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Looking forward

The American College of Surgeons (ACS) exists to ensure optimal care for the surgical patient and to promote the interests of surgeons in order to enable them to achieve this goal. Many current issues challenge this vision. If we are to succeed in the future, clear leadership and organizational focus will be essential. We can debate whether the College is, or should be, a trade or professional organization. Elements of both are present in our structure, but first and foremost the College exists to uphold professional standards.

Today, no one organization is big enough or powerful enough to be independent of others, and the only thing that is constant is change. Effectively managing change requires vision, skills, incentives, and a work plan. Without these key elements, we are confused and anxious, or slow to evolve.

Providing leadership to secure the future of the surgeon during times of change is the responsibility of the ACS Board of Regents, its Officers, and its Executive Staff. The recent emphasis on defining the College as the “house of surgery” will help us balance our self-interests with the goal of achieving the greater good.

We will need specific strategic goals and measurable outcomes to be successful. Currently we have four areas of focus identified by our Regents and the members of the Board of Governors. These focal points are quality and safety of surgical care, patient access to surgical care, medical liability reform, and reduction of health care costs. Bringing diverse opinions to consensus will be essential to influencing public policy and demonstrating a unified voice to the outside world. Clarity of organizational roles will be critically important while moving forward. Engaging our membership in the decision-making process and communicating effectively as decisions are made are essential for our organizational success.

Optimal surgical care

Defining optimal surgical care and employing outcomes research will require a greater effort and participation by our members in the future. Public expectations will emphasize validated evidence-based care that is delivered safely, cost-effectively, and with appropriate access. The health of our citizens is our greatest national asset. We can be the most substantial force for good in America, and we can help lead real and effective health care reform.

Many thought leaders and legislators have made critical recommendations regarding health care reform. The common theme is effectiveness and safety. Ensuring that care is effective and safe will do the most in achieving the goal of reducing unnecessary costs.

Though presented as a new concept, the effectiveness initiative started with Ernest Codman, MD, about a hundred years ago. Dr. Codman was one of the founders of the American College of Surgeons and its Hospital Standardization Program—which ultimately became today’s Joint Commission. Our heritage positions us to lead. We must put forth what is best for the patient. Patient advocacy and our service to mankind are the only interests to be considered. If we fail in keeping true to this mission, we will find ourselves faced with more government-controlled medicine, loss of professional ideals, and, ultimately, mediocrity.

High performance surgical care will stress the principles of teamwork. Regionalized health systems will be necessary to achieve optimal outcomes in some areas. Many surgeons in the
future may be hospital based. Defining best practices and measuring relevant outcomes will provide key factors in our ability to produce the quality improvement techniques that will allow us to preserve our professional status. We have current evidence that the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) reduces complications, improves quality, and cuts costs. We can, and should, develop a blueprint for surgical performance and assist our membership with oversight of their practices. We should expand our verification programs. Establishing verification programs was a major turning point in our history, and these programs have perhaps improved care more than anything else we have done. Delivering on these programs will be essential to maintaining our leadership role in surgery.

Similar to creating standards for care, we need to further develop an effective infrastructure for research. It took from the dawn of creation until the 16th century to answer questions by experiment rather than authority. Even so, many things today are still done based on tradition and the views of thought leaders rather than on true research. The promotion of new knowledge by creating an infrastructure that encourages and supports basic and clinical research in all aspects of surgical innovation is essential for future optimal surgical care. Developing focused areas for surgical research will be an important goal for the College in the future. Appropriate collaboration with public support agencies and industry to create this structure will be essential to our success.

Educational efforts

Educational effectiveness has never been more important. The rapid accumulation of knowledge and the development of technology challenge every surgeon as soon as he or she leaves postgraduate training.

One of the most important tasks we can accomplish is to help surgeons educate themselves. Providing efficient learning through electronic access, focused curriculum development and assessment techniques, skills training and validation, and the definition of legitimate goals for Maintenance of Certification will be essential services we will provide. As a College, we need to better determine which educational programs are the most effective.

We must also maintain the principles of teaching surgery by example, as well as by precept. Though challenging because of current time constraints, mentorship and one-on-one communication and critique have never been more important. Our programs have to encourage ongoing iteration as we move forward.

This approach will allow surgeons to maintain confidence in their skills and a secure professional identity. It will assure the public about surgeons’ professional standing and credentials. Developing our partnerships with the American Board of Surgery and other surgical boards, as well as with the Residency Review Committees, will foster implementation of best practice in our educational efforts.

Membership

Membership in the American College of Surgeons will continue to be the mark of a surgeon who is committed to quality. The College’s focus on promoting optimal patient care, maintaining professional standing, and advocating for the patient within organized medicine will always be values that every surgeon and surgical patient will recognize. Growth of our membership will continue to occur if we achieve these essential goals.

In addition, we need to continue to advocate regarding pocketbook issues, liability reform, and the development of professional standards to help surgeons practice smartly. Enhancing reimbursement and reducing risk for the surgeon are completely aligned with this goal and can be important benefits of membership. Increasing the participation of our members in achieving these goals will be critically important to membership growth in the U.S. and in countries around the world, where opportunities for growth have never been better.

“FACS” should be the most important surgical identity any surgeon holds, and we can reestablish the primacy of this identity. “FACS” declares our dedication to the patient every time it is written, and this is a commitment we share with our subspecialty colleagues. Further expansion of collaboration with the surgical subspecialties
and our international partners will ensure the success of the house of surgery.

**Advocacy and Health Policy**

Involvement in advocacy efforts and the development of health policy are essential College activities because socioeconomic forces have changed the complexity and values of the practice of medicine. Some people say the overall state of the U.S. economy is linked to what has happened in health care. Thus, it is critically important that surgeons regain influence and our decision-making ability regarding patient care issues by studying relevant health policy, providing leadership and effectively interacting with government officials and payors, and successfully achieving leadership opportunities through direct participation in all aspects of organized medicine.

We must use the innate leadership abilities we have as surgeons to advocate for the individual surgical patient. The infrastructure being developed by the College to facilitate achievement of this goal is commendable, and needs to be expanded in the future. These efforts have been positively affected by our leadership in the last several months during the legislative debate, and we have good evidence that Congress is listening.

**Working together**

In looking forward to the future of our profession and this organization, it cannot be denied that many challenges lie ahead. However, it is also true that the opportunities for the American College of Surgeons have never been better. We must all work together to ensure that the challenges are minimized and the opportunities maximized, with the end result being that our dedication to our profession and our patients remains solidly in place.

David B. Hoyt, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
IMPROVE YOUR ADVOCACY SKILLS
by attending the 2010 JSAC in July

by SARA MORSE,
Manager of Political Affairs, Division of Advocacy and Health Policy

In recent years, the American College of Surgeons has made a top priority of bringing together the entire surgical community in a robust and active coalition, representing more than 250,000 surgeons and their patients. (For more information on building a coalition, see the “Advocacy advisor” column on page 25.) This effort has added to surgeons’ political influence through strength in numbers and the combined credibility of its membership. Surgical society staff regularly meet to discuss a wide scope of issues, and are often working in stride on numerous projects and endeavors. One of the most tangible and successful examples of this collaborative effort is the Joint Surgical Advocacy Conference (JSAC), which has been growing in size and scope since its inception two years ago. The 2010 conference will be held July 25–27 in Washington, DC.
The surgeon advocate
Every day in Washington, DC, lawmakers are working on legislation that directly affects surgery—both the surgeon and the surgical patient. Now, more than ever, elected officials need to hear from surgeons. The range of issues the ACS and our surgical society colleagues weigh in on is dizzying. Each group, including the ACS, has a professional lobbying presence, which ensures that all surgical specialties are adequately and accurately represented. But more can, and must, be done. The most effective means of telling surgery’s story is through you, the surgeon advocate.

JSAC
JSAC is the only legislative conference that provides an opportunity for surgery as a whole to band together en masse, and work to effect real change on Capitol Hill. JSAC has the potential to become the largest and most potent advocacy event in Washington, DC. However, an advocacy coalition is only as strong as the activism of its membership, and JSAC must continue to rapidly grow in size and sophistication. Simply put, surgery’s political influence depends on you.

All Fellows of the College, along with all the members of the 18 other JSAC-participating organizations, are encouraged to join hundreds of their colleagues in this three-day conference, designed to promote and educate constituent surgeon advocates. The first day is an intensive introduction to the legislative process—how Congress really works. Participants will hear from surgical society staff, key members of Congress, and congressional staff on the status of legislation important to surgery, and they will learn what major changes have been, and will be, facing the U.S. health care delivery system. Perhaps most importantly, participants will be inculcated in the skills and tools necessary to effect change, both during their time in Washington, DC, and throughout the year at home. In response to attendee feedback, this year’s conference will feature several breakout sessions, so that seasoned surgeon advocates may take their advocacy skills to the next level, while first-time attendees will be presented with the basic tools and information needed to get them started on the right track.

On the final day of the conference, surgeons will blanket Capitol Hill, visiting hundreds of members of Congress and their staffs to share their personal anecdotes and experiences with these policymakers. This activity provides a face for the issues that legislators and their health policy advisors hear about, year-round, from your Washington advocacy staffs. Last year, surgeons visited a total of 272 legislators’ Capitol Hill offices.

