Surgeons respond to the needs of a broken nation

HAITI
FEATURES

Surgeons respond to the needs of a broken nation 6
Diane S. Schneidman

Haiti impressions: January 23–26 and January 28–February 3, 2010 10
A. Brent Eastman, MD, FACS

Health care reform becomes law—with room for improvement 21
Kristen Hedstrom

Development of the Medical and Surgical Simulation Institute: Accra Ghana, West Africa 23
Lenworth M. Jacobs, Jr., MD, MPH, FACS, FWACS(Hon); Karyl J. Burns, RN, PhD; and Rudolph Darko, MD, FWACS

Who said that midterm elections aren’t interesting? 31
Sara Morse

DEPARTMENTS

Looking forward 4
Editorial by David B. Hoyt, MD, FACS, ACS Executive Director

Advocacy advisor 35
Grassroots, grasstops, and...Astroturf?
Melinda Baker

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On the cover: Members of the College responded with alacrity in providing disaster relief services in the wake of the recent earthquake devastation in Haiti. (See articles on pages 4, 6, and 10.)
In memoriam: J. Bradley Aust, MD, FACS

Arthur S. McFee, MD, FACS

ANZ Traveling Fellow selected for 2011

Presidential Addressess available on archives site

Did you know...

Martin, Carrico, and Argenta Fellowships awarded by College

Resident Research Scholarships for 2010 awarded

Report of the 2009 International Guest Scholar

Jaqueline Cruz Vargas, MD

International Guest Scholarships available for 2011

A look at The Joint Commission:

Revised medical staff bylaws standard approved

Report on ACSPA/ACS activities, February 2010

Michael J. Zinner, MD, FACS

Disciplinary actions taken

Trauma meetings calendar

NTDB® data points: Double McTwist 1260

Richard J. Fantus, MD, FACS

Chapter news

Rhonda Peebles
This issue of the Bulletin spotlights the efforts of the American College of Surgeons and our Fellows to provide disaster relief services in Haiti earlier this year. I commend all of the surgeons who volunteered their time and talent to help the people of this poverty-stricken island, as well the ACS leaders and staff who worked tirelessly to coordinate the College’s activities. We should all be very proud of what we were able to accomplish in a very short amount of time.

However, we must prepare for the future, as well. The people of Haiti, who are still in need of our help and who will be for some time, as well as potential victims of future natural and man-made disasters throughout the rest of world, cannot afford for us to remain complacent. The College—through the Committee on Trauma (COT), Operation Giving Back (OGB), and our leadership—is continuing to explore how our organization can be of assistance to people in need on a continuous basis.

Response to the earthquake
The ACS and the entire emergency surgical and medical community responded to the 7.0 force earthquake that hit Haiti on January 12 in exemplary fashion. Within an hour of the earthquake, ACS Fellows began contacting the College to find out what they could do to help, and within 24 hours, the College had established dedicated tools to communicate about the rapidly evolving situation. Coordination of relevant information was spearheaded through the COT and OGB.

Online resources included nine pages of clinical, cultural, and logistical information, disaster guidelines, media alerts, a registry of more than 950 volunteers, and a Google map of relief efforts. Feedback and situational updates from surgeons on the ground in Haiti and the Dominican Republic were instrumental in keeping electronic resources relevant and up to date. Two visits to Haiti by the Chair of the Board of Regents, A. Brent Eastman, MD, FACS, helped frame the direction of resources created in the early days of the relief efforts.

More than 200 ACS Fellows provided feedback either during or upon return from their deployment in Haiti, and were instrumental in supporting U.S. government rapid response teams, teams from not-for-profit organizations, academic disaster relief teams, and other efforts. As the U.S. Navy positioned the USNS Comfort off the shore of Port-au-Prince, the ACS was in the process of formalizing a memorandum of understanding in order to better support the humanitarian role of surgeons in the earthquake’s aftermath.

In addition, a modification of the ACS Case Log System was tailored to be appropriate for the Haiti situation, and access was opened to all surgeons who provided care on the island, so that all surgical cases could be entered into the system. The Case Log System was made available in response to several requests for patient data-gathering tools from physicians and surgeons who were deployed in Haiti.

Our future role
Kathleen Casey, MD, FACS, Director of OGB, initiated the long-term planning process for Haiti in late January by meeting with the Haitian and U.S. medical leadership on the ground. Ongoing communication with Haitian officials, the U.S. government, the military, and nongovernmental organizations that remain involved in the recov-
ery efforts form the basis for understanding the role of the ACS and the surgical community in the coming years. Opportunities for continued engagement will continue to be shared through the OGB Web site.

The College’s response to the Haitian earthquake demonstrates how nimbly and professionally this organization can step in when tragedy strikes. This experience also has provided us with insights into how we can solidify key relationships in such crises in the effort to better prepare and support the surgical community to respond in future disasters.

The College’s efforts to improve its ability to respond to cataclysmic events really started about five years ago, when surgeons expressed frustration with their inhibited ability to assist the victims of Hurricane Katrina. As a result, the COT’s Ad Hoc Committee on Disaster and Mass Casualty Management developed the Disaster Management and Emergency Preparedness (DMEP) Course, presently under the leadership of Leonard Weireter, MD, FACS. The DMEP has now been presented 56 times to health care professionals who would be first in line to respond to future natural and man-made catastrophes, wherever and whenever they may occur. The course serves as a primer for medical providers to assess their community’s likelihood of facing a disaster and their ability to respond adequately. The College is promoting this program through an advertising and publicity campaign. In fact, a segment about the Roanoke, VA course aired on National Public Radio on April 19.

In addition, the COT is developing a disaster response guidebook that will facilitate the College’s involvement in future relief activities. This effort will allow the ACS leadership to expeditiously collect, coordinate, and disseminate information and resources.

Furthermore, ACS Regent Bruce Browner, MD, FACS, has led an effort to develop an ongoing relationship with the U.S. Department of Homeland Security and the Department of Health and Human Services’ Office of the Assistant Secretary for Preparedness and Response. As a result of this process, plans are under way to develop a cadre of “federalized” trauma, orthopaedic, neurological, general, and plastic surgeons, as well as other specialists, such as anesthesiologists, involved in emergency care, who can be deployed to disaster areas. These health care professionals would be credentialed and mobilized as federal employees. Hence, the government would provide them with transportation, security, liability protections, food, shelter, and so on.

The College’s involvement in Haiti clearly demonstrated how quickly and compassionately surgeons can, and will, respond to crisis situations. We learned a great deal in the aftermath of Hurricane Katrina, and this knowledge and our resultant efforts allowed us to be better prepared when tragedy struck Haiti. I believe our swift and eager response to the earthquake will help us to continue to implement programs that will enable us to be even more effective the next time a disaster situation arises in the U.S. or abroad.

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.
Surgeons respond to the needs of a broken nation

by Diane S. Schneidman,
Manager, Special Projects,
Division of Integrated Communications
On Tuesday, January 12, a 7.0 force earthquake struck the nation of Haiti, killing at least 200,000 people, delivering devastating blows to more than 300,000 bodies, and ravaging families, homes, and the island’s entire medical infrastructure. At least one Fellow of the American College of Surgeons was in Haiti that day, while another Fellow, a native Haitian, began communicating with the College’s leadership to coordinate an organization-wide response to the disaster.

Peter Meade, MD, FACS, a general surgeon at Tulane University Medical Center, New Orleans, LA, was completing a one-week surgical mission sponsored by the Coalition of Children in Need Association in Ouanaminthe, Haiti, about 200 miles north of the earthquake’s epicenter in Port-au-Prince. “Having lived in California for 20 years, I knew what an earthquake felt like, so when the building started to shake, I told everyone to get out. I stayed where I was because I was in the middle of an operation. The shaking lasted only about a minute and a half, but it felt much longer,” Dr. Meade said. “Because the building I was in held together, I didn’t realize the enormity of the situation until the next day, when we started getting reports from CNN and other news organizations through our Blackberrys.”

Meanwhile, those same forms of communication were delivering the horrifying news to people back in the states, including Henri Ford, MD, FACS, professor and vice-chairman, department of surgery, and vice-dean for medical education, Keck School of Medicine, University of Southern California, Los Angeles. Dr. Ford called Haiti home for the first 14 years of his life, and several of his family members still reside there. When the earthquake hit, Dr. Ford was completing a visiting professorship at Duke University Medical Center, Durham, NC.

“Once I had learned about the devastation that had taken place, it was clear to me that I needed to get myself to Haiti for the simple reason that, when I reflected on all that I have been doing all my life, it occurred to me that I had been preparing to intervene in a catastrophe such as this one. Being a Haitian-American—someone who speaks the language, who knows the territory, who is a pediatric surgeon with expertise in trauma—when I saw bricks falling on little children, it was clear to me where I belonged,” added Dr. Ford, who is also vice-president and surgeon-in-chief at Children’s Hospital of Los Angeles.

However, Dr. Ford had one very important piece of business to take care of before he could leave the U.S. He was scheduled to attend the ACS Committee on Trauma (ACS-COT) meeting on January 13. During the course of the meeting, Dr. Ford worked with College officials—including the Chair of the Board of Regents, Brent Eastman, MD, FACS; ACS Executive Director David Hoyt, MD, FACS; and the Chair and Vice-Chair of the Committee on Trauma, John Fieldes, MD, FACS, and M. Margaret Knudson, MD, FACS—to secure the College’s commitment to developing an organization-wide response to the crisis. The COT, the College’s Operation Giving Back program, and key College staff sprung into action. For the two-week period immediately following the earthquake, Dr. Hoyt, Dr. Eastman, and others who were instrumental figures in this effort sent almost daily e-mail updates on the College’s activities to the membership, describing how Fellows could get involved and prepare for deployment. The College also operated a telephone answering center and encouraged volunteers to sign up online and then link with relief groups. Approximately 950 ACS members, including Dr. Eastman, volunteered their services. (For details about Dr. Eastman’s activities, see the sidebar on page 10.)

“[The ACS leadership] really put together a massive response, a massive call to action, mobilizing other trauma surgeons to go down to Haiti. It was absolutely overwhelming to me,” Dr. Ford said.

Teams deployed

Now confident that the College would be supportive of surgeons who wanted to help the people of Haiti, Dr. Ford departed for his homeland on January 16. Like many other surgeons who were
R. Shackford, MD, FACS, a vascular surgeon in San Diego, CA, has been going to Haiti with a team from the University of Vermont since 2003. This group of nurses, anesthesiologists, and two surgeons generally provides assistance at Hôpital Sacre Coeur, which is based in Milot and supported by the CRUDEM (Center for the Rural Development of Milot) Foundation. His daughter, Maureen, is a nurse and has accompanied him on several missions, including this one.

Selwyn O. Rogers, Jr., MD, FACS, got involved in this particular effort to assist the earthquake victims through Partners in Health (PIH), which is based in Boston and has strong ties to the Brigham and Women’s Hospital, where he specializes in surgical critical care. A surgical resident, Joseph Sakran, MD, has a special interest in global health initiatives and was able to participate in this particular effort through the help of Russell Seneca, MD, FACS. Dr. Seneca had been to Haiti numerous times through a collaboration that Inova Fairfax Hospital has with the Community Coalition for Haiti, Dr. Sakran said.

The surgeons who went to Haiti all agree that being involved in government- or university-based medical assistance programs or not-for-profit organizations was an important factor in getting to Haiti in a timely way and being able to accomplish as much good as possible.

Eileen Bulger, MD, FACS, who is active in the West Coast IMSuRT, said, “These groups take responsibility for ensuring that medical and surgical teams are organized ahead of time, that team members have been properly vaccinated, and that they are prepared to go at a moment’s notice.” Surgeons who carry out disaster relief efforts through well-established channels have all the resources they need. “They have the equipment, they have the security, they have the transportation,” Dr. Bulger explained. “I think when people get into trouble is when they want to help, but aren’t prepared and don’t go in an organized system. They get down there and find themselves in a situation where they can’t do very much.”

Christopher Born, MD, FACS, professor of orthopaedic surgery, The Alpert Medical School of Brown University, Providence, RI, is involved in the east coast IMSuRT. “The way our team is constructed, there is a large pool of people who are credentialed for the team, including nurses,

among the first responders to the crisis, Dr. Ford is involved in the National Disaster Medical System (NDMS), which is run by the U.S. Department of Health and Human Services. NDMS deploys Disaster Medical Assistance Teams (DMATs) and International Medical-Surgical Response Teams (IMSuRTs). DMATs are specifically designed for patient triage and emergency room-based care, whereas IMSuRTs are designed to operate field hospitals with operative capability. The U.S. has three IMSuRTs, covering the western, eastern, and southern coastal areas.

Other surgeons made their arrangements through universities with strong ties to Haiti, according to Dr. Knudson. For example, Steven

Scenes of post-earthquake destruction in Haiti. In the bottom photo of the collapsed pediatric hospital, a bed can be seen near the edge of the remaining tower at left.
emergency medical specialists, emergency medical technicians, pharmacists, surgeons, administrative people, logistics people, and so on. From that large pool, they were able to pull a team together in 12 hours,” Dr. Born said.

“Shortly after the earthquake struck, I contacted PIH medical director Joia Mukerjee, MD, and informed her that I would be willing and able to go at a moment’s notice. She arrived in Haiti on January 14 and arranged for a group of 15 nurses and physicians to be chartered on a flight to Port-au-Prince on the 16th,” Dr. Rogers said, explaining how PIH was able to pull together a team.

Thomas Scalea, MD, FACS, a trauma surgeon at the University of Maryland, went with a group representing that institution. “Because we had the relationships in place, we were able to get this up and going in a day or two,” he said. “We got there within about 10 days after the earthquake struck.” His 15-member team included representatives from nursing, anesthesia, orthopaedic care, general surgery, emergency medicine, and so on.

**Getting there**

Even some of the most well-established groups, however, were briefly thwarted in their efforts to provide immediate assistance due to logistical, security, and uncontrollable problems, including a 6.0 aftershock that slammed Port-au-Prince on Monday, January 18.

“It was difficult to get into Haiti because the flights were so limited. You basically had to have a number to get in. They didn’t have an air traffic control tower anymore—just some guys out on the airfield with walkie-talkies. They didn’t want anyone to get hurt, so they were trying very hard to avoid having a huge overflow of people all trying to land at the same time,” according to Sylvia Campbell, MD, FACS, a general surgeon based in Tampa, FL, who has done relief work in Haiti for 14 years.

Dr. Born said the biggest issue for his team was security. “We went from the airport to the American Embassy, and we stayed there for three days because they wanted to find a facility that could be properly secured. They didn’t want to put us out in the middle of a big soccer field where it would not be possible to secure the perimeter of the facility. I think at the moment that was an understandable decision, but it delayed our ability to set up the field hospital,” Dr. Born said.

**Initial reactions**

Although surgeons who have been involved in DMATs and relief groups were trained and ready to answer the call for help as soon as it continued on page 12
In health care, it strikes me that the issues are three: 
Realism, dignity, and love. 
—Sen. Jacob Javitz, during end-stage treatment 
for amyotrophic lateral sclerosis

In my career as a trauma surgeon, I have seen much 
grief and devastation, but nothing like what I saw 
in Haiti; I believe I’m a better surgeon for having 
been there. 

At Hôpital St. Francois de Sales in Port-au-Prince, 
one mile from the epicenter of the earthquake, Steve R. 
Shackford, MD, FACS, the Scripps Medical Response 
Team (SMRT), and I joined forces with our friend and 
colleague Thomas M. Scalea, MD, FACS, and his team 
from University of Maryland Shock Trauma Center, 
Baltimore, MD. We worked together by chance, but 
it was a fine example of what collaborative fellow 
surgeons can accomplish under austere and trying 
conditions.

