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In this, my last column, I would like to briefly present my own personal views regarding the future of surgery and of the College.

Value-based care

At press time, Congress was still debating legislation designed to improve patient access to affordable, cost-effective, high-quality care. Regardless of what our elected officials ultimately decide to do, vital systemic changes are likely to occur that will significantly affect surgical practice. The fact of the matter is that our nation simply cannot afford to maintain the status quo. Despite previous cost-containment efforts, health care spending has continued to rise at a breakneck pace. Consequently, the way in which physicians are compensated for their services will change. The system will truly be driven by high value rather than volume.

Policymakers anticipate that comparative effectiveness research will yield information about the financial and medical value of various treatment options. As new means of treating disease emerge, we will have to be active participants in comparative effectiveness research to make certain that surgical approaches yield value equal to, or greater than, other methods of treatment. Much of what we do also will be based on the results of clinical trials and other rigorous scientific studies. Surgeons and other physicians will be expected to use these findings in practice or run the risk of receiving reduced, or no, reimbursement for the care they provide. Hence, the College’s clinical trials program, which began some 12 years ago, should be expanded beyond oncology so that we can really test and validate new surgical procedures, devices, and approaches to providing care.

Furthermore, I believe surgeons and other health care professionals will be subject to increased public scrutiny, and we will need to be much more open to reporting our outcomes and to implementing best practices. Physicians, their practices, and medical institutions are going to have to be prepared for a great deal of oversight.

In addition, surgery as a profession could evolve in an iterative way. We are likely to provide fewer episodic services and to become more involved in the overall management of diseases. As a result, surgeons will need to have a solid understanding of different paradigms for delivering health care, such as the patient-centered medical home and accountable care models. Under these new models, surgeons will be much more active members of teams of medical professionals who are competent in managing the causes, symptoms, and secondary conditions related to a broad range of diseases. It is possible that our professional identity will not be as closely aligned with the operating room as it was previously.

The College’s future

This organization is about to undergo some important changes and face some significant challenges of its own. The new Washington, DC, office building located at 20 F St., NW, is scheduled for completion in 2010, and we will need to
make the best possible use of this new facility. I believe this new site should serve to bring the surgical community together to advocate for legislative improvements that will address issues of mutual concern, including Medicare payment reform, regionalization of emergency and trauma centers, and the surgical workforce crisis, among many others.

The ACS needs to break out of the surgical silo and continue to actively interact with other stakeholders who are participating in the health care reform debate. We need to think about systems reform and how surgery can contribute to efforts to increase quality, facilitate access to surgical care, and eliminate unnecessary fiscal waste in the system. The surgical community needs to come together and speak as a unified body representing a critical segment of the medical profession that recognizes the primacy of the patient.

The College also needs to be mindful of the nation’s continuing economic troubles and to strategize to determine which programs may need to be scaled back, and which ones need financial replenishment. For example, at a time when the College is facing increasing demands to participate in the development of evidence-based practice guidelines and measures that add value to the lives of our patients, it is of the utmost importance that we foster the development of the ACS Foundation. The funds the Foundation oversees allow us to recruit talented scholars who are able to analyze the sophisticated data gathered through the College’s databases and disseminate their findings for use in clinical practice. The Foundation also enables us to provide scholarships to promising surgical investigators working at leading research institutions.

With thanks

Finally, I want to once again express my appreciation for having had the extraordinary experience of serving as the Executive Director of the American College of Surgeons for 10 years. This has been a unique opportunity to attempt to help mold the College into a more influential, modernized, and relevant organization—one that will be critical to our profession as we go forward. I have truly appreciated the ongoing support and interest of the Board of Regents, the Officers, the Past-Presidents, the Board of Governors, the loyal volunteers, and the entire ACS staff. We have an extraordinarily dedicated, incredibly competent staff. All of the College’s programs ride on their shoulders. It is one thing to have an idea; it is something very different to execute and maintain it. In this time of transition, their sense of stability and morale are very important.

This is an uncertain time and there is unrest among our members and other stakeholders in our health care system. We will need to meet multiple challenges and to embrace cultural change. It’s been said that with great challenges come great opportunities. I believe that with Dr. Hoyt’s leadership, the College will become a major, positive force in building a system that will allow our members to better meet the needs of their patients.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
On July 31, the Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2010 Inpatient Prospective Payment System (IPPS) final rule. The rule addresses the financial effect of the payment system on hospitals, as well as the hospital-acquired conditions policy. It also covers a variety of changes and issues related to the Reporting of Hospital Quality Data for the Annual Hospital Payment Update (RHQDAPU) program, including the addition of new measures to the program, the retirement of measures from the program, and other changes. The College submitted comments to CMS related to the FY 2010 IPPS proposed rule, and CMS took our comments into consideration when preparing the final rule.

How will the final rule affect hospitals financially?

CMS estimates that the operating payments to all hospitals under the final rule will increase by $1.73 billion, or 1.6 percent, in FY 2010, and that capital payments will increase by $171 million, or 1.9 percent, when all of the changes are taken into account. The estimate of IPPS operating payments in FY 2010 does not include any projection of changes in hospital admissions or real case-mix intensity, which also would affect overall payments. These changes took effect October 1.

Did the final rule change the hospital-acquired conditions policy in any way?

No, the final rule did not modify the hospital-acquired conditions policy. Based on comments that were received from the College and other specialty societies, CMS did not add or remove categories of hospital-acquired conditions (HACs) at that time. Since October 1, 2008, an inpatient hospital discharge is not assigned to a higher-paying Medicare Severity-Diagnosis Related Group (MS-DRG) if a selected HAC is undocumented as present on admission (POA). In other words, the case will be paid as though the secondary diagnosis was not present. The College strongly supports CMS’ decision not to change the list of HACs or POA reporting at this time, and to use information gathered from experience with the HAC payment provision to inform maintenance of the HAC list, and consideration of future potential candidate HACs.

The current HAC list includes the following conditions:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcer stages III and IV
- Certain falls and trauma
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Manifestations of poor glycemic control
- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following certain orthopedic procedures
- Surgical site infection following bariatric surgery for obesity
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures

What new quality measures did CMS add to the RHQDAPU program?

CMS added two new Surgical Care Infection Prevention (SCIP) measures and two new registry participation measures to the RHQDAPU program for payment in the year 2011. The SCIP measures include:

- SCIP-Infection-9: Postoperative urinary catheter removal on postoperative day 1 or 2
- SCIP-Infection-10: Perioperative temperature management

The registry participation measures include:
• Participation in a systematic clinical database registry for stroke care
• Participation in a systematic clinical database registry for nursing sensitive care

The initial submission deadline for reporting the SCIP measures is August 15, 2010, for data from the first calendar quarter of 2010. Reporting for the registry participation measures would begin in July 2010 for the period January 2 through June 30, 2010.

CMS indicated that the agency anticipates registry-based data collection to be one method, but not the exclusive method, for submitting data for quality measures. CMS also intends to expand the types of measures used beyond process of care measures to include an increased number of outcomes measures, efficiency measures, and patients’ experience-of-care measures, while attempting to impose only a minimum burden on providers.

**Did CMS retire any quality measures from the RHQDAPU program?**

They did not retire any quality measures in this final rule. CMS solicited comments on whether any of the RHQDAPU program measures should be retired from the program, and the College’s comments included a recommendation that the following (current) SCIP measures be retired:

- SCIP 4: Cardiac surgery patients with controlled 6 am postoperative blood glucose
- SCIP 2: Prophylactic antibiotic selection for surgical patients
- SCIP 6: Surgery patients with appropriate hair removal

CMS stated that the agency will consider these suggestions for measures to possibly retire in the future. CMS also indicated that high levels of unvarying care across hospitals should be among the factors considered in measure retirement because such measures do not improve care. The agency also indicated that quality measures should relate to high-quality care processes, be related to better patient outcomes, align with current clinical guidelines when possible, and not be overly burdensome to collect. CMS also believes that outcomes measures are useful, but that they do not render process measures incompatible or redundant, and that all measures should be evaluated for negative unintended consequences.