In years past, the primary focus of the Capitol Hill visits was Medicare payment reform. In previous years, topics have included enhancing quality improvement initiatives, stabilizing the surgical workforce, preserving quality resident training, alleviating the medical liability crisis, improving trauma and emergency care, and investing in health care research.

As of press time, with efforts to achieve health care reform legislation well under way but not yet complete, it was unclear what specific issues will

2009 JSAC participating societies
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Surgeons
American Osteopathic Academy of Orthopedics
American Society of Cataract and Refractive Surgery
The American Society of Breast Surgeons
American Society of Colon and Rectal Surgeons
American Society of Plastic Surgeons
American Urological Association
Congress of Neurological Surgeons
Society of Gastrointestinal and Endoscopic Surgeons
Society of Gynecological Oncologists
Society for Vascular Surgery
The Society of Thoracic Surgeons
Save the date

2010
July 25–27, 2010
Hyatt Regency Washington on Capitol Hill
400 New Jersey Avenue, NW
Washington, DC

2011
March 27–29, 2011
JW Marriott
1331 Pennsylvania Avenue, NW
Washington, DC

2012
March 25–27, 2012
JW Marriott
1331 Pennsylvania Avenue, NW
Washington, DC

Visit http://www.facs.org/grassroots/index.html for more information and to register for the 2010 Joint Surgical Advocacy Conference

be facing surgeons in July. Whether or not Congress passes reform, and however comprehensive the final package signed into law by President Obama will be, there will certainly be no shortage of details that will require the swift and direct attention of surgical advocacy. No matter the final outcome, Congress will need direction for determining what must be accomplished to keep the American health care system running.

Other important activities

It is also important to remember that JSAC is not your only opportunity to participate in surgical advocacy. There are many things you can do throughout the year to help further surgery’s presence at the federal level, including the following:

Join the ACS Grassroots Network. Visit http://www.capitolconnect.com/acspa/ and follow the link to join the ACS Grassroots Network. As a Grassroots Network member, you will receive regular legislative updates, calls to action, and other pertinent advocacy information. Where the interest and circumstances exist, members of the Grassroots Network will be empowered to meet with members of Congress back in their home states, deliver American College of Surgeons Professional Association-Surgeons Political Action Committee (ACSPA-SurgeonsPAC) checks, and represent the College at various legislative and political functions. Grassroots Network members are encouraged to cultivate personal relationships with both senators and representatives as a further means to advance the legislative goals of the College.

Visit the ACS Federal Action Center. You can learn about, and take action on, issues pertinent to surgery, read about key legislation that the ACS is working on, find your legislators, and more by visiting this Web site: http://www.capitolconnect.com/acspa/.

Get to know your congressmen and senators by taking the following actions:

- Communicating with their offices on a regular basis, not just when you “need something”
- Setting up in-district delivery of ACSPA-SurgeonsPAC checks (a great way for you to get to know your member of Congress or to help foster your existing relationship)
- Scheduling a time for your member of Congress and/or his or her staff to tour your office and learn more about issues facing surgery, and how Congress directly affects your practice and your patients
- Hosting an in-district fundraiser for fellow surgeons and the greater physician community benefiting your member of Congress

Individual relationships with members of Congress and their staff are critical to the success of surgery’s advocacy efforts on Capitol Hill.

Get involved with your political action committee. For more information on ACSPA-SurgeonsPAC, visit http://www.facs.org/acspa/index.html.
TO SERVE AND PROTECT:
An interview with a surgeon-SWAT cop

by Tony Peregrin, Associate Editor
Andrew Dennis, DO, FACOS, DME, remembers the “call-out” as if it were yesterday: An agitated woman, recently released from Cook County Hospital in Chicago, IL, is now armed and barricaded inside a residence. The local SWAT team, which includes Dr. Dennis—a trauma surgeon and sworn police officer—responded to the call to assist.

“Well, Doc, what do you think about using a Taser in this situation?” SWAT team leaders asked this surgeon.

“This was a rare case,” recalls Dr. Dennis during a recent interview with the Bulletin. “This patient had recently been released from the hospital after undergoing a coronary catheterization; we actually knew all the medications she was on, and we knew that she had a tendency to drink. This was a rare occurrence because you usually don’t have this kind of information readily available to make this type of on-the-spot decision. I said, ‘Um, guys, this is probably not a great situation to use a Taser.’”

For nearly eight years, Dr. Dennis has worn two career hats: A combat helmet and a surgical cap. As an attending surgeon at the Cook County Trauma and Burn Units, Dr. Dennis works in one of the busiest trauma units in the U.S. He is the chairman of the department of surgery at Midwestern University, Chicago College of Osteopathic Medicine, and holds a faculty position at Rush University in Chicago. Dr. Dennis actively engages in both clinical and laboratory research, most recently as part of the Cook County Electrical Trauma Study Group, and has publishing several studies on electronic control devices, including the Taser.

A 39-year-old trauma and burn surgeon with a special skill for reconstructing abdominal walls, Dr. Dennis brings a unique and valuable skill set to not one, but two, Chicago-area SWAT teams: Cook County and its northern suburban counterpart.

Parallel worlds

“Police officers know how to face-read and are typically more hyper-aware of the situations unfolding around them—especially SWAT cops,” says Dr. Dennis, when asked about the similarities between his roles as a trauma surgeon and as a SWAT team member. “Trauma surgeons are not that much different. You learn, early on, how to read patients. When a person who is ill comes into the trauma unit, you learn to determine how serious their needs are right off the bat. You learn to read the ‘subtle tells’ that everyone broadcasts, whether they are a patient or an offender.”

Dr. Dennis began honing his people-reading abilities at the young age of 17 as a member of an emergency medical services squad along the northern Jersey shore. “Most 17-year-olds do not

Opposite: Dr. Dennis, in training at the federal law enforcement center, in surgery, and in front of the Cook County Hospital Trauma Unit.

SWAT medics in training with the Northern Illinois Police Alarm System in 2005. Left to right: Dan Romag (Northfield Police), Mark Wold (Glencoe Police), Matt Buckley (Lyons Police), and Dr. Dennis (Des Plaines Police).
The physical sensation—the rush—of working as both a trauma surgeon and a SWAT cop are very similar, admits Dr. Dennis. “Being a police officer and being a surgeon involve a certain degree of an adrenaline dump, but you have to remember that it is short-lived. The warrant that you are serving may have involved three or four days of planning, but the execution of the warrant may only take a minute. It’s no different for a surgeon. You train every day, you read, you study, but the reality is that the majority of trauma patients you see aren’t that sick. Maybe one or two patients who are seen each day qualify as true life or death trauma cases—and that’s when the adrenaline kicks in. The key is, you have to learn to control it. There’s an old saying in law enforcement: In extreme stress you will not rise to the occasion, but rather, you will sink to the level of training,” explains Dr. Dennis.

Dr. Dennis has never had to fire his gun in the line of duty, but he is required to have a firearm “at the ready” and to be fully capable of using it, should the situation arise.

“I don’t want to be the front door kicker. It’s fun, I would love to do it, but I am there to make sure these guys come home safely at the end of the day.” He admits that he sometimes plays the “what-if game,” whether he is performing the cop role or the surgeon role. “You are about to enter the building, and it’s a very critical moment. You look around, evaluate your surroundings, note possible paths for escape, but your fundamental goal is to do whatever you have to do to accomplish the mission, whether it’s rescuing a hostage or whatever the case may be. As a surgeon, if you are staring at an open belly full of blood, you can’t panic, you must stay focused and gather your senses in order to get the job done.”

**SWAT team scenarios**

The worst-case scenario for Dr. Dennis as a SWAT cop occurs when a fellow officer is critically injured. “When a police officer gets shot, and it’s one of your own, the psychological effects can be potentially far more reaching than the physical injuries. If you know his family, wife, and kids, and you saw him get shot or injured, you are immediately forced to channel your thoughts and actions and to fall back on your fundamental training for these types of situations. We train hard for the worst-case scenario, which, in reality, occurs about 2 percent of the time.”

The surgical tools that Dr. Dennis brings to a call vary according to the situation at hand. “We
have different load-outs and different kits for different missions, just as the ammunitions changes depending on the weapon. As for medical supplies, we minimize what we carry and what is on our person. It largely consists of basic life support tools, focusing on early hemorrhage control, basic airway adjuncts, preventing hypothermia, and devices to assist in forced extractions.”

There are three major scenarios that these specific SWAT teams are typically called in for, including:

- **Hostage barricades/barricaded subjects.** These situations include those who are armed and who lock themselves in a house/residence, with or without a hostage.
- **High-risk warrant services for search or arrest.** These are situations in which individuals may have guns and/or drugs and may be fortified and waiting for police to enter.
- **Weapons of mass destruction events,** which are law-enforcement responses for chemical, biological, or radiological scenarios; examples could include a terrorist attack or a methamphetamine lab.

