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On the cover: The goal of the ACS Foundation is to advance the mission of the College through increased philanthropic support for the College’s education, safety, and research programs. See the Foundation’s annual report on page 9.
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
From my perspective

As most of you know, my term as Executive Director of the American College of Surgeons concludes December 31. Serving our profession in this capacity has been a richly rewarding experience, and I am so proud to have had the opportunity to represent the members of this organization for the past 10 years. The Board of Regents, Board of Governors, Fellows, our chapters, and staff have accomplished a great deal in this time span, and I would like to take this opportunity to briefly reflect on our collective progress.

**Internal improvements**

In early 2000, the College was suffering from significant morale and organizational issues. Our employee turnover rate was 27 percent, and many staff members were worried about job security. Our budget was bloated, there was no transparency, and the *Bylaws* and policy procedures offered little guidance on how to resolve these problems. Amazingly, the College had no written mission, vision, or goals statements.

In 2001, we held our first strategic planning session and reorganized the College into four primary divisions centered on Advocacy and Health Policy, Education, Member Services, and Research and Optimal Patient Care, with complementary support service areas. We developed a mission and vision statement clarifying that the ACS is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment. Since we made these adjustments, our personnel turnover rate has remained in the 5 to 10 percent range.

In addition, we imposed new requirements for service on the ACS Board of Regents. Board members are now drawn from all surgical specialties and must be in active practice to ensure they have firsthand knowledge of the issues facing surgeons today.

Over the years, additional strategic planning sessions and retreats have occurred, the most recent convening in 2007. This effort culminated in the Board approving a plan to close the Surgeons Diversified Investment Fund and to eliminate a few staff positions. These actions allowed us to trim the operating budget and to add new staff positions in areas of critical importance to the College.

We have also sought to make optimal use of College-owned properties. The College now shares our Chicago headquarters building with the Society of Thoracic Surgeons, the American Board of Thoracic Surgery, the Society for Vascular Surgery, and the American Association for the Surgery of Trauma. The ACS has purchased a nearby building for potential future expansion and has traded the underused Nickerson Mansion to a local renovator in exchange for a total remodeling of the Murphy Memorial. In addition, we purchased a site near Capitol Hill in Washington, DC, for construction of a new building that will serve as the home base for our congressional and regulatory affairs staff. This location, which is scheduled for completion next year, will feature outstanding conference facilities, and will be spacious enough to accommodate the Washington staff of other health care organizations. It also eventually will house the administrative staff of the ACS Health Policy

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“I think we should all take pride in what we have accomplished these past 10 years.”
Research Institute, which will continue to develop data that will be useful in guiding the College’s public policy positions.

**Advocacy and health policy**

These Washington-based activities are particularly relevant at a time when many ACS members say that public policy issues, particularly the current health care reform proposals and the flawed methodology used to calculate Medicare reimbursement, are the greatest source of professional frustration. The College took the proactive move of developing a policy Statement on Health Care Reform, which was crafted by the ACS Health Policy Advisory Group and reviewed, amended, and approved by the Board of Regents and the Board of Governors, prior to President Obama’s inauguration. At press time, this group had just met to update this initial statement to reflect the specifics of the current climate related to health care reform. The document was to be reviewed by the Board of Regents and the Board of Governors during a joint session planned for the Sunday before the Clinical Congress.

Achieving a fair and equitable payment system is, to say the least, a complex challenge. Numerous economists, statisticians, politicians, and others have sought to develop models that limit spending while continuing to ensure that Medicare beneficiaries have access to appropriate services. Yet we still find ourselves with a reimbursement system that is financially unsustainable, and that is likely contributing to workforce shortages. As much as the College would like to be the one to redesign the payment system, we realize that is a completely unrealistic goal. So, instead, the College has sought to ensure that we have a seat at the negotiating table and that our membership is fully engaged in the reform process.

To further advance our influence in Washington, we created the American College of Surgeons Professional Association (ACSPA) and its affiliated political action committee (PAC) approximately six years ago. In the years 2003 through 2008, the ACSPA-SurgeonsPAC raised and distributed $2.6 million to political candidates who understand and support surgery’s legislative agenda.

Furthermore, the College has stimulated the grassroots of this organization by offering our members an electronic means for communicating with Congress. This service has significantly improved Fellows’ ability to weigh in on important legislation.

Reaching out to, and collaborating with, other stakeholders has also allowed us to increase our political capital. Remember, efforts to limit physician compensation affect all medical professionals, not just surgeons. A house divided cannot stand. We are striving for appropriate compensation for the delivery of high-quality care, regardless of specialty. To this end, we have developed positive working relationships with the American Medical Association (AMA), the National Quality Forum (NQF), the AQA, and the Hospital Alliance Steering Committee. In addition, we formed the Surgical Quality Alliance. And finally, it is important to note that our Washington staff meets weekly with representatives from the other surgical specialty societies to discuss mutual concerns.

**Improving quality and safety**

In the past decade, the demand for better care has increased significantly. Igniting the “quality movement” was a series of Institute of Medicine (IOM) reports on medical error and variations in quality. Soon after the IOM began issuing these reports, the American Board of Medical Specialties announced that surgeons and other physicians would need to possess six core competencies and meet new requirements for Maintenance of Certification (MOC). Consequently, surgeons have experienced new pressures to provide value-based surgical services—in order to demonstrate that our patients receive efficient, cost-effective care and experience positive outcomes. All of the College’s divisions have been active in the development of initiatives that enable surgeons to respond to the external forces that drive today’s health policy debate. For example, the Division of Education has done an extraordinary job of expanding and generating products designed to assist sur-
geons in their MOC efforts and in the acquisition of technical, cognitive, and interpersonal competencies, many of which are available online. In addition, the College has accepted responsibility for publishing Selected Readings in General Surgery, changed the direction of ACS Surgery, instituted an e-learning program, established a program for the accreditation of educational institutes, and initiated the Internet-based journal club, Evidence-Based Reviews in Surgery.

With regard to quality and research, the American College of Surgeons’ Oncology Group continues to conduct clinical trials in cancer care, and we are attempting to develop data programs that measure surgical outcomes in a meaningful way. To this end, we have enhanced the capabilities of the National Cancer Data Base and the National Trauma Data Bank®. Scholars in residence at the College are using these repositories to develop “best practices” and disseminate their findings to the medical community. The results of their efforts have been presented to the NQF and to the Physician Consortium for Quality Improvement at the AMA.

The ACS National Surgical Quality Improvement Program (NSQIP) and Case Log System represent our primary efforts to measure surgical outcomes at the hospital and individual level. ACS NSQIP continues to move forward at an impressive pace. More than 200 U.S. hospitals from across the country participate in the program, and most participating institutions have found ACS NSQIP to be useful in their efforts to improve outcomes. Meanwhile, the ACS Case Log System now contains more than 1 million cases for comparative analysis.

In addition, the Commission on Cancer and the ACS Committee on Trauma have traditionally accredited centers that provide related care. The College has built upon these experiences, and is now accrediting institutions that provide bariatric surgery and breast cancer care.

Visibility

The ACS is now a much more visible, open, and transparent organization. We have recently enhanced our efforts in this respect by formalizing our broad-based communications program as the Division of Integrated Communications. The overarching purpose of this division is to ensure that the College conveys a consistent, accurate, and positive message to the public and the Fellows.

In addition, we formed a Public Profile and Communications Steering Committee and contracted with the largest communications management company in the world. This collaboration has added to our visibility and outreach capacity, leading to heightened media interaction and greater public awareness about surgical issues. Meanwhile, we use our print and online publications, the Bulletin, Surgery News, and ACS NewsScope, to communicate with our members and other publics, and the Journal of the American College of Surgeons continues to maintain the highest standards for publishing scientific and clinical information.

We also developed the members-only Web portal—e-FACS.org—at the behest of the younger surgeons. This resource has proven valuable to Fellows who want an interactive means of communicating with other surgeons and to participate in continuing medical education and MOC programs online. In addition, our public Web site (www.facs.org) continues to be a robust presence in cyberspace.

Member services

We have attempted to attract young surgeons to our ranks by forming the Resident and Associate Society of the ACS (RAS-ACS) and, more recently, the Young Fellows Association. We also offer multiple programs designed specifically for medical students and residents. Moreover, we have reached out to our nonsurgeon colleagues by opening up the College to affiliate members, and assisting in formation of the Council on Surgical and Perioperative Safety, which comprises groups representing all professional members of the operating room team. Additionally, we recently developed a video, Wondering What the American College of Surgeons Does For You?, with the goal of recruiting and retaining members.

Finally, the Socioeconomic Issues Committee of the Board of Governors developed the con-
cept of Operation Giving Back (OGB), which provides our members with opportunities to learn about, and participate in, international and domestic volunteer activities. This program informs people about the role of surgery in global health and recognizes distinguished volunteers.

The ACS Foundation both supports and benefits from these activities. Contributions to the Foundation have consistently exceeded $1 million since 2003, with 2008 being the most successful year since 1996, with a total of $1.9 million contributed for the work of the College.

I think we should all take pride in what we have accomplished these past 10 years. We have become a more influential, recognizable presence in the public’s and profession’s consciousness. We have achieved this progress together, with the Regents, Governors, Fellows, our chapters and their officers, and staff all working in unison to further the College’s mission of ensuring that members of our profession can continue to provide their patients with optimal surgical care.

I am grateful to all of these individuals for their tireless efforts on behalf of surgical patients and the American College of Surgeons.

Thomas R. Russell, MD, FACS
What surgeons should know about...

The Socio-Economic Fact Center for Surgery Web site

by Caitlin Burley, Quality Associate, Division of Advocacy and Health Policy

For nearly 20 years, the American College of Surgeons published the Socio-Economic Factbook for Surgery on a regular basis. The Factbook contained information spotlighting the rapid and complex transformations occurring in health care, especially those relevant to surgeons and the patients for whom they care. The Division of Advocacy and Health Policy has updated the Factbook for 2008–2009, and it is now available on the ACS Socio-Economic Fact Center for Surgery Web site at http://www.facs.org/se-factcenter/. The purpose of this article is to provide details about the new Web site, the information available on it, and its potential uses.

Socio-Economic Fact Center for Surgery Web site

Socio-Economic Fact Center for Surgery is located on the American College of Surgeons Web site and includes statistical and other information relevant to health care professions. More specifically, the information reflects changes and trends in the financing, organization, and delivery of medical care.

How is the information presented?

The information on the Web site is separated into the following categories: vital statistics; medical education; surgical supply; hospital and ambulatory facilities; health insurance and managed care; medical economics; physician payment, patient safety, and quality; and Medicare and Medicaid. For each specific piece of information, a chart, table, or graph was chosen to best represent the data.

Where was this information gathered?

The data were gathered from a variety of reliable sources, including the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the U.S. Census Bureau, the Centers for Medicare & Medicaid Services, the American Board of Medical Specialties, the Medicare Payment Advisory Commission, and the American College of Surgeons.

Why do I need this information, and who will find this particularly useful?

The information in each section is a compilation of facts and figures pertaining to surgeons, other physicians, and the socioeconomic environment in which they practice. It provides a valuable resource for tracking changes and trends in health care. Legislative staff and policymakers in Washington, DC, will be directed to this Web site for up-to-date information on surgery topics and issues.

How do I use the Web site?

The Socio-Economic Fact Center for Surgery Web site will be organized by category. Each category will provide a list of facts by title that can be used to navigate to the site. Each chart, table, or graph will also be available to download.

There will also be links to other resources that provide additional information pertaining to the health care environment.

How can I access this Web site?

The Socio-Economic Fact Center for Surgery Web site will be available through a link on the College’s main page under the Division of Advocacy and Health Policy, or you can access it at http://www.facs.org/se-factcenter/.

The Socio-Economic Fact Center for Surgery Web site will be updated periodically as new information is compiled. For questions or more information, please contact Caitlin Burley at cburley@facs.org.
The American College of Surgeons (ACS) Foundation underscores the vital role that surgeons play in benefitting society by enhancing and extending life for patients. As a not-for-profit 501(c)(3) organization, the goal of the ACS Foundation is to advance the mission of the College through increased philanthropic support for our education, patient safety, and research programs. On behalf of the Foundation’s Board of Directors, it is our pleasure to report that the ACS Foundation concluded a most successful fiscal year.

