authorizes the Secretary to award trauma service availability grants to states for the development of new trauma services. $100 million is authorized for each grant program per year through 2015. This legislation makes specific reference to the ACS verification process and supports a national, centralized trauma care registry that is in compliance with ACS guidelines.

Congressman Edolphus Towns (D-NY) introduced the National Trauma Center Stabilization Act on the House side. At press time, it was unclear whether the House version of the bill would be included in the House health care reform bill. The ACS is supportive of the language as written in the Senate HELP bill and will continue to push for its inclusion on the House side.
advocacy staff has worked closely with advisors to Rep. Mary Bono-Mack (R-CA) to ensure reintroduction of this bill, which would provide physicians with a deduction equal to the amount of the Medicare fee schedule payment to help alleviate the financial burden associated with providing uncompensated care mandated by EMTALA.

- **The Access to Emergency Medical Services Act (H.R. 1188/S. 468).** Introduced by Representative Gordon and Sen. Debbie Stabenow (D-MI), this legislation would provide a 10 percent added bonus payment through Medicare to all physicians who provide EMTALA-related care to Medicare beneficiaries, including on-call specialists whose services are needed to stabilize the patient.

- **The Emergency Volunteer Health Care Professions Protection Act.** This legislation, which at press time was set for introduction later in this congressional session, would either provide civil immunity to certain medical personnel involved in the evacuation or treatment of patients during a declared state of emergency, or limit civil liability for the delivery of medical services during a declared emergency.

**Conclusion**

While universal access to health insurance does not equal access to care, ensuring the strength, structure, and longevity of our nation’s trauma and emergency systems by including the aforementioned language will better ensure that patients receive the right care, at the right time, regardless of location. Although the overall outcome of health care reform remains uncertain, ACS advocacy staff will continue to work to ensure that Congress includes language addressing the problems currently facing our nation’s trauma and emergency care systems as a crucial part of system reform.

**References**


Resident files and the peer review privilege

by Darryl S. Weiman, MD, JD, FACS;
and Eugene Mangiante, MD, FACS
During a recent malpractice action, a subpoena requesting a resident’s evaluation file was delivered to the department of surgery. Unfortunately, the files were surrendered, effectively losing any claims the department might have had for a “peer review” privilege in that case. As medical malpractice actions become more common and more contentious, any plaintiff’s attorney who can show weaknesses in a resident’s past performance may try to use that information to bolster his claims of negligence if the resident is involved.

In an effort to deflect any future subpoenas requesting a resident’s file, we reviewed the Tennessee law in regard to the “peer review privilege.” The different states may or may not recognize this privilege, but our review may allow other departments that train residents to develop a strategy to fight this very serious attack on our ability to candidly evaluate the residents we are training.

Under Article V of the Tennessee Rules of Evidence, privileges are described by which a person may refuse to produce an object or writing when requested to do so by the Court. The privilege that the department of surgery should claim is the “Medical Review Committee-Informant Privilege,” which is part of what is known as the Tennessee Peer Review Statute. The Tennessee Peer Review Statute defines a “peer review committee” as “any committee of a state or local professional association or society...the function of which, or one of the functions of which, is to evaluate and improve the quality of health care rendered by providers of health care service to provide intervention, support, or rehabilitative referrals or services, or to determine that health care services rendered were professionally indicated, or were performed in compliance with the applicable standard of care....”

In a recent Tennessee case—Alexander A. Stratienko, MD, v. Chattanooga–Hamilton County Hospital Authority et al—the Supreme Court of Tennessee held that “information, documents, or records otherwise available from original sources are subject to discovery pursuant to Tennessee Code Annotated section 63-6-219(e), but only to the extent that they are not requested from the peer review committee and are not otherwise privileged.” In Stratienko, appellee Stratienko was trying to discover the “peripheral vascular credentials” of another physician with whom he had had a physical altercation. Stratienko’s hospital privileges had been suspended because of the altercation. Stratienko was able to get a temporary restraining order prohibiting the suspension and he was looking to support his claim to have the suspension reversed. The court held that Stratienko could not get the requested information from the peer review committee but he was free to obtain the information from other sources as long as other privileges did not apply.

Although the facts in this case did not address a resident’s performance file, the case is relevant to this discussion. In Stratienko, the Tennessee Supreme Court recognized that the purpose of the Peer Review Law is “to encourage committees made up of Tennessee’s licensed physicians to candidly, conscientiously, and objectively evaluate and review their peers’ professional conduct, competence, and ability to practice medicine.” These are the same activities that surgical faculty engage in during their meetings to evaluate residents’ progress during their training. There is a strong public interest in surgical training programs and their ability to train competent surgeons who can operate and take care of patients safely and independently. This training would clearly be impaired if residents could not be evaluated in confidence—which would occur if the records of the meeting were subject to discovery.

Although there isn’t a Tennessee case dealing with the peer review privilege as it relates to the personnel files of surgical residents, there is a
case from Texas that is pertinent to this issue. In Garza v. Scott and White Memorial Hospital, a federal district court held that resident evaluations were privileged under the Texas Peer Review Statute. In Garza, a surgical resident was being sued for medical malpractice. As an employee of the hospital, the plaintiff was hoping to establish that the hospital was negligent for credentialing (hiring) this particular resident, and they needed the files to support that claim. The court held that these documents fell under the statute and were privileged. As a result, the residency program director did not have to release the file.

The plaintiff’s attorneys may still try to obtain the information in the files, but they will have to do it in a different way, such as by directly questioning the attendings and the resident during a deposition. They can do this because, although the peer review proceedings are protected, the facts that may have been used by the committee are discoverable. Artfully posed questions regarding the experience and training of a resident may be asked during the deposition and they must be honestly answered, but this may be less hazardous than revealing the cryptic minutes of the faculty meeting for resident evaluations.

Of course, claiming that the resident’s evaluation file is privileged is only the first step in deciding this legal issue. Under the Tennessee Rules of Civil Procedure Rule 26.02 section (5), the opposing party in the action will have to be informed that you are withholding the requested information and you must provide him or her with enough information so that he or she can assess the applicability of the privilege. If opposing counsel disagrees with the claim, the court will have to hear arguments and then make a decision as to whether or not the privilege applies.

We believe that a resident’s evaluation file is privileged and should not be made available even if subpoenaed for discovery. Only through candid discussions can the surgical faculty critically evaluate their residents so that, ultimately, the quality of care can be improved for the community. The courts will need to decide on this issue. If the first court rules that the files are not privileged, an appeal should be made to a higher legal authority. It is important that surgical faculty be able to evaluate their residents in confidence so that they can fulfill their obligations in training future surgeons for the U.S. and the world.

References


Dr. Mangiante is associate dean of graduate medical education and deputy chairman, department of surgery, University of Tennessee Health Science Center, Memphis, TN.
For some of the Bangladeshi villagers, the gift was sight. For others, it was the ability to hear again. And still others were given the gift of eating more easily.

For the surgical team from Tripler Army Medical Center (Honolulu, HI), the ability to provide much-needed medical care in one of the world’s poorest regions was a truly life-changing gift—for the medical team and the patients.

Six U.S. Army medical personnel returned to their home base in Hawaii in August 2008, after treating impoverished civilians at the Combined Military Hospital (CMH) in Bogra, Bangladesh. The surgical team treated 50 patients for three types of disease: cataracts (sight); chronic ear disease (sound); and cleft lip and palate (smile) on their second “Sight, Sound, and Smile” mission, a program undertaken in partnership with the Bangladesh Army.

The deployed team consisted of three ear, nose, and throat (ENT) surgeons and residents; an ophthalmologist; and surgical technicians. Because of the rural setting, the team brought all essential surgical items with them, while physicians from the Bangladesh Army assisted with surgery and provided after-care for patients.

Bangladesh is one of the poorest and most densely populated countries in the world, with approximately 150 million people living in an area slightly smaller than the state of Wisconsin.* Bogra, located in the northwest region of the coun-


Below: Members of the U.S. and Bangladeshi surgical team during the first, August 2007 mission in Bogra. U.S. members (light green uniforms) in the back row from left to right: CPT Andrew Senchak, DO; 1SG Robert Nelson; Dr. Cable; Dr. Klem; Dr. Brett Nelson; SPC Andrea Miller; and SGT Melissa Aschenbrenner.
Early in the mission, Dr. Cable and Dr. Senchak perform a cleft lip repair while Bangladeshi surgeons observe.

Dr. Senchak (left), SGT Aschenbrenner (far right), and Dr. Cable (standing) with patients and parents the day after surgery.

The country, was chosen for this mission because of its extreme poverty. Functioning within a largely agrarian economy, Bangladeshi people live mainly in rural areas such as Bogra, and thus have difficulty accessing the national health care system.

The purpose of this mission is to provide specialized surgical services to Bangladeshi patients in need, and to train Bangladeshi doctors to perform these surgeries. U.S. and Bangladesh Army physicians worked closely over four days of surgery to accomplish the complex task of surgically repairing cleft lips and aural passages and remov-
A Bangladeshi cleft lip and palate patient prior to surgery.

A Bangladeshi cleft lip patient before and after surgery.

ing cataracts. “Children born with a cleft lip deformity in Bangladesh are often ostracized and unable to lead a normal life. They are not able to go to school and often cannot work or get married,” explained LT COL Ben Cable, MD, FACS. “In developed countries, cleft lips are repaired when children are three months old, while the average age of the patients we treated was over five years old.” Diseases such as cataracts and chronic ear disease are usually treated at a much earlier stage in developed countries, but frequently progress to cause major problems when left uncared for. “We literally had people who came in blind from advanced cataract disease and were able to see after surgery,” said MAJ Brett Nelson, MD, the team’s ophthalmologist.