The majority of medical issues Dr. Dennis encounters as a SWAT team surgeon include minor orthopaedic injuries and environmental injuries, such as frostbite or heat exhaustion. “We see minor and major trauma, burns, dehydration, chest pain, and a varied array of other medical issues.”

**Medics as medical conscience**

Sometimes the injuries are experienced by fellow SWAT officers. “Not all SWAT team operators are young,” offers Dr. Dennis, with a good-natured laugh. “Many are in their mid-40s, and we have to prepare for that. It’s 98 percent of what we do.”

Dr. Dennis—whose official title is medical director for the two SWAT teams he services—is quick to emphasize the fact that he is part of a larger team that includes up to eight other EMTs and paramedics, in addition to snipers, negotiators, and entry and perimeter teams.

Dr. Dennis’ overall goal is to support the SWAT team’s mission and, specifically, to support the overall health of the team, especially during prolonged “call outs.” The average SWAT call out for a barricade situation lasts more than eight hours and can occur in variable extremes of temperature and weather. Dr. Dennis and his team of medics are responsible for ensuring and implementing proper rest and warming cycles for fellow officers and fulfilling food and nutrition needs. Additionally, they offer quick remedies for aches, pains, and simple orthopaedic complaints. “We spot-check offices and teach them to check on each other for things such as frostbite and heat exhaustion. We are the medical conscience to the command staff,” offers Dr. Dennis, with a grin.

**Getting involved**

Unfortunately, it is rare for a trauma surgeon to be a member of a SWAT team, according to Dr. Dennis, largely due to demands on time and because medical liability malpractice insurance can be difficult to secure. (Dr. Dennis’ insurance is covered by the city of Des Plaines, IL, and Cook County.) “I think this expense is the number one factor that precludes doctors from doing what we do here with other tactical teams.”

In 2001, during his residency at St. James Hospital in Chicago Heights, IL, Dr. Dennis was approached by police officers who suggested that he join a SWAT team. “I was asked to do this, I didn’t seek this out,” he reveals. “As a third-year resident, I began interfacing trauma with EMS.
I would go out to the firehouses and set up post-action case reviews, and these turned out to be well attended meetings by both fire and police. I think I established my reputation with the local police by doing these case reviews and then one thing led to another, and here I am.”

Most recently, Dr. Dennis and colleagues have developed the Medical Tactics course series, an eight-hour practical and didactic training module designed to give officers the mindset and skills necessary to assess and manage trauma in tactical situations. According to Dr. Dennis, this is the first course of its kind developed specifically for patrol-level officers who have little or no prior medical training.

In addition, the Cook County Trauma Unit recently began incorporating emergency medicine and surgery residents into the tactical medicine experience. Dr. Dennis and his colleagues at Cook County, in cooperation with several law enforcement agencies, have developed the Law Enforcement Medical Asset Team. This group of residents, directed by Dr. Dennis, offers forward embedded medical support to supplement the SWAT medics. “Tactical medicine is a frequently requested rotation, and now we can offer this to interested residents. It has created a very close relationship between the Cook County Trauma Unit and our local law enforcement and pre-hospital agencies” says Dr. Dennis.

“Every night that I am on call at the Cook County Trauma Unit, I make it a point to open our doors to local, state, and federal law enforcement officers and agents,” says Dr. Dennis, who wears pink scrubs and wooden clogs while on call. “On average, we see about three to four gunshot wounds every night. Now, some police officers, especially suburban police officers, won’t see this type of penetrating trauma very often, and I think it’s important that they understand that most people who get shot or stabbed will survive. This is especially important because if they are the ones who are injured, they will have a mindset to prevail. Eliminating the Hollywood mindset is critical to survival in the streets.”

(A quick note regarding the wooden clogs: Dr. Dennis enjoys wearing them because they are comfortable and because they are very noisy. “The residents hear me coming, and tend to scatter as I come down the hall,” he says.)

**Finding balance**

Unwinding after a long day as a trauma surgeon and SWAT cop isn’t always easy for Dr. Dennis, but he finds comfort in his family: He has two small children with his wife, an obstetrician at Advocate Illinois Masonic Medical Center in Chicago.

“Yes, I work in two very high-stress environments, but at times the two can be very different and I love them each for their own merits. My partners at Cook County are the best anyone could ask for, and as for SWAT, I love the guys I work with, and some of them are my closest friends in the world. I also like not having to talk medicine all the time, to be honest with you, and to be able to hold a conversation that is not about health reform, for a change.

“I sometimes say police work is my hobby, but my wife will tell you it is my other job. She says, ‘You don’t have a hobby!’ And it’s true—I unwind from being a doctor by being with the police, and I unwind from my police officer role by being a doctor.”
On the importance of role models: The views of a senior surgeon

by Ivan Shulman, MD, FACS

Editor’s note: The Bulletin has published a number of articles related to younger surgeons and their role models/mentors. The following offers the perspective of an experienced surgeon as he looks back at the individuals who influenced his career and accomplishments.

In a recent issue of General Surgery News was an article about the “eternal fellow,” an autobiographical description of one resident’s journey to surgical completeness in order to fulfill his dreams of surgical excellence. I admired his determination and willingness to follow his intellectual and technical curiosity, as well as the patience of his wife and children to bear him through the consequences of his choices.

Mostly, however, I heard the importance to this young surgeon of several role models and mentors who he encountered in his training experience. One may quibble as to the difference between a role model and a mentor, but for purposes of this brief observation, I will consider them almost as equals, for the result in this case appears to be the same.

When we complete our training and begin our formal careers as surgeons, no matter if it is in an academic setting or a private group practice, like it or not, we are subject to observation and evaluation—sometimes with consequences that are unexpected. A surgeon is like an athlete or a performer on stage. We have a special room where we change into unique operating uniforms, we enter the operating theatre amid a cast of other performers, we turn on special lights, we do our work on a field, and occasionally in the audience we find younger individuals who may be either students or residents. And, whether we realize it or not, our performances are closely observed and internally graded by the next generation of “could-be” surgeons.

I refer to this group as could-be surgeons because, if current trends in surgery continue, there will not be enough new surgeons trained to take our place, and to be there when we need surgical care ourselves. One of the reasons for this impending crisis in surgery is that we, as practicing surgeons, fail to be good role models for the next generation. Too often, our performance as human beings in the operating room and in the hospital leaves much to be desired. We may think that it is sufficient to be technically deft and to wield a scalpel or laparoscopic instrument better than anyone else around, and to expect recognition for our expertise. But even if the patient does well, we may not have succeeded in the important area of providing those around us with a model of who a surgeon can be.

Recently, the daughter of a surgical colleague of mine, a bright, dedicated, and observant medical student, began her first clinical rotation on a general surgical service at a large teaching hospital. She had grown up with exposure to surgeons who were, for the most part, kind, careful, generous, intellectually curious, and patient people with families, who seemed to be able to balance the pressures of modern life with some degree of equanimity. And so on the first day of her first clinical rotation, when she encountered surgeons speaking disrespectfully and acting out to nurses, other physicians, operating room staff members, and to the medical students, she was not only shocked at this kind of behavior, but, at the same time, very impressed by it. Impressed, you say? Yes, impressed to the degree that discussions with her father, with me, and with other surgeons she knew could not dissuade her from concluding that surgeons were not the kind of people who she wanted to work with professionally every day, and that a career in surgery was not for her. I believe that this kind of event is surgery’s loss, and is something that we can ill afford.

I was fortunate enough in my younger years to have had several important physician role models who helped to shape my life as a surgeon. Charles Wood was my pediatrician, and it was his kindly, yet professorial demeanor that caused me, after my check-up as a 10-year-old, to turn to my parents that very day and say that I wanted to be a doctor just like Dr. Wood.

Henry Bahnson, chief of surgery at the Uni-

versity of Pittsburgh, was my next role model, having completed the first cardiac transplant in the state of Pennsylvania—a feat I heard about on the radio as I drove to medical school for the first time. And two days later, as our class sat together in our initial meeting, a tall, elegant man in a long white coat entered the back of the lecture hall and quietly slid into a seat behind me. He took time away from what I would have thought were much more important matters to attend to than the induction of a new class of medical students. For months after, that I would observe surgery in the dome above Dr. Bahnsen’s operating room, and I never failed to be amazed, and in admiration of, what he and other surgeons were able to do.

Kenneth Rogers, another pediatrician and public health specialist, provided me with the tools to begin to explore the service aspects of our profession, to expand for me what we as physicians can do in the best of medical traditions.

And lastly, Jack Porvaznik, a master surgeon of the old school who could do everything, was my role model and mentor for two years when I served in the Indian Health Service in Arizona. Jack had decided to make his entire professional career in service to those who lived in rural and isolated settings, and, as such, showed me a wonderful diversity of surgical skills, from orthopaedics to urology to gynecology to neurosurgery and anesthesia. Jack’s incredible devotion to his patients and his ability to see the big picture when evaluating a surgical case has never left me. I would like to think that I have been successful if I have been even half as good as he has been in the service to others.

I do not believe that any of these physicians purposely set out to impress me or shape me, nor do I think these individuals specifically set out to be role models for who I might become as a surgeon. They all succeeded at being role models simply by being themselves, by being the kind of physicians and surgeons that we should all strive to be. They did not act differently as physicians because I, or any one else, was around. It was because that was who they really were.

