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In order to succeed, surgeons and surgical trainees will need to have a better sense of how the business world operates, while still maintaining surgery’s enduring standards of clinical expertise and professionalism.

Business and medicine

Of course, business and medicine have been tied to one another for several decades—often to the detriment of patient care. Indeed, as the health care sector has grown into a big business, it has adopted many of the market-based philosophies that drive corporations, including the notion that “bigger is better.” Our patients have come to believe that more tests, more procedures, and more medications equal better care, and payors have provided physicians with incentives to meet “consumer demand.”

As a consequence, health care costs have spiraled upwards of $2.2 trillion a year. Most lawmakers, patients, business leaders, health care professionals, and other stakeholders agree that the current system is unsustainable and is putting American businesses at a competitive disadvantage. Some corporate executives have gone so far as to claim that the cost of providing just health insurance alone to the head of an American family outweighs the total compensation, including wages and benefits, given to an employee in a developing country.

In other words, businesses say they are being forced to outsource jobs, in part because of rising health care costs.

New way of doing business

Given these realities, controlling costs has become a key goal of health care reform. Many of the solutions that the government and other stakeholders are suggesting in order to cap spending are rooted in practices the private sector has been applying for decades—increased use of information technology to maintain records and to handle basic communications, incentives for providing high-quality services, evidence-based guidelines, and so on.

Hence, if surgeons want to effectively lead the change from a market-driven system to one that is value-driven, they must be armed with at least a rudimentary knowledge of economics and fiscal policy, as well as an understanding of how businesses work to limit costs. They also must be able to look at their own practices and determine what they could be doing differently to provide more effective and efficient care.

Many hospitals that have experienced financial problems are already being forced to merge with facilities to avoid closure. Indeed, half of all hospitals are now part of organized systems, typically anchored by large teaching institutions. Some experts predict that these networks could benefit patients and the medical system as a whole in the following ways: (1) by building up physician workforces that can adequately meet patient demand; (2) by

From my perspective

One of the primary functions of the American College of Surgeons has been to help surgeons-in-training prepare for the challenges they face upon entering practice. The current generation of young surgeons will be confronted with a work environment that has undergone much change in recent years and that will no doubt evolve further in the near future. Hence, the College and academic institutions must reshape some programs to conform to the new expectations being placed on this new generation of surgeons.

The new health care milieu is likely to be characterized by the intersection of business and professional values and practices. In order to succeed, surgeons and surgical trainees will need to have a better sense of how the business world operates, while still maintaining surgery’s enduring standards of clinical expertise and professionalism.

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Many hospitals that have experienced financial problems are already being forced to merge with facilities to avoid closure. Indeed, half of all hospitals are now part of organized systems, typically anchored by large teaching institutions. Some experts predict that these networks could benefit patients and the medical system as a whole in the following ways: (1) by building up physician workforces that can adequately meet patient demand; (2) by
investing in uniform health information technology systems; and (3) by working with clinicians to use resources more efficiently, eliminate errors, and better manage patients with chronic illnesses.³

Many provider networks already in place are implementing more value-based, coordinated models of care. Health care providers that have come to epitomize the public’s perception of value-driven, high-quality care include the Cleveland Clinic, Geisinger Health System, the Mayo Clinic, Kaiser-Permanente, and so on. Patients at these institutions receive evidence-based care from highly coordinated teams of health care professionals, from the moment they are admitted into the system until they leave it. The fact that surgeons will need to play a leadership role in teams-based systems of care has been widely acknowledged in the surgical literature.

What we need to work on, however, is building a curriculum that will assist young surgeons in negotiating their contracts with these health care systems. Most health care professionals on staff at provider networks are paid annual salaries, and surgeons who are attracted to the financial stability and defined work schedules these situations afford rarely have experience in contract negotiations. The College has offered workshops that address this concern, and the 2009 Leadership Conference featured a session on the topic. However, we will likely need to provide more programs centered on this issue, and medical schools and training institutions will need to start adding related courses to their curricula.

In addition, provider networks will offer financial incentives to produce the best possible outcomes. Because of their unique understanding of patient care, physicians and other health care professionals likely will be called upon to define which elements of clinical data could translate into improved performance, to help interpret outcome measures, and to then design effective responses. Hence, surgeons will need to be properly trained in quality measurement methodologies and the management of organizational change.⁴

Principles

U.S. health care is at a crossroads. As the nation seeks to implement a value-based health care system, we will most likely incorporate certain strategies that have worked in the business world. Young surgeons must be prepared to address these new policies, understand how they work, and learn what they need to do in order to position themselves for success in new delivery models. Professional organizations, medical schools, and training programs are obligated to provide the next generation of surgeons with the business acumen they will need to be leaders in patient care.

It is also imperative, however, that we continue to be the standard bearers of our profession’s ethical and philosophical tenets. Young surgeons will need to apply these principles as the leaders of patient care teams and as the guardians of patient safety. And it goes without saying that we must continue to be mindful of the fact that our primary responsibility is to provide medical students, residents, and practicing surgeons with the technical skills and cognitive knowledge they need to provide excellent care for their patients.

As the business and health care sectors continue to intersect, we must continue to work to fulfill our traditional mission of instilling in young surgeons the principles that set professionals apart from profiteers.

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
Mentorship program
designed to advance
women in academic surgery

by Lola Butcher

Trauma surgeon Kathryn M. Tchorz, MD, FACS, can see her career unfolding in front of her. “I know the kind of future leader I will become because of Mary McCarthy, and I will be that leader because I am being groomed to do that,” said Dr. Tchorz, associate professor at Wright State University Boonshoft School of Medicine in Dayton, OH.

Mary C. McCarthy, MD, FACS, a professor of surgery at Wright State, is Dr. Tchorz’ mentor through the Early Career Women Faculty Mentorship Program, jointly sponsored by the Women in Surgery Committee of the American College of Surgeons and the Association of Women Surgeons (AWS). The purpose of the program is to help early-career assistant professors achieve promotion and tenure.

“The whole idea is to break the glass ceiling that still exists today,” said M. Margaret Kemeny, MD, FACS, director of the Queens Cancer Center; professor of surgery at Mount Sinai School of Medicine, New York, NY; and Chair of the Women in Surgery Committee.

Top photo: Dr. McCarthy at work. Right-hand photos, top to bottom: Dr. Tchorz, Dr. Kemeny, Dr. Sanfey, and Dr. Harthun.
History of women in surgery

Women have been performing surgery in the U.S. since the “beardless lad”—an army surgeon known as Dr. James Barry—operated during the Napoleonic wars. When Dr. Barry died in 1865, she was discovered to be a woman, shocking even her closest associates.

The ACS admitted its first female member in 1913, and five or fewer women each year thereafter, until 1975, according to an AWS presentation by Dixie J. Mills, MD. The number of women applying to medical school began to increase in the 1970s, but the prevalence of women in surgery has never matched that of other medical specialties. Since the AWS was founded in 1981, the number of women surgeons has grown significantly. The organization has been represented on the ACS Board of Governors since 1995. The association’s goals are to promote professional growth and advancement, to facilitate interaction among female surgeons around the world, to advocate the highest standards of competence and ethical behavior—and to foster an environment supportive of personal values and individual diversity. A supportive environment has been sorely lacking, according to many successful women surgeons.

When Dr. Kemeny started her residency in 1972, the very few women who were practicing surgery at that time were the victims of sexist prejudice. “We were discriminated against, and it was extremely hard for us to get into academia, and for us to stay in academia,” said Dr. Kemeny.

Of course, many more women are choosing surgery as a profession today, although not in proportion to their total numbers in medical residency programs. Although women accounted for 44.6 percent of all medical residents in 2007, only 30.8 percent of surgical resident slots were filled by women that year. (See Figures 1 and 2, pages 11 and 12.)

Similarly, women are underrepresented in the faculty ranks. Women account for 34 percent of the faculty members in basic sciences, clinical sciences, and related departments such as dentistry and veterinary sciences. But they fill just 18 percent of surgical faculty positions, and only 7 percent of full professor positions, according to the Association of American Medical Colleges.

“We have a very, very low rate of full professors of surgery,” Dr. Kemeny said. “We still feel there’s a glass ceiling there, and that’s what we want to go after.”

How the program works

The mentoring program, now in its second round, is open to women who are assistant professors in academic practice in general surgery, or a general surgery subspecialty. The 15 early career surgeons, all of whom are Fellows or Associate Fellows of the College, or are in the process of applying for Fellowship status, will convene at the ACS Clinical Congress in Chicago, IL, in October to meet members of the mentorship program committee.

After mentorship matches are made, the mentors and mentees will work together to help the mentees achieve a promotion to associate professor, and to reach other professional goals. The duration of the mentor-mentee relationship is open-ended because different mentees will have different career needs and goals.

“For example, a mentee may want a mentor to help with a grant writing project, and that would obviously be a very short-term goal,” said Hilary Sanfey, MD, FACS, professor of surgery at Southern Illinois University School of Medicine in Springfield, IL, and current past-president of the AWS. “Other people may find that the match is wonderful and the relationship is one that’s going to last through their whole career.”

Mentee experiences

Nancy L. Harthun, MD, FACS, a vascular surgeon at the University of Virginia School of Medicine in Charlottesville, VA, remembers feeling like a kid in a candy store when she received a list of potential mentors in 2005. “It was really a tremendous list of fantastic surgeons,” she said. “There were so many talented people, I didn’t know who to pick.”

Dr. Harthun sought advice from her department chair, Irving L. Kron, MD, FACS. Soon, she was paired with G. Patrick Clagett, MD, FACS, a vascular surgeon at the University of Texas Southwestern Medical Center in Dallas, in a successful mentorship that continues to this day. “He is a wonderful person and a wonderful ambassador for the profession,” Dr. Harthun said. “Any time you spend time with someone
like that, you can’t help but learn something.”

Now entering her 10th year of practice, Dr. Harthun considers Dr. Kron to be an important mentor. Good mentors like him, she said, encourage their mentees to find additional mentors, like Dr. Clagett, who offer a range of experience and perspective to help early-career professionals advance quickly.

“Mentoring certainly doesn’t replace motivation and hard work and discipline, but having somebody with Dr. Clagett’s experience review what I am doing is wonderful,” she says. “A mentor can give you 15 or 30 minutes of their time and save you from making mistakes that are very time-consuming and take years to recover from.”

Dr. Harthun is a fan of formal mentoring relationships because they improve the chances of meeting one’s professional goals. Climbing the academic ranks comes with a tight timetable that requires early successes. Almost any obstacle can be overcome, she believes, but understanding and addressing challenges quickly is much easier with the help of an experienced mentor.

“The typical situation is you write up a grant, you think it’s a good grant, and then you get feedback that is not totally clear—or you get a long list of things to fix but it is hard to tell what the most important things are,” she said. “Having a mentor means you have success a lot quicker—and things are a lot more fun when you’re not getting rejection letters all the time.”