“It’s just a privilege to go on such missions—when we take care of somebody’s family, any cultural difference there is set aside,” said Dr. Cable in an interview with the Honolulu Star Bulletin.†

Prior to the team’s arrival, local newspapers and radio broadcasts announced the mission so prospective patients could be screened by local civilian doctors at one of the Bogra rural health clinics. Through coordination between the regional health minister and the Bangladesh Army, patients were given access to the Bogra CMH, where further evaluation was conducted by Bangladesh Army physicians.

The Sight, Sound, and Smile mission was supported through the Peace Through Health Care Initiative—congressional funding specifically designated to promote the U.S. through humanitarian medical and surgical care in impoverished regions of the world. Additional Sight, Sound, and Smile teams from Tripler have been to Malaysia and Cambodia already this year, with the hope of expanding to other Pacific Rim countries in the future.  


Dr. Klem is chief of head and neck surgery, Tripler Army Medical Center, Honolulu, HI.
Governors’ Committee on Surgical Practice in Hospitals and Ambulatory Settings: An update

by R. Phillip Burns, MD, FACS

The Board of Governors’ Committee on Surgical Practice in Hospitals and Ambulatory Settings remains active in its evaluation of multiple issues influencing surgical practice. A few of the prominent issues discussed and evaluated by the committee include the following: continued evaluation and promotion of patient safety efforts, continued diligence in analysis of surgical workforce needs nationwide, support for enhanced surgical quality evaluation in hospitals, and changes in surgical practice structure.

Patient safety
The committee has worked diligently over the last two years to develop an enhanced, and more detailed, ACS Statement on Surgical Patient Safety. The finalized proposal was approved by the ACS Board of Governors in October 2008 and subsequently approved by the Board of Regents. Many individuals on the committee contributed to the work that led to the final document, and we were provided additional assistance by some past members of the committee who have extensive experience and expertise in this area.

The approved statement expands efforts to improve patient safety in several ways. It continues to emphasize the significance of accurate surgical site selection during the preoperative, time-out, and operative phases of the procedure in an effort to further reduce the incidence of this surgical complication. Additionally, the updated statement goes further than the previous version and emphasizes the need for improvement in communication between all members of the operative team in the preoperative, intraoperative, and immediate postoperative stages.

The new statement offers some flexibility for individual institutional variation in regard to adopted standards for implementation of this improved communication scenario. For example, a previously tested communication outline by the World Health Organization has functioned well in other institutions and could be used as a starting point in most operating rooms. Recent research...
For three years, this committee has discussed and expressed their concern about current, and future, surgical workforce availability. This concern has been shared with, and championed by, the Executive Committee of the Board of Governors, the Board of Regents, and the ACS leadership. It is encouraging to the committee that the ACS leadership has intensified efforts to gain more accurate information regarding surgical workforce demographics with initiatives such as the ACS Health Policy Research Institute. It is well known that the surgical workforce shortfall is having a strong impact on adequate health care in rural areas, but many urban centers are now suffering from the lack of availability of surgeons willing to take emergency call. This problem cannot be easily corrected—and the fact that the ACS leadership is making this issue a priority is encouraging. Our committee will continue to contribute to the discussion and study of this problem.

Surgical practice structure

Members of the committee continue to report significant change in the surgical practice structure’s business model across the country. The number of surgeons who currently work in an employment model appears to be growing rapidly as many are converting from time-honored mod-
double gloving, blunt-tip suture needles, neutral zones, and protective sharp device use.\(^4\)

Dr. Burns is professor and chairman of the department of surgery, University of Tennessee College of Medicine, Chattanooga. He is Chair of the Governors’ Committee on Surgical Practice in Hospitals and Ambulatory Settings.

has indicated significant improvement in patient safety as well as operating room effectiveness and efficiency when these steps are incorporated as a standard operating room algorithm of care.\(^3\) The ACS statement provides the added suggestion that defined points, or stages, of some operative procedures should be designated as “no hand-off time”—when certain members of the team will not be rotated—to further enhance efficient and effective teamwork and therefore improve results. The statement also incorporates previous recommendations by both the ACS and The Joint Commission regarding safety issues such as
The Socioeconomic Issues Committee is a committee within the Board of Governors’ structure with a broad base of surgeons in private and academic practices. This diverse and large group (the committee is composed of more than 40 members) provides optimal insight and active discussion on relevant socioeconomic topics.

The committee is currently focused on providing feedback to the Executive Committee regarding the desirability of a joint Board of Governors/Board of Regents meeting in 2009, which was overwhelmingly supported by both Boards, as well as providing suggestions on an appropriate topic for the meeting.

Our committee supports discussion of workforce issues, a comprehensive topic that might realistically address some of the following issues: ensuring the survival of the general surgeon; exploring the differences between rural and urban practice; incorporating the foreign surgeon; deciding what is “core surgery” and what can be delegated to physician extenders; and investigating issues related to the employed physician, physician privileging, work hours, and resident training.

In addition, each year the Socioeconomics Issues Committee manages the process of reviewing and selecting the American College of Surgeons/Pfizer Humanitarian and Surgical Volunteerism Award winners. The current nomination process has been completed, with 14 individuals nominated for the Humanitarian Award and 21 for the various volunteerism awards. Review and selection of the nominees is currently under way. As always, the caliber of the nominated individuals is outstanding and the selection process will be a challenging task for the reviewers. The award winners will be featured at the College’s Clinical Congress in October in Chicago, IL, in a three-hour panel session entitled Humanitarian Surgical Outreach at Home and Abroad: Reports of the 2009 ACS/Pfizer Volunteerism and Humanitarian Award Winners, which is cosponsored by Opera-
Giving Back and the Socioeconomics Issues Committee.

The committee has a panel session scheduled for the Clinical Congress. The committee is very excited to have recruited five excellent panelists who will each present a seven-minute presentation discussing a question relevant to their area of expertise, with comments from the other panelists to highlight their perspective on that question. In this panel presentation, William D. Petasnick, FACHE, current chair of the American Hospital Association board of trustees, will consider how the surgeon affects the financial health of the hospital; Richard Dean, MD, FACS, past-president and chief executive officer of Wake Forest University Health Sciences, will discuss joint ventures; O. William Brown, MD, JD, FACS, will focus on the employed surgeon; Mary H. McGrath, MD, MPH, FACS, a Past First-Vice-President, will consider the management of accreditation and regulations; and Sanjay R. Parikh, MD, FACS, will round out the panel by providing insight from the perspective of the “young surgeon.” There will be 20 to 30 minutes for audience participation at the conclusion of the formal presentations. The committee is excited about the pertinent topics this panel is presenting and committee members hope that a large and involved audience will make the educational process even more robust.

This year, the committee has determined two topics that are of considerable interest to our members and to the ACS membership in general. We believe that a statement from the ACS Board of Governors is required to clarify the difference between drug use and the use of devices. Regulatory agencies require that a company train treating physicians on the proper use of devices. The committee is excited about the pertinent topics this panel is presenting and committee members hope that a large and involved audience will make the educational process even more robust.

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Members of the Governors’ Committee on Socioeconomic Issues

- Michael C. Dalsing, MD, FACS, Chair
- Robert M. Zvolak, MD, FACS, Vice-Chair
- Gabriel S. Aldea, MD, FACS
- Lisa Bailey, MD, FACS
- Ruth L. Bush, MD, FACS
- Kathleen M. Casey, MD, FACS
- Joseph A. Corrado, MD, FACS
- Paul R. G. Cunningham, MBBS, FACS
- Joseph A. Corrado, MD, FACS
- Walter C. Dandridge, Jr., MD, FACS
- Charles M. Ferguson, MD, FACS
- Aaron S. Fink, MD, FACS
- Robert C. Flanigan, MD, FACS
- Timothy C. Flynn, MD, FACS
- James W. Gigantelli, MD, FACS
- Julian Gomez III, MD, FACS
- Daniel P. Harley, MD, FACS
- Burton L. Herz, MD, FACS
- Verne L. Hoshal, Jr., MD, FACS
- Edwin L. Kaplan, MD, FACS
- Daniel A. Leary, MD, FACS
- Sheila G. Lindley, MD, FACS
- David N. Linz, MD, FACS
- Charles D. Mabry, MD, FACS
- Stephen D. McBride, MD, FACS
- John E. McDermott, MD, FACS
- Charles T. McHugh, MD, FACS
- Gerhard H. Mundinger, Jr., MD, FACS
- Edward W. Nelson, MD, FACS
- Sanjay R. Parikh, MD, FACS
- Anathea Carlson Powell, MD, FACS
- Edward W. Nelson, MD, FACS
- Mark A. Praeger, MD, FACS
- John T. Preskitt, MD, FACS
- Robert V. Rege, MD, FACS
- Peter P. Rojas, MD, FACS
- David J. Schoetz, Jr., MD, FACS
- Gary R. Seabrook, MD, FACS
- Selwyn M. Vickers, MD, FACS
- Harold J. Wanebo, MD, FACS
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Dr. Dalsing is the E. Dale and Susan E. Habegger Professor of Surgery and director of vascular surgery, Indiana University School of Medicine, Indianapolis. He is Chairman of the Governors’ Committee on Socioeconomic Issues and a Governor from the Indiana Chapter of the College.
Advocacy advisor

Communicating with elected officials
by Melinda Baker, State Affairs Associate, Division of Advocacy and Health Policy

Whether an issue is being addressed through legislation or the regulatory process, communication is vital. Surgeons can reach out to policymakers via letter, fax, e-mail, telephone call, face-to-face meeting, and so on. Legislators want to hear from their constituents and are sensitive to their opinions. Thoughtful, sincere, and precise comments are most helpful and may be useful to a legislator or regulator in debates or discussions on a bill or proposed rule.