The immediate response by ACS Executive Direc-
tor David B. Hoyt, MD, FACS; Operation Giving Back 
Director Kathleen Casey, MD, FACS; the Committee 
on Trauma leadership; and ACS staff in coordinating 
Haitian relief efforts has been exemplary. We have been 
able to help not only in Haiti, but closer to home, as 
the lessons learned by our many ACS volunteers will 
be critical in dealing with inevitable future disasters— 
natural or man-made—on American soil.

Soon after the earthquake on January 12, our SMRT 
was put on notice by the state of California to stand 
by in order to staff California’s 222-bed Mobile Field 
Hospital (MFH) in Haiti. However, logistics of the mo-
bilization were never worked out between California 
and the federal government—which was unfortunate, 
as the MFH would have been an invaluable asset, as 
was the Israeli MFH which was, in fact, effectively 
deployed.

On our own, then, on January 23, post-quake by 11 
days, Chris Van Gorder, chief executive officer (CEO) 
and president of Scripps Health (and also commander 
of the San Diego, CA, Sheriff’s Search and Rescue Unit 
and EMT) and I arrived in Haiti on a reconnaissance 
mission to find a place to work, and a safe house for 
our SMRT team. We found both through one of my 
former trauma surgeons at Scripps, Edward Gamboa, 
MD, FACS, who learned—through an ACS communica-
tion from Dr. Hoyt—that I was going to Haiti, and I 
learned that he was there with his friend, Archbishop 
Bernardito Auza, the Papal Nuncio to Haiti—who is 
the Vatican’s envoy to that country. We were graciously 
lodged at the Nuncio’s residence, and taken to the total 
ruins of the Nuncio’s Catholic hospital, St. Francois 
de Sales, where, amid the devastation, a four-story 
pediatric building had collapsed, with an estimated 200 
1odies entombed in the rubble. The stench of death 
was overwhelming.

Patients at St. Francois were all being housed and 
cared for in tents and minimal shelters in the central 
courtyard, because no one would enter the few rooms 
left standing for fear of another quake. The hospital 
is surrounded by a wall with a steel gate and guards— 
controlling access for the teeming masses on the 
rubble-filled streets outside.

W hen we arrived, we found a Belgian relief team, 
led by Dr. Luc Beaucourt, a trauma surgeon from 
the University of Antwerp, Belgium, who took us 
on “rounds” within minutes of our arrival, and asked 
me to see a young man with a crushed right arm and 
leg and, although not yet diagnosed, an obvious com-
partment syndrome. Luc asked if I knew how to treat 
it. When I said I did, he said “This one’s yours,” and 
tied a red ribbon on the bed as the pre-op order. We 
picked our way over rubble to the “OR” in a partially 
collapsed building, and “scrubbed” for surgery under
a broken faucet in a broken wall, dripping into a dirty plastic bucket. Our CEO, Chris, was my scrub nurse. Anesthesia was a single dose of ketamine given by a Belgian anesthesia tech, and there was zero monitoring of the patient.

There was also a small German team, including an orthopaedic surgeon, from Hanover. Discussions were held in Creole, Dutch, French, and German; we mostly just listened and operated.

Unbeknownst to us, our first patient, Jean Kendu, had been given “pre-op” heparin because of two deaths from pulmonary emboli the week before, and had extensive bleeding. There was no electrocautery unit, but he survived, as he was cared for and fed by his fiancée. Over the next two weeks, we took him back to the OR several times for further debridement of extensive dead muscle. Thankfully, his arm, leg, and life were saved. The Nuncio made rounds with us one day and told Jean, in Creole, that he was my favorite patient. Jean responded “I like him too.” I was gratified, and I hope that was my Haitian “patient satisfaction score.”

Our SMRT arrived on January 28, and we, along with the Maryland team, rapidly organized supplies and equipment in the OR. After several operations on the first day, the head Haitian nurse took me aside to ask why we had come in and started operating, without asking them to scrub. “Is it because we are black?” she asked. I was mortified, and assured her that it was only a great oversight on our part, and we requested her nurses on every subsequent case. We worked together well after that, and one of my favorite pictures is one featuring the head nurse and me together. Her dignity had been preserved.

The experience also made us more sensitive to the Haitian surgeons who were intermittently present. We made sure they had first choice of their operating area rooms and the services of our anesthesiologists. I reflected on how I would feel in my own hospital under similar disastrous circumstances with outside volunteers coming in. We were there to help, not to occupy and dominate.

Dr. Scalea and his team from Maryland plan to rotate teams in and out of St. Francois for six months (see article on page 6), and Scripps Health continues to send in new teams and supplies. Dr. Scalea and I are coordinating the interactions and composition of our medical teams on an ongoing basis. We do this in concert with the Haitian medical director of Hôpital St. Francois de Sales. Both Scripps and the team from Maryland continue to send major shipments of medical supplies to Haiti.

The reality in Haiti is that you try to save one life or limb at a time in a place where approximately 230,000 others have already died, and the stench of death hangs in the air. We had critically ill patients with massive injuries, mostly extremity-related, and we operated on them with the most rudimentary of surgical instruments, anesthesia, and supplies—but despite all of these hurdles, the work was conducted by passionately committed and talented team members.

The Haitians are courageous, uncomplaining human beings, some of whom would sing rather than cry, who deserved the best we could do with what we had. It was a privilege and honor to represent the College in Haiti.

Even as we face the issues of health care reform in our own country, participating in this sort of humanitarian effort helps restore a balanced perspective of realism in the surgeon, dignity in the patient, and love of our fellow man.

Dr. Eastman is chief medical officer, Scripps Health, and N. Paul Whittier Endowed Chair of Trauma, Scripps Memorial Hospital, La Jolla, CA. He is also clinical professor of surgery-trauma, University of California, San Diego. Dr. Eastman is Chair of the Board of Regents.
was issued, nothing could really prepare for them for the devastation they would find on the ground—homes and buildings leveled, parents searching for missing children, heaps of rubble covering crushed bodies, the stench of decaying corpses hanging in the air, and the look of peril on people’s faces.

Arriving in Port-au-Prince “was one of those life-changing experiences that just leaves you breathless. I saw more devastation, more injuries, more suffering than I ever thought imaginable or possible. The images that were being broadcast on TV and the Internet did not capture the desolation and devastation that really was taking place,” Dr. Ford said.

“I’ve been going to Haiti since 1996, so I have a pretty good understanding of the people and of the country and of the poverty that’s there, along with the lack of medical care and of food and things like that, but I could never have imagined anything as awful as this,” Dr. Campbell, who arrived in Haiti on January 16, said. “There was so much devastation and so many injuries and no way to get them treated correctly.”

The emotional damage from the earthquake was inestimable. Walking out of the airport in Port-au-Prince, Dr. Sakran saw that “a sea of Haitians filled the streets, most of whom were standing behind the metal barricade put up by the U.S. Army. One could see the look of desperation in their eyes.”

Dr. Campbell concurred. “Haitian people don’t complain much. They accept their fate in a way that’s just uncanny because they’ve faced so much tragedy over the years. But in this case, it was almost like they were in a state of shock. They didn’t have a lot to say. They didn’t cry. They just had a look of despair,” Dr. Campbell said.

After traversing the rugged terrain around them and reaching a specified location, the first assignment for many surgeons was to get field hospitals and clinics up and running.

“When we got there, there was pretty much nothing,” Dr. Scalea said. “Sanitation was horrifying. People were dumping human waste right outside the hospital tents and washing their clothes downstream with the same water. And the tents weren’t even tents when we got there. They were sticks with a tarp on them,” he said. His team set up a pharmacy, supply room, three operating rooms, and a smaller procedure room.

Dr. Ford’s team set up a field hospital at Universite Quisqueya, which was designed to care for HIV and tuberculosis patients. “On the soccer field of the university was a very large tent city that housed 7,000 refugees,” he said. “A lot of the patients we cared for came from that tent city, but also from other places.”

As a trauma surgeon, Joan L. Huffman, MD, FACS, assistant professor of surgery at the University of Florida, Jacksonville, was instrumental in establishing a mobile clinic that served the tent cities in some of the poorest areas surrounding Port-au-Prince. Although she was the lead physi-
cian on her team, she had never before participated in, let alone overseen, a disaster response effort. Hence, she left some of the management-related aspects of running the medical center to another physician. “We had a family practice intern from Brown who had actually been in Haiti three times before, so he knew how to operate a mobile clinic,” she said.

Dr. Rogers’ team deployed to St. Marc, about 60 miles north of Port-au-Prince, which had two functioning operating rooms. “It was a PIH-supported hospital that we got up and running and transformed into a smooth machine, conducting 20-plus operations per day,” he said.

Hôpital St. François de Sales, where Dr. Shackford’s team was based, was in shambles. “The hospital, except for one building, which had recently been built by the global health ministry as a birthing center, was destroyed. Basically, we had to bootstrap the hospital, because the staff was terrified to go back into the building because of the earthquake and the aftershocks,” Dr. Shackford said.

Furthermore, many of the Haitian medical personnel were still reeling from witnessing the collapse of a four-story pediatric hospital attached to the main building. “The estimates are that there were 200-250 children in that building, many of whom were alive after the collapse. The staff could hear them calling for help, and there was nothing that they could do. That tragically affected the staff,” he said.

Crush injuries, necrotizing infections

News of the field hospitals and clinics spread quickly. “As soon as the people in the tent cities found out that we had a functioning hospital, we went from seeing 50 patients in triage to seeing 350 a day, and they just kept coming,” Dr. Shackford said.

In the earliest days of the effort, surgeons were typically treating open fractures, closed fractures, crush injuries, blunt and penetrating trauma, burns, and fatally infected wounds.

Dr. Ford reported doing laparotomies for people who had been in buildings that had collapsed on their abdomens. In addition, he said, “We had a girl who had a penetrating skull fracture because the ceiling collapsed on her head. A brick was essentially impaled in her skull and was pressing on her brain.” Dr. Campbell recounted the story of a little girl who had half of her face burned off. “She had crawled under a car when the earthquake hit, and the car was running, and the exhaust burned her face and arm, straight up
her shoulder, through to the muscle,” Dr. Campbell said.

Dr. Rogers estimated that he treated more than 140 patients with orthopaedic and soft tissue injuries. Dr. Huffman calculated that 1,000 people received care through the mobile clinics her 25-member team operated for 10 days. Dr. Bulger, associate professor of surgery and a trauma surgeon at the University of Washington, Seattle, arrived in Haiti about 10 days after the earthquake for a two-week rotation. In a total of six weeks, the members of her IMSuRT saw about 3,000 patients and did 300 operations, she said.

As Dr. Bulger’s data imply, surgeons in Haiti had to do much more than operate. “In this type of situation, where the medical infrastructure is completely compromised, places like ours literally become the county hospital for the area, because there is no place else to get medical care. So we would have to care not only for patients with the acute injuries sustained during the earthquake itself, but, with the passage of time, you start seeing people who have other medical needs that they would have had irrespective of whether or not there was an earthquake,” Dr. Born said.

In addition, they had to deal with health care problems that are specific to Haiti, like malaria, typhoid, and a host of other tropical diseases. “We saw a lot of infectious diseases that people don’t get [in the U.S.] because they get vaccinated. We had a child with full-blown tetanus,” Dr. Bulger said.

“One of the things that I think made us a very powerful team is that we had two or three infectious disease doctors with us on every team. They were able to provide generalist internal medicine support, as well as support for specific infectious diseases. Their presence made the surgeons a whole lot more effective,” Dr. Scalea said. Almost all of the participants said they delivered a fair number of babies, as well.

Frustrating to many of the surgeons involved in the earliest stages of the relief effort was the fact they were often working with limited access to electricity and in unsanitary conditions.

“We couldn’t operate too late into the evening because there wasn’t any electricity. Luckily, I brought a battery-operated headlight, which someone had loaned me. It really helped a lot in the OR, where the light wasn’t very good,” Dr. Campbell said.

“I didn’t have access to any sterilization equipment for my instruments, so basically I would clean them with a baby wipe and then soak them in peroxide and shake them in a baggie of alcohol. I did all clean procedures—no sterile procedures,” Dr. Huffman, who is both a trauma surgeon and wound specialist, said. “It was pretty shocking the first day, when I was debriding wounds and cutting off fingers, to see flies sitting on my wounds; but by the end of the week I didn’t even notice them anymore.”

The surgeons also had to do without many of the drugs, supplies, and instrumentation that they use on a daily basis in the U.S. For instance, Dr. Rogers said his unit had no computed tomography (CT) scanners, no intensive care unit, and no ventilators. Several surgeons noted that they had little or no anesthesia, and were often reliant on local anesthetics and large doses of over-the-counter pain relievers.

“When we first got there, there were not a lot of supplies. They started getting there before we left,” Dr. Campbell said. “We got to a point where we were mixing sugar and Betadine to put on wounds because we didn’t have anything else.”

Dr. Shackford said of the first day at Hôpital St. Francois de Sale, ‘Our ‘scrub sink’ was a spigot on the outside of the hospital. We had nobody
to transport patients. We didn’t really have any reasonable X-ray [machine]. There was a lab that was set up and functioning in a tent, and there was a pharmacy set up and functioning in a tent. But everything else, we had to do,” Dr. Shackford said.

In many cases, the problem wasn’t a lack of basic resources per se, but a dearth of the right kinds of equipment. Dr. Sakran reported that his crew had bags full of broad-spectrum antibiotics. “Is this really what Haitians needed during this disaster? In my opinion, resources should be tailored to the specific needs of the community. What we needed was equipment for basic wound care, such as bandages, saline, gauze, cast material for fractures, intravenous fluids, and vaccines to protect against tetanus,” he said.

Dr. Ford noted a marked shortage of appropriate instrumentation for treating the Haitian population. “When you’re going to a country where half the population is younger than 15, you need to figure that you’re going to need supplies that are designed to treat children. Not only did we run out of supplies in general, which was because people had underestimated the number of people who were going to be injured, but also we didn’t have anything to handle the children adequately,” he said. For example, his team didn’t have any pediatric ventilators for children who had been critically injured. “It took more than two weeks for us to get one. So we had to support the children by bagging them—ventilating them by hand—for 14 hours or longer until we could transfer them to the USNS Comfort,” Dr. Ford said. (Run by the U.S. Navy’s Military Sealift Command, the USNS Comfort is an oceanic vessel equipped to serve as a general hospital, and is usually used for humanitarian efforts.)

Due to the lack of sufficient or useful supplies and equipment, surgeons found themselves needing to rely on the diagnostic skills they learned in medical school, many of which certain specialists have not needed to call upon since. Dr. Campbell noted that to determine what was wrong with a patient, physicians needed to really look at the patient, talk to the patient, and touch the patient. Many surgeons, including Dr. Scalea, found they really enjoyed the opportunity to interact with patients on that level, after many years of just reading scans and X rays and having little contact with patients prior to operating on them.

According to Dr. Bulger and others, however, some surgeons are more comfortable making diagnoses without an armamentarium of images. “If you’re a trauma surgeon, you’re used to making decisions with very limited data. Sometimes you just have to act on the way the patient looks in the emergency department and take him or her to the operating room without really having a definitive diagnosis. So, I think, for trauma surgeons, it’s not as hard a transition; but I do think for some specialties that are very dependent upon the CT scanner or other equipment in order to make a diagnosis, it could be difficult. This is the ideal situation for trauma surgeons to be involved,” Dr. Bulger said.
Postoperative patient at the mobile clinic established in the courtyard of a devastated church in Port-au-Prince.

