10 questions and answers about disasters and disaster response
FEATURES

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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
Regardless of whether a sweeping health care reform law is enacted this year, we are likely to see continued progress in all of these areas.

Issues and positions
Congress is acutely aware that the current Medicare payment system is unsustainable, and congressional leaders continue to signal that they will enact some sort of long-term SGR reform this year, either through health care reform legislation or through a separate measure, such as the debt relief proposal under consideration at press time. The College is lobbying for permanent repeal of the SGR and for resetting the budget baseline for Medicare reimbursement.

Efforts to improve quality and measure outcomes have been under way for some time. The stimulus package enacted last year contained incentives for the expanded use of health information technology and for comparative effectiveness research (CER). The College supports the plans that would provide financial assistance to surgeons who move toward the use of electronic health records and use CER as a tool to establish high-quality decision making, rather than to determine cost-effectiveness.

Another key element of the federal government’s efforts to evaluate quality of care is the Physician Quality Reporting Initiative (PQRI), which was initiated in 2007. At this point, the College’s regulatory experts believe that the PQRI is riddled with a number of systemic problems. Until these flaws are fixed, we oppose proposals that would mandate physician participation in the program.

With regard to liability reform, the College has long supported national legislation that follows the model set forth in California’s Medical Injury Compensation Reform Act (MICRA), including a cap on noneconomic damages. At this point, the federal government is opposed to nationwide implementation of MICRA-type reforms. However, lawmakers do seem to be open to the possibility of offering incentive payments to states that enact or implement alternative dispute resolution (ADR) mechanisms. In recent years, we have voiced support for ADR and for extended protections for those health care professionals who adhere to clinical guidelines.
Perhaps the most controversial concept under consideration is the creation of an IPAB composed of 15 members appointed by the President. This panel would be responsible for making proposals to Congress aimed at extending the solvency of the Medicare program, slowing Medicare spending, and improving quality of care for beneficiaries. The College and many other surgical, medical, and patient advocacy organizations oppose the IPAB concept because such an entity ultimately would divest Congress of its authority over Medicare and, thereby, replace the transparency of congressional hearings and debates with a minimally open process overseen by unelected officials.

Looking forward

Regardless of whether a sweeping health care reform law is enacted this year, we are likely to see continued efforts to move forward in all of these areas. So, the big question is: What does the American College of Surgeons and its members need to do to prepare for the future?

With regard to payment, the ACS will need to accumulate and disseminate information about how surgeons are faring in efforts to hold down costs, yet provide high-quality services. Individual surgeons will need to hone their practice management skills and engage in practice-based learning, and the College will need to continue to develop educational programs to assist its members in these efforts.

The College also will need to promulgate core measures of quality surgical care and articulate to payors the value of surgical care. The ACS trauma programs provide a template for accurately measuring outcomes and developing standards that lead to safer, more effective patient care. We also will need to continue to develop and refine the ACS National Surgical Quality Improvement Program and to work with the Centers for Medicare & Medicaid Services to address the deficiencies associated with PQRI and to offer clinically relevant guidelines for care. Our members will need to participate in all of these efforts so that we can bring reputable, statistically relevant information to the negotiating table.

If, despite the medical community’s best efforts, an IPAB proves to be an inevitability, we cannot waste precious time complaining about it after the fact. Instead, we will need to work with the Administration to ensure that one of the College’s payment experts is appointed to the committee, so that surgery is properly represented.

In addition, we will continue to push for liability reforms that will ensure that patients are appropriately compensated for any injuries or losses they experience while receiving surgical care. Equally as important, the ACS also will need to continue to develop standards that can be used as a defense in lawsuits and to inculcate surgeons in risk avoidance.

Finally, we need to think about how this country will address the spike in demand for our services that is likely to occur if access to insurance should be broadened at some point in the future. An estimated 30 million more Americans will have coverage if health care reform passes. Who will serve them? Therefore, we need to continue to expand the workforce by taking the steps necessary to attract bright young people to our profession and to appropriately mentor them.

These are just a few thoughts about where the profession needs to head as the health care reform debate continues. I welcome your thoughts about what the College can do and encourage you to get involved in those activities that match your individual talents and interests.

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.
n the days following the tragic earthquake in Haiti, media reports focused on the time that was required to mobilize assistance for the people of Haiti, as well as on the huge death toll. The reports led many individuals to conclude that aid was being delayed due to bureaucracy and red tape. Most injuries and deaths in the immediate post-disaster phase are due to physical force trauma. Trauma is a surgical disease, and, as a result, surgeons are often called upon to serve as information sources for patients, friends, and colleagues.

The authors believe that a short review of some of the fundamental principles of disaster response would be helpful for surgeons seeking to understand and interpret media reports related to the situation in Haiti, as well as other disasters.
Why did it take so long for the disaster relief response to start working in Haiti?

Successful management of a disaster requires that local authorities have some level of preparedness. The resources to make certain that preparedness training was done were not available in Haiti. The authority to provide effective early command and control was eliminated by the damage to government buildings and infrastructure with resultant loss of communication capability. Roads were destroyed, so rescue and triage of casualties could not occur.

The first rescuers in all disaster events are always the people in the disaster area who were not hurt or killed. They can rescue some of the injured. However, without some response from government and health care agencies, evacuation and care of the injured will be delayed. This was clearly the case in Port-au-Prince. Help from adjoining geographic areas, such as other Haitian cities and the Dominican Republic, was not possible because passable roads were not available.

Medical facilities were damaged. Destruction of infrastructure and widespread communications failure rendered the Haitian government unable to exert effective leadership to coordinate the relief operation. The capacity to render care was impeded by the lack of capacity and materials necessary to treat the large number of wounded generated by the disaster. Ideally, triage is done at one or more points outside of the medical facilities and safely away from danger. When transport is done by “first rescuers” (as described in the opening paragraph), a large number of patients arrive at the nearest medical care facility. The first are typically the least severely injured, and if they are allowed inside the facility, the resources are quickly overwhelmed. Because there was no authority to enforce a plan to keep the least severely injured from entering the facilities, the facilities were overwhelmed.

This absence of a prevailing authority to coordinate all aspects of the response resulted in many rescue and medical teams operating independently and disjointedly, without knowledge of the “big picture,” although they no doubt have been rendering excellent care to the victims they have encountered.

The airport in Port-au-Prince was not functioning for an interval after the earthquake because air traffic control capability had been destroyed. After U.S. military personnel established air traffic control, the ability of incoming flights to arrive and depart was hampered by the availability of only one runway, and by a lack of fuelling facilities. The arrival of help by sea was hampered by virtue of the fact that the only docks available to receive ships had been destroyed by the earthquake.

Under the best of circumstances, for disasters that have occurred in the U.S., organized response and delivery of necessary supplies does not occur for a minimum of 96 hours after the disaster event occurs. Given the circumstances in Port-au-Prince—which included the loss of communication, damage to government organizations, damage to medical facilities, and lack of transport capability—the fact that many of the initial challenges have been met within one week of the disaster is impressive.

Thoughtful considerations of the situation that unfolded in Haiti should raise a number of questions about how well we are prepared for a similar event. These questions are intended to clarify what a disaster is and how we should think about preparation if we are to minimize the short and long-term consequences of any such event.
What is a disaster?

A disaster is a catastrophic event that disrupts the infrastructure of a community or society, to such a degree that they cannot cope with the consequences using routine methods or resources. In many ways, nothing will ever be the same, as disasters are typically associated with the tragedies of great loss of life and property, and a relatively long period of recovery. Disasters have been described as many people trying to do quickly what they do not normally do, working with people with whom they do not normally work, in an environment with which they are not familiar, and at a time and place that is completely unexpected.

However, the response to a disaster should not merely involve a mobilization of more personnel, supplies, and other resources. In fact, disaster management requires a new and different approach from our routine daily management of emergencies, because disasters pose unique problems and challenges rarely faced under normal conditions. The management response to a disaster must encompass many disparate elements that normally do not work together, and the people involved must suddenly cooperate with each other and foster a close working relationship in order to reach the common goal of establishing order out of chaos, and to minimize mortality and morbidity among the surviving victims. Because all disasters are sudden, unexpected, unpredictable, and random events, and because they are rare, they cannot be managed without established plans in place that are regularly rehearsed.

What makes a disaster different?

The most common feature of disasters, especially in terms of the medical management of casualties, is that the demand for resources outstrips the supply. This is a situation rarely, if ever, encountered in medical care in developed countries. The most common reason for this relative scarcity of resources is related to the large number of casualties that present all at once, which impedes the ability of medical providers to fully evaluate and treat each casualty and allocate available resources to those most in need, as we normally do. This situation is the most fundamental characteristic of a true “mass casualty event.” It should be distinguished from the more common “multiple casualty event,” otherwise termed “limited mass casualty event,” in which larger than normal numbers of injured victims present to a medical care facility, but are able to be handled with the resources at hand.

Successful management of the patients occurs even though it does involve extra work, some local mobilization, and straining of resources (for example, a busy weekend night in a major trauma center). A true mass casualty disaster must involve some level of rationing of resources to most accurately and effectively match needs with supplies, and must involve some mechanism for evacuation or redistribution of casualties to other facilities for full care, because by definition, all casualties cannot be handled locally. This requires a fundamental change in approach to the care of injured victims. A shift must occur from an orientation where there is a provision of the greatest good for each individual to the greatest good for the greatest number. The population, rather than the individual, must become the focus of medical care. It is not “business as usual, just busier.”

There may be casualties so severe that time and resource needs and requirements
Why should we be concerned about disasters?

Disasters are relatively rare events, even though modern global communication makes us more aware of them. According to the Federal Emergency Management Agency, events with more than 1,000 casualties occur only a few times each century, and only 10–15 events each year result in more than 40 casualties. So, why should medical providers be at all concerned about these events? In fact, the idea that “it will never happen to me” is a major barrier to learning and training in the unique challenges of mass casualty management.

The following factors have the potential to result in large-scale natural and man-made disasters:

- Increasing population density, with its associated increased settlement in high-risk areas
- Increasing environmental degradation
- Increasing special needs populations
- Increase in the amount and transport of hazardous materials
- The emergence of new infectious diseases
- The increasing threat of terrorism

The health care sector is thus challenged with an increased likelihood of confronting mass casualty disasters in future years.
How may disasters be classified?

Table: Classification schemes for disasters

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number of casualties</th>
<th>Mechanism</th>
<th>Nature of injuries</th>
<th>Extent and duration</th>
<th>Level of response required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td>Allows facilities to prepare</td>
<td>Permits individualized plans</td>
<td>Allows accurate triage</td>
<td>Allows planning for supply and personnel recruitment</td>
<td>Allows for accurate planning</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td>Number often not known until days after event</td>
<td>Casualty types are usually similar in most disasters</td>
<td>Nature of injuries may not be important. Physical force trauma predominates.</td>
<td>Duration is frequently not known until after event</td>
<td>No real disadvantages</td>
</tr>
</tbody>
</table>

Disasters come in all shapes and sizes, and even similar types of disasters may involve very different variables, ones that can influence casualty outcomes. Therefore, the comparison of one disaster to another can be problematic. The Table on this page lists several methods of classifying disasters in order to gauge their magnitude.

