Training surgeons in palliative medicine
FEATURES

Postgraduate palliative medicine training for the surgeon: An update on ABMS subspecialty certification
Michael D. Adolph, MD, FACS; and Geoffrey P. Dunn, MD, FACS

Pacific Partnership 2008: U.S. Navy Fellows provide humanitarian assistance in Southeast Asia
CDR Kimberly D. Davis, MD, FACS, MC, USN; CDR Trent Douglas, MD, FACS, MC, USN; and CAPT Eric Kuncir, MD, FACS, MC, USN

ACS Practice Patterns Survey, Part III: Use of surgical instruments and devices among surgical specialties
Charles M. Balch, MD, FACS; and Thomas R. Russell, MD, FACS

The IVUmed Resident Scholar Program: Aiming to “Teach one, reach many”
Catherine R. deVries, MD, FACS, FAAP

Statement on all-terrain vehicle injuries

Statement on guidelines for collaboration of industry and surgical organizations in support of continuing education

DEPARTMENTS

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

On the cover: ABMS subspecialty certification and hospital-based programs are helping surgeons to catch up in the rapidly expanding field of palliative medicine (see article, page 6).
NEWS

College appoints new Director of Division of Advocacy and Health Policy

2009 ACS Japan Traveling Fellow selected

Dr. McGrath named ACS commissioner to The Joint Commission

Trauma meetings calendar

In memoriam: Shukri F. Khuri, MD, FACS: May 27, 1943–September 26, 2008

Kamal M. F. Itani, MD, FACS

Call for nominations for the ACS Board of Regents

Fellows in the news

Call for nominations for ACS Officers-Elect

A look at The Joint Commission: Alert warns of blood thinner deaths and overdoses

2009 Call for Abstracts: CoC Paper Competition

NTDB® data points: 2008: V8 for kids

Richard J. Fantus, MD, FACS; Avery B. Nathens, MD, PhD, FACS

Chapter news

Rhonda Peebles
Last month’s column centered on the likelihood that our new President’s Administration and Congress will push for health care system reform this year. Indeed, it appears that many of the factors necessary to achieve passage of sweeping health care reform are now in play. The changes that will emerge from this process will undoubtedly have profound effects on surgeons and surgical patients. Therefore, the American College of Surgeons, the rest of the surgical and medical communities, business leaders, patients, and other stakeholders must work together to ensure that the transformation occurs in a smooth and sensible way.

History’s lessons

Health policy scholars David Blumenthal, MD, MPP, and James Morone, PhD, assert that several factors contributed to the passage of the nation’s most transformative health care law to date—PL. 89-97.* Also known as the Social Security Amendments of 1965, this legislation established what we now know as the Medicare and Medicaid programs. Interestingly, many of the same elements that led to enactment of these programs are evident in today’s politically charged atmosphere.

For example, for several years before PL. 89-97 was enacted, liberal Democrats had sought to ensure health care coverage for elderly Americans. However, Wilbur Mills, a conservative southerner, was the Chair of the powerful House Ways and Means Committee, and he and like-minded committee members blocked passage of related legislation throughout John F. Kennedy’s presidency. Nearly one year after President Kennedy’s assassination, Lyndon B. Johnson won the 1964 election in a landslide victory, carrying large Democratic majorities into the House and Senate. During his many years as a Senate leader, President Johnson built a reputation as a master political strategist. He used this acumen to increase the probability of Medicare’s enactment by (1) recruiting a talented legislative staff, (2) making Medicare the highest priority on his legislative agenda, (3) emphasizing to his staff that time was of the essence, and (4) relentlessly pressuring his staff and congressional leaders to move forward.

Ultimately, Representative Mills accepted the inevitable and changed from a Medicare opponent to its greatest expansionist. In fact, Representative Mills amended the original legislation, which would have used Social Security to cover a limited number of hospital days for senior citizens, to include coverage for physicians’ services (Medicare Part B) and relief for indigent families and individuals (Medicaid).

There are several similarities between the political environment in 1965 and the present climate. Like Johnson, President Barack Obama made health care reform a touchstone of his campaign and won the White House with a clear majority of the electorate. In 1965 as now, both chambers of Congress were under Democratic control. Furthermore, soon after the election, President Obama, who is also considered a savvy political strategist, began assembling an experienced cabinet and cadre, tapping former Senate Majority Leader Thomas A. Daschle (D-SD) to serve as Secretary of the U.S. Department of Health and Human Services and Director of the Office of Health Reform.

Moreover, before actually taking office, the Obama Administration sought to build public support for overhauling the U.S. health care system. For example, Mr. Daschle scheduled nationwide

public forums to discuss the problems facing patients, physicians, business owners, and so on. These meetings have demonstrated that health care reform remains a high priority for the public, especially now that many of the hundreds of thousands of Americans who have recently lost their jobs have simultaneously lost their health insurance coverage.

Activity in Washington

Members of Congress are responding. Last November, Senate Finance Committee Chairman Max Baucus (D-MT) issued a “Call to Action” for health care reform in 2009. This “white paper” outlines policy options for the 111th Congress to consider in an effort to achieve universal coverage, to reduce health care costs, and to improve quality of care. Some specific concepts that Senator Baucus advances in his plan include mandating that all Americans have health insurance coverage and revising the Medicare physician payment formula to encourage the provision of value-based care.

Sen. Edward Kennedy (D-MA), Chairman of the Senate Health, Education, Labor, and Pensions (HELP) Committee, also is playing a leading role in the development of health system reform legislation. At press time, Senator Kennedy was putting together working groups to address prevention and public health, quality improvement, and insurance coverage issues.

Other senators and representatives and their health advisors also have been crafting health system reform proposals for consideration within the first half of 2009. Most of these blueprints have many components that the College supports. However, the College and other surgical specialty societies have grave concerns about plans that would increase payments to primary care physicians by reducing reimbursement to other specialists. Senator Baucus’ Call to Action includes these provisions, and the Medicare Payment Advisory Commission has offered similar recommendations. Supporters of this policy change claim that it is necessary to stop the deepening primary care workforce shortage. However, as the College and 13 other surgical specialty societies said in a December 5, 2008, letter, primary care “is not alone among physician specialties facing significant workforce and reimbursement difficulties.” In recent weeks, we were quite successful in getting that story told: a front-page article in the Washington Post was also picked up by numerous major media outlets around the country and widely circulated on Capitol Hill.†

The College’s lobbying staff has been meeting regularly with health advisors to key Members of Congress and to other legislators who serve on the Senate Finance, the Senate HELP, and the House Ways and Means committees. During these discussions, ACS staff has expressed the College’s desire to work with policymakers to enact fair and responsible health reform legislation. Many of these meetings have involved representatives of other medical and surgical specialty societies as well. We also have met with the leaders of these groups away from the confines of Capitol Hill to develop solutions that are acceptable to all health care professionals.

Sticking together

We all need to present a cohesive message about which changes to the health care system will be of most benefit to our patients and to our nation’s economic stability. We need to understand each other’s problems, and we need to seek out common ground. As an example, whereas surgeons will not tolerate a Medicare payment increase to primary care physicians if the rest of the medical profession is expected to pay for it, I do believe that surgeons need to understand primary care’s views on this and other issues. In return, we should expect primary care to empathize with our concerns.

Without question, change is imminent. If we present a fragmented message, lawmakers will heed the advice of those stakeholders who do present a clear and unified vision. However, if we all work together, the transformation is more likely have a positive outcome for our profession and our patients.


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

Thomas R. Russell, MD, FACS
Postgraduate PALLIATIVE MEDICINE training for the surgeon:

An update on ABMS subspeciality certification

by Michael D. Adolph, MD, FACS; and Geoffrey P. Dunn, MD, FACS
In 1997, the Bulletin made a farsighted decision in publishing a brief article to raise surgeons’ awareness about the (then) very new field of palliative care. Now, following a decade of support from the American College of Surgeons and the equally farsighted decision of the American Board of Surgery (ABS) to co-sponsor new subspecialty board certification in hospice and palliative medicine, surgeons have the opportunity for formal training in this rapidly expanding field. Available evidence suggests that hospital-based palliative care programs are rapidly diffusing throughout the U.S. health care system. According to the Center to Advance Palliative Care (CAPC), a clinical palliative care program existed in more than 31 percent (1,299) of 4,136 hospitals appropriate for palliative care in 2008 (the analysis excluded rehabilitation and psychiatric facilities). This growth reflects an increase from just 632 programs in 2000. Hospitals with palliative care consultation services, as compared with peer organizations, were more likely to have a cancer program approved by the ACS, to have greater than 250 beds, and to be a member of the Council of Teaching Hospitals. Nearly 50 percent of hospitals located in cities with populations larger than 1 million have palliative care services. Hospital-based palliative care programs have proliferated in the past 10 years, and the surgeon is likely to experience more frequent clinical interactions with palliative care in their hospitals (see box, page 8, for definitions of terms related to palliative care). Despite this growth in hospital-based clinical palliative care programs, the organization of formal fellowship training programs for physicians has lagged behind this growth.

The rationale for palliative care

There are currently 36 million Americans older than 65 years; 90 percent have one chronic illness, and more than 77 percent have two or more chronic illnesses. The CAPC notes that, by 2030, it is expected that the number of older Americans will have more than doubled to 70 million—or one in every five Americans. With the availability of advanced medical technologies the growing number of older adults are expected to live longer, but often with serious, chronic, and costly illnesses. By improving physical and psychological symptoms, caregiver well-being, and patient/family/doctor communications, palliative medicine is widely viewed as an important solution to the mounting problems faced by patients, families, and the health care system.

Analysis of approximately 1.5 million annual Medicare beneficiaries revealed that up to 31 percent undergo surgical procedures in the last 12 months of life. Typical procedures included intubation and tracheostomy (10.7 percent), hip and femur surgeries (5.63 percent), feeding tube placement (5.25 percent), colon resection (1.82 percent), enterolysis (1.24 percent), and lower extremity amputation (1.18 percent). In 1999, 50 percent of feeding tube placements and 60 percent of intubations and tracheostomies were performed on people who would soon die. In addition, the majority of injections for esophageal varices and brain biopsies in study years 1985 and 1999 were performed on patients who would die during that hospital stay. The trajectory of illness for Medicare beneficiaries and other chronically ill persons appears to frequently cross the path of a surgeon shortly before the end of life.

The rationale to justify the training of surgeons to deliver palliative care has been described by other authors. Briefly, on an individual patient basis, the surgeon understands surgical illness and can place it in the context of overall patient welfare, including indications and contraindications for palliative surgery. Surgeons are committed to the primacy of patient welfare as a responsibility of professionalism. In addition, surgeons feel comfortable with complex illness and routinely encounter complex family dynamics within complex health care organizations—all frequent themes found in the delivery of palliative care.

On a public health level, surgeons may be the ideal clinicians to offer and provide palliative care concurrently with curative measures when surgical disease trajectories are uncertain. The literature on end-of-life care is replete with the incorrect assumption that terminal illness defined retrospectively carries no distinction from terminal illness defined prospectively. Advances in technology, therapeutics, and surgical techniques have rendered prognosis more uncertain for the patient, family, and clinician.
Although training in palliative medicine may help a surgeon recognize and manage imminent death, predicting imminent death with certainty for all patients remains difficult. Lamont and Christakis describe the difficulty physicians experience when trying to relieve uncertainty by prognosticating outcomes such as death.\textsuperscript{12,13} They propose that a physician who demonstrates transparency must be able to communicate uncertainty while delivering simultaneous curative and palliative care in order to relieve patient distress. Mosenthal and colleagues describe a successful interdisciplinary palliative care approach to accomplish effective communication, regardless of prognosis, in a trauma intensive care unit (ICU) environment.\textsuperscript{14}

Myers and Linder have emphasized a concurrent “progressive palliative care” that readily applies to surgical practice—that is, working with patients to limit suffering while the trajectory of disease unfolds over time, not solely reserving palliative care for “crisis management at the

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**DEFINITIONS related to palliative medicine and hospice care**

The Center for the Advancement of Palliative Care (CAPC) states that “Palliative care is the medical subspecialty focused on relief of the pain, symptoms and stress of serious illness. The goal is to ensure the highest quality of life possible for patients and their families. Palliative medicine treats serious illness regardless of prognosis, and patients can receive it at any point in their illness, with or without curative treatment.” The World Health Organization’s definition is that “Palliative care improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support to from diagnosis to the end of life and bereavement” (http://www.who.int/cancer/palliative/en/).

Palliative care is defined by the CAPC as follows:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten or postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient’s illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated
- Will enhance quality of life, and may also positively influence the course of illness
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

The discipline of palliative medicine is what physicians do, whereas the discipline of palliative care is what clinicians of all backgrounds—including physicians, nurses, clinical pharmacists, psychologists, social workers, chaplains, and many other specialists—may do.

According to Osoba,\textsuperscript{*} as cited by McCahill et al, “Palliative surgery is best defined as surgery aimed at alleviation of patient symptoms and improvement of patient quality of life, with minimal anticipated impact on overall patient survival.”