Through the generosity of many donors, we have been able to expand the significant accomplishments of the College and provide even greater benefits to Fellows and surgical patients throughout the world. During the 2008–2009 fiscal year, a total of $2,043,508 was contributed to support the outstanding work of the College. As you will read in the following pages, this philanthropy has had tremendous impact on the College’s efforts—from invaluable gifts to be used for scholarships to underwriting for volunteerism efforts.

The ACS Foundation offers many opportunities for Fellows and friends to invest. Whether your primary interest is making a difference in clinical practice, surgical research, education, or patient safety, we pledge to use your investment wisely, in accordance with your direction, and in the spirit of the goals of the American College of Surgeons and its Foundation. As the work of the Foundation is supported by the College, 100 percent of each contribution is dedicated to the program designated by the donor.

Each and every gift is important, and we are extremely grateful to the many donors who have shared their investment to advance the mission of the College. We extend our profound appreciation.

Sincerely,

Edward R. Laws, M.D., FACS

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The American College of Surgeons Foundation is recognized as a tax-exempt, not-for-profit organization. Contributions to the American College of Surgeons Foundation are tax-deductible to the extent allowed by law.

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Thank You

The Board of Directors of the American College of Surgeons Foundation is grateful for the continued investment of our many donors. Through their generous support, we have been able to expand the significant accomplishments of the College and provide even greater benefits to Fellows and surgical patients throughout the world.

Charitable gifts and grants are helping us meet the increasing need to provide the latest in education, research, and patient safety to benefit surgeons and their patients. Scholarships, faculty fellowships, lectures, paper competitions, and volunteerism programs are only a few of the many initiatives supported by our donors.

It is heartwarming to see the growing number of donors who choose to invest in the mission of the American College of Surgeons. Thank you for your generosity.

GIFT INCOME REPORT
July 1, 2008–June 30, 2009

SOURCE ■ AMOUNT
FELLOWS AND FRIENDS ■ $855,558
CORPORATIONS ■ $1,014,500
CHAPTERS AND SOCIETIES ■ $173,450
TOTAL $2,043,508

DESIGNATION ■ AMOUNT
SCHOLARSHIPS AND FELLOWSHIPS ■ $799,253
SUSTAINING FUND ■ $419,306
RESEARCH AND PATIENT SAFETY ■ $322,253
OPERATION GIVING BACK ■ $290,377
EDUCATION PROGRAMS ■ $212,319
TOTAL $2,043,508

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**“Your Gifts at Work”**

The American College of Surgeons has an enduring purpose: to provide surgeons with the knowledge and skills they need to deliver optimal patient care. But while the College’s mission has remained constant, surgical care has changed dramatically in the last century, and even greater transformations are developing.

Hence, the ACS has continually expanded the variety and scope of its educational and research-based programs and activities. Over the years, the College also has sought to pay tribute to some of the great leaders of our noble profession and to promote altruism and ethics.

Many of these programs exist through the charitable contributions provided to the ACS Foundation.

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**SCHOLARLY PURSUITS**

The College views the task of offering scholarships, fellowships, and other learning opportunities as one of its foremost responsibilities because these efforts lead to advancements in the quality and safety of surgical patient care. These initiatives cultivate the brainpower, fresh ideas, and new perspectives young surgeons have to offer, while empowering surgeons at all stages of their careers to pursue both their clinical and nonclinical interests. Scholarly activities supported through generous gifts to the ACS Foundation include:

- Resident research scholarships
- Faculty fellowships
- Scholars-in-Residence
- Traveling scholarships
- Traveling fellowships
- International guest scholarships
- Health policy scholarships

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**NAMED FELLOWSHIPS AND LECTURES**

Some of the educational and research efforts the College has developed over the years are named in recognition of a few of the great leaders in surgery—past and present.

An example of a recently added named program is the *Claude H. Organ, Jr., MD, FACS, Traveling Fellowship Award*. This fund was established by Dr. Organ’s family and many of his colleagues and friends to provide a lasting memorial to his extraordinary life and work. The award is intended for presentation to an outstanding underrepresented minority or female surgeon who is engaged in research that will foster the art, science, practice, or teaching of surgery or health policy.

The first recipient of the fellowship is Patricia L. Turner, MD, FACS, assistant professor of surgery and surgical training program director at the University of Maryland School of Medicine in Baltimore.

“I am very flattered to have been chosen as the first recipient of this award because Dr. Organ made so many significant contributions to surgery and was a personal mentor of mine. Certainly this is a wonderful opportunity, and I’m very pleased and honored to have been chosen,” she said.

Dr. Turner intends to use the grant to work collaboratively with the Cleveland Clinic and the ACS National Surgical Quality Improvement Program to study predictors of outcomes in bariatric surgical procedures.

“This collaboration will, hopefully, allow me to do something that I have been interested in for quite some time but never had the resources to undertake,” she said.

A named fund was also recently established to support the annual *Herand Abcarian, MD, FACS, Lecture*, which is presented during the ACS Clinical Congress. A Fellow of the College since 1974, Dr. Abcarian is a gifted and compassionate surgeon, teacher, role model, and mentor who has won the admiration and affection of both his patients and his trainees at the University of Illinois–Chicago School of Medicine. Many of Dr. Abcarian’s associates and affiliated organizations have generously contributed to this fund.

Although Dr. Abcarian is considered a trailblazer in the movement to have colon and rectal surgery attain recognition as a surgical specialty, the lectureship is not limited to specialists in that discipline. Rather, speakers at this session address issues of relevance to the surgical community at large, particularly emerging trends in the profession.
**SERVICE TO ALL**

The American College of Surgeons encourages surgeons not only to commit to lifelong learning and professional development, but also to use their skills and knowledge wherever the need is greatest. That’s why the College established the *Operation Giving Back* (OGB) program in 2003. This comprehensive program is designed to help surgeons discover volunteer opportunities, whether on the other side of town or the other side of the world. Operation Giving Back connects surgeons with opportunities to provide charitable services through clinical outreach, educational partnerships, and training programs. OGB and the ACS are pleased to acknowledge the support of Pfizer, Inc, in this effort to develop safe, effective, sustainable health care solutions for underserved populations.

In addition to supporting the growth of the program, Pfizer’s sponsorship has supported the ACS’s annual presentation of *Surgical Volunteerism and Humanitarian Awards*, which are accorded to those Fellows who best manifest the spirit of “giving back” to domestic and international patient communities. Since the College and Pfizer began collaborating in 2003 to present the volunteerism awards, 12 individuals have received this honor.

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**EMERSON SCHOLAR-IN-RESIDENCE IN MEDICAL ETHICS**

The American College of Surgeons Foundation is proud to announce a grant from the Emerson Charitable Trust to establish the ACS-Emerson Scholar-in-Residence in Medical Ethics in collaboration with the Saint Louis (MO) University Emerson Ethics Center. This program provides a promising surgical resident with a two-year immersion in the study of the ethical issues facing surgeons today.

Under the mentorship of C. Rollins Hanlon, MD, FACS, the first Emerson Scholar, Jason Keune, MD, a surgical resident at Washington University, began the fellowship in June 2009. During the scholar-in-residence period, Dr. Keune will have the opportunity to:

- **Participate in a collaborative learning environment centered on critical ethical challenges that arise in modern-day surgical practice.**
- **Develop the analytic skills necessary to evaluate complex ethical issues.**
- **Acquire the leadership and interpersonal skills relevant to improved patient care in an atmosphere that promotes constructive and problem-solving abilities.**
- **Contribute to the advancement of medical ethics through widely disseminated articles and discourse based on findings arrived at through the program.**

William F. Sasser, MD, FACS; Walter Galvin (Senior Executive Vice-President, Chief Financial Officer, and Director, Emerson); Jason Keune, MD; Thomas R. Russell, MD, FACS; Tim Keane, PhD (Director, Emerson Ethics Center, John Cook School of Business, Saint Louis University)
"The American College of Surgeons is held in such high esteem, that I really wanted to be part of the organization ever since I was in high school. I have been a member of the Fellows Leadership Society for many years. I wanted to contribute to the Foundation because I feel that I have benefited greatly from meeting and working with the wonderful, skillful surgeons whom I have met over the years through my training, practice, and Fellowship in the ACS. Contributing to the ACS Foundation, in my mind, is really a matter of returning the favor, as it were. I wanted younger surgeons to have the opportunity to have the same experience that I have had."

—Thomas G. Howrigan, MD, FACS, Fairfield, VT

"I’ve been donating to the ACS through my family’s foundation since it was established eight years ago. I grew up in West Virginia, and I really appreciate the College’s emphasis on the surgical workforce shortages in rural areas and its efforts to find ways to combat the problem. I also like Operation Giving Back’s efforts to get surgeons interested in volunteering in underdeveloped countries and other areas of need. I have participated in two trips to Africa for fistula surgery, and these experiences were very meaningful to me. I’m sure that other surgeons who respond to the ACS efforts will find they feel the same way."

—Christopher K. Payne, MD, FACS, Associate Professor of Urology, Director of Female Urology, Stanford University Medical Center

"I was introduced to the ACS development program by my surgical partner, Charles E. Lucas, MD, FACS. He took me to the FLS luncheon at the Clinical Congress in the late 1990s. It was there that I learned he had been donating to the ACS on his meager salary while raising five children. He pointed out that the ACS allows us to do what we do, and we have an obligation to support the organization. I became a member of the Fellows Leadership Society in 1999 and have continued to contribute each year. I have designated my funds to be used for the scholarship program because I believe our greatest investment is in the bright young surgeons who have good ideas but no funds. I suspect that I will continue to contribute to those organizations that have allowed me to succeed—my college, medical school, the ACS, and other professional associations—as long as I have the ability to do so."

—Anna M. Ledgerwood, MD, FACS, a professor of surgery at Wayne State University, Detroit, MI
THE PHILANTHROPIC SPIRIT

“My husband had always wanted to join the Fellowship Leadership Society (FLS) because he was very proud to be a Fellow of the American College of Surgeons. He was the only one in his family to get through high school. So, the fact that he went to medical school, specialized in surgery, and had considerable professional success was just miraculous to him. He felt that he was just so blessed. After he died, I remembered he had always wanted to be a member of the FLS. I divided up some of his savings and gave it to several organizations, including the American College of Surgeons. Because of his dedication to improving cancer care, our family’s personal battles with breast cancer, and the advances that continue to occur in oncology, I specified that the donation be used to support the residents paper competition in cancer. I was there to present the awards to some wonderful young doctors. The idea that my donation was supporting a program like that meant so much to me. I’m very glad I did it.”

—Mrs. A. Lee Campione, widow of the late Matthew P. Campione, MD, FACS, Meriden, CT

THE PHILANTHROPIC SPIRIT

“Since I first became a Fellow in 1996, I have given money each year for the College to use as necessary. The College hosts many important programs for surgeons and for residents and does so much—not just here in America, but internationally as well. If you are a member, you need to support all of these activities. This past year is the first time that I decided to give a donation for a specific purpose. I established a named fund in memory of my parents. My mother was a housewife and my father was a farmer in India. They emphasized education as means of achieving a better life, and for this reason I wanted to make this gift in their memory. The Baxiram S. and Kankuben B. Gelot Fund will provide annual funding for a selected international Fellow to attend the Clinical Congress. U.S. healthcare is the most advanced in the world, and I wanted to give international scholars a chance to see and learn about new technology and procedures so they can apply this knowledge in their native land.”

—Raghuvr Baxiram Gelot, MD, FACS, an otolaryngologist in private practice in Absecon, NC

A complete report on the ACS Foundation, including donor listings, is provided on our Web site. Visit http://www.facs.org/acsfoundation/about/annualreport.html for more information.