It is obvious that our “eternal fellow” has been the beneficiary of similar outstanding role models, and it is to all of their credit that he has been encouraged to act on his skills and abilities, and to realize his aspirations as a surgeon. On the other hand, I feel badly for my colleague’s daughter, whose surgical role models were individuals who did not seem to understand or care about the effect that their actions and words had on a could-be surgeon. I look back at the difficult people that I encountered during my training, and came away from those episodes vowing that I would not do what was done to me by senior staff. I hope I have been true to my vow.

While, ideally, it should come as second nature to us, it is important that as surgeons, no matter how concerned and occupied we might be at a given time, we must take time to realize that, willingly or not, we are always serving as role models for the next generation of surgeons. It is not likely that we will succeed every day in our quest to put a good foot forward, but we must always be aware of the influence that we have on others, not just our patients. It is incumbent upon us, through a creative use of all the means available, to do better than we have done before in encouraging and welcoming that next generation of could-be surgeons. If we do not do so, indeed, we will have only ourselves to ask, “Who will be there to care for us?”

**Dr. Shulman** is a general surgeon in Los Alamos, NM, and clinical assistant professor of surgery, University of Southern California, Los Angeles, CA. Dr. Shulman may be reached at ivans01@gmail.com.
A 44-year-old woman from Papua New Guinea (PNG) was referred to the USNS Mercy for evaluation of a left breast mass. During my assessment, I was surprised by the size and appearance of the ulcerated fungating tumor that had engulfed her breast (see Figure 1, page 18). She was weak and anemic, but the remainder of her physical exam was unremarkable, and the mass did not involve the chest wall. Due to the size (about 17 cm in diameter) and weight of the tumor, it was necessary for her to carry it within her left antecubital fossa when standing upright. She would fashion scarves and pieces of cloth to hide the disfigurement. She reported that the mass had slowly grown over a five-year period, but she had never sought help due to limited family resources and poor access to health care.

Upper left: LCDR Tadlock (right) operating with Dr. Kapfer. Main photo: The USNS Mercy off the coast of PNG.
My differential diagnosis included primary breast sarcoma or phyllodes tumor. I assisted Project Hope surgeon Ivan Shulman, MD, FACS (see article, page 15), and LCDR Amitabh Mohan, MD (of the Indian Navy), in performing a simple mastectomy. The final pathologic diagnosis was benign phyllodes tumor. Her postoperative recovery was unremarkable, and upon discharge, the woman and her husband expressed relief and gratefulness.

The ultimate away rotation: USNS Mercy

As a third-year general surgery resident from the Naval Medical Center San Diego (NMCSD), I had the unique opportunity to participate in the Pacific Partnership 2008 program on board the hospital ship USNS Mercy (T-AH 19). Over a four-month period during the summer of 2008, the Mercy, along with several partner nations, including some nongovernmental organizations, provided humanitarian and civic assistance in five host countries throughout Southeast Asia, including the Republic of the Philippines, the Socialist Republic of Vietnam, the Democratic State of Timor-Leste, the Independent State of Papua New Guinea, and the Federated States of Micronesia. During a six-week period, I assisted surgeons from the U.S. Navy, Indian Navy, Royal New Zealand Navy, and the volunteer organization Project Hope in treating surgical diseases in PNG and Micronesia.

The USNS Mercy, one of two hospital ships in the U.S. Navy, homeports in San Diego, CA. Originally converted from an oil tanker and then commissioned in 1986, the Mercy has 12 operating rooms, a 1,000-bed capacity, and an 80-bed intensive care unit, as well as radiology, endoscopy, pharmacy, laboratory, and pathology capabilities. In addition to the three general surgeons on board, I worked with specialty surgeons from pediatric and plastic surgery, otolaryngology, urology, and orthopaedic surgery. Gynecologic, oral-maxillofacial, and ophthalmologic specialists were on board, as well.

While I was involved in an international humanitarian assistance mission, it was also a structured educational experience. Under the guidance of CAPT Eric Kuncir, MD, FACS, a trauma and acute care surgeon from NMCSD who was my faculty mentor, I assisted in the surgical screening clinics, performed history and physicals on all admitted general surgery patients, and was intimately involved in all aspects of patient care.

Formal rounds were performed daily with attending general surgeons.

Ples Bilong Katim Man: Bread and butter general surgery in PNG

Approximately the size of California, the island of New Guinea is second in size only to its southern neighbor, Australia. Currently, the western portion of the island is a province of Indonesia. PNG is on the eastern portion of the island, and has been an independent state since 1975. The estimated 6 million people of PNG speak more than 800 different dialects, but the official language is the lingua franca Tok Pisin (also known as Talk Pidgin or New Guinea Pidgin), which is composed of mostly English and German words.

Our first two days in PNG were filled evaluating hundreds of potential surgical patients at Port Moresby General Hospital in the nation’s capital. Our clinic space was labeled “Ples Bilong Katim Man” (“place belong cutting man”), which means “general surgeon” in Tok Pisin. The more complex cases were scheduled earlier in the mission to allow for appropriate recovery time. Unfortunately, we had to turn some patients away, since we would not be in port long enough for the necessary recovery.

Many of the people we evaluated had poor dentition, with the brilliantly red-orange stained teeth, gums, and lips that are associated with the chewing of betel nut—or what the locals call buai (“boo-eye”). These seeds of Areca palm trees are commonly mixed with lime or mustard powder to improve the bitter taste. When chewed, they act as
a mild stimulant, giving the user a sense of euphoria. Betel nut use is a part of the everyday culture in PNG and is also a source of many informal jobs; however, it is associated with oral leukoplakia and oral cancer. The geographic region of Melanesia, which includes PNG, has the highest incidence of oral cancer in the world. Recently, it was reported that the chewing of betel nut in the streets of Port Moresby was banned because the spittle is associated with the spread of tuberculosis. Given how prevalent betel nut use is, this may be a difficult law to enforce.

Our next 10 operative days were very busy. I assisted with a variety of operations, including the repair of massive inguinal hernias, treatment of anorectal disease, laparoscopic cholecystectomies, and an urgent incarcerated incisional abdominal wall hernia repair. Moreover, we treated patients with advanced tumors, such as the patient with the phyllodes tumor. I assisted NMCSD plastic surgeon, CDR Trent Douglas, MD, FACS, with the excision of a 9 cm anterior right shoulder mass, and subsequent coverage with a split thickness skin graft (see Figures 2 and 3, this page). The superficial mass was enclosed by a pseudocapsule and easily separated from the underlying muscle. The final diagnosis was poorly differentiated (grade 3) spindle cell sarcoma. Upon the patient’s discharge from the Mercy, the Royal Australian Air Force arranged for the appropriate adjuvant therapy in Australia. With NMCSD otolaryngologist CDR Kevin Bach, I also had exposure to several head and neck cases (including a left superficial parotidectomy for a salivary duct cyst), and gained some experience in the evaluation and management of solitary neck masses.

The people of PNG were warm, generous, and very appreciative. After being treated on the ship or in one of the many mobile clinics that were dispersed to local villages, patients would travel several hours or more to Port Moresby to give handmade gifts to the providers who treated them.

Trauma in paradise

The Federated States of Micronesia are a lush tropical paradise composed of four states/island groups, with a total population of approximately 100,000 people spread over 607 different islands. We anchored in Truk Lagoon, famous for its shipwreck diving sites and naval history. In 1944, dur-

Figure 2: Soft tissue sarcoma of the right anterior shoulder in a 56-year-old woman.

Figure 3: Coverage with a split thickness skin graft.

Figure 4. Fillipin slingshot metal darts. (Photo provided by Dr. Arsenal.)
ing World War II, a large portion of the Imperial Japanese Navy fleet was destroyed in this area.

The people of Micronesia were exceptionally welcoming. The surgical screening clinics took place at Chuuk State Hospital, a small 30-bed facility on Weno Island. The hospital has limited resources, but it does have an operating room and a general surgeon, Julius Caesar Arsenal, MD. Originally from the Philippines, where he trained, Dr. Arsenal is truly a rural surgeon, as he practices in a remote part of the world. While I was there, a 14-year-old boy presented to the emergency room with penetrating trauma to his left posterior thigh. Embedded in his thigh were two long, metal darts. These Fillipin darts (see Figure 4, page 19) are made from 6 to 8 inch nails and fired with slingshots by local gangs. The name Fillipin is derived from the Filipino carpenters who taught locals how to make them. In a well-received presentation, Dr. Arsenal discussed his experiences managing hundreds of injuries from these darts, including penetrating cardiac trauma, to the crew of the Mercy.

We were not as busy in Micronesia, but the cases were interesting. I performed several pediatric hernia and hydrocele repairs with pediatric surgeon CDR Stephanie Kapfer, MD. Other cases included a terminal duct excision for an intraductal papilloma, two thyroid lobectomies, several adult hernia repairs, and a right-hand scar contracture release in an eight-year-old girl.

While in Micronesia and PNG, 550 operations were performed on board the USNS Mercy. I assisted with 46 of these cases, in a unique and rewarding international experience. (See Figure 5, this page.)