A hospice is an organization, health care benefits structure, or clinical practice devoted to providing interdisciplinary palliative care for terminally ill patients and their families in the home setting, skilled nursing facility, or inpatient hospice unit.

end of life.”15 The cancer patient, however, may represent a more predictable prognosis based on disease trajectory; as Scitovsky notes, “It is no accident that hospice programs serve primarily [cancer] patients.”10 Although uncertainty may be a hallmark of many surgical illnesses, the benefits of a concurrent palliative care approach are within the capabilities of the surgeon. The surgeon is also uniquely skilled to evaluate the risks and benefits of palliative surgery or interventional procedures to best achieve quality of living. How does the surgeon acquire training to provide for more effective communications (for example, in delivering bad news16), to enhance patient-family decision making, and to relieve distressing symptoms?

**Educational opportunities**

If you provide surgical care for chronically ill, critically ill, or terminally ill patients, there are benefits from additional training, resources, and support to deliver palliative care concurrently with standard curative measures or at the end of life.5,6,17 Recognizing the benefits of palliative care for surgical patients, the ABS became one of 10 sponsoring boards for subspecialty training in palliative medicine.18 Perhaps the seeds for this commitment were sown in 1997 by the Bulletin article mentioned previously, which recognized the palliative care needs of surgical patients. Shortly after the article was published, a well-attended colloquium on end-of-life care—presented at the 1997 Clinical Congress in Chicago, IL, and moderated by Thomas Krizek, MD, FACS—addressed the nationally debated topic of physician-assisted suicide. Both sides of that debate at least agreed that palliative care is essential for good patient care and that surgeons had much to learn in order to provide it. Many of the panelists subsequently drafted the College’s first Statement on Principles of Care at the End of Life, which was approved by the Board of Regents in February 1998.19

In 2001, the College received a grant from the Robert Wood Johnson Foundation that provided initial funding of the Surgical Palliative Care Task Force in the Division of Education. The initial purpose of the Task Force was to raise surgeons’ awareness of the palliative care needs of their patients and to provide educational opportunties about the principles and techniques of palliative care in surgical practice. The task force has contributed to a valuable position paper,19 monthly journal articles for the Journal of the American College of Surgeons (JACS) over a period of three years,20 an educational Web portal,21 and symposia at the ACS Clinical Congress every year since 2000. Additional available educational resources for the practicing surgeon are thoroughly described in a review by Brasel and Weismann in JACS.22 Supported by the ACS Board of Regents, the task force continues to develop and promote learning activities within the ACS Division of Education.

Palliative care services are generally codified and billed by evaluation and management Current Procedural Terminology codes on the basis of time spent, symptoms managed, and/or care coordinated. Charges are typically codified with a submitted claim’s first International Classification of Diseases, Ninth Revision, code to reflect the dominant symptom or sign prompting palliative care interventions (for example, the first code on the claim would be abdominal pain, 789.0; or neoplasm-related pain, 338.3; or encephalopathy, 348.39). If billing for time spent, documentation in the medical record should reflect total time spent as well as the clinical focus of timed efforts (for example, medication counseling, coordination of care, or end-of-life goal setting).23

**Practice pathways and board certification**

Ultimately, the American Board of Medical Specialties (ABMS) unanimously approved palliative medicine as a subspecialty in 2006, affording it all of the rights and privileges of other subspecialty training tracks leading to board certification.18,24 Given the support of the ABS as a sponsoring board, surgeons may pursue subspecialty fellowship training in palliative medicine toward an ABMS-approved board certification in palliative medicine. How does a surgeon train in palliative medicine, and why? How does a surgeon integrate palliative medicine fellowship training into a surgical career?

Training in palliative care during postgraduate surgical residency is limited and very early in its development, though surgical residents frequently encounter patients with terminal or
incurable illness.\textsuperscript{22,25,26} For example, the management of malignant bowel obstruction requires complex decision making involving palliative,\textsuperscript{27} ethical,\textsuperscript{28} and interdisciplinary\textsuperscript{29} considerations.

Limited work hours and a jam-packed curriculum in surgical training result in precious few opportunities for added training of any sort. However, Klaristenfeld and colleagues have demonstrated that three one-hour palliative care teaching sessions for surgical residents proved helpful and led to retained knowledge at a three-month reevaluation.\textsuperscript{30} Chipman and colleagues at the University of Minnesota developed an Objective Structured Clinical Exam (OSCE) for leading family conferences in the surgical ICU. The surgical ICU OSCE required surgical residents to lead an end-of-life discussion and to disclose an iatrogenic complication.\textsuperscript{31} Surgical educators and mentors of young surgeons can help trainees implement palliative care alternatives concurrently with surgical intervention in advanced disease or develop beneficial alternatives when surgery is not indicated.\textsuperscript{32}

Surgeons have already received certification in palliative medicine by an experiential pathway and a training pathway. Before 2008, these non-ABMS pathways were sponsored by the American Board of Hospice and Palliative Medicine (ABHPM). As of 2006, 27 surgeons were ABHPM-certified in palliative medicine, out of a total of 2,145 certified physicians in the U.S. (personal communication, Dale Lupu, PhD, ABHPM chief executive officer, July 3, 2006). Beginning in October 2008, surgeons previously certified in palliative medicine will have until 2012 to retake the new ABMS certification exam sponsored by the ABS, given every two years.\textsuperscript{33,34}

From 2008 to 2012, a practice pathway is still available for physicians already involved in hospice or palliative care, including surgeons. Surgeons involved in interdisciplinary care of chronically diseased, critically ill, or terminally ill patients are candidates to apply for the examination. Applicants must be able to document at least 800 hours of clinical involvement in the subspecialty-level practice of hospice or palliative medicine. The 800 hours must have been completed over at least two years and include 100 hours of participation with a hospice or palliative care team, as well as participation in the active care of 50 or more terminally ill patients (or at least 25 patients for pediatric surgeons). Diplomates who were previously certified by the ABHPM may also enter through this ABMS pathway, with their previously earned certificate documenting their experience.

For the training pathway, until 2010, 12-month fellowships in palliative medicine associated with an academic program approved by the Accreditation Council for Graduate Medical Education (ACGME) (for example, a palliative medicine fellowship associated with an ACGME-approved internal medicine or anesthesiology academic program) qualify a graduate to sit for the palliative medicine board exam. After 2010, completion of an ACGME-certified palliative medicine fellowship will be necessary for all other surgeons to achieve palliative medicine board certification. To date, the authors are aware of only two surgeons who have completed fellowship training in this relatively new subspecialty. Given that surgeons represent only 1.2 percent of existing board-certified palliative medicine physicians, the evidence suggests that additional surgeons are needed in this calling to provide expertise in this growing subspecialty.

The chief prerequisite to apply for a palliative medicine fellowship is that one simply needs to be board certified or board eligible in surgery. An additional key component to success in palliative care training is the desire to help incurably diseased or chronically ill patients improve the quality of living for themselves and their families in the short or long term. Fellowship curricula and competencies are complementary to surgical care.\textsuperscript{35-37} If you have felt the frustration of realizing that you cannot cure Crohn’s disease or chronic bowel obstruction caused by adhesions, atherosclerosis, or disability as a result of cancer treatments, you are familiar with the needs of the chronically ill. Perhaps you simply have a desire to do more when your instincts tell you that a surgical cure is not feasible, particularly near the end of a patient’s life or for critically ill patients and their families. You may simply feel the need for more training or resources to meet the demands of disabling disease. The palliative medicine fellowship teaches physicians how to deliver bad news more effectively and engage the patient and family in the process. Participants
also learn to implement and maintain comfort in practical terms. This approach permits patients and families to develop and achieve new goals and relief from suffering caused by chronic illness or at the end of life.

It can take courage to help patients and families confront obstacles in chronic illness or at or near the end of life. A surgeon already has the boldness needed to help the most vulnerable of patients in complex, life-threatening medical situations. Finally, an innovative spirit helps fellowship applicants. The authors have never met a surgeon who didn’t have an innovative spirit to meet the challenges of a new field. It not only takes a desire to improve patient care at the bedside but also the recognition that the way that entire organizations “do” health care for chronic and advanced illness needs to change. And, at this juncture in the development of this subspecialty, participating surgeons will be at the focal point of that change in their institution or specialty practice.

Approval by the ACGME provides national academic stature for the subspecialty and encourages the development of competency standards as fellowships expand. Currently there are 63 fellowships available, with 161 annual positions to fill. Approximately 30 more anticipated fellowships will begin filling in 2009 (see Figure, this page). Training is typically 12 months in duration. Future applications for fellowships will likely be through the electronic ERAS system, similar to other postgraduate training program applications today (see http://www.aamc.org/audienceeras.htm). A listing of current fellowships is located on the American Academy of Hospice and Palliative Medicine (AAHPM) Web site at http://www.aahpm.org/fellowship/directory.html.

**Integrating palliative care to practice**

What are the available professional opportunities and how does a surgeon integrate palliative medicine expertise? Currently, the most common model is a practicing general surgeon who also provides state-of-the-art palliative care to his or her own patients or to the patients of other clinicians by consultation. However, it is also clear that the patient populations of many surgical subspecialists have unique palliative care needs. These palliative care needs may be best met by the surgeons delivering the care themselves. For example, there are exclusive needs to be met for cancer patients, the critically ill, transplant patients, and patients afflicted by trauma or burns. Critical care specialists already have some of the most well-developed consensus palliative care guidelines available today.

What about the mid-career surgeon? One of the reasons the 10 specialty boards unanimously approved palliative medicine as a subspecialty was to encourage mid-career physicians and surgeons to participate in the growth of this young specialty. After fellowship training, one could also conceivably take a path of full-time palliative medicine or hospice clinical work, because demand for physicians far exceeds supply. In all of these opportunities, surgical background and surgical approach to problem solving is invaluable.

Interested surgeons will want to evaluate a fellowship training program closely, as fellowships are a heterogeneous group. How did the clinical program begin? What is the historical background of a fellowship program? For example, the service at Ohio State University started an anesthesiology cancer pain service (led by Costantino Benedetti, MD) at a cancer research hospital. More than 80 percent of the program’s clinical work has been with advanced
cancer patients, and the program delivers expert cancer pain therapy, symptom control in chronic cancer survivorship, and support care of the dying cancer patient.

The clinical interests of the program’s medical director are important factors. There is considerable professional diversity in palliative medicine right now. This professional diversity can be either a strength or a weakness when considering the depth and breadth of the fellowship experience, depending on the clinical emphasis of the program itself.

Not only do clinicians in palliative medicine determine the focus of care, but the needs of the institution itself also plays a substantial role. Is there a large medical ICU associated with the fellowship program? If so, expect a lot of inpatient end-of-life care. Is there an ambulatory clinic? For example, there are more than 12 million cancer survivors today, many of whom are living with disabling symptoms in their cancer survivorship; this is true of the majority of the 800 outpatients in the ambulatory care clinic at the James Cancer Hospital.

Conclusion

Despite evidence that hospital-based palliative care is rapidly diffusing throughout the U.S. health care system, few physicians and fewer surgeons are certified in this subspecialty. On average, only 1.7 board-certified physicians are available to serve each of the 1,299 hospital-based palliative care programs in the U.S. (2,145 physicians compared with 1,299 programs, based on available data). The majority of the palliative medicine board-certified physicians (98.8 percent) are not surgeons. As such, there may be obstacles to this innovation diffusing through surgical patient populations. Judging from the growth of hospital-based programs, the recent ABMS subspecialty approval, and an anticipated increase in future graduates of expanding fellowship training programs, hospital-based surgeons can expect to collaborate with palliative care teams more frequently in their surgical practice.

The authors believe that surgeons actively becoming involved in palliative care education, training, and experience are the most effective means of helping surgical patients who need palliative care. Surgeons bring unique expertise to palliative medicine, and surgeons hold a unique trust with their patients for total care in complex medical circumstances. The curriculum in a 12-month fellowship is comprehensive and complementary to a surgical career. Surgeons have a unique opportunity to join and contribute to this movement, including undergoing fellowship training themselves. Postgraduate fellowships will ultimately determine what the subspecialty aspires to become in terms of research, education, and clinical care. There is also a practice pathway to board certification available until 2012. Independent of a surgeon’s interest in palliative care, clinical interactions with hospital-based palliative care services are expected to increase in the near future.