Telephone
If you are using the telephone to communicate with a legislator, don’t be surprised if you end up talking to the staff person responsible for the issue, such as the health legislation aide. However, because staff are very influential, it is beneficial to speak with them and begin developing a personal connection.

It is important to limit the message to a few simple points. Reference the bill number, offer comments, and ask what position the legislator has taken.

Avoid being argumentative or trying to “win” the discussion; simply present your position matter-of-factly and encourage support or opposition to the bill. At the end of the call, offer to follow up with a letter recapping the points raised in the discussion. Give the staff person your telephone number so they can easily contact you if they need further information. One rule of thumb: if the staff person has been helpful, courteous, or otherwise accommodating, note it in the letter; which should be addressed to the legislator. Positive strokes are valuable in an environment where often the negative is emphasized.

Meeting with an official
There are a few simple guidelines to follow when meeting with a legislator or another governmental official.

• Setting up the meeting. When calling to set up a meeting, ask for the appointment scheduler. Be flexible with the time you can meet, provide the scheduler with the number of people who will be in attendance, and offer a short synopsis of why you want to meet. Expect to be asked to fax a formal written request containing the same information, and understand it is fairly common to be allotted approximately 15 minutes maximum.

• Confirming the meeting. Once the time and date are finalized, send a confirmation letter to the legislator (it can be faxed), as well as any advance informational materials as a way to brief the legislator on what you want to discuss.

• During the meeting. Be clear and concise in your discussion. Bring handouts that briefly summarize your comments to leave with the legislator. As with any other meeting, even if the legislator disagrees with your position, be polite and courteous. Arguing with a lawmaker or government official is an ineffective way to advocate for a position. Offer to serve as a resource on health care issues. If questions arise during the meeting that you are unable to answer, make it a priority to obtain and send informational materials addressing them. Also, invite the official and their staff to stop by and meet your staff and to take a tour of your office or hospital surgery department.

• After the meeting. Send a letter thanking the legislator for his or her time. Reiterate the main points made during the meeting. If the legislator agreed to support a position, thank him or her. If the legislator chose to remain silent or opposed your position, it is appropriate to once again encourage support. Answer any questions that came up in your meeting, and, again, if possible invite them to tour your facility.

Written correspondence
To make your written communication effective, there are a few simple rules to follow:

• Personalize: Keep it local. If you are being asked to send a letter or e-mail that is prewritten, add your own comments at the beginning, or at least change the subject line of the e-mail so it

continued on page 49
Editor’s note: The following is the first of a series of columns initiated by the ACS Health Policy Research Institute (HPRI). The mission of the HPRI is to improve the understanding of surgical patient care from a policy perspective in order to educate the public, federal and state governments, health care consumers, and the policy community to enable advocacy for superior, efficient, and compassionate surgical patient care. The goal of the HPRI is to create a data-driven, knowledge-based program for examining issues related to surgical services, the surgical workforce, and public policies affecting surgery.

The bimonthly column will feature research data on topics of interest to Fellows and Members of the College.

Between 1981 and 2006, the U.S. surgical workforce increased by 53 percent—from 87,345 to 133,796 surgeons. During the same time period, the national population grew 31 percent. This raised the per capita surgeon supply from 38.1 to 44.7 surgeons per 100,000 persons. However, most of the gains during the 25-year period were attained by the early 1990s, after which growth tapered, and even reversed, for general surgery. Furthermore, data suggests a worsening problem of geographic distribution of surgeons in future years.

**General surgery**

Growth in the surgical workforce during the 25-year period was fueled by an increase in physicians in surgical subspecialty groups at the expense of general surgery. Only 4 percent (1,881) of the 46,451 net gain in surgeons between 1981 and 2006 were general surgeons; an additional 3,349 (7.2 percent) were in specialties requir-
1981 to 18 percent by 2006, reflecting both the slow growth in the number of general surgeons and the expansion of several specialty groups such as obstetrics and gynecology (OBGYN), orthopaedic, plastic, and thoracic surgery.

**Workforce growth slowdown**

Analysis also shows unsteady growth in the surgical workforce, particularly for general surgery, between 1981 and 2006 (Figures 1 and 2, this page). The net change in surgeon supply varied considerably for both general surgery and surgical specialties during each five-year interval of the study period, and growth for all surgeons has slowed considerably since 1996. Surgical specialties had double-digit growth in each period until 1996, when growth slowed to approximately 7 percent in each of the two subsequent periods. General surgery growth was up and down, peaking in 1991 and again in 2006, but with nominal or negative growth in the other periods. Meanwhile, population growth was fairly consistent, hovering around 5 percent during each five-year interval, with the exception of 1996–2001, when it increased by 7.5 percent. Amid these inconsistent trends, what appears consistent is a sudden slowdown in the surgery workforce growth beginning sometime after 1991.

**Geographic maldistribution**

To examine geographic variation in the surgical workforce supply, we analyzed physician and population data for all U.S. counties over

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**Figure 1. U.S. specialist and general surgeons per 100,000 population, 1981–2006**

![Graph showing the number of specialist and general surgeons per 100,000 population from 1981 to 2006.]

**Figure 2. Growth in the U.S. surgical workforce by primary specialty, 1981–2006**

![Bar chart showing the growth in the U.S. surgical workforce by primary specialty from 1981 to 2006.]

the 25-year period. Overall, we found that the average surgeon-to-population ratios held steady or improved in more than three-quarters of U.S. counties for all surgeons, but the general surgery-to-population ratio declined in 41 percent of counties between 1981 and 2006 (Figure 3, this page). More than half of all counties experienced an increase in surgeon-to-population ratios between 1981 and 2006, while a smaller percentage (30 percent) of counties gained general surgeons. The number of counties with no surgeons declined steadily over the 25-year period, such that 925 counties (30 percent) had no surgeons by 2006, a slight improvement from 1981 when 1,025 (33 percent) had none. As expected, more counties had no general surgeons throughout the 25-year period; however, in contrast with the improvements observed, with the ratio of all surgeons to population, we found that the number of counties with an inadequate supply of general surgeons (fewer than 4.7 per 100,000 population as recommended by the Graduate Medical Education National Advisory Committee (GMENAC*)

ratios in 2006. Regional variations in the gain or loss of surgeons show that counties (see Figure 4, this page) in the Northeast experienced significant gains, while losses were more common in the South.

Geography, trends in supply
Change in the geographic distribution of general surgeons was slightly worse than for all surgeons between 1981 and 2006. Approximately 41 percent of all counties experienced a declining ratio of general surgeons per 100,000 people, and a disproportionate number of those counties were urban. Whereas 34 percent (781) of rural counties had declining general surgeon-to-population ratios during the 25-year period, 60 percent (506) of all urban counties experienced declining ratios (see Figure 5, this page). Regional patterns of change in surgeon-to-population ratios for general surgeons did not mirror those for all surgeons. In every region of the country (and particularly in the Northeast), more counties experienced declines in general surgeon-to-population ratios than increases. Consistent with other findings, this data suggest that there has been a substantial loss of general surgeons across the nation, and that this loss has been greatest in urban areas, where surgical specialists have grown more rapidly.

In 1981, one-third (1,025) of all U.S. counties had no practicing surgeons (see Figure 6, page 31). By 2006, 303 of those counties gained a surgeon, but 203 other counties had lost all their surgeons. These 925 counties without a surgeon had a collective population of 14.7 million people in 2006.
Implications

Although the overall surgical workforce experienced considerable growth during the 25-year period between 1981 and 2006, the supply of general surgeons has not kept pace with population growth or the expansion of other surgical specialties. Many U.S. counties have no practicing surgeons and even more continue to lose surgeons, particularly generalists. These trends have implications for access to care, as the competencies of general surgeons are broadest and include emergency and trauma care. Further, the failure of general surgery to keep pace with population growth has resulted in a significant number of areas that do not meet the minimum standard of geographic access to surgical care, as defined by the GMENAC. These findings are important from the perspective of medical training and workforce planning, in that new policies may be necessary to increase the number of general surgeons through a program similar to the National Health Service Corps’ loan repayment program or focused support for residency training.

Data and methodology

American Medical Association Masterfile data representing all licensed physicians were analyzed in six consecutive periods, separated by five years each. Census Bureau population data for corresponding years was used to calculate provider-to-population ratios at the county, state, and regional levels of analysis. Providers with a self-reported primary specialty of surgery, as identified in the Table on page 27, were included in the analysis. Only providers who identified their practice type as “direct patient care,” were 69 years old or younger, and who reported a practice location within a U.S. county or county-equivalent (according to Federal Information Processing Standard [FIPS] codes) were included in the analysis. Physicians were excluded from the analysis in a given year if they reported being in residency training, semi-retired, or if they reported their primary present employer was the U.S. government, locum tenens, medical school, or other nonpatient care employment. For the purpose of this analysis, counties were defined by FIPS codes, regions by the U.S. Census Bureau, and rural–urban was defined using the U.S. Office of Management and Budget’s core-based statistical area definitions for metro and micropolitan areas.
The realization that many talented, energetic young people have had limited opportunities to participate in the American College of Surgeons’ activities prompted the Committee on Young Surgeons (CYS) to propose the formation of a new Young Fellows Association (YFA). The ACS Board of Regents approved that proposal at their June 5-6 meeting in Chicago, IL.

**YFA’s purposes**

Under the chairmanship of Perry Shen, MD, FACS, the 15-member CYS began formulating plans to establish the YFA about two years ago. As conceived, this group would provide an outlet for the broad spectrum of Fellows ages 45 and younger who want to play an active role in the ACS and in its state and local chapters.