The number of casualties is not very useful information in this context, due to the fact that the amount of casualties that overwhelm resources is relative. For example, five victims of a motor vehicle crash could be easily handled in an urban trauma center, but this number of casualties, presenting all at once, would overwhelm a rural hospital.

Injury patterns tend to be similar in the various natural and man-made mechanisms (for example, the earthquake in Haiti or the attack on the World Trade Center), as well as in specific types of injuries within each mechanism. Geographic and time elements pose distinct challenges and implications for the medical response to disasters. “Open disasters” are those occurring over a wide geographic area, such as a tornado that goes across an entire state, while “closed disasters” are those in a discrete location with an easily defined scene, such as an urban building collapse.

Disasters can also be classified in terms of time. “Finite disasters” are those occurring at one point in time, such as a building collapse, from which all consequences follow, while “ongoing disasters” involve continuing damage and dangers, such as a leaking gas main that explodes and causes a fire, the aftershocks following an earthquake that continue for days or weeks, or armed conflicts. The most useful categorization scheme classifies disaster events according to the level of response needed to cope effectively with the event. This classification system works because the mismatch between needs and resources is the element that most fundamentally defines a disaster.
What is disaster preparedness?

Active involvement in the process of planning for a disaster, such as engaging in hospital drills and community exercises, and learning fundamental disaster principles and putting them into practice—and educating and engaging others in these activities—are the fundamental elements of disaster preparedness. This includes not only readying one’s hospital, community, and region for potential disaster events, but also preparing oneself and one’s own family for the many challenges that disasters pose. Preparedness should not only be directed at the management of the acute phases of a disaster response, but also for the very difficult long-term management phases of recovery, rebuilding, and return to normal.

What are the elements of a disaster response?

Effective disaster response begins with planning. Without local and regional plans based on sound analyses of all likely hazards, no organized response can occur. One “all-hazards” plan that encompasses a generic approach to the common challenges of all disasters is more effective than multiple plans addressing individual types of disasters. Plans should include inventories of local resources, arrangements for redundant communications systems (telephones, internet, and cell phones immediately fail during a disaster), and designation of roles for each of the following: government, health care, police, emergency medical services, food and water suppliers, and heavy equipment operators, to name only a few.

After planning comes education and training. These efforts involve working through scenarios (also known as rehearsals) of various hazardous events until everyone is familiar with their respective role, and lines of communication are established. Planning, education and training, and rehearsals are expensive. This fact probably explains why poor countries have little in the way of preparedness for disasters.
How should health care facilities prepare for disaster response?

Success or failure is determined by how well the institution can deal with the rapidly changing disaster situation. The command structure is an essential element that must be designated, and must be recognized by all participants of the response team. The many independent and disparate entities involved in a disaster response cannot function effectively without being willing to answer to one authority. The Incident Command System (ICS) has been used for this purpose in the U.S., as it has proven to fulfill the major command and control requirements in numerous disasters. All participants of any disaster response should have training in this system.

The ICS, with its core functions of planning, operations, logistics, and finance, allows the health care facility to organize the response and utilize workers and materials in the most efficient manner possible. The additional key functions of acting as the liaison to other responding agencies, provision of victim and caregiver safety, and dissemination of public information, round out the essence of the ICS. This is a system that requires training, and it should not be operated de novo or by novices. For a fuller discussion of this topic and a list of comprehensive educational materials, go to this Web site: http://training.fema.gov/IS/crslist.asp.

Disaster plans for health care facilities include plans for maintenance of forward-flow of casualties from triage to emergency assessment, and from there to the operating room, intensive observation area, routine observation area, and transfer to another facility or discharge. Ideally, the hospital should “lock down” on notification of the disaster event. Triage and decontamination stations are located away from the emergency treatment areas.

Teams of caregivers organized to perform initial assessment and care report to a medical control officer in the emergency reception area. This individual works with a representative of the hospital emergency response management group to coordinate communications, supply, and personnel. Choke points in hospitals include laboratory and radiology. Protocols for injury assessment and management that do not require lab or radiology are important. Clinical assessments conducted during a mass casualty event are not perfect, and provision is made for repeat assessments. Intensive care areas rapidly fill, so other areas where monitored beds are available should be identified. Some potential areas are endovascular surgery, endoscopy, and day surgery facilities. Patients who will survive if an airway is obtained and/or bleeding is stopped go immediately to the operating suite. Patients who need observation can be watched by nonsurgeon medical personnel. Personnel who are going to transport patients need to know where they are going, and this knowledge is developed during rehearsals. Dining areas should be reserved for feeding staff, and should not be converted into patient care areas.

A sad fact of mass casualty events is that most patients go to the nearest hospital. A perfect plan would include provision for “leapfrogging” to facilities that are more distant. Even if such a plan is in place, it almost never functions effectively in the early phase following a disaster event. As a substitute, health care facilities should have communication and transfer agreements with nearby facilities. Hospital supply inventories are kept at minimal levels for financial reasons. Caches of emergency supplies are important components of each emergency plan.
How can I become involved in disaster response?

Consult the disaster management community on the American College of Surgeons Web portal at http://www.efacs.org. Involvement in a disaster response is best accomplished through a long-term commitment to a variety of relief organizations, medical teams, or the military. These entities provide extensive training in the concepts and procedures of disaster planning and management, safety, command and control, and disaster casualty care, and they provide abundant experience with the collection and dispersal of needed resources.

Running into a disaster setting with noble intentions of helping, but without this education, training, and experience, tends to fail, is potentially dangerous, and adds a further burden to an already overwhelmed setting. Those without this experience can best help through support of relief organizations and by remaining in their hospitals to help care for victims who are transported to the U.S.

What is the role of health care providers in a disaster response?

Physicians and surgeons should participate fully in planning, education, and rehearsals, as they will be the first receivers of most disaster casualties and, therefore, must function as an integral part of the overall disaster response. Specific roles for nonsurgeon providers will need to be developed. Medical staff members need to stay in the hospital and away from the scene of the disaster event.

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Heart and soul: A surgeon rebuilds his life after a cardiac crisis

On July 14, 2002, Marc K. Wallack, MD, FACS, a surgical oncologist and chief of surgery at Metropolitan Hospital in New York, NY, developed severe angina when running toward Central Park while training for the New York City marathon. After an angiogram revealed that his arteries were 95 percent blocked, he underwent quadruple bypass surgery, and later found himself unprepared for the physical and emotional fallout of his recovery.

Dr. Wallack recounted his experience of “discovering life’s chapter two” following a major surgical procedure in an article that appeared in the Bulletin in June 2006. “In the same way that a near-miss car accident might cause a person to drive more slowly, the memory of a near-death experience forces a reinvention of one’s life, a close examination of life passed and missed opportunities,” he noted.

Dr. Wallack indicated that one of the most important aspects of his recovery took place just two weeks following his open-heart procedure. While at home he read Lance Armstrong’s book, It’s Not About the Bike: My Journey Back to Life (Berkeley Trade, 2001). He says he knew then that he had to prove to himself that he was ready to engage in life again, that he would not be a victim, and that he would return to work, perform his job, and be involved with his family and friends.

Dr. Wallack ran the New York marathon in 2004. “Two years following my surgery, running the marathon marked my return from the dead and showed me that I had reclaimed my life. It was a return from the darkness to the light,” he remembers.

Dr. Wallack’s hard-fought lessons surrounding physical and emotional recovery prompted him to write the article in the Bulletin. “I thought maybe the article would cause others to move to a chapter two in their life with assuredness, so that involvement in their careers and their lives can be sustained and maintained,” he explains.
Back to life
The feedback from the *Bulletin* article surprised Dr. Wallack. “I must have received 60 to 70 e-mails at home following publication of that article, most from Fellows of the College and other individuals who had undergone similar experiences,” he said. The response was such that Dr. Wallack was moved and encouraged to expand his thoughts and practical experiences. A book seemed the next logical step.

The result was *Back to Life After A Heart Crisis: A Doctor and His Wife Share Their Eight-Step Cardiac Comeback Plan*, published last month by Avery. His coauthor and wife of 19 years is Jamie Colby, a longtime network news anchor and reporter who now hosts the Fox News Channel program *America’s News HQ* and *Sunday Housecall with Dr. Isadore Rosenfeld*. Ms. Colby offers the unique and special perspective of the caregiver, and tells how attending to someone in recovery from an operation can place considerable strain on the caregiver and their relationship.

In the book, Dr. Wallack and his wife address the physical, emotional, and career-affecting issues surrounding a cardiac recovery. From the most ordinary suggestions, ranging from how to use a shopping cart in the grocery store to protecting your midline incision, from relearning how to drive a car, to dealing with symptoms associated with post-traumatic stress disorder—including re-experiencing the initial trauma through flashbacks or nightmares—Dr. Wallack discusses major aspects of the recuperation process through the eyes of the surgeon/patient. “I wanted the book to serve as a prescriptive guide for reclaiming your life after confronting the issues of mortality and vulnerability raised by a traumatic heart event—whether it be a heart attack or a surgical procedure,” he explains.

Back to work
Dr. Wallack returned to work two months after his heart procedure. His mind was filled with questions: “Who am I going to be?” “What am I going to be able to do?” “Do I have the stamina to stand in the OR for as many hours as it took to finish a complicated operation?” He weighed 138 pounds (down from his “norm” of 147–150 pounds). “I was physically not the same person and I knew that people would be watching me closely in the operating room,” he reveals. He was careful to have trusted, experienced colleagues consult on difficult cases. He built up his stamina for standing and took frequent breaks as needed.

Dr. Wallack found that he had to continually remind himself that your job is what you do—it’s not who you are. He avoided negative coworkers and congratulated himself for small accomplishments, even when no one else did. Other insights from Dr. Wallack: delegate tasks to others—you are only human; hit the “forget it” button as needed; create a comfortable “oasis” in your office; fill out the “I accomplished list” daily; and take breathing and walking breaks as needed.

The finish line
Dr. Wallack has completed nine marathons, one triathlon (after the quadruple bypass operation), and hundreds of shorter running races. “I thought I was too important, too invincible, and too necessary to have heart disease. Being a heart patient taught me about vulnerability. Completing a marathon taught me what it took to not give up. My life is better, I’m stronger, happier, and healthier than ever,” he observes.

Had he not finished the marathon in 2004, Dr. Wallack believes he might not have had the will or the faith to deal with the adversity that was to come. He continues to run an average of three times a week. Each footstep reminds him that life is fragile, to live it to the fullest.
Bullets, betel nut, and bacteria:
Medicine in the Solomon Islands

by Eileen Stack Natuzzi, MD, FACS
In 1942, during World War II, nearly every American could tell you where the Solomon Islands were located and why they were important to us. Some of the fiercest and most savage battles between Allied and Japanese forces were waged on land, sea, and air throughout the islands. Over time, and with the gradual loss of many World War II veterans, very few Americans know about this small island country.