**Did CMS make any additional changes to the quality measures in the RHQDAPU program?**

CMS finalized a proposal to combine the following RHQDAPU program measures:

- PSI 04: Death among surgical patients with treatable serious complications
- Nursing sensitive—failure to rescue

The combined, new quality measure is titled “Death among surgical inpatients with serious, treatable complications.” CMS finalized this combination in order to maintain consistency with the National Quality Forum’s (NQF’s) voluntary consensus standards. In May 2008, the NQF gave the two measures the same title: “Death among surgical inpatients with serious, treatable complications,” with the same measure specifications.

**Did CMS make any changes to MS-DRG classifications?**

CMS finalized a proposal to move the procedure codes 80.05 and 80.06 (cases involving the removal of hip and knee prostheses) from their current assignments in the MS-DRGs 480, 481, and 482 and 495, 496, and 497 respectively, and assign them to MS-DRGs 463, 464, and 465. This proposal is based on a DRG reassignment request suggesting that these cases are significantly more expensive to treat than those in their current MS-DRG assignments.

Presidential Address:

Professionalism in the 21st century

by

LaMar S. McGinnis, Jr., MD, FACS
It is my great privilege to address this most distinguished Convocation class of 2009. While I am speaking directly to you tonight, I hope to be speaking through you to all of our 74,000 Fellows worldwide and to other interested parties.

On behalf of our College, Fellows and staff—a sincere “thank you” to John Cameron, MD, FACS, Immediate Past-President, L. D. Britt, MD, FACS, Immediate past-Chair of the Board of Regents, the Regents and Governors, and to Thomas R. Russell, MD, FACS, Executive Director, for your exemplary leadership.

I must express how honored I am to be the 90th President of the College. I feel especially honored as a simple, community general surgeon to have been so chosen. I should note that our archives reveal only six community surgeons to have been honored with this presidency in our 96-year history, with the first being J.M.T. Finney, MD, FACS, as so clearly depicted by Dr. Cameron in his Presidential Address last year. I feel that I stand here representing the thousands of community surgeons who rise daily, well before dawn, serve their patients with dedication, skill, and compassion, arrive home late in the evening, often returning as needed for further care, with little heed to nights, weekends, holidays, and special occasions.

Let me offer a specific example—Anne Williams, MD, FACS, a California native and Parkland-trained general surgeon, who has practiced in Glasgow, MT, for more than 20 years (see photo, page 10). I made her acquaintance last spring as we worked together on Operation Patient Access. She is the only surgeon in a 500-mile range, on call 24/7/365, yet she loves this practice. She does not feel oppressed; her only concern is who might join her or replace her when she must ultimately leave her practice. Dr. Williams may be in the extreme; however, she is but one of the many community surgeon heroes and heroines across our land. I proudly accept this office in their stead.

My heartfelt congratulations to our most distinguished Honorary Fellows, and to you new Fellows seated before me on this memorable evening. You have chosen your career well. You have spent many years preparing yourself to be a surgical professional. You are indebted to many on this night—your spouse, your children, your parents, your mentors, your peers, and, yes—even your creditors. We wish you Godspeed, fulfillment, and pride in your accomplishments to date and in those to be anticipated in the years ahead.

I also take joy in expressing my gratitude to all who have directed, assisted, supported, and guided me along my life and particularly along my surgical professional life. A sincere thank you to my mentors, peers, associates, and staff, in all venues. My profound gratitude extends to my devoted, self-sacrificing parents and to my wonderful children. However, my principal debt and gratitude extends to one. I met her in the latter part of the last millennium when she was a student nurse at the Royal Victoria Hospital in Montreal, where I was interning. Two years later, I returned to Canada on a ski vacation at Mont Tremblant. Now a graduate nurse, this lovely person was also there skiing as a guest of the McGill Redbird ski team. We became reacquainted and were married three months later. That was 52 years ago, and my love and admiration for her continues to grow. Her name is Julia, my wife and my love, here with us tonight.

We live in interesting times, particularly as related to our chosen profession, medicine, and, more specifically, surgery. Despite the remarkable advances that have occurred over the last century, I believe that never before have opportunities been brighter for surgeons to care for sick and injured patients than are now occurring and will continue in this first century of this new millennium. Admittedly, change is upon us, possibly even epochal change, but when viewed objectively, the convergence of ideas—scientific, technological, social, economic, and political—that are occurring have the true potential for turning our present “sick care” system into a true health care system, with benefit for all. The uniqueness of the surgeon will persist following this evolution. Surgeons are different; we have different abilities and skill sets. We think differently, approach problems and deal with patients and their families in a...
surgical way. We are not interchangeable with others; you cannot call in a primary care doctor, a nurse, a technician, a nurse practitioner, or a physician’s assistant to fill our shoes, even though they are all most important and essential members of the perioperative team.

Our heritage is our greatest strength

So my early message is: surgeons will continue to be valued and sought out in this 21st century and to be important players as we move to more integrated systems of health care delivery, often delivered by teams. Readily available, near real-time, risk-adjusted outcomes data and appropriate response to that data will result in greater health care value, and the integral role of the surgeon will persist.

Someone once said, “Without a heritage, every generation starts over.” The profession of surgery, and our College in particular, has a proud and abundant heritage. Carl Becker, a University of Chicago economist and Nobel Laureate, once remarked that “The most significant accomplishment of the 20th century, a century filled with accomplishment, was the doubling of life expectancy.” It is a truly remarkable fact, considering the state of health care and of the surgical care of patients as the last century began. Hospital care, surgical care, and medical education were in an appalling state. In this country, leadership appeared. Abraham Flexner, a Louisville, KY, educator with a Carnegie Foundation grant (see photo, page 11), visited all of the medical diploma mills extant at that time, wrote a scathing report issued in 1910, and turned medical education upside down. Franklin Martin, MD, FACS (see photo, page 11), a Chicago gynecologist, wished to improve the practical education of surgeons and founded the journal *Surgery, Gynecology and Obstetrics* (now the *Journal of the American College of Surgeons*), and the Clinical Congress of Surgeons of North America, which has grown into our annual Clinical Congress: the single largest annual educational venue for surgeons in the world.

This dynamic red-haired Wisconsin farm boy was filled with energy and ideas, and along with other surgical luminaries of the time, fathered this, our American College of Surgeons (see painting, page 12). Our College was modeled after the historic Royal College of Surgeons of England, who, in 1920, presented this Great Mace to us in a meeting in Montreal (see photo, page 13). From the vision of that group of founding fathers, and as a result of initial committees appointed, major impactful forces evolved. A committee on the standardization of hospitals, led by E. A. Codman, MD, FACS, of Boston, MA (see photo, page 14), resulted in what we know today as The Joint Commission, surveying and accrediting more than 15,000 health care organizations worldwide. Dr. Codman’s further idea of a registry for tumors has resulted in our extensive system of cancer registries and databases and indirectly, in 1959, in the formation of the American Joint Committee on Cancer, our important cancer staging body. Thomas Cullen, MD, FACS, of Baltimore, MD (see photo, page 14), chaired a committee to educate the public on cancer and the importance of early detection and treatment. This activity grew into the American Cancer Society, the largest voluntary health organization in the world. Simultaneously, at Johns Hopkins Hospital, William S. Halsted, MD, FACS(Hon) (see photo, page 14), established the surgical residency training program that has been so admired and widely emulated. In 1922, the Committee on Fractures,
Driven by Charles Scudder, MD, FACS, of Boston (see photo, page 15), was formed and renamed in 1939 as our Committee on Trauma. Likewise, in 1922, the Committee on the Treatment of Malignant Disease was appointed, chaired by Robert Greenough, MD, FACS, also of Boston, MA (see photo, page 15), later becoming our Commission on Cancer. The Committee on Trauma and the Commission on Cancer have had a most significant impact on the care of trauma patients and cancer patients and continue to evolve, not only nationally, but internationally.