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5. Dunn GP. The surgeon and palliative care: An

Dr. Adolph is board-certified in surgery and palliative medicine and is one of two surgeons in the U.S. who has completed a palliative medicine fellowship. He has served as associate director of the palliative medicine fellowship program at Ohio State University.

continued on page 47
Pacific Partnership 2008:
U.S. Navy Fellows provide humanitarian assistance in Southeast Asia

by
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On May 1, 2008, the hospital ship USNS Mercy left San Diego, CA, to participate in Pacific Partnership 2008, the fourth humanitarian assistance operation in Southeast Asia in as many years. This mission is an extraordinary opportunity for not only the U.S. Navy, but also nongovernmental organizations and partner nations—such as Australia, Canada, Chile, India, Indonesia, Japan, the Republic of Korea, New Zealand, Portugal, and Singapore—to promote peace and stability in Southeast Asia and the Western Pacific, largely in regions that have been medically underserved for many years. Beginning with the tsunami relief effort in 2005, the U.S. and partner nations have maintained a steady presence throughout the South Pacific, providing medical, dental, veterinary, and engineering services to a diverse array of people and cultures. Pacific Partnership 2008 coordinated these efforts with the assistance of host nations in five countries: the Republic of the Philippines, the Socialist Republic of Viet Nam, the Democratic State of Timor Leste (also known as East Timor), the Independent State of Papua New Guinea, and the Federated States of Micronesia.

Commissioned in 1986, the USNS Mercy (T-AH 19) is a 1,000-bed hospital ship fashioned from a converted oil tanker whose mission is to provide medical and surgical services afloat and ashore in support of U.S. disaster relief and humanitarian operations worldwide. The Military Sealift Command is responsible for the ship navigation and maintenance. The ship has 12 operating rooms, including an interventional radiology suite. Patient transport is by either boat or helicopter, typically two MH-60Ss, with Navy Seahawks on board. The greatest capabilities aboard lie in the skillsets of her crew. Surgical specialists represent general, oral-maxillofacial, orthopaedic, pediatric, plastic, urologic, and gynecologic surgery as well as otolaryngology and ophthalmology. In addition to the surgical capabilities, the ship is staffed with individuals representing a full spectrum of medical specialties ranging from gastroenterology to infectious disease. Ancillary services include physical therapy, blood bank, laboratory, pharmacy, biomedical repair, and radiology. The dental and optometry departments are also kept extremely busy and provide high-impact humanitarian services, often in austere surroundings. The Mercy serves as a unique enabling platform taking specialized medical services to the doorstep of countries that are happy to be receiving any medical treatment.

Ship vital signs:
Life on USNS Mercy, 24/7

The odd marriage of a seagoing vessel and a hospital consumes whatever space is available. The ship, although large for a naval sailing vessel, is only 894 feet long and 105 feet wide. As a result, lodging is relatively cramped and each stateroom houses six to 10 officers with personal space limited to a locker, a few drawers, and choice of an upper or lower bunk. Four of eight decks separate the sleeping quarters from the galley and the endless flights of stairs that double as a way to burn the calories from the hearty meals. Cooks prepare more than 3,000 meals per day and are some of the hardest working people aboard. The basic diet is augmented with local fruits and vegetables, which are sometimes a treat and sometimes not. Starbucks was an unexpected luxury until the supply ran out near Timor Leste and we were relegated to drinking Maxwell House. The milk is suspect, as it comes in a small, square box with an indefinite expiration date. Meals are a chance to catch up with friends and also for sharing information and team building.

One of the immediate observations made by newcomers is the number of different groups on
board. The majority of personnel are U.S. Navy, but there are also Marines, Army soldiers, Air Force personnel, Public Health Service representatives, and civilians. In addition to medical personnel, there are security forces, an aircrew, legal, public affairs, information technology, construction battalion, and Pacific Fleet Navy Band. In total, there are approximately 1,000 people aboard, all supporting the humanitarian and civic assistance mission of Pacific Partnership 2008.

**Putting resources to work:** Republic of the Philippines

An initial 350-person crew brought the USNS *Mercy* halfway around the world, safely arriving in Guam. After taking on an additional 500 personnel and needed supplies, the ship departed for the Republic of the Philippines and spent the next five days traversing some 1,515 nautical miles to get to the first mission site. The *Mercy*’s arrival in the southern province of Mindanao was greeted by scorching tropical sun and a level of humidity unfamiliar to all but those individuals from the Deep South. For the next two weeks, we provided high-quality care to the people of Cotobato City, Samar, Calbayog, and Zamboanga. Mindanao is an area fraught with conflict and terrorist activity. The Joint Special Operations Task Force, providing support for the Pacific Partnership mission, expertly provided security and dutifully ensured our safety. Conditional to our safety was the donning of Kevlar vests when leaving the ship while traveling between the hours of dawn and dusk and only traveling with armed escorts. While in Cotobato, one of the helicopters sustained a gunshot to the tail.

Arriving at dawn, the USNS *Mercy* surgical screening team lands dockside ready to start the day in the Republic of the Philippines.
section just below the rear rotor. Fortunately, the helicopter returned safely to the ship; the bullet hole was discovered during the pilot’s postflight close inspection.

During the 12 days in the Republic of the Philippines, Pacific Partnership surgeons performed more than 200 operations involving the specialties of plastic surgery, orthopaedics, general surgery, urology, otolaryngology, pediatric surgery, gynecology, and ophthalmology. Thyroid lobectomies were frequent and it was not uncommon to operate on 10 cm to 15 cm nodules.

One of the biggest treats while in the Philippines was working with the local surgeons of the host nation. Dr. Manuel Yambao, a plastic surgeon, and Dr. George Lao, an ophthalmologist, quickly became familiar faces in the operating rooms and a welcome addition to the team. Five additional ophthalmologists from Manila also integrated with our surgeons and a participating nongovernmental organization, the 3P foundation. The success of this mission, measured both in numbers treated and new partnerships formed, was typical and would be repeated four more times over the course of the summer. As the Mercy moved to each new mission site, host nation physicians and large numbers of crew members changed; the care, compassion, and quality of patient care never wavered.

One particularly touching case in the Philippines involved a special young boy who was injured in a bomb blast six years ago. He was unable to walk because of scar contractures of his left leg. His legs were atrophied and unable to be extended, yielding little to no freedom of movement. His father literally had to carry him from place to place. The boy had huge calluses on his hands from pulling his useless legs behind him as he crawled around on the ground. Orthopaedic and plastic surgeons combined to release his contractures and perform a skin graft on the resultant defect. Recognizing the extraordinary opportunity to change this boy’s life, we invited him to stay on board for the entire two weeks that the ship was on site. After initiating an intense physical therapy regimen, this remarkable young man started moving around on crutches, and by the time he left us, he was riding a bike that some of the staff had purchased for him. This case was only one of the amazing stories and experiences of how the surgical team was able to provide lasting changes, and improve the life of not just one individual, but his entire family. The crew received a huge morale boost, and the Pacific Partnership mission was only getting started.

After leaving Cotobato, the Mercy made a three-day port call in Manila. Here, surgeons had an impact on the professional community through training, participating in an information-exchange program that invited guest lecturers at the University of Santo Tomas. Lasting friendships were made during the time spent in the Philippines, but quickly it was time to move on to the next mission site: Nha Trang, Viet Nam.

**USNS Mercy makes history: Socialist Republic of Viet Nam**

Two days later, the Mercy crew skillfully and safely set anchor in beautiful Nha Trang harbor in the Socialist Republic of Viet Nam. Taking in the scenery for the first time was surprising for many. It was not a dense jungle full of unknown dangers but rather a skyline that boasted luxury hotels, exclusive resorts, and tropical beaches. It
was an incredible honor to be invited to Viet Nam; this mission site would mark a number of historic “firsts,” not only for the medical staff, but for the U.S. The international impact could be epitomized by the words of one elderly veteran of the Viet Nam War: “The war belongs to the past. We are looking to the future.” Working side-by-side in the now familiar heat, Partner Nation and Vietnamese physicians evaluated patients and decided which cases would be best performed aboard the Mercy. Two days of surgical screening took place in a collegial but controlled setting where patients came on an appointment basis and the local custom of a three-hour daily lunch break was closely observed. The Mercy made history, as the surgical team became the first group of U.S. military surgeons to operate in Viet Nam since 1975. The first case, a laparoscopic cholecystectomy, was proudly performed by one of the authors (Kuncir) and assisted by the senior regional surgeon, Dr. Troung.

More patients came from the Medical Civic Action Programs (MedCAPs) with approval required by the Vietnamese Department of Health before these patients could receive care aboard the ship. In Viet Nam, the Pacific Partnership Medical staff provided care to more than 11,576 patients. The patients and their families were genuinely grateful for our care and the Vietnamese surgeons proved to be wonderful professional colleagues.

Viet Nam was an opportunity
for medical instruction and cultural enlightenment. Dr. Le Phu, the director of ophthalmology at the local hospital, was smitten with our team approach to patient care and safety protocols. His four operating room nurses came onboard for training, an experience that they greatly enjoyed. Additional educational endeavors were fulfilled through teaching basic life support and initial burn management at both Khan Hoa General Hospital and the Rehabilitation Hospital. Dr. Kuncir introduced the concept of damage control surgery for trauma during well-attended grand rounds at the regional medical center.

Medical information exchange was a key aspect of the Vietnamese mission site with everyone involved gaining insight about the procedures and processes each used. For instance, patients in Viet Nam are allowed to eat right up until the time of their surgery. For ophthalmology, there was no anesthesia support staff or monitoring available in the operating suite. The surgeon puts a gown on that he wears for the entire day, changing gloves between patients. A single operating room has three beds for simultaneous surgery. Double-armed sutures are cut in half and the unused half stored in alcohol for a future case. A flamed muscle hook is used in place of traditional cautery.

Despite limitations of consumables, the Vietnamese team was highly efficient and produced consistently excellent surgical outcomes. The medical training also differs between our two countries. Vietnamese physicians attend a combined college and medical school for six years. There are no internships, and many of the surgeons are not permitted to select a specialty but are guided to a specialty of the government’s choosing. Once assigned to a specialty, surgeons serve as an understudy until mastering the specialty, a task that has no defined time period. There are no subspecialty fellowships and additional training
comes from reading, research, and attending international conferences.

During our visit to Viet Nam, we had a few additional surprises. Cindy McCain, a board member of Operation Smile and wife of Sen. John McCain, stopped by our first surgical screening. The Miss Universe pageant was being held in Nha Trang and five of the contestants came aboard the Mercy for a tour. Julie Gerberding, MD, MPH, head of the Centers for Disease Control and Prevention, was also in town and visited the ship. The humanitarian and diplomatic impact our services provided was very rewarding, but everyone was in need of a break from the weeks of 12-hour mission days. The ship left Nha Trang for Singapore to take on supplies, swap out some of the crew members, and to provide the crew with needed rest and relaxation.

**Adapt and overcome:**

**Timor Leste**

After five days of liberty (free time) in Singapore, the Mercy pulled away from her berth and carefully navigated the Singapore Straits, one of the busiest shipping channels in the world. Once in the open ocean, we headed southeast for the island of Timor Leste. During the transit, a number of us took part in one of the Navy’s oldest traditions, the “crossing the line” ceremony. Starting off the day as “pollywogs,” we participated in the good-humored pranks designed to test our seaworthiness as we crossed the equator to become “trusted shellbacks.” Rested up, the crew was ready to take on a new mission in Timor Leste.

Timor Leste is a country with a history of political turmoil and civil unrest. The annual
flying patients and physicians in and out of mountain villages too difficult to access by conventional vehicles. The Mercy helicopters were performing double-duty because the seas were very rough and frequently made safe patient transport via the ship’s 42 passenger “band-aid boat” impossible. Although it was anchored, the rough seas caused the ship to rock. Surgeons had to compensate for large-scale swaying motions that caused both fine and coarse vibrations, making microsurgery difficult at times.

Adventures ahead: Australia

We weighed anchor the next morning and steamed for Darwin, Australia. The city of Darwin and its mix of native cultures could be right out of Crocodile Dundee. This outback countryside is filled with large saltwater crocodiles and kangaroo steaks are on the menu at many of the local restaurants. Many of us had a chance to play the Aboriginal didgeridoo. The breaks never seemed long enough, but there were people in need and work that was to continue for the Mercy in two more countries.

After taking on fuel and supplies, we set our sight on Port Moresby in the Independent State of Papua New Guinea. With a new group of partner-nation surgeons, residents, and military reservists, we turned northeast and started back toward the equator. Everyone looked forward to the summer Olympics in China and since we had more than 10 nations represented on the ship, it provided for some great entertainment as we each cheered for our country’s athletes.

Collegial collaboration continues: Papua New Guinea

Papua New Guinea, our fourth mission site, was another port providing cultural and medical enrichment. Our work at Port Moresby General Hospital proceeded without incident and our host nation colleagues generously treated us to an elaborate buffet lunch with local delicacies and a performance by traditional dancers adorned with body tattoos, wild boar necklaces, and feathers. Communication between us and the host nation doctors was excellent, as many
of the younger citizens of Papua New Guinea speak English; the remainder speaks Pidgin, which is a Franca-linga or Creole dialect. Working in this part of the world allowed many of us to see textbook cases that would not ordinarily be encountered in the U.S. In Papua New Guinea, there were advanced head and neck cancers associated with chewing betel nut. The New Guineans grow this fruit on trees in their yards and the white gelatinous fruit is removed from its thick green coating and sucked. To improve the taste, many people have personal recipes that mix the fruit with lime and/or mustard that turns the substance orange and stains the teeth. Because of the permanent staining and mess associated with its use, betel nut was strictly forbidden aboard the ship.