Transporting patients with multiple injuries from St. Damien Hospital to outside facilities.

Fortunately, most of the first responders were trauma surgeons. But they weren’t the only specialists who were needed in Haiti. Dr. Ford and Dr. Knudson said pediatricians, obstetricians, and plastic surgeons were in too-short supply. When on a medical mission in an underdeveloped country, Dr. Sakran observed, “I am not only a general surgeon, but I am also an internist, a pediatrician, an obstetrician, and so on.”

Dr. Bulger said surgeons and other health care professionals also had to exercise their creative abilities to make supplies that weren’t readily available. “When we needed a pediatric cervical collar for a little boy who was hit by a car, we cut up the foam from one of the supply boxes. When we needed traction weights, we used rubble from the earthquake,” she said.

Dr. Huffman recounted the story of a man with a lumbar spine fracture, who was unable to access the field clinic until a week after the earthquake. “Basically, his family had been carrying him around on a sheet the entire time. I made a brace for him using a cardboard box and Ace bandages to stabilize him, and then we were able to put him on a truck and get him down to the DMAT hospital,” she said.

Heartbreaking cases

Due to the severity of many of the patients’ injuries and the austere working environment, surgeons often had no choice but to perform procedures, such as amputations, that they normally would have done only as a last resort.

“Some people have likened it to Civil War surgery, where you have one chance, one operation, and that operation may mean sacrificing the limb to save the life. That was done in a widespread fashion in Haiti. There just weren’t any other options,” Dr. Born said.

“I had a two-year-old boy who had his leg crushed and had an open fracture, and by the time he came to us, it was about six days after the earthquake. His leg had been splinted, but he had a compound fracture that was totally infected, and we wound up amputating his leg above the knee,” Dr. Born added. “That was probably one of the hardest things I’ve had to do in nearly 30 years of being a trauma surgeon, not only because of the child’s age and the nature of the surgery, but also because under normal circumstances this was an injury that would have been very manageable.”

These types of cases profoundly affected other surgeons in Haiti as well. A 14-year-old teenager, who had a severe open tibia/fib fracture that had become infected, left an indelible mark on Dr. Sakran. “He had late-stage tetanus characterized by spasmodic contractions. This was a terrifying situation, not only for us but for the numerous patients lying next to him. All the training, all the equipment, all the determination, and here I was standing next to this young man’s gurney with the inability to provide him with a second chance.
He was taken to a quiet, dark room, where we were able to provide him with some comfort” in his final hours of life, Dr. Sakran recalled.

“Many [patients] touched me deeply, like the 23-year-old male crush injury patient who died of rhabdomyolosis, which is preventable with early fasciotomies and dialysis, or the 14-year-old girl who needed an above-knee amputation to save her life, or the two-year-old below-knee amputee sucking on a lollipop,” Dr. Rogers said. “I am haunted by the faces of those who died too young of pulmonary emboli and overwhelming sepsis, and wish I could have done more to ease their suffering and pain.”

A second wave

As the weeks wore on, some surgeons needed to return to their practices in the U.S. A second wave of surgeons and other health care professionals was then deployed. Perhaps not surprisingly, surgeons who participated in this part of the recovery initiative—that is to say, those who were there in early to mid-February—provided care to patients with different types of diseases and conditions. For example, Dr. Knudson began working on the USNS Comfort in mid-February. “We were doing things like skin grafts to cover open wounds, flap operations, a few operations for people who had suffered head injuries and spinal cord injuries. We got an occasional patient with a fresh trauma that was not necessarily earthquake-related, but related to some of the violence that goes on after a big disaster like this, as well as some secondary injuries due to buildings that were unstable,” Dr. Knudson said.

In addition, the Comfort had become a referral center for patients who had been treated by teams that were leaving. “We were the only place that had ventilators and could operate at night, so we got a lot of referrals from the regional hospitals there for new trauma—people hit by cars, gunshot wounds, and the like. We also saw the same type of acute general surgery emergencies that you would see in a hospital here, a lot of infectious disease, and a lot of pediatric critical care,” Dr. Knudson said.

Some surgeons who had been there in January participated in these second-stage efforts, as well. Dr. Ford returned in mid-February. On his second mission, he said, he saw fewer acute trauma injuries due to the simple fact that by that time the earthquake’s victims had either died or been treated for their injuries. His second team was “more engaged in correcting some of the emergent operations that had been performed under austere conditions. The reason they needed to be revised was that many of the incisions had become infected. They had become infected because people were doing operations with dirty instruments in really less than sterile conditions,” Dr. Ford explained.

Rewards

All of the surgeons interviewed for this article agree that the weeks they spent caring for victims of this catastrophe were, in the words of Dr. Huffman, “eye-opening and life-changing.”

The aspect of this activity that many surgeons found particularly remarkable was the opportunity to experience the Haitian culture and spend time with the people.

According to Dr. Shackford, the Haitian people have a strong sense of community and look out for each other. On this mission, “I had a little girl who I operated on. Her name was Sengalla.
She was about eight or nine years old, and all of her siblings and her parents were killed in the earthquake. So, she was totally alone,” he said. The parents of the child in the next bed adopted her. “They took her in. They clothed her, they fed her, they took care of her. That’s the way Haitians do things,” he added.

Dr. Huffman saw other examples of how Haitians work together while traveling from tent city to tent city. When they’d first arrive at a site, “We didn’t have exam tables or anything. We’d get out some folding chairs and tell them we needed a place to set up, and they would run and pound some sticks in the ground and put some sheets over them so we’d have shelter. They’d bring us doors to use as tables to examine people on. They helped us to help them,” she said.

“Our [Haitian] volunteers, all of whom had lost their homes, had lost their family members, were sleeping on the ground, came every day wearing clean clothes, shined shoes, wanting to help their fellow Haitians,” she added.

Dr. Rogers was impressed by what he called “the resiliency of the human spirit. Despite incredible suffering and loss, mothers held their children, kids laughed and cried, people prayed, families turned [over] their [bed-ridden] para-

lyzed loved ones, grown men were given sponge baths, and people came to work, despite losing their entire family in the quake,” he said.

These demonstrations of grace under pressure touched Dr. Bulger as well. “They’re patients in a hospital, they’ve had these horrible injuries and amputations, yet they will sing at night. I just don’t think that people who live in a privileged setting like we do would take that type of event as well as they seem to have taken it,” she said.

The surgeons also found the opportunity to work in teams rewarding. “We had an excellent team of dedicated nurses, physicians, and surgeons who all shared similar values about alleviating human suffering.” Dr. Rogers said. “Some were wonderful organizers, and they organized. Some were incredible doers, and they did. Some were skilled communicators, and they communicated. We did whatever was necessary to get the job done.”

When she first arrived in Haiti to participate in this mission, Dr. Campbell and the anesthesiologists she works with on these outreach programs didn’t know who they would end up working with, “but it turned out to be wonderful. It was really a great working situation. We were with people who truly had the heart for what they were doing,” she said.

And the surgeons believe their teams’ efforts will have a lasting impact on the health and well-being of the Haitian people. “There’s no question that I think we’ve made a difference in the lives of many, and that we brought hope to so many [people]. I have to be pleased with what we were able to do and what we accomplished,” Dr. Ford said.

Current situation

At press time, the problems directly related to the earthquake were abating, but new concerns were mounting.

“Obviously, the response to acute injury from the earthquake is done,” Dr. Scalea said in mid-March. “What we’re doing now are skin grafts, reconstructive operations, closures, and a modest amount of community health,” Dr. Scalea said. “We’re following about 700 people as outpatients now, plus whatever walks through the door, and as the word has gotten out, more people show up. We are now
seeing somewhere in the range of 300 patients a day. That’s a big emergency department,” he said.

“We are seeing both the people on whom we operated, as well as the people who had operations through one of the groups that was there for a week or two, and now [the patients] have no follow-up care,” Dr. Scalea added, noting that his team intends to remain in Haiti at least through the fall. “One of the very illuminating things has been seeing a number of the complications that have arisen. One of the things we hope is going to be good about our staying for at least six months is the opportunity to do some long-term follow-up.”

Now the focus is on medical care—dealing with tropical diseases, malaria, and so on, Dr. Campbell said. “I think over 300,000 people are going to die as a result of this disaster, because the numbers just keep going up. And without the sanitation, without the proper wound care, without the treatment of regular diseases that are common in Haiti, I just think that’s going to be the case,” she added.

On April 23, Dr. Campbell returned to the Haitian hospital where she usually provides care on the island, because that facility is now one of the referral sites for earthquake victims needing follow-up care. “We’re going back to the mountains, which is where we normally go in April,” Dr. Campbell said, before she left for the recent trip, “because the little hospital we go to has been inundated with refugees coming out of Port-au-Prince, and they’re overwhelmed. I know there will be surgical needs up there at that time, and I’m taking an OR team with me.”

“I think what we’re all worried about now is what will happen during the rainy season, because the risk of infection and of widespread infectious disease will be significant due to the living conditions that these people currently have,” Dr. Bulger said. “Haiti before the earthquake had extreme poverty and very limited access to health care. Now all of that is 100 times worse. Add to that the homelessness, the tent cities, the lack of food, the lack of potable water, and it becomes clear that in addition to addressing ongoing health care issues, the real need is to focus on the basics—making sure that people have places to live out of the rain, that they have food, that they have water and proper sanitation,” she added.

**Long-term commitment**

The next step in the U.S.’s efforts to help Haiti get back on its feet with respect to health care is to develop a long-term strategy that will allow Haitian health care professionals to start taking over, Dr. Scalea said.

From a medical standpoint, the primary concern is ensuring that all Haitians have access to quality health care. “That means they need
a massive investment in the health care infrastructure. They need to build more hospitals. I would estimate 75 to 80 percent of the hospital structures have been destroyed,” Dr. Ford said. They also need rehab facilities in every state and to establish a trauma system.

Dr. Ford is playing a role in efforts to develop an organized Haitian health care system. During his second deployment to Haiti, he started working with a nongovernmental organization (NGO), Project Medishare for Haiti, Inc., to try to develop a trauma health system on the island. “This is a project that is supported not only by Project Medishare, but that also is endorsed by the Ministry of Health in Haiti, by the private sector in Haiti, and by other NGOs, including Partners in Health, as well as some leading universities in the U.S., such as the University of Miami and the University of Southern California,” Dr. Ford said. “Our hope is to be able to establish this much-needed trauma system and a trauma, critical care, and rehab hospital in a country that simply does not have anything when it comes to emergency medical service.

“Most of the NGOs that came to Haiti thought that they would intervene during the acute phase and then go home,” Dr. Ford said. “If Project Medishare had done the same thing, then Haiti would have been left with a major void, because Project Medishare is the only place providing trauma and critical care with any modicum of success in the entire country.”

The College intends to be part of the effort to develop the Haitian health care system. “I have the reassurance of the Chair of the Board of Regents, the Chair of the COT, the Executive Committee of the Board of Governors, and the Executive Director, Dr. Hoyt, that they are prepared to support this initiative in any capacity possible. So, that’s quite exciting,” Dr. Ford added.

Furthermore, in February, the College signed a memorandum of agreement with the U.S. Navy, which enabled the ACS to serve as an NGO on board the USNS Comfort hospital ship during this disaster, and in any that might occur in the future, Dr. Knudson said. “It’s really important that we’ve opened this door for the College. Now [the military knows] who we are, we’ve signed up. There were over 950 volunteers who signed up on the College’s Web site to go to Haiti. Now we have a way for them to find places they can go and be useful,” she added.

In addition, Project Medishare is working to move its services into the only hospital left intact in Port-au-Prince, L’Hôpital de La Paix—the Hospital of Peace, Dr. Ford said.

“Hopefully, if there’s any silver lining to this earthquake, it is that there is a consciousness of Haiti in one of its wealthiest and closest neighbors, and that’s the U.S.,” Dr. Shackford said. “When I was down there in 2006, they had a horrible hurricane, and 8,000 people were killed in a town called Gonaives, and that didn’t even make news in the U.S.”

Dr. Campbell also hopes that people will remain cognizant of how this cataclysmic event has affected the people of Haiti. “I think it is important to keep people aware of the tragedy, because the difficulties are going to continue for an extended period of time, and people get compassion fatigue. You can’t hear about such sadness over and over again—but we can’t just forget these people,” Dr. Campbell said.
HEALTH CARE REFORM BECOMES LAW—
with room for improvement

by Kristen Hedstrom,
Assistant Director, Legislative Affairs,
Division of Advocacy and Health Policy

Following more than a year of partisan
debate and numerous missed deadlines, health care reform became law
when President Barack Obama signed
H.R. 3590, the Patient Protection and Affordable Care Act (PPACA) on March 23,
and the Health Care and Reconciliation Act
of 2010—which amended the PPACA—on
March 30. Throughout the development and
deliberations surrounding comprehensive
health care reform, the American College
of Surgeons was guided by a strong commitment
to four key principles that were drafted
by the Board of Governors and approved
by the Board of Regents. Those principles
include the promotion of quality and safety,
access to surgical care, medical liability reform,
and the reduction of health care costs.

While committed to the passage of meaning-
ful health care reform, after a thorough
analysis and careful consideration, the Col-
lege felt that PPACA fell short of meeting
these four principles and, therefore, opposed
the legislation when it was considered in the
U.S. Senate in December 2009. The College
was deeply disappointed with the Senate’s
decision not to address several provisions
that we believe will have a negative effect
on surgical patients, and on the surgeon’s
ability to provide quality, efficient health
care, including the following:

- **Creation of an independent Medicare commission.** This commission would
  undermine efforts to provide transparency, fairness, and stability in the health care de-
  livery system by leaving Medicare payment policy decisions in the hands of an unelected,
  unaccountable governmental body.

- **Failure to permanently repeal the flawed sustainable growth rate (SGR) formula.** The SGR formula threatens patient
  access to surgical care, and does nothing to address the pending 21.2 percent cut to
  Medicare physician payments scheduled to go into effect on April 1.

- **Lack of meaningful medical liability reforms.** These reforms include protections
for physicians who follow established evidence-based practice guidelines or who are volunteering services in a disaster or emergency situation.

Despite the law’s significant shortcomings, throughout the year-and-a-half debate, the College did work extensively with key Congressional leaders to ensure that several provisions were included in the final legislation, prior to passage.

For several years, the ACS has advocated to Congress about the critical need to improve and support our nation’s trauma systems, and the College leadership was pleased to learn that the PPACA includes a significant number of trauma-related provisions, which authorized funding for the following:

- **Trauma centers**—by establishing three programs to award grants to qualified public, not-for-profit Indian Health Service, Indian tribal, and urban Indian trauma centers to defray the substantial uncompensated care costs, further the core missions of the centers, and provide emergency relief to ensure the availability of trauma services.

- **Trauma service availability**—by creating a new grant program to support trauma-related physician specialties and access to trauma-related services.

- **Trauma EMS Program**—by reauthorizing the Trauma-EMS Program.

- **Regionalization of emergency care**—by requiring the Secretary to award no fewer than four multiyear contracts or competitive grants for pilot projects to improve regional coordination of emergency services. Eligible entities would design, implement, and evaluate certain emergency medical and trauma systems.

While the focus of much of the law relates to improving the primary care workforce, the College was successful in ensuring the inclusion of several provisions that make the first steps in addressing the surgical workforce crisis, including the following:

- **Creating an incentive payment program for major surgical procedures**—which provides a 10 percent bonus payment for procedures provided by a general surgeon practicing in a Health Professional Shortage Area beginning January 1, 2011.