So, in the early part of the 20th century, surgeons were instrumental in forming our own American College of Surgeons, The Joint Commission, the American Cancer Society, and the surgical residency program. Also, beginning with the American Board of Ophthalmology in 1916, all surgical specialties have subsequently formed boards. Imagine how different surgical education, training, practice, and care would be without all of these organizations. I ask you, have patients benefited?

Over the last century, the resulting influence and benefit from that early 20th century foundation has continued to flow. Our College’s educational, oversight, accreditation, research, and patient care programs, and now advocacy activities, have been, and continue to be, monumental! Our surgical forefathers set the model and the standards for our professionalism. Our heritage is our strength!

With our founding heritage undergirding us, post-World War II saw the burgeoning of scientific surgery. Anesthesia and antibiotics opened the door to opportunity. The chest and the cranium joined the abdomen as sites for surgical adventure. The holy heart could be manipulated, and blood became readily available for extension of our scope of activity. With each subsequent war, our ability to care for the traumatized patient has expanded and improved. Eyes and ears are mended and made new. Organs and tissues are transplanted almost at will—when available. Bones are mended and extended, and new joints are very much in vogue. The field of surgery has been exploding, with the doors opening ever more widely. As Michael DeBakey, MD, FACS, said in 1995, “More progress has been made in medicine in the last 50 years than in all of recorded history.” Not only is our lifespan extending, but the quality of these extra years is greatly enhanced, and much of this is attributable to surgical care.

Oh yes, I have not mentioned the minimally invasive surgical approach and now single orifice and natural orifice surgery; robotic surgery, tissue engineering, and on and on, are examples of how technology has run rampant. Our cup runneth over.

But the bell tolls—health care costs worldwide have increased 2 percent per year for 20 years. Health care costs in this country approach 18 percent of gross domestic product, estimated to be 20 percent by 2020, and 50 percent by 2050. The Institute of Medicine began a series of landmark reports in 1999 that turned heads. Perhaps Crossing the Quality Chasm and To Err
Is Human: Building a Safer Health System are the most impactful of these reports. Quality and safety concerns became a focus, and never events such as wrong site surgery and wrong patient surgery are no longer reimbursed, much less tolerated, though still occurring (estimated at 40 per week). Our critics abound. The American public loves their doctor, but is frustrated by our “sick care” non-system, and the associated, continually burgeoning costs.

These cyclic, recurrent concerns have been voiced for more than 150 years in most of the developed world, but at this point in time, in this country, the forces for change are dominant, and some change will occur. Most people in our profession agree that change is needed. Our College supports change and has been joined by 19 surgical specialty organizations in seeking the right kind of change: change that will benefit our patients and the public’s health overall. Health measures, where the U.S. is often found lacking—such as neonatal death rates, complications of pregnancy, obesity and its accompanying complications, and chronic disease management—are not primarily surgical problems, not even totally medical problems, but, rather, social, socioeconomic, and educational issues, and issues of personal responsibility, as well. Let me note that the cost issue in health care is not significantly impacted by the oft-maligned discipline of surgery. Nonetheless, we are part of this complex medical system, and must be part of any sustainable set of solutions.

Professionalism will guide our future

This brief overview of the past brings us to this new century and beyond. What is it that sustains us, embodies us, invigorates us, and carries us onward? I maintain that our underlying professionalism and humanism will see us through this epochal time at the dawn of the 21st century and beyond. Our historic evolution as a profession is our greatest strength. Though we often think of our College as old and established, we are, in fact, relatively new, even as we approach our centennial in 2013. Despite our rich history and traditions, we are young, especially when contrasted with the Royal Colleges and societies of the world.
But even in our relative youth, we share in the history of the long-acknowledged classical professions of the world: the ministry, law, and medicine, with surgery evolving a bit later as we emerged from a guild status.

What is a profession? What is professionalism? What are the distinguishing characteristics of this noble order that you join tonight? What are the characteristics and principles that will carry us through the millennium, though ever evolving and strengthening, though periodically challenged and attacked?

The Council of Academic Societies attached professionalism to a “set of values reflected in the philosophy and behavior of individuals whose calling is first and foremost to serve individuals and populations whose care is entrusted to them, prioritizing the interests of those they serve above their own.” But as Haile Debas, MD, FACS, has stated, “Professional status is not an inherent right, but one granted by society. This obligates surgeons to put their patients’ interests above their own.” Past-President George Sheldon, MD, FACS, has stated that “Ethical codes are the major characteristics that differentiate professions from occupations.” Other elements inherent in professionalism include the acquisition of special knowledge and skills, advanced and continuing education, ethics, and evidence of competence (including licensing and certification). Certainly a professional manner and a professional appearance are other visible and palpable elements of professionalism that are expected by our patients and by the public. Terms often significantly associated with professionalism include altruism, honor, compassion, integrity, dedication, empathy, responsiveness, prudence, trust, and an ethos of self-regulation. The ability to communicate clearly and to be humble in the face of adulation or scorn will prove to be an asset.

Do remember, Hippocrates admonished us to “sometimes give your services for nothing and if there is an opportunity of serving one who is a stranger, in financial straits, give full assistance to all such, for where there is love of man, there is also love of the art.” Never forget, though science and technology are enthroned in our armamentarium, art is ever-present in what we do and how we deal with those we serve.

What greater trust and bond exists among humans than that between a patient and their treatment?
surgeon? Perhaps this bond is only exceeded by that between a parent and a child. That is the joy of being a surgeon, a professional. Yet, that joy is bridled by the enormity of our responsibility. No assault by government, managed care, the insurance industry, trial lawyers, or other maligned entity will ever break that bond.

The joy of being a professional is what keeps us going. It is what inspired William Mayo, MD, FACS (see photo, page 15), to say, “There is no fun like work,” and also, “The best interest of the patient is the only interest to be considered.” And another great professional, but in basketball, Julius Irving (a.k.a. Dr. J.) offered, “Being a professional is doing the things you love to do on the days (nights, weekends, holidays) that you don’t feel like doing them.”

You men and women seated before us tonight join the legions preceding you in the proudest profession. Embrace the honor, the traditions, and the responsibilities of your chosen profession. Accept the mantle proudly, with dedication, and, through your own individual efforts, further advance, enhance, and romance all that you are becoming a part of. Stand tall, let your chest swell as you proudly declare, “I am a surgeon, a professional!” Treat your patients well, your family even better. Pass on the heritage burnished brighter than you received it, and grow old in the joy of being a surgeon.

Some recent College presidents have focused on the topics of humanism, mentoring, and role modeling. Several former presidents have addressed the subject of ethics. I believe that these most important subjects are embraced in the concepts embodied in surgical professionalism. Out of concern that professionalism has been under assault and fading in significance from external pressures and forces, major significant bodies such as the American Surgical Association, the American Board of Surgery, and the American College of Surgeons have focused on this issue. I would direct your attention to the 2004 ASA Blue Ribbon Committee Report on Surgical Education; to Fred McCulloch’s 2006 Lancet article, “Surgical Professionalism in the 21st Century”; to Wiley Souba and Stephen Steinberg’s ACS Surgery chapter, “Professionalism in Surgery”; and to a number of activities devoted to the subject by a College task force led by Alden Harken, MD, FACS, and Ajit Sachdeva, MD, FACS, FRCSC—including an ACS Code of Professional Conduct, an ACS DVD entitled
Professionalism in Surgery Second Edition, and an earlier DVD entitled Medical Professionalism in the New Millennium, each presenting professionally related vignettes in a CME format (see photo, page 16). You will gain significant insight and benefit from viewing these resources that are available from the College.

These precepts of professionalism extend beyond the operating room, the clinic, and the hospital, to your family, your peers, and other professional associates, your casual contacts, your community, and wherever you venture. You are specially acknowledged, privileged, and remunerated, but this must be constantly earned. This is the embodiment of the surgical profession, now and persisting on through this new millennium. Each generation has this obligation to our past, to the present, and to the future.