While the diverse caseload contributed greatly to my surgical education, working with surgeons from different countries and interacting with the people of PNG and Micronesia was, personally and culturally, enriching. I would like to thank all of the surgeons who allowed me to participate in the care of their patients.

For more information about the USNS Mercy and the Pacific Partnership, visit http://www.mercy.navy.mil.

The views expressed in this article are those of the author and do not reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. government.

References


LCDR Tadlock is a fourth-year general surgery resident at the Naval Medical Center, San Diego, CA, and has completed seven years of active duty. He is a Resident Member of the College.
Dangers of postoperative opioids: Is there a cure?

by Robert K. Stoelting, MD; and Matthew B. Weinger, MD

Editor’s note: The following article originally appeared in the Summer 2009 issue of the Anesthesia Patient Safety Foundation (APSF) Newsletter. Surgeons are a critical link in this safety issue, as patient-controlled analgesia is often ordered and supervised by the surgeon. Reprinted with permission.

On October 13, 2006, the APSF conducted a workshop in response to concerns about the safety of the use of patient-controlled analgesia (PCA) in the postoperative period. The workshop focused on improved detection of postoperative opioid-induced respiratory depression. A number of clinical observations and recommendations resulted, including the following:

• Even though current methods for detecting and preventing opioid-induced respiratory depression have limitations, APSF believes that continuous monitoring using available technologies could still prevent a significant number of cases of patient harm.

• Thus, the APSF urges health care professionals to consider the potential safety value of continuous monitoring of oxygenation (pulse oximetry) and ventilation in patients receiving PCA or neuraxial opioids in the postoperative period.

• Although pulse oximetry will monitor oxygenation during PCA, it may have reduced sensitivity, as a monitor of hypoventilation, when supplemental oxygen is administered. When supplemental oxygen is indicated, monitoring of ventilation may warrant the use of technology designed to assess breathing or estimate arterial carbon dioxide concentrations. Continuous monitoring is most important for the highest risk patients, but depending on clinical judgment, should be applied to other patients.

We believe that unexpected and potentially harmful opioid-induced respiratory depression continues to occur. In most cases, there is inadequate monitoring (as described previously) of
oxygenation and/or especially ventilation, as well as a failure to consider unique characteristics of the patient’s history and physical status that place them at higher risk for respiratory depression from opioid analgesics.

Standardized protocols for PCA or neuraxial opioids may promote a “one size fits all” approach to pain management without sufficient consideration of individual patient characteristics and medical conditions. Continuous pulse oximetry is not being routinely employed. More commonly, respiratory monitoring relies on nurses’ periodic observation and documentation of breathing or respiratory rate. Even when continuous pulse oximetry is utilized, supplemental oxygen may be administered, sometimes without confirming its necessity, or appreciating its potential to mask progressive hypoventilation.

It is critically important to emphasize the need to individualize postoperative pain management (opioid dose and infusion rate are not the same for every patient) and to insist that continuous monitoring of oxygenation (pulse oximetry) be the routine and not the exception. The use of supplemental oxygen must be justified. Finally, during PCA or neuraxial opioid therapy, intermittent subjective assessments of ventilation or level of consciousness are unreliable predictors of future respiratory depression even over short time frames (10 to 15 minutes).

We recommend consideration of the use of technology to continuously monitor ventilation in all patients receiving postoperative PCA or neuraxial opioid pain management. Where appropriate, this should be a routine component of postoperative care for patients known to be at high risk for opioid-induced respiratory depression (existing depressed level of consciousness or respiratory impairment, sleep apnea, or the very sick or elderly). Even if ventilation assessments are performed intermittently during routine nursing observations, the use of respiratory monitoring technology (capnometry) would improve the detection of progressive or unrecognized hypoventilation.

In summary, we believe that every patient receiving postoperative opioid analgesics should be managed based on the following clinical considerations:

- Individualize the dose and infusion rate of opioid while considering the unique aspects of each patient’s history and physical status
- Make continuous monitoring of oxygenation (pulse oximetry) the routine rather than the exception
- Assess the need for supplemental oxygen, especially if pulse oximetry or intermittent nurse assessment are the only methods of identifying progressive hypoventilation
- Consider monitoring ventilation (even if intermittent) with technology capable of detecting progressive hypoventilation

Unrecognized postoperative opioid-induced respiratory depression can be reliably detected only if an understanding of the pathophysiology of the sequence of events and available monitoring technology are considered in all patients.

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

Dr. Stoelting is president of the Anesthesia Patient Safety Foundation, Indianapolis, IN.

Dr. Weinger is secretary of the APSF.
The American College of Surgeons recognizes that safe patient care requires contributions from many providers and disciplines practicing together. Team science has shown that teamwork leads to better performance outcomes. Teamwork before, during, and after operations is essential to achieving the best patient outcomes. Therefore, the surgeon must be able to function effectively both as a leader and member of high-performing teams.

Critical attributes of high-performing teams include the following:

- A commitment by all team members to teamwork for the best interest of the patient
- Respectful behaviors, where contributions of all disciplines and providers are valued
- Recognition and constructive resolution of conflict
- Coordination among all team members that includes accountability for mutual performance awareness and backup behaviors
- Leadership characterized by the following:
  — Clearly defined leadership roles, particularly in critical situations
  — Leadership style appropriate to the clinical situation
  — Clear direction to the team from the leader(s)
  — Leaders who continuously solicit input from team members and engage in team-based decision making
- Timely, accurate, and structured communication with verification of understanding
- Effective care coordination, including structured hand-offs through all phases of care
- Ability to remain flexible and adaptable to changing situations

All health care organizations and venues have an obligation to promulgate teamwork. There are four critical components for success:

This statement was developed by the interdisciplinary ad hoc Committee on Development of High Performance Teamwork in Surgery through Education, and approved by the Board of Regents at its October 2009 meeting.
• Ensuring that all staff learn and use team-based knowledge, skills, and attitudes. The institution must provide appropriate education and training.

• Providing opportunities to practice team-based skills in a supportive environment that includes feedback and fosters experiential learning.

• Building teamwork techniques, prompts, and structure into the institutional workflow, such that teamwork becomes the routine and team behaviors are the norm.

• Institutional leadership and governance must support sustained team-based practice through the following:
  — Recurrent refresher training
  — Monitoring performance
  — Rewards for teamwork and team behaviors
  — Willingness to sanction noncompliant individuals regardless of status or role
Developing a successful coalition

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

Creating and maintaining a successful coalition is a key element in any state or federal advocacy campaign, but what makes a successful coalition? Coalitions have many components, and it’s important that you determine what type of coalition is best for achieving your legislative goals.

Membership

It’s important to keep in mind the key reasons people participate in coalitions. These reasons are also commonly known as the six R’s: recognition, role, respect, reward, results, and relationships.

Keeping the six R’s in mind will not only help you recruit your members, but also keep them happy.

Don’t forget to think outside the box. There are nonphysician organizations that may be interested in supporting your position. Consumer groups, unions, disease-specific associations, church groups, chambers of commerce/business groups, AARP chapters, hospital associations, and others could be approached to request their support and participation in a coalition.

Take trauma, as an example. Local businesses, chambers of commerce, and community service organizations may not be thought of as traditional “stakeholders” in trauma issues, but they can be an important part of your coalition. These business leaders can discuss the “cost” of trauma as it relates to their businesses and communities.

Patient groups are also vital to coalitions; they put a face to the issue. The more personal the story can be made, the more it will resonate with legislators. Also, recruiting new members for the coalition is not something that just happens once, but should be an ongoing goal of any coalition.

Preplanning

After identifying the groups you would like to engage, it’s important to define your mission statement. What exactly is the coalition hoping to accomplish? Is this a short-term goal or a long-term effort? Is your goal to better the overall medical liability climate in your state, or to pass “I’m Sorry” legislation? Often, successful, short-term coalitions will evolve into more formal, long-term groups, and a well-planned structure will make the transition easy.

Structure

You will also need to determine your organizational structure. Is this an informal group, or do you need or want a more formal structure? Some coalitions exist merely as networking groups. They exchange information, but do not share resources or collaborate on projects. Will the group have an executive board or a rotating chair? Who will administer the group, plan the meetings, arrange locations, keep minutes and agendas, and file necessary legal paperwork?

It’s important to determine each group’s responsibilities. Identifying each individual group’s resources, and what they are willing to share, is vital to the long-term planning and success of your coalition.

Decision making also should be discussed early in the formation of the coalition. Does each group get a vote? Will action be taken by consensus only, or will a unanimous vote be required on every item? How will disagreements be resolved?

In his article, “A practitioner’s guide to successful coalitions,” published in the American Journal of Community Psychology, Thomas Wolff points out that “the existence of collaboration will not eliminate conflict. Coalition leaders need to model conflict management and create settings where conflict can emerge and be handled productively.”