Our surgical team, a well-oiled machine, was firing on all cylinders and performed a surprising 346 life-altering procedures—our highest total to date. The plastic surgery service focused on performing cleft palate cases. Seeing the beautiful new smiles and self-confidence beaming, we knew we had helped change their lives forever. The 12-day operating schedule allowed us to perform more difficult cases early on, giving ample time for recovery, and we were even able to build initial physical therapy into the lineup.

Throughout our travels, safety has been paramount. It was particularly important to maintain extremely high standards in operating procedures in Papua New Guinea, where there is a high number of people who are carriers of human immunodeficiency virus (HIV) and hepatitis. The Mercy laboratory tests for HIV and hepatitis revealed prevalence rates as high as 50 percent among the at-risk population. Working with partner nations, all having similar, but not identical, procedures in the operating room, we were extremely careful with sharps and, during Pacific Partnership 2008, implemented a standardized process for passing needles and scalpel blades.

Practicing medicine in a tropical paradise: Federated States of Micronesia

We left Port Moresby August 18, 2008, and arrived at our last mission site, Chuuk, Micronesia, four days later. This country is made up of hundreds of islands, a number of them uninhabited, spanning two time zones. Electricity and running water are luxuries. The islands are lush and this area is known as one of the top diving locations in the world for World War II wreckage. Despite this reputation, the country is very poor and lacks infrastructure. The Feder-
States of Micronesia is a U.S. protectorate and although the people have access to a higher level of health care than we had seen, health care was limited even on the most populated island of Micronesia.

As the Mercy steamed into the tropical paradise that is Chuuk, helicopters carried 40 staff members from the Directorate of Surgical Services to the mainland on a short, but beautiful flight to perform the surgical screening at Chuuk State Hospital. Micronesia is divided into four states and this is the only hospital serving the state of Chuuk’s 53,600 people spread across 16 inner-lagoon islands. The building was a small facility with 30-bed capabilities and medical, surgical, pediatric, and obstetric care. Of note, Micronesia is located 7° north of the equator, where the sun is intense. Most of the population work on or near the water and do not wear sunglasses. This makes pterygia extremely common. Many patients have both nasal and temporal lesions. Some cover the pupil. At the mission conclusion, RADM Christine S. Hunter, the Commanding Officer of Navy Medicine West, visited the Mercy to thank us for our hard work over the past four months.

**Mission accomplished**

The practice of medicine is a great diplomatic tool. It is generally agreed that people who require care should receive it, and using the Navy and the unique platform of the Mercy, people are getting the help they need. Problems such as language barriers, the occasional rough seas, and being away from family pale in comparison to all that we have done. Collectively, Pacific Partnership 2008 did a lot of good for a lot of people. We examined more than 90,000 people and performed 1,370 operations. Summer 2008 gave us a taste of humanitarian medicine and showed what teamwork between the U.S. military, partner nations, and nongovernmental organizations can do to provide care and training in countries that need it most. Until the next mission, our experiences made us realize how lucky we are to practice medicine in the U.S. with freedom of specialty choice, improved access to medical care, and the luxury of consumables. The views expressed in this article are those of the authors and do not reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. government.

**CDR Davis** has been on active duty with the U.S. Navy for 16 years. After deployment, she will return to the Naval Medical Center San Diego (NMCSD) as division head of glaucoma services and associate ophthalmology residency program director.

**CDR Douglas** has 13 years of active duty service and is stationed at NMCSD. His current practice focuses on reconstruction of complex war injuries and breast cancer reconstruction.

**CAPT Kuncir** is the surgical intensive care unit director at NMCSD and practices trauma and acute care surgery at University of California, San Diego, where he is an associate clinical professor of surgery. He has been in the Navy for 18 years.
ACS Practice Patterns Survey, Part III: Use of Surgical Instruments and Devices Among Surgical Specialties

by Charles M. Balch, MD, FACS; and Thomas R. Russell, MD, FACS

Until now, very little data were available to determine how frequently surgeons use equipment and devices in the operating room and, in turn, which devices are used within each of the surgical specialties. To address this issue, an electronic survey of members of the American College of Surgeons was carried out in fall 2007. The response rate was impressive: 4,207 individuals participated, representing the broad range of practice settings and surgical specialties. Nearly 45 percent of the respondents work in a university/teaching hospital, 39 percent are in private practice, and the remainder provide care in other environments. The survey results
The breakdown of surgical subspecialties among survey participants was very similar to that of the ACS membership overall. The largest percentage of respondents (40 percent) classified themselves as general surgeons, and the other 60 percent represented the majority of surgical specialties. The age groups were spread evenly over the categories, with the largest group represented by surgical respondents in the age range of 55 to 70 years (28 percent), followed by the group representing 45- to 54-year-olds.

Table 1: Survey Respondents—Breakdown by Specialty and Age*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Younger than 35</th>
<th>35–44 years</th>
<th>45–54 years</th>
<th>55–70 years</th>
<th>Older than 70</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>23.41%</td>
<td>25.35%</td>
<td>23.74%</td>
<td>25.22%</td>
<td>1.61%</td>
</tr>
<tr>
<td>Otolaryngology–Head and Neck Surgery</td>
<td>7.06%</td>
<td>29.80%</td>
<td>33.33%</td>
<td>26.67%</td>
<td>2.35%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>8.02%</td>
<td>25.00%</td>
<td>35.85%</td>
<td>28.77%</td>
<td>1.42%</td>
</tr>
<tr>
<td>Colon and Rectal Surgery</td>
<td>9.52%</td>
<td>30.16%</td>
<td>36.51%</td>
<td>21.16%</td>
<td>1.59%</td>
</tr>
<tr>
<td>Urology</td>
<td>7.56%</td>
<td>19.77%</td>
<td>30.81%</td>
<td>38.37%</td>
<td>2.33%</td>
</tr>
<tr>
<td>Trauma/Critical Care</td>
<td>7.06%</td>
<td>48.82%</td>
<td>26.47%</td>
<td>17.06%</td>
<td>0.59%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>3.59%</td>
<td>20.96%</td>
<td>34.73%</td>
<td>35.33%</td>
<td>4.79%</td>
</tr>
<tr>
<td>Pediatric Surgery</td>
<td>4.29%</td>
<td>34.36%</td>
<td>37.42%</td>
<td>22.09%</td>
<td>1.84%</td>
</tr>
<tr>
<td>Plastic and Maxillofacial Surgery</td>
<td>8.33%</td>
<td>27.56%</td>
<td>30.13%</td>
<td>30.77%</td>
<td>1.92%</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>2.40%</td>
<td>32.80%</td>
<td>32.80%</td>
<td>29.60%</td>
<td>2.40%</td>
</tr>
<tr>
<td>Surgical Oncology</td>
<td>8.13%</td>
<td>43.09%</td>
<td>26.02%</td>
<td>17.89%</td>
<td>3.25%</td>
</tr>
</tbody>
</table>

*Data apply to results described in this report and the previously published results on the survey responses to prescribing habits.

Table 2: Use of Surgical Instruments and Devices Among Surgical Specialties

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Biopsy instruments</th>
<th>Minimally invasive surgical instruments</th>
<th>Surgical stapling products</th>
<th>Access and trocar products</th>
<th>Portable ultrasound</th>
<th>Stationary ultrasound</th>
<th>Self-retaining retractors</th>
<th>Venous access devices</th>
<th>Gamma probe</th>
<th>Liver resection equipment</th>
<th>Robotic Instruments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery (1,663)</td>
<td>82%</td>
<td>95%*</td>
<td>97%*</td>
<td>94%*</td>
<td>63%</td>
<td>28%</td>
<td>90%*</td>
<td>66%</td>
<td>46%</td>
<td>17%</td>
<td>5%</td>
</tr>
<tr>
<td>Otolaryngology–Head and Neck Surgery</td>
<td>66%*</td>
<td>66%*</td>
<td>55%*</td>
<td>11%</td>
<td>16%</td>
<td>10%</td>
<td>50%*</td>
<td>9%</td>
<td>15%</td>
<td>&lt;1%</td>
<td>5%</td>
</tr>
<tr>
<td>Vascular Surgery (227)</td>
<td>19%</td>
<td>46%*</td>
<td>57%*</td>
<td>40%</td>
<td>88%*</td>
<td>71%*</td>
<td>50%*</td>
<td>84%*</td>
<td>3%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Colon and Rectal Surgery (204)</td>
<td>76%</td>
<td>90%*</td>
<td>98%*</td>
<td>87%*</td>
<td>40%</td>
<td>33%</td>
<td>50%*</td>
<td>41%</td>
<td>7%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery (201)</td>
<td>65%</td>
<td>84%*</td>
<td>92%*</td>
<td>76%*</td>
<td>50%</td>
<td>31%</td>
<td>77%*</td>
<td>57%</td>
<td>7%</td>
<td>1%</td>
<td>10%</td>
</tr>
<tr>
<td>Urology (182)</td>
<td>93%*</td>
<td>73%*</td>
<td>81%*</td>
<td>66%*</td>
<td>77%*</td>
<td>54%</td>
<td>45%*</td>
<td>81%</td>
<td>15%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Trauma/Critical Care (179)</td>
<td>45%</td>
<td>82%*</td>
<td>95%*</td>
<td>86%*</td>
<td>91%*</td>
<td>27%</td>
<td>77%*</td>
<td>87%*</td>
<td>49%</td>
<td>13%</td>
<td>35%*</td>
</tr>
<tr>
<td>Pediatric Surgery (178)</td>
<td>77%*</td>
<td>94%*</td>
<td>95%*</td>
<td>94%*</td>
<td>49%</td>
<td>13%</td>
<td>49%*</td>
<td>85%*</td>
<td>17%</td>
<td>70%*</td>
<td>41%</td>
</tr>
<tr>
<td>Plast and Reconstructive Surgery (167)</td>
<td>36%*</td>
<td>42%*</td>
<td>64%*</td>
<td>17%</td>
<td>13%</td>
<td>5%</td>
<td>50%*</td>
<td>56%*</td>
<td>47%</td>
<td>64%</td>
<td>88%*</td>
</tr>
<tr>
<td>Breast Surgery (132)</td>
<td>90%*</td>
<td>44%*</td>
<td>56%*</td>
<td>17%</td>
<td>13%</td>
<td>5%</td>
<td>50%*</td>
<td>95%*</td>
<td>47%</td>
<td>64%</td>
<td>35%*</td>
</tr>
<tr>
<td>Surgical Oncology (134)</td>
<td>92%*</td>
<td>85%*</td>
<td>95%*</td>
<td>83%*</td>
<td>41%</td>
<td>52%</td>
<td>50%*</td>
<td>48%</td>
<td>64%</td>
<td>68%</td>
<td>88%*</td>
</tr>
</tbody>
</table>

*Indicates the four highest frequency of instruments used.
(27 percent), and the group representing the 35- to 44-year-olds (26 percent). Interestingly, younger surgeons (that is, surgeons younger than 45 years) who responded to the survey were in the specialties of trauma/critical care, general surgery, and surgical oncology, whereas older surgeons (that is, surgeons ages 55 years and older) were more commonly in the specialties of urology and cardiothoracic surgery (see Table 1, page 25).

**Use of surgical devices**

This study, the largest ever published on this subject, clearly indicates that surgeons in a range of settings and specialties use a variety of devices and surgical instruments. The vast majority of respondents (70 percent) said that, on average, they or trainees working under their supervision use suction or drainage devices, surgical stapling devices, or some type of minimally invasive instrument, a trocar product, or a biopsy instrument.
The specific breakdown of instrument use is as follows:

- Suction and drainage devices: 87 percent (3,410 respondents)
- Surgical stapling products: 85 percent (3,299 respondents)
- Minimally invasive surgical instruments: 81 percent (3,146 respondents)
- Access and trocar products: 72 percent (2,828 respondents)
- Biopsy instruments: 71 percent (2,778 respondents)
- Portable ultrasound: 56 percent (2,204 respondents)
- Venous access devices: 53 percent (2,061 respondents)
- Stationary ultrasound: 38 percent (1,204 respondents)
- Gamma probes: 27 percent (1,055 respondents)
- Liver resection equipment: 15 percent (596 respondents)
- Robotic instruments: 7 percent (279 respondents)

Among the surgical specialties, there were notable trends in the use of the 11 instruments or devices on the survey that were distinctive to each of the surgical specialties as listed in Table 2 (page 25), which describes the use of surgical instruments and devices among surgical specialties. Clearly, there were different patterns of use among the surgical specialties. For example, general surgeons, colon and rectal surgeons, surgical oncologists, and pediatric surgeons reported the highest use and breadth of instruments used, especially minimally invasive instruments and stapling devices. Vascular surgeons, breast surgeons, surgical oncologists, and urologists reported the highest use of ultrasound devices (both portable and stationary ultrasound), whereas 91 percent of trauma/critical care surgeons reported use of a portable ultrasound device. More than 90 percent of surgical oncologists, breast surgeons, and urologists used biopsy instruments. Some instrument use was quite specialty-specific; for example, the primary specialists to use a gamma probe (as part of the sentinel lymph node biopsy procedure) were breast surgeons (89 percent), surgical oncologists (69 percent), and general surgeons (46 percent), whereas urologists were the prime users of robotic devices.