In her own career, Dr. Harthun appreciates Dr. Clagett’s willingness to help get involved in professional organizations. In addition to general networking introductions, he recommended her for service on a Society of Vascular Surgery committee. She is eligible for tenure next year—and has asked Dr. Clagett to write a letter on her behalf.

When Dr. Tchorz applied for the ACS/AWS mentorship program in 2005, she was working at another university and struggling to know what direction her career should take. From their e-mail exchanges, Dr. McCarthy was able to discern Dr. Tchorz’s strengths and challenges with a clarity that the mentee could not see herself.

The two surgeons met in 2005, when Dr. Kemeny, who helped start the mentoring program, suggested they be paired as mentor and mentee. Within a year, Dr. Tchorz had accepted a position in Dr. McCarthy’s department.

More significantly, however, Dr. Tchorz had come to understand why her first academic position had been so frustrating, and what she needed to do to give her career a fresh start.

“One of the most important things she said to me was ‘Kathryn, you have got to learn to say no,” Dr. Tchorz recalled. “She said, ‘You have fallen into the trap. You are talented and you can multi-task so everybody is getting part of your precious time. Unfortunately those things are not yielding the kinds of end products—the

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manuscripts and the leadership opportunities—that you need to succeed.”

Dr. McCarthy asked Dr. Tchorz to create a list of 10 personal and professional goals and an action plan for accomplishing each of her goals. That approach has helped Dr. Tchorz make progress on her own agenda.

Since moving to Wright State, she has regained the passion for her career that had been lost during her frustrating early experience, and she credits the mentorship from Dr. McCarthy for “leading me out of a dark tunnel.”

“She has made my professional interest of paramount importance, and I am starting to reap the benefits of that,” Dr. Tchorz said. “It is absolutely exciting.”

Why mentors are needed

The American Journal of Surgery’s survey of the characteristics of women surgeons, published in 1998, found that women who chose surgery as a specialty did so for the same reasons their male peers chose it: the intellectual challenge of the work, the technical aspects of surgery, and the decisiveness demanded of surgeons.³

Women physicians who opted not to choose surgery as a profession, on the other hand, cited the lack of encouragement to pursue the specialty, and the lack of available role models, as reasons for their decision. Other reasons cited in the survey include the idea that a surgical career was considered too time-consuming and not family-friendly, and offered a lifestyle with an unpredictable schedule.

In her presidential address to the Society of Surgical Oncology in 2005, S. Eva Singletary, MD, FACS, said effective mentoring is especially critical in the training of surgeons and especially for those who enter academic medicine.⁴

“Because of the notorious problems with funding, overcommitment of time, and difficulties with the promotion process, the best and brightest people are becoming increasingly reluctant to enter academia, although the future of medicine depends on successfully recruiting them,” Dr. Singletary wrote. “The broader scope of responsibilities required in an academic position makes the need for strong mentoring especially urgent.”

The first generations of women surgeons obviously had no female mentors to help them—and women surgeons sometimes found their male colleagues unsupportive.

“The progression to getting tenure was much more difficult for me and took much longer than if I would have had someone helping me along the way,” Dr. Kemeny said. “I don’t want other people to have to go through the things that I went through, without having some help.”

Dr. Sanfey, a transplant surgeon and the first woman in Ireland to pursue higher surgical training, had a similar experience—and developed a similar empathy for early career women surgeons.

“There weren’t any women I could look to for role models or for advice,” said Dr. Sanfey. “It was a very different environment for me, and since then, I’ve had an interest in helping other women avoid making a lot of the mistakes that I made because I did not know who to turn to for advice.”

Dr. Singletary, writing in the Annals of Surgical Oncology, said effective mentoring for women surgeons is important because of tradi-

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tional gender roles that give women a dispro-
portionate share of responsibility for homes and
children. “This is exacerbated by institutional
infrastructure and culture that makes no allow-
ance for family obligations: meetings scheduled
in the evenings and on weekends; hardwired pro-
motion timelines, with no part-time tenure track
available; no emergency child care; and no formal
parental leave policy,” wrote Dr. Singletary.4

Dr. Singletary also noted that women academic
surgeons tend to be assigned excessive commit-
tee service and other tasks that may not be in
their best career interests.

How the program has evolved

In its second round, the ACS/AWS mentoring
program is changing the way mentors and men-
tees are matched. In the original round, the men-
tees received a list of surgeons willing to serve
as mentors, but the program’s organizers were
not involved in making matches. An exception to
this was Dr. Tchorz. She was fortunate to meet
Dr. Kemeny at the 2005 ACS Clinical Congress,
which served as the kickoff for the original men-
torship program. When Dr. Kemeny learned that
Dr. Tchorz was fellowship-trained in trauma and
surgical critical care, she immediately suggested
that she pursue a mentorship relationship with
Dr. McCarthy, who is chief of trauma at Miami
Valley Hospital, a Level I trauma center in Day-
ton, OH.

Despite that happy match, the mentor pro-
gram as originally conceived did not work as
well as its founders had hoped. Some mentees
were intimidated to ask high-profile surgeons for
their time and attention, according to Dr. Sanfey.
Others took the initiative to approach their ideal
mentors—only to find that the mentor’s interests
and personality were not a great fit with those of
the mentee. “That’s why we want to make the
introductions this time,” Dr. Sanfey said.

In the new iteration, each mentee submitted
a written statement identifying her professional
goals and what she hopes to accomplish through
the mentoring program. Program organizers will
use that information, along with information
gained from the personal meetings at this year’s
Clinical Congress event, to identify potential
mentor-mentee matches, and at that point, they
will facilitate introductions.

For example, Dr. Kemeny, a surgical oncologist,
will meet with the mentees who are in surgical
oncology to find out their particular interests. She
will then identify a mentor who could be helpful
to that early-career surgeon, and she will contact
the mentor to help establish the mentorship rela-
tionship.

The mentoring program will be evaluated to
measure the participants’ satisfaction and wheth-
er they achieved the goals they set for themselves,
as well as whether mentees achieved promotion
and tenure.

Already evaluated a success by some

Dr. Harthun appreciates the altruistic efforts
of the surgeons who are revamping the mentor-
ship program, and the mentors as well. “They are
just doing [this work] for the promotion of the
field, and they deserve a lot of credit for that,”
she said. I certainly would recommend that other
people getting started in their career should take
advantage of this [program], absolutely. It has
been a huge plus for me.”

Likewise, Dr. Tchorz values the honest feed-
back she has received from Dr. McCarthy, cre-
ating an atmosphere of trust that has allowed
Dr. Tchorz to thrive. “If it had not been for the
personal attention and the dedication of Mary
McCarthy, I don’t know where I would be today,”
she said. “I am eternally grateful—she is a true
mentor and colleague.”

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Ms. Butcher is a freelance writer in Springfield, MO.
EVIDENCE-BASED REVIEWS IN SURGERY:
An update

by Robin S. McLeod, MD, FACS, FRCSC
Uncertain whether nuts, corn, and popcorn consumption really are associated with an increased incidence of diverticular disease? There are a lot of ways to manage pilonidal sinus, but do medical professionals know what the evidence is to support those treatments? Should physicians prescribe steroids to patients in septic shock? What about beta-blockers in patients undergoing noncardiac surgery?

If a physician is uncertain about what to do in these situations, the American College of Surgeons invites practicing surgeons and residents to participate in the Evidence-Based Reviews in Surgery (EBRS) program. The EBRS program is an internet-based journal club designed to teach critical appraisal skills to both residents and practicing general and colorectal surgeons. EBRS consists of eight monthly packages per academic year, beginning in October and running through May of the following year. Each package includes a clinical article relevant to the practice of general surgery, plus a methodological article that can be used to assist in the evaluation of the clinical article. In addition, methodological and clinical reviews are provided by experts in the field. The selected articles cover a spectrum of important clinical and methodologic topics.

The aim of this program is for participants to evaluate the clinical article, as well as further their knowledge about the topic, and to learn critical appraisal skills that can be used to evaluate other articles in the future. It is free to all members (including residents) who are members of the ACS. You can access the EBRS program through the ACS Web site: http://www.facs.org/education/ebrs.html.

If you want to participate in the listserv discussions and receive continuing medical education (CME) credits, then you can register with Marg McKenzie, RN, by e-mailing her at mmckenzie@mtsinaion.ca.

The EBRS program topics for 2009–2010 include:

- Use of the World Health Organization checklist
- Management of biliary tract disease in pregnant females
- Use of computed tomography for cervical spine clearance in trauma patients
- Association between nut, corn, and popcorn consumption and diverticular disease
- Management of pilonidal sinus
- Use of beta-blockers in the perioperative period in patients undergoing noncardiac surgery
- Efficacy of hydrocortisone in patients in septic shock
- Value of methicillin-resistant staphylococcus aureus screening of surgical patients

In addition, the program will include four packages on colorectal surgery topics in 2009–2010:

- Role of a defunctioning stoma following low anterior resection
- Comparison of quality of life following abdominoperineal nearection and low anterior resection
- The association of colonoscopy and death from colorectal cancer
- Effect of the type of anastomosis on the risk of recurrence following ileostomy for Crohn’s disease

The EBRS program will resume in October of 2009, and the schedule for the upcoming year is posted on the EBRS Web site. The following list outlines benefits of the EBRS program. These benefits may be unfamiliar to some surgeons and residents, but the College believes they add true value to the EBRS program:

- We have two listserv discussion groups: one for general surgery topics and one for colorectal surgery topics. All members are invited to participate in both discussion groups.
- At the end of the listserv discussion, members can complete five multiple-choice questions pertaining to the methodological and clinical articles and reviews. Upon completion of the questions, the user will receive feedback from the pertinent sections of the articles or reviews that support the correct answer.
- Our clinical and methodological reviews are completed by national and international experts. Each article features a clinical review written by an American and a Canadian expert—so two different perspectives on the issue are often obtained.
- We have an “Archives” section that is indexed by clinical and methodological topic. We now have almost 100 packages that have been reviewed over the past 10 years and can be used as a resource by members interested in a particular topic.
• Members can also access online some of the most widely read journals, including the New England Journal of Medicine, the Canadian Medical Association Journal, the Journal of the American Medical Association, the Annals of Surgery, Diseases of the Colon and Rectum, and Surgery, and use them for their own reading. A member may simply go to the EBRS Web site and look for “Journals.”

• We have added a section called “Evidence-Based Medicine” to the program, which includes a glossary of terms and links to other Web sites that may be of value to members.

• All of the EBRS reviews are published and up to date, and almost 50 articles have appeared in the Canadian Journal of Surgery, Journal of the American College of Surgeons, and Diseases of the Colon and Rectum; a new link is available with access to all of the review articles.