Where are we today? On the positive side, the science and the technology surrounding us is abundant, in full flower, and growing toward unimaginable new opportunities. A professional’s hunger for knowledge and improved skills never abates, thus highlighting the need to continue to enhance our knowledge and our skills. Our College is ready and determined to assist you in an abundance of ways in this regard. Know that most of what you have learned will be passé shortly. Only principles, and your ability and capacity to learn and to relate to and communicate with your peers, patients, and associates, will persist. So, evolve a regular program of professional enhancement and advancement and adhere to that program diligently. A professional is never a finished product. That incessant search for knowledge and skill improvement is what makes our life so exciting.

The health care reform debate is on in full fervor. Our College is engaged and active. We believe that health care reform is vital and needed—the right kind of reform, reform that benefits patients, the public, and surgeons, and that will result in a true system of “health care,” rather than continuing an excellent but dysfunctional “sick care” system. I believe that we will be happier within a system where all citizens have access to health care, where disparities in care and in outcomes are but dim memories, where we are informed by, and responsive to, reliable, risk-adjusted, near real-time data that will guide and improve our actions; where we practice hassle-free; where our health care is widely viewed as

Dr. Scudder  Dr. Greenough  Dr. William Mayo
safe and of the highest quality without regional variations; where value is unquestionable and where the best and the brightest—like you—will continue to be attracted. This is not beyond our reach! We can help make this happen if we are all actively engaged. This is a pivotal point in our nation’s history, perhaps somewhat akin to the 1910–1915 era, when our College was forming.

You might ask—how do we engage and participate? First, be engaged and active in the full spectrum of your profession and especially within your College. Seek out opportunities, locally, regionally, nationally, and internationally. Further, let me briefly introduce another element of professionalism, that of civic professionalism. This differentiates physicians and surgeons from other knowledge workers. Because of our relative autonomy, our self-regulation, our focus on service, care, and the public good, void of self-interest, and our focus on quality and continual improvement, we are not typical knowledge workers—we are expert, but we are more. Thus, we have a responsibility to keep in mind and act upon our broader societal obligations and expectations.

Our focus has been, and should remain, on our individual patients, but do we not also have a civic professional duty to embrace the public good more consciously, and to help improve the system and society on matters of health? Our surgical forefathers were so involved. Some recent, and present, surgeon examples might include Surgeons General C. Everett Koop, MD, FACS, and Richard Carmona, MD, FACS, and Sen. Bill Frist, MD, FACS, and Rep. Tom Price, MD, FACS. But more relevant may be this example: Jim Pope, MD, FACS, of Carrollton, GA, has been on the state board of education for 25 years, following in the footsteps of his senior partner. Next year, he will become the chairman of the Georgia Board of Education. Our history is full of surgeons serving as health board chairs, school board chairs, mayors, county commissioners and on—true civic professionals. Each of us has a role to play. LaSalle D. Leffall, Jr., MD, FACS, and Edward Cornwell, MD, FACS, of the District of Columbia offer more contemporary role models, as does Steven Chen, MD, FACS, of California, a member of this new class of Fellows.

Now let us look ahead. As that great American philosopher Yogi Berra once said, “The future ain’t what it used to be.” This is an appropriate statement for a new beginning for this millennium, whether looking at health care, health care delivery, surgical care, or any other aspect of our society.

But as the sage and prescient futurist Peter Drucker once said, “The best way to predict your future is to create it.” And as Will Rogers so aptly stated, “Even if you are on the right track, you will get run over if you just sit there.”

Health care delivery will change, and in the short term. Health care policy is presently under intense debate represented by polar opposites. Something will happen over the next few months. The College leadership, our Division of Health Policy and Advocacy, the Health Policy Advisory Group, and the Health Policy Research Institute are fully engaged and participatory. Each of you, as a part of civic professionalism, should likewise be fully engaged, informed, and participatory. Communicate clearly with your patients, legislators, and friends, and
do not be self-serving. Let us work to come out of this debate with an improved system that benefits patients, the public, surgeons, and society as a whole.

Medical education and training are under intense scrutiny and study. The Halsted paradigm that has served us so well is changing. The demographics and work hours of our surgical workforce have already changed, but we need to adapt even further, and more rapidly, to these realities. Our College is becoming the leader in simulation technologies, in evolving regional training centers, in encompassing young surgeons as scholars within the College, and in many other areas that will offer opportunities for enhancement of knowledge and skills. Our National Surgical Quality Improvement Program is becoming the “gold standard” for risk-adjusted outcomes data to be utilized for improvements in quality care and safety. Large databases in cancer and trauma likewise are utilized for analysis and for care improvement. The College intends to be the lynchpin in comparative effectiveness research for surgery.

A more exciting time for surgery has never existed. As Bill Cance said in his Society for Surgical Oncology Presidential Address, “We are moving from tradition, through transition to transformation.” More personalized, tailored treatments will become the norm. How will “microRNA” transform our view of disease? How profoundly will “disruptive innovation” alter the changing processes of health care delivery? Transparency of data and shared decision making based on evidence that will include patient input derived from long-term follow-up will directly impact surgical therapeutic choices and reimbursement policies.

Suffice to say that change will occur even more rapidly than we can imagine—from evolutionary to revolutionary. As surgeons, and as a College, we might consider becoming even more proactive regarding change, as well as anticipatory and proactive rather than reactive. Should we not formalize a process that will keep us at least even with, or better still, ahead of evolving thought on a broad plain? This will not occur easily. It is not a part of our history or of our rigid psychological makeup. We can—perhaps we must—do this.

But, as historian Daniel Boorstin said, “Trying to plan for the future without a sense of the past is like trying to plant cut flowers.” It is my desire and hope that you will agree that professionalism has been, is presently, and will be the bulwark that enables us to thrive and to stand tall in any storm. It sets us apart.

Our great seal, chosen from a competitive design process at our founding, embodies what we are all about—Aesculapius and an Indian medicine man under the tree of knowledge—the
old world and the new world, with the admonition to serve all with skill and fidelity.

Conclusion

Let me close with the following suggestions to this new class of Fellows, to our College broadly, and to its leadership.

- **Our past:** Though we are a young organization, let us remember to demonstrably value our heritage. It has afforded a strong foundation that has served us well and continues to evolve. A new College history is being skillfully written by David Nahrwold, MD, FACS, and is anticipated to be available for our centennial celebration. Make our heritage readily available and it will be utilized. Treasure it and remember lessons learned, not to be re-learned.

- **Our present:**
  1. Live vigorously in the present. Be surgical and civic professionals. Continue innovation, discovery, and surgical advancement. Apply advancement only with a strong evidence base. Be patient centered. Be proactive participants in evolving a true health care system in an ongoing manner. Be a team player and a leader (the two may coexist). Things will not be as they have been. We all know that improvement is always necessary and essential. Be a part of it!
  2. Look at our American College of Surgeons organizationally. What should change? How do we improve? Our vast educational endeavors must always be contemporary. How might chapters be more activated, strengthened, and empowered? How might individual Fellows, from all over, be made to feel a part of, and a participant in, our great College endeavor? How do we enhance our collaborative, representative, and advocacy role as an umbrella organization for all of surgery? Should our College governance structure be reassessed? What have we learned from our recent history? How might we function better, at all levels?
- **Our future:** This century will be a century of change like no other. Successful paradigms of the past and of the present will rapidly fade. Medical education, training, and delivery of health care will radically change, perhaps change akin to that which occurred in the first two decades of the last century. Our College should proactively lead this change, looking ahead to the near-term, the mid-term, and on into the misty future. A formal futuring exercise is essential to begin now and to be built into all of our activities as an ongoing function.

We are challenged. We can and must respond to that challenge.