### The Solomon Islands

The Solomon Islands are located in the Melanesian portion of the South Pacific, just northeast of Australia and New Zealand. The country consists of approximately seven large islands, 30 small islands, and many islets, spanning more than 1.3 million square kilometers. The population is just over 500,000, with 82 percent of the population living in a rural setting where there is limited electricity and no clean drinking water. Spoken languages include Solomon Island Pidgin, English, and 120 indigenous languages. The capital is Honiara, a dusty, dirty town located on the northern coast of Guadalcanal. Most of its infrastructure—including the airport, known as Henderson Field—was built during World War II. There are limited inter-island flights, and transportation between islands is mainly by ferry, outboard motorboat, or canoe.

I first heard of the Solomon Islands as a child during family gatherings. My mother’s oldest brother, Bill, went there while in the navy during World War II. He was killed in action when his ship, the USS Quincy CA-39, was sunk during the Battle of Savo Island just off the coast of Guadalcanal. To my aunts and uncles, the Solomon Islands were very remote, tropical, and hostile. Their assessment was not unlike that of most Americans, post-World War II, after all the waters of Iron Bottom Sound and the jungles of Guadalcanal and Tulagi had claimed thousands of lives and kept the remains of many men. I visited the Solomon Islands for the first time in 2004, drawn there by family history. But I came away from the trip with another take—what life was like for the people of the Solomon Islands.

The Solomon Islands is a country lost in time. There is very little manufacturing and production, and most people hunt, fish, and grow their own food. People live in villages and have very strong connections with their own village people, a support system known locally as wantok.

The Solomon Islands has had civil unrest over land use and ownership in the past. Thanks to the RAMSI (Regional Assistance Mission to Solomon Islands) multinational police force, the country is stable now.

Since being granted its independence from Britain in 1978, this young democracy has struggled to provide basic services, including health care, to its citizens. The ratio of practicing physicians to islanders is 1:28,000. In the U.S., the ratio is 1:300. There is one main hospital in the Solomon Islands. It is the National Referral Hospital (NRH), also known as “Number Nine,” or the Ninth Army Hospital from its World War II days (see Figure 1, page 18). The NRH is located in Honiara on Guadalcanal. This is the specialty care facility for the country, providing general surgery, orthopaedic surgery, gynecology, and obstetrics, as well as other forms of medical care. The hospital has three operating theaters. Patients are referred into the NRH from throughout the country, resulting in overcrowded clinics and long delays in the delivery of specialty care.

There are seven provincial hospitals, one of which, located in Gizo, was seriously damaged in the 2007 tsunami and is not yet fully operational. Each provincial hospital provides medical care for 30,000 to 40,000 people. Each hospital is staffed by nurses, and usually has a general medical doctor associated with it, but he or she is not necessarily present at all times. The most common procedure performed at the provincial hospitals is obstetrical deliveries; however, cesarean sections are not done. With the exception of incision and drainage of abscesses, surgical care is woefully lacking at the provincial hospitals. Nearly all of these hospitals are lacking an operating theater.
Throughout the different islands, there are hundreds of village-based small clinics or health outposts, staffed by nurses and nurse aids. Nurses confer with physicians via shortwave radio before prescribing drugs to patients. Doctors might visit a village once a year. Clinics, hospitals, and pharmacies frequently run out of supplies and medicines.

Geography adds to the problems the people of the Solomon Islands have in accessing urgent medical care. Since specialty care, including surgical services, is centralized to the NRH, a child with appendicitis might have to travel across rough seas for hours in a small outboard motor boat in order to get surgical treatment. Delays in surgical treatment result in children dying from the sequela of a ruptured appendix, and from curable diseases presenting in advanced stages. Emergency helicopter transportation for a critically ill patient can be provided by the medical arm of the RAMSI police force known as Aspen Medical Care, but provincial doctors hesitate to use this service, as charges for evacuation come out of their already meager monthly operational grant.

**The Loloma Foundation**

I am a member of the Loloma Foundation, which provides volunteer medical and surgical services in the Solomon Islands. The Loloma Foundation is the brainchild of Lance Hendricks, MD, an anesthesiologist at Scripps Clinic in San Diego, CA. “Heartchild” would probably be a better term, as loloma means “from the heart” in Fijian. Dr. Hendricks and other like-minded professionals recognized that the South Pacific is an area in dire need of a volunteer medical workforce because of a critical shortage of physicians. Loloma started out working in the outer islands of Fiji, and now it provides medical and surgical care for thousands of people in the Solomon Islands, as well.

For the past two years, we have sent teams of volunteer health care providers to the Solomon Islands in order to provide dental, medical, surgical, and vision care. On each trip, our group brings more than $2 million dollars worth of donated medical supplies, corrective lenses, sunglasses, and tooth care products into the country. Gore, Ethicon, Abbott Point of Service,
Sonosite, ConMed, Direct Relief International, Americares, Dioptics, and MAP International donate supplies to us. These supplies ship out of Santa Barbara, CA, in a 40-foot container, a few months before our trips, in order to have them in Honiara when we arrive.

**Spirit of the Solomons**

In order to reach the outer western islands of the Solomon Islands, where medical and surgical care is most needed, we charter a 125-foot dive boat, the *Spirit of the Solomons*. Medical supplies are loaded on the bow of the boat. We travel from island to island at night in order to treat patients during the day. Sites where we provide surgical care are visited for three days, in order to set up our MASH operating theater and conduct surgery as well as medical clinics (see Figure 2, page 18).

Our most recent team of health care providers included one obstetrician/gynecologist, two nurse practitioners, five internal medicine doctors, three optometrists, three support staff, and a video filmmaker, in addition to the surgical team. On previous trips, we have had a dentist and dermatologists with us as well. The ship’s crew members, normally accustomed to assisting passengers with their dive gear, helped us with eye exams and translating. As a result of this experience, one of them, Philip, a local Solomon Islander, has decided to go on to medical studies.

The surgical team consisted of four very hardworking operating room (OR) nurses and two recovery room nurses from Scripps Green Hospital in San Diego (see Figure 3, page 18). We had three surgeons: myself, a general and vascular surgeon; Gerry Schneider, MD, FACS, a plastic surgeon (see Figure 4, this page); and Gary Noble, MD, a retired plastic surgeon. We also had two anesthesiologists: Dr. Hendricks, and Gabriel Tupuna, MD (see Figure 5, this page). Dr. Tupuna is an anesthesia registrar at Fiji School of Medicine, where Lance is a faculty member through the Scripps-Fiji Alliance. This alliance was created in order to facilitate academic exchanges between Scripps Health in San Diego and the Fiji School of Medicine in Suva, Fiji. Dr. Tupuna is from the Solomon Islands, so this trip gave him a chance to see how our team provides mobile surgical care.

In Munda, Dr. Natuzzi (left) teaches Dr. Andrew Soma how to do a hernia repair. Teaching is very important, as it is a sustainable way to impact health care.
at the provincial hospitals in his country, and it gave us a chance to learn about Solomon Island tradition and culture from him.

Sites to provide surgical care were determined by reconnaissance visits months in advance of the trip, as well as by the overall need for surgical care due to remote location and lack of available surgical services. The participating provincial hospital doctors screened patients for surgical evaluation. Upon arriving at a surgical site, setup usually took about three hours, including conversion of a preselected room into an operating theater.

There were no working anesthesia machines at the provincial hospitals where we worked. Dr. Hendricks and Dr. Tupuna used an oxygen tank available at each of the hospitals, and ran the oxygen through a sevoflurane vaporizer into a T-piece breathing system attached to a reservoir bag for ventilating the patients. All controlled ventilation for intubated, paralyzed patients was done manually. Whenever possible, procedures were done under spinal, regional, or local with monitored anesthesia care. Propaq monitors with EKG, blood pressure, and oximetry readings were used in the OR and in the makeshift post-anesthesia care unit (PACU). Pre-op lab assessment, mainly basic electrolytes and hemoglobin and hematocrit, were screened using a handheld iStat analyzer donated by Abbott Point of Care. We were unable to get a portable suction machine, so a very resourceful Dr. Hendricks created one using a shop vacuum.

The type of surgery we provided was practical and basic surgical care. We did not do laparoscopic procedures, due to the lack of equipment and at times lack of electricity.

Whenever possible, local provincial doctors scrubbed in as assistants in order to learn surgical skills (see Figure 6, page 19).

To date, we have treated more than 7,000 patients, and provided surgical care to just under 100 people in the Solomon Islands. In addition to excising lumps, treating trauma, and draining abscesses, our surgical team has performed umbilical and inguinal hernia repairs, varicose vein excisions, thyroid goiter excisions, parotid tumor excisions, cleft lip and syndactyly repairs, and exploratory laparotomies for ovarian tumors that were resectable and unresectable, as well as operating on advanced breast cancer and filariasis.

Diseases present in advanced stages due to lack of health care access. A large necrotic and fungating breast cancer, and the post-op mastectomy result.

Treating cancer on the islands

One of the most advanced cases of breast cancer I have ever seen was on Guadalcanal. The patient’s name was Frieda. She was brought into one of our clinics with the diagnosis of a “breast lump.” When Freida arrived, I noticed a striking asymmetry to her chest. When she removed her shirt and some rather old and soiled bandages, I was shocked. She had the largest necrotic, fungating breast cancer that I had ever seen. It encompassed her entire right breast and had...
eroded through the skin, completely destroying the nipple (see Figure 7, page 20). I cleaned the open wounds with betadine and removed as much dead tissue as I could. It had just rained, and so the air was hot, thick, humid, and still. I was overwhelmed by the smell of rotting flesh and the numerous flies that surrounded Frieda, and could not imagine what it was like for her to live with this. We performed a palliative mastectomy at the NRH that night (see Figure 8, page 20). The weight of the tumor had stretched the skin over the breast like a tissue expander, and so we were able to close the defect primarily. Unfortunately, her axilla was full of matted tumor laden lymph nodes and she expired six months after surgery.

Breast cancer, cervical cancer, oral cancer, and lung cancer are the most common cancers in the Solomon Islands. The number of cases is difficult to determine, because many patients do not seek medical treatment due to availability, cost, or distance to travel to get care. Their village healers treat them, and then most succumb to their disease locally. There is limited chemotherapy treatment available, and no radiation treatment.

Cancer of the oral cavity has a strong association with the habit of chewing betel nut. 77 percent of adults in the Solomon Islands chew betel nut. Islanders’ teeth are stained blood red from chewing betel nut, and the roads are peppered with red spit splats, the product of excess salivation caused by chewing the mix of betel nut, betel leaf, and lime powder made from coral. The mix is tucked between the gums and cheek, keeping its irritating contents in contact with the oral mucosa. We operated on two men with superficial parotid tumors, both of whom chew betel nut; studies from the British Columbia Cancer Research Center suggest there is a correlation between betel nut chewing and these types of tumors.

**Infectious diseases**

Infectious diseases and their long-term sequelae remain the leading cause of morbidity and mortality in the Solomon Islands, with malaria leading the scourge. Although malaria is not a surgical disease, it is important to know that it is the most common cause of an enlarged spleen
in young children in the Solomon Islands. Young children are particularly vulnerable to this complication of the disease. All throughout the islands, we saw children with complications resulting from prior malaria attacks, including cerebral palsy, dense hemiparesis, and deafness. The Pacific Malaria Initiative, through funding from the Australian Agency for International Development (AusAID), is very active in prevention and eradication of the disease in the Solomon Islands, as well as in Vanuatu. The introduction of Coartem (Novartis) combination drug therapies of artemether-lumefantrine and rapid malaria testing protocols to provincial hospitals and clinics may decrease the number of people suffering from malaria.