• All general surgery and colorectal surgery programs should have received a schedule of the topics for 2009–2010 by this time, and the complete packages will be sent in early September.

• For individuals planning to attend the ACS Clinical Congress in Chicago this year, the College invites practicing surgeons and residents to attend the EBRS symposium entitled What Is the Evidence for Antibiotic Prophylaxis in Mesh Inguinal Hernia Repair: Let’s Do Journal Club, October 12, 4:15–5:45 pm. We will have touch pads at the symposium and audience participation will be encouraged.

EBRS is a program of both the American College of Surgeons and the Canadian Association of General Surgeons and is endorsed by the American Society of Colon and Rectal Surgeons and the Canadian Society of Colon and Rectal Surgeons. EBRS continues to be funded by Ethicon and Ethicon Endo-Surgery Canada, and Ethicon Inc. and Ethicon Endo-Surgery Inc. in the U.S., and we are grateful for their ongoing support, which enables EBRS to be provided, without charge, to members of the ACS.

The members of the steering committees include: Nancy Baxter, University of Toronto; Carl Brown, University of British Columbia; Karen Brasel, Medical College of Wisconsin; Prosanto Chaudhury, McGill University; Suzanne Cutter, Cedars Sinai Los Angeles; Bill Fitzgerald, St. Anthony; Harry Henteleff, Dalhousie University; Andy Kirkpatrick, University of Calgary; Steve Latosinsky, University of Western Ontario; Tony MacLean, University of Calgary; Tara Mastracci, Cleveland Clinic; Arden Morris, University of Michigan; Leigh Neumayer, University of Utah; and Larissa Temple, Memorial Sloan Kettering, NY. We welcome a new representative of the Canadian Association of General Surgeons Resident group, Luc Dubois, and a new general surgery program director, Celia Divino, from Mount Sinai, NY. Our administrative coordinator is Ms. McKenzie.

If you have any comments or wish to be part of the listserv discussion and receive Maintenance of Certification credits for completion of the monthly packages, you can register by contacting Ms. McKenzie at mmckenzie@mtsini.on.ca.

Dr. McLeod is professor of surgery and health policy, management and evaluation, University of Toronto; and head, division of general surgery, Mt. Sinai Hospital, Toronto, ON. She is a Regent of the College.
When the Accreditation Council for Graduate Medical Education (ACGME) implemented its duty hours regulations (DHR) in 2003, it did so with a promise to study the impact of this revolutionary change five years later. That study is ongoing, and the ACGME has solicited input from every conceivable source. They have hired three independent contractors to review the scientific literature for papers on the impact of DHR, reached out to every stakeholder organization for written position statements, and have commissioned a team of sleep scientists to summarize the most current evidence on the impact of sleep deprivation. With the recent release of the Institute of Medicine (IOM) report, Resident Duty Hours: Enhancing Sleep, Supervision and Safety, the ACGME’s efforts are particularly timely. The most restrictive features of the IOM report are summarized in the box on page 15.

In June 2009, the ACGME sponsored a Duty Hours Congress as a way to gather feedback regarding the IOM report. Seventy-seven stakeholder organizations submitted written responses to the IOM report, and 67 of these, including numerous specialty societies, hospital and accreditation organizations, and medical student and resident organizations, presented testimonies. I was privileged to speak on behalf of the Resident and Associate Society (RAS) of the College, based on our previously published position statement.

The consistency of opinions among the vast majority of presenting organizations was staggering. There was widespread opposition to further reductions in work hours, and support for removing the rigidity in scheduling, both of which are called for by the IOM. Every organization, except for the Committee on Interns and Residents and the American Medical Student Association, agreed with these positions. Representatives from pediatrics, internal medicine, radiology, psychology, psychiatry, and pathology all urged the ACGME to fight the implementation of the restrictive elements in the IOM’s new recommendations.

The main reasons cited for opposing the IOM’s recommendations were the dearth of evidence demonstrating an improvement in patient safety since the introduction of the DHR, and the growing recognition of the prevalence of errors due to miscommunication during patient handoffs. Most presenters also highlighted concerns regarding the effect that strict adherence to the hours has had on professionalism among residents. All presenters agreed that a mandatory five-hour nap was unworkable, but that resident safety was paramount. There wasn’t a debate concerning the fact that residents should be provided adequate sleeping facilities, and transportation home for the times that they are too tired to drive safely.

While the call for flexibility was unanimous, there was some variability in how the various
stakeholders defined “flexibility.” Most presenters simply asked for a reduction in the rigidity of scheduling recommended by the IOM. They sought the elimination of the “no averaging” clauses, and of the four consecutive night maximum recommended by the IOM for night duty. Many surgeons, though, called for a different kind of flexibility—the elimination of the duty hours restrictions for chief residents.

Many surgeons discussed the need to provide chief residents with scheduling flexibility so that they could participate in rare cases and emergencies whenever they arise, and to avoid a potential conflict between their educational experience and after-hours education. Another important reason they cited for scheduling flexibility is the requirement to prepare trainees to operate and respond to emergencies at all hours, which is something surgeons are expected to engage in upon graduation.

Certainly, senior residents should never be forced to choose between having to go home and their desire to work on a rare case. Moreover, I agree that there is an element of training that affects the physician’s ability to cope with sleep deprivation, but I disagree that those are the most pressing reasons for flexibility and exemption of senior residents from hours regulations.

I believe that the most important reason to give chief residents autonomy over their work schedule is the preservation of their very role, which for decades has been unique. A surgical chief resident’s function is, and should remain, more akin to that of junior faculty member. As such, they are personally responsible for the welfare of all of the inpatients on their service. If a patient takes a turn for the worse, it is the chief, regardless of whether he or she operated on the patient, who is charged with overseeing the restoration of that patient’s health. This is not the time to look at the clock; it is a time of commitment to patient care and of invaluable learning opportunities.

Another reason that surgery chief residents need, and deserve, different standards of training has to do with the fact that, immediately upon graduation, they are thrust into leadership roles, both in and out of the operating room. Beyond direct patient care, chief residents are charged with educating and training medical students and junior residents.

With increasingly stringent hours regulations, chief residents are being stripped of important leadership development opportunities—such as leading the surgical team on afternoon teaching rounds—which are now almost nonexistent. Moreover, we have seen a sharp decline in teaching cases, in which chief residents take their junior colleagues through cases under the watchful eye of an attending surgeon. Finally, in many residencies, administrative responsibilities have been deemed “noneducational,” and have also been reassigned to staff.

I believe that in the past five years we have seen the gradual erosion of the surgery chief resident role into that of a senior resident who comes in,

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Highlights of the IOM recommendations (December, 2008)

- Maximum shift length: (a) 16 consecutive hours or (b) 30 hours, including a non-regulated 16-hour working period, followed by a required five-hour protected sleep period between 10:00 pm and 8:00 am. The remaining nine hours can be used only for transition and educational activities.
  - In-house call frequency: Maximum on-call frequency every third night, averaging no longer allowed.
  - Minimum time between shifts: 10 hours after day shifts, 12 hours after night shifts, 14 hours after any extended duty period.
  - Maximum frequency of inhospital night shifts: Four-night maximum, with a required 48 hours off after three or four nights of consecutive duty.
  - Mandatory time off: Four days off and one 48-hour period off per month, one day off per week, no averaging.

Source: Resident Duty Hours: Enhancing Sleep, Supervision, and Safety.1
It is our collective responsibility to restore the surgery chief resident to his or her vitally important role. Granting chiefs autonomy over their own schedules will go a long way toward this goal, and the faculty should redouble their efforts to instill in them the deep sense of responsibility that is so crucial to a successful practice in medicine.

References


Dr. Moalem is assistant professor, endocrine surgical oncology, University of Rochester Medical Center, Rochester, NY, and Chair of the RAS-ACS.
This past summer, the Special Libraries Association (SLA) recognized the Journal of the American College of Surgeons (JACS) as one of the 100 most influential journals in biology and medicine published over the course of the last century. Other prestigious publications that made the cut include the Journal of the American Medical Association, The Lancet, Nature, the New England Journal of Medicine, and Science; however, JACS was the only surgery-specific journal to receive this recognition. Publications that focus on medical and surgical care in urology and obstetrics-gynecology also were on the SLA’s list.

This list of influential journals was compiled by the more than 680 members of the SLA’s Division of Biomedical and Life Sciences (DBIO). More specifically, in 2008, the SLA DBIO convened an international panel of nine eminent subject experts to compile a ballot for an electronic poll of SLA members concerning the 100 most influential journals of biology and medicine to be recognized at the SLA centennial conference this past June in Washington, DC.

JACS continues to gain recognition as an influential surgical journal

An interview with Timothy J. Eberlein, MD, FACS

by Diane S. Schneidman, Manager, Special Projects, Division of Integrated Communications
In light of this important achievement, the staff of the Division of Integrated Communications decided that Bulletin readers were due for an update on the status of JACS. With this objective in mind, the Bulletin interviewed the current Editor-in-Chief, Timothy J. Eberlein, MD, FACS. The following are highlights of that discussion.

**Why do you think the SLA singled out JACS from other surgical journals for this commendation?**

This award recognizes the most influential journals in the fields of medicine and science. Independent surveys—that means studies that were commissioned by neither the publisher, Elsevier, Inc., nor by the College—indicate that JACS is far and away the most widely read surgical journal in the nation. That may have something to do with the fact that JACS has such a large circulation, since it has been sent to all members of the ACS in recent years. In any event, these numbers indicate that it has a high influence factor for surgeons who are in community practices as well as in academic settings.

**What does receiving this honor mean for JACS?**

Winning this award is a validation of the tremendous amount of “sweat equity” that editors-in-chief, editorial boards, and the JACS editorial staff have put into the publication over the years. I’d like to think that this recognition also reflects on the quality of the work that is published in the Journal and demonstrates that JACS is an important asset to the American College of Surgeons.

**What was your vision when you assumed the editorship of JACS in 2004?**

I wanted to see it become the best and most influential surgical journal in the world. That’s really been the goal.

**What steps have you taken to achieve this ambitious goal?**

The first thing we did was to eliminate any copy that was not peer-reviewed. The Journal used to publish items like “What’s New in Surgery,” which were very educational but were not peer-reviewed contributions. So, over the years, we’ve increased the number of peer-reviewed submissions to JACS.

Second, we were among the first journals to switch to an entirely electronic submission process. The reason for this change was to ensure that new submissions would be quickly peer-reviewed and published in a timely manner. For most of our submissions, a first decision about whether to publish is made within two-and-a-half weeks of the date of submission. This rapid turnaround time has been possible because of the fantastic editorial staff at the ACS [Managing Editors Anne Magrath and Anne Wolfe] and at Elsevier, but it is also possible because we have used a large number of outside peer reviewers. Last year we used about 1,100 ad hoc reviewers.