It is important not to forget to periodically review coalition goals and successes. Studies have shown that documenting successes, even if the larger goal is not achieved, will help people stay positive and focused. Planning formal feedback sessions is a great way to keep coalition members energized and focused. If your coalition is large enough, continued on page 35


In memoriam:

**Paul F. Nora, MD, PhD, FACS**

by C. Rollins Hanlon, MD, FACS, Executive Consultant; and Thomas R. Russell, MD, FACS, former ACS Executive Director

When Paul Francis Nora, MD, PhD, FACS, died on November 22, 2009, at the age of 80, it marked the end of the second phase in a distinguished career as surgical author, teacher, administrator, and philanthropist. His early years had been devoted to establishing his surgical credentials with the customary specialty certification, followed by a fellowship at a famed private clinic, a PhD in surgery, and the editorship—at age 43—of a multi-authored textbook on the topic of operative surgery. Dr. Nora’s second phase established him as a leader in the long, challenging fight against the scourge of legislation and litigation gathered under the misnamed heading of “medical malpractice.”

Accomplishing these two distinctive careers from the central location of a religiously oriented, immigrant-focused hospital—albeit one with university affiliation—made his achievements especially noteworthy.

Dr. Nora was prominent for many years as a pro bono consultant on professional liability with the College, and the pinnacle of this work occurred in 2008, when he endowed the College with the Nora Institute for Surgical Patient Safety. For this, and other contributions to the College in the Fellows Leadership Society, he was named in 2008 as a Distinguished Philanthropist of the American College of Surgeons.

**A leader in patient safety**

In the 1970s, the College recognized Dr. Nora as a unique resource whose ethical background and multiple talents could be allied with the College’s efforts against the persistent threat of professional liability. Working actively in a hospital with a strong moral tradition, buttressed by the dominant example of his father and brothers in a busy clinical practice consistent with the ideals of the hospital’s founder, Mother Frances Xavier Cabrini, it was natural that Paul Nora might come to occupy a leadership role in promoting College programs in surgical patient safety. The early efforts of the College in hospital quality assurance matured into the Joint Commission on Hospital Accreditation, which took on hospital systems as these developed, and is now known as The Joint Commission, a vast enterprise that was erected on some three decades of quality assurance under solitary College management, before assuming its multiple institutional character. Dr. Nora served as a College representative on The Joint Commission as a skilled commissioner during a critical phase in the organization’s history.

**Academic excellence**

Born in Chicago, IL, to a strong tradition of family medical service, Dr. Nora graduated in 1952 from Loyola University’s Stritch School of Medicine, in Chicago, IL. An internship at Cook County Hospital, Chicago, IL, was followed by service as a lieutenant in the U.S. Navy, from 1952 to 1955. Thereafter, he completed a general surgical residency at Cook County Hospital in 1959, and spent a fellowship year at the Lahey Clinic, Boston, MA, in 1960. He added a surgical PhD at Northwestern University, Chicago, IL, in 1968, and served as assistant professor of clinical surgery from 1969 to 1972, progressing to full profes-
sorship of clinical surgery at Northwestern in 1978.

Dr. Nora established a successful surgical residency program at Columbus-Cabrini Hospital, and edited the first edition of his textbook, *Operative Surgery*, in 1972, with 72 collaborating surgeons. A second edition was published in 1980, and a third was published in 1990.

**The second phase**

Dr. Nora’s home hospital base was diminishing gradually under the financial pressures that have been attacking all independent health care facilities, and his personal clinical surgical activities were winding down as he focused on administrative work with the College. The progressive advancement of his wife’s malignant disease and its therapy were based in California, and led Dr. Nora to gradually divide his time between the West Coast and the Midwest—where the second phase of his professional career was evolving.

In 1991, he published *Professional Liability/Risk Management, A Manual for Surgeons*. A second edition was published in 1997, at a time when the field was in the process of rapid development, with a specific focus on patient safety. A strong stimulus to enhanced professional and lay interest in patient safety occurred with the November 1999 publication of a report by the Institute of Medicine entitled *To Err is Human: Building a Safer Health System*. This alarming estimate of deaths, as a result of preventable errors, served to galvanize public and professional attention, and intensified a widespread plan for education and prevention of patient injury at the hands of physicians in training and in clinical practice.

In 2004, the College published *Surgical Patient Safety: Essential Information for Surgeons in Today’s Environment*, edited by Barry M. Manuel, MD, FACS, and Dr. Nora. In 15 chapters covering a wide range of topics from human factors to institutional organization, as well as contentious issues such as resident duty hours and error detection, the authors provide a valuable handbook calculated to increase patient safety by reducing error at every level of the patient encounter. In addition to co-editorship of the volume, Dr. Nora was also an author of the chapter on Accountability in Surgery, which advocates change in the “...prevalent culture of blame,” replacing it with a team approach to quality control. Such an approach critiques the operative surgical experience from the selection of surgical staff members to the details of the operation itself, as reported and analyzed with relentless objectivity.

Paul Nora left a splendid legacy in education, administration, and clinical surgical practice, before embarking on his outstanding accomplishments in quality control and surgical patient safety. With his late, beloved wife Valerie, and their five children and 10 grandchildren, complemented by 31 nephews and nieces, he provided a “great cloud of witnesses” to a life of immense achievement and quiet devotion. It was peculiarly appropriate that his final episode of illness began on the steps of his parish church as he was leaving his customary morning Mass. His work will continue in the Nora Institute for Surgical Patient Safety that Dr. Nora and his family instituted for the greater safety of innumerable future patients.
The American Medical Association (AMA) Interim House of Delegates (HOD) meeting was held November 7–10, 2009, in Houston, TX. “Climate change” came early to the meeting, as passions were aroused by passage of H.R. 3962, the House of Representatives reform bill. In the ensuing debate regarding the AMA health system reform policy, the College’s delegation effectively articulated the ACS’ positions, including support for H.R. 3961 (the Sustainable Growth Rate fix), and concerns with the Senate version of reform.

By a 2-1 margin, the AMA HOD affirmed support for H.R. 3962 as a legislative vehicle for health system reform, and declined opposition to the public option. Further, AMA policy was amended to include the following seven critical health system reform components:

• Health insurance coverage for all Americans
• Insurance market reforms that expand the choice of affordable coverage and eliminate denials for both pre-existing conditions or arbitrary caps
• Assurance that health care decisions will remain in the hands of patients and their physicians, and not with insurance companies or government officials
• Investments and incentives for quality improvement and prevention, and wellness initiatives
• Repeal of the Medicare physician payment formula
that triggers steep cuts and threaten seniors’ access to care.

- Implementation of medical liability reforms to reduce
  the cost of defensive medicine.
- Streamline and standardize insurance claims processing
  requirements to eliminate unnecessary costs and administra-
  tive burdens.

**Issue highlights**

Highlights of the HOD meeting included the following:

- **Funding to support training of the health care work-
  force.** Originally a request to oppose the expansion of graduate medical education funding to nonmedical doctor/doctor of osteopathy “residency” programs, this item was clarified to state that any new funding to support graduate medical education (GME) positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA)-accredited residency programs. It also emphasized that funding for the training of nonphysician health care providers should not be made at the expense of ACGME and/or AOA accredited residency programs.

- **Definition of physician/use of the term “doctor.”** A recent action by The Joint Commission (TJC) to revise the definition of “physician” in its glossary (incorporating Medicare’s definition, which includes non-MDs/DOs) raised the ire of many delegates. The HOD adopted a clear policy to indicate that a physician is a “doctor of medicine or osteopathy,” and to support AMA efforts to work with TJC and others to implement this definition. It also strongly agreed to support current AMA Scope of Practice Partnership initiatives to pass truth-in-advertising legislation in the states. The College is a member of the Scope of Practice Partnership Steering Committee.

- **Financial relationships with industry in continuing medical education (CME).** The AMA Council on Ethical and Judicial Affairs brought back, for a third time, proposed ethical guidance for both physicians and the profession, with respect to industry support for CME. Not unexpectedly, the HOD sent it back for further revisions, citing concerns that the guidance proposal did not adequately take into account existing guidelines or give sufficient thought to the likely impact of the recommendations on smaller CME providers.

**Surgical Caucus of the AMA**

The Surgical Caucus of the AMA remains an active and independent voice in the surgical and affiliated specialty community of the HOD. During the meeting, a robust review of HOD resolutions and reports resulted in clear positions on issues of greatest concern to surgeons, anesthesiologists, and emergency physicians. In addition, the caucus sponsored an educational session entitled Surgical/Anesthesia Patient Safety and Error Reduction.

**Elections**

During the business meeting of the Surgical Caucus, elections were held, with the following results:

- **Chair:** William Huffaker, MD, FACS (second term—plastic surgery)
- **Chair-elect:** Charles Drueck III, MD, FACS (second term—general surgery)
- **Secretary:** Michael Simon, MD (second term—anesthesiology)
- **Treasurer:** Michael Deren, MD, FACS (second term—cardiothoracic surgery)
- **Member-At-Large:** David Gerkin, MD (three-year term—ophthalmology)

Finally, the current ACS delegation should be recognized for their hard work and commitment to participating in the HOD: John H. Armstrong, MD, FACS, Delegation Chair, Gainesville, FL; Carlo Dall’Olmo, MD, FACS, Flint, MI; Sanjay Parikh, MD, FACS, Bronx, NY; Richard Reiling, MD, FACS, Charlotte, NC; Chad Rubin, MD, FACS, Columbia, SC; Patricia Turner, MD, FACS, Baltimore, MD; Jacob Moalem, MD, FACS, YPS Delegate, Rochester, NY; Christopher Shults, MD, RFS Sectional Delegate, Arlington, VA; and Hannah Zimmerman, MD, RFS delegate, Tucson, AZ.