- **Establishing a pediatric specialty loan repayment program**—by which participants, (including pediatric surgeons) would agree to work full-time for no less than two years in pediatric medicine or surgery, or in child and adolescent mental and behavioral health care. The program would pay up to $35,000 per year for each year of service, for a maximum of three years. The bill authorizes $30 million per year for loan repayments for pediatric medical and surgical specialists.

- **Redistributing unused graduate medical education (GME) residency slots**—by increasing the number of GME positions in states with the lowest resident physician-to-patient ratios. Specifically, 65 percent of currently unused GME slots would be redistributed. Seventy-five percent of the redistributed slots must be used for primary care or general surgery residencies.

In addition, the College, working with many of the surgical specialty groups and organized medicine, was successful in making improvements to H.R. 3590 that included the following:

- Exclusion of a tax on cosmetic surgery
- Removing budget neutrality as the funding mechanism for bonus payments to rural general surgeons
- Removal of the Medicare application fee, which would have required physicians to pay an application fee to cover a background check for participation in Medicare

The ultimate impact of the Patient Protection and Affordable Care Act will not be known for several years, as many of the major provisions go into effect in 2014 and 2015. However, as the law is implemented, the College, guided by our core principles, will continue to work to ensure the sustainability of the practice of surgery and access to the highest-quality surgical care for all Americans.
Development of the Medical and Surgical Simulation Institute:

Accra Ghana, West Africa

by Lenworth M. Jacobs, Jr., MD, MPH, FACS, FWACS(Hon);
Karyl J. Burns, RN, PhD;
and
Rudolph Darko, MD, FWACS
In 2003, a collaborative relationship was developed between the West African College of Surgeons and the American College of Surgeons to explore what educational programs could be implemented in West Africa. After a series of meetings, the Advanced Trauma Operative Management (ATOM) Course was selected and made available at the Korle Bu Teaching Hospital in Accra, Ghana, in 2005.

The Surgical Skills Training Center was also established in 2005 to provide training in advanced trauma operative management. The name was changed to Medical and Surgical Skills Institute (MSSI) in December 2008. The new name was designed to reflect the expanded functions of the center. The center now trains multiple subspecialties in medicine and surgery, and includes, in addition to the ATOM Course, educational offerings in laparoscopy, anesthesia, orthopaedics, ophthalmology, and other surgical procedures. The center educates surgeons, anesthesiologists, nurses, and technical personnel.

The purpose of this article is to describe the process involved in creating the MSSI, a comprehensive surgical simulation education center in West Africa, which was initiated with the implementation of the American College of Surgeons’ ATOM Course.

The ATOM Course

The ATOM Course was developed by surgeons at the Hartford Hospital, Hartford, CT, and the University of Connecticut, Farmington, in association with the American College of Surgeons’ Committee on Trauma.¹ The course material consists of a CD-ROM and an illustrated textbook that thoroughly describe the operative procedures.² The one-day educational experience features six lectures on injuries to various organ systems in the chest and abdomen. These lectures are presented in the morning didactic session. In the afternoon, there is an operative experience in a formal operating room environment, where 12 standardized injuries are created in a 50 kg swine, and students are presented with five clinical scenarios. The students are required to develop appropriate treatment plans, identify the injuries, and effectively manage and repair the injuries operatively. The injuries include trauma to the bowel, bladder, ureter, kidney, duodenum, pancreas, liver, stomach, spleen, diaphragm, inferior vena cava, and heart.

The course, including the evaluation methods, is grounded in educational theory and has been standardized to ensure its consistent replication.³⁻⁵ Evaluation of students includes pre- and
post-assessments of knowledge and self-efficacy. Knowledge of ATOM and self-efficacy for ATOM have been documented to improve from pre- to post-ATOM.1,6

ATOM participants from across the world have responded overwhelmingly positively to two surveys that assessed their perceptions of the value and quality of the course.5,8 However, when establishing the course in a country that has not previously been a site for ATOM, the teaching methods need to be reviewed and evaluated to ensure that they are culturally appropriate. In West Africa, medical education has been influenced by a number of inherently different training paradigms. Surgeons in West Africa may have been trained in programs based upon African, British, Belgian, French, or American educational systems. When the ATOM course was introduced in West Africa, the following questions were evaluated:

• Will the CD-ROM, textbook, lecture format, and style of presentation be conducive to the students’ learning needs?
• Will the structure of the laboratory experience conform to students’ expectations and behaviors?
• Are there cultural aspects of the teacher/student relationship that need to be considered?
• Will the student evaluation instruments reflect true quantities of knowledge and self-efficacy, and not variance due to cultural or linguistic differences?

A simulation education center in West Africa

Preliminary decisions

In order to implement the ATOM Course in West Africa, a number of decisions needed to be made to move the project forward. First, an international agency that was skilled in developing complex projects in Africa needed to be identified. This agency would bring the technical skill and assistance necessary to implement the project. International Aid was selected for this role. Next, a teaching hospital and a university setting had to be identified, preferably locations that included a veterinary laboratory with the capabilities to operate on live animals. The facility needed several modern and complete operating suites with sterilization capabilities, and equipment including anesthesia, operating tables, operative lights, and surgical instruments. Korle Bu Teaching Hospital in Accra, Ghana was chosen as the site, and Rudolph Darko, MD, FWACS (co-author of this article), was named as the principal investigator of the program. Finally, a funding agency needed to be recruited that understood the immediate short-term and long-term implications of a project of this magnitude; Johnson & Johnson graciously accepted this responsibility.

Visionary leadership and goal setting

The visionary leadership at the Korle Bu Teaching Hospital recognized the potential for a major educational center that would not only teach surgery for penetrating trauma to surgeons, but would continue to develop into a site that could bring other operative education, including laparoscopy, minimally invasive surgery, ophthalmologic procedures, and other surgeries, to the region. They envisioned that this educational site would train anesthesiologists, operating room nurses, technologists, and technical personnel needed for a complete and realistic surgical experience. Furthermore, the center would be embedded with the professional leadership that would sustain it for many years, in order to foster its growth and development as a major educational resource for West Africa, and as part of an international network of educational facilities. An ongoing goal is that the center becomes approved as an accredited educational institute of the American College of Surgeons.

Table 1.
Challenges to developing a surgical simulation education center in an international location

| • Learn unfamiliar customs and requirements to initiate the project |
| • Involve of all stakeholders |
| • Locate an appropriate physical site that replicates an operating room |
| • Provide a veterinary facility |
| • Allow equipment to be brought into the country |
| • Transport equipment to the center |
| • Locate technical staff to maintain equipment |
Collaborative planning

Having clarified the vision to bring the ATOM Course to West Africa and develop a comprehensive education center there, a number of partners were involved in extensive planning discussions. These included the leadership of the American College of Surgeons, the West African College of Surgeons, the University of Ghana, the government of Ghana, Johnson & Johnson, and International Aid. Faculty from the University of Connecticut and Hartford Hospital became the proponents of the project. Having developed the ATOM Course at Hartford Hospital and having participated in the initial collaboration between the West African College of Surgeons and the American College of Surgeons, the faculty knew what needed to be accomplished in order to bring the ATOM Course to West Africa, and to initiate a comprehensive simulation education center there.

These partners delineated the scope of the task and identified the technical and financial hurdles that had to be overcome. These challenges included the medical-political interaction of two international colleges of surgeons and the coordination of the interactions of the government of Ghana, the Ministry of Health, and the Prime Minister’s office, as well as Johnson & Johnson and International Aid (see Table 1, page 25). All the permissions to conduct the course needed to be obtained from the government of Ghana and the University of Ghana.

Once there was agreement that this was a worthy project and that the financial and political hurdles could be overcome, it was critical to have the surgical leadership at the Korle Bu Teaching Hospital travel to Hartford Hospital to take the ATOM Course, in order to understand the details involved in implementing the course in Ghana. A number of surgeons from the West African College of Surgeons came to Hartford Hospital and successfully completed the course. The principal investigator of the Simulation Center worked closely with the veterinary laboratory and equipment personnel to be sure that the operating room equipment and instruments could be completely reproduced in the center in Ghana.

Securing funding

The financial requirements to establish, sustain, and grow a comprehensive center were significant. The director of Johnson & Johnson’s corporate contributions met with the leadership of the West African College of Surgeons, the American College of Surgeons, and the University of Ghana in order to stay informed of the goals of the project and the financial requirements to create a simulated operating suite. Johnson & Johnson agreed to provide substantial financial assistance for the project.

Securing equipment

Once the financial support was secured, it was essential to involve an organization that had moved, implemented, and maintained complex medical equipment in other geographic locations. International Aid had worked closely with Johnson & Johnson on several projects and had the appropriate professional and technical assistance to support the project. They were able to procure the necessary surgical and an-
Left to right: Dr. Jacobs, Dr. Darko, and Dr. Yeboah.

Anesthesia equipment and transport it from the U.S. to West Africa. Once there, an experienced technical team from International Aid worked with the local personnel to assure that all the equipment would function flawlessly in the simulation education center. A major consideration was the compatibility of the equipment with the electrical supply. With the help of the team from International Aid, the local personnel became experts at troubleshooting and maintaining the anesthesia and surgical equipment.

Securing a facility
An effective architectural plan for the center was critical to ensure the success of the project. Since the center was envisioned to grow over time to include new and different technical innovations, the ability to expand the center was necessary. Classrooms and computer access to the Internet for multiple students were required. Additionally, the culture of the center needed to support educational theory that mandates that simulation be in a setting that is as similar as possible to the real practice environment. The visual and auditory cues, as well as the correct placement of the equipment and the location of the various support services such as anesthesia, scrub nurses, and technical assistants, are needed, so that the students envision themselves in a real operating room. Because the center would use a live porcine model, there had to be a fully approved veterinary facility on site. There needed to be the space to house and anesthetize the animals and a way to transport them to the operating room.

Implementation of the ATOM course
The planning and development process, which took more than a year, culminated in the inaugural ATOM Course at the Simulation Center at the Korle Bu Teaching Hospital in Accra, Ghana in February of 2005. It was offered in West Africa in the same format, with the same objectives, content, and teaching strategies that had been implemented in the U.S.

Several courses were given with a team from the American College of Surgeons. The team included Lenworth Jacobs, MD, FACS (co-author of this article); Stephen Luk, MD, FACS; Edward Cornwell, MD, FACS; Samuel Adebonojo, MD, FACS; Peter Ekeh, MD, FACS; Fiemu Nwariaku, MD, FACS; and William Dyckman, a veterinary specialist from Hartford Hospital who assisted the local team with anesthetizing and preparing the swine. Conrad Person, director, Johnson & Johnson corporate contributions, and Myles Fish, chief executive officer, International Aid, observed the course. The technical expertise of the support team provided by International Aid was essential to ensure that four operative cases could be conducted simultaneously. This meant that 48 procedures were performed within four hours in the Simulation Center. This is a significant challenge for any major teaching hospital. Not only was this successfully carried out during the inaugural course, but the operations were performed on two consecutive days.
The evaluative component of the course required that students complete Web-based pre- and post-course assessments. The computer interface allowed the students to take the pre- and post-tests electronically, allowing the instructors to immediately identify the pre-course knowledge and self-efficacy of each student. This information was extremely important to objectively quantify the level of preparation and receptiveness of the students. The pre-course scores were consistent with other students who had taken the course elsewhere in the U.S. and Canada. Following the completion of the course, the students were required to take a multiple-choice examination and complete a self-efficacy questionnaire. These evaluations were also completed immediately following the operative laboratory portion of the course. The instructors were able to review the results of the examinations prior to the students leaving the center. The electronic database was essential in providing immediate feedback for the students—which is key, as a number of these surgeons had come from other countries. The students were appreciative of the objective and subjective evaluation of their performance prior to their returning to their home states or countries.

The department of anesthesia, under the leadership of Henry Baddoo, MD, at the University of Ghana Medical School and Korle Bu Teaching Hospital, recognized the educational benefit of the ATOM Course for anesthesiologists. Dr. Baddoo, in association with Dr. Jacobs and Mr. Dyckman, the veterinary specialist, developed an education curriculum for practitioners who would be providing anesthesia for the swine.

The curriculum included knowledge of specific details of porcine anesthesia, the appropriate doses of anesthetic agents, the appropriate volume per kilogram settings for the anesthesia machines, and the technical details of porcine intubation, as well as arterial and venous surgical exposure and cannulation of the porcine anatomy.

Four separate teams were utilized to sedate, anesthetize, and prepare each of the four animals. A significant component of the educational program was to maintain meticulous records of the weight, size, volume, and dosage of medications and crystalloid infusions, as well as of the physiological responses to the operative interventions during the course. These records were carefully analyzed following the completion of the course. The results of the research were presented in the *Ghana Medical Journal*. This document has become an important adjunct to any educational site that will be conducting an ATOM Course.

A number of nurses were attendant at each course, and were able to assist in the operative management and instrument preparation and se-

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**Table 2.**
Actions to facilitate development of a surgical simulation education center in an international location

- Recruit leadership of respected organizations to clarify the vision
- Educate all stakeholders on the vision
- Establish a commitment from all stakeholders
- Engage in collaborative planning
- Secure funding and identify sources of continued support
- Secure an appropriate physical site
- Recruit experienced technical personnel
- Demonstrate training of instructors
- Demonstrate potential of the center by successfully implementing a course

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**Table 3.**
Number of ATOM participants in West Africa, by country, 2005–2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>33</td>
</tr>
<tr>
<td>Nigeria</td>
<td>22</td>
</tr>
<tr>
<td>Ivory Coast</td>
<td>2</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>2</td>
</tr>
<tr>
<td>Senegal</td>
<td>1</td>
</tr>
<tr>
<td>Gabon</td>
<td>3</td>
</tr>
<tr>
<td>Malawi</td>
<td>1</td>
</tr>
<tr>
<td>Kenya</td>
<td>1</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1</td>
</tr>
<tr>
<td>Zambia</td>
<td>1</td>
</tr>
<tr>
<td>Uganda</td>
<td>1</td>
</tr>
<tr>
<td>Niger</td>
<td>3</td>
</tr>
</tbody>
</table>

Total participants: 71
collection for procedures in the abdomen and chest. There was also an opportunity to become facile with the preparation and loading of numerous stapling devices. Similarly, there was significant benefit derived from the preparation of instruments and selection of suture equipment for major injuries to the liver, inferior vena cava, and heart. The first-hand observation and involvement in managing these major procedures in a real, but controlled, environment were found to be extremely beneficial to the operating room nursing and technical staff.

Conducting the ATOM Course was a noteworthy event for the West African College of Surgeons, and was attended by the leadership of Korle Bu Teaching Hospital and the medical school, as well as by a number of officers of the West Africa College of Surgeons. The President of Ghana, the leadership of the Ministry of Education, and the Ministry of Tourism formally recognized the importance of this educational activity at a reception at the Office of the President.

**A commitment to state-of-the-art education**

The success of the ATOM Course reinforced the institution’s commitment to develop a comprehensive surgical simulation education center at the Korle Bu Teaching Hospital. However, this commitment needed to be endorsed by all stakeholders in the project. This required a substantial initiative by the leadership of the West African College of Surgeons, and involved developing relationships with the Minister of Health, the Prime Minister’s office, and with members of the U.S. embassy. In addition, the support of the administration of the University of Ghana, including the dean of the medical school and the administrative and clinical staff of Korle Bu Teaching Hospital, needed to be secured. To all stakeholders, the center was highlighted as a significant enhancement to the health care of the citizens and visitors to Ghana and the surrounding countries in West Africa. (The development of the MSSI in Accra Ghana, West Africa is summarized in Table 2, page 28.)