So, it’s not just the editorial board members who are making decisions about whether an article will be relevant to your readership.
Obviously, the editorial board members’ opinions take precedence, and then we usually recruit a couple of outside reviewers to evaluate the submissions. This combination ensures that the quality of the reviews fit the Journal’s standards. This process also is a good way to “audition” potential new members of the editorial board.

How many submissions does the Journal receive each month, and what is the acceptance rate?

Currently, we receive approximately 100 original scientific articles each month. We’re down to about a 15 percent acceptance rate, which is another big change. When I first joined the Journal, the acceptance rate was around 40 to 50 percent.

To what do you attribute the large number of submissions and the ability to be so selective in what JACS publishes?

I would attribute it to a couple of factors. First of all, we were very fortunate to be able to become the official publication for the Southern Surgical Association about two years ago. The manuscripts that emanate from the Southern Surgical Association are of very high quality, so I think that collaboration has been a real boost to our journal. Also, we have been receiving a much larger number of excellent manuscripts from surgeons across the country, which have improved the caliber of what we can publish in the Journal.

What are the criteria you use to determine what does or does not get published?

What we’re really looking for are articles that will have a high-impact or high-influence rating among our readership. We determine the likelihood that an article will meet this criterion based on the level of enthusiasm expressed by the peer reviewers for the original submission. If an article centers on a randomized trial and is setting a new standard of care, that’s going to have a high influence rating in contrast to an item that is a retrospective, descriptive look at a series of patients. JACS seeks to publish articles that are potentially paradigm-changing or that offer a new direction in treatment.

Would you say that the Journal has developed a more scientific focus than it had before?

I would say it is scientific in the broad sense of the word because the vast majority of our papers are clinically related and/or provide information that can be translated to clinical practice. But, we also publish some high-caliber basic science articles that may eventually lead to new treatment paradigms, the identification of new markers for disease, and so on.

What are your plans for the future of JACS?

Primarily we are thinking about ways to educate our readership about the most up-to-date modes of treatment. And, we’re not focused on one particular specialty. We’re looking for high-impact articles that look at a broad range of topics. So, we may have papers in cardiothoracic, vascular, breast, colon-rectal, or trauma and critical care operations. The College’s membership is very broad and diverse, so we need to keep in mind that we need to publish papers that will influence the full range of surgical disciplines, as opposed to a specific subspecialty. But overall, our goal continues to be the rapid dissemination of information signaling new directions in treatment and/or significant advances that will lead to earlier diagnoses.

It’s a work in progress, but I think it is great that all of the efforts and all of the investments that the Board of Regents has made in the Journal are paying off in the sense that JACS is improving in quality and better meeting the needs of our membership. Hopefully, over time we’ll get more and more citations, and that will improve our impact factor. Over the past five years, we have significantly improved the stature of our journal and are now ranked 12th out of 148 surgical journals in terms of impact factor, so it continues to improve. We are committed to continuing to enhance the quality of JACS.
Requiem for the general surgeon:
The end of an era (Who will repair that hernia now?)

by George Kasotakis, MD

Editor’s note: The following two articles are part of an ongoing series of articles written by members of the Resident and Associate Society of the American College of Surgeons (RAS-ACS). The series provides a forum for the concerns and needs of residents and young surgeons in all surgical specialties. This month we offer two views on the subject of the general surgeon.

Each year approximately 1,000 general surgeons graduate from 251 accredited residency programs in the U.S.1 At the same time, approximately 700 general surgeons retire annually from the current workforce, which is composed of 21,500 surgeons.2 This shortage in the general surgical manpower is becoming increasingly apparent (see Figure, page 21), and its impact on the American public is echoing louder than ever in the mainstream media.3 Yet, despite the expanding deficit in surgical generalists, the number of residency programs and training facilities has remained largely unchanged in the past two decades.4 Additionally, interest in general surgery among U.S. medical students appears to be declining, mainly due to lifestyle concerns.5 Even among the graduating general surgery residents, more than 70 percent seek fellowship training6—and the trend is increasing.

The reasons behind the desire to subspecialize are multiple and diverse, and some of those reasons are specifically related to the nature of surgical training in itself: The majority of surgery residents in the U.S. train in large university-based programs, and are exposed almost exclusively to surgical subspecialties.5 Not unexpectedly, they often choose to emulate their mentors. But with the rapid proliferation of post-residency fellowships, more and more procedures are being performed by fellows in training, and not by the residents, who are being deprived of valuable operative time. And with the operative experience in decline, combined with the current work hour restrictions, many residents believe that the model of general surgical education, as it currently
exists, fails to prepare them adequately to be independent practitioners, and they feel compelled to seek additional training.

In addition, the advances made in basic science research and surgical technology have had a serious impact on the technical skills and knowledge required for a surgical generalist to remain proficient in treating a wide variety of conditions. At the same time, well-informed patients and customers continue to drive super-specialization by seeking out experts in lieu of general surgeons, even for the simplest procedures. Evidence that practitioners who perform complex procedures in large volumes have better outcomes than generalists only reinforces the value of a limited spectrum subspecialty practice. To be competitive in today’s modern health care arena, many general surgery graduates aim at refining their skills and knowledge in narrow areas, and at the same time enjoy the financial rewards and more controllable lifestyle that typically accompany a highly specialized practice.

And while the incentives to enter a specialized field are multiplying, the obstacles facing general surgeons continue to mount. With the introduction of the relative value units in 1992—which, it is interesting to note, were only meant to function as a research tool—reimbursement from Medicare (and subsequently from private insurers too) for general surgical procedures was devalued precipitously. Most medical specialties were affected, but general surgery was hit disproportionately hard. Malpractice liability, the pressure to provide charitable care in emergency settings, and the loss of procedures (and income) to specialists have all contributed to an increasingly “unfavorable workplace,” which is cited as the single most important reason for retirement by most mid-career surgical generalists.

These trends in the general surgical field were not without significant implications, and nowhere is this crisis more tangible than in rural America. While 25 percent of Americans live in towns with a population of 50,000 or less, less than 9 to 12 percent of the surgical workforce practices in those rural areas. Many rural and suburban hospitals are threatened with closure, as their fates are intertwined with general surgical coverage, with up to 40 percent of their income derived from surgical procedures.

The field of general surgery is undeniably going through a crisis with significant socioeconomic ramifications, and radical steps need to be made toward redesigning surgical education and practice. First of all, considering the confines of current work hour limitations and subsequent dwindling operative exposure experienced by residents today, the addition of a sixth clinical year of training could help strengthen technical skills and knowledge, and reinforce graduates’ confidence as generalists, especially if that time is dedicated to
Many residents believe that the model of general surgical education, as it currently exists, fails to prepare them adequately to be independent practitioners, and they feel compelled to seek additional training.

Core general surgery rotations. Early diversification into subspecialty training, following the increasingly popular model of plastic and vascular surgery (similar to the European prototype) can also help augment exposure in traditional general surgical procedures for the non-subspecialty-minded trainees. Revisions in the compensation model from Medicare need to be made, and federally funded insurance coverage for the underprivileged should be offered to counter the effects of declining reimbursement. Another measure to consider is the establishment of a rural surgery fellowship for those who wish to practice traditional general surgery in its full breadth and scope.

Surgical education and the practice of general surgery now, more than ever before, require urgent transformation. It is the responsibility of the American College of Surgeons to seize the opportunity to conceive and to implement the process of change through specific recommendations (such as the addition of a sixth clinical training year and early diversification of subspecialty residencies) to prepare and to sustain the general surgeon of the 21st century. Or a hernia specialist consult will be needed in the near future for a routine inguinal hernia repair.

References

Generally speaking:

Is the role of the general surgeon obsolete?

by JaBaris D. Swain, MD

Surgeons must be very careful when they take the knife! Underneath their fine incisions stirs the culprit—Life!

Emily Dickinson

While the general surgeon is still in the sterile bay preparing to scrub for the next case, specialty residents and fellows race to the bedside at the urgent prompting of their generalist colleagues, scouring the patient to evaluate a particular organ or body part of interest. Inherently, one would assume that this compartmentalized care has a justifiable advantage for the patient, as each part of his or her anatomy can command the attention of a skillfully trained specialist. Yet, among this era of surgical territorialism, the obvious question comes to mind: Wherein exists the role of the general surgeon?

Dating back as early as the thirteenth century in western Europe, when personal grooming barbers were recognized as practicing surgical clinicians, it appears that the role of the general surgeon has always been broad-based and encompassing a spectrum of surgical interventions, from hepatic lobe resections to tubal ligations and mastectomies. Historically, any measure of incision made on the human body has been well within the general surgeon’s professional jurisdiction. Specialized training, subspecialty fellowships, and subsidiaries of the art, however, have now taken claim to much of the case load that was formally relegated as sole proprietorship of the general surgeon. Furthermore, academic surgery centers are now more actively recruiting subspecialists, as data has demonstrated that these fields have an overall favorable impact on general surgery training, specifically for enhancing both operative exposure and the management skills of residents and medical students alike. Consequently, this sudden spurt in the sexiness of the subspeciality experience, its flexible lifestyle, and its unique, organ-specific mentality debuts with the threatened demise of the general surgeon and his or her craft.

So, what is left for the general surgeon to do? Opponents would suggest that the role is passé and that the days of the general surgeon have expired. Arguably, other medical professionals would sup-
The fact remains that general surgery still hosts the broadest armamentarium of clinical proficiency, fashioning the discipline as an endur-ing mainstay of modern medicine. Ironically, recent studies report that there is, indeed, a shortage of general surgeons and recommend a re-evaluation of the responsibilities of both the system and the individual general surgeon in dealing with this important crisis. In essence, general surgery as a trade can never go out of vogue, even in light of the intimate court-ship of basic general surgery mechanics with advanced techniques, which have merged to create fusion subspecialties, such as onco-plastics. Inevitably, it is important to preserve the role of the general surgeon as the field of surgery—generally speaking—will rely on the longevity of this stem profession in perpetuity.

References


Dr. Swain is a third-year general surgery resident and NIH postdoctoral research fellow, division of cardiothoracic surgery, department of surgery, University of Pennsylvania, Philadelphia.
Creating a legislative agenda

by Melinda Baker, Senior Associate, State Affairs, Division of Advocacy and Health Policy

There are many variables that go into determining a successful state or federal legislative strategy. Some of them are process-oriented, others are organizational, and all involve commitment and dedication on the part of ACS chapter and College leadership and fellowship.

Review the environment

Understanding the political environment in the capitol and in Congress is one of the most critical things a chapter can do to establish an effective legislative agenda. Some common questions to ask when assessing the political environment may include:

- Which party is in control and who are their major donors?
- Does the elected leadership all get along?
- What is the fiscal status of the state or the nation?
- Is it an election year?