“The way the committee has been structured doesn’t allow other young surgeons—those who are not one of the 15 members—to really be involved in the College’s many activities,” said Dr. Shen, associate professor of surgery at Wake Forest University School of Medicine, Winston-Salem, NC. Dr. Shen explained that young surgeons often have approached him after the Initiates Program at the Clinical Congress and at the Leadership Conference for Young Surgeons and Chapter Leaders, wanting to know what they can do to get more involved in the organization. “Meetings like the Leadership Conference are inspiring experiences for young surgeons,” Dr. Shen said. “After sitting through the sessions and hearing about all of the College’s activities and the work it is involved in on behalf of the Fellows, people say, ‘wow, I didn’t realize that the ACS does all of that,’ and they want to be part of what we are doing.”

Mark Savarise, MD, FACS, who helped to spearhead the

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**Call for Nominations for the Executive Director of the ACS position**

A Search Committee, appointed by the Board of Regents, has initiated the process of selecting the next Executive Director of the ACS. The following guidelines will be used by this committee and the Board of Regents when reviewing the names of candidates for potential nominations to this position:

- The nominee must be a surgeon and a Fellow of the American College of Surgeons.
- The nominee has demonstrated outstanding medical statesmanship, along with an unquestioned devotion to the highest principles of surgical practice.
- The nominee possesses strong leadership qualities, with particular expertise in strategic planning, advocacy, executive-level management, and fiscal stewardship.
- The nominee recognizes the importance of representing all who practice surgery.

Nominations should include a cover letter of introduction and the nominee’s current curriculum vitae. Submit nominations to Barbara Dean, Director of Executive Services (e-mail: bdean@facs.org), by Tuesday, September 1, 2009.

If you have any questions, contact Dr. L.D. Britt—Chair, Board of Regents of the American College of Surgeons, at ldbrtit@evms.edu or 757-446-8964.

The American College of Surgeons is an equal opportunity employer.
YFA’s formation, said that he had been in similar situations, and that “up until now, we have not had a satisfactory answer for them. We would refer these Fellows to their chapter leadership or encourage them to apply for a spot on the CYS.” Because of the restricted size of the committee and a lack of interest among some of the chapters, “we lost some people who would have been helpful to the College,” he said.

Furthermore, individuals who have matriculated through the Resident and Associate Society (RAS) of the ACS are often eager for opportunities to remain actively involved in the College. These individuals have expressed concern that the College has not provided a next logical home base for them as they strive to shape the future of the organization, according to Rhonda Peebles, ACS Division of Member Services, staff liaison to the YFA.

“The RAS is a very active group. They’re very organized, and sometimes when their members have become Fellows, they want to stay involved in the College,” Dr. Shen said. The YFA will give these individuals opportunities to further develop their skills and “to continue working in leadership areas of the College.”

The formation of the YFA “is really an opportunity for the group to be inclusive rather than exclusive,” Ms. Peebles added.

The CYS anticipates that the YFA will ensure that young surgeons will stop getting lost in the shuffle and will allow them to sustain their enthusiasm for the work of the College. Young surgeons often “join the organization, obtain Fellowship status, and then—nothing,” said Dr. Savarise, a general surgeon in private practice in Sandpoint, ID. “We hope our new structure allows us to engage a large number of these young Fellows and to make them active participants in the workings of the College.”

In addition, the YFA will focus its initiatives on the issues of particular relevance to surgeons who have recently entered into practice. These topics include legislative issues, reimbursement, personal financial stability, practice management and set up, and strategies for balancing their family and professional lives, Dr. Shen said.

To help ensure that the YFA is, in fact, responsive to young surgeons’ concerns, for its first new project the group will conduct a comprehensive survey of young Fellows and Initiates. “We want to obtain metrics to make sure that what we are doing really represents the interests of our colleagues,” Dr. Savarise said. He explained that whereas the actual needs of young Fellows are similar to those of more senior members, their perceived needs may differ.

Opportunities to participate
The YFA will be managed by a 15-member governing council and a five-member Executive Committee. It will comprise four work groups, in which YFA members will be expected to actively participate. These task forces, their objectives, and activities are as follows:

• Advocacy Work Group: Responsible for representing the needs of young surgeons on the various committees that shape the College’s legislative agenda. The members of this panel will also help to coordinate the annual ACS Leadership and Joint Surgical Advocacy Conferences in Washington, DC, and represent the ACS at the American Medical Association’s Young Physicians Section meetings.

• Communications Work Group: Charged with increasing awareness of, and involvement in, the YFA among young Fellows, Associate Fellows, and Initiates by improving the College’s communication with these individuals. The members of the work group will prepare and distribute a quarterly electronic newsletter and will seek to improve relationships with ACS chapters.

• Education Work Group: This task force will participate in the development of education programs targeted at younger members. The group will also be responsible for informing young Fellows about the educational resources that the College offers, for surveying the YFA membership and reporting the findings, for developing a traveling award for young Fellows, and for working with the College’s education committees.

• Member Services Work Group: Responsible for increasing awareness about the ACS among young Fellows. Members will be tasked with promoting programs and initiatives that serve the needs of young Fellows and with providing a voice for young surgeons at all levels of the College.
“The main goal initially is going to be to see if a structure like this is viable and if people around the country are going to be willing to get involved with these work groups,” Dr. Shen said.

All YFA members also will be responsible for being involved in their state/local ACS Chapter and for contacting their chapter leaders at least once a year. YFA members also may serve as intermediaries to state and national surgical specialty societies. “The YFA has the potential to evolve into a national network of young Fellows,” Dr. Shen observed.

Furthermore, members of the Governing Council will be charged with serving as liaisons to the ACS Board of Regents, the standing committees of the Board of Governors, and other standing committees of the College, including the Program Committee and the RAS. Members of the CYS have traditionally served as representatives on many of these ACS panels. For example, Dr. Savarise has been the CYS liaison to the General Surgery Coding and Reimbursement Committee for the last three years.

“The longer I serve, the more valuable my contributions are to the committee. I do feel that my committee chair values my opinion as a young surgeon,” he said.

In addition, the YFA will assume responsibility for all of the CYS’s ongoing projects, such as co-hosting the annual Leadership Conference, presenting the Initiates Program at the Clinical Congress, and co-sponsoring a session with the RAS at the annual meeting. The YFA also intends to arrange a forum for young Fellows at this year’s Clinical Congress, where young surgeons will have an opportunity to meet, to discuss issues of relevance to them, and to have a dialog with a member of the Board of Regents or the Board of Governors.

**Good for everyone**

The leadership of the CYS anticipates that the new YFA will be useful not only in the advancement of the young Fellows’ agenda, but to all members of this organization.

“Hopefully, we will identify people who want to get involved and can nurture those people,” so that they will become committed volunteers for the ACS, Dr. Shen said.

“The new structure of the Young Fellows Association should benefit all involved. The current CYS members will benefit from the input of many more young Fellows; the leadership of the College will benefit from the involvement of so many more of its young, energetic, and enthusiastic members; and the young Fellows will benefit from the opportunity to become more involved in this organization that is so important to them,” Dr. Savarise said.

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**Oweida Scholarship availability announced**

The Board of Governors of the American College of Surgeons is pleased to announce the availability of the 2010 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, 2009**. For the complete requirements for this scholarship, visit [http://www.facs.org/memberservices/oweida.html](http://www.facs.org/memberservices/oweida.html) on the College’s Web site, or contact Kate Early at kearly@facs.org.
What is the CSPS?

COUNCIL ON SURGICAL & PERIOPERATIVE SAFETY
One Team. One Goal. Surgical Patient Safety.

The CSPS is a unique multidisciplinary coalition of seven professional organizations representing key members of the surgical team:

• American Association of Nurse Anesthetists
• American Association of Surgical Physician Assistants • American College of Surgeons
• American Society of Anesthesiologists • American Society of PeriAnesthesia Nurses
• Association of periOperative Registered Nurses • Association of Surgical Technologists

The CSPS envisions a world in which all patients receive the safest surgical care provided by an integrated team of dedicated professionals.

And why should you be interested?

• Because you are concerned about the safety of your patients.
• Because you want a caring perioperative workplace environment.
  • Because you want integrated teamwork and improved communication to result in better patient outcomes.
  • Because you care!

For more information, visit www.cspsteam.org, or call the CSPS Administrative Director, Denise Goode, at 312/202-5700

Recent activities:

• The CSPS released a statement on violence in the workplace
• The CSPS cosponsored the second National Conference on Perioperative Care and Safety: “Improving, Enhancing & Sustaining Positive Patient Outcomes,” in Chicago, IL, May 8–9, 2009, in collaboration with Joint Commission Resources, Inc.
Faculty research fellowships offered for 2010–2012

The American College of Surgeons is offering two-year faculty research fellowships, through the generosity of Fellows, chapters, and friends of the College, to surgeons entering academic careers in surgery or a surgical specialty. The fellowship award is $40,000 per year for each of the two years, and is intended to assist a surgeon in the establishment of a new and independent research program. Applicants are required to demonstrate their potential to work as independent investigators.

Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the College. The Franklin H. Martin, MD, FACS, Faculty Research Fellowship honors the founder of the College. The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors the late Dr. Carrico.

General policies covering the awarding of the American College of Surgeons Faculty Research Fellowships are:

- The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the United States, or by the Committee for Accreditation of Canadian Medical Schools in Canada. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

- This award may be used by the recipient for support of his or her research or academic enrichment in any fashion that the recipient deems maximally supportive of his or her investigations. The fellowship grant is to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient’s institution.

- Application for this fellowship may be submitted even if comparable applications have been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award. The Scholarships Committee reserves the right to review potentially overlapping awards and adjust its award accordingly.