**Use of ultrasound equipment**

In the survey, respondents were asked separate questions about use of portable and stationary ultrasound equipment. Vascular surgeons were...
unquestionably the most frequent users of both types of equipment. Otherwise, there is likely an overlap of utilizing stationary versus portable ultrasound equipment by the specialties listed below, so the survey results are reported separately.

Portable ultrasound was used most frequently by trauma/critical care surgeons (91 percent responded that they had used the device during the past year), followed by vascular surgeons (88 percent), urologists (77 percent), breast surgeons (70 percent), surgical oncologists (64 percent), and general surgeons (63 percent). Stationary ultrasound was used most frequently during the past year by vascular surgeons (70 percent), urologists (54 percent), breast surgeons (52 percent), and surgical oncologists (48 percent) (see Figure 1, page 26).

Minimally invasive instruments

Widespread use of minimally invasive equipment was common among the surgical specialists who responded to the survey in greatest numbers. Practitioners in general surgery (95 percent), pediatric surgery (94 percent), colon and rectal surgery (90 percent), surgical oncology (85 percent), cardiothoracic surgery (84 percent), and trauma/critical care (82 percent) were the major users of minimally invasive equipment. The majority of urologists (73 percent) and otolaryngologists—head and neck surgeons (66 percent) also reported that they used minimally invasive equipment (see Figure 2, page 27).

Although robotic devices are a relatively new form of minimally invasive instruments, they are being used with some frequency by urologists (27 percent of respondents), pediatric surgeons (14 percent), cardiothoracic surgeons (10 percent), surgical oncologists (8 percent), and colon and rectal surgeons (7 percent).

Surgical stapling products

Virtually all surgeons, regardless of specialty, used surgical stapling equipment. More than 90 percent of surgeons reported that they use sta-
Dr. Russell is Executive Director of the College.

Figure 4: VENOUS ACESS DEVICES—USAGE BY SPECIALTY

pling equipment. Represented in that group were colon and rectal surgeons (98 percent), general surgeons (97 percent), surgical oncologists (95 percent), trauma/critical care surgeons (95 percent), pediatric surgeons (94 percent), and cardiothoracic surgeons (92 percent)—whereas a majority of surgeons who used stapling devices were urologists (81 percent) or plastic/maxillofacial surgeons (64 percent) (see Figure 3, page 28).

Use of venous access devices

The surgical specialists who responded to the survey in greatest numbers were more selective use of venous access devices. The vast majority of surgeons using venous access devices were vascular surgeons (84 percent), trauma/critical care surgeons (80 percent), and pediatric surgeons (79 percent). Surgical oncologists (68 percent), general surgeons (66 percent), and cardiothoracic surgeons (57 percent) were also major users, whereas plastic/maxillofacial surgeons reported only occasional use (10 percent) (see Figure 4, this page).

Conclusion

These data provide new insights into the practice habits of surgeons caring for their patients. There were differences in both the types of instruments and devices used as well as the frequency of using them among the various surgical specialties. Most notable was the high frequency with which all surgeons used ultrasound equipment in the management of their surgical patients.

The data described in this report reflect the practice patterns of surgeons who responded to the College-sponsored Internet-based survey; it is uncertain whether this reflects the usage patterns of all surgeons among all of the specialties. If anything, there might be a bias toward those surgeons who are major users of drugs and devices in their practice and who would be more inclined to respond to a survey about this topic. Nevertheless, the distribution of respondents based on age and surgical specialty is similar to that of the American College of Surgeons’ membership profile.
The IVUmed Resident Scholar Program:
Aiming to “Teach one, reach many”

by Catherine R. deVries, MD, FACS, FAAP
As American urological training rapidly becomes more technical, trainees are losing skills once considered fundamental to a well-rounded surgical experience. Emphasis on cutting-edge technology such as robotics, magnetic resonance imaging, and positron emission tomography scanners is supplanting certain skills such as end-to-end anastomosis of bowel, open stone surgery, and open prostatectomy. This technological trend is more profound, considering that the gap between resource-rich and resource-poor surgical environments grows by the year, as a large number of surgeons worldwide are limited by the lack of availability of suture, stents, and catheters—even basic necessities such as instruments and electricity.

In an effort to bridge this gap, IVUmed, formerly known as International Volunteers in Urology, formed the Resident Scholarship Program in 1999 to give American trainees early in their surgical experience an opportunity to visit and participate in an overseas, mentored training setting. The long-term commitment to sharing educational and material resources will hopefully help to bridge the resource gap experienced by colleagues in developing countries. IVUmed’s motto—“Teach one, reach many”—embodies that long view of surgical education.

**History**

The IVUmed scholarship program was initially designed by a committee of urologists who personally served as volunteers in developing countries and became the first mentors. The purpose of the program was to strengthen the training of urology residents by exposing them to varied surgical environments and a range of techniques that they may not experience in their own training programs. By working with mentors from different training programs or private practice, they also would have an opportunity to interact with a broader range of surgical teachers. The on-site host surgeons invariably would teach trainees new approaches to dealing with surgical problems. The seed grant for the program’s inception came from the American Urological Association under the guidance of Charles McKiel, Jr., MD.

The program was designed for trips of 10 days to one month, with residents commonly traveling during research time or vacation, thereby making this experience an “away rotation.” In recent years, funding has come from grants made by sections of the American Urological Association, industry foundations, and individuals. To date, 125 scholars from 64 different American training programs have matched in the program. One training program has sent six residents, but most others have sent between one and three. These scholars have visited 28 sites in 22 countries.

### Table: IVUmed statistics, 1999–2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Scholars</th>
<th>Mentors</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>9</td>
<td>5</td>
<td>5</td>
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<tr>
<td>2000</td>
<td>16</td>
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<td>2005</td>
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<td>10</td>
<td>8</td>
</tr>
<tr>
<td>2006</td>
<td>13</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>2007</td>
<td>14 (11 residents, 3 fellows)</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>2008</td>
<td>12</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

### Host countries

- Honduras
- Haiti
- Peru
- Nigeria
- Mozambique
- South Africa
- Morocco
- Mongolia
- Bangladesh
- Tanzania
- Ethiopia
- Nicaragua
- Mexico
- Cameroon
- Ghana
- Jamaica
- Namibia
- Viet Nam
- India
- Kenya
- Yemen
- Egypt

Opposite: Dr. deVries (right) performing an operation in Nigeria with Sunday Lengmang, MD, medical director and director, vesicovaginal fistula program, Evangel Hospital, Jos, Nigeria.
Scholar Tim Davies, MD, demonstrates harvesting buccal mucosa for urethral reconstruction at Evangel Hospital, Jos, Nigeria.

Hanging X rays in the OR at State Central Clinical Hospital, Ulaanbaatar, Mongolia.

(see box on page 31 for a list of host countries); 42 urologists have served as mentors for their junior colleagues in these overseas experiences.

In 2006, IVUmed launched a new fellowship program for urologists who have completed their urological training but would like to spend an additional year traveling as a urologist in developing countries. The first fellow, Kristin Chrouser, MD, traveled to seven countries to acquire advanced experience in tropical urology and reconstructive surgery. She has subsequently gone on to earn a master’s degree in public health with an emphasis on leadership in international surgery. IVUmed has now moved to include scholarships for advanced training in urology for surgeons from developing countries. The first two scholars, from Children’s Hospital #1 in Ho Chi Minh City, Viet Nam, visited two American children’s hospitals in 2007. Three pediatric urologists from Honduras will visit the U.S. in 2009 through the new Dr. Pieter A. deVries Pediatric Surgery Scholarship Fund.

**Program**

Scholarships have been awarded annually to eight to 16 American residents depending on available funding and availability of mentors.

Residents: Residents are selected through a rigorous process that requires recommendation by their program directors and an additional faculty member. Only a minority of applicants is fluent in a foreign language or has a specific interest in visiting a particular country. The IVUmed Resident Scholars Committee reviews all applications and matches the scholars with mentors. An attempt is made to match specific interests, such as pediatrics, with mentors or teams traveling on similar service or training workshops. Currently the ac-
ceptance rate is approximately 50 percent and preference is given to more senior residents and fellows. In 2008, IVUmed received 32 applications for 12 scholarships.

Mentors: The criteria for mentorship are that a mentor must be certified by the American Board of Urology or be board eligible or must hold an equivalent certificate in his or her home country. Although most mentors are American urologists, a few are foreign nationals, some of whom have trained in urology in the U.S.

IVUmed’s mentors currently reflect a balanced mix of 22 academicians and 18 private practitioners. A core group staffs the four to six annual trips to India and includes Gopal Badlani, MD, professor and vice-chair of the department of urology at Wake Forest University Baptist Medical Center, Winston-Salem, NC; Sakti Das, MD, emeritus professor of urology at University of California–Davis; Manoj Monga, MD, associate professor of urology, University of Minnesota, Minneapolis; and Raju Thomas, MD, professor and chairman of urology at Tulane University, New Orleans, LA. These “India Camps” are organized by a local Indian not-for-profit that provides urological services to the poor.

Richard Williams, MD, professor and head, department of urology, University of Iowa, Iowa City, has taken one or two residents to Haiti annually since the program’s inception. John Gazak, MD, a private practitioner in Charlotte, NC, has mentored in Mongolia and Honduras. Annual trips to Viet
Nam are coordinated through joint efforts with Friendship Bridge, primarily through Theodore Ning, MD, clinical professor of urology at University of Colorado, Denver, and Peter Bergreen, MD, a private practitioner from Eugene, OR. Other trips are organized as resources allow and are often initiated by the special interests and contacts of the mentor.

Logistics: Before each trip, IVUmed verifies with the host surgeons, the hospital, and (through the hospital administration) the Ministry of Health that the trainees are welcome to come to their hospital and to participate in surgery in the capacity of trainees. It is critical to the success of the program that the cultural norms of the host country be respected at both the social and professional levels.

Trainees are expected to have obtained all immunizations appropriate to the site being visited. They then usually travel with their mentors, who will have been in contact with the hosts about the details pertaining to the trip. The IVUmed program director coordinates most of these details. When they are working in teaching hospitals, they are often also mentored and supervised in cases by the local faculty who have current skills in such procedures as anatrophic nephrolithotomy and other open stone cases. Scholars also learn from their hosts about patient expectations regarding surgery, pain management, and the panoply of cultural norms with respect to medical care. Many of these cultural practices diverge significantly from the norms at the home hospitals where the residents train, yet the quality of surgical outcomes may not differ significantly.

The amenities and resources at the sites vary widely. Whereas some residents travel to teaching hospitals, many travel to remote hospitals that normally do not offer urological service to patients. At these hospitals, all specialized urological equipment and supplies, such as scopes and stents, must be brought with the team. In some hospitals, glycine irrigation for transurethral resection of the prostate (TURP) must be mixed by the visiting teams, whereas at others, water is still used for irrigation. Saline in small bottles is easily found in most locations. Sorbitol is rarely available. A sterilized can works well to hold irrigation solution when irrigation must be available in liter or multi-liter quantities, and irrigation tubing must be brought, as it is not standard equipment in many hospitals in developing countries. Suture is at a premium in most locales. It is standard in many countries that the patient is required to purchase all medicines and supplies, including surgical gloves and intravenous solutions, before surgery; but during the team visits, attempts are made by the visiting surgeons to bring many necessary supplies. This effort often means that the mentors and scholars carry extra suture, medication, catheters, and instruments, and it is not unusual to incur significant excess baggage charges with the airlines, particularly when flights connect through Europe.

Although there is some variability, typically a urology resident would scrub on several large open stone cases, open prostatectomies, and
Quotes from residents who participated in IVUMed

Who would have ever thought one could operate in flip-flops. Curious as to how it would work out, I graciously accepted them and entered the operating room. As usual, it was all I needed and became one of my fondest memories of operating in Viet Nam. The operating room, a place we are all familiar with and enjoy working in, was our common ground. It was a place to work together and share knowledge and experience. Working alongside each other allowed us to quickly build friendships that extended well beyond the hospital. The staff was wonderful. They were friendly, incredibly gracious, and generous with their time. It was a pleasure to get to know them both personally and professionally. When I think back on my time in Viet Nam, it can be summed up in this: a big smile.

—Jill Buckley, MD, University of California–San Francisco, 2005

The operative experience [in Egypt] was nothing short of spectacular. Working with Drs. Sakti Das and Carlos Angel, both of whom were excellent technicians and teachers, was an incredible experience for me, and after doing nearly 30 consecutive hypospadias repairs of all varieties, I can safely say that I’ve had a fellowship’s worth of training in that particular operation. The operative days were long and grueling, and the combination of old, elevation-challenged operating room tables and the height difference between Dr. Das and me unquestionably did some permanent damage to my cervical spine. But at the end of the day, all of us were equally exhausted—a good exhaustion, though—the kind where you know it means you’ve done something worthwhile with your time.