I love this College. I love surgery and still dream of operating. I love being a surgical professional and a civic professional. We are all so fortunate and blessed by God. You before me have labored long and hard. You have also been given much. Now begins your opportunity to give back. In that vein, let me close with these comments from John Wesley, an Anglican minister and the founder of Methodism:

Do all the good you can
By all the means you can
In all the ways you can
In all the places you can
To all the people you can
As long as ever you can.

Once again, I congratulate you Honorary and new Fellows on this special night in this city of our founding. I thank all of you for this most special honor and opportunity.

Dr. McGinnis is senior medical consultant and advisor for the National American Cancer Society, and clinical professor of surgery, Emory University, Atlanta, GA. He is the 90th President of the American College of Surgeons.
A surgeon in the eye of Hurricane Gustav

by Ralph J. Doerr, MD, FACS
Hurricane Gustav was a Category Four hurricane that struck the Gulf Coast at Cocodrie, LA, September 1, 2008. The wind speeds were clocked at 150 miles per hour and the pressure was recorded as 941 mbar.

The National Disaster Medical System (NDMS) was activated for deployment to Hurricane Gustav on August 27. The author, as a member of the International Medical Surgical Response Team (IMSuRT)-East, was included in the deployment.

NDMS
The NDMS is a major component of the federal health and medical response to national disasters, transportation disasters, terrorism, and technological disasters. Formed in 1981 by a presidential initiative, the NDMS is a public and private sector partnership whose mission is medical response, patient evacuation, and definitive medical care. The federal partners are Health and Human Services, Department of Defense, Veterans Affairs, and the Federal Emergency Management Agency. Within the NDMS there are specialty teams: pediatric, burn, disaster, mortuary teams, veterinary medical assistance teams, disaster medical assistance teams, and IMSuRTs. The IMSuRTs are composed of multidisciplinary physicians and surgeons. The IMSuRT deployments are generally for two or three weeks in 60-bed pressurized military-style tents with self-sustaining medical cache, pharmacy, blood, lab equipment, monitors, and an operating room (with two operating room tables). The teams are configured to provide initial stabilization, operative, intensive care, and evacuation with logistic and administrative support. Generally there are 50 self-sustainable volunteers deployed for 72 hours, capable of performing 20 major and 20 minor operative cases without re-supply. The teams are composed of surgeons and orthopaedists, gynecologists, anesthesiologists, critical care personnel, operative nurses and technicians, respiratory technicians, pharmacists, logistics, communication, and security and safety.

The range of deployments include hurricanes, national presidential conventions, inaugurations, mass casualty events (such as 9/11), marathons, earthquakes, floods, and massive fires. For IMSuRTs, these can include international deployments.

Hurricane Gustav
The NDMS mission for Hurricane Gustav was to arrive in Baton Rouge, LA, at the Louisiana State University (LSU) campus facilities in preparation for the evacuation of New Orleans, which was the anticipated landfall of Gustav. Two 500-bed federal medical station (FMS) facilities were rapidly set up at the LSU Pete Maravich Athletic Center and the LSU Carl Maddox Field House.

Evacuees were transported by helicopter from New Orleans all day on August 30. All arrivals were triaged according to standard protocol. There was significant structural damage as Hurricane Gustav passed directly over Baton Rouge. Portions of roofs were blown off, major leaks appeared in patient care areas, glass doors were broken, and power was lost for four days. The roof of one local hospital collapsed, and rapid evacuation to an FMS and intact health facilities ensued. An interesting component of the mission was the return of 5,000 evacuees back to New Orleans with NDMS assistance. This was accomplished by rail, the first mass evacuation by rail in modern times.

Over the course of the two-week deployment, more than 500 individuals were admitted to the two FMS facilities at LSU. These facilities provided shelter medicine needs to approximately 350 patients and an additional 175 personal caregivers. Some of these caregivers became patients during the ordeal. Thirty-eight hospice patients were cared for, four of whom died during the mission.

Unique needs of disaster victims
The types of diagnoses seen at the FMS facilities were typical of special needs individuals: a significant portion were oxygen-dependent and wound care was required for the bed-bound. Acute asthma and chronic obstructive pulmonary disease exacerbation, rule out myocardial infarction and congestive heart failure worsening, and poorly controlled diabetes were common. Surgical issues included a rattlesnake bite, lacerations, debridements, gangrenous toes,
glass in the arm of a Federal Express worker, contusions, and fractures. This experience is in line with other reported hurricane medical support.1-3

From these past reports, deaths and injuries in hurricanes occur primarily during the post-disaster recovery period, with relatively few sustained in the impact period. Other hurricane rescue effort workers have observed chainsaw injuries, puncture wounds, stings, gasoline aspiration burns, and assaults as requiring surgical evaluation.4 As the time from the original event lengthens, the mission changes to supporting lost or diminished medical and surgical assets in the region.

Getting involved

How should surgeons become involved in disaster medicine? First, surgeons need to better educate themselves. There is an extensive array of online and American College of Surgeons-sponsored courses available on these topics. These courses are both comprehensive and relevant to surgeons. Become involved in your hospital’s emergency management committee. Surgeons are often overlooked when these committees are formed, yet arguably, from a decision-making and injury perspective, surgeons are a perfect fit for such a role. Participate in your hospital disaster drills.

On a wider scale, surgeons can become involved with community disaster planning committees. Each state has a credentialing mechanism to join the Medical Reserve Corps. Under this auspice, it is possible to volunteer at the time of local, regional, or national crisis. The ACS has recently taken much more of an interest in the preparation, education, and providing of opportunities for disaster participations. And of course, surgeons can also take the initiative to join the NDMS.

On an academic level, surgeons may consider pursuing involvement with disaster committees within specialties, along with dedicated publications and national and international societies. Ultimately, remembering that all disasters start out at the local level, and by employing an all-hazards approach, informed general surgeons are a perfect match for any emergency management team. The need to make rapid decisions with less-than-optimal information is our daily bailiwick. Surgeons need to understand that they will be called upon to manage many different aspects of disaster medicine, including the need for definitive operative and critical care. Finally, there is particular gratification in helping our fellow citizens in a time of great need.

Grateful acknowledgment to Team Commander Susan Briggs, MD, FACS, IMSuRT-East for inspiration, guidance, and editorial assistance.

References


Dr. Doerr is chief, department of surgery, Rochester General Hospital, Rochester, NY. He has been a medical officer on the IMSuRT-East team since 2006 and was deployed to assist during Hurricane Gustav in 2008.
The surgical mask
has its first performance standard—
A century after it was introduced

by Nathan L. Belkin, PhD
From the day of its conception more than a century ago, there hasn’t been a standardized test method for demonstrating the filtering efficiency of the surgical mask.

Today, however, there are two test methods that manufacturers are required to use in order to be granted marketing approval by the Food and Drug Administration. The first test measures the mask’s particulate filtration efficiency using a non-neutralized aerosol of 0.1 um latex spheres, at a challenge velocity between 0.5 and 25 cm/s (approximately 8 to 380 L/min for a 9-cm radius mask).

The second test measures the mask’s bacterial filtration efficiency using a non-neutralized 3 × 0.3-pm Staphylococcus aureus and a flow rate of 28.3 L/min.

The FDA does not require a minimum level of filter performance for either of the test methods.

To the surgical community, the significance of the scientific tests developed by the industry-driven group, the Association Society for Testing Materials (ASTM), was the granting of manufacturer approval to market the product. However, the results of these testing methods do not appear to be relevant to the work conducted by previous clinical investigators.

**Early testing for effectiveness**

Mikulicz, a German physician, published the first study supporting the need for a mask, in 1897. Its use was predicated by the work of Flügge, another German clinician, who demonstrated the presence of bacteria in droplets from the nose and mouth.

It was Hamilton’s study in 1906 that focused on the transmission of communicable diseases and the importance of droplets of sputum in the dissemination of tuberculosis infection. Having found that the mouth was a fruitful source of streptococcal infection, he recommended that physicians wear a specially constructed mouth-guard. Notably, tests of these mouth-guards indicated that they almost completely held back the sputum droplets.