- The College encourages the applicant to leverage the funds provided by this fellowship with time and monies provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

- The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

- A minimum of 50 percent of the Fellow’s time must be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

- The Fellow is expected to attend the Clinical Congress of the American College of Surgeons in 2012 to present a report to the Forum on Fundamental Surgical Problems (Surgical Forum) and to receive a certificate at the annual meeting of the Scholarships Committee.

The closing date for receipt of applications and all supporting documents is November 2, 2009. Application forms may be obtained from the College’s Web site: http://www.facs.org/memberservices/research.html.
The American College of Surgeons is offering two-year resident research scholarships for July 1, 2010, through June 30, 2012. Eligibility for these scholarships is limited to the research projects of residents in surgery or a surgical specialty. American College of Surgeons’ Resident Research Scholarships are supported by the generosity of Fellows, chapters, and friends of the College to encourage residents to pursue careers in academic surgery.

**General policies**

The policies for granting of the American College of Surgeons Resident Research Scholarships are as follows:

- The applicant must be a Resident Member of the College who has completed two post-doctoral years in an accredited surgical training program in the U.S. or Canada at the time the scholarship is awarded (July 1, 2010) and shall not complete formal residency training before June 2012. Scholarships do not support research after completion of the chief residency year.
- The scholarship is awarded for two years, and acceptance of it requires commitment for the two-year period. The award is to support a research plan for the two years of the scholarship, July 2010 through June 2012. Priority will be given to the projects of residents involved in full-time laboratory investigation. Study outside the U.S. or Canada is permissible. Renewal of the scholarship for the second year is required and is contingent on the acceptance of a progress report and research study protocol for the second year, as submitted to the Scholarships Section of the College by May 1, 2011.
- Application for these scholarships may be submitted even if comparable application to other organizations has been made. If the recipient is offered a scholarship, fellowship, or research award from another organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award. The Scholarships Committee reserves the right to review potentially overlapping awards and to adjust its award accordingly.
- The scholarship is $30,000 per year; the total amount is to support the research of the recipient and is not to diminish or replace the usual or expected compensation or benefits of the recipient. Indirect costs are not paid to the recipient or to the recipient’s institution.
- The scholar is expected to attend the Clinical Congress of the American College of Surgeons in 2012 to present a report on the research as part of the Forum on Fundamental Surgical Problems (Surgical Forum), and to receive a certificate at the annual meeting of the Scholarships Committee.
- Approval of the application is required from the administration (dean or fiscal officer) of the institution. Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor who will be supervising the applicant’s research should be submitted. Only in exceptional circumstances will more than one scholarship be granted in a single year to applicants from the same institution.

The closing date for receipt of completed applications and all supporting documents is **September 1, 2009**.

Application forms may be obtained at [http://www.facs.org/memberservices/research.html](http://www.facs.org/memberservices/research.html), or upon request from the Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
We hate lawsuits. We loathe litigation. We help doctors head off claims at the pass. We track new treatments and analyze medical advances. We are the eyes in the back of your head. We make CME easy, free, and online. We do extra homework. We protect good medicine. We are your guardian angels. We are The Doctors Company.

The Doctors Company is devoted to helping doctors avoid potential lawsuits. For us, this starts with patient safety. In fact, we have the largest Department of Patient Safety/Risk Management of any medical malpractice insurer. And, local physician advisory boards across the country. Why do we go this far? Because sometimes the best way to look out for the doctor is to start with the patient. Our medical professional liability program has been sponsored by ACS since 2002. To learn more about our program for ACS members, call (800) 862-0375 or visit us at www.thedoctors.com.
The International Relations Committee of the American College of Surgeons has established an exchange program with the Japan Surgical Society and the ACS Japan Chapter. In early April, Lorenzo Ferri, MD, FACS, of McGill University, Montreal, PQ, attended the annual meeting of the Japan Surgical Society in Fukuoka, and visited several other Japanese surgical centers. The Japan Exchange Traveler, Hiroshi Saeki, MD, PhD, of Kyushu University Hospital, Fukuoka, has been selected to attend the College’s Clinical Congress in Chicago, IL, in October. Dr. Saeki will give a presentation at the Congress and will tour several surgical institutions in North America. Dr. Saeki is highly involved in researching proliferation and prognosis of esophageal carcinoma.

The German Surgical Society and the ACS Germany Chapter have also developed a similar exchange program with the College. Richard A. Santucci, MD, FACS, of Michigan State College of Osteopathic Medicine, Detroit, attended the German Surgical Society’s annual meeting in Munich in late April, and visited additional surgical sites around Germany. (See Dr. Santucci’s report on his travels on page 40.) His German counterpart, Prof. Bjoern Bruecher, MD, PhD, of the University of Tübingen, will attend our Clinical Congress and choose several surgical sites to visit with the guidance of his mentors at home and in the U.S. Professor Bruecher’s research focuses on the radiocative therapy treatment of esophageal carcinoma.

Fellows encouraged to complete Johns Hopkins HCC survey

Fellows of the American College of Surgeons who have an interest in hepatobiliary or liver transplant surgery are invited by researchers at the Johns Hopkins University School of Medicine and School of Public Health, Baltimore, MD, to participate in a brief online survey on surgery for early hepatocellular carcinoma (HCC).

Surgical therapy for early HCC is a controversial topic, and the therapeutic strategies chosen by surgeons vary considerably. Participation in this survey will help researchers to understand how surgeons approach this disease, aid in the formulation of treatment guidelines, and identify targets for future research on HCC treatment.

The survey will take approximately five minutes to complete. All respondents will receive a summary of the survey results upon completion of the study. To begin the survey, visit http://hccsurvey.questionpro.com/.
Report of the 2009 ACS Germany Traveling Fellow

by Richard Santucci, MD, FACS

The ACS Germany Traveling Fellowship is awarded every year to an American or Canadian surgeon who will travel to Germany, and to a German surgeon who will travel to North America. The Germany Fellowship awardee attends the German Surgical Society meeting, and travels and lectures at two or more additional medical centers over a two-week period. I was fortunate to be the 2009 Fellow, and this is my report.

The German Surgical Society meeting

The meeting is attended by approximately 8,000 surgeons and affiliated medical personnel and lasts for four days. It is very similar to the international ACS Clinical Congress in terms of tone and composition, though it is smaller than that meeting (see photo, this page). The meeting provides the standard didactic lecture format, as well as some excellent hands-on opportunities for live training in laparoscopy and visceral surgery (see photo, page 41). Most German surgeons speak English exceedingly well, and most equipment companies advertise in English, so it was quite easy to navigate the meeting with limited German-language skills.

One of the major elements of the Fellowship is to attend and speak at the annual meeting (or “Congress,” as it is referred to in Germany) of the 126-year old German Surgical Society (Deutschen Gesellschaft für Chirurgie). The Society is made up of general surgeons and 10 specialty societies including plastic, cardiac, pediatric, neurosurgery, trauma/orthopedics, thoracic, general/visceral, vascular, and a separate cardiac/thoracic/vascular section. You may notice that gynecology and urology are not included in the society (they have their own separate groups)—a fact that initially caused consternation among my German contacts until I was able to convince them that the common ground of trauma surgery, laparoscopic surgery, and reconstructive surgery that makes up my practice would have much overlap with their meeting agenda, and that all would be fine (and it was).

The German ACS

A crucial aspect of the Congress is attending the ACS German Chapter meeting. The ACS German Chapter has approximately 50 members and is the principal contact organization for the Germany Traveling Fellow. I made a short presentation of my travel plans to the ACS German Chapter and met up with the General...
Secretary of the chapter, Prof. Norbert Senninger, MD, FACS, chairman of surgery and chief of transplantation at Münster University (see photo, page 42). I was pleased to meet a number of German ACS members and to hear that they perceived their ACS application process to be respectful and efficient, and their association with the ACS valuable. Only a fraction of eligible German surgeons become ACS members, and I often saw that members who had worked or trained in the U.S. were perhaps more inclined toward membership for this reason.

This ACS German Chapter also meets during the Clinical Congress annually in the U.S. I would encourage any ACS member to try to attend this German section ACS meeting at any future ACS national meeting (or you may visit any international ACS section meeting), as a sign of friendship and solidarity for our surgical colleagues worldwide.

At the end of the Congress, I lectured on the subject of Genitourinary Trauma: 21st Century Update for the General Surgeon. This topic was chosen by the German ACS section and me as having the most universal interest for my general surgery audience in Germany (see photo, page 42).

The Germany-to-U.S. Fellow

It was a pleasure to meet Prof. Bjoern Bruecher, MD, PhD, FACS—my German counterpart in the Germany Traveling Fellowship program. He has amassed an impressive curriculum vitae, not the least of which is attainment of full professorship at a tender age. Among his most impressive accomplishments, for me, is the creation of the Theodor Billroth Academy, a German medical academy that trains and nurtures young medical students with an interest in surgery. According to a press release issued by the academy, fewer than 5 percent of German medical students profess an interest in surgery and this academy, which started its first two-week “summer school” for medical students last year, is designed to support those interested few, aggressively and early in their training. The students attend lectures and learn surgical techniques on cadavers. It is cross-pollination of ideas like this that make the ACS Traveling Fellowship programs so useful.

Heidelberg visiting professorship

Traveling Fellows can be assisted in their selection of centers to visit by the ACS German Chapter, or they may make their own arrangements. I have a long history of working with German surgeons, so I was granted my wish to visit my colleagues in Heidelberg and Bremen. The urology department in Heidelberg runs an amazing program, with a level of surgical competence, organization, and resources that is truly impressive. The department is headed by my friend and colleague Prof. Markus Hohenfellner, MD—professor of urology and chair of the department of urology at the Heidelberg University—with whom I co-edited our textbook Emergencies in Urology. Heidelberg University is the oldest in Germany, established...
in 1386, and it was an exciting place to tour.
Professor Hohenfellner created a robust educational program for my visit. In Germany, surgical visitors are permitted to operate on patients, and I was able to perform several challenging cases which utilized my expertise in reconstructive urology. I performed these surgeries as I usually do, allowing the senior resident to perform the entire case with close direction and control, in order to maximize the value and teaching impact of the experience (see photo, page 43).