—Brad Erickson, MD, Northwestern University, Chicago, IL, 2007

countries, such as tuberculous kidneys, lymphatic filariasis, or bladder extrophy presenting in older children.

Outcomes

Outcomes of the resident scholar international surgical experience can be difficult to measure quantitatively. One measure might be the number of new procedures to which the scholars are exposed. Another gauge might be new insights into the difficulties experienced daily by colleagues in developing countries or different styles of operating room etiquette. A third measure might be the willingness of scholars to make a long-term commitment to a career that includes international collaborations. Another possible aspect to assess is service as mentors after completion of training. Measuring the experience from the host perspective would also be ideal. These outcomes measures have recently been implemented and will be reported as they gain sufficient data points.

Scholars’ obligations

In addition to the required trip report, pictures, narrative, and case log, many resident scholars also make presentations at the annual IVU Traveling Resident Scholar reception held at the American Urological Association (AUA) annual meeting. This reception honors the mentors, resident scholars, donors, and overseas hosts and serves as a point of introduction to new potential scholars and mentors. Scholars often also present their experiences at the AUA section meetings, especially when the sections have supported them. Occasionally they also present their experience to other sponsoring organizations.

A substantial majority of residents has expressed amazement at conditions in the hospitals where they worked. Having trained in situations where even the most impoverished American county hospitals usually have a ready supply of medication and basic instruments, the residents have found the need to bring ingenuity to their new situations. See the box on this page for comments some of the resident scholars have made about the program.

reconstructive cases for urethral stricture or hypospadias. The quality of the learning experience is emphasized over the quantity of operations. In a two- to four-week rotation, residents may see unusual cases more often found in developing
In addition, scholars may now report in real time via a weblog on the IVUmed Web site, www.ivumed.org.

Scholars generally have found the host staff to be most generous with excellent food and good cheer, and despite difficult working conditions and fatigue, the sense of camaraderie has made them feel welcome in a foreign setting.

To date, 65 to 70 scholars have completed their urological training, fellowships, and board certification. One has pursued a master’s degree in education, two have earned a master’s degree in public health, and three have become mentors. Many scholars have expressed an intent to dedicate a portion of their careers to collaborate in developing countries. The lag time in the ability to assess career outcomes stems from the fact that most scholars still have two to five years of urology and fellowship training or precertification work experience before they again will have the time and resources to travel. As they become financially able to do so, past scholars are encouraged to support the scholarships of new scholars in order to increase the number of opportunities available to residents.

**Conclusion**

The Traveling Resident and Fellow Scholarship Program embodies IVUmed’s motto of “Teach one, reach many.” The program allows residents to expand their experience and horizons by working with well-trained surgeons from other regions of the U.S. and the world. It benefits the hosts by expanding the network for collaboration beyond their own locale and often by bringing new technology to their geographic region. Although it has been operational for only nine years, the program is beginning to see its scholars choose to join a growing community of American urologists who share a commitment to collaboration with colleagues in developing countries.

Alice Tsao, MD, a scholar from the Mayo Clinic in 2006, captured the spirit of the program when she reported the following:

> On our last day, we made hospital rounds on every patient we had operated. Although I could not understand or speak Hindi, I could see the appreciation in these patients’ eyes. With their eyes hopeful and thankful, they would press their rough, tanned, hardworking hands together vigorously to greet me. Then, they would lift their thin, worn blanket to show me their surgical site. Most of these patients lived in remote villages with limited access to health care, and some had waited over two years or longer to seek medical attention.... Despite the language barrier, cultural distinctions, and new surroundings, I saw the universal language of hope and humanity rooted in medicine. This experience has not only broadened my urological knowledge but also allowed me to give back to the community....

Alice Tsao, MD, Mayo Clinic

**Acknowledgments**

The author wishes to acknowledge the IVUmed participants, mentors, hosts, and staff for our scholars here and abroad.

**Dr. deVries** is clinical professor of surgery (urology) at the University of Utah, Salt Lake City, and president of IVUmed.
The American College of Surgeons’ Committee on Trauma, through its Subcommittee on Injury Prevention and Control, prepared the following statement on all-terrain vehicle (ATV) injuries and prevention to educate surgeons and others about ATV injuries and encourage them to support ATV legislation in their respective states.

The American College of Surgeons supports legislative and manufacturing efforts to improve safety and prevent injuries from ATV use. Such legislation should include ATV safety design for rider protection, rider training and licensure, and a limitation of recreational use in children younger than 16 who are not otherwise licensed to drive. The College believes that surgeons, legislators, public safety advocates, and other government officials should be aware of the following facts related to ATVs when considering responsible regulation of these vehicles:

- ATVs can reach speeds consistent with interstate highway traffic, but in a more hazardous environment; hence, ATVs deserve vehicle safety studies, occupant protection devices, and training and licensure similar to other motorized vehicles.
- The annual incidence, severity of injuries, and economic burden of ATV injuries continues to rise.
- Children who operate ATVs are at increased risk both by number of riders and frequency of injury; hence, protection of this age group (younger than 16) should be a national priority. Recreational use of ATVs should be limited to people who have licenses to operate other motorized vehicles.
- Although safety legislation has been associated with decreased death rates in some states, legislative efforts in general to prevent ATV injuries have had limited success.
- The most severe injuries and deaths are related to crash characteristics of the vehicle; hence, attention must be directed toward improving the safety of the vehicles themselves to decrease the likelihood of incident occurrence that can result in injury. Additional safety design
should be directed toward protecting the rider from injury at the time of the incident.\textsuperscript{7}

\textbf{References}

C ollaboration between surgical organizations and the medical industry has benefited patient care in North America for many years. The primary objective of professional interactions between surgical organizations and industry should be the improvement of patient care, and such interactions should not be driven by financial or proprietary interests. Likewise, industry continues to be one source of support for continuing medical education (CME) for surgeons; however, surgical organizations must ensure that education is not influenced by collaboration with industry. These guidelines seek to provide a framework to permit corporate support of CME programs while maintaining the autonomy and impartiality of individual surgeons and surgical organizations. The guidelines are consistent with the Updated Standards for Commercial Support.*

I. Independence in planning and implementation of educational programs

A. Surgical organizations have the ultimate responsibility for the planning and development of CME programs. They must ensure that all decisions are made without any influence by commercial interests. Industry supporters of CME programs must not influence the planning, content, or implementation of an organization’s CME program.

B. The organization must ensure that everyone who is in a position to influence the content of an education activity has disclosed all relevant financial relationships with any commercial interests within the last 12 months. Potential conflicts of interest must be managed through appropriate mechanisms established by the organization and disclosed in writing to the learners prior to the start of the activity.

C. All individuals who have any role that has influence over or responsibility for the development, management, presentation, or evaluation of the CME activity must disclose relevant financial relationships. Refusal to do so will preclude their participation in that role.

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II. Commercial support for educational programs

A. The terms, conditions, and purposes of the commercial support must be documented in a written agreement between the commercial supporter and surgical organization.

B. A commercial entity must not directly pay a speaker or an individual involved with the development or implementation of the program. All commercial support must be provided to the surgical organization. Expenses for travel, accommodations, or honoraria for speakers are to be paid by the organization in compliance with its written policies and procedures. The surgical organization is responsible for all decisions regarding the disposition and disbursement of the funding. Accurate documentation detailing the receipt and expenditure of the commercial support should be maintained.

C. Industry support through educational grants should be acknowledged in a printed announcement at the meeting, but reference must not be made to any specific product. When commercial support is provided in kind, the nature of the support must also be disclosed to the learners.

D. Financial support of CME activities may also be provided through advertising and exhibit opportunities. Advertisements must not be placed in proximity to educational content and must be limited to nonscientific publications such as schedules and content descriptions. Advertisement and exhibit fees must not be combined with an educational grant.

E. No industry promotional materials are to be displayed or distributed in the same room as scientific presentations at single session meetings. In larger meetings with multiple simultaneous sessions, the access to promotional materials must be controlled by the surgical organization in order to avoid the appearance of any connection between the distribution of promotional materials and scientific presentations.

F. Industry supporters are prohibited from use of the surgical organization’s name, logo, or seal in conjunction with advertising or promotion without written permission of the organization.

G. Industry supporters must not organize any functions involving attendees that conflict with sessions of the meeting program. All industry-sponsored functions must be approved by the surgical organization prior to implementation. Industry exhibits should enhance the scientific activities of the CME program and not interfere with the scientific program.

H. For industry-sponsored symposia, a disclaimer is to appear on all printed materials, stating that the activity has no connection with the official organization’s program. All proposals and printed materials developed in connection with sponsored symposia must be submitted to the organization for approval prior to publication. Such symposia must not interfere with the scientific program of the organization.

I. Representatives of industry sponsors must not engage in sales or promotional activities during sessions of the meeting program. Sales and promotional activities must be limited strictly to the exhibit floor or industry events approved by the surgical organization and will not be conducted in conjunction with CME activities.

J. If work that is supported by industry is presented, the poster, presentation, or manuscript must include an acknowledgment of the funding source.

K. Written or recorded details of the scientific program must not be reproduced without the written consent of the surgical organization.
College appoints new Director of Division of Advocacy and Health Policy

Christian Shalgian, a long-time employee of the College based in the Washington, DC, Office, has been named Director of the College’s Division of Advocacy and Health Policy. Mr. Shalgian has held the post of Acting Director of that division since April 2007.

Mr. Shalgian began his tenure at the College in 1998, when he was hired as a Government Affairs Associate. In 2000, he was promoted to Senior Government Affairs Associate and became Manager of Legislative Affairs in 2004. He had been serving as Assistant Director of Legislative Affairs since 2006 at the time he was named Acting Director.

From 2002 to 2007, Mr. Shalgian was also chairman of the board of directors of the Health Coalition on Liability and Access, a Washington, DC-based partnership of associations organized to support medical liability reform. During his tenure, the membership expanded from 25 to 60 members.

Before he came to the College, Mr. Shalgian was the associate director of government relations (1997–1998) at the American Osteopathic Association (AOA) in Washington, DC. Prior to holding that position at the AOA, he was a legislative assistant for the organization from 1996 to 1997.

A graduate of Saint Anselm College in Manchester, NH, Mr. Shalgian holds a bachelor’s degree in political science. He lives in Germantown, MD, with his family.

2009 ACS Japan Traveling Fellow selected

Lorenzo Ferri, MD, FACS, FRCSC, assistant professor of surgery, McGill University, Montreal, QC, has been selected as the 2009 ACS Traveling Fellow to Japan. As the Japan Traveling Fellow, Dr. Ferri will participate in the annual meeting of the Japan Surgical Society in Fukuoka, Japan, April 2–4. He will also attend and participate in the ACS Japan Chapter meeting during that event. In addition, Dr. Ferri will travel to several surgical centers in Japan, with assistance from mentors provided by the Japan Surgical Society and the Japan Chapter. Dr. Ferri performs and researches surgical oncology and cardiothoracic surgery, with a particular interest in esophageal and lung carcinoma.

The deadline for receipt of all application materials for the 2010 Traveling Fellowship to Japan is June 1, 2009. The requirements are posted on the College’s Scholarship Web page at http://www.facs.org/memberservices/research.html and will be published in a future edition of the Bulletin.
Dr. McGrath named ACS commissioner to The Joint Commission

Mary H. McGrath, MD, MPH, FACS, has been appointed to the board of commissioners of The Joint Commission. Dr. McGrath will represent the American College of Surgeons and is one of five prominent health care leaders who were recently added to the 29-member board, which serves as The Joint Commission’s governing body. The board includes representatives from each of The Joint Commission’s corporate members—the American College of Surgeons, the American College of Physicians, the American Hospital Association, the American Medical Association, and the American Dental Association—six public members, one at-large representative of the nursing profession, and the Joint Commission president.

Dr. McGrath is professor of surgery in the division of plastic and reconstructive surgery at the University of California–San Francisco and actively practices plastic surgery. She has held numerous leadership positions with the American College of Surgeons, including serving as the First Vice-President (2007–2008), as a member of the Board of Regents for nine years, and as Vice-Chair of the Board of Regents. Dr. McGrath has been a panel member and consultant for the U.S. Food and Drug Administration for more than 20 years, serves regularly on review panels at the National Institutes of Health, and frequently writes journal articles and books. She received her medical degree from St. Louis (MO) University and holds a master of public health degree in health policy and management from The George Washington University, Washington, DC.

LaMar S. McGinnis, Jr., MD, FACS, the current President-Elect of the College, and Kurt D. Newman, MD, FACS, a Past-President of the Metropolitan Washington Chapter of the American College of Surgeons, also serve as representatives of the College on the board of commissioners.

For more information, visit http://www.jointcommission.org/.

Trauma meetings calendar

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

• Trauma, Critical Care, & Acute Care Surgery–2009, April 5–8, 2009, Las Vegas, NV.
• Trauma, Critical Care, & Acute Care Surgery 2009–Point/Counterpoint XXVIII, June 8–10, 2009, Atlantic City, NJ.