Filariasis, caused by Wuchereria bancrofti, is also prevalent in the Solomon Islands. We saw more than one patient with elephantiasis involving the lower extremity (see Figure 9, page 21). We also resected what we believe to be a lymphadenovarix involving the face, a variation from the usual presentation of filariasis. Both men we treated presented with soft mobile drooping masses hanging from the lower side of the face (see Figure 10, page 21). The most impressive case of filariasis that we saw involved both breasts in a 26-year-old woman. Her breasts were enormous and so heavy that she could no longer stand upright (see Figure 11, page 21).

Appendicitis is a serious problem, and can result in death. It is usually diagnosed very late, and typically the appendix has already ruptured, causing generalized peritonitis or abscess formation. Treatment is further delayed by the need to travel long distances in order to get to the NRH, where surgical care is available. While we were working in Munda, a 28-week pregnant woman came to the hospital with right side and flank pain. Her urine dip test was normal and ultrasound evaluation showed normal adnexal structures and a viable fetus. My clinical suspicion was appendicitis. After admitting her to the hospital for a short period of observation, I decided to operate. The decision was the right one; she had a ruptured appendix that was compressed between her uterus and the right psoas muscle. Although she developed some mild contractions after surgery, we were able to control them and prevent premature delivery of her baby.
● Physician shortage crisis

The physician shortage in the Solomon Islands is a crisis that cannot be ignored. Cuba has begun sending doctors to assist with the critical doctor shortage, and programs have been put in place for Solomon Island students to obtain their medical education in Havana.

Pacific Partnership, a U.S. Navy-supported program, treated patients in the western part of the Solomon Islands during their missions in 2007 and 2008. This year, we coordinated our efforts in the Solomon Islands with Pacific Partnership in order to provide seamless care to the people. Loloma Foundation and Pacific Partnership’s medical trips collectively assist in the care of thousands of people in the Solomon Islands, but we must recognize that these are band-aid solutions for a country that needs a comprehensive program in order to end the physician shortage and improve the delivery of health care to its people. The type of program needed would require an initial infusion of volunteer manpower in the form of physicians, nurse practitioners, and nurse anesthetists. The program must include training and recruitment of the indigenous people of the Solomon Islands in order to create a sustainable health care force.

Surgical services must be considered a part of the “preventative medicine” strategy, and therefore, operating theaters and surgical care must be distributed throughout the islands. Without a basic health care scaffolding, money from the World Health Organization, AusAID, and the Global Fund that is directed toward treating specific diseases, such as malaria and tuberculosis, could be wasted, and could actually make things worse for the people of the Solomon Islands. I believe it is time for the U.S. to join with Australia and New Zealand, as well as the people of the Solomon Islands, in creating a sustainable health care system. With adequate numbers of doctors and nurses, in addition to well-stocked clinics and hospitals, the life expectancy and maternal mortality—which are measures of how well a health care system is providing for its people—will improve. Only then will the eradication of diseases such as malaria, tuberculosis, and HIV follow.

Bibliography


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Species evolve. John Robinson, vice-president of the Wild Life Conservation Society, notes that the rate of species extinction is currently “one hundred times above baseline.” Dr. Robinson continues, “…but when it comes to large, charismatic species…we don’t lose our large, iconic, charismatic, culturally important megafauna....”

The purposes of this essay are (1) to reassure the house of surgery that surgeons are, and always will be, large, charismatic, iconic, and culturally important megafauna; (2) to acknowledge that our country is currently in the throes of an evolutionary milestone in health care; and (3) to characterize surgeons as a cadre of our population uniquely qualified to recognize and communicate health care solutions to the American public.
Our strategic analysis will derive directly from the deliberate dialectic of the Mad Hatter’s Tea Party:

“Then you should say what you mean,” the March Hare went on.

“I do,” Alice hastily replied. “At least—at least I mean what I say—that’s the same thing, you know.”

“Not the same thing a bit,” said the Hatter. “Why, you might just as well say that ‘I see what I eat’ is the same thing as ‘I eat what I see!’”

“You might just as well say,” added the March Hare, “that ‘I like what I get’ is the same thing as ‘I get what I like!’”

“You might just as well say,” added the Dormouse, who seemed to be talking in his sleep, “that ‘I breathe when I sleep’ is the same thing as ‘I sleep when I breathe!’”

**Surgeons mean what we say**

Our government tells us that Americans can now expect to live to be 77.7 years old. Nobody wants to die—so, that’s great. And Malcolm Gladwell reports an astounding complement of successful “…social phenomena [which] can be linked to relative age.” Indeed, Mr. Gladwell assures us that everyone from Canadian hockey players to American four-year college students are disproportionately advantaged if their stork arrived during the first three months, as compared with the last three months, of any calendar year. Interestingly, this apparently extravagant psycho-social windfall, which initially boasts only a couple of months, seems to grow. So, at the rewarding conclusion of a 35-year career, a clinically active surgeon still has several decades of productive life left in him or her—and bountiful competence to burn!

But, let’s look at what that surgeon “means to say,” and how he or she gained, and continues to exalt in, the compounded accrual of that initial calendar head start.

**Surgeons say what we mean**

So, if what we say isn’t what we mean, we simply bend the words to fit—we do it by fiat. Let’s examine this strategy using “time” as an example. The logical unit of time is a day. Un fortunately, Earth’s spin is not comfortably divisible into the interval required for our Earth to slog its way around our sun; a full circuit requires 365 days, 5 hours, 48 minutes, and 46 seconds. The moon is pretty easy to see, so the lunar month seemed practical for early agricultural communities, who required direction as to the appropriate season to plant and harvest. But the lunar month is made up of about 29½ days. After three years, a lunar year was more than a month behind the solar year or season cycle. For farmers this was a real problem. The Romans solved this in typically surgical fashion—by fiat. They simply declared seven 30-day months, five 31-day months, and—because they regarded February as unlucky—they abbreviated the potential February ill-fortune to 28 days. They just did it—like a surgeon—and it worked.

**Surgeons see what we eat**

Perhaps fortuitously, Adam Smith’s Wealth of Nations and our own Declaration of Independence were both published in 1776. Surgeons, accepting Smith’s familiar example of the pin factory, “hold these truths to be self-evident” that clinical focus or broad specialization enhance both expertise and efficiency. Smith’s espousal of commercial liberty would appear to be tailored-made to match the surgical free enterprise spirit. Gratifyingly, but perhaps surprising for this original champion of free enterprise, Smith’s first book, Theory of Moral Sentiments, espoused an “invisible inner man” that guided a primary principle of altruism. That socially conscious “invisible inner man” is what talked us all into going to medical school in the first place.

**Surgeons eat what we see**

A career in surgery accrues a multitude of rewards. We establish, at lightning speed, an ego-boosting emotional bond with our patients. These bonds can be an aspect of life that is the most difficult to relinquish as a surgeon cruises into retirement. An active surgeon voraciously consumes the manifold gifts tied to our unique profession.

On Inauguration Day, January 20, 1953, Harry Truman transferred the presidency to
GEN Dwight D. Eisenhower. Dean Acheson had been Truman’s Secretary of State through the military attacks of the tumultuous Korean War and the political (and personal) conflict generated by the hearings of Sen. Joseph McCarthy. On the day prior to the inauguration, Mr. Acheson, as Secretary of State, held one of the most influential and powerful positions in the world. On the day after the inauguration, Mr. Acheson described himself as in a state of “bewildered emptiness at being so wholly uninformed, impotent and on the outside.”6

The potential for “bewildered emptiness” at the conclusion of a gratifyingly rewarding surgical career is very real. As a form of solace, Mr. Acheson steeped himself in the postpresidency letters of rapprochement between John Adams and Thomas Jefferson. Mr. Acheson was inspired that Adams “Never for one moment believed that the holding of office [as President or surgeon] was a source of power—it was an obligation to service.”6

Surgeons like what we get

Surgery has been described as a “fickle mistress.” Katharine Graham, the former editor of the Washington Post, observed, “To love what you do, and feel that it matters, how could anything be more fun?”7 That’s us! We drive into work in the morning—or in the middle of the night—knowing that what we are doing is important. And our patients, their families, our colleagues, and society respect what we do. That makes it really easy to feel good about ourselves. The profession of surgery is vastly better and more rewarding than whatever profession is second best, according to several direct and recent communications the authors have had with Hiram C. Polk, MD, FACS (professor of surgery, University of Louisville; personal communication, April 23–25, 2009).

Surgeons get what we like

Species—and professions—are evolving. As we ruminate upon the “future of surgery,” we happily acknowledge the unique capacity of surgeons to make decisions and respond to change “while the clock is ticking.” No one likes to be rushed; but the ability to “do something now” is robustly expressed in the surgical genome. In addition, as we review our surgical colleagues we are reminded of an observation of Mr. Acheson: “The longer I live the more I find myself stressing character as the indispensable element.”6 Again, that’s us! We live happily in a professional world of characters with character.

In plumbing our future, the fortunate coincidence of facile flexibility and confident character comfortably conspire to guarantee a rewarding niche for the surgeon of the future.

Surgeons breathe when we sleep

And, like dragons, some of us breathe fire. But, dragons are mythical creatures. And now so are fire breathing surgeons.8 This observation may serve as the basis for the most formidable tectonic shift in surgical culture in recent decades. Mr. Gladwell relates studies of a Dutch psychologist, Geert Hofstede, who examined national cultural variations and delineated these as a power-distance index (PDI).3 Cultural deference to an aristocratic hierarchy prevents subordinates from questioning authority even in instances in which their own lives are endangered. Although the hierarchical totem pole still lives in surgery, intimidation is no longer the lingua franca.

We associate a high PDI with dignified, respectful, and comfortably civilized societies. Mr. Gladwell notes that America is a classically low power-distance culture. Anyone wishing to experience a microscopically low PDI, in glorious Technicolor, may simply hail a taxicab in New York City. So, some communication structure between paralyzingly respectful (high PDI) to pugnaciously rude (low PDI) is optimal in the operating room. Neither self-effacing Bodhisattvas nor Bronx cabbies need apply.

Surgeons sleep when we breathe

But, as Hamlet proclaimed in the English language’s most famous soliloquy, “To sleep—perchance to dream.”9 Hamlet must have been acknowledging the formidable benefit that derives from surgical training that is traditionally associated with a hard road: “...the slings
and arrows of outrageous fortune....”9 Then, Hamlet continues as a clinically active surgeon, “…takes on a sea of troubles, and by opposing end [s] them….“9 A life in surgery is (and always will be) the most gratifying, rewarding, and fun life conceivable.