To make a gift to the ACS Foundation, visit our Web site at www.facs.org/acsfoundation/contribute/. Or contact us at: ACS Foundation, 633 N. Saint Clair St., Chicago, IL 60611-3211; 312-202-5338.
While most of the country has been focused on the health reform debate in Washington, DC, state legislatures have also been waging their own war with budgets, taxes, and health care issues. From January to mid-July, more than 140,000 bills were introduced in various states and more than 34,000 were adopted.1 Contrast that number with the just slightly fewer than 6,000 bills introduced in Congress, and you can appreciate the impact that state lawmakers have on the regulation and practice of medicine.

Because there are so many bills with health-related topics introduced in state legislatures, it is important for the College to focus on state affairs resources. Once again, College leadership has directed State Affairs staff to focus on five primary issues:

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

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

The State Affairs staff is currently tracking more than 780 bills in all 50 states. The following bills are a representative sample of the types of bills that have been monitored over the past several months.

Medical liability reform

Due to a number of factors, the last few years have seen a significant decrease in the number of bills addressing large-scale Medical Injury Compensation Reform Act reforms. This is due, in large part, to the fact that more than 30 states now have some type of cap on noneconomic damages, and many have enacted other significant reforms. The political climates in those states without reforms are not favorable to this type of legislation, or constitutional barriers exist prohibiting these reforms. Once again this year, most of the legislation related to liability was defensive, with many of these battles taking place not at the statehouse, but in the courts.

For the first time since 2006, one state did pass a significant liability reform package—Oklahoma. H.B. 1603, which creates a $400,000...
cap on noneconomic damages, was signed on May 21. This cap would not apply in certain situations, such as:

- The plaintiff or injured person has suffered permanent and substantial physical abnormality or disfigurement; loss of use of a limb; or loss of, or substantial impairment to, a major body organ or system
- The plaintiff or injured person has suffered permanent physical functional injury which prevents them from being able to independently care for themselves and perform life-sustaining activities
- The defendant’s acts, or failures to act, were: (1) in reckless disregard for the rights of others, (2) grossly negligent, (3) fraudulent, or (4) intentional or with malice.\(^2\)

Oklahoma’s H.B. 1603 also includes other reforms, including expert witness qualifications, joint and several liability, rules for affidavit of merit, and sanctions against attorneys who knowingly, and in bad faith, file frivolous lawsuits.

The medical community in North Dakota was able to defeat H.B. 1390, which would have repealed the state’s 14-year cap on noneconomic damages.

The New York State chapters have been battling a potentially devastating increase (possibly up to a 15 percent increase) in their liability rates. Although a long-term solution was not achieved this session, the legislature did extend the rate freeze until June 30, 2010. The New York chapters will continue to work with the medical community to push for a long-term fix to the liability crisis in New York.

Many states continue to defend their reforms in court—Illinois, Georgia, and Missouri all have pending cases. In early 2009, Arizona’s Supreme Court upheld statutes that challenged the 2005 legislation refining expert witness qualifications and affidavit of merit.

Texas also successfully defeated S.B. 152, which would have lowered the liability protections for emergency physicians from the current “willful and wanton” to “willful or wanton”—a seemingly small change, that in reality would likely have opened the door to many more lawsuits. The proposed bill would have also limited the emergency protections only to Good Samaritans.

After four years of debate in the state legislature, Arizona Gov. Jan Brewer signed S.B. 1018, known as the “burden of proof” bill. This legislation raised the burden of proof in medical liability lawsuits involving care provided in emergency departments from “a preponderance of” to “clear and convincing” evidence; Utah also passed similar legislation this year.

**Trauma**

Arkansas had a very successful year passing trauma-related legislation. Arkansas passed several automobile safety bills, including a primary seat belt law, an all-driver texting while driving ban, and a ban on younger drivers using cell phones. (Minnesota also passed a primary seat belt law this year.)

Arkansas also passed S.B. 315, which increased the excise tax on cigarettes and smokeless tobacco, and is expected to generate $88 million a year. Some of the money being raised will pay for a trauma center in northwest Arkansas, and $25 million has been earmarked for a statewide trauma system. The package includes $25 million for fiscal year 2010, and $28 million in 2011 for a proposed trauma system to treat severe, sudden, shock-inducing injuries.

Although the Georgia legislature and governor agreed that their trauma system is in need of serious funding, there were many disagreements over where to find the funding this year. Ultimately, H.B. 160 passed a “super speeder” bill that is expected to generate approximately $23 million, which is far less than what is needed to update the system. The medical community in Georgia worked tirelessly in support of this bill, even hosting a “trauma day” at the capitol, and they are expected to continue their efforts in 2010. Visit [http://www.georgiaitsabouttime.com/](http://www.georgiaitsabouttime.com/) for more information on Georgia’s ongoing efforts.

Florida also passed a primary seat belt law, and developed several proposals to increase funding for their trauma system. These bills focused on the red-light cameras many counties are placing at intersections. Despite the hard work of many dedicated surgeons in the state, these funding proposals failed to get the traction they needed. Florida also hosted a trauma day and invited many stakeholders to the capitol. The Florida Chapter and the Florida Committee on Trauma
are making plans to push for significant funding of the trauma system in 2010.

North Dakota passed S.B. 2048, which mandates hospital participation in the state’s trauma system. This bill is a result of the recommendations that came from the trauma system consultation that the ACS performed in April of 2008. The bill was amended to provide that, effective January 1, 2011, a hospital that offers emergency services to the public must meet trauma center designation standards and participate in the trauma system. As amended, the bill would also require the State Health Council to adopt rules that allow provisional trauma designation status for a hospital that is partially compliant with trauma designation standards. When issuing a provisional trauma designation, the State Health Council would be required to allow a reasonable amount of time, determined by the department, for a hospital to fully meet all trauma designation standards.

The Missouri legislature passed legislation to significantly relax the mandatory helmet law in Missouri; however, Gov. Jay Nixon vetoed the bill.

“In terms of lives and of dollars, the cost of repealing Missouri’s helmet law simply would have been too high,” Governor Nixon said. “By keeping Missouri’s helmet law intact, we will save numerous lives, while also saving Missouri taxpayers millions of dollars in increased health care costs. Keeping our helmet law in place was the safe and cost-effective choice for Missouri.”

A bill to repeal the helmet law in South Carolina was defeated, in large part due to concerns over health care costs. Although the bill required riders to carry proof of $25,000 in insurance coverage, legislators were concerned that the average cost of this type of trauma was actually closer to $200,000.

Repeal of the UPPL

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

The chapters of New York State have been working to repeal the UPPL for several years. S.B. 3554/A.B. 6843 has passed the Assembly and, as of press time, is on its way to the Senate.

States that prohibit insurers from denying coverage

California, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Iowa, Maine, Maryland, Nevada, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, and Washington State

States that never enacted UPPL

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

Massachusetts, Michigan, Minnesota, New Mexico, New Hampshire, Oklahoma, Utah, Vermont (repealed the explicit law; but never enacted prohibitions), and Wisconsin

South Carolina failed to pass H. 3650/S. 499, which would have repealed the UPPL. However, the Ohio legislature successfully repealed the UPPL this year. (See sidebar, this page.)

UEVHPA

A new priority for the State Affairs staff is the UEVHPA, which was created in 2006, and modified in 2007 by the Uniform Law Commission; 11 states have already adopted this legislation.

In October of 2008, the ACS Board of Governors and Board of Regents formally adopted a statement in support of this legislation. (To read the statement, visit http://www.facs.org/fellows_info/statements/st-63.html.)

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

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

In 2007, the model bill was modified to include liability protections. The model legislation includes two options that may be selected by a sponsor. “In Alternative ‘A,’ a volunteer health practitioner is not liable...unless the conduct in question rises to the level of willful misconduct, or wanton, grossly negligent, reckless, or criminal conduct.... Alternative ‘B’ utilizes the same basic exclusions, but caps the compensation a volunteer can receive in connection with the emergency (not including reimbursement of reasonable expenses) at $500 per year, and does not include the limitation on vicarious liability.” A third “unofficial” option is to simply reference the state’s current Good Samaritan laws.

Five out of the 14 states that introduced UEVHPA ultimately passed the legislation (see sidebar, this page). In four states—Connecticut, New Hampshire, Oregon, and Texas—legislation was introduced as a direct result of ACS Fellows and Chapters in those states. In addition, ACS Chapters and Fellows submitted testimony and wrote letters in support of this act. (See photo, page 20.) Melanie Korndorffer, MD, FACS, and James Korndorffer, MD, FACS, of Louisiana, generously provided a letter about their experiences during Katrina that has been used in many states to illustrate the importance of this legislation.

Scope of practice

As with every year, the physician community battles nonphysician providers as they continue to try and expand their scope of practice. Over the years, many states have created coalitions, recognizing the impact that a unified physician community can have on this issue. Having an otolaryngologist fighting to stop podiatrists from expanding to the knee, for example, shows the legislature that this is truly a patient safety issue, and not just another turf battle.

New York State successfully defeated legislation that would have allowed single-degree oral and maxillofacial surgeons to perform cosmetic surgery unrelated to oral health (A.B. 4656/ A.B. 2397), as well as a bill that would expand the scope of podiatrists by allowing them to treat the ankle (S.B. 2992).

Almost half the states in the country had bills expanding optometrists’ scope, including several states that tried to authorize them to perform surgery.

Nebraska’s L.B. 417 would have expanded the scope of optometrists to include, among other things, the performance of laser and nonlaser surgical procedures, as well as the administration of injectables such as Botox and dermal fillers; the bill died in committee.

Another bill that did not make it out of committee in South Carolina was H.B. 3303. This bill would have allowed optometrists to perform various surgical procedures, including incisional cosmetic surgery.

Massachusetts had a bill that would use the ACS definition of surgery (as found in the ACS Statement on Surgery Using Lasers, Pulsed Light, Radiofrequency Devices, or Other Techniques). Unfortunately, S.B. 826 did not make it out of committee. To read the full statement, visit http://www.facs.org/fellows_info/statements/st-11.html.

In an attempt to be proactive and assist patients in selecting the appropriate health care professional, many states are introducing Truth in Medical Education (TIME) acts. Modeled after Florida’s 2006 bill, TIME acts generally require health care professionals to inform their patients of their licensure either verbally or by wearing a nametag. Some states have also included licensure disclosure in print ads (stand-alone bills pertaining to this are often referred to as TIA, or Truth in Advertising, bills). The 2006 federal Healthcare Truth and Transparency Act was also modeled after Florida’s bill.
Arizona, California, Hawaii, New York, Oklahoma, Oregon, and Virginia all had TIME/TIA bills introduced.

Oklahoma and Oregon both passed their respective bills, and as of press time, California’s A.B. 501 was awaiting action by the governor.

Provider taxes
Due to the tough fiscal climate, many states are having difficulties balancing their budgets. As a result, several states, including Oregon, Texas, and Washington, each had bills that would have taxed elective cosmetic procedures. None of these bills passed.

New Jersey also had a bill (A.B. 2521) that would increases gross receipts assessments on ambulatory care facilities to 7 percent, or $400,000, or whichever is less. The bill never made it out of committee.

The only state to pass a physician taxation bill was West Virginia, which passed S.B. 724, a 2 percent gross receipts tax on the business of providing physician services.

A final reminder
ACS staff has added a link to the advocacy page of the Web portal (http://efacs.org/advocacy), which allows fellows to have access to all the state legislative bills that ACS is tracking.

On this page, members of the College can read information regarding the status of legislation in their own, or other, states. A map of the U.S. allows users to click on an individual state to get an overview of pending legislation, and a list of topics allows Fellows to search by content.

Information available through the tracking service includes bill number, title, sponsor(s), abstract, scheduled hearings, and notes added by ACS staff. To access the most recent version of a bill, click on the legislation’s title. If the College is asking surgeons to take action on a particular bill, a link to the Surgery State Legislative Action Center will be provided.