Several years later, in 1918, Weaver published the results of his study on the mask’s role in preventing the spread of diphtheria, meningitis, pneumonia, and so on. He introduced the practice of covering both the nose and mouth when caring for patients. Masks proved to be such successful barriers when treating patients that they were recommended for use in households containing diseases that could be spread by nasopharyngeal discharge.

That same year, Doust and Lyon examined the role of face masks in preventing infections of the respiratory tract. They defined the mask’s twofold purpose: to protect the wearer from the infectious material from the patient’s respiratory passages, and to protect the patient from such material that the wearer himself may carry in his or her nose and mouth. At that point, the authors assessed the filtering efficiency of some common types of masks that were said to prevent the dissemination of infectious material from the mouth during speaking or coughing.

As the first study of its kind, the findings proved to be quite revealing. For example, they found that speaking without a mask in an ordinary conversational tone for five minutes projected relatively few bacteria from the mouth, to a distance of only 1 to 2 feet. Speaking in the same manner, but for 30 minutes, produced similar results. On the other hand, speaking without a mask in a loud tone for five minutes generated considerably more bacteria, with one organism projecting more than 3 feet.

As was to be expected, coughing periodically, without the use of a mask, for five minutes generated the greatest number of colonies, some of which projected as far as 10 feet. In the process, they also observed that the effectiveness of masks consisting of as few as two layers of coarse gauze, compared with those consisting of as many as 10 layers of coarse gauze, was not dramatically different.

It is to be noted that the results from the use of masks made of five layers (rather than two) of a medium-quality of gauze did prove to be more effective in all circumstances.

A year later, in 1919, Weaver investigated droplet infection in terms of the distance traveled by mouth compared with droplets that had been driven out in forced respiratory efforts. His tests indicated that the distance to which the droplets were carried in the air depended principally on the force with which they were driven, and that small droplets could travel some distance, especially when carried by currents of air. He also reported that gauze could remove bacteria from the air when carried in a moist spray; the efficiency of the gauze was in direct proportion to the density of the weave and the number of layers used.
Based on these findings, Weaver’s research group adopted the use of a mask made of three layers of absorbent gauze with a total thread count of 84 threads per square inch (44 x 40). They found the absorbent material preferable, because particles of mucus seemed to adhere to it more quickly and firmly.

**Failure of an in vivo test**

An outbreak of influenza in 1919 brought about a challenging situation, warranting compulsory use of the mask in order to keep the epidemic in check. Considering the fact that influenza is a droplet-borne infection, it appeared that wearing masks was a preventive measure based on sound reasoning, and that favorable results could be expected from their use. But that was not the case.

The failure of the masks to prevent the spread of the disease was disappointing. Although the masks had been worn cheerfully and universally, the state’s health care officials reached two conclusions: that a mask’s filtering capability varied by the number of layers and thickness of the mesh of the gauze; and when a sufficient degree of gauze was used to create a useful filtering influence, breathing was difficult, and leakage took place around the edges of the mask.11

**New developments**

These results were not a complete loss, however tragic the circumstances, as these early masks were the forerunners to the era of new materials. The first change in mask design was disclosed in Walker’s study in 1930.12 In establishing the minimum standards for a mask to be germ-proof, he determined that it should be constructed so as not to permit organisms to pass through the mask. When a sufficient degree of gauze was used to create a useful filtering influence, breathing was difficult, and leakage took place around the edges of the mask.

**The need for a surgical mask**

Although Walker’s article was the first to mention a “surgical” mask, previous attention had been primarily directed to its use in conjunction with respiratory infections. At the time, the general belief was that there was no room for improvement in the operating room, as these techniques had been handed down for several decades. In other words, there was no need to improve the excellent results that were already being achieved in healing wounds.

Nevertheless, the use of masks during surgery did become widespread after 1926 with the publication of Meleny’s first study, in which he reported having experienced a reduction in the incidence of surgical site infections (SSI).13 However, in his subsequent study, published nine years later, he reported that the rate of infection with the use of masks was closer to 15 percent than the 2 percent to 5 percent range that had been originally anticipated.14

The fact of the matter is that since the days of the Meleny studies, much has been written about the mask’s impact on surgical site infections.15,16 To date, the use of a mask is still not evidence-based, since its effectiveness for preventing infections has yet to be conclusively demonstrated. One of the many variables to be considered is the filtering efficiency of the mask during in vivo conditions. Others variables include:

- 15 to 20 air changes per hour in high-efficiency particulate air (HEPA)-filtered circulatory systems
- The length of time it can be worn while maintaining filtering efficiency
- A discomfort for the wearer that could be accompanied by the leakage of exhaled air around its edges

It should be noted that one manufacturer has already announced the availability of a new surgical mask that incorporates proprietary filtration media that meets the requirement of a totally different standard. Although the new mask is recommended for wearing in longer procedures where comfortable, breathable masks are important, the manufacturers qualify its performance by saying that their testing protocol does not reflect expected levels of filtration in actual in-use conditions.

**Conclusion**

During the early period of the development of the surgical mask, Castaneda eloquently and astutely summarized its status:
The ideal mask has yet to be developed. None, so far, has succeeded in combining comfort with bacteriologic security. Even upon the development of such a device, whether it is in the form of a more perfect mask or some bactericidal medium, other aspects of surgical technique and the care of the wound will continue to be of paramount importance in the prevention of post-operative sepsis.¹⁷

Thus, to this day, questions remain unanswered. What effect, if any, will the new standard for the mask’s filtering efficiency have on a reduction in the incidence of SSIs? On the other hand, should mask use continue to be predicated on its theoretical effectiveness? In the meantime, alleged improvements will increase the cost of masks at a time when continuous pressures are being put on reducing, let alone containing, costs. This, then, raises the question as to whether the performance standard is just another example of an industry generating the need for a more expensive product rather than the surgical community generating a genuine need.

Although this article will not have any impact on present practices, its purpose is to enlighten the reader on the new performance standard that does nothing other than provide the manufacturer with a point of reference for the filtering efficiency of his product.

References

8. Weaver GH. The value of the face mask and other measures. JAMA. 1918;76-78.

Dr. Belkin retired in 1991 after 40 years in research and development of surgical textiles. He lives in Largo, FL.
A. Brent Eastman, MD, FACS, was elected Chair of the Board of Regents of the American College of Surgeons during the College’s annual Clinical Congress, held in Chicago, IL, October 11–15. A general, vascular, and trauma surgeon, Dr. Eastman is chief medical officer of Scripps Health and the N. Paul Whittier Endowed Chair of Trauma at Scripps Memorial Hospital La Jolla, CA. He is also a clinical professor of surgery–trauma at the University of California, San Diego.

In his role as Chair of the Board of Regents, Dr. Eastman will work closely with the ACS Executive Director and will chair the Regents’ Finance and Executive Committees. The College’s 22-member Board of Regents formulates policy and is ultimately responsible for managing the affairs of the College. The Board’s diversity and the variety of experiences and interests among its members enable the Regents to represent views related to myriad issues in contemporary surgery.

Dr. Eastman has been instrumental in the development of trauma systems worldwide. He is one of the co-founders of San Diego County’s trauma system and has lectured and helped put trauma systems into place in countries including the U.S., England, Argentina, Canada, Mexico, Australia, Brazil, South Africa, India, and Pakistan. He participated in the ACS/AAST Distinguished Visiting Surgeon in Combat Casualty Program at the U.S. military hospital, the Landstuhl Regional Medical Center, Landstuhl, Germany, in July 2007. He subsequently was granted and assigned the distinction of Honorary Member of the U.S. Army Medical Regiment, by order of the Surgeon General.

A Fellow of the American College of Surgeons since 1976, Dr. Eastman began serving on the College’s Board of Regents in 2001. In addition to serving as a Regent, Dr. Eastman has been an active member of many College committees, particularly the College’s Committee on Trauma (COT). He helped create, and was the first chair of, the COT Trauma System Consultation Committee and is an instructor for the internationally renowned Advanced Trauma Life Support® course. In addition to chairing the COT, Dr. Eastman has chaired the College’s Scholarship Committee and Central Judiciary Committee.