We are currently in the throes of an evolution in health care. In 1929, a western Oklahoma physician, Michael Shadid, MD, proposed a medical agricultural cooperative.10 He suggested that each farmer contribute $50 annually to a central fund that would pay doctors to provide all the health care any self-respecting, tough old farmer might ever need. In gratitude, Dr. Shadid’s colleagues tried to strip him of his medical license. Subsequent, quite honorable attempts to conquer the health care dragon have been envisioned by Presidents Roosevelt, Truman, Nixon, Clinton, and now Obama. Since Dr. Shadid’s initial foray, several important aspects of the health care equation have, however, changed. Eighty years ago a farmer (or patient) was delighted (and even surprised) if his or her interaction with the medical community proved—on balance—helpful. Today, Americans expect immediate access to high-tech care at low cost. And, it is very clear that we can have any two of these expectations, but never all three. Like xenotransplantation, comprehensive health care reform is just around the corner—and always will be.

Perception is usually more important than reality. In survey after survey, patients trust their doctors. Paradoxically, the health reform adversaries are decrying government intervention as despicable “socialized” medicine. In fact, through multiple current subsidies (including the formidably successful Medicare and Medicaid), our government has been a major health care payor for almost half a century.

Jennifer Graham notes that medicine has wrought a 30-year increase in U.S. citizen life expectancy during the 20th century—the largest catapulting of species survival in all of world history.11 Actually, Ms. Graham is disappointed that the aging boomers are refusing to die off to make room for the hungry Generation Xs and Ys. In this regard, surgeons are the biggest offenders. Exercise has always been part of our job. Relatively few of us smoke. And, a chubby surgeon is rare. We surgeons incorporated all the effective disease prevention strategies generations ago. Surgeons are also effective communicators. We routinely and successfully talk patients into accepting something that they really don’t want to do. We are extroverts—the parties don’t start until we get there.

So, our current problem with health care is that health care is too good. People are living too long, and their postretirement years are too bountiful. That’s the fault of us docs. And, the super high-tech molecular targeting of successful therapies is (no surprise) expensive. Again, that’s the fault of us docs.

Surgeons know that some therapies are more effective than others. Indeed, the most cost-effective medical therapy year after year is lanc ing an abscess. Routinely, an analysis of the most beneficial risk-adjusted therapies identifies the majority as surgical.
Whether or not you believe that health care is a right or a privilege, the consuming consensus of citizens currently consider immediate access to high-tech care as emblazoned into our constitutional Bill of Rights. Unfortunately, they also believe that the government (or someone else) should pay for it.

Both the problem (generated by successes) and the solution (delightfully vulnerable to surgical input) are issues of perception.

Unlike “all men are created equal,” all health care is not. Is there a group among us that is capable of discerning the financial cost of a risk-adjusted additional quality calibrated year of life? By virtue of medical and disciplinary psychosocial successes, is that same cohort of the comfortably aging population uniquely able and qualified to communicate its critically important ruminations to the American public? The answers are yes and yes.

In conclusion, we propose that cultural and biological evolution have coincidentally produced and solved one of our era’s most vexing problems. A large, charismatic, iconic, and culturally important cohort of evolutionary history’s megafauna are retiring in droves. This group is uniquely qualified to assess the individual and societal value of the plethora of scientific advances that are now perpetrated upon the unsuspecting public. Pivotal to the socially appropriate application of these therapies is comprehensible communication to the hungry populace. We surgeons have the solution to health care reform in hand.

But, if we do not accomplish this laudable goal in our generation, the senior authors of this essay are confident that the junior authors will.

References

Less than a decade ago, states began facing a full-blown health care workforce crisis. Due to the skyrocketing costs of professional liability insurance premiums, nearly one out of 11 obstetricians nationwide had stopped delivering babies. In Wheeling, WV, all of the neurosurgeons had left town, forcing trauma patients to be airlifted to Pittsburgh, PA, to receive care. Across the country, physicians were ordering additional tests due to fear of litigation. State governments, physicians, and patients were in trouble due to a lack of comprehensive medical liability reform (MLR). Without MLR in place, patients could not access health care services, medical liability premiums were on the rise, litigation was out of control, and many physicians were abandoning high-risk procedures.

In response to this crisis, many states have since taken action to defend physicians and their practices through comprehensive medical liability reform. These traditional reforms have been included as caps on noneconomic damages, joint and several liability reform, periodic payments, limits on attorney fees, and revisions in collateral source rules. More recently, attention had been given to passage of “I’m sorry” laws.

Caps on noneconomic awards

Medical liability reform saw its first great success when California enacted landmark legislation in 1975. The Medical Injury Compensation Reform Act (MICRA) entitled patients to recover unlimited economic damages, limited noneconomic damage awards to $250,000, and placed limits on attorney fees. MICRA is a model for reform because it has produced a stable, competitive medical liability insurance market, while ensuring that patients have full access to the courts.

In the 35 years since MICRA was enacted, medical liability premiums increased by more than 1,029 percent across the country—except in California, where premiums grew by less than one-third of that amount, largely due to limits on noneconomic damages. A 2003 survey showed that MICRA lowers health care costs by an estimated 6 percent—saving Californians $6 billion every year on health care.

As of last year, 32 states have placed caps of various dollar levels on the amount of noneconomic damages that a plaintiff can collect from a physician. Caps can be solely on noneconomic damages, but may also be applied just in cases involving wrongful death or severe permanent physical impairment, or even on total damages. States with caps of some type include Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Mis-
souri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, and Wisconsin.

Numerous independent research articles show that over the long term, patients have greater access to physicians in areas with reforms, such as caps on noneconomic damages, than in areas without reforms. For example, since enacting major reform in 2003, Texas has seen liability rates cut by an average of 27 percent, as well as a statewide increase in the number of physicians, particularly specialists.

“Im sorry” laws

One of the criticisms of the current litigation system is that it prevents a provider from expressing any sort of apology for an unanticipated outcome, due to the fear of having such statement used against the physician in a subsequent lawsuit. To address this concern, over the past few years 30 states have passed “I’m sorry” laws— including Arizona, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, and Wyoming.

The type of expressions covered by the law and their level of protection vary among the states. The majority of the states with “I’m sorry” laws protect any statements, gestures, or expressions of apology, benevolence, sympathy, or commiseration regarding pain or discomfort, suffering, injury, or death made to a patient, or the family of a patient, who experienced an unanticipated outcome.

A growing body of evidence in the peer-reviewed medical literature shows that patients and families file lawsuits against physicians because of anger, not greed. In response to this data, several hospitals and insurance companies have adopted disclosure and apology programs, often called “Sorry Works!” The Sorry Works! program teaches doctors and nurses to be empathetic and caring, and to stay connected with patients and families when a medical error occurs.

Many successes have been credited to the Sorry Works! programs. For example, in 37 cases at the University of Illinois Medical Center in which the hospital acknowledged a preventable error and apologized for it, only one patient filed suit. In the eight years since adopting Sorry Works!, the University of Michigan, Ann Arbor, has cut lawsuits in half, reduced litigation expenses by two-thirds, and reduced their reserves from $72 million to less than $20 million.

Future of liability reform

Due to political and constitutional barriers that exist in the many states where caps on noneconomic damages have not been enacted, it will be very difficult for caps to pass. To pass legislation in those situations expensive, multiyear efforts would be required to revise state constitutions.

References

General equivalency mapping helps convert ICD-9-CM codes to ICD-10-CM

by Debra Mariani, CPC, Practice Affairs Associate, Division of Advocacy and Health Policy

By October 1, 2013, physicians must start using ICD-10-CM codes rather than the ICD-9-CM codes currently in use. ICD-10-CM has been updated to reflect the current clinical understanding and technological advancements of medicine, and the code descriptions are designed to provide a more consistent level of detail. The new codes contain a more extensive vocabulary of clinical concepts, body part specificity, patient encounter information, and other components from which codes are built.

**GEM**

Fortunately, several tools are available to assist practices in making the shift. One such instrument is general equivalency mapping (GEM), which is designed to aid in converting diagnosis codes from ICD-9-CM to ICD-10-CM. The GEM program will have bidirectional mapping for finding and replacing codes or lists of codes. GEMs were developed by the National Center for Health Statistics (NCHS) and the files are published by both NCHS and the Centers for Medicare & Medicaid Services (CMS). The GEM tool is available free to the general public. This tool is critical for any health care professional who wants to understand the conversion from ICD-9-CM to ICD-10-CM. The GEM files will also convert ICD-10-CM codes back to ICD-9-CM codes, in the event you need to file a claim for a service provided before the October 1, 2013, deadline. When ICD-10-CM is implemented, it will be by a single date for all users—by date of service for ambulatory and physician reporting, or by date of discharge for inpatient settings.

Your office can use the GEM system to develop crosswalks for your most frequently used diagnosis codes. However, it is important to be aware that GEMs are not traditional crosswalks. They are reference mappings, to help the user navigate the complexity of translating meaning from one code set to the other. The GEMs are more complex than a simple one-to-one crosswalk, but ultimately more useful.

This article will present examples of the conversion on the CMS Web site (http://www.cms.hhs.gov/ICD10/02m_2009_ICD_10_CM.asp), the American Academy of Professional Coders (AAPC) Web site (http://www.aapc.com/icd-10/codes), and the Center for Disease Control’s Web site (http://www.cdc.gov/nchs/icd/icd10cm).

### Table 1

<table>
<thead>
<tr>
<th>ICD-10 code conversion</th>
<th>The ICD-10 code online conversion tool allows you to convert ICD-9 codes to ICD-10 codes or vice versa. ICD-9 is being expanded from 13,900 to approximately 120,000 ICD-10 codes, and this online tool can help you map that expansion.</th>
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<tr>
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</tr>
<tr>
<td></td>
<td>□ ICD-10 to ICD-9</td>
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<td><strong>ICD-9 577.0 &gt; ICD-10</strong></td>
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<td><strong>DESCRIPTION</strong></td>
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<tr>
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<td>Other acute pancreatitis</td>
</tr>
<tr>
<td>K85.9</td>
<td>Acute pancreatitis, unspecified</td>
</tr>
</tbody>
</table>

**Table 1**
— all of which are available for free. The first conversion is from the AAPC Web site, using an example for the ICD-9-CM code 577.0, *Acute pancreatitis*. Table 1 on page 31 shows this single code has now turned into a choice of seven different codes.

As always, you will still have to reference the ICD-9-CM and the ICD-10-CM codebook to see if there are any further codes and/or coding instructions. CMS and the NCHS use a flat text and table method for mapping.

There are two basic types of entries in these GEMs. They are “single entry” and “combination entry.” In special cases, a code in the source system may be mapped using both types of entries.

**Single entry**

A single entry is an entry in the GEM for which a code in the source system linked to one code option in the target system is a valid entry. An entry of the single type is characterized by a single correspondence. Each row in the entry can be one of several valid correspondences, and each is an option for a one-to-one applied mapping. An entry may consist of one row, if there is a close correspondence between the two codes in the code pair. A code in the source system may be used multiple times in the GEM, and each time it will be linked to a different code in the target system, as in the example in Table 2 on this page.

The GEM contains alternative equivalent relationships from which the appropriate applied mapping can be selected. Taken together, all rows containing the same source code linked to single code alternatives are considered one entry of the single type.

Both ICD-9-CM and ICD-10-CM contain “combination codes.” These are codes that contain more than one diagnosis in the code description. An example is ICD-10-CM code R65.21, *Severe sepsis with septic shock*. In this case, ICD-9-CM does not have an equivalent combination code, so in order to link the ICD-10-CM to its ICD-9-CM equivalent, a combination entry must be used in the GEM.