The best legislation can be killed because the chamber “doesn’t like” the sponsor. In an article written for the Public Affairs Council, Dennis Brown, CAE, writes, “...I once saw a state university’s sterling research findings invalidated by a committee chairman evidently offended with anything coming from his alma mater’s greatest sports rival. On the other hand, we once gained broad approval after commissioning the alma mater of another state’s Senate president to undertake intensive research supporting our position on a high-visibility issue.”

Defining and prioritizing

Defining and prioritizing the issues is one of the most important steps in developing a legislative strategy. Many take this step for granted, but deciding exactly what the most important issues may be before the start of a legislative session is vital to determining what resources will be needed, and will save time in the long run.

Defining the issues sounds easy, but there’s more to it than most people realize. It’s easy to identify the problem, but what is the solution? Can it be solved legislatively?

Once the issues have been properly defined, a common decision matrix is used by government relations professionals to prioritize legislation. An example of the decision matrix is shown in the Figure on this page.

In a decision matrix, issues are placed on a scale according to two criteria: “impact on the organization” (y axis), and “ease of influence” (x axis). These two criteria are determined by a rating of one to 10, with a rating of 10 signifying an issue that will have the most impact on an organization and an issue that will likely be very easy to pass through the legislature. Issues that are placed into box “A” will have a great impact on the organization, but will be difficult to pass, whereas issues that are placed into box “D” will

have a little impact, but are the easiest to pass through the legislature. Ideally, this matrix will help chapters prioritize and focus their resources on legislation that has the greatest impact on the practice of medicine and the best chance of passing.

Prioritization also occurs within an issue. An example is medical liability reform—while a hot issue in many states, it is still important to define the reforms to be introduced, as well as the individual components of each issue. Is a cap on noneconomic damages more important than alternative dispute resolution, and is alternative dispute resolution more important than limiting attorneys’ fees? By prioritizing these elements, allies will be prepared for the negotiations that will inevitably occur during the legislative session.

**Categorize**

After the issues have been defined and prioritized, they should be categorized into one of three areas: proactive, reactive, or opportunistic. The terms proactive and reactive are fairly self-explanatory. Proactive issues are those important enough to warrant the initiative to introduce the legislation, or are issues on which to be actively engaged. Reactive issues are often defensive in nature, and usually require a response. It is very important to try and identify reactive/defensive issues before they are introduced, so that you may start earlier and plan ahead. It’s especially worthwhile to define reactive issues ahead of time, because this will allow time to formulate a response, rather than scrambling to come up with a message at the last minute.

Less familiar to most people are opportunistic issues. Many bills get passed because of the “perfect storm” scenario. An incident makes headlines, people are clamoring for change, and the legislators demand action. For example, a particularly horrific accident may highlight the need for better child restraint laws, or hospital-acquired infections may make the news and spark new reporting requirements, and so on. There is little time to create a plan for these opportunistic issues, so identifying them ahead of time or having a system in place to handle these issues quickly and effectively is key to a successful outcome.

Opportunistic issues are also issues for which a chapter or the College may have a position, but may not warrant, at that particular time, an allocation of very many advocacy resources, such as an increase in a state’s “sin tax” to pay for trauma funding.

Opportunistic issues may also be piggy-backed on to other legislation. Perhaps a state is considering an increase in the penalties for traffic violations—it may be possible to add an amendment to allocate some of the increased funds to hospitals and physicians for uncompensated emergency care.

Whether or not a legislative issue is federal or state, College staff are available to assist Fellows and chapters in advocacy-related activities. They may be contacted at ahp@facs.org
It is with a tremendous amount of honor and pleasure that I am providing the report as the ACS Australia and New Zealand (ANZ) Chapter Traveling Fellow for the year 2009. It was indeed a memorable experience to travel to Australia, meet a variety of our Australian colleagues throughout the country, and visit with them during their annual Scientific Congress of the Royal Australasian College of Surgeons. I had the opportunity to experience firsthand the surgical environment within Australia and to develop what I hope will be long-lasting friendships. This opportunity clearly demonstrated that many of the issues we are facing within the profession span international boundaries, as my Australian colleagues are struggling with the same complex circumstances in practice and delivery of quality surgical care to patients.

Brisbane

The initial part of my journey was centered around The annual Scientific Congress for 2009 of the Royal Australasian College of Surgeons. This meeting was held in Brisbane, Australia, beginning May 6, and lasted for four days. Prior to my arrival, I had worked with the three conveners responsible for organizing the various scientific programs of the meeting. These included Rob Finch, MB, FRACS, an upper GI and hepatobiliary surgeon from the Royal Brisbane Hospital, responsible for organizing the hepatopancreatobiliary and upper GI surgery section; Andrew Barbour, MD, FRACS, from the Greenslopes Specialist Clinic, Queensland, who organized the surgical oncology section; and Daniel De Viana, MB, from the Gold Coast Health Care Center in Southport, Queensland, who organized the breast cancer section. With the help of these three conveners, I became integrated into the scientific program of the meeting. In addition, my host, John Buckingham, MB, FACS (President of the ANZ Chapter), facilitated my travel. One of the topics of the ANZ Chapter meeting was focused on potential mechanisms to foster young surgeons joining the chapter, and Dr. Buckingham asked that I offer...
my view of a surgical career from the perspective of a young surgeon.

Dr. Finch was the most gracious of hosts, beginning with my arrival in Brisbane and throughout the entire meeting. My participation in the hepatopancreatobiliary session included three lectures that paralleled the theme that he had established regarding pancreatic diseases. Dr. Finch also invited Irvin Modlin, MD, from Yale University, New Haven, CT, to give the keynote lecture on pancreatic neuroendocrine tumors. I provided an additional lecture on the surgical strategies for pancreatic neuroendocrine tumors. Although I had never met Dr. Modlin prior to the meeting, his work had impressed me, and as a direct consequence of this meeting, I think I have developed a great friendship with him. I was fortunate enough to have my family accompany me as part of my traveling fellowship, and at the congressional dinner, Dr. Finch and his wife, Raechelle, hosted my wife, Kristine and me, as well as Dr. Modlin (see photo, page 27).

Two additional sessions that I participated in during the meeting focused on pancreatic adenocarcinoma. My ACS lecture to the surgical congress was entitled Population-Based Outcomes in Pancreatic Cancer, and detailed the investigation into the epidemiology, as well as outcomes, of patients with pancreatic adenocarcinoma in the state of California. There are a number of similarities between Australia and the state of California, including ethnic diversity, geographic diversity, and access to health care, that made this lecture very relevant to the audience. Unbeknownst to me, and with very little fanfare, John Cameron, MD, FACS, President of the ACS, was attending the congress as well. On the day prior to my ACS lecture, Dr. Cameron gave his personal perspective on the treatment of pancreatic cancer. I truly enjoyed the opportunity to meet Dr. Cameron and to have our two lectures juxtaposed as part of the meeting (see photo, this page).

As part of my final presentation in the overall topic of pancreatic adenocarcinoma, I discussed Optimal Staging in Patient Selection: Where Are We Now? This session led to a very spirited debate among surgeons involved in treating pancreatic cancer, in which, regardless of national boundaries, we struggle with the same difficulties in the management of this deadly disease.

My participation in the surgical oncology section detailed the implementation of telemedicine resources at University of California (UC) Davis Cancer Center to facilitate community-based interaction in the multidisciplinary care of cancer patients. This lecture was entitled Multidisciplinary Clinics and the Community Surgeon, and it related the development of a virtual tumor board with real-time video and data conferencing to allow four regional cancer centers to participate in the disease-specific tumor boards at UC Davis. Given
the vast geographic diversity of Australia, this concept was very intriguing to this group of surgical oncologists for the facilitation of disease management and referral, as well as optimal patient treatment and consequent outcomes. The remainder of this session focused on ongoing clinical trials in surgical oncology, for which we have used our telemedicine platform to disseminate information, and even to identify patients remotely for clinical trials accrual. This concept had significant traction for this group of investigators and there is some degree of hope that this mechanism can facilitate ongoing patient accrual in these types of clinical trials.

Dr. De Viana asked me to participate in the section related to sentinel lymph node biopsy for breast cancer. This was a delight, as this session was truly high-powered, with involvement by Pat Whitworth, MD, FACS, from Nashville, TN, as well as Emil Rutgers, MD, from Amsterdam. My lecture, entitled Impact of Implementation of Sentinel Node on Stage and Survival in Breast Cancer, reviewed the impact of sentinel lymph node biopsy on ultra-staging of early breast cancer, and the potential impact stage migration may have on disease-specific outcomes. Again, the audience’s discussion was quite spirited, as is typical of breast cancer sessions, and it became clear that while sentinel lymph node biopsy is well entrenched in the current management of breast cancer in Australia, the evolution is proceeding similarly to that of the U.S.

The clinical trials discussed as ongoing in Australia paralleled the clinical investigation performed worldwide.

**Sydney**

From Brisbane, I traveled to Sydney for a visit that was coordinated by Andrew Biankin, MB, FRACS, of the Bankstown Hospital and the Garvin Institute. Dr. Biankin first had me visit the Bankstown Hospital, during which time I participated in their Gastrointestinal Tumor Board. This visit was followed by a lecture entitled Clinical Management of Pancreatic Cancer, offered to this multidisciplinary group of clinicians involved in treating pancreatic cancer.

From there, I participated in their ward rounds, which made me realize that while hospitals throughout the world may have different external facades and internal configurations, the teams of health care providers are all committed to the highest level of patient care. It was interesting to note that we struggle with the same issues. For example, I saw patients who had undergone futile exploratory laparotomies for presumed pancreatic cancer that was, unfortunately, found to be unresectable at exploration. Furthermore, issues of outpatient hospital care, whether in skilled nursing facilities or residence-based sites, paralleled the complexity of discharge management that I encounter on a weekly basis.

Dr. Biankin then asked me to lecture at the Garvin Institute, a free-standing facility dedicated to biomedical research.
My arrival at the center occurred simultaneously with the announcement that the federal government of Australia had awarded $70,000,000 (AUS) to the Garvin St. Vincent Campus Cancer Center to enable construction of an expansion of their biomedical research facility. While I thought the enthusiasm exhibited by the audience at my lecture was due to the subject matter, it was really excitement related to the fact that the Australian federal government had deemed the Garvin Institute a site of excellent biomedical research and worthy of further expansion. In any event, I provided their research seminar entitled Autophagy in Cancer to the community of biomedical investigators at the Garvin Institute.

Following this, Dr. Biankin asked me to participate in his laboratory research conference (see photo, page 29). During that time, he had organized a variety of short presentations from his research group, including various graduate students and postdoctorates, as well as collaborators. Dr. Biankin and I are two birds of a feather, in that we are both pancreatic surgeons focused on the clinical care of patients with this deadly disease, but we’re also very strongly invested in benchtop research, as well as clinical outcomes research, to further the progress in the management of this disease. During this half-day research meeting, we shared similar thoughts and opinions on barriers to furthering progress, and hopefully developed a lifelong relationship.