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

References
What surgeons can do to reduce the impact of smoking on surgical outcomes

by
John Maa, MD, FACS;
David Warner, MD;
and
Steven Schroeder, MD
Smoking is the number one cause of preventable death in the U.S. and worldwide. Approximately 19.8 percent of U.S. adults smoke cigarettes, and up to one-half of these individuals will die prematurely because of their use of tobacco. Each year, tobacco use causes 440,000 deaths in America, and 50,000 deaths due to second-hand smoke. Nearly 5 million deaths each year worldwide are the result of tobacco use.

Cigarette smoking is a powerful independent risk factor for developing heart disease and stroke, and is also strongly linked to developing cancer, sudden cardiac death, emphysema, and chronic bronchitis. A smoker’s risk of developing heart disease is estimated to be two to four times higher than that of nonsmokers. At the national level, lost-work productivity from tobacco use amounts to more than $92 billion per year, and health care expenditures for smokers are estimated at $90 billion per year. More than 8.6 million people in the U.S. are disabled from smoking-related diseases, and smoking causes more than twice as many deaths as human immunodeficiency virus and AIDS, alcohol abuse, motor vehicle collisions, illicit drug use, and suicide combined. As a result, tobacco use places a tremendous strain on our nation’s health care system, impeding our ability to provide access to the uninsured in the U.S., and to address important diseases such as heart disease and stroke. Though the smoking prevalence among adults in the U.S. has been in slow decline over the past five decades, youth smoking is on the rise. Of the current 44 million smokers in America, nearly 75 percent would like to quit smoking. The majority of smokers eventually succeed after several attempts, and the encouraging news is that there are currently more ex-smokers in this country than there are active smokers.

Smoking-related surgery and anesthesia complications

Each year, millions of cigarette smokers require surgery and anesthesia in the U.S. Although all physicians can, and should, help their patients quit smoking, there are especially good reasons for anesthesiologists and surgeons to do so. Smoking may cause the disease that requires surgery, or it may complicate anesthetic management and surgical outcomes for other nonsmoking related conditions. Smoking is a risk factor for perioperative cardiovascular, respiratory, and wound healing complications such as pneumonia, myocardial infarction, and surgical site infections. Surgeons and anesthesiologists witness the devastating consequences of cigarette smoking on a daily basis, as well as the hidden costs to society associated with smoking that we often don’t discuss. Complications such as wound infection, respiratory failure requiring intubation, prolonged hospital stay, and anastomotic leak are clearly linked to current smoking; quitting, even for a relatively brief time prior to surgery, can reduce the risks.

The good news is that the risk of premature death and disability is dramatically reduced when smokers quit, even if they have smoked for decades. The average smoker gains six to eight years of extra life from stopping smoking. A 2004 report by the U.S. Surgeon General showed that after one year of not smoking, the excess risk of coronary heart disease is reduced by half. After 15 years of abstinence, the risk for cerebrovascular disease is similar to that for people who’ve never smoked.

What we can do

Surgeons and anesthesiologists encounter smokers at a unique, teachable moment for behavioral change. Extensive research has already documented that patients recently diagnosed with tobacco-related disease are most responsive to counseling and advice to quit. Inpatient hospital smoking cessation counseling has proven effective after myocardial infarction. While quitting smoking shortly before or after surgery is often perceived as difficult, it is not impossible. Even a few minutes spent by a physician advising smokers to quit can be effective, and there are now referral resources, such as free telephone-based “quit lines,” that are available free of charge. A variety of effective methods are available to help smokers quit, including counseling and medications such as nicotine replacement therapy: nicotine patches, varenicline (Chantix®), bupropion, nicotine gum, lozenges, nasal sprays, and inhalers. (For more information, visit http://...
Unfortunately, current evidence shows that surgeons and anesthesiologists are currently not taking advantage of this teachable moment opportunity, as very few provide any assistance to their patients in stopping smoking.6

Traditionally, smoking cessation efforts on the part of physicians have emphasized the five “A’s” of breaking this habit, as identified by the *Treating Tobacco Use and Dependence Clinical Practice Guideline*.4 The five “A’s” of an expanded social history assessment of tobacco use are: Ask, advise, assess, assist, and arrange. However, a newer recommendation by the American Society of Anesthesiologists’ (ASA) Smoking Cessation Initiative Task Force suggests utilizing the simplified version, ask-advise-refer, during preoperative discussions with patients considering surgery:

- **Ask** all patients if they use tobacco.
- **Then advise** smokers to quit.
- **Refer** the patient to smoking cessation counselors or toll-free telephone quitlines (1-800-QUIT-NOW).

The ASA recently performed a pilot study in 14 representative anesthesia practices, showing that the ask-advise-refer strategy to provide tobacco interventions was feasible and well-received by both anesthesiologists and patients.7 Participating anesthesiologists found that by using this strategy, they could quickly and easily intervene with their patients, without extensive training in tobacco control methods. The ASA subsequently adopted an official policy statement on tobacco control, with the intent to increase awareness regarding the essential role that anesthesiologists can play in improving the overall health and surgical outcomes of their patients.

We recommend that you take a few minutes to make a lasting difference in the life of your patients who smoke. First, all patients should be asked whether they are currently smoking or using tobacco. Patients will likely appreciate that you care enough just to ask this question. Next, every smoker needs to be advised to quit. Focus on these two points: abstaining from smoking may help patients better recover from their surgery, and many people often find that surgery is an optimal time to make a sustained attempt to quit. Encourage patients to abstain from smoking for as long as possible postoperatively. Finally, familiarize yourself with the resources available in your practice setting for those patients who want help in quitting.

**Examples of efforts to help surgical patients quit smoking**

The ASA has developed an initiative to help surgical patients quit smoking. This initiative includes materials that equip anesthesiologists to get involved in tobacco control efforts (available at [http://www.asahq.org/stopsmoking/providers](http://www.asahq.org/stopsmoking/providers)), public educational efforts, and collaborations with others involved in perioperative care.

Another example of a successful smoking cessation initiative is that of the University of California–San Francisco (UCSF), Medical Center, a multidisciplinary inpatient effort targeting smoking cessation involving physicians, nursing, and physician extenders, which has been championed by respiratory therapists. The intent is to identify all hospitalized patients who smoke, and to link them with the wide range of comprehensive programs available to help them stop smoking. Inpatients admitted to the UCSF Surgery Hospitalist program are referred to the UCSF Habit Abatement Center ([http://www.ucsf.edu/nosmoke](http://www.ucsf.edu/nosmoke)), as well as the Tobacco Education Center. An interactive video developed by the UCSF School of Medicine to educate medical students and residents to become tobacco cessation counselors is available to the public at [https://surveys.ucsf.edu/Surgery110Tobacco_public.ucsf](https://surveys.ucsf.edu/Surgery110Tobacco_public.ucsf).

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Future health policy considerations

An Institute of Medicine report released in May of 2008 entitled Ending the Tobacco Problem has defined a national strategy to reduce smoking so that it is no longer a significant public health threat. A key recommendation was to grant the Food and Drug Administration the authority to regulate the production, advertising, and distribution of cigarettes, a major goal that was fulfilled in June of 2009.

There is strong evidence to support four key health policies that reduce the rate of smoking: price increases through state and national taxes; clean indoor air laws; counter-marketing campaigns to deliver prevention and cessation messages; and smoking cessation services. Substantive progress is occurring in each of these areas except counter-marketing campaigns, where fiscal crises have reduced air time for advertisements.

As the debate regarding reform to the American health care system evolves, we may learn valuable lessons from the experiences of other nations in the creation of disincentives to continued smoking. Interestingly, in other countries, active smokers are often refused elective surgery, and referred to preoperative smoking cessation programs.

Increases in the price of cigarettes have been demonstrated to be a powerful incentive to help smokers to quit. In 2009, the U.S. government legislated a 62-cent increase in the price for a pack of cigarettes, which raised the national average for a pack of cigarettes to $4.80. But in some Canadian provinces, the average price for a pack of cigarettes is as high as $9.00 USD. The extra revenues generated from these excise taxes can help to fund smoking cessation programs for active smokers, and to promote clean indoor air laws to reduce nonsmoker exposure to secondhand smoke. Further research in the areas of tobacco control policy, nicotine addiction, and smoking cessation research will be essential to increase the ability of health care professionals to assist smokers to achieve their cessation goals.

Another key recommendation from the Institute of Medicine report is the requirement that all public and private health insurers cover smoking cessation programs. In response, representatives from the health insurance industry have proposed that active smokers pay higher insurance premiums as a mechanism to increase patient responsibility in the discussion of access to health care.

At the federal level, tobacco control efforts to improve the future health of U.S. citizens are strongly consistent with the American Heart Association’s mission to reduce the health impact of heart disease and stroke, which are the number one and number three leading causes of death. Together, heart disease and stroke claim approximately 1 million lives each year. The estimated direct and indirect cost of cardiovascular disease in the U.S. for 2009 was more than $475 billion. Future efforts to integrate the tobacco control effort into the public health and policy process may result in health care savings that will expand access to cover the uninsured.

Conclusion

Given the enormous societal cost of tobacco, the fields of anesthesia and surgery are presented with a special opportunity to deliver a unified message about smoking cessation that will make a real difference in the lives of patients. The first step is to make surgeons around the world fully aware of the risks of smoking so that they can educate their patients who smoke about the increased risks of surgery. Surgeons should include a discussion of active smoking and its risks during the preoperative informed consent discussion when weighing the overall risks and benefits of
an operation. Perhaps a better understanding of the added risks of active smoking will result in a mutual decision to postpone elective operations in the interest of patient safety. The next step is to make surgeons aware of the free resources that are readily available to allow patients to succeed in their cessation efforts. Successful smoking cessation usually requires multiple attempts, and surgeons and anesthesiologists can collaborate to identify smokers preoperatively, and steer them toward treatment. As we move forward, future solutions will involve a multi-pronged effort focused both on prevention and treatment of those afflicted by smoking-related disease. Central to this solution will be effective smoking cessation education that keeps people from ever starting to smoke, while helping people who do smoke to quit. Through empowerment and education, surgeons can play an important role in reducing tobacco’s deadly toll across America and worldwide.

References

A plastic surgeon comments on smoking

by

Mary H. McGrath, MD, MPH, FACS

Plastic surgeons hold strong opinions about the harmful impact of cigarette smoking on wound healing and postoperative complications, as well as on a patient’s overall general health. These convictions date back to 1984, when a visually compelling paper showed varying degrees of facial flap necrosis in face-lift patients who smoked. The report reviewed more than 1,100 face lifts and found that a smoker was 12.46 times more likely to suffer skin loss than a patient who did not smoke. This finding prompted the authors to state that “Heavy smokers can reasonably be denied elective aesthetic surgery unless they stop smoking.”1 While there were prior experimental studies indicating that smoking had an adverse effect on wound healing, this clinical study had a formative impact on later plastic surgical practice guidelines.

Cigarette smoke contains nicotine, carbon monoxide, and hydrogen cyanide, and each has been shown to impair wound healing by producing relative tissue hypoxia. Nicotine is a vasoconstrictor that diminishes tissue oxygenation, predisposes to microvessel thrombosis through increased platelet adhesion and direct endothelial cell damage, and diminishes cell proliferation and function. Carbon monoxide reduces oxygen carrying capacity and hydrogen cyanide inhibits oxidative metabolism and oxygen transport.2

The consequences of tissue ischemia are most evident in surgical procedures where tissue is at risk for interrupted circulation, as in surgical undermining, the transfer of skin flaps, microsurgical tissue transfer, and grafts of all types, including bone. Many of the techniques used in plastic surgery rely on good blood supply, and tobacco use compromises the outcome.