**Combination entry**

A combination entry is an entry in the GEM for which a code in the source system must be linked to more than one code option in the target system to be a valid entry. The following is the combination type entry for R65.21, *Severe sepsis with septic shock*, as it is depicted in the flat text GEM format from NCHS, and repeated in Table 3 (this page), which is formatted with the code descriptions and attributes.
It is important to note that there are no decimals in most GEM files.

**Flags**

For any particular code entry, the GEM may contain several possible translations, each on a separate row. Flags are the final group of digits used to indicate additional attributes for entries in the map. The first three digits are called flags. The last two digits, scenario and choice list, are used in combination entries.

The following are three types of flags:
- **Approximate**: Indicates that the entry is not considered equivalent
- **No Map**: Indicates that a code in the source system is not linked to any code in the target system
- **Combination**: Indicates that more than one code in the target system is required to satisfy the full equivalent meaning of a code in the source system

A “scenario” designates one version of the meaning of the source system diagnosis as specified in a combination code. In other words, it identifies one roughly equivalent expression of the source system code. The “choice list” will indicate that many codes are required to satisfy the equivalent meaning in the combination code. For a more thorough explanation, go to ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2010/.

**Things to consider**

There are a few structural differences in the ICD-10-CM codebook compared with ICD-9-CM, as indicated in Table 4 on this page. The greatest challenge is the volume of diagnosis codes growing from 14,025 to 68,069.

With the coming of ICD-10-CM, providers will need more precise documentation of clinical care, which will lead to more accurate coding. This will contribute to health care quality improvement initiatives. The costs for the providers will include the following:
- Training physicians, coders, billers, and others
- Lost productivity
- System changes

The loss of productivity will be attributable to the following:
- Queries from coders to clarify documentation in the medical record

**Table 4**

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–5 digits</td>
<td>3–7 digits</td>
</tr>
<tr>
<td>All characters are numeric in chapters 1–17</td>
<td>1st digit is alpha, the second digit is numeric, and digits 3–7 are alpha or numeric</td>
</tr>
<tr>
<td>Supplemental chapters first digit is alpha (V &amp; E codes)</td>
<td></td>
</tr>
<tr>
<td>Presently 14,025 codes</td>
<td>Presently 68,069 codes</td>
</tr>
</tbody>
</table>

- Increased billing inquiries by payors
- Increased number of adjustments and pending or suspended claims.

Suggested steps for surgeons’ offices to take leading up to the implementation of ICD-10-CM, include the following:
- Create a committee to be in charge of the change from ICD-9-CM to ICD-10-CM
- Budget planning
- Create a timeline
- Identification of training needs
- Information management system upgrades and review

Additional resources to reference in order to get your office ready for ICD-10-CM:
- CMS
- Outreach and education:
  —http://www.cms.hhs.gov/ICD10/05_Educational_Resources.asp
Indiana’s legendary surgeon, Harris B Shumacker, Jr., died on November 14, 2008, in Gladwyne, PA, at the age of 101. Dr. Shumacker received the College’s Distinguished Service Award, its highest honor, in 1968. With his death, surgery lost one of the last great triple-threat giants on whose shoulders so many of us have stood.

Dr. Shumacker was born in the Deep South in Laurel, MS, where he lived until age seven, when his parents, both native Mississippians, moved to Marianna, AR—a small town on the Mississippi Delta. His first memory was of wanting to be a doctor, “like other boys wanted to be a policeman or fireman,” he said.*

Academic excellence
The school system in Marianna was noted for its excellence. Dr. Shumacker, an outstanding student, was admitted to Harvard without admission testing or a visit. But before he enrolled, one of his cousins, who lived in Chattanooga, TN, contacted him to say that he had to stay in Chattanooga for college because his father was having financial problems. He pleaded with Harry to attend the University of Chattanooga, a small Methodist college that is now part of the University of Tennessee. Dr. Shumacker turned down his acceptance at Harvard and attended the University of Chattanooga, the first in a lifetime of unusual career decisions that went against the grain, but always seemed to turn out well. He had been told by his high school adviser to get permission from the dean to take more than the conventional number of courses in college, and he did, which resulted in Dr. Shumacker graduating in just two years. He was then accepted into the Johns Hopkins University School of Medicine, Baltimore, MD.

Again, he went against the grain. A professor Dr. Shumacker respected thought he should become a basic scientist and obtained a biochemistry fellowship for him at Vanderbilt University, Nashville, TN. Worried that he might have some trouble with biochemistry at Johns Hopkins, and aware that he was two years younger than most potential medical students, he accepted the fellowship and received a master’s degree in chemistry. Chemistry was not a subsequent forte, but it was at Vanderbilt that he learned how to do research, working long hours into the night on his projects. Although much later he expressed regret for not attending Harvard and not entering Johns Hopkins a year earlier, his lifelong penchant for serious inquiry and his commitment to basic and clinical research may well have been founded from that year at Vanderbilt.

He entered Johns Hopkins in 1928, when the curriculum was very flexible, and the faculty encouraged students to think and act on their own. This was

*Interview of Dr. Harris B Shumacker, Jr. Indiana University Oral History Research Center. Indiana University, Weatherly Hall, North 112, Bloomington, IN. Accession #93-9-1, 2, 3, 1993.
the perfect environment for Dr. Shumacker, whose curiosity was insatiable, and he flourished. He gravitated toward surgery, substituting for interns in obstetrics and otolaryngology. He spent six months at the Massachusetts General Hospital, Boston, MA, with the venerable Arthur Allen, MD, FACS, himself a Johns Hopkins graduate who was delighted to have a Hopkins student with him. After the death of a patient from a transfusion, then not a minor procedure, Dr. Allen asked Dr. Shumacker how they conducted the procedure at Hopkins, and then used the technique that he described.

After graduating from Johns Hopkins in 1932, he interned there and subsequently worked in the laboratory with his Johns Hopkins surgical mentor, Warfield “Monte” Firor, MD, FACS, performing basic animal studies to study the pituitary-adrenal axis. Dr. Shumacker immersed himself in research, publishing papers on adrenal hormones with Dr. Firor and on macrocytosis with the young hematologist Max Wintrobe, MD, who later became an icon in the field. Dr. Shumacker observed that some patients with liver disease develop macrocytic anemia, wrote a paper describing this new finding, and gave it to Dr. Wintrobe, who submitted it listing himself as the first author. Dr. Shumacker told this story again and again as a humorous tale, but he had difficulty disguising his real feelings about the incident. It was the stimulating Dr. Firor who became his advocate and advisor, directing him to the residency at Yale University, New Haven, CT, when it became apparent that he would not be appointed resident at Johns Hopkins.

At Yale, under Samuel Harvey, MD, FACS, he was appointed resident and had a very broad surgical experience, performing the gamut of general surgery procedures as well as head and neck surgery, hysterectomies, and cesarian sections. Dr. Harvey offered him a faculty position, but Dr. Shumacker, now married to his southern belle Myrtie, decided to look around. When nothing exciting materialized, he consulted Dr. Firor, who arranged for him to return to Johns Hopkins to develop the cardiovascular service, which consisted mostly of sympathectomies. Most of them were done by the neurosurgical service, but the supposedly avaricious chief, Walter Dandy, MD, FACS, graciously turned them over to Dr. Shumacker.

Alfred Blalock, MD, FACS, who was appointed chairman in 1941, kept him on as his senior associate and asked him to stay with him during World War II, but the adventurous Dr. Shumacker chose to go to war with the Johns Hopkins General Hospital unit, which was using a portion of the Royal Prince Albert Hospital in Sydney, Australia. After a year, he was appointed chief of service of a station hospital that later moved to New Guinea; however, he developed a partial paralysis of his leg and was sent back to the states in 1944.

A leader and a teacher

During his recovery, Dr. Shumacker was assigned by GEN Fred Rankin, probably with help from Dr. Blalock, to establish the Vascular Center at Mayo General Hospital in Galesburg, IL. It was there that his understanding of vascular problems and his vascular surgery skills were honed, due to the fact that he was in charge of a unit that housed as many as 400 patients with vascular injuries and diseases. As Dr. Shumacker once wrote, “…traumatic aneurysms filling one entire ward, arteriovenous fistulas another, injuries of a major artery another, various vasomotor difficulties still another, and so many troublesome sequelae of frost bite and trench foot that hundreds had to be put on sick leave.” In Galesburg, he also developed a deep and enduring relationship with John “Jack” Gibbon, MD, FACS, who was chief of the surgical service. Later, as his biographer, he described Dr. Gibbon as his best friend. He wrote many papers from that experience, and by the time he returned to Johns Hopkins in 1946, more than a year after the war ended, he had a national reputation within surgical academia. He was admitted to membership in the Society of Clinical Surgery and to fellowship in the American Surgical Association.

Within a week, Yale beckoned once again, and later in 1946, he returned as associate professor to start their cardiac surgery program. This was an exciting time in medicine, marked by early efforts to ameliorate, or cure, congenital conditions of

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the heart and great vessels with the Blalock-Taussig procedure, ligation of patent ductus, and repair of coarctation of the aorta.

In 1948, he was persuaded by its celebrated president, Herman B Wells, to come to Indiana University as the professor and chairman of surgery. Mr. Wells wanted to develop a full-time faculty in the medical school and understood the need to provide them with research facilities and seed money. Dr. Shumacker’s East Coast mentors and colleagues, including Dr. Blalock, thought he was crazy to give up his position at Yale for a job in the hinterland, but taking on a challenge like this was now characteristic of the man who went to Chattanooga instead of Harvard.

A magnet for patients
Dr. Shumacker established a five-year residency program, gradually built up the full-time faculty by selecting young men from his residency program, and established a research laboratory that was always in operation, staffed either by his own residents or a long succession of research fellows from all over the world—many of whom returned to their countries to become leading surgeons.

Because no cardiovascular surgery had been done in the state up to that point, Dr. Shumacker was the magnet for every patient in Indiana who had a surgical vascular or cardiac problem. The Riley Hospital for Children, Indianapolis, IN, and its clinics were filled with infants and children with every imaginable congenital lesion of the heart or great vessels. Dr. Shumacker performed almost all of the cardiac and vascular “firsts” in Indiana.

Soon, pediatric and adult cardiologists were on the faculty, using the latest technology such as catheters (supplied by the fledgling Cook organization in Bloomington) to make diagnoses, and a crude ultrasound apparatus used to diagnose pericardial tamponade. It was not unusual for him to do two mitral valvulotomies using his finger through the left atrial appendage, an abdominal aortic aneurysm resection (at first replaced by a nylon graft made from a parachute, sewn by a nurse), and division and suture of a patent ductus in an infant—all before lunch.

Before coronary artery surgery, he began every morning with an open heart procedure using cardiopulmonary bypass. Interspersed throughout the day, at night, and on weekends were patients with ruptured aneurysms, emboli, ischemic limbs, and vascular or cardiac trauma. In the early years, the mortality and morbidity rates were high, as they were everywhere. In due course, the load was shared by his faculty, and the procedures became routine.