2010 ACS Japan Traveling Fellow selected

David Shibata, MD, FACS, an associate professor specializing in surgical oncology at H. Lee Moffitt Cancer in Tampa, FL, has been selected as the 2010 ACS Traveling Fellow to Japan. As the Japan Traveling Fellow, Dr. Shibata will participate in the annual meeting of the Japan Surgical Society in Nagoya, Japan, April 8–10. He will also attend and participate in the ACS Japan Chapter meeting during that event.

Dr. Shibata will travel to several surgical centers in Japan, with assistance from mentors provided by the Japan Surgical Society and the Japan Chapter.

Dr. Shibata’s practice focuses on the surgical management of primary, recurrent, and metastatic colorectal cancer, and his clinical research involves the study of the surgical management, quality of care, and quality of life issues of patients with colorectal cancer.

The deadline for receipt of all application materials for the 2011 Traveling Fellowship to Japan is June 1. The requirements are posted on the College’s Scholarship Web page at http://www.facs.org/memberservices/research.html, and will be published in a future edition of the Bulletin.

2010 International Guest Scholars selected

During the 95th annual Clinical Congress in Chicago, IL, the Board of Regents awarded nine International Guest Scholarships for 2010.

This program, administered by the College’s International Relations Committee, enables talented young academic surgeons from countries other than the U.S. or Canada to attend and participate in the activities of the Clinical Congress. The Scholars also make tours of surgical institutions in North America that are specially tailored to their interests.

The 2010 International Guest Scholars are as follows: Laurent Brunaud, MD, Vandoeuvre les Nancy, France (Abdol Islami Scholar); Jorge G. Curi Lehmann, MD, Montevideo, Uruguay; Ruben H. Hovhannisyan, MD, Yerevan, Armenia; Toru Ikekami, MD, Fukuoka, Japan; Anil Mandhani, MB, BS, Lucknow, India; Michel Michaelides, BSc, MB, BS, MD, London, United Kingdom (Louis Argenta Scholar); Eduardo E. Montalvo-Javé, MD, FACS, Mexico City, Mexico; Simon Ng, MB, BS, FRCS(Ed), Shatin, Hong Kong, China; and Teffera Tekle, MD, Hawassa, Ethiopia.


Correction

The caption for the painting of the first ACS Board of Regents that appeared on page 12 of the December 2009 Bulletin misidentified several of the individuals in the painting. The correct listing, left to right, is: Drs. Albert Ochsner, Charles Mayo, John B. Murphy, Franklin Martin, George W. Crile, William D. Haggard, and William Mayo.
NAPBC now surpasses 100 accredited centers mark

The National Accreditation Program for Breast Centers (NAPBC) has announced that the number of centers that it has accredited has surpassed the 100 mark, and that its accredited breast centers can now be found in 38 states, including Alaska and Hawaii. To date, 120 breast centers have successfully completed the NAPBC’s rigorous evaluation and review process. NAPBC accreditation is given only to those breast care centers that have voluntarily committed to provide the highest quality care in breast disease diagnosis and treatment, and that have demonstrated compliance with the accreditation program standards.

The NAPBC is a consortium of national, professional organizations dedicated to the improvement of the quality of care and the monitoring of outcomes for patients with diseases of the breast. Bringing together leaders from the major medical disciplines that routinely work together to diagnose and treat breast disease, this multidisciplinary group created 27 program standards and 17 program components of care that collectively provide the most efficient and contemporary care available for patients diagnosed with diseases of the breast. NAPBC-accredited breast centers have met the criteria set forth for each discipline treating breast disease patients.

When a breast center applies for NAPBC accreditation, it does so with the understanding that it will offer a multidisciplinary approach to diagnosing and treating breast disease. Moreover, the center must be willing to undergo a rigorous application process and on-site survey to assure its patients that NAPBC standards are being met. Accredited breast centers also agree to maintain their high level of clinical care with recertification by the NAPBC, which is required every three years.

NAPBC-accredited breast centers offer the following:
- A complete range of state-of-the-art services
- Multidisciplinary team approach to coordinating the best available treatment options
- Information regarding ongoing cancer clinical trials and new treatment options
- Access to prevention and early detection programs, cancer education, and support services
- Ongoing monitoring and improvements in cancer care

Administered by the College, the NAPBC began developing its program in 2005, and the formal process of surveying breast centers for accreditation started in September 2008. With a multidisciplinary membership, the NAPBC pursues its mission through standard-setting, scientific validation, and patient and professional education. To learn more about the National Accreditation Program of Breast Centers and to view the complete list of NAPBC-accredited breast centers, visit: http://www.accreditedbreastcenters.org.
2011 Traveling Fellowship to Germany announced

The International Relations Committee of the ACS announces the availability of the Traveling Fellowship to Germany. The purpose of this fellowship is to encourage international exchange of surgical science, practice, and education, and to establish professional and academic collaborations and friendships. The ACS Traveling Fellow will visit Germany and, as part of the exchange program, a German Traveling Fellow will visit North America.

**Basic requirements**

The scholarship is available to a Fellow of the American College of Surgeons in most of the surgical specialties who meets the following requirements:

- A major interest, and accomplishment, in clinical and basic science related to surgery
- Holds a current full-time academic appointment in the U.S. or Canada
- Younger than 45 years of age on the date the application is filed
- Enthusiastic, personable, and possesses good communication skills

**Activities**

The Fellow is required to spend a minimum of two weeks in Germany and to engage in the following activities:

- Attend and participate in the annual meeting of the German Surgical Society in Munich, Germany, May 3–6, 2011
- Attend the German ACS Chapter meeting
- Visit at least two medical centers (other than the center in the annual meeting city) in Germany before or after the annual meeting of the German Surgical Society to lecture, and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and designated representatives of the German Surgical Society and the German ACS Chapter. The surgical centers selected for a visit would depend, to some extent, on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Germany.

His or her spouse is welcome to accompany the chosen applicant. There will be many opportunities for social interaction, in addition to professional activities.

**Financial support**

The College will provide $6,000 to the chosen applicant, who will also be exempted from registration fees for the annual meeting of the German Surgical Society.

He or she must meet all travel and living expenses. Senior German Surgical Society and ACS German Chapter representatives will consult with the Fellow about the centers to be visited in Germany, the local arrangements for each center, and other advice and recommendations regarding travel schedules. The Fellow is urged to make his or her own travel arrangements in North America, due to the likely availability of reduced fares and travel packages for travel in Germany.

The ACS International Relations Committee will select the Fellow after reviewing and evaluating the final applications. A personal interview may be requested prior to the final selection. Applications for this traveling fellowship may be obtained from the College’s Web site, http://www.facs.org/memberservices/acsgermany.html, or by writing to the International Liaison, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications and all supporting documents is **April 1, 2010**. The successful applicant, and an alternate, will be selected and notified by July 31, 2010.
College seeks nominations for 2010 Jacobson Promising Investigator Award

The American College of Surgeons is accepting nominations for the sixth Joan L. and Julius H. Jacobson II Promising Investigator Award, to be conferred in 2010. This award has been established to recognize outstanding surgeons engaged in research advancing the art and science of surgery, who have shown through their research early promise of significant contribution to the practice of surgery and the safety of surgical patients. The 2010 award, funded through a generous endowed fund established by the donors, is in the amount of $15,000. The College’s Surgical Research Committee administers the award.

Award criteria

• Candidate must be board-certified in a surgical specialty and must have completed surgical training in the last six years.
• Candidate must be a Fellow or an Associate Fellow of the American College of Surgeons.
• Candidate must hold a faculty appointment at a research-based academic medical center (military service position included).
• Candidate must have received peer-reviewed funding such as a K-series award from the National Institutes of Health (NIH), Veterans Administration, National Science Foundation, or U.S. Department of Defense merit review to support their research effort.
• Nomination documentation must include a letter of recommendation from the nominee’s department chair. Up to three additional letters of recommendation will be accepted.
• Only one application per surgical department will be accepted.
• Nomination documentation must include an NIH-formatted biosketch and copies of the candidate’s three most significant publications.
• Nominee must submit a one-page essay to the committee explaining why he or she should be considered for the award and discussing the importance of the research he or she has conducted/is conducting.

Special consideration will be given to surgeons who are at the “tipping point” of their research careers, with a track record indicative of early promise and potential (such as degree program in research or K-award). Surgeon-scientists who are well established (for example, funded by NIH R01 grants) are not eligible candidates.

Award criteria and nomination procedures are available on the College Web site at http://www.facs.org/cqi/src/jacobsonpia.html.