He is an active member of many leading surgical organizations, including the American Surgical Association, the American Association for the Surgery of Trauma, International Society of Cardiovascular Surgery, Society of Clinical Vascular Surgery, and the Pacific Coast Surgical Association. In addition, Dr. Eastman served as chair of the Centers for Disease Control and Prevention (CDC) Research Agenda Steering Committee and is a member of the Board of Scientific Counselors, National Center for Injury Prevention (CDC).

Throughout his distinguished career, Dr. Eastman has authored or co-authored multiple publications and articles related to trauma. He served on the Institute of Medicine (IOM) committee that in 2006 published the landmark report, The Future of Emergency Care in the United States Health System. This year, shortly before his election as Chair of the Board of Regents,
Dr. Eastman delivered the Scudder Oration, the signature speech on trauma care at the annual Clinical Congress. Dr. Eastman received his medical degree in 1966 from the University of California, San Francisco, where he also completed a surgical internship and residency and served as chief surgical resident. In addition, Dr. Eastman spent one year as a surgical registrar at Norfolk and Norwich Hospital, Norwich, England.

A look at The Joint Commission

New alert focuses on leadership’s role

A new Joint Commission newsletter titled Sentinel Event Alert urges health care leaders to step up efforts to prevent errors by taking the zero-defect approach used in other high-risk industries such as aviation and nuclear energy. The newsletter suggests that a thorough and appropriate evaluation of errors is necessary to prevent future occurrences. The Joint Commission is advocating greater involvement by health care trustees, executives, and physician leaders, contending that the overall safety and effectiveness of a health care facility ultimately depends on administrative and clinical leaders who set the tone and drive improvements.

To improve patient safety, the newsletter recommends that the governing body, chief executive officer (CEO), senior managers, and medical and staff leaders at health care organizations implement a series of 12 specific steps, including the following:

• Define and establish an organization-wide safety culture that includes a code of conduct for all employees
• Institute an organization-wide policy of transparency that sheds light on all adverse events and patient safety issues
• Make the organization’s overall safety performance a key, measurable part of the evaluation of the CEO and all leadership
• Create and communicate a policy that defines behaviors that are to be referred for disciplinary action, and a timeframe for that action to take place
• Add a human element to safety improvement by having patients communicate their experiences and perceptions to leadership

Other strategies for improving safety include creating a culture of safety where adverse events are openly discussed without fear of reprisal; ensuring that caregivers involved in an event that results in unintentional patient harm receive attention that is just, respectful, compassionate, supportive, and timely; and rewarding and recognizing staff whose efforts contribute to patient safety.

In addition to specific recommendations contained in the newsletter, The Joint Commission urges health care organizations to use the Leadership chapter of its accreditation standards to improve patient safety. The standards require health care organizations to create systems to support a culture of safety, and provide the human and financial resources necessary to assure safety. The standards also cover reporting systems for adverse events and near-misses, and the design of processes to support safety.

The complete Sentinel Event Alert is available at http://www.jointcommission.org.

Correction

The name of Anton N. Sidawy, MD, FACS, was spelled incorrectly in the October 2009 Bulletin article, “Members in the news” (page 37). The editors regret the error.
Did you ever wish you could be in 5 places at once?

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ACOSOG news

Promoting patient safety
by Heidi Nelson, MD, FACS; and David Ota, MD, FACS

When you think about the American College of Surgeons Oncology Group (ACOSOG), patient safety probably isn’t the first thing that comes to mind. Your first impulse might be to associate ACOSOG with the scientific programs we support or the new techniques and therapies we are testing. In fact, patient safety is fundamental to the mission of ACOSOG. Clinical trials are all about the safe introduction of new therapies and, as a clinical trials organization, ACOSOG is squarely focused on patient safety.

We can all recall from our younger years procedures or therapies that were once considered vogue and appealing, but were later found to be ineffective or deleterious, such as sigmoid resection for constipation or hormone therapy for menopause.

The goal of a clinical trials group is not only to ensure that all new and approved therapies provide more benefit than risk, but also to make sure that patients are safeguarded from inadvertent harm during the testing process. The need to safeguard patients participating in clinical trials evolved to its current state when several serious infractions became public knowledge, including the Tuskegee syphilis and the Willowbrook viral hepatitis studies. In the Tuskegee study, patients with syphilis were left untreated long after effective therapies were available. In the Willowbrook study, state hospital residents were purposefully infected with viral hepatitis for a natural history study. This was considered an acceptable study based on the premise that all residents were at risk of developing the disease over time. To protect against similar misconduct in the future, ACOSOG has several safeguards in place, including a comprehensive review and oversight process, and the involvement of patient advocates at all critical decision-making steps.

Ensuring patient safety in clinical trials begins with the vetting of a novel idea within an ACOSOG disease committee, where a multidisciplinary team considers the potential ramifications of conducting a trial based on the proposed idea. Assuming a high degree of enthusiasm for the proposed idea, statistical input is compiled and drafted into a more formal concept, which is evaluated through a peer review process. The ACOSOG Peer Review and Prioritization Committee is a non-conflicted multidisciplinary team of experts that provides due diligence on the merits and feasibility of the proposed study, and decides whether it is appropriate to expose patients and the group to the risk that may come from testing the new therapy. As ACOSOG is a government-sponsored clinical trials program, the National Cancer Institute (NCI) also reviews and issues approval on the concept, based on the strength of its scientific foundation and potential benefits of the study without undue risk to patients. Once the trial is NCI-approved, it moves on to either a national or local institutional review board and undergoes one last non-conflicted review before it can be opened for patients to participate. Once a trial is opened, emphasis shifts away from the trial idea and on to the experience of the patients and the institutions conducting the trial.

Patient adverse events in the course of a trial are monitored in a graded fashion, with specific reporting guidelines based on the seriousness of the event. Patient adverse events are followed on a routine basis (as part of the ACOSOG Data Monitoring Committee reports, for example) and they are also followed in a rapid response manner when a certain severity or frequency of events triggers pre-specified rules for halting the trial at an early stage.

To ensure that patient safety
is a priority at the institutional level, each participating institution is periodically reviewed by an ACOSOG audit team. Field auditors review local records to make sure the institution is compliant with federal regulations. To complement this complex oversight process, ACOSOG has enlisted a team of patient advocates.

Patient advocates have been integrated into all levels of decision making within ACOSOG, including the Executive Committee. Patient advocates, although relatively new to the NCI Cooperative Group over the last decade, are growing in their numbers and expertise. In a short span they have become familiar with the complexities of the diseases, the treatments, and the conduct of clinical trials. In a future issue of the Bulletin, we will introduce Bettye Green, RN, and her team of advocates to learn how they contribute to the success of the ACOSOG enterprise and how they provide a unique strategy for safeguarding patient safety in cancer trials.

Dr. Nelson, of Rochester, MN, and Dr. Ota, of Durham, NC, are ACOSOG Co-Chairs.
In last month’s issue of the Bulletin, transportation, as it pertained to getting the right patient to the right place, revealed a situation where more than one mode of transportation may be required to get the patient where they need to go. One of those modes included transport by helicopter.

The origins of transporting injury victims by air date back to 1870 and the Franco-Prussian War, when 160 wounded French soldiers were transported by hot-air balloon from the battlefront to army hospitals in France (Green PL. The carriage of invalid passengers by air. Br J Hosp Med. 1977;17:32). Aviation pioneer Igor Sikorsky flew the first helicopter mission in 1939.

In the U.S., the use of helicopter transport for patient care was developed during World War II, the Korean War, and the Vietnam War. Many likely remember the TV series from the 1970s and early 1980s, M*A*S*H, in which it was common to hear “Incoming!” at least once during each episode. This one-word announcement broke up the comedic storylines and often referred to the arrival of casualties by helicopter.