The visiting professorship featured nighttime lectures to the department and community urologists, and daytime lectures to the residents. I had the opportunity to give lectures on the following topics: Nonoperative Management of Even High Grade Renal Trauma, Hemostatic Agents in Renal Sparing Surgery, and Simplified and Unified Approach to Urethral Stricture Disease.

A highlight of the trip was a dinner with only the residents and me, where we had a chance to get to know each other and I could learn their personal stories. This allowed an excellent opportunity to advise these young surgeons on patient care and career issues in a “safe” environment away from their overlords, and provide friendly advice when appropriate.

iClinics collaboration
Face-to-face meetings with Professor Hohenfellner allowed us to complete work on our latest international collaborative effort—the first free, high-speed, high-definition surgical video Web site in the world. Named iClinics (http://www.iclinics.org), it is a not-for-profit endeavor that allows registered users to upload high-definition surgical videos into a peer-reviewed space, and allows any user to view it without the barriers of required registration. Videos feature space for both author and user commentary, very much like Amazon.com allows users to comment on the quality and characteristics of individual products. We believe this Web site can be an excellent source of high-quality surgical videos for surgeons worldwide, and we encourage ACS members to upload their own videos to the site (authors keep the rights to their own videos).

Bremen visiting professorship
I completed my journey with a lovely train trip up the Rhine River Valley to Bremen. Bremen is an ancient town in northern Germany set on the river Weser, and situated about 40 miles south of the North Sea. Its center is a UNESCO World Heritage Site, and it is a beautiful place to be a tourist. My host was “Herr Professor Doktor” Sebastian Melchior of the Klinikum Bremen-Mitte. (Notably, formal German social protocol requires the use of the full title of a professional person’s name, and in the correct order. Professor Melchior and I have been friends since residency, so I have been permitted to call him by his first name, but formal reference should always include the full title, especially in writing or in public. Any university professor of any description must be referred to as “Professor” in Germany, even though in the U.S. one might refer to a physician with a university appointment as simply “Doctor.”)
In Bremen I was allowed to lecture on the subject of urethral stricture to the university and community urologists, and I gave a lecture titled 21st Century Overview of Genitourinary Trauma to the urology department at the university clinic. We completed a very challenging surgical case of proximal urethral avulsion after pelvic trauma where the bladder neck had also been ligated closed during previous pelvic exploration for bleeding. In this case, Professor Melchior and I completed the case together (instead of with a resident), as it was very difficult. Professor Melchior is an accomplished cancer and transplantation surgeon, but his experience with exotic trauma cases is naturally less robust, and we both benefited from each other’s perspective during this arduous case. It is interesting to note that chairmen of urology departments in Germany do not specialize in narrow surgical disciplines as much as we do in the U.S., and often they are expert surgeons who regularly operate across several urologic subspecialties.

Performing a complex urethroplasty on an adult patient with urethral stricture after childhood hypospadias repair in the efficient and familiar German operating room, together with a senior resident.

What the traveling fellowship means

Improving and nurturing international relations in surgery is my main avocation in organized medicine. There are approximately 194 countries worldwide, encompassing almost 7 billion people. These billions of people in hundreds of countries have much to teach and much to learn. The ACS has a robust international mission that serves to train and educate worldwide, but this mission also allows cross-pollination from foreign experts in the U.S. (an important thing if we are to keep innovating at full speed, and crucial to avoid becoming intellectually insular). I am so grateful to the ACS and the German Surgical Society, and to the many people in Germany and the U.S. whose efforts made my trip possible and who gave me the opportunity to increase friendly and professional ties, as well as to increase the scientific cross-pollination between our two great nations. The ACS can conceivably become the uncontested global brand leader in surgical innovation and education—and while the Germany Traveling Fellowship is only one thread in that planet-wide web, it is only through such programs that this is an achievable goal.

Dr. Santucci is specialist-in-chief, urology, Detroit Medical Center system; full clinical professor, Wayne State College of Osteopathic Medicine; and director of The Center for Urologic Reconstruction, Detroit, MI. He is a full-time trauma and reconstructive urologist.
NEW! ACS MULTIMEDIA ATLAS OF SURGERY Colorectal Volume. This DVD and accompanying book provide an interactive demonstration of 26 colorectal surgery procedures, both laparoscopic and open. Especially designed to address the cognitive element of surgical procedures, each procedure is presented in a step-wise fashion, offering expert commentaries that highlight specific nuances and actions to be taken to prevent errors. Upcoming volumes include Pancreas Surgery and Hernia Surgery.

NEW! PROFESSIONALISM IN SURGERY, 2nd Edition: This DVD presents an additional 12 new vignettes that depict professionalism challenges faced by surgeons in everyday practice, as well as possible courses of action in the context of the core competency of professionalism. The vignettes are ideal for teaching purposes and CME credit is available.

NEW! ACS SURGERY RESIDENT OSCE: This program provides a tool to assess the entry-level knowledge and skills of PGY-1 surgery residents to deliver safe care to surgery patients with critical and life-threatening conditions. It includes a CD-ROM manual with all the materials needed to administer the OSCE, and a DVD that provides a gold standard performance of each clinical scenario. This project was supported by grant number U18 HS12021 from the Agency for Healthcare Research and Quality.

NEW! PATIENT SAFETY 2008 CD. This CD features patient safety sessions from the 2008 Clinical Congress.

BASIC ULTRASOUND COURSE CD: This CD provides a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications and is available for CME credit.

PRACTICE MANAGEMENT for Residents and Young Surgeons: This series of three CDs covers important topics such as mechanics of setting up or running a private practice, essentials of an academic practice and career pathways, and basics of surgical coding. CME credit is available.

ADDITIONAL CDs, including the Bariatric Surgery Primer and Personal Financial Planning and Management for Residents and Young Surgeons.

DVDs AVAILABLE AT NO CHARGE, including Disclosing Surgical Errors: Vignettes for Discussion, and Communicating with Patients About Surgical Errors and Adverse Outcomes, each supported by a grant of the Agency for Healthcare Research and Quality.

VIDEO-BASED EDUCATION SESSIONS: Select video sessions from the Clinical Congress are available on CD/DVD. The ACS Video Library contains narrated videos, donated by the authors.

For purchase and pricing information, call ACS Customer Service at 312/202-5474 or visit our E-LEARNING RESOURCE CENTER at www.acs-resource.org

For more information, contact Olivier Petinaux, MS, at elearning@facs.org, or 866/475-4696.
The portfolio of neoadjuvant clinical trials for the American College of Surgeons Oncology Group (ACOSOG) continues to expand. ACOSOG Z5041 is a phase II study of preoperative gemcitabine and erlotinib followed by pancreatectomy and postoperative gemcitabine and erlotinib for patients with operable pancreatic adenocarcinoma (study chair: Peter Pister, MD, FACS).

Pancreatic adenocarcinoma has a particularly poor prognosis, with the majority of patients dying less than one year following diagnosis. Operable pancreatic carcinoma accounts for only 10 to 15 percent of new cases and surgical resection offers the only known curative treatment. Unfortunately, many patients who undergo complete tumor resection experience systemic disease recurrence within two years. Long-term follow-up demonstrates that only 10 percent to 15 percent of patients who undergo pancreatectomy survive five years. It is clear that effective systemic therapies are needed in the adjuvant setting. In 2008, ACOSOG reported the results of our completed postoperative chemoradiation therapy trial following a pancreatectomy (ACOSOG Z5031). Z5041 incorporates a neoadjuvant systemic therapy regimen for operable pancreatic adenocarcinoma and, thus, is a unique trial design among adjuvant trials conducted thus far.

Surgeons play a key role in the design and conduct of neoadjuvant regimens for resectable disease. This neoadjuvant trial design is consistent with other ACOSOG neoadjuvant trials in breast (ACOSOG Z1031, ACOSOG Z1041), gastrointestinal (ACOSOG Z6041), and thoracic (ACOSOG Z4051) malignancies. (These are available at http://www.acosog.org). Patients with potentially operative pancreatic adenocarcinoma are initially seen by surgeons who will play a significant role in the decision for preoperative therapy.

There are a number of reasons to adopt a neoadjuvant therapeutic regimen for resectable pancreatic adenocarcinoma. The adjuvant therapies for resected pancreatic adenocarcinomas have shown some survival benefit to infusion 5-FU. Likewise, there is some benefit to adjuvant gemcitabine therapy following curative resections. While adjuvant radiation therapy has been used in some patients following surgical resection, convincing level 1 evidence has been lacking. The European Study Group for Pancreatic Cancer trial showed that patients randomized to receive postoperative adjuvant chemoradiation therapy had an inferior median survival compared with patients not receiving chemoradiation therapy.

Other European adjuvant trials are now focusing on studying adjuvant chemotherapy without radiation. Z5041 incorporates an epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor, erlotinib. The gemcitabine and erlotinib regimen was selected for this neoadjuvant trial based upon a small, but statistically significant, increase in the one-year overall survivor compared with gemcitabine alone in patients with unresectable or metastatic pancreatic adenocarcinoma.