**Benefits to the local team**

Since the inception of the ATOM Course in Ghana in 2005, 71 surgeons from 12 countries in Africa have taken the course (Table 3, page 28). The MSSI has become a central location for training surgeons, anesthesiologists, ophthalmologists, nurses, and technical personnel. It has become a forum for practicing techniques, training professionals in new procedures, provid-

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**Table 4. Training offered at the MSSI**

- Advanced Trauma Operative Management
- Basic surgical skills
- Anastomoses workshops
- Fundamental laparoscopic surgery
- Flap plastic surgery
- Orthopaedics–joint replacement
- Ophthalmology
- Anesthesia technology
- Lymphatic filariasis
- Laboratory technology chemical analysis
- Nursing
  - Wound management
  - Infection control
  - Time and ward management
  - Ophthalmic nursing
  - Pre- and postoperative care
  - Ethical and legal issues in nursing

**Table 5. Institutions collaborating with the MSSI to offer accredited education**

- West African College of Surgeons, Lagos, Nigeria
- American College of Surgeons, Chicago, IL
- Hartford Hospital/University of Connecticut, Hartford, CT
- The Royal College of Surgeons of England, London, UK
- The Royal College of Surgeons of Edinburgh, Edinburgh, UK
- University of Michigan, Ann Arbor, MI
- University of Strasbourg, Strasbourg, France
- University of Toronto, Toronto, ON
- University of Tübingen, Tübingen, Germany
- The Society of American Gastrointestinal Endoscopic Surgeons, Los Angeles, CA
ing didactic lectures, and evaluating the results of the educational process. To satisfy the demand for certified courses, the MSSI has provided a platform for universities, professional associations, nongovernmental organizations, and corporations to provide affordable in-country medical training. Medical professionals from 13 African countries have taken courses at the MSSI. Table 4 on page 29 lists the educational topics that have been presented at the MSSI. These offerings have created strong academic links with major international institutions. Video conferencing is now available at the MSSI through connections with the University of Michigan, Ann Arbor; the Royal College of Surgeons of England; and the Royal College of Surgeons of Edinburgh. Table 5 on page 29 presents the institutions that have collaborated with the MSSI to deliver accredited programs.

References


Dr. Jacobs is professor of surgery and chairman, department of traumatology and emergency medicine, University of Connecticut School of Medicine, Farmington, CT. He is also director, trauma program, Hartford Hospital, Hartford, CT.

Dr. Burns is a research scientist with Hartford Hospital, Hartford, CT.

Dr. Darko is professor of surgery and director, MSSI, Korle Bu Teaching Hospital, Accra, Ghana, West Africa.
Who said that MIDTERM ELECTIONS aren’t interesting?

by Sara Morse, Manager of Political Affairs, Division of Advocacy and Health Policy

In an interview in the February issue of the National Journal, respected nonpartisan political guru Charlie Cook shocked many inside the Beltway by declaring that he found it “very hard to come up with a scenario where Democrats don’t lose the House” in the coming 2010 election. Earlier this year, Stuart Rothenberg, editor of the esteemed Rothenberg Political Report, stated in his weekly column, “With a nearly 80-seat House majority, 60 seats in the Senate for more than eight months, a GOP brand so damaged that the party looked completely incompetent, and a charismatic African-American president taking over from a failed two-term Republican president, you’d have thought that Democrats were set up for a pretty decent two years. But...Democrats are headed for big losses in the House and Senate.”

These statements illustrate how suddenly the political climate can change, and how volatile it can be for the party in power. In November 2008, the evaporation of Democratic momentum in 15 short months would have been dismissed as an impossibility. The 2006 elections represented what Cook once referred to in a political briefing as a “tsunami,” with Republicans losing 30 seats. With the Obama movement in full force and Bush fatigue a powerful factor, Republicans lost yet another 24 House seats in 2008, handing the Democrats a 79-seat majority. After a long and drawn-out legal battle with incumbent Sen. Norm Coleman (R-MN), Sen. Al Franken (D-MN) was seated in July 2009, giving Democrats a 60-vote majority in the Senate. Democrats were shouting from the rooftops and Republicans were whispering behind closed doors, but they were all saying the same thing: Democrats had been handed a mandate and would be in control for years to come.

Cook and Rothenberg’s assertions serve notice that the political pundits have identified a dramatic nationwide shift, with the election of Sen. Scott Brown (R-MA) as the exclamation point. Just days before the election, even the most respected experts were still doubtful that a Republican could find the votes to take the seat left vacant by the death of Senate stalwart Edward “Ted” Kennedy. Senator Brown’s election made clear to both parties that although the desire for change expressed in the 2008 election is still strong, the winds appear to be blowing in a different direction.
In response, the national party committees of both the Republicans and the Democrats have brought 2010 election activities into high gear.

**Republicans rally**

At a political briefing in early 2008, the National Republican Congressional Committee (NRCC) Chairman, Rep. Pete Sessions (R-TX), expressed frustration with the previous status quo of NRCC dollars being poured into races in which the candidates themselves were not exerting the necessary level of effort, resources, and dedication to run successful and efficient campaigns. In this election cycle, the NRCC has established a more formal system of race-tracking, evaluation, and participation, in order to hold vulnerable incumbents, targeted open seats, and challenger candidates accountable for pulling their own weight.

First, the Patriot Program was created for sitting members of Congress who could be at risk of losing their seats. According to the NRCC, the program provides a “mechanism by which potentially targeted incumbents commit themselves to meet rigorous goals that will strengthen their campaigns to ensure victory. These ‘Patriots,’ who work tirelessly to build winning campaigns, do so with the full support and participation of the NRCC and the entire House Leadership.” (See box, this page.)

Similarly, the NRCC has established the “Young Guns” program to promote strong open-seat and challenger candidates. The NRCC describes Young Guns as “not just a political program, but an ongoing movement to go on offense and strengthen the GOP…. (See box, this page.) The initiative has several tiers, and a candidate’s status within the Young Guns program is determined by the viability of the race, as well as the level of effort and dedication displayed by the individual candidate. Candidates who show early potential are designated as “On the Radar,” while those who appear to be making progress are “Contenders.” Candidates with the clearly demonstrated strength to win “Young Gun” status, and are given the highest level of attention and resources.⁴

**Democrats protect turf**

Coming off of two consecutive, hugely successful election cycles, Democratic Congressional Campaign Committee (DCCC) chairman Chris Van Hollen (D-MD) acknowledged early in 2009...
that Democrats would face a steep challenge maintaining their recent gains. To that end, the DCCC has placed particular emphasis on its Frontline program to protect vulnerable incumbents. The Committee describes the Frontline Program as “a partnership between the DCCC and Democratic Members of Congress which lays the groundwork for the 2010 cycle by supporting and expanding their fundraising and outreach operations.”5 (See box, this page.)

In the previous election cycle, the DCCC “Red to Blue” program for taking seats held by Republicans was a towering success. Whereas the DCCC appears to be dedicating much of its resources to incumbent retention in this election cycle, it does place emphasis on certain “Races to Watch,” which are promising challenger and open-seat races in which the DCCC will pour the greatest consideration and capital (see box, page 34).

While the DCCC has almost doubled the number of vulnerable House members by its classification, it is important to note that its fundraising is still far more vigorous than its Republican counterpart. To date in the 2010 election cycle, the DCCC has raised more than $60 million, compared to the NRCC’s total of slightly more than $40 million.6,7 At this time, the DCCC has more money to spend, but more seats to defend, whereas the NRCC has fewer incumbents to defend, and some latitude to go on the offensive and commit revenue toward emerging races.

**Physician candidates**

With a highly charged electorate and an inordinate number of open seats and at-risk incumbents, 2010 is undeniably a fascinating year in politics. Every day there are breaking news reports concerning retirements, scandals, and resignations. With health care at the forefront of ongoing debates, more than 40 physicians have been spurred to run for Congress in the coming election.

The American College of Surgeons Professional Association’s political action committee (ACSPA-SurgeonsPAC) will play an active role in many of the House and Senate races shaping the makeup of the 112th Congress. The PAC board and staff are always eager to hear from ACSPA members regarding House or Senate races in their districts and states. There are many ways surgeons can get involved and help to elect Members of Congress who understand the critical role that surgeons play in the U.S. health care system, including the following:

- Visit the ACSPA-SurgeonsPAC Web site at [http://www.facs.org/acspa](http://www.facs.org/acspa) for more information on how to get involved with the PAC, and for disbursement lists of candidates the PAC has supported.
- Contact Sara Morse at 202-337-2701 or at smorse@facs.org with your input and analysis regarding the elections in your region.
- Volunteer for, and contribute to, the candidate’s campaign, and be sure to be included on his or her health care advisory board if applicable.
Races to Watch—Top races

John Hulburd (AZ-03, open—Rep. John Shadegg retiring)
Ami Bera, MD (CA-03, challenging Rep. Dan Lungren)
Steve Poungnet (CA-45, challenging Rep. Mary Bono Mack)
John Carney (DE-AL, open—Rep. Mike Castle running for Senate)
Lori Edwards (FL-12, open—Rep. Adam Putnam retiring)
Dan Seals (IL-10, open—Rep. Mark Kirk running for Senate)
Raj Goyle (KS-04, open—Rep. Todd Tiahrt running for Senate)
Tom White (NE-02, challenging Rep. Lee Terry)
Paula Brooks (OH-12, challenging Rep. Pat Tiberi)
Roy Herron (TN-08, open—Rep. John Tanner retiring)
Suzan Delbene (WA-08, challenging Rep. Dave Reichert)

LA-02 (challenging Rep. Joseph Cao), MN-06 (challenging Rep. Michelle Bachmann), and PA-06 (challenging Rep. Jim Gerlach) are also listed by the DCCC as “Races to Watch,” where a primary still must be held to determine the candidate.

(Many members of Congress and candidates set up boards or panels composed of physicians and others with medical expertise to help guide policy decisions.)

• Attend the 2010 Joint Surgical Advocacy Conference in Washington, DC, July 25–27, where political pundit Charlie Cook will be the featured keynote speaker. (Visit http://www.facs.org/grassroots/index.html for more information and to register for the 2010 Joint Surgical Advocacy Conference.)

You can also work with ACSPA-SurgeonsPAC staff to do the following:

• Set up in-district delivery of ACSPA-SurgeonsPAC checks (a great way for physicians to get to know their member of Congress or candidate and/or to help cultivate the existing relationship).
• Schedule a time for the member of Congress or candidate to tour the physician’s office and learn more about issues facing surgery, and how Congress directly affects the physician’s practice and patients.
• Host an in-district fundraiser for fellow surgeons and the greater physician community, benefiting the candidate in the physician’s district.

Individual relationships with members of Congress and staff are critical to the success of surgery’s advocacy efforts on Capitol Hill. There is no better time to cultivate these vital contacts than when a member or candidate needs your help.

References

Grassroots, grasstops, and... Astroturf?

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

The term “grassroots” has been used a lot during the recent debate over health care reform, but what defines a grassroots movement?

A traditional grassroots movement is a movement started by a concerned group of individuals to promote an idea or cause. These activities are not limited to influencing legislators—media outlets (for example, newspapers and television news stations) are now often the target of these types of “informational campaigns.” These informational campaigns may include organizing voter registration drives, hosting house meetings, putting up posters, even knocking on doors—all traditional grassroots activities.

In recent years, grassroots initiatives have started to include advocacy groups (such as the American College of Surgeons), especially when they encourage their membership to call or write legislators regarding a certain piece of legislation. Many companies and associations have formal grassroots programs, designed to encourage direct participation in the political process, but many question if that is, in fact, “true” grassroots. Doug Pinkham, president of the Public Affairs Council, addressed this issue in a post on the Council’s Web site last September, by stating the following:

Those in the “spontaneous” camp need to remember that every grassroots campaign has its organizers. The spark may be one savvy person (like Jody Williams of the International Campaign to Ban Landmines) or a group able to motivate a large number of followers (like AARP on the health care issue). Grassroots campaigns, when conducted ethically, help democracy because they allow large groups of people—on all sides of the issue—to be heard.

Astroturf

In the last year, a new term has come to define fake or exaggerated grassroots campaigns—“Astroturf.” In a well-published case, a consulting firm that specialized in grassroots was accused of writing fake letters to members of Congress urging them to vote against a piece of legislation. Much has been made of this issue in the news, and certainly blatant cases of unethical behavior such as this exist—but where do we draw the line? When an organization uses their resources to facilitate contact between the public and a legislature, is that true grassroots, or Astroturf?

Author and New York Times op-ed contributor Ryan Sager sums up this debate perfectly in the following quote:

Here’s a rule: Organizing isn’t cheating. Doing everything in your power to get your people to show up is basic politics. If they believe what they’re saying, no matter who helped organize them, they’re citizens and activists. The language at the town halls may get ugly and rough. But it’s not Astroturf.

Grasstops

Just as cultivating the grassroots has become an important advocacy strategy, so, too, is having an “executive buy-in.” The term “grassstops” has come to define the strengthening of relationships between higher-level executives and policymakers. The term may also be used to refer to individuals who have a personal connection with the policymaker; identifying these individuals is key to a strong public policy campaign and can also be the next logical step for
traditional grassroots advocates. It is important to note that while grassroots is a broad-based approach, grassstops are used for more specific targets and goals.

Getting involved

The College has two grassroots programs designed to help Fellows become more involved in their state legislatures and at the federal level. The State Advocacy Representative (StAR) program is an opportunity for all members of the College to become involved in state affairs. By participating in the StAR program, surgeons have the opportunity to act as the “eyes and ears” of the College at the state level. StARs pay attention to current legislation and inform the State Affairs team at the College what is happening in their region. StARs may be recruited to take action on an issue at the grassroots level, or to provide testimony at a state legislative committee hearing. StARs are also invited to participate in conference calls throughout the year, to share what they know with their colleagues and College staff.

For those interested in participating in the StAR program, contact Alexis Walters, Regional State Affairs Associate, 312-202-5446, awalters@facs.org.

In Congress

The ACS Federal “Grassroots Network” provides members an opportunity to get actively and personally involved in surgery’s federal advocacy efforts. All Fellows are strongly encouraged to join. As a Grassroots Network member, Fellows 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 http://www.capitolconnect.com/acspa/ and follow the link to join the ACS Grassroots Network, or for more information contact Sara Morse, Manager of Political Affairs, at 202-672-1512 or smorse@facs.org.
In memoriam:

**J. Bradley Aust, MD, FACS**

_by Arthur S. McFee, MD, FACS_

Joseph Bradley Aust, Jr.—born September 8, 1926, the elder son of Joseph Bradley, Sr., and Edith Aust, in Buffalo, NY—died at his home in San Antonio, TX, on March 17, after an increasingly frustrating contest with a common bile duct cancer. The 83 years of his life saw unprecedented progress in medicine and surgery in the U.S.; he was to be an integral part of that development.

A Fellow of the College since 1969, Dr. Aust served as Vice-Chair and Chair of the Board of Governors (1982–1985), as a member of the Board of Regents’ Communications Committee (1992–1993), and as First Vice-President (1992–1993).

**Academic excellence**

Dr. Aust was educated in New York at the University of Buffalo, at Union College, Schenectady, NY, and at the University of Buffalo Medical School. His wife, Connie, was a teenage companion; they were married in 1949, as he completed his medical degree. Postgraduate training at the University of Minnesota, Minneapolis, under the aegis of Owen Wangensteen, MD, PhD, FACS, began promptly. At that time, Minnesota was one of the major crossroads in American surgery, in an era when surgical innovation and aggressive-ness were being constantly pressed and tested. Dr. Aust was privileged to observe, and to participate in, much new and imaginative work. Equally, at a time when—almost by definition—if some operative surgery was good, more was better, he learned from experience when more surgery was too much, and which problems might lend themselves properly to this type of solution. My personal contact with Dr. Aust dates from this period.