Melbourne

From Sydney, I traveled to Melbourne, where I was hosted by Bruce Mann, MB, FRACS, of the Royal Women’s Hospital of Melbourne. Dr. Mann has coordinated a group of breast cancer surgeons from throughout the Melbourne area who are engaged in ongoing educational meetings to consolidate the treatment of breast cancer, as well as promoting progress in these patients. To that end, Dr. Mann hosted me at their clinical lecture, during which I spoke on Current Controversies in Breast Cancer. As discussed at the breast cancer section of the Royal Australasian College of Surgeons, the management of breast cancer here remains very complex, with multiple levels of nuances related to the intricacies of disease management. It became apparent that despite attending this meeting in a foreign country, I had often had the same discussions with my surgical partners, as well as with breast cancer colleagues at UC Davis Cancer Center.

Dr. Mann was a most gracious host, in that he opened up his home and allowed me to visit with his lovely wife (Julie Miller, MD, FRACS), as well as with his family, during my visit in Melbourne. I also had the opportunity to attend the weekly morbidity and mortality conference of the general surgery division at the Royal Melbourne Hospital, and, subsequently, to participate in its Hepatobiliary Tumor Board meeting. The similarities to my own environment were overwhelming, and I was once again reminded that the delivery of general surgical care is independent of geography.

Performance measurement

From this last visit at the Royal Melbourne Hospital, I had the opportunity to springboard into a discussion with Dr. Mann that illustrated the importance of examining surgical outcomes. The practice of general surgery in Australia is undergoing an evolution, and this was most apparent in Melbourne and Sydney, where the surgeons related their ongoing struggles to balance elective practice with emergency practice, and coordination of academic effort with private practice—all while maintaining optimal patient outcome. The National Surgical Quality Improvement Project, coordinated by the ACS, allows for the evaluation of individual patient outcomes in subsequent benchmarking. This concept is currently not implemented in Australia, but, throughout our discussions, it was apparent that it had the potential to be broadly embraced.

A subject of significant debate during my visit to Australia had to do with the recent recommendations regarding the implementation of pay for performance, issued by the government’s National Health and Hospital Reform Commission. Indeed, a common ground shared between American surgeons and those internationally is the relationship between physicians and state or federal governments as significant payors of medical care. Evaluation of optimal outcomes and subsequent re-
warding of physicians compliant with parameters linked to improved outcomes remains a controversial issue. While this has already been implemented in the U.S., the absolute benefit of the improvement of health care delivery has yet to be fully realized.

As I left the U.S. for my journey, the state of California was struggling with an increasing budgetary deficit. The potential consequence of this deficit could be reduced payment to health care providers through MediCal, the state-funded health care program, as well as reduced support for academic medical institutions within the University of California. In addition, many universities throughout the U.S. have suffered a significant decline in their endowments, which support various aspects of academic medicine, including faculty retention, expansion of infrastructure, and occasional subsidization of the research environment. Upon my arrival in Australia, the impact of the recession was clearly evident, as many of the major universities had suffered significant declines in their endowment portfolios. While the recession in Australia may not seem severe to some, it will clearly have an impact on the practice of academic surgery. This situation fostered some shared commiseration regarding the impact the economy can have on surgical practice.

**Practice differences**

Despite all of these similarities, there are dramatic differences in the way our Australian colleagues practice surgery compared with my current practice at UC Davis. While I am an academic surgeon with a single site of practice, it is much more common for our Australian colleagues to practice at multiple-site hospitals—while maintaining an academic affiliation. Australian health care is essentially a two-provider system in which the majority of patients have federal insurance, with an additional minority supplementing that with a private payor source. Many academic surgeons will engage in a parallel private practice to supplement their income, but also to ensure sufficient clinical volume to maintain necessary competence.

As was evident in Sydney, the high-volume center and tertiary referral source for pancreatic adenocarcinoma was directed toward Bankstown Hospital by non-university-affiliated clinical sites. In fact, the university sites within Sydney would be viewed as low-volume providers within the arena of pancreatic cancer, and it is for this reason that Dr. Biankin has aligned himself with Bankstown Hospital. This hospital provides him with a clinical outlet, as well as a resource for his ongoing translational investigation in pancreatic cancer.

One surgeon that I had met at the Royal Melbourne Hospital was affiliated with 11 different hospitals. He would frequently travel between these sites within the duration of a week, and even within a single day. While this type of practice would ensure proximity of clinical care to the patient residents, we are confronting the possibility that outcomes may be improved through the regionalization of resources, especially within the cancer arena and complex surgical procedures.

**Opportunity of a lifetime**

After a whirlwind tour of Australia visiting the cities of Brisbane, Sydney, and Melbourne, meeting and interacting with numerous Australian physicians, and providing the previously described lectures, it is with genuine sincerity that I report this experience was a once-in-a-lifetime opportunity. I am tremendously grateful to the ACS for the opportunity to serve as the 2009 ANZ Traveling Fellow. It is clear that many of the issues facing the delivery of surgical care, the finances of health care delivery, and the impact of the economic recession transcend our national borders.

It is with fondness that I reflect on the long-lasting relationships that I have developed with the surgeons in Australia, most notably, Rob Finch, Andrew Biankin, Bruce Mann, and John Buckingham.

As an ambassador of the American College of Surgeons, I hope that I have served its constituents well in representing American surgery to our colleagues in Australia.

*Dr. Bold* is a professor and chief of the division of surgical oncology, department of surgery, for the University of California, Davis.
AMERICAN COLLEGE OF SURGEONS 96th ANNUAL

Clinical Congress

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Join us in Washington, DC, for the 96th Annual Clinical Congress. As always, it will be an educational opportunity you won’t want to miss!

Be sure to visit www.facs.org in the coming months for more details regarding the educational program, registration, housing, and transportation.
The Committee on Trauma (COT) honored two of its members for their exceptional service at the COT banquet, held March 20th.

John B. Kortbeek, MD, FACS, FRCSC, received the 2009 Meritorious Achievement Award for state/provincial chairs. This award recognizes a member of the Regional COTs for outstanding contributions to the care of the injured patient. Each year, the 16 Chiefs of the Regional Committees select nominees for this award by ballot poll, and the winner is subsequently approved and confirmed by the COT Executive Committee.

Dr. Kortbeek is professor of surgery and critical care at Foothills Medical Centre in Calgary, AB. He has served on the COT for many years: first as Chair of the ACS Alberta Committee on Trauma, 1996–1999, and then as Chief of COT Region 11 (Western Canada), 1999–2006. Since 2006, he has been Chair of the Advanced Trauma Life Support (ATLS) subcommittee, and his leadership is generally recognized to have been key to the revision and launch of the 8th edition of ATLS, which incorporates significant improvements to the course materials.

David G. Burris, MD, FACS, received the 2009 ATLS Meritorious Achievement Award, which honors the recipient for unselfish commitment and dedication to ATLS. The ATLS subcommittee is charged with nominating and voting on this award every year, and the person receiving the highest number of votes is presented to the COT Executive Committee for approval.

Dr. Burris is interim chair and professor of surgery in the Norman Rich Department of Surgery at the Uniformed Services University of Health Sciences (USUHS), in Bethesda, MD, which presented him with the USUHS Meritorious Service Award in 2001. He has served abroad in Germany, Turkey, Honduras, and most recently, in Iraq with the 912th Forward Surgical Team in Baghdad. Dr. Burris has been active in teaching ATLS since 1989, and has personally trained thousands of doctors. In addition, he was also a major supporter and contributor to the 8th edition revisions, generating many of the ideas for streamlining course delivery and management.

The ACS COT membership is pleased to have this opportunity to publicly acknowledge the many important contributions to trauma care made by Dr. Burris and Dr. Kortbeek during their long and selfless service on the COT.
The Committee on Trauma (COT) announced the winners of this year’s Residents Trauma Papers Competition at its annual meeting in Chicago, IL. There were 15 regional winners, who each received a prize of $500. An additional $500 was received by the two second-place winners, and an extra $1,000 was awarded to the two first-place winners. The competition is funded by the Eastern and Western States COTs, Region 7 (Iowa, Kansas, Missouri, and Nebraska), the National Trauma Institute, Wyeth Pharmaceuticals, and the American College of Surgeons.

The competition is open to surgical residents and trauma fellows. Papers are first submitted for state or provincial competitions. Those winners are then judged at a regional level. Papers should describe original research in the area of trauma care and/or prevention in one of two categories: basic laboratory research or clinical investigation.

Winning papers from 15 regions were presented at the Scientific Session of the COT meeting, which was moderated by M. Margaret Knudson, MD, FACS, Vice-Chair of the COT and Chair of the COT Regional Committees. The four final winners were announced at the Trauma Banquet on March 20.

The 2009 final winners are as follows:

- **First Place, Basic Laboratory Research:** Elizabeth A. Sailhamer, MD, Boston, MA: Histone Deacetylase Inhibition: A Novel Treatment for Lethal Septic Shock.
- **Second Place, Basic Laboratory Research:** Captain Reed B. Kuehn, MD, MC, Washington, DC: Behavioral and Histological Evaluation of a New Closed Head Injury Model in Rats by Utilizing Frontal Impact with Rotation and Extension.
- **Second Place, Clinical Investigation:** Maj. Joseph DuBose, MD, Los Angeles, CA (Major DuBose was stationed in Balad, Iraq, so the paper was presented by co-author, Maj. Bradley S. Putty, MD): Measurable Outcomes of Quality Improvement Using a Daily Rounds Checklist: One-Year Analysis in a Trauma ICU.
We fight frivolous claims. We smash shady litigants. We over-prepare, and our lawyers do, too. We defend your good name. We face every claim like it’s the heavyweight championship. We don’t give up. We are not just your insurer. We are your legal defense army. We are The Doctors Company.

The Doctors Company built its reputation on the aggressive defense of our member physicians’ good names and livelihoods. And we do it well: Over 80 percent of all malpractice cases against our members are won without a settlement or trial, and we win 87 percent of the cases that do go to court. So what do you get for your money? More than a fighting chance, for starters. Our medical professional liability program has been sponsored by ACS since 2002. To learn more about our program for ACS members, call (800) 862-0375 or visit us at www.thedoctors.com.

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American College of Surgeons
Mentorship essay winner selected

The Resident and Associate Society (RAS) of the ACS is pleased to announce that Anathea C. Powell, MD, of New York, NY, has won the prize in the 2009 mentorship essay contest for her submission on the late Erwin F. Hirsch, MD, FACS. Dr. Powell will receive her $500 award at the annual RAS meeting, Sunday, October 11, during the Clinical Congress in Chicago, IL.

We encourage all of Dr. Powell’s peers to attend this meeting and congratulate her on her fine accomplishment.