Neoadjuvant systemic therapy for resectable pancreatic adenocarcinoma is unique. The rationale for preoperative therapy is that many patients with resectable disease harbor micrometastatic disease. At least 80 percent of patients who undergo resection of the primary tumor recur at a later date. There is a need to eradicate micrometastasis prior to surgical resection. Another potential benefit is primary tumor regression, which is commonly seen with neoadjuvant therapies for breast and rectal adenocarcinomas. Lastly, toler-
ance to preoperative therapy is likely to be higher prior to pancreaticoduodenectomy.

The primary objective of Z5041 is to determine the overall survival at two years. Secondary objectives include: (a) to determine the resection rate following neoadjuvant therapy, (b) to determine the time to disease relapse, (c) to determine the rate of R0, R1, and R2 resection following preoperative gemcitabine and erlotinib, and (d) to determine the toxicity profile of this regimen and to assess the accuracy of pretreatment staging in response to neoadjuvant therapy. Z5041 is a single arm, nonrandomized phase II study. Up to 91 patients will be enrolled in the study, with the expectation that 78 patients will be eligible and evaluable for the primary end point.

The following is the trial schema.

Eligibility criteria for this trial include:

1. Cytologic or histologic diagnosis of adenocarcinoma of the head or uncinate process. Patients with tumors of the neck, body, or tail are not eligible. Duodenal and ampullary adenocarcinoma are not eligible.

2. Patient must have no radiologic evidence of metastatic disease. Resectability is defined as “no evidence of tumor extension to the celiac axis, hepatic artery, or superior mesenteric artery, no evidence of tumor encasement or occlusion of the superior mesenteric vein or the portal vein confluence.” ECOG 0 or 1 status, weight loss ≤ 15 percent of previous weight, and CA19-9 < 1,000 are also required.

The correlative science component of Z5041 involves FNA diagnostic or core biopsy material to assess the epithelial-mesenchymal transition (EMT) theory for pancreatic adenocarcinoma. Tumor cells can duplicate either the epithelial phenotype expressing e-cadherin or mesenchymal phenotype which invades surrounding tissues and blood vessels establishing distant metastasis and expresses vimentin or fibronectin. Preliminary data show that mesenchymal phenotype is insensitive to EGFR inhibitors. Z5041 has the potential to correlate a pancreatic adenocarcinoma response to this gemcitabine and erlotinib neoadjuvant regimen with EMT marker expression. Z5041 will also determine if the EGFR intron-1 polymorphism is a prognostic marker of pancreatic adenocarcinoma response to anti-EGFR therapy and clinical outcome. The hypothesis is that peripheral blood EGFR intron-1 polymorphism is a prognostic marker of clinical outcome and response to EGFR therapy.

ACOSOG is moving in a new direction to development effective adjuvant therapies following resection of pancreatic adenocarcinoma. This multisite neoadjuvant trial design for pancreatic adenocarcinoma is consistent with many of the trials ongoing within ACOSOG disease sites. Surgeons play an extremely important role in decision making in treatment of resectable pancreatic adenocarcinoma before surgery. ACOSOG is recruiting site investigators who have a strong interest in conducting prospective clinical trials and who treat pancreatic adenocarcinoma.

Visit the ACOSOG Web site or contact Dr. Pisters (ppisters@mdanderson.org) for additional information.

References


Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG Co-Chairs.
els of private practice to a variety of institutional/hospital employee models. This rapid shift in the business model for a growing number of College members has been acknowledged by the Board of Governors’ Executive Committee. Some members are concerned that such shifts may ultimately become a threat to the structure and, possibly, the long-term viability of the ACS. Hopefully, further discussion, study, and ACS program presentations will highlight and elucidate the magnitude and potential influence of such change. It is important to generate ongoing suggestions for dialogue topics between the Board of Governors and the Board of Regents to continue further collaborative evaluation of this issue.

Quality/NSQIP
The committee continues to address issues of transparency in evaluation of surgical care outcomes through peer-reviewed, surgeon-driven evaluation models such as the National Surgical Quality Improvement Program (NSQIP). The public image of the surgical community will be significantly enhanced by championing efforts to assess surgical quality, with the anticipation that those measures can be used to improve surgical care and outcomes. The public—and especially our patients—deserve to know that, both as a group and as individuals, surgeons are responding to transparency issues with programs that analyze shortcomings and provide a road map for improved surgical care.

References

their devices, yet they restrict the educational interaction between industry representatives and the physician. If this statement is generated in conjunction with other interested organizations, this effort may be a joint statement of clarification from the perspective of the College. Currently, this initiative is in the design stage. The second topic of concern is related to the need to retain advancing levels of independence during surgical training, which is becoming ever more difficult in the current environment of external controls. A statement from the College may allow a more reasonable and understandable approach to how we train our future surgeons. It is hoped that this statement might influence our educational process.

For next year’s Clinical Congress in Washington, DC, the Socioeconomic Issues Committee will again schedule a panel session. The potential topics under consideration for next year’s Congress include the following: The Surgeon’s Interaction with Industry; The Implications of an Employed Surgeon; Where the Business of Medicine Meets the Profession; Expectations of Surgeons Finishing Training; and Surgical Training: Current Challenges and Whose Responsibility. Discussion is ongoing as to which topic is most pertinent for the following year, and which would contribute most to the members’ needs and concerns. Future considerations for the Socioeconomic Issues Committee encompass the scope of the surgeon’s world, and topics abound. The challenge is focusing on the issues that we can most have an effect on within our committee structure. The economy is likely to have an impact on what topics will be of the greatest concern to the membership. The Socioeconomic Issues Committee is open to the concerns of all members and would like feedback from surgeons who believe that an issue is going unrecognized. The committee would like to provide a voice for the surgeon experiencing challenges pertinent to the charge of this group.
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A look at The Joint Commission

ASC standards change

Several changes were recently made to the standards that apply to the Ambulatory Care Accreditation Program in order to align them with changes made by the Centers for Medicare & Medicaid Services (CMS). These changes apply only to ambulatory surgical centers (ASCs), which use Joint Commission accreditation for the purpose of meeting CMS’s requirements for reimbursement. Failure to comply with these changes could adversely affect an organization’s accreditation status. The new requirements became effective May 18. Some of the key changes include the following:

• Revised ASC definition—patient stays in the ASC must be less than 24 hours.
• Patient rights information, including advance directives, must be provided (verbally and in writing), prior to the date of the procedure.
• Information about physician ownership in the ASC must be provided prior to the date of the procedure.
• Patient rights must be posted and must contain specific information on how to report complaints to the state and to the CMS Ombudsman.
• ASCs must have a qualified professional, with training in infection control, directing its infection control activities.
• ASCs must have a process for submission, investigation, and disposition of complaints.

For a full list of the changes please refer to the April 2009 issue of The Joint Commission Perspectives, the official newsletter of The Joint Commission. All accredited organizations receive a complimentary copy of the newsletter. For additional guidance on complying with the standards updates and additions, contact The Joint Commission Standards Interpretation Group at 630-792-5900.

ADVOCACY ADVISOR, from page 26

stands out. Tell them how this issue will affect you and your patients. They get many facts and figures from lobbyists, but only you can provide the personal touch.

• Avoid starting your letter with a tone of righteous indignation. Use a polite, informative tone. Stay away from writing an opening sentence saying “as a citizen and taxpayer,” because the legislator assumes you are both. A standard opening sentence could be something like, “This letter is being written to comment on H.B. 1234, the Health Care Reform Act. H.B. 1234 is currently before the legislature, and I encourage you to support it.”

• Focus on a few key points. Don’t make the communication too wordy, and use common terms and language. Overly technical language is indecipherable to most legislators, who generally have no medical or clinical training. Explain the potential effects on quality, access, and surgical practice. A one-page letter is ideal, but two pages are acceptable. Avoid discussing tangential issues because they will only confuse the issue.

• Be sure to note a bill number or title of a proposed rule, as well as a brief description of what the bill/rule will do. Thousands of bills are introduced every year, and referencing a bill only by description of the issue may not mean much to a legislator, as he or she can’t possibly memorize each and every bill.

• Offer to speak further with the legislator/regulator, and provide contact information.

Physicians are viewed in a generally positive light and are seen as experts on medical/clinical issues. Legislators and regulators or their staff may very well take you up on the offer.

Final reminder

You don’t always need to ask for something when you contact your officials. A letter or thanks for a good job is always appreciated and rarely sent, and will set you apart from the crowd.
NTDB® data points

Older but wiser vs. helmetless and lifeless

by Richard J. Fantus, MD, FACS

In 2008, the U.S. bicycle industry accounted for $6 billion of the overall economy, according to research funded by the National Sporting Goods Association (NSGA). This included the retail value of bicycles, related parts, and accessories. Sales are completed through four channels of distribution: the mass merchant, specialty bicycle retailer, full-line sporting goods stores, and “other,” which includes outdoor retailers, internet sales, and the like. The mass merchants accounted for 74 percent of the sales, but this figure accounts for only 35 percent of the dollars spent due to the (low) average selling price of those bicycles (http://nbda.com/page.cfm?pageID=34).

Along with these robust sales figures, the number of Americans, age seven and above, who rode a bicycle at least six or more times in 2008 was up 11 percent from 2007, to 44.7 million riders (http://www.nsga.org/files/public/2008ParticipationRankedbyAlpha_4Web_080415.pdf).

With the struggling economy and rising gasoline prices, more and more Americans are biking their way across town as an alternate means of transportation. Unfortunately, with this increase in the numbers of cyclists, there continues to be a stagnant percentage of riders wearing helmets. In the May 2008 Bulletin article “Pedal to the metal”(pages 43–44), helmet use was noted at 33 percent, which is the same percentage found in the National Trauma Data Bank® (NTDB) dataset review. The $20 cost of an average bicycle helmet is relatively inexpensive when compared to the estimated $2.3 billion indirect costs of cyclists’ injuries each year due to not wearing a helmet (http://www.bhsi.org/stats.htm).