Nomination procedures

To be considered for the award in 2010, submissions must be e-mailed or postmarked no later than March 12. After compiling the necessary award criteria documentation in an electronic format, you may submit it via e-mail to Mary T. Fitzgerald at mfitzgerald@facs.org. Nomination materials can also be submitted on a CD-ROM and mailed to Ms. Fitzgerald at the following address: American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

Applicants are encouraged to verify that all necessary documentation has been received before the March 12 deadline. For additional information, contact Ms. Fitzgerald by e-mail, or call 312-202-5319.
Call for nominations for the ACS Board of Regents

The 2010 Nominating Committee of the Board of Governors has the task of selecting two nominees for pending vacancies on the Board of Regents, to be filled during the 2010 Clinical Congress in Washington, DC. The following guidelines are used by the Nominating Committee when reviewing the names of candidates for potential nomination to the Board of Regents.

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
- Recognition of the importance of their representing all who practice surgery
- Also to be taken into consideration are geography, surgical specialty balance, and academic or community practice. The College encourages consideration of women and other underrepresented minorities.
- Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the Board of Regents. Priority consideration should be given to representatives of general surgery.

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, February 26.

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

For information only, the current members of the Board of Regents who will be considered for re-election are as follows: Barrett G. Haik, MD, FACS; and Howard M. Snyder III, MD, FACS.

Call for nominations for ACS Officers-Elect

The 2010 Nominating Committee of the Fellows has the task of selecting nominees for the three Officer-Elect positions of the American College of Surgeons: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The following guidelines are used by the Nominating Committee when reviewing the names of potential candidates for nomination as Officers of the College.

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

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, February 26.

If you have any questions, please contact Patricia Sprechsel, Staff Liaison for the Nominating Committee of the Fellows, at psprechsel@facs.org.
Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its October 10, 2009, meeting:
• Roy E. Berkowitz, a general surgeon from Slidell, LA, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following disciplinary action by the Louisiana State Board of Medical Examiners, which placed his license to practice medicine on probation for three years following charges that he prescribed, dispensed, or administered legally controlled substances without legitimate medical justification.
• Michael Q. Durry, a general surgeon from Baltimore, MD, was expelled from the College following a period of temporary suspension pending completion of the ACS disciplinary process. These actions were taken following disciplinary action by the Maryland Board of Physicians in response to allegations that he engaged in a sexual relationship with a former patient, a female inmate at Jessup Correctional Institute.
• A general surgeon from New York, NY, was censured 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.

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 CJC 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;

ADVOCACY ADVISOR, from page 25

newsletters and end-of-year reports are an easy way to facilitate this.

Barriers
Industry experts stress the importance of avoiding turf battles. Remember the members of the coalition are there for a common goal, a common purpose, and it may be necessary to modify the organization’s activities in order to achieve what is best for the group. However, be prepared for handling conflict among disparate positions; consensus building can be difficult, but the eventual outcome will be worth it when the governor or President signs a bill into law.
A look at The Joint Commission

Joint Commission International celebrates a milestone

In December 2009, Joint Commission International (JCI) celebrated the 10th anniversary of the first health care organization to be awarded accreditation under its globally developed international standards for hospitals. JCI is the international arm of The Joint Commission. Established to respond to a growing demand around the world for standards-based evaluation of quality in health care, today JCI accredits or certifies more than 300 health care organizations and clinical care programs in 39 countries. (See Figure, this page.) JCI offers accreditation programs for hospitals, clinical laboratories, continuum of care (non-acute care settings such as home care), medical transport, ambulatory care, and primary care. JCI also offers a certification program for disease- or condition-specific clinical care programs. JCI’s accreditation standards are the first, and only, international sets of standards that apply to health care organizations worldwide while accommodating cultural differences.

In December 1999, Hospital Israelita Albert Einstein, a private, not-for-profit, non-governmental facility in Sao Paulo, Brazil, was the first hospital accredited by JCI under the international standards. The hospital has also since achieved JCI Disease- or Condition-Specific Care Certification for its stroke program. “Quality and safety challenges know no borders, and health care organizations around the world want to create environments that focus on quality, safety, and continuous improvement,” says Karen H. Timmons, president and chief executive officer (CEO) of JCI. “Accreditation meets this demand by stimulating continuous, systematic improvements in a hospital’s performance, and the outcomes of patient care. Health care organizations that have achieved JCI accreditation have made a public commitment to quality and patient safety.”

“Health care is a basic human right,” says Claudio Luiz Lottenberg, MD, CEO, and president of the board of trustees for Hospital Israelita Albert Einstein. “And JCI is the barometer for quality and safety as we meet patient needs.”

JCI, which is accredited by the International Society for Quality in Health Care, extends The Joint Commission’s mission worldwide. In addition to accreditation, JCI has extended its efforts to promote safe, quality care over the years with the following:

• The International Essentials for Quality and Patient Safety. This program is for hospitals starting the quality journey or facing the challenges of providing high-quality, safe
patient care, despite limited equipment or financial and human resources. The Essentials program helps organizations begin the process of designing and implementing a risk reduction program that will lead to improved patient safety.

- The World Health Organization (WHO) Collaborating Centre for Patient Safety Solutions. The WHO redesignated The Joint Commission and JCI as the world’s first WHO Collaborating Centre for Patient Safety Solutions, dedicated solely to patient safety. The Centre focuses worldwide attention on patient safety and best practices that can reduce safety risks to patients. The Collaborating Centre coordinates efforts to spread these solutions as broadly as possible, internationally, through its work with ministries of health, patient safety experts, national agencies on patient safety, health care professional associations, and consumer organizations. In 2007, the Collaborating Centre launched nine solutions that are applicable to a wide variety of countries and health care settings.


2010 Leadership Conference to be held in July

The College’s 2010 Leadership Conference will be held July 24–25 at the Hyatt Regency Washington on Capitol Hill in Washington, DC. Chapters are encouraged to send their Chapter Officers, two or three young surgeons (age 45 or younger), and their Chapter Administrator or Executive Director. Immediately following the Leadership Conference, the Joint Surgical Advocacy Conference will convene.

The tentative schedule of events includes:

- Saturday, July 24, 5:00–7:00 pm: Welcoming reception hosted by the Washington, DC, Chapter
- Sunday, July 25, all day: ACS Leadership Conference for chapters and young surgeons, opening reception; individual society briefings
- Monday, July 26: Congressional speakers; Capitol Hill reception
- Tuesday, July 27: Capitol Hill meetings. The College’s Washington, DC, Office will schedule Capitol Hill visits for all the chapters that participate. The visits will be conducted on Tuesday afternoon.

To register, call the Chapter Hotline at 1-888-857-7545, or visit the Chapter homepage at http://www.facs.org/about/chapters/index.html.

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:

- 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/cme/traumtgs.html, or contact the Trauma Office at 312-202-5342.
The Executive Committee on Video-Based Education, through the Division of Education and Ciné-Med, has developed the interactive Multimedia Atlas of Surgery. Each volume presents a comprehensive list of surgical procedures, featuring:

• Narrated surgical video  
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• Foreword by Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, American College of Surgeons

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American College of Surgeons • Division of Education
“Improving the Quality of Surgical Care Through Education”
The 2009 Annual Pediatric Report: How old is old enough?

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

The 2009 Annual Report of the National Trauma Data Bank® (NTDB) is an updated analysis of the largest aggregation of U.S. trauma registry data that has ever been assembled. In total, the NTDB now contains more than 3 million records. The 2009 Annual Report is based on 627,664 records, submitted by 567 facilities, from the single admission year of 2008. The 2009 Annual Pediatric Report is based on 132,126 2008 admission year records from 553 facilities.

A new feature of this year’s report is an expanded section on facility information. This section includes information on registry inclusion criteria for participating hospitals, and allows the reader to consider differences in case mix across hospitals while reading the report. For example, what is the age of a pediatric patient? There is variability with the age cutoff for inclusion in a pediatric trauma registry that may be a result of local, regional, or state criteria. The Figure on this page addresses the question, “How old is old enough to no longer be considered a pediatric patient?”

The mission of the American College of Surgeons Committee on Trauma (COT) is to develop and implement meaningful programs for trauma care. In keeping with this mission, the NTDB is committed to being the principal national repository for trauma center registry data. The purpose of this report is to inform the medical pediatric community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured infants, children, and adolescents in our country. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.

Many dedicated individuals on the ACS COT, including the Pediatric Surgery Specialty Group, along with dedicated individuals caring for pediatric patients at trauma centers around the country, have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, our goals in the coming years include improving data quality, updating analytic
methods, and enabling more useful inter-hospital comparisons. These efforts will be reflected in future NTDB reports for participating hospitals, as well as in the pediatric annual reports.

Throughout the year we will be highlighting these data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Pediatric Report 2009 is available on the ACS Web site as a PDF and a PowerPoint presentation at http://www.ntdb.org. In addition, information is available on our Web site regarding how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB at mNeal@facs.org.

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

**Dr. Nathens** is Canada Research Chair in Systems of Trauma Care, division head of general surgery, and director of trauma of St. Michael’s Hospital, and medical director at Ontario Critical Care Program, Toronto, ON. He is the Chair, National Trauma Data Bank Subcommittee.

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### American College of Surgeons Official Jewelry & Accessories

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**Form No. 95909-07-09**