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/traumtgts.html, or contact the Trauma Office at 312/202-5342.
In memoriam:

Shukri F. Khuri, MD, FACS: May 27, 1943–September 26, 2008

by Kamal M. F. Itani, MD, FACS

On September 26, 2008, the world of surgery lost one of its giants. A friend, educator, and innovator, the unwavering dedication, enthusiasm, and accomplishments of Shukri Khuri, MD, FACS, are forever engrained in our memory. It is with the utmost respect that we pay tribute to a friend and to a life served for helping to improve the quality of care in surgery.

Dr. Khuri is best known for his leadership in developing the National Surgical Quality Improvement Program (NSQIP). In conjunction with his colleagues Jennifer Daley, MD (now chief medical officer at Partners Community Healthcare Inc., Boston), and William Henderson, PhD (previously director of the Cooperative Studies Program at Hines, and now professor of biostatistics at the University of Colorado Health Outcomes Program), Dr. Khuri led this unique national effort within Veterans Affairs (VA), which was established in 1994. The NSQIP is the first national, validated, outcomes-based, risk-adjusted, and peer-controlled program for the measurement and enhancement of the quality of surgical care; it allows for a comparison of the quality of surgical care among various institutions using validated models for risk adjustment of surgical outcomes. The NSQIP is now recognized by the surgical community at large as the model for the comparative assessment of quality of surgical care and for continuous improvement in surgery.

At the 2002 annual meeting of the American Surgical Association, Haile T. Debas, MD, FACS, then-chancellor and dean at University of California–San Francisco and president of the American Surgical Association, paid tribute to Dr. Khuri, whom he described as “the VA surgeon who has effectively placed surgery on the forefront of the new revolution.”

The Institute of Medicine, in a report published in November 2002, singled out the NSQIP as one of three elements that have made the VA the best health care system in quality management. In 2001, Dr. Khuri led a large collaborative study between the VA and the American College of Surgeons, funded by the Agency for Healthcare Research and Quality, which was conducted in 14 non-VA academic medical centers. The study demonstrated the feasibility of applying the NSQIP to the private sector at large and validated its effect on quality improvement. The results of that study prompted the Board of Regents of the American College of Surgeons to establish the ACS NSQIP for private sector hospitals, modeled after the VA NSQIP. Dr. Khuri continued to advise the ACS as it enrolled hospitals into this program, which Thomas R. Russell, MD, FACS, Executive Director...
of the College, called “the most important initiative the College is undertaking today.”

Dr. Khuri was born in Jerusalem and moved as a child with his family to Beirut, Lebanon. At a young age, he distinguished himself as an outstanding student, receiving the Stephen Penrose Award—which is given annually to a student who most contributes to the school through scholarship, character, and leadership—twice at the end of high school and later upon graduating from medical school.

Although one might think that the Penrose Award criteria were written to describe Shukri Khuri’s achievement later in life, they truly reflected what he already achieved early at school: he received both his bachelor and medical degrees from The American University of Beirut (AUB) with distinction and was elected alpha omega alpha; he was the editor-in-chief of the yearbook for his high school and later for the university; he achieved leadership status in the Lebanese boy scouts, started the music club at AUB, and produced several plays for the drama club.

One of his former teachers at AUB described him as “a person with unfailing courtesy and generosity in dealing with others, with intense curiosity, with dedication to preserve the wisdom of the body, with unique team leadership, an ability to objectively quantify in all areas of studies; all of these qualities being unified in an individual with infinite capacity for friendship and loyalty” (personal communication, Michel Slim, MD, FACS, September 2008).

After completing his first year in surgery at AUB, he married Randa Domian, the woman who would become his lifelong teammate, his supporter in all his academic endeavors, and the one person he was so proud to describe as “the reason for my success.”

After general surgery training at AUB, Dr. Khuri decided to take the advice of his mentor Timothy Harrison, MD, FACS, chair of the department of surgery, and move to the U.S. to pursue his interest in cardiothoracic surgery. He left Lebanon in 1972 and completed two years of research in the cardiovascular laboratories at Johns Hopkins under Vincent Gott, MD, and Vivien Thomas. This experience was followed by two and a half years of training in cardiothoracic surgery at the Mayo Clinic, Rochester, MN. He was then recruited by Ernest Barsamian, MD, FACS, to the West Roxbury VA, Harvard Medical School, and the Brigham and Women’s Hospital in Boston, MA.

Within one year, Dr. Khuri became chief of cardiac surgery and after another seven years, chief of surgery. Within the same period, he rose to the rank of professor of surgery at Harvard Medical School and vice-chairman of the department of surgery at Brigham and Women’s Hospital at the age of 43. He spent 20 years as chief of surgical services at the West Roxbury VA Medical Center (now the VA Boston Healthcare System) and stepped down in September 2004.

His research laboratory at West Roxbury has been continuously funded since 1977 and has trained more than 60 residents and postgraduate students in applied and translational research. It has also established close associations with the Naval Blood Research Laboratory in Boston and other laboratories at the Brigham and Women’s Hospital and the Massachusetts Institute of Technology. Dr. Khuri’s laboratory has made major contributions in the fields of myocardial protection, where his research led to the development of the first metabolic tool for the online assessment of myocardial protection during
cardiac surgery. The research in his laboratory also led to the development of long-term preservation of vascular conduits and organs. Dr. Khuri was also closely associated with the VA’s Cooperative Studies Program, where he participated in several of the program’s multicenter studies as principal investigator or member of the executive and planning committees.

Dr. Khuri was instrumental in the VA’s efforts over the years to automate medical records. In 1978, he established at the West Roxbury VA Medical Center the first automated data-management system in a surgical intensive care unit in the Northeast and subsequently chaired the VA Surgery Specific Interest Users Group, which developed the first clinical module in the VA’s Decentralized Hospital Computer Plan (DHCP). Today, the electronic patient record in the VA is by far the most advanced and comprehensive electronic medical record system in the world. Dr. Khuri has contributed significantly to its development by serving on the advisory panels that set the direction for the development of DHCP (including the Undersecretary’s Information Resource Advisory Council) and by leading the development of the Surgery Package, which remains the main framework of surgical informatics in VA DHCP and its evolution into VISTA.

Based on his experience as co-founder and Chair of the NSQIP, Dr. Khuri’s expertise in quality of care was recognized nationally and internationally, as evidenced by the numerous invitations he had received over the years for lectureships and professorships in the U.S. and abroad. He was a member of numerous professional organizations, including the American Surgical Association, where he served as vice-president in 2005–2006. In addition, he served on and chaired numerous regional and national committees and served a three-year term as president of the Massachusetts Affiliate of the American Heart Association.

Dr. Khuri was the recipient of numerous awards, including the Brigham and Women’s Robert Matson teaching award, the American Heart Association’s Paul Dudley White Award, and the Nicholas G. Berens Veterans Association’s Distinguished Service Award. In 1998, he was the first physician from the VA to receive the prestigious Frank Brown Berry Prize, which singles out annually an outstanding physician in the U.S. federal health care system, which includes in part the National Institute of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare and Research Quality, the health care system of the U.S. Department of Defense, and the Veterans Health Administration. In 2006, Dr. Khuri was awarded the Philip Crosby Award for Quality and the American Heart Association Mentorship Award in Surgery, and in 2008, he was awarded the Presidential citation by The Association of VA Surgeons.

Two days after his death, Randa was informed that Dr. Khuri had been chosen to be the recipient of the 2008 Ernest Amory Codman Award for improvements in safety of care to the public. In a press release, Mark R. Chassin, MD, MPP, MPH, president of The Joint Commission, which administers the award, stated, “The 2008 Codman Award recipients exemplify how performance measurement improves the quality and safety of health care. Their achievements demonstrate the progress that can be made when process and outcomes measures are combined into meaningful practices that result in better patient care.”

In his 65 years, Dr. Khuri made a lasting impact on the practice of medicine and health services and an enduring impression on countless lives. His legacy stems from his unwavering dedication; his enthusiasm; and his accomplishments as a remarkable surgeon, innovator, and leader. He courageously fought a battle against brain cancer and even while receiving chemotherapy and recovering from surgery, he was always planning the next move with the NSQIP, the next step in the research that he loved, and the next chapter for a book on surgical outcomes.

Dr. Khuri and his wife Randa were always the consummate host and hostess. Each one of their friends and colleagues were treated in their home as family members. Their hospitality was legendary and their friendship everlasting.

We are deeply indebted to Dr. Khuri and we will best honor him by continuing to strive for safer and better care for all our patients.

Dr. Itani is chief of surgery, VA Boston Health Care System, and professor of surgery, Boston University, Boston, MA.
CALL FOR SUBMISSIONS

2009 Clinical Congress of the American College of Surgeons

❖ The American College of Surgeons
Division of Education
welcomes submissions
to the following programs
to be considered
for presentation at
❖
the 95th annual
Clinical Congress,
October 11–15, 2009,
Chicago, IL
❖

Oral presentations
❖ Surgical Forum*
Program Coordinator: Kathryn L. Matousek,
312/202-5336, kmatousek@facs.org
(11 $1,000 Excellence in Research Awards
were given in 2008)
Accepted Surgical Forum abstracts will be published in
the September Supplement of the Journal of the
American College of Surgeons (JACS)
❖ Papers Session*
Program Coordinator: Beth Brown,
312/202-5325, ebrown@facs.org

Poster presentation
❖ Scientific Exhibits
Program Coordinator: Kay Anthony,
312/202-5385, kanthony@facs.org

Video presentation
❖ Video-Based Education
Program Coordinator: GayLynn Dykman,
312/202-5262, gdykman@facs.org

Submission information
❖ Abstracts are to be submitted online only
❖ Submission period begins November 3, 2008
❖ Deadline: 5:00 pm (CST), March 1, 2009
❖ Late submissions are not permitted
❖ Abstract specifications and requirements for
each individual program will be posted on
the ACS Web site at www.facs.org/education/.
Review the information carefully prior to
submission.
❖ Duplicate submissions (submitting
the same abstract to more than one program)
are not allowed.

*Accepted authors are encouraged to submit full
manuscripts to JACS.
Call for nominations for the ACS Board of Regents

The 2009 Nominating Committee of the Board of Governors has the task of selecting three nominees for pending vacancies on the Board of Regents to be filled during the 2009 Clinical Congress in Chicago, IL. One of these pending vacancies is a Canadian seat, which, in accordance with ACS Bylaws, must be filled by a Canadian surgeon. The following guidelines are used by the Nominating Committee when reviewing the names of candidates for potential nomination to the Board of Regents:

• Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
• Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
• Recognition of the importance of their representing all who practice surgery

Also to be taken into consideration are geography, surgical specialty balance, and academic or community practice. The College encourages consideration of women and other underrepresented minorities.

Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the Board of Regents. Priority consideration should be given to representatives of general surgery. Note: Consideration of the surgical specialty does not apply to the Canadian seat.

Nominations should include one or two paragraphs on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, February 27, 2009.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Board of Governors, at psprecksel@facs.org.

PALLIATIVE CARE, from page 13

<table>
<thead>
<tr>
<th>Location</th>
<th>Dates</th>
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<td>February 26</td>
<td>2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding</td>
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<td>February 27</td>
<td>2009 Surgical and Office-Based Coding and Reimbursement (Advanced)</td>
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<td>August 28</td>
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For more information and to register, go to
http://www.facs.org/ahp/workshops/index.html

or contact
Debra Mariani,
Practice Affairs Associate,
tel. 202/672-1506,
e-mail dmariani@facs.org
Fellows in the news

V. K. Kapoor, MBBS, FACS, FACG, FRCS, of the department of surgical gastroenterology at the Sanjay Gandhi Postgraduate Institute of Medical Sciences in Lucknow, India, has been awarded a Fulbright Fellowship by the U.S. Educational Foundation in India. Beginning in August 2008, Dr. Kapoor visited U.S. educational institutions—including Oregon Health and Science University, Portland; Mayo Clinic, Rochester, MN; Case Western Reserve University, Cleveland, OH; and Fox Chase Cancer Center and Thomas Jefferson University in Philadelphia, PA—and attended the Clinical Congress in San Francisco, CA, and the American College of Gastroenterology’s meeting in Orlando, FL.

Cato Laurencin, MD, PhD, FACS, dean of the School of Medicine and vice-president for health affairs at the University of Connecticut, Farmington, received the Excellence in Science and Technology Award at the 15th Annual Caribbean American Heritage Awards, which honor and celebrate individuals of Caribbean heritage and Friends of the Caribbean who have been standard bearers of excellence, and who have made positive contributions to the American and international landscape.

The staff of Cedars-Sinai Medical Center selected Jack Matloff, MD, FACS, in recognition of his lifetime of achievement and leadership in cardiac medicine, as the organization’s 2008 Pioneer in Medicine. His four-decade career at Cedars-Sinai began when he was recruited in 1969 to design and develop the center’s division of cardiothoracic surgery.