A number of clinical studies have documented increased morbidity in plastic surgical patients who smoke. A review of 132 patients having abdominoplasty showed wound healing problems in 47.9 percent of smokers versus 14.8 percent of non-smokers.3 In patients having free trans-
verse rectus abdominis musculocutaneous flap breast reconstruction, smokers have two times the incidence of mastectomy flap necrosis than nonsmokers. Abdominal wall donor site complications are also twice as common and include abdominal flap necrosis and hernia.4

Similarly, complications in women having breast reconstruction with expanders are significantly more frequent in smokers, as is mastectomy flap necrosis, regardless of the type of reconstruction.5 Numerous additional studies document poorer outcomes in patients using tobacco products; a few among these include reviews of smokers having digital replantation surgery,6 flap reconstruction in the lower extremity,7 head and neck reconstruction,8 and breast reduction.9

The clinical evidence of adverse outcomes in smokers has resulted in several suggested practices in plastic surgery. Reduction of risk by smoking cessation is routinely discussed. Depending on the acuity of the situation and the nature of the surgery, many plastic surgeons refuse to operate until the patient has achieved smoking cessation for at least four to six weeks preoperatively and is prepared to refrain from smoking for two to four weeks postoperatively. These avoidance guidelines are offered to the patient accompanied by educational materials and information about pharmacologic replacement therapy. For some surgical candidates, it is useful to encourage compliance by alerting the patient that a serum cotinine concentration, or use of a test strip for nicotine content in the urine, will be done just before surgery. This message is accompanied by the assurance that surgery will be cancelled if there is evidence of noncompliance.

For many plastic surgeons, the response to this position on smoking is surprisingly effective and very gratifying. It is uncommon to find patients who do not express the desire to quit smoking. The majority of patients respond readily to the information about skin necrosis and tissue loss when it is accompanied by good explanations delivered by the surgeon, and successfully stop smoking through the perioperative period. This is anecdotal experience, but many never return to tobacco use and will comment later that smoking cessation turned out to be an ancillary benefit of the surgical experience for which they are grateful.

References


Dr. McGrath is professor of surgery, division of plastic surgery, University of California–San Francisco.
Retained foreign objects in surgical patients continue to be a significant public health issue. Retained foreign objects refer to any surgical sponge, instrument, or tool that is left in the patient following completion of the operation. The rate of retained foreign objects ranges from 1:1,500 to 1:19,000 operations.\(^1,2\) Roughly two-thirds of retained foreign objects are sponges, and one-third are instruments. With more than 28 million operations performed nationwide, it is possible that 1,500 retained foreign bodies occur in the U.S. each year. At that rate, a large hospital could experience one case of a retained foreign body per year.

Prevention of retained foreign objects

by LTC Paul Brisson, MD, FACS
Although 1,500 cases of retained foreign objects sounds like a large per-year number, it is a relatively small number when viewed on a national level. Individual surgeons and operating room (OR) staff members have very limited experience with this devastating complication, thus giving surgical staff members the impression that this is not a serious problem. Also, since a retained foreign body may not be identified for many years postoperatively, in some cases for as long as 25 years, the statement “that has never happened here” may not be true for any institution.3 Instruments as large as 14 inches have been left in surgical patients.4 The consequences for the patient of a retained foreign body can be devastating. Reoperation for infection, intestinal obstruction, or fistula is common. Death as a result of a retained foreign body occurs in approximately 0 to 35 percent of reported cases.1,2,5,6 The consequences for the surgeon can be equally devastating—personally, professionally, and legally.

Multiple-risk factors have been suggested by the medical community, and many interventions have been recommended in order to prevent retained foreign bodies. The tenets of this article are taken from a community hospital training program, and describe specific interventions and educational tools that can be employed to continually reinforce the principles for the prevention of retained foreign objects. The goal is not only to make preventive practices routine for the surgical staff, but also to eliminate relying on memory in the prevention of retained foreign bodies.

**Risks related to 4x4 sponge use**

The use of 4x4 (Raytec) sponges during many surgical procedures is risky due to their small size and the difficulty in identifying them on routine X rays. In abdominal cases, these sponges can be particularly hazardous due to the difficulty in palpating the sponge, and also due to the fact that X-ray identification of sponges is unreliable, despite the presence of the radio-opaque marker.2 Unfortunately many surgeons were trained to pack 4x4 Raytec sponges into small spaces, but the use of 4x4 sponges in neck and groin cases should definitely be avoided. This training program recommends elimination of 4x4 sponges completely from all cases.

**The ring is the thing**

I have been unable to identify a reported case where a surgical laparotomy sponge with an attached radio-opaque ring was left in a patient undergoing surgery, whereas thousands of laparotomy sponges without attached radio-opaque rings have been left in surgical patients. A radio-opaque ring attached to a laparotomy sponge requires a portion of the sponge, specifically the ring, to remain outside the patient. A hard ring is easier to palpate than a soft, wet sponge when performing a hand exploration of the abdomen at the conclusion of the case. A large radio-opaque ring is more easily identified on an X ray than a small, irregular radio-opaque thread. The community hospital training program on which this article is based recommends adding radio-opaque rings to all laparotomy sponges. Also notable is the fact that the authors of the Advanced Trauma Operative Management course also recommend the use of radio-opaque rings on laparotomy sponges as a patient safety initiative in all trauma cases.7

**Thorough, thoughtful search**

Prior to initiation of the wound closure, a thorough, thoughtful search of the wound should be made for foreign bodies. The surgeon must remember to perform the search—but unfortunately, memory is unreliable. Therefore, we have added a “closing checklist” to our open abdominal surgery cases. The circulating nurse reads this checklist when the surgeon announces that he is about to start his abdominal wound closure. A “thorough, thoughtful search” is part of this checklist (see Figure, page 30). The recommended checklist includes all the issues that should be reviewed at the end of the case, without relying on memory. Of notable interest: sponges or instruments that are used in closing the abdominal fascia (malleable, rubber fish, laparotomy sponges) are at particularly high risk for becoming retained foreign bodies.4,8,9

**Risk factors for retained foreign bodies**

Many risk factors have been identified regarding retained foreign objects, but our surgical department has focused on three primary concerns:

- Emergency cases
- Cases with a change in the planned procedure
Obese patients
At the conclusion of the surgical procedure, these three risk factors should be reviewed, and patients with one or more risk factors should be considered for X ray, even in the face of a normal instrument and sponge count.1,10 (A review of “High risk factors for retained foreign bodies” is also part of our closing checklist.

Recommendations
Members of the surgical staff should be made aware that this public health issue requires multiple interventions and constant vigilance, similar to other complex surgical problems. The following list highlights recommendations for the prevention of retained foreign objects.

- It is important to make sure your staff is acutely aware that the surgical count can be unreliable. It is very disappointing and alarming to learn that in 62 to 90 percent of the cases of retained foreign bodies, the surgical count was correct.2,10 Although a count is important to every case, it is only one of multiple interventions required to prevent retained foreign objects. Also, consider adding a “miscellaneous” category to the count sheet to include objects not usually listed on the count sheet.
- The staff should be made aware that intraoperative X rays, often used to rule out retained foreign bodies, can be unreliable and misread. A high index of suspicion for retained foreign bodies is required, even in the presence of a normal X ray, and, in fact, your suspicion that something is wrong may even lead to reopening the patient’s wound.11
- Surgeons should continually remind their staff about the major risk factors for retained foreign bodies, particularly emergency cases, cases with a change in the planned procedure, and obese patients. Utilize your OR newsletter, e-mail, or posters as constant reminders. Consider adding an OR checklist to eliminate the reliance on memory. Reliance on memory has been identified as a high risk factor that contributes to medical errors.12 Note that one very recent publication did not identify a correlation between these three factors and retained foreign bodies, suggesting that vigilance is required on every case.2
- Eliminate 4x4s from surgical cases. These sponges are easy to lose and difficult to detect on X ray.
- Be aware that any sponge or instrument that is used to aid the closure of the abdominal fascia is at particularly high risk for becoming a retained foreign body. If you cannot eliminate the use of sponges or tools to aid the closure of the abdominal fascia, then avoid placing the entire sponge or tool completely beneath the fascia.13
- Non-radiographically detectable sponges or towels should never be used,14 but recognize that surgical sponges that contain radiographically detectable threads are not completely reliable in the prevention of retained sponges. The X-ray detection of surgical sponges is dependent on the

Figure. Closing checklist
The following is a safety checklist that should be read at the completion of the case to ensure that important interventions have been accomplished.

Closing checklist: Open abdominal surgery

- Sponge and instrument count
- Thorough and thoughtful search of wound
- Adequate IV access
- Is a drain needed?
- Is a NGT needed or positioned?
- Is a gastrostomy or jejunostomy tube needed?
- Is a seprafilm needed?
- Is local anesthetic for wound needed?
- Is a continuous flow pain device needed?
- Are there risk factors for retained foreign objects (do we need an X ray)? Such as:
  - Emergency procedure
  - Change in procedure
  - Obese patient

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size of the sponge and its location in relation to bone.2,15

- Notify your staff that the Centers for Medicaid and Medicare Services has identified “retained foreign bodies” as a preventable event (“never event”) and that hospital costs related to this problem may not be reimbursed. Private insurers will surely follow.

- Look to the future. Private industry is far ahead of health care in the fields of quality and safety. One example is the ubiquitous use of bar coding and radiofrequency microchips to keep track of products.16 Both systems are currently available for OR use.

- Your surgical department should emphasize the urgency of the problem and identify surgeon champions and staff champions for the cause. Make “Prevention of Retained Foreign Objects” an organized performance improvement program for your department of surgery or OR committee. Articles like this one should be required reading for credentialing of your hospital’s surgeons.

There are many barriers to the institution of these changes. Long-established habits of surgeons and OR staff are difficult to change. The current goal of the community hospital training program on which this article is based is to educate surgeons and OR staffs in the processes that can provide safer surgery for their patients.

References


6. Porteous J. Surgical counts can be risky business. Can Oper Room Nurs J. 2004;22(4):6-8,10,12.


Disclaimer

The opinions or assertions contained herein are the private views of the author and not to be construed as official or as reflecting the views of the U.S. Army Medical Department, Department of the Army, or the Department of Defense. Citation of commercial organizations and trade names in this manuscript do not constitute any official Department of the Army or Department of Defense endorsement or approval of the products or services of these organizations.

Dr. Brisson is chief of surgery, DeWitt Army Community Hospital, Fort Belvoir, VA.
The ACS investment portfolio: A review and update

by Gay L. Vincent, CPA, Chief Financial Officer

The American College of Surgeons’ investment portfolio had a total market value of $372,726,670 as of June 30, 2008. Not unlike the investment experience of many ACS members, the market value of the College’s investments declined significantly from early September 2008 through the end of October 2008, resulting in an October 31, 2008, portfolio balance of $279,931,036. The market continued to decline, reaching a cycle-low in March 2009.

The College’s investment policies and the underlying investment concepts—asset allocation, diversification, and rebalancing—remain unchanged. The College has adjusted its asset allocation and diversification on an interim basis because of collateral loan requirements in connection with the financing of the building project at 20 F Street NW in Washington, DC. The current allocation is more defensive given the collateral requirement. The ACS entered into a promissory loan for the Washington, DC, project based on the fact that its investment portfolio is being used as collateral for the loan. While the collateral requirement has required the College to adjust the portfolio, the adjustment is not significant. On the positive side, the interest rate and ex-

![Figure 1: Asset allocation](image_url)

<table>
<thead>
<tr>
<th>Asset class</th>
<th>Current</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. large cap equity</td>
<td>13%</td>
<td>21</td>
</tr>
<tr>
<td>U.S. small cap equity</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>International equity</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Emerging markets equity</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Marketable alternatives</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Real assets (energy, real estate, commodities)</td>
<td>8%</td>
<td>15%</td>
</tr>
<tr>
<td>U.S. bonds</td>
<td>32%</td>
<td>20%</td>
</tr>
<tr>
<td>Cash</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
pense, which is tied to LIBOR (London Interbank Offered Rate), for the Washington, DC, project has fallen significantly below expectations, dropping below 2 percent most recently. In addition, unlike many investors whose investment funds have dried up, the College’s funds are available, and the Washington, DC, project is proceeding.

The market value of the College’s investment portfolio as of August 31, 2009, was $290,438,744. The current asset allocation, as compared with the College’s long-term target allocation, is shown in Figure 1 on page 32.

The College’s investment return compared with the Standard & Poor’s (S&P) 500 and compared with a blended 80/20 percent of S&P 500 and Barclay’s Capital aggregate bond index for the past 10 years through August 31, 2009, is shown in Figure 2, this page.