I entered as an intern in June 1957 on Dr. Wangensteen’s service, where Dr. Aust was the senior resident. A persistent memory from that time is an oft-repeated phrase of his, which preceded many operations and undertakings: “Okay, team.” From the outset, he realized the value of the team in surgery and the interdependence of all of its members. Surgery, for him, was not for solo performers. His training—which had been interrupted by a two-year stint of naval duty from 1950 to 1952—was completed by 1958, as was his family of six. He was certified that year and joined the faculty of the University of Minnesota Hospitals, Minneapolis, where he rapidly assumed much responsibility and rose to full professorial level by 1965.

At that time, post–postgraduate fellowships were few, and the credentialed graduate could interest himself widely. Bradley chose three major areas: Transplantation, then new and developing, and an area in which he had much laboratory training; oncology, at a time when chemotherapy was just being developed; and complex general surgery, as permitted by better anesthesiology and newer antibiotics.

**A leap of faith**

In fairly short order, Dr. Aust acquired a degree of national recognition that served him well. In 1965, his name was brought up by a medical oncological colleague in Texas for...
consideration for a position in a new medical school being assembled in San Antonio. Carter Pannill, MD, the second dean of the school, offered him a position to form a combined department of surgery and anatomy in 1965. Bradley accepted the appointment in surgery and declined the appointment in anatomy. (A practice of that institution at its inception was to combine basic science and clinical chairs. Dr. Aust did not feel that an appointment to such a position in a basic science was appropriate.) He then set about a new task, in real earnest, at a time when neither the hospital or the school had been physically completed—it was a true leap of faith.

A second characteristic of Dr. Aust as a leader was his capacity to commit himself to an individual firmly, and to remain committed. My own principal recruitment was a chance meeting with Dr. Aust in July 1965, on a warm afternoon outside Dr. Wagensteen’s office. He asked me if I would be coming with him to San Antonio. I replied that I had a two-year naval commitment. His response was that this was a good fit, since neither the hospital nor the school had been completed. His commitment of two minutes of conversation with me came to fruition in 1967, when I arrived in San Antonio; similar commitments marked his initial recruiting efforts. His recognition of the value of the team and of personal commitment were to form a basis for his direction of a new department for at least three decades, and were to make it secure.

Appointment as a department head in a brand-new school is a position that most in academic surgery likely cannot imagine. In a country with 130 medical schools, it is a relatively rare event. Dr. Aust brought to this department an almost unique personal touch, as well as experience gleaned during his tenure at the University of Minnesota. Between 1965 and 1968, he engaged eight founding members for the department: five in general surgery and three specialists. Six came from the University of Minnesota, and two came from outside the university. Of the eight, only one left to pursue a private career. After more than 40 years, six retired founding members still maintain a discernible active clinical relationship with the department. Like Dr. Aust, they were, and continue to be, aware of the value of teamwork and personal commitment. With these tenets in mind, they set about to make this new experiment succeed, and did so remarkably well.

An “honest joiner”

Dr. Aust was an honest joiner, in that he remained sincerely committed to the organizations of which he was a part. Over more than two decades, he earned a local sobriquet of “traveling professor” as he attended meetings and committees faithfully. He gave more than 60 invited lectures, and completed a remarkable list of publications. The presence of a bald head in the center front row at these meetings was taken for granted by many organizations. He could not have fulfilled these obligations without the unwavering support of those at home. In so doing, however, he became the voice and face of our department nationally, and gave us a prominent presence quite out of proportion to our size. His commitments included the American College of Surgeons; five editorial consultantships; 32 society memberships (of which he was an officer or founding member in 10); and participation in the American Board of Surgery. Each was regarded as an obligation, and all received Dr. Aust’s attention. His duties were discharged fully and well until less than a year before his death.

Significant accomplishments

It is in the nature of surgeons to keep track of their own accomplishments; Dr. Aust was no exception. Toward the end of his life, he put together a short list of what he regarded as significant accomplishments. This list reflects much of that was transpiring at his institution in Minnesota in the mid 20th century. The list centers on vascular problems, and demonstrates some remarkably visionary work:

• 1950: Early use of I 131 albumin to determine blood volume
• 1956: Estimates of tissue flood flow with deuterium oxide and antipyrine
• 1959: Isolated chemotherapy perfusion

A major step in 1955 was the demonstration of successful
coronary artery bypass using the internal mammary artery in a dog model, after coronary artery ligation. In 1961, Dr. Aust introduced hemi-corporectomy for major problems.

Many items on the list were technical advances, reflecting the activity in the department. The concept of hemi-corporectomy for extreme problems came directly from current Minnesota thinking about the then-popularity of aggressive operation, and it has a place in the spectrum of surgery.

In my view, Dr. Aust’s legacy in surgery is much broader. He was given a chance to participate in a new venture with minimal support and much local antagonism—he did so with relish. Developing a small surgery department, in an out-of-the-way town, where medical care was parochial, was a big step in the overall formation of what has become a major health science center. In just four decades, this unit has given rise to four major clinical departments within a large and prominent medical school. More than 200 surgeons have been trained at this facility, and the department has exercised a major impact on medical and surgical care over 25,000 square miles of southern Texas. Dr. Aust took a Wangensteen aphorism sincerely to heart: “The teacher is the only one who affects the future.”

Dr. Aust’s legacy is his role in the development of an institution from zero to major medical center in four decades. It is the establishment of a functional and effective surgical department. It is the molding of many minds in the correct practice of surgery. It will endure as a legacy because these minds will mold others. It is a gift to the future.

In 1995, Dr. Aust retired after 30 years of service to the medical community. He remained active clinically and in the operating room until 2009.

Lest one conclude that little time was left for matters outside of surgery, there is much to refute that argument. His interests were broad, and each was pursued enthusiastically. Hunting, annually and often, almost always produced a deer or an elk. Dr. Aust also enjoyed playing poker with friends, wine collecting, and fine food. He could be relied on to know at least three good restaurants in any city, either at home or abroad, when traveling. Biking occupied many of his weeks. Dr. Aust also enjoyed optics and cameras (he was a remarkably talented photographer), and he collected knives. Some of Dr. Aust’s other favorite pastimes included: reading, movies, classical music, skiing, tennis, travel, and being au courant with current events. He enjoyed many hobbies, but never to the exclusion of family or individuals.

He leaves behind his wife, Connie, six children, and many grandchildren.

A very little-known aspect of Dr. Aust’s free-time activity was his interest in philanthropy. As individual supporters, he and Connie, at their own expense, established a home for mentally disabled individualals in San Antonio, TX, in an effort to care for one of their own children, where no such facility existed. Thirty years later, more than 60 such centers exist in San Antonio, in large part because of his and Connie’s work and active, generous support. It has become a true community endeavor.

In my mind, it would be officious to say Dr. Aust was “larger than life,” but he certainly realized that there was much to living—professionally and otherwise. A phrase from the wonderful Broadway character “Auntie Mame” is fitting. A paraphrase of the famous quote is, “Life is a banquet and most people are starving.” In the banquet of life, Brad Aust did not starve. He accepted a rare and unpredictable challenge early in his career, and discharged it faithfully and well. He left a major impression on 20th and 21st century American surgery, and he had a good time doing it. His death is a loss; his life was an excellent example.

Dr. McFee is professor emeritus of surgery, The University of Texas Health Science Center, San Antonio.
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ANZ Traveling Fellow selected for 2011

Thomas A. Aloia, MD, FACS, assistant professor of surgery at the Methodist Hospital, Weill Cornell Medical Center, Houston, TX, has been selected as the ACS Traveling Fellow to Australia and New Zealand (ANZ) for 2011. This is now an exchange fellowship.

As the Traveling Fellow, Dr. Aloia will participate in the annual Scientific Congress of the Royal Australasian College of Surgeons in Adelaide, Australia, May 3–6, 2011. He will attend the ANZ Chapter meeting during that congress and will then travel to several other surgical centers in Australia and New Zealand.

Dr. Aloia specializes in hepatobiliary and liver transplant surgery. His research focuses on liver malignancies, particularly hepatocellular carcinoma.

The application deadline for the 2012 ANZ Traveling Fellowship is November 15. The requirements for the 2012 Traveling Fellowship will appear later this year in the Bulletin, and will also be posted on the Scholarships page on the College’s Web site at http://www.facs.org/memberservices/research.html.

President Addresses available on archives site

The History and Archives page of the ACS Web site now has links to PDF files of all existing Presidential Addresses from the annual Clinical Congress. The files, which can be accessed and downloaded from the site at http://www.facs.org/archives, include the Presidential Address of J.M.T. Finney, MD, FACS, from 1913, and continue to the 2009 presentation by LaMar S. McGinnis, Jr., MD, FACS.

The Digital Collections highlight four categories of historic records from the College’s archives:
- The Clinical Congress Daily News, 1911–1979
- Board of Regents photos, 1920–2006
- The 1927 volume of the Franklin Martin Memoirs, a set of binders prepared by Franklin H. Martin, MD, FACS, and his wife, Isabelle, that documents the history of the College. Dr. Martin founded the ACS and served as managing editor (1905–1935) of the College’s scientific journal, Surgery, Gynecology and Obstetrics, which is today called the Journal of the American College of Surgeons.
- Volume 4 of a 26-volume set of the Eleanor Grimm Notebooks, a rich resource of ACS history, compiled by Ms. Grimm, who served as Dr. Martin’s secretary from the College’s founding in 1913 until his death in 1935.

After viewing the Digital Collections, take a moment to complete a Web survey of the site. For more information, contact the Archivist at srishworth@facs.org.

Did you know... THAT INFORMATION REGARDING THE RELIEF EFFORTS IN HAITI! for responders and others is posted on the Committee on Trauma “Update Haiti” page and on the Operation Giving Back Disaster Response Center page? The Update Haiti page is updated on a continual basis and offers special alerts from the College and resources for responders. For more information, go to http://www.facs.org/trauma/updatehaiti.html or http://www.operationgivingback.facs.org/content2911.html.
Martin, Carrico, and Argenta Fellowships awarded by College

The American College of Surgeons Faculty Research Fellowships for 2010 were awarded by the Board of Regents in February. These two-year fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty, and carry awards of $40,000 per year from July 1, 2010, through June 30, 2012.

Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the College. The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons honors the founder of the College. The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors the late Dr. Carrico. The new Louis Argenta, MD, FACS, Faculty Research Fellowship is presented by Kinetic Concepts, Inc. to support research in wound healing in honor of Dr. Argenta, who is a plastic surgeon; the fellowship is one year in length.

The recipients of these fellowships are as follows:

- Franklin H. Martin, MD, FACS, Faculty Research Fellow: Elizabeth C. Wick, MD, assistant professor of surgery, Johns Hopkins University, Baltimore, MD.

  Research project: The Role of Stat3 in colonic inflammation and tumorigenesis.

- C. James Carrico, MD, FACS, Faculty Research Fellow: Adil H. Haider, MD, MPH, FACS, assistant professor of surgery, Johns Hopkins University, and assistant professor of health policy and management, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD.

  Research project: Understanding mechanisms that lead to disparities in trauma.

- Louis Argenta, MD, FACS, Faculty Research Fellow: Kathleen G. Raman, MD, MPH, FACS, assistant professor of surgery, Washington University, St. Louis, MO.

  Research project: Analysis of inflammatory cell and cytokine mediators in abdominal aortic aneurysm.

The Scholarship Endowment Fund was established to provide income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome. Fellows wishing to make tax-deductible gifts to fund these vital programs are encouraged to contact the ACS Foundation at 312-202-5338.
Resident Research Scholarships for 2010 awarded

Four American College of Surgeons Resident Research Scholarships for 2010 were awarded by the Board of Regents in February. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of $30,000 for each of two years, beginning July 1, 2010. These scholarships are sponsored by the Scholarship Endowment Fund of the College.

The recipients for these scholarships are as follows:

Sara J. Runge, MD, resident in surgery, University of California, San Francisco.

Research project: Genetic modulation of vascular smooth muscle phenotype and intimal hyperplasia.

Jesse Daya Vrecenak, MD, resident in surgery, Hospital of the University of Pennsylvania, Philadelphia, PA.

Research project: Early gestational gene transfer to mammary epithelial stem cells and potential clinical, biological, and biotechnology applications.

Filip Bednar, MD, resident in surgery, University of Michigan, Ann Arbor, MI.

Research project: Cancer stem cells in genetically engineered mouse models of pancreatic adenocarcinoma.

Stefan S. Kachala, MD, resident in surgery, Weill Cornell Medical Center, New York, NY. (Research to be performed at Memorial Sloan-Kettering Cancer Center, New York, NY.)

Research project: Regionally administered TLR7 agonist augments lung cancer antigen targeted T-cell immunotherapy.

The requirements for these research-oriented scholarships offered by the College for 2011 will be published in a later issue of the Bulletin. This information will also appear on the College’s scholarships Web page, at http://www.facs.org/memberservices/research.html.
The online resource, *So, You Want to Be a Surgeon...A Medical Student Guide to Finding and Matching with the Best Possible Surgery Residency*, is now available on the American College of Surgeons Web site at:

http://www.facs.org/residencysearch

This online, contemporary version of the popular “Little Red Book” has proved to be an invaluable resource for medical students seeking opportunities in graduate medical education. The revised online version of this helpful reference includes a searchable database containing a complete list of accredited surgical specialty residency programs, as well as a section devoted to assisting students in choosing a residency program that is their best match.

For further information, contact Elisabeth Davis, MA, Education Research Associate, Division of Education, at 312-202-5192, or via e-mail at edavis@facs.org.
Report of the 2009 International Guest Scholar

by Jaqueline Cruz Vargas, MD

As International Guest Scholar, my pre-Congress tour started in June 2009 at the Mayo Clinic Symposium in Reconstructive Microsurgery. At that point, I visited Samir Mardini, MD, at the Mayo Clinic in Rochester, MN, and in October 2009, I met Allen Van Beek, MD, FACS, in Minneapolis, MN. My post-Congress tour included a visit to Luis Vásconez, MD, FACS, in Birmingham, AL, and participation in the Plastic Surgery Congress in Seattle, WA.

Mayo Clinic Symposium

I attended the first Mayo Clinic Symposium in Reconstructive Microsurgery in Rochester, MN. The guest of honor and principal speaker was Fu-Chan Wei, MD, an international expert from Chang Gung Memorial Hospital in Taiwan (see photo, this page). The intensive four-day program covered the latest innovations and techniques in free tissue transfers and local flap options for treatment of body-wide reconstruction. Forty of the most knowledgeable and experienced faculty worldwide also attended.

On the first day of the symposium, I observed anatomical dissection of pedicle and microsurgical flaps, performed by renowned experts. I then performed the same dissection under their supervision. During the following three days, I listened to presentations of research in the field, and reports on experiences gathered over several years of thoughtful study.

In Peru, regular courses on microsurgery did not exist until very recently. I have organized small courses on the subject for residents and young plastic surgeons since 2007. The symposium at the Mayo Clinic helped me further improve these courses. At the Universidad Peruana Cayetano Heredia, Lima, Peru, where I work, we do not have an exclusive laboratory for training in microsurgery. During a recent basic course of microsurgery that I organized in January, I implemented a provisional laboratory. We used low-cost resources, including stereoscopes for visual magnification (commonly used by the faculty of biology), and training on microvascular anastomosis, using vessels of less than 1 mm in diameter, on chicken pieces purchased from the market. With these resources, a large number of surgeons can be trained to develop microsurgical skills in their specialties. A workshop...
of pedicle and microsurgical free flap techniques took place in March. This course was based on the format employed in the symposium at the Mayo Clinic. An advanced course of microsurgery is scheduled for July in Lima. There, again, I will be able to put in to practice my latest knowledge on microsurgery.