The Indiana State Medical Association installed David Welsh, MD, FACS, a surgeon from Batesville, IN, as president of its 8,300-member organization. Dr. Welsh is employed at the Margaret Mary Community Hospital in Batesville.

Call for nominations for ACS Officers-Elect

The 2009 Nominating Committee of the Fellows has the task of selecting nominees for the three Officer-Elect positions of the American College of Surgeons: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The following guidelines are used by the Nominating Committee when reviewing the names of potential candidates for nomination as Officers of the College.

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
- Recognition of the importance of their representing all who practice surgery

The College encourages consideration of women and other underrepresented minorities.

Nominations should include one or two paragraphs on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, February 27.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Fellows, at psprecksel@facs.org.
A look at The Joint Commission

Alert warns of blood thinner deaths and overdoses

Surgeons need to be cognizant of the potential dangers facing their patients when an anticoagulant is administered during a procedure and when they are receiving anticoagulation therapy before an operation. The need for greater attention to dangers associated with the use of anticoagulants is emphasized in The Joint Commission’s new Sentinel Event Alert.

A number of recent, high-profile errors related to commonly used blood thinners highlight a safety issue that too frequently results in harm or even death to patients, according to the Alert.

“Anticoagulants are vital to maximizing the effectiveness of many medical treatments and surgical procedures that benefit patients, but the systems necessary to ensure that these drugs are used safely are not adequate,” says Mark R. Chassin, MD, MPP, MPH, president, The Joint Commission. “The strategies contained in this Alert give health care organizations and caregivers the tools to make a difference in preventing anticoagulant medication errors.”

Anticoagulant medication errors are such a serious patient safety issue that The Joint Commission addresses these types of errors in the 2009 National Patient Safety Goals. In addition, The Joint Commission’s medication management standards require organizations to pay particular attention to high-risk drugs such as anticoagulants in order to improve safety.

The Joint Commission’s Alert highlights factors that contribute to anticoagulant medication errors, including lack of standardized labeling and packaging, failure to document and communicate patient instructions during handoffs, and inappropriate dosing for pediatric patients.

To reduce the risk of errors related to commonly used anticoagulants, The Joint Commission’s Alert recommends that health care organizations take a series of 15 specific steps, including the following:

• Assess the risks of using anticoagulants
• Use best practices or evidence-based guidelines regarding anticoagulants
• Establish standard dose limits on anticoagulants and require that a doctor confirm any exceptions
• Clearly label syringes and other containers used for anticoagulants
• Clarify all anticoagulant dosing for pediatric patients, who are at higher risk because these drugs are formulated and packaged for adults

Other strategies for reducing the errors related to anticoagulants include staff communication and collaboration; patient education and participation; designating pharmacists to manage anticoagulant services; and use of computerized physician order entry and bar coding technology, if available.

The warning about preventing errors related to commonly used anticoagulants is part of a series of Alerts issued by The Joint Commission. Much of the information and guidance provided in these Alerts is drawn from The Joint Commission’s Sentinel Event Database, one of the most comprehensive voluntary reporting systems for serious adverse events in health care in the U.S. The database includes detailed information about both adverse events and their underlying causes. The complete list and text of past issues of Sentinel Event Alert can be found on The Joint Commission’s Web site at www.jointcommission.org.
The Commission on Cancer (CoC) announces its 2009 Paper Competition. You are encouraged to share this information with surgical residents and oncology fellows. Your residents won’t want to miss this opportunity for presentation, visibility, and networking.

The competition is open to general surgery residents, surgical specialty residents, subspecialty residents, and oncology fellows in the U.S. Abstracts should describe original research in cancer care, including basic laboratory research, clinical investigation, and quality of care/health services research.

Abstracts must be submitted to the CoC by March 31, 2009. Five finalists will be chosen and requested to submit their full paper to the CoC by July 1, 2009. The final three winners will be announced in August 2009.

First place winners will receive a $1,000 award and will present at the CoC Annual Meeting on Sunday, October 11, 2009, in Chicago, IL. Second and third place winners will be granted a $500 award and the opportunity to present a poster at the CoC Annual Meeting.

This competition has been funded by the CoC and by a memorial gift from Mrs. A. Lee Campione in honor of her late husband, Matthew P. Campione, MD, FACS.

For information, visit the CoC Web site at http://www.facs.org/cancer/canews.html or contact the CoC office at 312/202-5183 or cjones@facs.org.
I Need an Operation... Now What?
A Patient’s Guide to a Safe and Successful Outcome

I Need an Operation... Now What? gives patients the information they need to boost their chances of having a successful surgical experience, with the best possible results. Written in patient-friendly, nontechnical language, this book is designed to help patients understand the process of having an operation from start to finish. Inside they’ll learn:

» How to find a qualified surgeon—one who’s right for them
» When to get a second opinion about their treatment—and how to go about finding one
» How to ask about the risks and benefits of having an operation
» How to prepare for an operation—from what to pack and what to wear to when to stop eating
» What to expect, including advice from patients who’ve had various operations, from major gastrointestinal procedures to back surgery—and who will care for them—while in the hospital
» Numerous “insider’s” tips, such as how to help prevent infection and the best times to schedule an operation
» All the costs of the operation
» How to ensure a comfortable recovery period

“The experts agree...

“Along with your love and support, the greatest gift you can give a loved one or friend facing or weighing the benefits and risks of surgery is a copy of this book. With his thoughtful, clear, very accessible writing, Dr. Russell, with the American College of Surgeons, provides a wealth of informational resources that every patient can draw on. He gives excellent advice on how to ask good questions and become an informed, empowered consumer. Most importantly, he urges you, the patient, to ‘take control and become fully informed about your options.’ This book will help you do that, prepare you for the effects of surgery and how to deal with them and give you confidence as you navigate through the health care system.”

Helen Darling, president of the National Business Group on Health

“Like a true professional, Dr. Russell gives surgical patients-to-be all the information and support needed to make decisions that meet their needs as only they can know them. This book is not only practical, but also highly respectful, most educational. Patients can use this book to navigate through their surgical experience while we all push for a better-organized health care delivery system.”

Richard J. Umbdenstock, president and CEO of the American Hospital Association

“Research shows that people who are well informed about their treatment options enjoy better surgical outcomes and are more satisfied with their results.”

To order or for further information, visit http://www.facs.org/public_info/patientguidebook.html or call 312/202-5474
The 2008 Annual Pediatric Report of the National Trauma Data Bank® (NTDB) Version 8.0 is an updated analysis of the largest aggregation of trauma registry data that has ever been assembled. This year marks the first pediatric data collection under the new NTDB dataset, also known as the National Trauma Data Standard (NTDS).

In total, the NTDB now contains more than 3 million records. The 2008 Annual Pediatric Report is based on the first call for data under the NTDS. As this is a new data standard, only records with an admission year of 2007 that fulfilled the pediatric age criteria were allowed, in contrast to past years’ annual reports that involved a five-year sliding window. In spite of limiting the call for data to a single year of discharge, 108,863 records for patients aged 19 years and younger and with a valid trauma diagnosis made it through the validator and are the basis for version 8.0. This report also includes new features, analyses by abbreviated injury score body region and geographic region, and the addition of data tables regarding drug and alcohol use and protective devices (see graphic on this page).

The purpose of this report is to inform the medical pediatric community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured infants, children, and adolescents in our country. It has implications in many areas including epidemiology, injury control, research, education, acute care, and resource allocation.

The NTDB Committee and Pediatric Surgery Specialty Group would like to thank all of the adult and pediatric trauma centers that contributed pediatric data and hope that this report will attract new participants.

The full NTDB Annual Pediatric 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.

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

Dr. Nathens is Canada Research Chair in Systems of Trauma Care, division head of general surgery and director of trauma at St. Michael’s Hospital, and medical director at Ontario Critical Care Program, Toronto, ON.
Chapter news

by Rhonda Peebles, Division of Member Services

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

Tennessee Chapter joins ESRD coalition

Last November, the Tennessee Chapter reported that it had joined a statewide coalition for patients who are affected by end-stage renal disease (ESRD). The coalition is being run by QSource, the Quality Improvement Organization for Tennessee. Wanda Johnson, the Tennessee Chapter Executive Director, noted that part of the coalition’s mission will be to encourage and facilitate dialogue to increase understanding about chronic kidney disease, to remove barriers to care, and to decrease the racial disparities of chronic kidney disease care and services.

Chapter execs convene in Chicago

On December 8, 2008, chapter executives convened at College headquarters for a daylong education program (see photo, this page). In addition to a review and discussion about state legislative activities, Paula Goedert, Esq., the College’s legal counsel, reviewed intellectual property principles governing chapters’ communications programs and activities. In addition, Carolyn Sitkiewicz, an electronic communications expert, shared her strategies for chapters’ electronic newsletters.

Chapters continue support for the College’s funds

In 2008, 14 chapters contributed a total of $17,500 to the College’s endowment funds. The chapters’ commitments to the various funds support the College’s pledge to surgical research and...
**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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<td>February 19–21</td>
<td>South Texas (CS)</td>
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<td>Contact: Janna Pecquet, 504/455-4640, <a href="mailto:janna@southtexasacs.org">janna@southtexasacs.org</a></td>
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<td>Paul E. Collicott, MD, FACS</td>
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<td>February 20–21</td>
<td>North Texas (CS)</td>
<td>Location: Cityplace Conference Center, Dallas, TX</td>
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<td>Contact: Marcia McIntyre, 314/579-9707, <a href="mailto:marcia@lettuceplanet.com">marcia@lettuceplanet.com</a></td>
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<td>March 14</td>
<td>Metropolitan Chicago (CS)</td>
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<td>Contact: Mary Hines 312/263-7150, <a href="mailto:hines@isms.org">hines@isms.org</a></td>
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<td>April 2–4</td>
<td>Japan</td>
<td>Location: Fukuoka Convention Center, Fukuoka City, Japan</td>
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<td>Contact: Kyoichi Takaori, MD, FACS, 81-75-751-4323, <a href="mailto:takaori@live.jp">takaori@live.jp</a></td>
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<td>April 4</td>
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<td>Contact: Amy Clinton, 518/283-1601, <a href="mailto:NYCoFACS@yahoo.com">NYCoFACS@yahoo.com</a></td>
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<td>Contact: Leann Tschider, 701/223-9475, <a href="mailto:leann@ndmed.com">leann@ndmed.com</a></td>
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<td><a href="mailto:h_kalbasi@yahoo.com">h_kalbasi@yahoo.com</a></td>
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education. Chapters can contribute to several different funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Endowment Fund. The chapters that contributed during 2008 include the following:

Recipient of the R. Gordon Holcombe, MD, FACS, Chapter Award*: Louisiana

Governors Circle: Arizona, Brooklyn—Long Island (NY), Florida, Illinois, Maryland, Nebraska, North Carolina, North Texas, Ohio, South Carolina, South Florida, and Southern California

Annual Members: Arizona, Florida, Georgia, Indiana, Japan, Kansas, Metropolitan Philadelphia, Nebraska, South Dakota, South Florida, Southern California, Southwest Pennsylvania, Virginia, and Wisconsin Surgical Society—A Chapter of the ACS

New Jersey Chapter appoints new Executive Director

Last December, the New Jersey Chapter appointed Andrea Donelan as its new Executive Director. Ms. Donelan also serves as the executive director of the Morris County Medical Society in Morristown, NJ. Ms. Donelan succeeds Art Ellenberger, who retired after serving the New Jersey Chapter for more than 40 years. Ms. Donelan can be reached at 973/539-8888 or mcms1816@aol.com.

2009 Leadership Conference—Register Today!

The 2009 Leadership Conference will be held March 22–24 at the Grand Hyatt Hotel in Washington, DC. Chapters are encouraged to send their chapter officers, two to three Young Surgeons (age 45 or younger), and their chapter administrator or executive director. The College’s Washington Office will schedule Capitol Hill visits on Tuesday afternoon for all the chapters that participate. To register, call the chapter hotline at 888/857-7545, or visit the chapter homepage at http://www.facs.org/about/chapters/index.html.

* The R. Gordon Holcombe, MD, FACS, Chapter Award was established in 2004 for chapters that have contributed $100,000.

†The Fellows Leadership Society is the distinguished donor organization of the College. Chapters that contribute at least $1,000 annually are members. Chapters that have contributed $25,000 to $99,999 are members of the Governors Circle.

Chapter anniversaries

<table>
<thead>
<tr>
<th>Month</th>
<th>Chapter</th>
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<tbody>
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<td>January</td>
<td>Northern California</td>
<td>57</td>
</tr>
<tr>
<td></td>
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<td>57</td>
</tr>
<tr>
<td>February</td>
<td>Arizona</td>
<td>57</td>
</tr>
<tr>
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<td>Australia—New Zealand</td>
<td>24</td>
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<td>57</td>
</tr>
</tbody>
</table>

ACS Career Opportunities

The American College of Surgeons’ online job bank

A unique interactive online recruitment tool provided by the American College of Surgeons.

An integrated network of dozens of the most prestigious health care associations.

Residents:

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