Every so often one hears of an unfortunate incident in the press in which an aero medical helicopter has crashed. The media tends to sensationalize these events and they become national news. With each crash, concerns are raised regarding the safety of this mode of transport. Helicopter transport has saved many lives over the years and remains an integral part of the trauma care delivery system, especially in geographic regions where patients have to travel long distances to access definitive trauma care.

In order to examine the occurrence of patients who were transported by helicopter, in the National Trauma Data Bank®, research dataset 2007 admissions records were searched for the field “transport mode” with field value 2 for helicopter ambulance. This field is defined by the National Trauma Data Standard as the mode of transport delivering the patient to your hospital. 4,215 incidents were found with a field value of 2 for helicopter ambulance. Patients were 71 percent male, and on average, 38.1 years of age; they had an average length of stay of 7.9 days, and an average injury severity score of 13.1. Of these, 2,639 records had discharge status recorded, including 1,708 discharged to home, and 545 to acute care/rehabilitation; 200 were sent to nursing homes, and 186 died...
Transport by helicopter is not without risk. Pilots and crew put their lives on the line on a daily basis throughout the U.S., and around the world, transporting the right patient to the right place, in the right amount of time. So the next time you have “incoming” to your hospital, take a moment to thank these brave individuals.

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 mneal@facs.org.

Acknowledgment

The author acknowledges the assistance of Chrystal Price, data analyst, NTDB, 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.
Chapter news

by Rhonda Peebles, Division of Member Services

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

**Lebanon Chapter convenes annual meeting**
Unable to conduct the annual meeting in 2008, the Lebanon Chapter reconvened in August for an education session and a social event. The Lebanon Chapter members welcomed their country’s Minister of Health, Mohammed Khalifeh, MD (see photo, this page).

**Chapter anniversaries**

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**Oregon Chapter hires new manager**
Last September, the Oregon Chapter announced that a new executive director has been hired. The new Chapter Executive Director is Alan Morasch, CAE, the president of Innovative Management Concepts, an association management company located in Vancouver, WA. Mr. Morasch can be reached at 360-859-4188, or via e-mail at alan@imc360.com.

**Connecticut Chapter continues advocacy campaign**
The Connecticut Chapter recently met with Connecticut Lt. Gov. Michael Fedele to discuss issues of importance to its membership. The agenda included the Uniformed Emergency Volunteer Health Practitioner’s Act, which the chapter is working to get passed during the state’s 2010 legislative session. The appointments of Fellows to statewide committees and commissions were also addressed during the meeting. (See photo, this page.)

**Two new chapters formed**
During the 2009 Clinical Congress, on October 15, the Board of Regents approved the formation of two new international chapters: the Austria-Hungary Chapter and the Pakistan Chapter. These two new chapters bring the total number of international chapters to 35. In addi-
tion to the international chapters, there are 65 U.S. chapters and two Canadian chapters, for a total of 102 chapters.

Albert Tuchmann, MD, FACS, the Governor representing Austria, was responsible for proposing and developing the new Austria-Hungary Chapter (see photo, this page). The new officers for the Austria-Hungary Chapter include (all MD, FACS): Fritz Stellwag-Carion, President; Wolfgang Ulf Wayand, Vice-President; Stephan Kriwanek, Secretary; and Peter Lechner, Treasurer.

Saeed Akhter, MD, FACS, the Governor representing Pakistan, began developing the Pakistan Chapter in 2006. The officers of the Pakistan Chapter include (all MD, FACS): Muhammad Mussadiq Khan, MD, FACS, President; Naseer Pakistan Chapter, front row, left to right: Dr. Sultan, Dr. Baloch, Dr. Akhter, Dr. Hanif, and Shehzad Hayat, MD, FACS. Back row: Dr. Iftikhar, Dr. Condie, Dr. Khan, and Dr. Ahmad.

At Clinical Congress: Austria-Hungary Chapter, left to right: Kevin Lally, MD, FACS, Chair, Governors’ Committee on Chapter Activities; Dr. Tuchmann; and Michael Zinner, MD, FACS, Chair, Board of Governors.

At Clinical Congress: Pakistan Chapter, left to right: Dr. Lally, Dr. Akhtar, and Dr. Zinner.

Pakistan Chapter, front row, left to right: Dr. Sultan, Dr. Baloch, Dr. Akhter, Dr. Hanif, and Shehzad Hayat, MD, FACS. Back row: Dr. Iftikhar, Dr. Condie, Dr. Khan, and Dr. Ahmad.
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. (CS) following the chapter name indicates that the ACS is providing AMA PRA Category 1 Credit™ for this activity.

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<td>January 15–17</td>
<td>Louisiana (CS)</td>
<td>Location: Ritz Carlton, New Orleans, LA Contact: Janna Pecquet, 504-455-4640, <a href="mailto:pecquet@LAACS.org">pecquet@LAACS.org</a> ACS representative: LaMar S. McGinnis, Jr., MD, FACS</td>
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<td>January 21</td>
<td>South Florida (CS)</td>
<td>Location: Hyatt Regency Pier 66 Resort &amp; Marina, Fort Lauderdale, FL Contact: Bill Bouck, 305-687-1367, <a href="mailto:wtbouck@bellsouth.net">wtbouck@bellsouth.net</a> ACS representative: John H. Armstrong, MD, FACS</td>
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<td>Southern California (CS)</td>
<td>Location: Four Seasons Biltmore Resort, Santa Barbara, CA Contact: C. James Dowden, 310-364-0193, <a href="mailto:jdowden@prodigy.net">jdowden@prodigy.net</a> ACS representative: Thomas R. Russell, MD, FACS</td>
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<td>February 11–12</td>
<td>Hawaii</td>
<td>Location: Honolulu, HI Contact: Gary Belcher, 808-586-8234, <a href="mailto:gbelcher@hawaii.edu">gbelcher@hawaii.edu</a> ACS representative: Bruce L. Gewertz, MD, FACS</td>
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<td>February 12–13</td>
<td>North Texas (CS)</td>
<td>Location: Cityplace Conference Center, Dallas, TX Contact: Nonie Lowry, 913-402-7102, <a href="mailto:meetings@ntexas.org">meetings@ntexas.org</a></td>
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<td>Puerto Rico</td>
<td>Location: La Concha Hotel, San Juan, PR Contact: Aixa Velez-Silva, 787-277-0674, <a href="mailto:genteinc@prtc.net">genteinc@prtc.net</a> ACS representative: Frederick Greene, MD, FACS</td>
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<td>April 23–25</td>
<td>Virginia (CS)</td>
<td>Location: Hotel Roanoke, Roanoke, VA Contact: Susan McConnell, 804-643-6631, <a href="mailto:smcconnell@ramdocs.org">smcconnell@ramdocs.org</a></td>
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<td>North Dakota &amp; South Dakota (CS)</td>
<td>Location: Sioux Falls, SD Contact: Terry Marks, 605-336-1965, <a href="mailto:tmarks@sdsm.org">tmarks@sdsm.org</a> ACS representative: Jon Sutton</td>
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<td>Indiana (CS)</td>
<td>Location: University Place Conference Center, Indianapolis, IN Contact: Carolyn Downing, 317-261-2060, <a href="mailto:cdowning@ismanet.org">cdowning@ismanet.org</a></td>
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Ahmed Baloch, Vice-President; Jan Iftikhar, Treasurer; Muhammad Hanif, Secretary; Council Members Nadeem Ahmad (for Islamabad/Rawalpindi); Luke Cuthell (for Peshawar/Abbotabad); John Douglas Condie, Jr. (for Peshawar/Abbotabad); Shazia Malik (for Lahore); and Sattar Memon (for Hyderabad); as well as Naheed Sultan, Chair of Surgical Education, and Zafarullah Chaudry, Chair of the Trauma Committee. (See photos, page 35.)

Ohio Chapter unveils new Web site


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