**Mayo Clinic, Rochester, MN**

I spent one week in June 2009 with Dr. Mardini, one of the organizers of the symposium, at the Mayo Clinic. I met Dr. Mardini during a visit he made to Peru a year ago. He wrote a book about voice reconstruction produced with Hung-chi Cheng, MD, in Taiwan, and another about microsurgery reconstruction with Dr. Wei. Mayo Clinic is recognized and respected for its excellence in health care internationally, so it was a privilege to be there and to benefit from the excellent opportunity to attend the surgeries and conferences.

I attended many operations performed by various surgeons at St. Mary’s Hospital, Rochester, MN. I was especially impressed by the operation involving facial reanimation in a child with a congenital facial palsy, reconstructed with a gracilis free flap. I learned a lot about this type of surgery. I was also present in a cranesosinostosis surgery, and breast, chest, and extremities reconstructions, some requiring free and pedicle flaps to cover the wounds.

I was impressed not only by the professionalism with which the surgeons operated, but by their extraordinary teamwork.

Dr. Mardini offered to collaborate with me and surgeons from my country in developing microsurgery, particularly in facial palsy. These types of surgery are just beginning in Peru, so expertise is very much required. Dr. Mardini goes periodically on missions to Peru to perform free surgeries for disadvantaged children who otherwise would never receive operations of this kind.

My experience at the Mayo Clinic was academically enriching. The innovations observed in patient care, medical research, and the academic formation of human resources will improve my teaching and research skills.

**Centennial Medical Lakes Center, Minneapolis, MN**

During a single week, in June 2009, I visited Dr. Van Beek at Centennial Medical Lakes Center (see photo, this page). I had chosen to visit him due to the fact that he is a recognized plastic surgeon who has published many articles about plastic surgery, particularly an article on cleft lip nose, which was published in the *Plastic and Reconstructive Surgery Journal.* He helps poor children from South America, doing cleft lip, cleft nose, and reconstructive surgery in various missions. A past-president of the American Society of Hand Surgery, Dr. Van Beek is also well-regarded for hand reconstructive surgery.

In the consulting rooms, I observed patients with hand damage. Dr. Van Beek explained the situations of the patients, case-by-case. I observed a fine dissection that he used performing a micro-dissection of the hand nerves in one patient with nerve injuries. He dissected all the branches carefully, and then repaired the nerve under the microscope. At the end of the process, I was able to witness the wonderful results during the follow-up consultation.

In Peru, the incident of labial fissure is high. For every 700 children who are born, there is one case of labial and/or cleft palate. The facial sequels that a child has after the repair of the lip include an asymmetry marked with the nose, the nasal collapsed wing, a nasal fallen tip, and the nasal septum deviant. Therefore, one of my
goals was to learn from Dr. Van Beek the way he corrects cleft nose. It was amazing to witness this kind of surgery and the immediate results. After the surgeries, we had a chance to discuss cleft patients. I showed him the cases I performed, and he offered me precious advice on how to get improved results. I am now putting in to practice his advice when attending to cleft patients at my hospital.

**2009 Clinical Congress**

I attended the very well-organized and unforgettable ACS Clinical Congress, including the Convocation Ceremony for new Fellows. Personally, it was a great honor to rise to the platform in McCormick Place Convention Center when they named the International Guest Scholars for 2009, in front of researchers, teachers, and directors of the College. I must acknowledge the excellent work of the International Relations Committee for providing all the necessary support to the scholars (see photos, this page).

On October 10, 2009, I attended the College’s International Travelers, 2009 Session, where the International Guest Scholars presented their surgical interests and described the practice of surgery in their homelands. I presented my work, entitled Development of Microsurgery in a Developing Country. I explained how I was able to deliver a microsurgery course training in my country without a sophisticated laboratory and few resources, such as used stereoscopes obtained from the biology faculty, and practicing with chicken pieces. My work has greatly benefited from my pre-Congress tour, the last visit to Mayo Clinic, the comments of Dr. Van Beek, and the symposium on microsurgery. I enjoyed all the sessions because they gave me an opportunity to share my best experiences, and to hear the experiences of my colleagues in their countries.

**University of Alabama-Birmingham, AL**

During the two weeks after the 2009 Clinical Congress, I visited Dr. Vásconez at the University of Alabama-Birmingham (see photo, this page). I chose to visit him because he is a well-published, eminent plastic surgeon, and highly respected due to his work in breast reconstruction. Dr. Vásconez receives difficult cases referred by other surgeons from various parts of the world. We worked...
out a detailed schedule for the week’s activities with his team that included surgeries and academic activities.

I was present in the OR at UAB Highlands Hospital in Birmingham, AL, where I had the opportunity to observe many difficult cases of breast reconstruction, with and without implants. I also saw difficult cases of advanced skin cancer on the face, and reconstruction with flaps. I learned how to determine and solve an infection in a patient who had breast reconstruction with a saline implant—conserving the implant, cleaning the implant, and revitalizing the tissues following careful management.

I saw other reconstruction surgeries on different parts of the body, performed by Dr. Vásconez’s team. I also accompanied the follow-up procedures of the surgeries in the consulting room at the Kirklin Clinic, Birmingham, AL, and I enjoyed watching the excellent results of the surgeries, and the management of complex cases referred to Dr. Vásconez.

Once a week, we had an academic session. I had the opportunity to discuss cleft nose repair, and I exchanged ideas about the cleft nose treatment with other surgeons on Dr. Vásconez’s team, and participated in discussions about complex cases and the best ways to manage them. The well-organized program, the numerous appointments, and the sense of partnership and collaboration showed to me by Dr. Vásconez’s team made me feel comfortable all the time. I also had the opportunity to establish good relationships with the surgical team, for future collaboration.

**Plastic Surgery Congress, Seattle, WA**

Many important plastic surgeons presented their work at this meeting. Typically, each presentation was followed by expert faculty debates, during which different approaches to surgical problems were discussed. These debates provided a forum for discussing, for example, the strengths and limitations of cosmetic and reconstructive techniques. This meeting offered an opportunity for participants to learn about the latest plastic surgery research.

Out of this experience, I learned surgical techniques for achieving best results. As a result of what I learned at this meeting, I have made some modifications to the content in the courses that I teach, and I have translated these concepts into practice in my daily performance at the public hospital.

**Conclusion**

It was a wonderful opportunity for me, as a young surgeon from Peru, to learn from the most prestigious surgeons of the world, attend their surgeries, and, most of all, exchange ideas and knowledge personally. Thanks to that, I gained confidence in my medical practice. At the same time, it gave me a perspective on how to contribute to the development of microsurgery here in my country.

With the knowledge I acquired, I was able to optimize
the basic microsurgery course that I run at the university, using locally available resources (see photo, page 48). In March 2010 I presented the first course on flaps in microsurgery. This was an opportunity to put into practice all the knowledge gained through this scholarship at the American College of Surgeons, and to share my experiences with other colleagues at the university, with students of our faculty, and with colleagues from my public hospital. I would like to thank the American College of Surgeons and its International Relations Committee for the great opportunity to learn about the latest research and development in surgery, and, at the same time, obtain international exposure. This experience has stimulated my interest in new areas of specialization, and has encouraged me to continue teaching at a medical facility, and to pursue in-depth medical research—which is much needed in my home country.

Dr. Cruz is a plastic surgeon with the Hospital Nacional Cayetano Heredia and the Universidad Peruana Cayetano Heredia, Lima, Peru.
International Guest Scholarships available for 2011

The American College of Surgeons is offering International Guest Scholarships in 2011 to competent young surgeons from countries other than the U.S. or Canada who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $8,000 each, provide the International Guest Scholars with an opportunity to visit clinical, teaching, and research institutions in North America and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons Clinical Congress in San Francisco, CA, in 2011.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, FACS(Hon), former Director of the College. In addition, a 1994 bequest from the families of Abdol Islami, MD, FACS, and Baxiram S. and Kankuben B. Gelot, and gifts from others to the International Guest Scholarship endowment, have enabled the College to expand the number of scholarship awards.

The scholarship requirements are as follows:

- Applicants must be medical school graduates.
- Applicants must be at least 35 years of age, but younger than 45, on the date that the completed application is filed.
- Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
- Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of their respective home country.
- Applicants whose careers are in the developing stage are deemed more suitable for receipt of this scholarship than those who are serving in senior academic appointments.
- Applicants must submit a fully completed application form provided by the College on its Web site. The application and accompanying materials must be typewritten and in English. Submission of a curriculum vitae only is not acceptable.
- Applicants must provide a list of all of their publication credits and must submit three complete publications (reprints or manuscripts) of their choosing from that list.
- Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment or a Fellow of the American College of Surgeons residing in their country. The chair’s or the Fellow’s letter must include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted in envelopes sealed by the writers.
- Applicants are required to submit a curriculum vitae of no more than 10 pages.
- Applicants may submit a photograph. (Passport size is preferable.)
- The International Guest Scholarships must be used in the year for which it is designated. The scholarship cannot be postponed.
- Applicants who are awarded scholarships are expected to provide a full written report of the experiences provided through the scholarships upon completion of their tours.
- An unsuccessful applicant may reapply only twice, and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

International Guest Scholarships provide successful applicants with the privilege of participating in the College’s annual Clinical Congress in October, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses, plus admission to
all lectures, demonstrations, and exhibits, which are an integral part of the Clinical Congress. Assistance will be provided in arranging visits (following the Clinical Congress) to various clinics and universities of the scholars’ choosing.

To qualify for consideration by the selection committee, all of the requirements must be fulfilled. Formal American College of Surgeons International Guest Scholar applications are available online on the College’s Web site at http://www.facs.org/memberservices/igs.html. Supporting materials and questions should be directed to: Administrator, International Liaison Section, American College of Surgeons. 633 N. Saint Clair St., Chicago, IL 60611-3211 USA; fax: 312-202-5021.

Completed applications, including all of the supporting documentation, for the 2011 International Guest Scholarships must be received at the office of the International Liaison Section before July 1. All applicants will be notified of the selection committee’s decision in November 2010. Applicants are urged to submit their completed application package as early as possible in order to provide sufficient time for processing.

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**A look at The Joint Commission**

**Revised medical staff bylaws standard approved**

Revisions to The Joint Commission Medical Staff Standard MS.01.01.01, formerly known as MS.1.20, were approved by The Joint Commission Board of Commissioners in March. The standard is designed to contribute to patient safety and quality of care through the support of a well-functioning, positive relationship between a hospital’s medical staff and governing body.

The revisions are based on the unanimous recommendations of an 18-member expert task force representing the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, the American Medical Association, the Federation of American Hospitals, and the National Association Medical Staff Services, as well as hospital trustees and health care attorneys.

Standard MS.01.01.01 addresses the medical staff’s self-governance and its accountability to the governing body for the quality and safety of patient care, and recognizes that while a hospital’s governing body is ultimately responsible for the quality and safety of care, the governing body, medical staff, and administration must collaborate to achieve this goal.

An important element for achieving this collaboration is a written set of documents, known as medical staff bylaws, that describes the medical staff’s organizational responsibilities, and how the medical staff and governing body will work together. Standard MS.01.01.01—which underwent an extensive field review with accredited organizations, physicians, and other interested parties—provides the framework for constructing, writing, and implementing these bylaws.

The revised standard goes into effect March 31, 2011, which provides hospitals and their medical staffs a year to come into compliance with the revised requirements, and offers The Joint Commission an opportunity to answer any questions that may arise regarding the revised standard. Following the March 31, 2011, implementation date, all hospitals and critical access hospitals must be in full compliance.

Detailed information about revised standard MS.01.01.01 can be found on The Joint Commission Web site, www.jointcommission.org, and in the 2011 version of the accreditation manuals for hospitals and critical access hospitals that will be published and distributed in the fall of 2010.
American College of Surgeons Professional Association (ACSPA)

The ACSPA-SurgeonsPAC (political action committee) raised $609,569 in 2009. Contributions for 2009 among ACSPA leaders were as follows:

- U.S. Regents and Officers: 93 percent, with an average contribution of $562, for a total contribution of $14,050
- U.S. Governors: 57 percent, with an average contribution of $364, for a total contribution of $44,470

The ACSPA-SurgeonsPAC set a fundraising goal of $2 million for the 2009–2010 election cycle. The PAC board and staff are working to implement diverse and innovative fundraising techniques in an effort to reach this goal.

American College of Surgeons

Board of Governors

The Board of Regents approved the following recommendations from the Board of Governors.

Three criteria relating specifically to International Fellowship were changed to read as follows:

- Graduation from a medical school acceptable to the American College of Surgeons and listed in the Avicenna Directories, published by the World Health Organization and the University of Copenhagen, available at http://avicenna.ku.dk/database/medicine/.
- Three years of continuous, uninterrupted surgical practice in one location (same institution or same country, city, town, or village), after completion of all formal training.
- After notification of a Governor, or Governor in consultation with a chapter’s officers, the Member Services Liaison Committee determines whether the requirements for Fellowship are satisfied, and may, at its discretion, defer any application until such requirements are met. The Board of Regents makes the final decision regarding the applicant’s eligibility for Fellowship. The Board of Regents may, at any time, modify the requirements for Fellowship.

Report on ACSPA/ACS activities

February 2010

by Michael J. Zinner, MD, FACS, Chair, ACS Board of Governors
The Regents approved the appointment of Hugh E. Scully, MD, FACS, Toronto, ON, to the College’s Health Policy and Advocacy Group. They also approved an Advocacy Grant Program for the chapters.

**ACS Health Policy Research Institute (HPRI)**

The ACS HPRI held a second surgery workforce meeting. Approximately 100 people were invited; 29 attended the meeting. The meeting’s goals were to share research and data, further discuss opportunities for data collaborations and improvements, and discuss current and emerging workforce and policy issues relevant to surgery.

**ACS National Surgical Quality Improvement Program (NSQIP)**

In January, the College submitted a proposal to evaluate the feasibility of merging ACS NSQIP clinical data with Centers for Medicare & Medicaid Services (CMS) claims data. CMS responded with an agreement to fund the ACS and merge and evaluate the use of ACS NSQIP and CMS data. The project will begin in the spring of 2010.

**Advocacy**

Health care reform continues to be the focal point for the College and its Division of Advocacy and Health Policy (AHP). The division director, Christian Shaljian, updated the Regents on activities that have taken place since the October 2009 Clinical Congress, in Chicago, IL. For details on those activities, visit the AHP Web site at [http://www.facs.org/ahp/index.html](http://www.facs.org/ahp/index.html).

**Education**

Development of the *Surgical Education and Self-Assessment Program 14 (SESAP 14)* is proceeding well. A new, more robust electronic format is being planned with features to address the new continuing education mandates. *SESAP 14* will include a totally redesigned model for self-assessment, which will be more rigorous and should meet the new requirements for Part 2 of Maintenance of Certification as defined by the American Board of Surgery.

A new Web-based educational program, *SESAP Sampler*, was launched in October 2009. *SESAP Sampler* consists of content that was developed with the same stringent, multi-step, peer-review process used for *SESAP 13*, and includes items that have not been published. *SESAP Sampler*, which is offered as an annual subscription, offers participants the opportunity to earn a maximum of six Category 1 continuing medical education (CME) credits.

Eight issues of *Selected Readings in General Surgery (SRGS)* are planned for 2010. *SRGS* offers participants the opportunity to earn a maximum of 10 Category 1 CME credits per issue.