The Investment Subcommittee and the Finance Committee of the Board of Regents, with the approval of the full Board, sets and approves the College’s investment guidelines. The Investment Subcommittee and the Finance Committee will continue to address the College’s asset allocation targets in light of current market conditions and collateral requirements.
Socioeconomic tips

Complex abdominal repairs

by Mark T. Savarise, MD, FACS; Christopher K. Senkowski, MD, FACS; and Linda M. Barney, MD, FACS

This column responds to several coding questions regarding the topic of complex abdominal repairs recently posed to the ACS Coding Hotline, and raised during ACS coding workshops. The article is designed to help Fellows of the College to correctly code ventral hernia repairs.

It should be noted that ACS Fellows and their staff may consult the ACS Coding Hotline five times annually without charge. If your office has coding questions, please contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain Time, Monday through Friday, holidays excluded.

Coding for ventral hernia repairs

General surgeons have many options for how they repair ventral, incisional hernias. In recent years, more complex operations for larger ventral hernias have become more commonplace. Techniques including component separation of the abdominal wall (so-called “separation of parts”), onlay or underlay of prosthetic or biologic mesh, and laparoscopic transperitoneal approaches have been used with increased frequency. Current Procedural Terminology (CPT)* codes available for operative hernia repair have evolved, but may not always include specific codes to adequately describe current techniques. The American College of Surgeons believes that the majority of ventral hernia repair cases can be correctly coded using the CPT codes identified in this article.

Incisional hernia with mesh repair

Use codes 49560–49566, Incisional or ventral hernia repair; reducible or incarcerated, initial or recurrent, to describe the primary procedure. Code 49568, Implantation of mesh or other prosthesis, is an add-on code for use with 49560–49566. A modifier is not required with an add-on code. This code does not specify type of mesh, and therefore is

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2008 American Medical Association. All rights reserved.
appropriate for use of biological mesh. All codes in the 15000 series were specifically created for burn wounds, and fall within the skin substitute/integumentary section of the CPT Codebook.

These codes are not intended to be used for abdominal wall fascial repair. More specifically, 15330, Acellular dermal allograft, trunk, arms, legs first 100 sq cm or 1% body area of infants and children, and 15430, Acellular xenograft implant first 10 sq cm or 1% body area of infants or children, are included in this skin substitute section and do not apply to reconstruction of the abdominal wall hernia.

Some general surgeons now perform component separation of the abdominal wall, where the oblique or transversalis muscles are incised lateral to the hernia and the rectus muscles are mobilized toward the midline, to facilitate wound closure. For this operation, the use of code 15734, muscle, myocutaneous, or fasciocutaneous flap, trunk, would be appropriate; add modifier –50 if both sides are mobilized; and because this action represents an additional procedure through the same hernia incision, it should also carry the –51 modifier. Addition of CPT codes for complex closure of a wound (such as 13101, Repair, complex, trunk; 2.6 cm to 7.5 cm) is considered inappropriate, because the closure would be included in the hernia code (49560–66) and flap codes.

If the procedure requires removal of an old mesh, now infected or involved in an enterocutaneous fistula, use code 10180, I&D complex postoperative wound infection, or 11005, Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection, abdominal wall, and include 11008, removal of prosthetic material or mesh, abdominal wall for infection (if applicable). This is an add-on code and is modifier –51 exempt.

In 2009, new codes for laparoscopic repair of ventral hernias were introduced, codes 49652–49657. For the laparoscopic hernia codes, the 49568 modifier is not used, as the relative value of mesh placement is included in all of these codes. For more complicated laparoscopic procedures, such as the inclusion of separation of components, there is a code for unlisted laparoscopic hernioplasty, 49659. Procedures which are hybrid laparoscopic and open repairs should be reported with the appropriate open codes.
LaMar S. McGinnis, Jr., MD, FACS, a general and oncologic surgeon from Atlanta, GA, was installed as the 90th President of the American College of Surgeons during Convocation ceremonies that preceded the official opening of the College’s 95th annual Clinical Congress in Chicago, IL, in October. Dr. McGinnis is a senior medical consultant and advisor for the National American Cancer Society and a clinical professor of surgery at Emory University, Atlanta, GA.

A 1954 graduate of the Medical College of Georgia (MCG), Dr. McGinnis was elected to the Alpha Omega Alpha Honor Medical Society in 1953. As a MCG alum, he received the MCG Physician’s Physician Award in 1982 and its Distinguished Alumnus Award in 1988.

He completed an internship at the Royal Victoria Hospital, Montreal, PQ (1954–1955); and undertook a general surgery residency at University of Texas Medical Center, Galveston (1955–1956 and 1957–1959); and Bellevue Hospital Center, New York, NY (1956–1957). He became a diplomate of the American Board of Surgery in 1960. From 1959 to 1963, he served in the U.S. Air Force as chief of professional services and surgical services at the Plattsburg Air Force Base (SAC) in the state of New York.

Dr. McGinnis has been a fellow of the American College of Surgeons since 1962. Dr. McGinnis has been an active leader and participant in the College for more than four decades. As President-Elect, he served on the Board of Regents’ Finance, Honors, and Member Services Liaison Committees from 2008 to 2009. He is also a member of the Public Profile and Communications Steering Committee (2008–present).


From 2000 to 2001, he was Second Vice-President of the College and served on the Board
of Regents Communications Committee that year. In 1998, Dr. McGinnis was awarded the ACS Distinguished Service Award, the College’s highest honor. He is a Life Member of the Fellows Leadership Society.

Additionally, Dr. McGinnis was actively involved with the College’s Commission on Cancer (CoC) for many years. He served as Chair of the Cancer Liaison Committee (1983–1985) and the Education Committee (1987–1990), and as Vice-Chair (1985–1986) and Chair (1983–1985) of the CoC Executive Committee. Dr. McGinnis was a senior member of the CoC from 1987 to 1990, was an ex-officio member from 2001 to 2009, and also served as Georgia State Chair for the CoC’s Cancer Liaison Program (1978–1983). He was Secretary (1980–1985) and President (1986–1987) of the College’s Georgia Chapter, and since 1987 has served on the chapter’s Board of Directors.

In addition to his service to the College, Dr. McGinnis has been an active leader and member of several national surgical and medical organizations, including serving in numerous capacities within the American Cancer Society since 1983. Among his activities with the society, Dr. McGinnis has served as chair for many committees, and as the organization’s vice-president (1993–1994) and president (1994–1995).

Dr. McGinnis has also been actively involved with the American Medical Association (AMA). He was treasurer (2000–2003) and secretary (2003–2004) of the AMA Surgical Caucus and was an alternate delegate (1992–1994), delegate (1994–2006), and chair (1994–2006) of the ACS delegation to the AMA. He has been one of the College’s commissioners to The Joint Commission since 2005 and is vice-chair of the Joint Commission Resources Board. In addition, Dr. McGinnis was first vice-president of the Southern Surgical Association (2004–2005), president of the Southern Society of Clinical Surgeons (1997–1998), and president (1986–1987) and secretary (1991–2001) of the Georgia Surgical Society.

He is also a member of the American Society of Clinical Oncology, Eastern Surgical Society, Society of Surgical Oncology, and Southeastern Surgical Congress. Additionally, he is a member of the Atlanta Surgical Society, Clinical Oncology Association of Atlanta, Georgia Society of Clinical Oncology, the Atlanta Medical History Society, the Gridiron Secret Society, and is an honorary member of the Midwest Surgical Association. From 1988 to 1990, Dr. McGinnis chaired the Governor of Georgia’s Cancer Advisory Committee.

Throughout his distinguished career, Dr. McGinnis has shown a commitment to the dissemination of surgical and oncologic knowledge and to improving the quality of surgical care. Many of his articles and clinical studies have been published in medical periodicals and in surgery and cancer journals, including Cancer and the Journal of Surgical Oncology.

Dr. McGinnis currently resides in Atlanta with his wife Julia. They have two sons, L. Scott and Christopher, and two daughters, Susan and Katherine.

Honorary Fellowships presented to five prominent surgeons

Honorary Fellowship in the American College of Surgeons was awarded to the following five prominent surgeons from Japan, the United Kingdom, Sweden, Argentina, and Nigeria during Convocation ceremonies at this year’s Clinical Congress in Chicago, IL:

- Masaki Kitajima, MD, FACS, FRCS(Hon), FASA (Hon). Dr. Kitajima is president of International University of Health and Welfare’s Mita Hospital, Tokyo, Japan.
- Sir Bruce Edward Keogh, KBE, BSc, MD, FRCS, FESC, FETCS. Professor Sir
Keogh is medical director of the National Health Service, London, and professor of cardiac surgery, University College, London. He is also the director of surgery, The Heart Hospital, London, United Kingdom.

- **Ingemar Ihse, MD, PhD, FRCS.** Dr. Ihse is emeritus professor of surgery, Lund University, and director of practicum, Lund Clinical Skills Centre, Lund, Sweden.
- **Vicente P. Gutierrez, MD, MAAC, FACS.** Dr. Gutierrez is a consultant for Hospital de Clínicas, Buenos Aires, and Professor Emérito, Universidad de Buenos Aires, Argentina.

- **Adelola Adeloye, MB, MS, FRCP(Edin), FRCS(Eng), FACS, FWACS, FMCS(Nig), FAS, FCOSECA.** Professor Adeloye is professor of neurological surgery, University College Hospital, Ibadan, Nigeria.

Presenting the Honorary Fellowships on behalf of the College will be Edward R. Laws, MD, FACS, Boston, MA; Carlos A. Pellegdini, MD, FACS, FRCSI(Hon), Seattle, WA; Richard A. Prinz, MD, FACS, Chicago, IL; Timothy J. Gardner, MD, FACS, Newark, DE; and Thomas R. Russell, MD, FACS, Chicago, IL.

This year 1,259 surgeons from around the world were admitted into Fellowship during the College’s Convocation ceremonies.

Sir Rickman Godlee, President of the Royal College of Surgeons of England, was awarded the first Honorary Fellowship in the College during the College’s first Convocation in 1913. Since then, 418 internationally prominent surgeons, including the five chosen this year, have been named Honorary Fellows of the American College of Surgeons.

Following are the citations presented during the Convocation.

**Citation for Prof. Adelola Adeloye**

*by Edward R. Laws, MD, FACS*

Mr. President it is a great pleasure to introduce Prof. Adelola Adeloye of Ibadan, Nigeria, for Honorary Fellowship in the American College of Surgeons. He is the most revered figure in all of African neurosurgery, setting a marvelous example for all who have followed him.

In the U.S., we have one neurosurgeon for approximately 60,000 of our citizens. In Africa, this number is one to 250,000, and there are some countries where the figure is one to 16 million people. It is difficult to imagine the courage and dedication of those individuals willing to take on the daunting challenge of providing neurosurgical care under such circumstances. Professor Adeloye has done so, and has done it with grace, wit, and intellect that complement his surgical and educational skills.

Born in Nigeria, Professor Adeloye received his medical education at the University College of London’s affiliate, University College Medical School in Ibadan. His surgical and neurosurgical education were completed in the UK, culminating in his fellowship in the Royal College of Surgeons of England. He completed an MS thesis in neurological surgery, and was a registrar at The National Hospital at Queen Square, under Mr. Valentine Logue and Mr. Lindsay Symon, who also became an Honorary Fellow of the American College of Surgeons.

Upon returning to Nigeria, he served with distinction during the Nigerian Civil War at the Base Hospital, organized by the University College Hospital, Ibadan. This experience was the foundation for his world-renowned expertise in missile wounds and head injury, the subject of one of his many books. Later he was to spend two years as head of a neurotrauma unit in Kuwait, and was actively saving...
lives during the Iraq invasion of 1990.

Ultimately, Dr. Adeloye became professor and chair of neurosurgery at the University College, Ibadan, serving with distinction until his retirement in 1995. During his 24-year tenure there, he was responsible for training many outstanding African neurosurgeons and was a superb administrator, investigator, and clinical surgeon.