In order to examine the occurrence of injuries to bicyclists in the NTDB research dataset 2007 admissions (formerly called research dataset 8.0), records were searched utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) cause of injury code E826.1 (pedal cycle accident where the injured person is the pedal cyclist) and E810 through E819 (motor vehicle traffic), with the fourth digit .6 (to identify injured person as the pedal cyclist). 12,807 incidents matched these E codes and of these, 8,215 had information regarding helmet use.
There were 5,521 (67.2 percent) records with no helmet use, compared to 2,694 (32.8 percent) records where a helmet was utilized. The helmeted patients were 76.4 percent male and on average 37.6 years of age; they had an average length of hospital stay of 3.9 days, an average injury severity score of 9.3, and 1.34 percent mortality. When comparing the non-helmeted group with the helmeted group, there was a statistically significant increase in death (defined by emergency department discharge disposition = death, or hospital discharge disposition = expired), and the average age was lower (see Figure on page 50).

Cycling is an invigorating form of exercise as well as an inexpensive mode of transportation. There are no fossil fuels used in bicycling, so it also qualifies as a green mode of conveyance as opposed to a greenhouse gas-producing one. There are many advantages to riding a bicycle, and, likewise, for wearing a helmet when riding one. Next time you take to the streets it might be a good idea to be older but wiser, versus helmetless and lifeless.

The full NTDB Annual Report Version 8.0 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 mmeal@facs.org.

Acknowledgment

The author also acknowledges the assistance of Sandra Goble, MS, in the preparation of this column.

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

West Virginia Chapter conducts annual meeting
The 59th annual West Virginia Chapter Meeting was held May 7–9, 2009, at The Greenbrier in White Sulphur Springs, WV. ACS Regent J. David Richardson, MD, FACS, served as the College’s representative to this year’s education program (see photo, this page). In addition, new officers were elected (see photo, this page).

Connecticut participates in ACS membership demonstration program
Last April, the Connecticut Chapter hosted an education program for young surgeons and residents that focused on practice management issues, as well as personal finance management concerns. This program was part of a demonstration project that the College is conducting in three sites to examine membership recruitment strategies.

Several leaders of the chapter served as faculty members for this education program, including Philip Corvo, MD, FACS, President; Juan Sanchez, MD, FACS; J. Alexander Palesty, MD, FACS; and Christopher Tasik, Executive Director. In addition, Ted James, MD, FACS, the former Chair of the College’s Resident and Associate Society, reviewed the special programs and products for Resident Members of the College.

North Dakota wraps up legislative session
Bruce Levi, Executive Director of the North Dakota Chapter, reported that before concluding this year’s session, the North Dakota Legislative Assembly passed several laws favorable to surgeons and other physicians, including:

- Based on recommendations from the College relative to the North Dakota trauma system, S.B. 2048 was passed, which directs all North Dakota hospitals to participate in the trauma system.
- H.B. 1073 was passed, which adopted the Uniform Emergency Volunteer Health Practi-
## Chapter meetings

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

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

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<thead>
<tr>
<th>Date</th>
<th>Chapter</th>
<th>Location/contact information</th>
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<tr>
<td><strong>August 2009</strong></td>
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| August 18–21    | Colombia      | Location: Convention Center, Medellin, Colombia  
Contact: Francisco Henao, MD, FACS, 571 2362831, fhenao@javeriana.edu.co |
| August 28       | Oklahoma      | Location: Tulsa, OK  
Contact: Linda O’Rourke, 405-271-5506, surgery@ouhsc.edu |
| **September 2009** |             |                              |
| September 2–4   | New Mexico    | Location: Albuquerque, NM  
Contact: Sally Blackstad, 505-828-0237, sblackstad@nmms.org  
ACS representative: Leigh A. Neumayer, MD, FACS |
| September 12–13 | Kansas (CS)   | Location: Doubletree Hotel, Overland Park, KS  
Contact: Gary Caruthers, 785-234-3319, gcaruthers@kmsonline.org |
| September 13–16 | Kentucky (CS) | Location: Hyatt Regency, Louisville, KY  
Contact: Linda Silvestri, 859-323-6346, lsilv2@uky.edu |
| September 17–18 | Italy         | Location: Catania, Sicily  
Contact: Nicola Di Lorenzo, MD, FACS, 39 06 20902927, nicola.di.lorenzo@uniroma2.it  
ACS representative: John L. Cameron, MD, FACS |
| September 23    | Jacksonville  | Location: Marriott Southpoint, Jacksonville, FL  
Contact: Patti Chapman, 904-994-7355, rotaryeexcsec@aol.com |
| September 26    | Arkansas (CS) | Location: Jackson T. Stephens Spine and Neurosciences Institute, Little Rock, AR  
Contact: Linda Clayton, 501-753-3500, lindac92@comcast.net |
| **October 2009** |               |                              |
| October 23–24   | Iowa          | Location: University of Iowa Hospitals and Clinics, Iowa City, IA  
Contact: Sue Hyler, 515-270-3613, sue.hyler@pioneer.com |
| October 25      | Argentina     | Location: Sheraton Hotel & Convention Center, Buenos Aires, Argentina  
Contact: Roberto Lamy, MD, FACS, 54 11 4474488, rlamy@fibertel.com.ar |
| October 30      | Connecticut (CS) | Location: Holiday Inn, Waterbury, CT  
Contact: Christopher Tasik, 203-674-0747, info@ctacs.org |
tioners Act, as recommended by the College.
  • H.B. 1390, which proposed to repeal the current $500,000 cap on noneconomic damages, was defeated.

For more information on this year’s legislative session in North Dakota, contact Bruce Levi at 710-223-9475, or at blevi@ndmed.com.

Chapter anniversaries

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<tr>
<th>Month</th>
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<td>West Virginia</td>
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<td>Rhode Island</td>
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Illinois Chapter goes online

Beth Mahlo, the Administrator for the Illinois Chapter, reported in April that the chapter has a new Web site available at http://www.ilchapteracs.org/. With the publication of this new site, there are currently more than 40 U.S. chapters that have Web sites. All chapter Web sites, including a directory of chapter officers and chapter education programs, are available at http://www.facs.org/about/chapters/index.html.

Brooklyn-Long Island Chapter hosts 2008 Clinic Day

Last December, in conjunction with the Nassau Surgical Society (NSS), the Annual Clinic Day was held. The education event, which featured separate sessions for the various surgical specialties, also included a special luncheon that featured Elizabeth Vargas from ABC News (see photo, this page).

Ohio Chapter convenes

Meeting in Cleveland, the Ohio Chapter conducted its 2009 Annual Meeting at the Hyatt Regency. Highlights of this year’s event include:
  • The first “Past Presidents” dinner was held May 7, and Richard Reiling, MD, FACS, served as the master of ceremonies.
  • The Ohio Chapter’s Distinguished Service Award was presented to Margaret Dunn, MD, FACS. The award was presented by Mark Malangoni, MD, FACS, a new Regent for the College (see photo, this page).
  • In conjunction with the Ohio Cancer Society, the Ohio Cancer Liaison Physicians hosted a special lecture that featured Jocelyn Logan-Collins, MD, a resident at the University of Cincinnati, as well as presentations on quality improvement.
and the ACS accreditation program for breast centers, conducted by Stephen Edge, MD, FACS; and David Winchester, MD, FACS, respectively; nearly 150 physicians and cancer registrars attended this event.

• The Women in Surgery Conference was presented by the Ohio Chapter and the Association of Women Surgeons, and was supported by a grant from Covidien; Amy Reid, MD, FACS, served as course director.

• The Ohio Chapter’s new Web site was introduced; the URL is http://www.ohiofacs.org/.

• The election of new officers included Michael Sarap, MD, FACS, President; Joseph Sferra, MD, FACS, President-Elect; and Amy Reed, MD, FACS, Secretary.

SGO annual meeting on women’s cancer webcast now available

A webcast/podcast of selected sessions from the Society of Gynecologic Oncologists’ (SGO) 40th annual Meeting on Women’s Cancer is currently available for purchase online. The webcast, which is SGO’s first e-learning educational offering, features the following educational programming:

• All plenary and focused plenary sessions including discussant presentations

• American Cancer Society and Hugh K. Barber, MD, FACS, guest lectureships and presidential address delivered by Thomas W. Burke, MD, FACS

• SGO symposia and select PG, XPG, and Sunrise Sessions

The SGO annual meeting webcast includes all PowerPoint slides presented during the sessions, a voice recording of the presenter, full multimedia presentations including embedded videos when available, the ability to download the accompanying PowerPoint slides for select presentations, and the option to assemble a unique collection of slides based on a simple keyword search using the “Search’n Build” feature available at http://www.multiwebcast.com/sgo/2009/40th/listing.

The webcast is being offered at a special introductory package price of $200 for annual meeting registrants and $500 for nonregistrants. Both packages represent a $1,140 savings off of the on-site registration fee. Women’s cancer health care professionals will find the sessions of value to their practice and for delivering care to their patients.

To view a sample of the webcast’s programs, see the presidential address, or to purchase the webcast/podcast session, visit http://www.sgo.org/.

Trauma meetings calendar

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

- **Disaster and Mass Casualty Management 2009**, December 10, Kansas City, MO.
- **Advances in Trauma 2009**, December 11–12, Kansas City, MO.
- **Medical Disaster Response 2010**, March 21, 2010, Las Vegas, NV.
- **Trauma, Critical Care, and Acute Care Surgery, 2010**, March 22–24, 2010, Las Vegas, NV.
- **Point/Counterpoint XXIX**, May 24–26, 2010, National Harbor, MD.

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