The first ACS Comprehensive General Surgery Review Course is scheduled to be held June 17–20 in Chicago, IL. This landmark course will provide a four-day intensive review of the essential content areas in general surgery.

A new educational program, Beyond the Morbidity and Mortality Conference: Analysis of Surgical Errors and Complications in Contemporary Practice, was launched in October 2009. The Web-based program was developed to address practice-based learning and improvement, and systems-based practice. It focuses on systematic analysis of surgical errors, complications, and near misses as a means for improving patient outcomes. A framework is provided for use by individual surgeons or surgical teams to critically evaluate adverse events and near misses, identify opportunities for improvement, and implement and track changes in practice. Practical resources and sample cases are provided.

A six-hour course titled Team Training in Surgery: Lessons from Aviation has been offered during the Clinical Congress in past years. A multidisciplinary Ad Hoc Committee on Development of High-Performance Teamwork in Surgery through Education was appointed two years ago to develop a national educational program to promote ef-
effective teamwork in surgery. The committee developed a Statement on High-Performance Teams that was approved by the Board of Regents in October 2009. The statement can be viewed at: http://www.facs.org/fellows_info/statements/st-66.html. For more information on ACS education activities, visit the Education Web site at http://www.facs.org/education/index.html.

**Journal of the American College of Surgeons (JACS)**
The JACS CME Web site has been redesigned to meet the latest standards of the Accreditation Council for Continuing Medical Education. (Visit the Web site at http://www.facs.org/jacs/index.html.) From October 1 through December 31, 2009, 19,157.5 credits were earned; the program is provided as a member benefit.

**Web portal and Web site**
The College’s Web portal, e-FACS.org, has had more than 2 million total page views since its launch in 2006, and continues to be used by a growing number of surgeons. A new feature was added to the portal, under “Member Tools,” which offers the user the ability to view their product order history and/or print receipts. The “Communities & Specialties” area continues to provide quality content targeted to the main interests of the College’s members.

Additionally, the first of the new practice-based learning modules (Surgical Site Infection) has been posted to the portal. The modules will serve to tie the ACS Web portal and the ACS Case Log System together in a way that will help surgeons improve their performance in areas that may need improvement.

Traffic to the College’s public Web site continues to grow (http://www.facs.org/). In other Web site news, an “Update Haiti” section was added to the College’s Committee on Trauma Web page. The section was created as a resource containing the most up-to-date information related to the disaster, useful information from Fellows of the College, and information from other organizations.

**Operation Giving Back (OGB)**
The College’s response to the January 12 earthquake in Haiti began within hours. A dedicated Haiti Web site was live by noon the following day, and featured nine pages with more than 150 links to information including volunteer forms, resources for responders, OGB volunteer toolkit, responding organizations, Haiti news/information, response information for residents and medical students, and other relevant information and updates.

Other OGB actions in response to the earthquake in Haiti include the following: alerts and updates were sent to the membership via e-mail on a daily basis; a volunteer registry was created within 24 hours; a Google map was live in the first week, and updated regularly based on feedback; and a Case Log was made accessible to all surgeons.

**HealtheCareers (Job Bank)**
As of January 22, there were 994 active jobs listed on the Web site, with 309 posted resumes. This is a valuable service for all members of the College (and is complimentary to the Resident Members).

**Resident and Associate Society (RAS)**
The four RAS committees are thriving. The Issues Committee has communicated with the College’s state advocacy staff to collaborate on informational ways to keep young surgeons aware of the College’s advocacy efforts, and to demonstrate how young surgeons can influence the process. The Communications Committee is making progress on its series of articles for the July Bulletin, with “health care policy and the future of surgery” as this year’s theme. The Membership Committee continues to collaborate with Weber Shandwick on resident recruitment, and will continue to work with the firm on executing recruitment and retention strategies. The Education Committee is in charge of the question bank for Surgical Jeopardy.

**Young Fellows Association (YFA)**
Since the 2009 Clinical Congress in Chicago, IL, the Executive Committee of the YFA and
its four work groups have conducted numerous conference calls. The Executive Committee plans to initiate communications with the surgical specialty societies to invite their young surgeons to participate in the YFA.

The Advocacy and Education Work Groups have jointly planned the next Leadership Conference, which will be held July 24–25 in Washington, DC. The conference will conclude with a Town Hall Meeting featuring the College’s leadership.

The Membership Work Group intends to examine the reasons why Resident Members do not become Associate Fellows, and Associate Fellows do not become Fellows. An electronic survey will be prepared, and hopefully, based on the responses, strategies will be proposed that will enhance the retention of College members.

The Communications Work Group published the Winter 2009 edition of the YFA e-Newsletter. In addition to updates about the activities of the four YFA work groups and the YFA education programs, the e-newsletter will feature an ACS product or service.
The National Ultrasound Faculty of the American College of Surgeons has developed “Ultrasound for Surgeons: The Basic Course, 2nd Edition” on CD-ROM for surgeons, surgical residents, and anyone interested in ultrasound imaging.

The 2nd Edition includes:

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

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

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Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its February 12 meeting:

- A general surgeon from Houston, TX, was censured. This action was taken following a complaint to the College about this surgeon’s testimony as an expert witness in a medical malpractice lawsuit alleging that the testimony violated the ACS Statement on the Physician Acting As an Expert Witness and the ACS Bylaws, Article VII, Section 1(i).
- Jeffrey C. Hamm, MD, FACS, a plastic surgeon from Hollywood, FL, had his Fellowship status placed on probation with conditions for reinstatement. This action was taken following disciplinary action by the State of Florida after he was charged with failing to meet the standard of care in his treatment of a patient, and for failure to keep legible medical records that justified his course of treatment.

**Definition of terms**

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

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

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

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

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

**Expulsion:** The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.

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:

- **Advances in Trauma, December 10–11, 2011, Kansas City, MO.**
- **Trauma, Critical Care, and Acute Care Surgery 2011, April 11–13, 2011, 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](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312-202-5342.
Membership in the American College of Surgeons?

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AS A BODY REPRESENTING ALL OF SURGERY, THE COLLEGE:

• Provides a cohesive voice addressing societal issues related to surgery.
• Is working toward having an increasingly proactive and timely voice in setting a national tone and agenda with regard to health care.
• Is dedicated to promoting the highest standards of surgical care through education and advocacy for its Fellows and their patients.
• Serves as a national forum through which surgeons can reinforce the values and ethics that traditionally have characterized the surgical profession.

THERE IS STRENGTH IN NUMBERS.

Our members represent every specialty, practice setting, and stage of practice. Their views and concerns are helping to shape the College’s agenda for the future.

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Only by banding together and using our collective strength can we bring about positive change for our patients and ourselves—and for surgeons of the future.

HERE ARE SOME OF THE MANY BENEFITS BEING A MEMBER OF THE COLLEGE AFFORDS YOU:

• Access to the College’s free coding consultation hotline
• Subscription to ACS NewsScope, the College’s weekly electronic newsletter
• Subscription to the Bulletin of the American College of Surgeons
• Subscription to the Journal of the American College of Surgeons
• Access to Maintenance of Certification tools
• Access to all College-sponsored insurance, credit card, and other helpful programs
• Free posting of resume on ACS Career Opportunities

Information on becoming a member of the College and an application form are available online at www.facs.org/memberservices/documents.html

or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 800-293-9623, or via e-mail at chicks@facs.org.
NTDB® data points

Double McTwist 1260

by Richard J. Fantus, MD, FACS

The McTwist dates back to the 1980s, when it was invented by skateboarder Mike McGill; these days, the maneuver is often performed by snowboarders. The McTwist involves a front flip while at the same time spinning a backside 540° (an outward rotation with the back facing downhill while doing one-and-one-half rotations). It wasn’t until this February that the move became a household word. Earlier this year, the U.S. Olympic team made history as the most decorated winter team in U.S. history. One of the gold medal winners, Shaun White, is a pioneering snowboarding champion, and on February 18, 2010, he took his place in the record books. Through ingenuity, dedication, and hard work, he was able to perform a move that had the snowboarding world on their heads. He executed the Double McTwist 1260 (two flips and three-and-a-half spins) during his second run of the men’s halfpipe, after he had already been assured of gold from his first stellar run.

The first modern snowboard is known as the Snurfer (a blending of the words “snow” and “surfer”), and was designed by Sherman Poppen for his children in 1965 in Muskegon, MI. It was essentially a skateboard without wheels and bindings, and it was steered by a handheld rope.

Snowboarding has continued to evolve since its development in the 1960s and 1970s, and in 1998, it became a Winter Olympic sport (http://www.abc-of-snowboarding.com/info/snowboarding-facts.asp). According to a Centers for Disease Control and Prevention study on recreational injuries from 2004 to 2005, almost 213,000 people were treated each year in emergency departments for outdoor recreational injuries. Of those injured, 51.5 percent were ages 10 to 24, and the most common injuries were fractures of the arms and legs, with the top three mechanisms listed as snowboarding (25.5 percent), sledding (10.8 percent), and hiking (6.3 percent) (http://www.cdc.gov/media/pressrel/2008/r080610.htm).

In order to examine the occurrence of snowboarding injuries in the National Trauma Data Bank® research dataset 2008, admissions records were searched utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) cause of injury code E885.4 (snowboard). A total of 1,428 incidents matched this E code; 1,150 records had discharge status recorded, including 1,105 discharged to home, 31 to acute care/rehab, and 11 sent to nursing homes; three died (these data are depicted in the figure on this page). These patients were 82 percent male, on average 21.4 years of age,
had an average length of stay of 2.7 days, and an average injury severity score of 7.5.

Going down the slopes on a skateboard without wheels, like a surfer on the waves, appeals to a certain type of individual who enjoys the feeling of the wind in their face. With snowboarding as the leading mechanism of outdoor recreational sports injury, it is important for individuals to check their equipment, wear appropriate safety devices, know their limits, and leave the Double McTwist 1260 to the experts.

Throughout the year, we will be highlighting these data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Report 2009 is available on the ACS Web site as a PDF file 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.

Acknowledgment

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

Dr. Fantus is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago, IL. He is Past-Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.
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If you have questions or problems, contact dues@facs.org. Include your Fellowship ID number in your note.

IMPORTANT NOTE:
The American College of Surgeons does NOT provide your e-mail address to outside entities. E-mail addresses are used only for College communications.
Chapter news

by Rhonda Peebles, Division of Member Services

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

Oregon Chapter conducts annual winter meeting

The leaders of the Oregon Chapter met in Salem in March for their 2010 annual winter meeting. In addition to planning education programs, the chapter leaders also reviewed 2010 advocacy activities and programs. (See photo, below.)

Virginia presents humanitarian awards for two residents

In 2009, the Virginia Chapter established the VA-ACS Humanitarian Surgical Resident Travel Scholarship Program to offset travel expenses for surgical residents in Virginia who are participating in programs to deliver surgical care as part of humanitarian missions to underdeveloped countries. Two recipients have been selected for the 2010 travel scholarships: Stephen M. Wold, MD, and Phillip G. Chen, MD. Each recipient received $500 to offset travel expenses.

Dr. Wold (see photo, above left) will lead a team from Eastern Virginia Medical School, Norfolk, VA, to Hospital Loma de Luz (Hill of Light) near Balfate, Honduras. The medical mission team supports ongoing hospital efforts by providing head and neck consultation and surgery. Past procedures have included the treatment of facial

Oregon Chapter, left to right: Ron Jaecks, MD, FACS, President-Elect; Dave Oehling, MD, FACS, Councilor; John Handy, MD, FACS, Past-President; Melinda Baker, Senior State Affairs Associate, ACS Division of Advocacy and Health Policy; Monte Stewart, MD, FACS, Councilor; Keith Thomas, MD, FACS, Councilor; John Mayberry, MD, FACS, President; Erik Swensson, MD, FACS, Councilor; Alan Hay, MD, FACS, Councilor; and Alan Morasch, CAE, Executive Director.
trauma, thyroid malignancy, and benign tumors of the head and neck.

Dr. Chen (see photo, above right), from the University of Virginia, Charlottesville, will work with the Mission of Hope, Bolivia, which is an organization that runs a free medical clinic in Santa Cruz. Each year, a team of otolaryngologists, anesthesiologists, and nurses from across the U.S. volunteer their time and services to provide free surgical care for the needy patients of this clinic. Surgeries include tonsillectomies, sinus surgery, cleft lip and palate repairs, and excision of masses.

For more information about the Virginia Chapter’s humanitarian awards for residents, please contact Craig S. Derkay, MD, FACS, Chair, Humanitarian Surgical Resident Travel Scholarship Committee, at Craig.Derkay@chkd.org, or Susan McConnell, Chapter Administrator, at smmcconnell@ramdocs.org.

**2010 Leadership Conference and JSAC conference scheduled**

Young Fellows and Chapter leaders will meet on Sunday, July 25, for the annual Leadership

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**Chapter meetings**

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

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

<table>
<thead>
<tr>
<th>Date/time</th>
<th>Event</th>
<th>Information</th>
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<tbody>
<tr>
<td>July 23, 2010 -</td>
<td>Tennessee (CS)</td>
<td>Location: Paris Landing State Park, Buchanan, TN</td>
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<tr>
<td>July 25, 2010</td>
<td></td>
<td>Contact: Wanda Johnson (931) 967-4700</td>
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<td></td>
<td></td>
<td>e-mail: <a href="mailto:wandamck@aol.com">wandamck@aol.com</a></td>
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<td>August 05, 2010 -</td>
<td>Idaho, Montana, and Wyoming (CS)</td>
<td>Location: Sun Valley Resort, Sun Valley, ID</td>
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<tr>
<td>August 07, 2010</td>
<td></td>
<td>Contact: Lori Stacy (208) 993-0082</td>
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<td>e-mail: <a href="mailto:lori.stacy@hotmail.com">lori.stacy@hotmail.com</a></td>
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<td>ACS Representative(s): A. Brent Eastman, MD, FACS</td>
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<td>August 27, 2010 -</td>
<td>Georgia Society of the American College of</td>
<td>Location: To be announced</td>
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<td>Surgeons</td>
<td>Contact: Kathy D. Browning (404) 625-1520</td>
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<td>September 03, 2010</td>
<td>New Mexico</td>
<td>Location: Albuquerque, NM</td>
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<td></td>
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<td>Contact: Sally Blackstad (505) 796-3430</td>
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<td>e-mail: <a href="mailto:sbblackstad@nmms.org">sbblackstad@nmms.org</a></td>
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<td>September 11,</td>
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<td></td>
<td>Contact: Gary Caruthers (785) 235-2383</td>
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<td>e-mail: <a href="mailto:gcaruthers@kmsonline.org">gcaruthers@kmsonline.org</a></td>
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<td></td>
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<td>Contact: Linda Clayton (501) 753-3500</td>
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<td>Contact: Linda Silvestri (859) 323-6346</td>
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Conference. The theme of this year’s conference is “leadership from all angles.”

For Young Fellows and residents, sessions on managing will be featured, including topics such as managing meetings, time management, and managing surgical practices. Chapter leaders and chapter executives will focus on education program planning and development, as well as legal issues. This year’s keynote speaker will be Wiley W. Soub, MD, ScD, FACS, who will examine the “language of leadership.” In addition, the Washington, DC, Chapter will host a welcoming reception on Sunday, July 25, beginning at 5:00 pm.

The Joint Surgery Advocacy Conference (JSAC) also will convene on Sunday, July 25, beginning with an opening reception. The deadline to register for the Leadership Conference and the JSAC is July 21. For more information or to register, please call the Chapter hotline at 1-888-857-7545.

**Chapter anniversaries**

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