His educational activities included 10 years as a consultant to the Queen Elizabeth Hospital in Malawi, helping to develop a fine neurosurgical unit there.

His academic work in neurosurgery includes many original scientific papers and monographs, and the original description of congenital dermoid cyst of the anterior fontanel, which bears his eponym.

A man for all seasons, Professor Adeloye is a published poet, biographer, historian, and essayist. His wife is a physician, and their family is also extraordinary. One of his several books is a charming account of his amazingly talented father, entitled A Village Genius.

Mr. President, it is my special honor to present Prof. Adelola Adeloye for Honorary Fellowship in the American College of Surgeons. His compassion and kindness are legendary, and along with his dedication and energy, help him stand as a superb role model for all of us in our lives and our work as Fellows of the American College of Surgeons.

Citation for Prof. Vicente Patricio Gutierrez

by Carlos A. Pellegrini, MD, FACS, FRCSI(Hon)

Mr. President, it is a great pleasure to introduce Prof. Vicente Patricio Gutierrez of Buenos Aires, Argentina, for Honorary Fellowship in the American College of Surgeons.

Born in Buenos Aires in January of 1932, Professor Gutierrez’s roots were very influential in his life. Indeed, his mother came from a family of Irish immigrants, who had come to Argentina seeking the rich soil of the pampas to feed and raise their cattle. They instilled in our honoree a sense of hard work, adventure, the pursuit of new horizons, and love for the farm. He developed admiration, understanding, and respect for those who work the land.

His father, whose own family had roots in Spain, was an academic surgeon of great reputation. He became Professor Gutierrez’s closest teacher and mentor in his professional life, and someone he always tried to emulate.

Professor Gutierrez graduated with honors from the University of Buenos Aires and specialized in surgery of the gastrointestinal tract. His interest in research took him to Sheffield, England, where he joined Sir Andrew Kay’s physiology laboratory. He worked side by side with Leslie Blumgart, MD, with whom he became lifelong friends.

Upon return to his alma mater in Buenos Aires, he joined the faculty, and through intense research, education, and clinical practice, he rose through the ranks to become the chair of the prestigious department of surgery in 1982.

Anyone who has ever met Professor Gutierrez would describe him as the ultimate gentleman. He is a generous man, someone who always places the needs of others before his own. Those character traits were best exemplified in his development of a model residency program in surgery at the University of Buenos Aires.

At the time, developing and running such a residency program meant overcoming the fear that residents would detract...
from the faculty members’ opportunity to grow. It also meant that the leader had to walk the fine line of balancing the safety of patients with the training needs of residents, in a world where direction from regulatory institutions was not available. He expanded the traditional training in surgery by integrating the values of trust and ethics and the power of an attitude of lifelong learning among his trainees. He wrote many beautiful and insightful papers dealing with the responsibility that physicians in general, and leaders in particular, must bear.

At the end of his tenure at the university, two elements of his personality had left a distinct legacy for the institution and a “branding” mark in every one of his graduates: a profound respect for patients and colleagues, and a unique ability to embrace change when change means opening opportunities, enhancing education, and improving patient care. His inspirational leadership and his intense dedication to being a role model made him the natural leader of a young generation of surgeons.

Professor Gutierrez brought Advanced Trauma Life Support® (ATLS®) training to Argentina in 1989. The ATLS program expanded rapidly through the provinces and through many other countries in South America, helping save many lives. He served the American College of Surgeons in many other capacities, including his role as Governor for the Argentine Chapter, and as a member of the International Relations Committee.

Because of his many contributions, the major societies in surgery and gastroenterology in Argentina recruited him for leadership positions. He considered those positions, as he once wrote, as “challenges” rather than “honors.” And, true to his word, he used those positions to fuel changes that led to improvements in the quality of care, and to the integration of professionalism and ethics among practicing gastroenterologists and surgeons.

He has received some of his country’s top awards in many fields of endeavor and has been recognized with Honorary Fellowship in several surgical and medical societies, including, most recently, the American Surgical Association. Perhaps closest to his heart was his election to the presidency of the National Academy of Medicine in Argentina, which was created in 1822, and stands as the oldest and most prestigious such academy in Latin America.

Mr. President, it is said that “a teacher affects eternity because one can never tell where his influence stops.” I am honored to present to you a teacher of teachers, a role model for generations of surgeons in his country and around the world, Prof. Vicente Patricio Gutierrez Maxwell, to receive Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Ingemar Ihse

by Richard A. Prinz, MD, FACS

Mr. President, it is my distinct honor to present to you Prof. Ingemar Ihse, of Lund, Sweden, for Honorary Fellowship in the American College of Surgeons.

Professor Ihse was born in Ystad, a Hanseatic town located at the southern tip of Sweden. After completing his grammar and high school educations there, he entered medical school at Lund University and began a career-defining association with that institution.

He completed his surgical residency and obtained a PhD in surgery at Lund University. He went on to develop his clinical and research interests in the pancreas, and joined the faculty of medicine at the university as an assistant professor. Because of his productivity as a teacher, clinician, and researcher, he was quickly promoted to associate professor.
Professor Ihse was then lured away to become professor and chairman of surgery at Linkoping University. Under his leadership, the department became a recognized center for the investigation and management of pancreatic disease. Lund University recruited him back to become professor of gastrointestinal surgery and chairman of surgery. His department quickly became the leading center for pancreatic disease in Sweden and was internationally acknowledged for its expertise. His knowledge and administrative skills were then put to the test when he was appointed the medical director of Lund University Hospital. He initiated financially sound programs to improve the medical care provided to the inhabitants of Scania, and he promoted cooperation among the neighboring health care institutions. Currently, Ingemar Ihse is Emeritus Professor of Surgery at Lund University.

Professor Ihse has published more than 300 peer-reviewed articles and 96 book chapters, and coedited Surgery of the Pancreas. He has been an editor of HPB, the official organ of the International HepatoPancreato Biliary Association, and the Scandinavian Journal of Gastroenterology, and has been a member of 12 editorial boards. He has been president of the European Surgical Association, the IHPB Association, and six other medical organizations. He is an honorary fellow of seven surgical organizations, including the American Surgical Association and the Royal College of Surgeons of England.

In addition to the many professional accomplishments of his surgical career, Professor Ihse continues to make new contributions to help patients in Scandinavia and worldwide. He has organized and developed a clinical skills training center in Lund. This is the first center in Scandinavia that allows practicing physicians and trainees to learn new technology and its uses in a controlled environment before applying it to patients. He chairs the board of Coloplus AB, a biotech and functional food company committed to delivering improved nutrition to third-world populations, especially those with HIV/AIDS. He is also the founder of AMeC, an information company providing patient access to recognized medical experts so that they can obtain a second opinion about their health problems.

Professor Ihse developed a Chicago connection while he was a student, and then a faculty member, at Lund University. The student social clubs put on skits, and one of their favorite subjects is Chicago gangsters. During his visits to Chicago, Professor Ihse has expanded his interest in this hobby. He crashed the party celebrating the closure of the jail where Al Capone was first imprisoned. He has also appeared on stage doing a Jimmy Cagney impersonation at one of our local restaurants called Tommy Guns.

Prof. Ingemar Ihse clearly embodies all of the attributes we expect of an Honorary Fellow of the American College of Surgeons. Mr. President, it is my privilege to present this leading pancreatic researcher and surgeon, this accomplished health care administrator, this innovator in surgical education and access to care, for Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Bruce E. Keogh

by Timothy J. Gardner, MD, FACS

Mr. President, I am pleased and honored to introduce Prof. Bruce E. Keogh of London, England, for Honorary Fellowship in the American College of Surgeons. Since 2004, Sir Bruce has been professor of cardiac surgery at the University College, and has served as director of surgery at the Heart Hospital in London. In addition, Professor Keogh has been the medical director of the UK’s National Health System since November 2007. As such, he is responsible for all of the clinical programs and the health care quality activities, as well as the pharmacy and industry directorates, within the Department of Health.

Professor Keogh was the British Heart Foundation senior lecturer and consultant...
Professor Keogh

Sir Bruce currently serves as the international Councilor of the Society of Thoracic Surgeons. Other positions have included his five-year tenure as secretary general for the European Society of Cardiothoracic Surgery, president of the Society for Cardiothoracic Surgery in Great Britain and Ireland, and his membership on the Council of the Royal College of Surgeons of England. More recently, he served as president of the cardiothoracic section of the Royal Society of Medicine.

Professor Keogh was born and raised in Rhodesia (now Zimbabwe), where his father was a newspaper editor. He gained entry to the UK by virtue of his Irish roots, which entitled him to an Irish passport. After arriving in the UK, he entered medical school, where he met and married a classmate, Dr. Anna Keogh, a practicing internist. They have raised four sons: Robbie, Christopher, William, and Mike.

Mr. President, it is my special honor to present Sir Bruce Keogh, who is leading the transformation of health care delivery in the UK, for Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Masaki Kitajima

by Thomas R. Russell, MD, FACS

Mr. President, it is my honor to present Prof. Masaki Kitajima of Tokyo, Japan, for Honorary Fellowship in the American College of Surgeons. Professor Kitajima was vice-president of the International University of Health and Welfare from April 2007 through June 2009. He currently is president of International University of Health and Welfare in Tokyo.

Professor Kitajima is truly the renaissance Japanese surgeon. He trained in Japan and did a fellowship in the department of surgery at the Massachusetts General Hospital in 1975. Following that fellowship, he returned to Keio University and Kyorin University School of Medicine and has spent the majority of his professional life at those two institutions. He is fluent in English, and comfortable with the Western lifestyle. Professor Kitajima truly has been a promoter and strong advocate for modernizing the Japanese surgical community through evidence-based
surgical practice. He has a huge influence on surgeons in Japan, in both academic and institutional practices, and he has been a strong advocate for health care reform at the highest professional, political, and governmental levels.

As a member of numerous Japanese professional organizations and international organizations, he has held the presidency position of the Japan Society of Clinical Oncology and of the 103rd International Surgical Society. As a long-standing Fellow of the American College of Surgeons, Professor Kitajima was a Governor representing the Japan Chapter of the College; he is also an honorary fellow in the German and Hungarian Surgical Societies as well as in the American Surgical Association.

An acknowledged oncologic surgeon and associated researcher, Professor Kitajima has served the Ministry of Health, Labor, and Welfare in Japan by participating on expert panels that have worked to chart the future course for cancer research and cancer care, and has also served on numerous other councils and expert panels to plan and implement comprehensive cancer care in Japan. In addition to his clinical, research, and teaching activities related to surgery, he has been intimately associated with governmental and political activities aimed at reforming the health care system in Japan. He has published numerous books and papers, primarily in the area of cancer care and prevention.

Recognized and acclaimed in Japan, and internationally, as a master surgeon, Professor Kitajima possesses a wonderful personality and has a strong commitment to the ethical principles governing behavior, and to professionalism. He has achieved the highest offices in his profession in Japan in both the academic and political arenas. These days, Professor Kitajima and his wife, Hiroe, are enjoying a more relaxed pace in semi-retirement.

Mr. President, it is with great pleasure that I present Prof. Masaki Kitajima, a master surgeon with the highest qualities of professionalism, for Honorary Fellowship in the American College of Surgeons.

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**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:

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

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at [http://www.facs.org/trauma/cme/traumtgs.html](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312-202-5342.
The National Ultrasound Faculty of the American College of Surgeons has developed “Ultrasound for Surgeons: The Basic Course, 2nd Edition” on CD-ROM for surgeons, surgical residents, and anyone interested in ultrasound imaging.

The 2nd Edition includes:

♦ Updated graphics using 3-D medical modeling developed by NASA researchers to teach ultrasound and rapidly demonstrate key ultrasound skills
♦ Targeted clinical applications are highlighted, including Head and Neck, Breast, Vascular, Abdominal, Thoracic, Critical Care/Trauma, Foreign Objects, and Fractures
♦ Cue Cards to view and print to prompt learners on three commonly performed scans
♦ Easier navigation and support of the CD-ROM
♦ Four CME credits available

The CD-ROM provides the learner with basic education and training in ultrasound imaging as a foundation for specific clinical applications.