Dr. Shumacker was a master of bedside teaching, asking patients to describe their illnesses and pointing out physical findings. He made rounds by himself every morning before 6:00, but he expected his team of residents, interns, and students to make all the necessary decisions and to write the orders and progress notes. He was a perfectionist, and he demanded the same in others through his example. Occasionally, he wrote an order for something insignificant, or a progress note that described, for example, the strength of the anterior tibial pulse in a revascularized leg. When he did so, his residents took it as their reprimand, but they had no idea if he meant it as such; they simply wanted to be as good as he was.

Leading by example
Dr. Shumacker inspired medical students and residents by his example, to think, to innovate, and to strive for perfection. He understood that leadership is one of the performing arts. He used his deep, southern voice, his command of grammar, logic, and rhetoric, and his considerable oratorical skill to impart the lesson he was delivering. More often than not, his students not only learned from him, they were smitten by his presence, what he had to say, and how he said it.

His basic and clinical research is recorded in approximately 600 publications. Many describe innovations and improvements in vascular and cardiac procedures. His studies on frostbite during the Korean conflict were seminal, showing that slow rewarming of the affected part produces the best outcomes. With Harold King, MD, FACS, he discovered the association between splenectomy in children and their susceptibility to severe infection, an observation that led to pneumococcal immunization, and, eventually, to splenic conservation techniques.

Fifteen years after Dr. Shu-
macker worked with Arthur Allen, MD, FACS, as a medical student, Dr. Allen, as Chairman of the Board of Regents of the American College of Surgeons, appointed him to the fledgling Surgical Forum Committee, which he chaired for five years. He made the Forum the premier assembly before which young surgeons presented their best work. The 1968 volume of Forum papers was dedicated to Dr. Shumacker.

After retiring as chairman in 1968, he moved his practice to St. Vincent’s Hospital in Indianapolis, IN, and with a former student and resident, John Isch, MD, FACS, began what is now called CorVasc, one of the largest multihospital cardiovascular surgery groups in the country.

Dr. Shumacker retired from clinical practice, but was not ready to retire from surgery. In 1981, at age 73, he joined the faculty of the Uniformed Services University of the Health Sciences in Bethesda, MD, as professor of surgery and senior advisor. For the next decade he taught, mentored, and assisted in the development of their department and school.

It is startling to realize that someone so recently in our midst, who so many of us knew or knew of, was a charter member of the Society of University Surgeons, the Society for Vascular Surgery, the International Surgical Group, and the Chest Club. He was president of all of them, as well as the Society of Clinical Surgery and several other surgical organizations. He was an honorary member of a long list of organizations throughout the world.

In his later years, Dr. Shumacker wrote prodigiously and traveled the world to research his subjects. In his biography of John Gibbon, A Dream of the Heart, he describes how his friend developed the first heart-lung machine, and tells the story of his life. In Leo Eloesser, M.D.: Eulogy for a Free Spirit, he shows how this remarkable surgeon, another close friend, who had a passion for music and art, fought in World War I (and with the Loyalists in Spain) and, later, freed people from poverty while living in China and Latin America. He chronicles the development of heart surgery in the scholarly The Evolution of Cardiac Surgery. He also wrote the histories of The Society of Clinical Surgery and the Society for Vascular Surgery.

His wife of 58 years, Myrtie, whom he adored, died in 1991. He later married Grace McConnel, who survives him, along with his sons Peter and James and their families, and Mrs. McConnel’s sons George and Mike McConnel and their families.

Harry Shumacker was one of the last of the great triple-threat surgeons. He excelled in caring for patients in the operating room and at the bedside, in solving clinical and basic research problems in the laboratory, and in teaching and mentoring students at all levels. The scope and complexity of each of these legs of the academic stool have expanded greatly, so surgeons in the current generation, or those to follow, will not be able to duplicate his feat. But we, and they, can emulate him by working hard, striving for perfection, pursuing humility, loving life, and occasionally going against the grain.

Dr. Nahrwold is emeritus professor of surgery at Northwestern University, Chicago, IL. He served under Dr. Shumacker as a medical student, resident, and faculty member.
As I write this review of the 2009 Clinical Congress in Chicago, IL, I am happy to relate the importance and impact the Nizar N. Oweida, MD, FACS, Scholarship had on my experience. As a surgeon freshly out of training, this was the ideal time for me to attend the Clinical Congress, and the Nizar N. Oweida Scholarship allowed me to accomplish this without added financial worries.

Having been in practice only one year, I was able to focus my sessions and courses on the areas I felt were most relevant to my everyday practice. As residency is completed, we are expected to perform Whipple's, aortobifemoral bypasses, esophagectomies, and every other difficult surgical procedure. However, the reality for the rural surgeon is that these procedures rarely come along. And if they do, most of the time, they are sent to specialists with adequate ICU, resident, or medical backup. The most difficult aspect of transitioning from resident to rural surgeon has not been the operating, but the decision making related to when to operate.

Educationally, I could not have been happier. I was able to attend all the sessions I wanted, and most of the postgraduate courses, as well. What I wasn’t able to attend, I have been able to review through the ACS webcasts and audio recordings. This has been a great resource, as I have been able to listen to the original session once at the Clinical Congress, and then review the lectures as needed at home. I am not sure I would have purchased this option without the assistance of the Nizar N. Oweida Scholarship.

Additionally, I was able to experience this Clinical Congress from a different perspective. It started on Sunday afternoon, with the scholarships luncheon. I was able to listen to discussions about all the great work that residents and staff are pursuing with the assistance of the College. I was also able to address a very distinguished panel at the Rural Surgeons Symposium that included Thomas R. Russell, MD, FACS, then ACS Executive Director, regarding the importance of the rural surgeon and how we need the support of the College now more than ever. It was through my Nizar N. Oweida Scholarship that I was given the opportunity to express my views and have them addressed by the ACS.
Lastly, I would like to express the importance of continuing relationships and forming new bonds with fellow surgeons. I was able to spend time with a mentor and friend, David Oehling, MD, FACS, from Grants Pass, OR. He is a member of the staff in Grants Pass for the Oregon Health and Science University’s year-long rural surgery program. He was an instrumental part of my decision to pursue rural surgery as a career. I would also like to recognize Patrick O’Hara, MD, FACS, vascular surgeon at the Cleveland Clinic, in Cleveland, OH. I met him at last year’s Clinical Congress. He was extremely open to all of my questions regarding a rural surgeon performing vascular surgery. I truly enjoyed our conversations during sessions and on the shuttle bus to and from the convention center.

In conclusion, I would like to thank the Oweida family for having the foresight to establish this scholarship. I hope it will be as beneficial for future recipients as it was to me. I know I, as well as my patients, have benefited from the generosity of the Oweida family and the ACS.

Dr. Kanning is a staff surgeon with Selkirk General Surgery, Sandpoint, ID.

Coding and Rule Changes
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- American Association of Surgical Physician Assistants
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- American Society of Anesthesiologists
- American Society of PeriAnesthesia Nurses
- Association of periOperative Registered Nurses
- Association of Surgical Technologists

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For more information, visit www.cspsteam.org, or call the CSPS Administrative Director, Denise Goode, at 312-202-5700

Recent activities:

- The CSPS released a statement on violence in the workplace
Members in the news

The University of Missouri Health Care (Columbia, MO) has unveiled permanent signage on the hospital’s building with the wording “Frank L. Mitchell, Jr., MD, Trauma Center.” The signage was displayed at a ceremony honoring Frank L. Mitchell, Jr., MD, FACS, on November 7, 2009.

With more than 50 years at the facility, Dr. Mitchell has been instrumental in building the hospital’s trauma program. The Frank L. Mitchell, Jr., MD, Trauma Center is one of only two Level I trauma centers in Missouri that is nationally verified by the College’s Committee on Trauma.

Robert A. Milch, MD, FACS, of The Center for Hospice and Palliative Care (Buffalo, NY), is among four American physicians whose distinctive work in palliative care has earned them the inaugural Hastings Center Cunniff-Dixon Physician Awards. Dr. Milch, who has been involved with hospice and palliative care for more than 30 years, received the established physician award of $50,000. Dr. Milch was recognized for his commitment to clinical care for patients with advanced illness and for his regional and national leadership in palliative care and surgery. The awards were given by the Cunniff-Dixon Foundation, whose mission is to enrich the doctor-patient relationship at the end of life, in partnership with The Hastings Center, a bioethics research institute known for its pioneering work on end-of-life decision making. The nomination and selection process was administered by the Duke Institute on Care at the End of Life.

Lewis Wetstein, MD, FACS, President of the College’s New Jersey Chapter, was awarded the Legion of Merit from the New Jersey Air National Guard upon his retirement as the New Jersey State Air Surgeon. After 33 years in the active Air Force Reserve, Dr. Wetstein retired at the rank of colonel on July 11, 2009. At the time of his retirement, Dr. Wetstein was the chief flight surgeon and State Air Surgeon for the New Jersey Air National Guard.

College announces Clinical Scholars Program

The American College of Surgeons invites surgical residents to apply for its Clinical Scholars Program, a fellowship in outcomes research, health services research, and health care policy. The fellowship provides firsthand experience with various aspects of ongoing ACS projects, including surgical oncology, surgical quality improvement, trauma, guideline development, and accreditation programs. The scholar will also complete a master of science degree in clinical investigation or in health care quality and patient safety through Northwestern University in Chicago, IL.

This fellowship will prepare the scholar for a career in academic surgery. Applicants must be U.S. citizens who have completed two or three years of surgical residency. Funding for the fellowship is currently not available through the ACS; the resident must have obtained two years of funding from a home institution or other granting agency. Applications are due July 15, 2010.

For more information about this program visit http://www.facs.org/ropc/clinicalscholars.html.
We reward loyalty. We applaud dedication. We believe doctors deserve more than a little gratitude. We do what no other insurer does. We proudly present the Tribute® Plan. We go way beyond dividends. We reward years spent practicing good medicine. We salute a great career. We give a standing ovation. We are your biggest fans. We are The Doctors Company.

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ACS Traveling Fellowship to Japan available

The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Japan.

Purpose
The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America.

Basic requirements
The scholarship is available to a Fellow of the American College of Surgeons in most of the surgical specialties who meets the following requirements:
- Has a major interest and accomplishment in clinical and basic science related to surgery
- Holds a current full-time academic appointment in Canada or the U.S.
- Is younger than 45 years on the date the application is filed
- Is enthusiastic, personable, and possesses good communication skills

Activities
The Fellow is required to spend a minimum of two weeks in Japan, pursuing the following goals:
- To attend and participate in the annual meeting of the Japan Surgical Society, which will be held in Tokyo, Japan, May 26–28, 2011
- To attend the ACS Japan Chapter meeting during that congress
- To visit at least two medical centers (other than the annual meeting city) in Japan before or after the annual meeting of the Japan Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons

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

A spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction, in addition to professional activities.

Financial support
The College will provide the sum of $7,500 U.S. to the successful applicant, who will also be exempted from registration fees for the annual meeting of the Japan Surgical Society.

The selected Traveling Fellow must meet all travel and living expenses. Senior Japan Surgical Society and ACS Japan Chapter representatives will consult with the Fellow about the centers to be visited in Japan, the local arrangements for each center, and other advice and recommendations regarding travel schedules. The Fellow is to make his or her own travel arrangements in North America, as this makes reduced fares and travel packages available for travel in Japan.