This contest was a result of efforts made by the RAS in launching its first essay contest asking residents, fellows, and new faculty to describe in 500 words or less the role that a mentor has played in their development.

The RAS exists to provide a forum for all residents and young surgeons to express their ideas and concerns about the issues of surgery.
E. Marino Blasini-Rivera, MD, FACS, was awarded the 2009 Humanitarian Choice Award by Oriental Group and BuenaVIDA magazine in San Juan, Puerto Rico, for his exemplary service in the medical field. Dr. Blasini-Rivera is a general surgeon and has been associated for many years with the department of surgery at the University of Puerto Rico School of Medicine, and was the chair, department of surgery, San Juan City Hospital, for many years.

Verne E. Chaney, MD, FACS—founder and president of Intermed International, Inc. (formerly the Dooley Foundation/Intermed, Inc), a not-for-profit that offers medical assistance to refugees in underserved countries—was the first recipient of the Sir Edmund Hillary Humanitarian Award (2009) from The Explorers Club. The award was presented to Dr. Chaney in recognition of his long-term commitment to humanitarian endeavors.

John Fildes, MD, FACS, and Gregory J. Jurkovich, MD, FACS, have been awarded certificates of appreciation for their leadership in defining triage criteria for injuries, by the U.S. Department of Health and Human Services Center for Disease Control and Prevention. Dr. Fildes is professor of surgery and vice-chair, department of surgery, University of Nevada School of Medicine, Las Vegas, and Chair of the ACS Committee on Trauma.

Dr. Jurkovich is professor of surgery, chief of trauma, University of Washington, Seattle; president of the American Association for the Surgery of Trauma; and Past Vice-Chair of the ACS Committee on Trauma.

John R. Handy, Jr., MD, FACS, director of Providence Thoracic Surgery, co-director, Providence Thoracic Oncology Programs, Portland, OR, and Immediate Past-President of the ACS Oregon Chapter, has been awarded an honorary doctorate for his selfless contributions to the development of cardiothoracic surgery in Mongolia, by the National Institute of Health Mongolia.

Eugene N. Myers, MD, FACS, distinguished professor and emeritus chair, department of otolaryngology, University of Pittsburgh Medical Center, received a gold medal from the International Federation of Oto-Rhino-Laryngological Societies for his contributions to the organization and for his work for international otolaryngology.

John A. Ridge, MD, FACS, chief of head and neck surgery, Fox Chase Cancer Center, Philadelphia, PA, has been elected president of the American Head and Neck Society.

Christian C. Shults, MD, a fourth-year general surgery resident at Washington (DC) Hospital Center, has been named a recipient of the American Medical Association Foundation’s 2009 Leadership Award.

Anton N. Siawy, MD, FACS, chief of surgical service, Veterans Affairs Medical Center, Washington, DC, and professor of surgery at both Georgetown and George Washington University Schools of Medicine (DC), was elected 2009–2010 president of the Society for Vascular Surgery.
A dominant theme in cancer therapy is tailoring therapeutics based on specific tumor biology. While this may seem more relevant to systemic treatments, the concept of targeted surgical procedures is also developing. Sentinel lymph node biopsy (SLNB) is an excellent example of targeted surgical therapy. In the past, many breast cancer patients underwent axillary lymph node dissection (ALND) only to discover postoperatively that all nodes were negative for metastatic disease. For early stage breast cancer and melanoma, lymphatic mapping (LM) and SLNB are now standard procedures that identify those patients who have node positive disease and may benefit from a regional lymph node dissection.

The American College of Surgeons Oncology Group (ACOSOG) has a strong history of targeted surgical procedure trials in breast cancer. ACOSOG Z10 (5500 patients) and ACOSOG Z11 (891 patients) were two SLNB trials for early stage breast cancer. However, the role of LM and SLNB for locally advanced breast cancer treated with neoadjuvant chemotherapy remains controversial. Preoperative chemotherapy regimens are effective in inducing primary tumor regression, which can lead to increased breast-conserving surgery. For example, ACOSOG Z1041 is studying neoadjuvant chemotherapy-trastuzumab regimens and preliminary data suggest a 60 percent pathologic complete response (pCR) rate at the primary tumor site.

As systemic neoadjuvant regimens improve for locally advanced disease, surgeons are seeing greater response rates both in the primary tumor and in the axilla. Many patients who present with locally advanced breast cancer have axillary nodal metastases that are biopsy proven, using axillary ultrasonography and either fine needle aspiration (FNA) or core needle biopsy. Such nodal disease can also respond to neoadjuvant therapy. An important question is whether SLNB is sufficiently accurate to predict node negative disease throughout the axilla, following neoadjuvant therapy. The fibrosis and distorted architecture of a sentinel lymph node (SLN), which once contained metastatic disease, could impair the lymphatic drainage from the breast, and thereby alter the accuracy of LM and SLNB.

ACOSOG Z1071 is a phase II study entitled Evaluating the Role of Sentinel Lymph Node Surgery and Axillary Lymph Node Dissection Following Preoperative Chemotherapy in Women with Node Positive Breast Cancer T1-4, N1-2, M0 at Initial Diagnosis. The study chair is Judy Boughey, MD, FACS. This trial was activated on July 15 and is available on the ACOSOG Web site in order for ACOSOG surgical investigators to submit to their institutional review board and begin enrollment. The primary objective of the trial is to determine the false negative rate for SLN. The false negative rates are defined as the number of patients declared to have no evidence of cancer in the SLN, and are found to have at least one positive lymph in the ALND, divided by the total number of patients with at least one positive axillary lymph node by ALND. The secondary objectives include determining the following factors:

- The accuracy of axillary ultrasound in assessing nodal disease after neoadjuvant chemotherapy
- The nodal status of patients after preoperative chemotherapy
- Whether the false negative rate for SLN surgery after neoadjuvant chemotherapy is related to the extent of residual cancer overall or separately in the breast or regional node basin
- The pCR rates for both

ACOSOG news

Targeted surgical procedures in oncology: Z1071 sentinel node protocol

by David Ota, MD, FACS; and Heidi Nelson, MD, FACS
breast and lymph nodes, and disease-free survival in node positive patients receiving neoadjuvant chemotherapy.

The correlative science objective is to determine the incidence and risk factors associated with the lymphedema following ALND. The target accrual for this trial is 550 patients. The eligibility criteria for Z1071 include:

- Histologic diagnosis of invasive breast cancer.
- Clinical stage T1-4, N1-2 (non-inflammatory), M0.
- Patients must have an FNA or core needle biopsy of an axillary node documenting nodal disease at the time of diagnosis.
- Patient will receive preoperative chemotherapy.

Clinical staging criteria has been adapted from the AJCC Cancer Staging Manual, 6th Edition, 2002. The interventions include preoperative chemotherapy and axillary ultrasound. The preoperative chemotherapy regimen will be determined by the treating medical oncologist. After completion of neoadjuvant chemotherapy, a restaging ultrasound is required to access the response in the breast and axilla. The site medical oncologist can use their regimen for neoadjuvant chemotherapy. Patients then proceed to surgery with LM, SLNB, and ALND and resection of the primary tumor.

ACOSOG continues to develop its portfolio of clinical trials that ask important surgical questions. Z1071 has the potential to determine the accuracy of LM and SLNB after patients have completed preoperative chemotherapy. The vast majority of patients undergo an ALND despite clinical evidence of primary and axillary nodal disease regression. This trial could determine the value of SLNB and reduce unnecessary ALNDs, which will reduce the morbidity associated with the treatment of node positive breast cancer.

Breast surgeons are encouraged to go to the ACOSOG Web site and evaluate this clinical trial for their patients.

Targeted surgery is about focusing treatment in order to reduce morbidity while controlling the disease—an important theme of many ACOSOG trials; we will continue to develop such trials in the future. We encourage you to learn more about ACOSOG by visiting http://www.acosog.org. You will discover that these trials address important questions that are relevant to practicing surgeons. Answers to these questions can only be obtained through our collective efforts.

We look forward to your participation in advancing the science of surgery.

References


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.

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/eme/traumtgts.html, or contact the Trauma Office at 312-202-5342.
CALL FOR SUBMISSIONS

2010 Clinical Congress of the American College of Surgeons

✧ The American College of Surgeons
Division of Education welcomes submissions to the following programs to be considered for presentation at

✧ the 96th annual
Clinical Congress,
October 3–7, 2010,
Washington, DC

✧ Oral presentations

✧ Surgical Forum*
Program Coordinator: Kathryn L. Matousek, 312-202-5336, kmatousek@facs.org
(12 $1,000 Excellence in Research Awards were given in 2009)
Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)

✧ Papers Session*
Program Coordinator: Beth Brown, 312-202-5325, ebrown@facs.org

✧ Poster presentation

✧ Scientific Exhibits
Program Coordinator: Kay Anthony, 312-202-5385, kanthony@facs.org

✧ Video presentation

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

Submission information

✧ Abstracts are to be submitted online only.
✧ Submission period begins November 2, 2009.
✧ Deadline: 5:00 pm (CST), March 1, 2010.
✧ Late submissions are not permitted.
✧ Abstract specifications and requirements for each individual program will be posted on the ACS Web site at www.facs.org/education/. Review the information carefully prior to submission.
✧ Duplicate submissions (submitting the same abstract to more than one program) are not allowed.

*Accepted authors are encouraged to submit full manuscripts to JACS.
The following disciplinary actions were taken by the Board of Regents at its June 6, meeting:

- **Aftab Ahmad**, MD, a thoracic surgeon from Portland, OR, was suspended from the College. Dr. Ahmad was charged with violation of the ACS Bylaws, Article VII, Section 1(b). The action was taken following disciplinary action taken by the Oregon Medical Board on October 16, 2008, placing limitations on his license to practice medicine. The ACS disciplinary action was reported to the National Practitioner Data Bank (NPDB) by staff.

- **Michael Omidi**, MD, FACS, a plastic surgeon from Los Angeles, CA, had his Fellowship status placed on probation by the College. This action was taken following charges that he had violated the ACS Bylaws, Article VII, Section 1(i), and the Statement on the Physician Acting As an Expert Witness, when he provided testimony in a medical malpractice lawsuit as an expert witness. This surgeon also appeared before the Central Judiciary Committee to testify on his own behalf. The ACS action was reported to the NPDB by staff.

- **Krishnarao V. Rednam**, MD, an ophthalmic surgeon from St. Louis, MO, was expelled from the College. Dr. Rednam was charged with violation of the ACS Bylaws, Article VII, Sections 1(a), (b) and (f), after his license to practice medicine in the State of Missouri was revoked. He pleaded guilty to the federal crime of obstructing a criminal investigation of a health care offense, and was convicted of that felony on April 11, 2008. The ACS action was reported to the NPDB by staff.