To purchase the NEW edition, go to www.acs-resource.org or call 888-711-1138.
A look at The Joint Commission

Center for Transforming Healthcare takes aim at patient safety failures

Teaming up with top hospitals and health systems across the country to use new methods to find the causes of, and put a stop to, dangerous and potentially deadly breakdowns in patient care, The Joint Commission launched the Center for Transforming Healthcare in September. The center’s first initiative is tackling hand-washing failures, which contribute to health care-associated infections, killing nearly 100,000 Americans each year and costing U.S. hospitals $4 billion to $29 billion annually to combat.

Eight leading hospitals and health systems volunteered to address hand-washing failures, which fix far more complex than simply putting up signs urging caregivers to wash their hands. Participants in the center’s first project include:

- Cedars-Sinai Health System, Los Angeles, CA
- Exempla Lutheran Medical Center, Wheat Ridge, CO
- Froedtert Hospital, Milwaukee, WI
- The Johns Hopkins Hospital and Health System, Baltimore, MD
- Memorial Hermann Health Care System, Houston, TX
- Trinity Health, Novi, MI
- Virtua, Marlton, NJ
- Wake Forest University Baptist Medical Center, Winston-Salem, NC

Recognizing that there is no quick fix, the participating hospitals set out to solve the problems—which included soap or alcohol-based hand rubs that were not convenient for caregivers to use, faulty data that lull facilities into thinking hand-washing is occurring more frequently than it is, and lack of individual accountability—by using Robust Process Improvement™ tools.

The front-line work of the hospitals shows that random observation is not enough. In fact, the eight hospitals, which used the center’s measurement methods consistently, found, on average, that caregivers washed their hands less than 50 percent of the time.

The targeted solutions from the center now being tested include holding everyone accountable and responsible—doctors, nurses, food service staff, housekeepers, chaplains, technicians, therapists; using a reliable method to measure performance; communicating frequently and using real-time performance feedback; and tailoring education in proper hand hygiene for specific disciplines.

The center’s work to identify and measure poor quality and unsafe health care will lead to the development and testing of targeted, long-lasting patient safety solutions. These proven and practical strategies, based on methods, such as Lean Six Sigma, long used by other industries, can help transform U.S. health care into a high-reliability industry that ensures patients receive the safest, highest quality care they expect and deserve.

Hand-washing is the center’s first patient safety challenge. The next project will involve safety experts and leading hospitals—including Fairview Health Services, Minneapolis, MN; Intermountain Healthcare, Salt Lake City, UT; Kaiser Permanente, Portland, OR; Mayo Clinic, Rochester, MN; North Shore-Long Island Jewish Health System, New York, NY; Partners HealthCare System, Boston, MA; New York-Presbyterian Hospital, New York, NY; and Stanford Hospital & Clinics, Stanford, CA—will target breakdowns in hand-off communications. A hand-off is a transfer and acceptance of patient care responsibilities achieved through effective communication.

Future projects will focus on improving other aspects of infection control, mix-ups in patient identification, and medication errors. The Joint Commission will share information about the proven solutions with its more than 16,000 accredited health care organizations nationwide to prevent bad outcomes that
touch thousands of Americans each year. The center is grateful for the generous leadership and support of the American Hospital Association, BD, Ecolab, GE Healthcare, and Johnson & Johnson, as well as the support of the Federation of American Hospitals and Hospira. For more information about the Joint Commission Center for Transforming Healthcare, visit www.centerfortransforminghealthcare.org.

Honor the perioperative professional on your surgical team

Perioperative Nurse Week, November 8–14, is a week set aside to recognize and honor perioperative nurses for their important role and commitment to safe patient care. The AORN Foundation is pleased to provide surgeons with the opportunity to honor their colleagues by making a donation to the foundation in their name. An acknowledge-ment note on your behalf will be sent to each colleague who is honored through a donation to the AORN Foundation.

The AORN Foundation is the philanthropic arm of the Association of periOperative Registered Nurses (AORN). In existence since 1992 as a 501(c)(3) charitable organization, the AORN Foundation advances surgical patient safety by supporting nurses through education and research. Your generous gift will reflect your gratitude and support for the perioperative nursing community.

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The American College of Surgeons is offering the 10th biennial Surgical Investigators Conference March 5–7, 2010, at the Bethesda North Marriott Hotel and Conference Center in North Bethesda, MD. The conference is designed to assist surgeon-scientists in obtaining extramural, peer-reviewed grant support for their work; to introduce them to the process, content, style, and people involved in successful grant-writing; and to interact with representatives of the National Institutes of Health (NIH).

As participants, surgeon-scientists meet their peers, selected mostly from surgery departments in U.S. and Canadian academic medical centers. The conference provides opportunities to meet and talk with key NIH staff and many of the leading surgeon-scientists who have been successful in obtaining NIH grant support for their work and who participate in the conference as leaders of various small-group meetings and as plenary session speakers.

The program includes intensive exposure to the following:
- NIH programs and policies
- What programs are most appropriate and available for your research project and how to apply
- Grant-writing strategies
- Workshops in hypothesis testing, methodology, background, and preliminary results
- Networking with representatives from 10-12 institutes about research priorities, pilot programs, and training grants targeted to new investigators
- Mock study sections reviewing model grants

The conference fee is $1,825 USD ($1,695 if registration and payment are received by December 17, 2009). This fee includes all related conference materials, meals, breaks, receptions, and lodging for two nights. Confirmation is contingent upon payment of the course fee and is subject to availability. Preference is given to surgeon members of the ACS. The deadline for registration is January 22, 2010.

Information and a registration form are available on the College’s Web site at www.facs.org/cqi/src/surginvconf.html. Direct questions to Mary Fitzgerald at mfitzgerald@facs.org or call 312-202-5319.

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The American College of Surgeons Oncology Group (ACOSOG) has reached another important milestone: ACOSOG Z1031 is a phase III neoadjuvant aromatase inhibitor trial for estrogen receptor-positive, stage II/III postmenopausal breast cancer patients. The trial was activated in June 2005, and in August 2009 it completed patient enrollment (sample size = 375). The top 10 enrolling sites are listed in the Figure on this page. There were 100 enrolling sites in total, and each site should be congratulated for this accomplishment.

Z1031 is a significant milestone for many reasons. First, this is the largest cooperative group neoadjuvant aromatase inhibitor trial to have been conducted to date. Second, and most importantly, the trial included a mandatory pretreatment research core needle biopsy of the primary tumor and peripheral blood collection. This required the surgeon to obtain informed consent for the trial treatment and for the research biopsy. Because patient eligibility criteria required a palpable stage II or III breast cancer, many of these biopsies were performed by surgeons. More than 95 percent of enrolled patients have a pretreatment tumor tissue stored in the ACOSOG central tissue bank. These specimens will be crucial for conducting laboratory investigations.

An important therapeutic question to consider involves the question of why there is a 60 percent tumor response rate when estrogen receptor-positive breast cancers are treated with an aromatase inhibitor. Scientists now have the tissue to study mechanisms of resistance, and such discoveries could lead to new therapeutic options for estrogen receptor-positive breast cancer patients.

A good example of new therapeutic options is already being incorporated into an amended Z1031. Z1031 has been amended to enroll an additional 140 subjects. Ki67 is a biomarker for tumor proliferation, and laboratory studies have shown that if tumor Ki67 is >10 percent after two to four weeks of aromatase inhibitor (AI) therapy, the ER+ breast cancer is unlikely to respond well to endocrine treatment. The amended Z1031 protocol, therefore, requires a second research biopsy in the two to four week window to assess Ki67. The biomarker information will be returned to the treating oncologist, who can recommend switching to neoadjuvant chemotherapy or continued aromatase inhibitor treatment.
The tissue specimens of Z1031 are annotated with clinical tumor response data in a very specific therapeutic trial. Further laboratory investigations are under way to identify the next generation of biomarkers that predict response to AI therapy. Whole genome DNA sequencing of 50 primary tumors from Z1031 is being planned. These could help us identify somatic tumor mutations or gene amplification associated with tumor resistance.

Z1031 has the potential to become the neoadjuvant therapy model for future trial designs. Surgeons see patients with primary breast cancer, which is accessible to local biopsy. For a surgeon-oriented cooperative, ACOSOG is well-positioned to take advantage of neoadjuvant therapeutic trial designs that incorporate fresh tissue collection; this tissue collection would apply to many solid tumors that are accessible to outpatient biopsy.

The ACOSOG Central Specimen Bank is funded by a National Cancer Institute core grant, and is designed to store appropriately preserved specimens. If you have a trial idea which requires multi-site participation and an associated specimen collection for your correlative science studies, you are welcome to contact ACOSOG (Dr. Ota or Dr. Nelson) at david.ota@duke.edu or nelsonh@mayo.edu. ACOSOG conducts therapeutic trials for breast, gastrointestinal, and thoracic malignancies.

Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG Co-Chairs.

Dr. Ellis, of St. Louis, MO, is Z1031 study chair.

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#S8 Solid 14K Gold $275

Charm (Not Shown)
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#S10 Solid 14K Gold $400

Miniature Charm
#S11 Dbl Gold-Filled $60
#S12 Solid 14K Gold $250
#S13 Sterling Silver w/ 18" Sterling Silver Neckchain $65

Ring
#S14 Solid 14K Gold $1375
#S14.1 Solid 10K Gold $725

Tie Bar
#S15 Gold-Filled Emblem $50

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#S19 Satin Silver Finish $415
8-1/2" x 11-1/2" walnut. Specify name, day, month, year selected.

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#S23 Maroon $35

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When referring to transportation of the injured patient, getting the right patient to the right place in the right amount of time may be not be as simple as it sounds. The “golden hour” concept from the Advanced Trauma Life Support® course describes the time period from a few minutes to several hours following a traumatic injury, during which there is the highest likelihood that prompt medical treatment will prevent death. Prompt recognition of the injured patient who requires trauma care, and where to take them, are only parts of the overall equation. How to get that patient from the scene to that trauma center may be more complicated due to local factors such as geography and trauma center availability, and may require more than one mode of transport.

When reviewing the coverage maps provided by the Trauma Information Exchange Program (TIEP) the majority of the U.S. population (82.6 percent in the Continental U.S., 70 percent in Alaska, 55 percent in Hawaii) are within 60 minutes transport to a Level I or II trauma center, by either ambulance or helicopter. TIEP is a program of the American Trauma Society, in collaboration with the Johns Hopkins Center for Injury Research and Policy, and funded by the Centers for Disease Control and Prevention. That leaves at least one-fifth of the population outside of that 60-minute transport time to a Level I or Level II center. Those patients may require either definitive treatment at a Level III, IV, or V trauma center or stabilization and transfer to another level of care. These patients may need multiple modes of transport to get from the scene of injury to definitive trauma care.

In order to examine the occurrence of patients requiring more than one transport provider prior to arrival at definitive care in the National Trauma Data Bank® research dataset 2007, admissions records were searched for the field “other transport mode.” This field is defined by the National Trauma Data Standard as all other modes of transport used during a patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital. 68,989 incidents were found with other transport mode filled out, and of these, 58,318 records had discharge status recorded, including 43,442 discharged to home, 6,433 sent to nursing homes, and 6,017 to acute care...
rehabilitation; 2,426 died. These patients were 67 percent male, and, on average, 38.6 years of age; they had an average length of stay of 6.1 days, and an average injury severity score of 10.3. The modes of other transport were known for 68,586 records, including 49,123 by ground ambulance, 15,384 by private/public vehicle, 3,496 by helicopter ambulance, 3,006 by police, and 215 by fixed-wing airplane ambulance (these data are depicted in the figure on page 51).

Since, for some, there remains a geographic disparity between the location of the trauma victim and the nearest appropriate trauma center, injured patients may at times take an indirect route to definitive trauma care.

The full NTDB Annual Report Version 8.0 is available on the ACS Web site as a PDF and a PowerPoint presentation at http://www.ntdb.org.

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

Acknowledgment

Statistical support for this article has been provided by Chrystal Price, data analyst, NTDB.

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.