- A general surgeon from New York, NY, was censured following charges that he had violated the ACS Bylaws, Article VII, Section 1(i), and the Statement on the Physician Acting As an Expert Witness, when he provided testimony in a medical malpractice lawsuit as an expert witness. This surgeon also appeared before the Central Judiciary Committee to testify on his own behalf.

**Definition of terms**

Following are the disciplinary actions that may be imposed for violations of the principles of the College.

- **Admonition**: A written notification, warning, or serious rebuke.

- **Censure**: A written judgment, condemning the Fellow or member’s actions as wrong. This is a firm reprimand.

- **Probation**: A punitive action for a stated period of time, during which the member (a) loses the rights to hold office and to participate as a leader in College programs; (b) retains other privileges and obligations of membership; (c) will be reconsidered by the Central Judiciary Committee periodically and at the end of the stated term.

- **Suspension**: A severe punitive action for a period of time, during which the Fellow or member, according to the membership status, (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the member’s name from the Yearbook and from the mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor’s registration fee when attending College programs; (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or member is returned to full privileges and obligations of Fellowship.

- **Expulsion**: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
A new brochure from The Joint Commission titled *Speak Up*: Prevent Errors in Your Child’s Care includes a section that offers advice for parents and caregivers of pediatric surgical patients. The complimentary brochure is available for download on The Joint Commission’s Web site and includes a section that can be customized to list the name and logo of a surgeon or a surgical practice.

This new education campaign is part of The Joint Commission’s award-winning Speak Up program. It offers parents questions and answers that can help them navigate many common, yet complex, health care situations. Among the topics covered are:

- Preparing for your child’s visit to the doctor’s office
- Symptoms that mean you need to take your child to the doctor or hospital immediately
- What you should ask the doctor
- Taking medicine safely
- Having a medical or laboratory test
- Going to the hospital
- Having a safe operation

Speak Up brochures also are available on pain relief, understanding caregivers, medical tests, recovering after leaving the hospital, preventing medication mistakes, preventing infections, preparing to become a living organ donor, avoiding wrong site surgery, and preventing errors in care.

Brochures can be found at [http://www.jointcommission.org/PatientSafety/SpeakUp/](http://www.jointcommission.org/PatientSafety/SpeakUp/). All of the Speak Up brochures are available in an easy-to-read format as well as in Spanish. Preprinted brochures and other Speak Up materials are available for purchase from The Joint Commission Resources Web site, [http://www.jcrinc.com](http://www.jcrinc.com), or by calling 877-223-6866.
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.
When people think of a train ride, various images come to mind. Some may think back to the glamorous travels of the Orient Express, which began service from Paris to Istanbul in 1883, crossing six different countries while enlisting the cooperation of 10 different railroads. Passengers, who were often diplomats, government couriers, or royalty, dined on fine, five-course French meals. Or perhaps what comes to mind are the more mundane travels of the City of New Orleans, an Illinois Central train running between Chicago and New Orleans. While riding on this train in 1970, Steve Goodman wrote the famous folk song popularized by Arlo Guthrie, relating the images that he saw through the window of the club car while he played cards as his wife slept, on their way to visit his in-laws. Living just 2 miles from the site of the largest train robbery in U.S. history, which netted the bandits $3 million one June day in 1924, I can’t help but think of all the train robberies that have taken place over the years and how they may have contributed to an increase in passenger fatalities.

The airline industry has the lowest passenger fatality rate of the four major modes of travel. While highway travel by personal vehicle represents the greatest risk of death, train travel is a safe mode of passenger conveyance and is closer to air travel, in terms of safety. In 2008, trains carried almost 600 million passengers over 18 billion miles, with only 24 passenger deaths (http://safetydata.fra.dot.gov/officeofsafety/pubsite/Query/statsSas.aspx). According to the National Safety Council, passenger transportation incidents account for approximately 30 percent of unintentional injury deaths. The U.S. passenger fatality rate per 100 million passenger miles is 0.01 for air travel, 0.04 for both railroad and bus travel, and 0.78 for passenger automobiles (http://www.airlines.org/economics/safety/stats/).

In order to examine the occurrence of all train-related injuries in the National Trauma Data Bank® research dataset 2007 admissions records were searched utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification cause of injury code E800–E807 (railway accidents). 331 incidents matched these E codes and of these, 292 records had discharge status recorded, including 170 discharged to home and 52 to acute care/rehabilitation; 36
were sent to nursing homes, and 34 died (see Figure on page 44). These patients were 81 percent male and, on average, 36.8 years of age; they had an average length of stay of 12.8 days, and an average injury severity score (ISS) of 15.7. Of those tested or suspected for alcohol, more than 40 percent tested positive. When comparing the overall group versus the pedestrian-only group reported in last month’s Bulletin (pages 63–64), pedestrian rail injuries had a longer length of stay, higher average ISS, and higher mortality rate.

We are fortunate to live during a time when there are several options for travel. We can take planes, trains, and automobiles to get from one destination to the next. No matter what your mode of transportation, as you travel across the U.S., take time to look out of the window and enjoy the scenery. Perhaps you, too, will be inspired to pen the lyrics for a great folk song.

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

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

Acknowledgment

The author acknowledges the assistance of Chrystal Price, data analyst, NTDB, in the preparation of this column.

Dr. Fantus is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago, IL. He is Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.
To report your chapter’s news, contact Rhonda Peebles toll-free, at 888-857-7545, or via e-mail at rpeebles@facs.org.

**Metropolitan Chicago Chapter hosts Jeopardy game for residents**

Last May, the Metropolitan Chicago Chapter (MCC) hosted its first Jeopardy game for surgical residents. The chapter extended congratulations to Vijay Maker, MD, FACS, and the University of Illinois at Chicago, Metropolitan Group Hospitals program, on their success in earning the title of 2009 Resident Jeopardy champions (see photo, this page).

**Ecuador Chapter hosts Dr. Bailey**

The College’s chapter in Ecuador served as host to Randolph Bailey, MD, FACS, a Regent of the College, during his participation at the XXI Congress of Coloproctology. In addition, the Ecuadorian Society of Coloproctology elected Dr. Bailey to correspondent membership status. During his visit, Dr. Bailey also met with representatives of the Ecuadorian-American Chamber of Commerce and the rotary club (see photo, this page).

**Washington, DC, Chapter completes change**

In July, the Washington, DC, Chapter (also known as the Metropolitan Washington Chapter) contracted with BLF Management for management and administration services. BLF Management, based in the Columbus, OH, area, also manages the Ohio Chapter.

**Carolina chapters and vascular society meet**

In July, for the second year in a row, the South Carolina and North Carolina Chapters and the South Carolina Vascular Society convened a meeting at the Grove Park Inn, Asheville, NC. A wide variety of topics were presented during the educational program, including health care reform, acute care surgery, and geriatric surgery.

In addition, a joint residents papers competition was held and two leaders from each chapter were honored: Stuart Todd, MD, FACS (North Carolina Chapter), and H. Biemann Othersen, Jr., MD, FACS (South Carolina Chapter). Naji Abumarab, MD, from Vanderbilt University, presented the keynote address, entitled American Surgery: Common Goals, Uncommon Means.

In addition, both chapters held annual business meetings, and elected new officers (see continued on page 48
**Chapter meetings**

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

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Chapter</th>
<th>Location/contact information</th>
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<tr>
<td><strong>October 2009</strong></td>
<td></td>
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<tr>
<td>October 23–24</td>
<td>Iowa</td>
<td>Location: University of Iowa Hospitals and Clinics, Iowa, City, IA Contact: Sue Hyler, 515-270-3613, <a href="mailto:sue.hyler@pioneer.com">sue.hyler@pioneer.com</a></td>
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<tr>
<td>October 23–24</td>
<td>Minnesota Surgical Society</td>
<td>Location: Assisi Heights, Rochester, MN Contact: Aliza Rongstad, 651-999-5346, <a href="mailto:arongstad@nonprofitsolutions.com">arongstad@nonprofitsolutions.com</a></td>
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<td>October 25</td>
<td>Argentina</td>
<td>Location: Sheraton Hotel &amp; Convention Center, Buenos Aires, Argentina Contact: Roberto Lamy, MD, FACS, 54 11 4474488, <a href="mailto:rlamy@fibertel.com.ar">rlamy@fibertel.com.ar</a></td>
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<td>October 30</td>
<td>Connecticut (CS)</td>
<td>Location: Holiday Inn, Waterbury, CT Contact: Christopher Tasik, 203-674-0747 <a href="mailto:info@ctacs.org">info@ctacs.org</a></td>
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<td>November 6–7</td>
<td>Arizona (CS)</td>
<td>Location: Doubletree Paradise Valley Resort, Scottsdale, AZ Contact: Joni Bowers, 602-347-6904, <a href="mailto:jonib@azmedassn.org">jonib@azmedassn.org</a> ACS representative: Christian Shalgian</td>
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<tr>
<td>November 6</td>
<td>Keystone (CS)</td>
<td>Location: Pennsylvania Medical Society, Harrisburg, PA Contact: MaryTherese Gallagher, 717-909-2685, <a href="mailto:mgallagher@pamedsoc.org">mgallagher@pamedsoc.org</a></td>
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<td>November 6–7</td>
<td>Wisconsin Surgical Society (CS)</td>
<td>Location: The American Club, Kohler, WI Contact: Terry Estness, 414-453-9957, <a href="mailto:wisurgical@execpc.com">wisurgical@execpc.com</a></td>
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<td>November 12</td>
<td>Maryland (CS)</td>
<td>Location: Sheraton Baltimore North, Towson, MD Contact: Kim Andrews, 443-849-2393, <a href="mailto:andrews@gbmc.org">andrews@gbmc.org</a></td>
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<td><strong>December 2009</strong></td>
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<td>December 2</td>
<td>Brooklyn-Long Island (CS)</td>
<td>Location: Long Island Marriott, Uniondale, NY Contact: Teresa Barzyz, 516-741-3887, <a href="mailto:acsteresa@aol.com">acsteresa@aol.com</a></td>
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<td>December 2–3</td>
<td>Western New York</td>
<td>Location: Adam’s Mark Hotel, Buffalo, NY Contact: Joanne Chittenden, 716-839-4239, <a href="mailto:jmcchittenden@aol.com">jmcchittenden@aol.com</a></td>
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<td>December 5</td>
<td>Massachusetts (CS)</td>
<td>Location: Westin Copley Place, Boston, MA Contact: Stan Alger, 978-927-8330, <a href="mailto:salger@prri.com">salger@prri.com</a></td>
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<td>December 5</td>
<td>New Jersey (CS)</td>
<td>Location: Woodbridge Hotel &amp; Conference Center, Woodbridge, NJ Contact: Andrea Donelan, 973-539-4000, <a href="mailto:njsurgeons@aol.com">njsurgeons@aol.com</a></td>
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photo, this page). The joint chapter meeting concluded with an update on College advocacy-related activities.

**Chapter anniversaries**

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