The American College of Surgeons International Relations Committee will select the Fellow after review and evaluation of the final applications. A personal interview may be requested prior to the final selection.

Applications for this traveling fellowship may be obtained from the College’s Web site at http://www.facs.org/memberservices/research.html, or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is June 1.

The successful applicant and an alternate will be selected and notified by November 1.
The Executive Committee on Video-Based Education, through the Division of Education and Ciné-Med, has developed the interactive Multimedia Atlas of Surgery. Each volume presents a comprehensive list of surgical procedures, featuring:

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American College of Surgeons • Division of Education
“Improving the Quality of Surgical Care Through Education”
In the past two issues of the Bulletin (Bull Am Coll Surg. 2009;94(12):29-30; 2010;95(1):57-58), we discussed how the American College of Surgeons Oncology Group (ACOSOG) promotes patient safety through the safe and measured introduction of new therapies, and how the ACOSOG patient advocates promote safety by having “the patient at the table.” In this article, we highlight how the ACOSOG Peer Review and Prioritization Committee (PRPC) promotes patient safety by ensuring that ACOSOG trials are well-designed, address important clinical needs and scientific questions, and are balanced for patient risks and benefits.

What is the peer review process? The National Cancer Institute (NCI) defines peer review as “Review of a clinical trial by experts chosen by the study sponsor. These experts review the trials for scientific merit, participant safety, and ethical considerations.”\footnote{U.S. National Institutes of Health. Glossary of Clinical Trials Terms. Available at: http://www.clinicaltrials.gov/ct2/info/glossary. Accessed January 4, 2010.}

ACOSOG conducts its peer review process through the activities and actions of the PRPC, led by Lee Gravatt Wilke, MD, FACS.

The PRPC is a multidisciplinary team formed to review the clinical trial concepts and protocols prior to their submission to the NCI’s Cancer Therapy Evaluation Program (CTEP). The goal of the committee is to approve high-quality, surgically relevant trials for consideration at the national level.

This administrative committee was formed in 2006, and its roster includes both academic and community surgeons and representatives from each oncologic discipline, as well as experts from each disease site. These disease site reviewers are not members of the ACOSOG disease committees, to ensure a nonconflicted review.

In the past year, surgical oncology fellows for each of the three disease sites (breast, gastrointestinal, and thoracic) have been added to the PRPC. Incorporating oncology fellows into the peer review process provides the committee with a fresh perspective, provides the fellows with an opportunity to be trained in the peer review process, and allows them to influence the future direction of cancer research.

As an administrative committee within ACOSOG, the PRPC, over the past two years, has developed a formal charter and standard operating procedures. The typical flow of a concept would include development and approval within a disease site committee, and then submission on a standard CTEP concept (protocol) form to the PRPC. Two primary reviewers from within the PRPC would be selected to review and critique the concept. These peer reviewers would then present the concept to the entire committee during a conference call or formal on-site meeting. The PRPC is charged with making sure each clinical trial can answer three key questions:

• Is there a testable hypothesis that has adequate background data and outcomes that will improve survival and/or quality of life for the patients with this disease?
• Can the membership of ACOSOG, as a primary surgical trials group, perform this trial safely and efficiently?
• Does the trial meet one of the three primary aims of ACOSOG: neoadjuvant treatment for cancer, a novel surgical approach or technique, and/or the use of innovative molecular or imaging techniques?

Once reviewed and discussed, the PRPC decides if the concept (or protocol) should be
rejected, or accepted with major or minor revisions. A written critique with recommendations from the multidisciplinary committee is provided to the principal investigator. If the concept is accepted, revisions are performed, and then the final draft sent to CTEP for review.

In addition to its role in critical appraisal of a trial to ensure improved patient outcomes and safety, the PRPC is also charged with making sure that ACOSOG has a balanced portfolio of trials among the three disease sites. Crucial to this process is the role of the protocol developer, who works with both the PRPC and the scientific leadership of ACOSOG to ensure that competing interests are balanced financially and scientifically.

As ACOSOG has grown and increased its portfolio of clinical studies, the opportunities for tissue banking and correlative science have also grown. In response to the increased volume of bio-specimen requests, an additional review committee has been formed within ACOSOG, the Scientific Peer Review and Prioritization Committee (SPRPC), led by Dennis Wigle, MD. The SPRPC is charged with working with the PRPC to ensure each trial has scientifically relevant correlative science studies that will advance the study of the particular disease type, and provide a foundation for future scientific research. The SPRPC is also responsible for making sure that the available tissue repository for each clinical trial is utilized appropriately to answer the most important molecular and basic science questions.

The processes, practices, and diverse membership of the SPRPC are similar to those of the PRPC. The SPRPC differs from the PRPC in that its membership includes experts with an emphasis on basic science.

If the goal of the PRPC over the last few years has been to ensure that ACOSOG pursues high-quality and clinically meaningful trials, the success of ACOSOG trials should reflect the success of the committee. Indeed, in this regard, the PRPC has been highly productive and highly successful. In the last two years, the PRPC has reviewed 25 clinical trial concepts, six full protocols, and five intergroup studies for endorsement. Of the six protocols that were approved by the PRPC, five have been approved by CTEP and are open to enrollment. Perhaps most impressive is the fact that 100 percent of the trials approved by PRPC, and currently open to enrollment, are accruing patients according to pre-established targets—a remarkable achievement. In the coming years, we have no doubt that these trials will impact the care of the surgical oncology patient.

Dr. Wilke is associate professor of surgery, department of breast and endocrine surgery, Duke University, Durham, NC, and is the ACOSOG Peer Review and Prioritization Committee Chair.

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

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**Trauma meetings calendar**

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

- **Medical Disaster Response 2010**, March 21, 2010.
- **Trauma, Critical Care, and Acute Care Surgery, 2010**, March 22–24, 2010. Las Vegas, NV.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at [http://www.facs.org/trauma/cme/traumtgs.html](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312-202-5342.
Submission of manuscripts

Electronic submission is encouraged; send files via e-mail to sregnier@facs.org. Submissions will be acknowledged and sent to appropriate reviewers.

If you are sending the manuscript on diskette or other hard copy of materials, forward these items prepaid, at the author’s risk, to:

Stephen J. Regnier, Editor
Bulletin of the American College of Surgeons
American College of Surgeons
633 N. Saint Clair Street
Chicago, IL 60611-3211

Manuscripts are accepted for consideration on the understanding that they are intended for publication solely in the Bulletin of the American College of Surgeons and that they are not under review nor have been published or committed for publication elsewhere. If a paper has been prepared for presentation at a meeting, this information should be noted on the cover letter accompanying the manuscript. All manuscripts are subject to editorial modification and revisions necessary to bring them into conformity with Bulletin style and publication-readiness.

Style and format

Manuscripts should be no more than 3,200 words in length, excluding tabular material or illustrations. Manuscripts should be composed of seven to nine pages in Microsoft Word—doublespaced and with one-inch margins. Please turn off tracked changes before sending the document. Manuscripts submitted as PDF will be returned to the author with the request that a Word document be submitted instead.

Give full names of authors and their degrees, academic or professional titles, professional affiliations, and complete addresses. Specify to whom galley proofs are to be sent.

References should be listed numerically in the text, with full citations to appear on a separate page at the end of the text of the article. Please be sure to keep the references separate; do not use the feature in Word that automatically generates footnotes. References should follow American Medical Association style guidelines. Following are some examples:


All manuscripts should include a brief biography (including employer name, position title, and city and state) and a photo of each author. Each photograph must be a head shot/portrait in JPG or TIF format, at least two inches wide, and at least 300 pixels per inch. Do not submit the photos in a Word document,
as this affects the publishing quality. If preferred, submission of a hard copy of photos (minimum passport size) is acceptable.

**Tables/illustrations**

Figures, tables, and/or other illustrations are welcomed as long as they add significantly to the author’s discussion in the text. Data display should be called a “Table” when presenting precise numerical values that show item-to-item comparisons; the term “Figure” should be used when presenting patterns or trends or illustrating comparisons in text.*

Displays that present lists of any kind (such as names of board members or checklist items) should be called “box.” Photos should be referred to in text as photos, not figures.

Drawings (including graphs and charts) should be created either in MSWord, PowerPoint, or as a JPG, TIF, or PDF file, with lettering large enough to be legible after necessary reduction. If camera-ready art is supplied in lieu of an electronic file, be sure that the original is clean, clear, and will be legible when reduced. A separate page with legends for the illustrations should be supplied. Tables submitted with the manuscript should be on separate pages at the end of the manuscript. Be sure to label the tables and illustrations clearly and be sure to refer to their placement in the text of the article.

Photographs or other illustrative art, if supplied in an electronic (JPG, TIF, or PDF) format, should have a resolution of no less than 300 pixels per inch, or at least 1200 pixels in width. Anything less than that may not reproduce at publishing quality. Photographs and illustrations pasted into a Word document are discouraged, as they do not always print at ideal resolution. Please provide captions for photographs on a separate page.

**Galley proofs**

Authors will receive galley proofs (as a Word document) of their edited manuscript for their review in advance of the scheduled month of publication. Galleys may include queries from editorial staff.

Before publication, revised proofs must be returned either as a Word document with any edits indicated using the tracked changes function or as a list of requested changes to the editors.

Authors of feature articles will have the opportunity to see a PDF of the article in magazine format that reflects any changes made to the document during the galley stage. After viewing the PDF, authors may only request changes to text that is currently outdated or presents egregious errors; all other edits will be rejected at that time.

**Inquiries**

Inquiries regarding potential articles for consideration, deadlines, the submission of manuscripts, author proofs, or style should be directed to Stephen J. Regnier, Editor, *Bulletin of the American College of Surgeons*; or Linn Meyer, Director, Division of Integrated Communications, via e-mail at sregnier@facs.org or lmeyer@facs.org, or by mail at American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; 312/202-5331; fax 312/202-5021.

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In order to receive reimbursement from Medicare, hospitals must be evaluated by an accrediting body that has been granted “deeming” authority by the Centers for Medicare & Medicaid Services (CMS), or their state licensing agency on behalf of CMS. Hospitals that successfully complete the accreditation process are then deemed by their accreditor to meet CMS’s certification requirements.

Unlike other hospital accrediting bodies, the 1965 Medicare statute exempted The Joint Commission’s hospital program from completing a formal application process for deeming authority. When the Medicare Improvements for Patients and Providers Act of 2008 became law, this unique status was retired.

During the past year, The Joint Commission worked with CMS to ensure a seamless transition for hospitals under the new law, and successfully completed the hospital deeming application. On November 27, 2009, the continuation of The Joint Commission’s deeming authority for hospital accreditation was announced by CMS, and will run through July 15, 2014.

This announcement confirms that CMS found The Joint Commission’s standards for hospitals meet or exceed those established by the Medicare and Medicaid program.

Accreditation is voluntary, and seeking deemed status through accreditation is an option, not a requirement. As required by CMS, all hospital-deemed status surveys are unannounced, a policy The Joint Commission instituted into its accreditation process in 2006.

In addition to hospitals, The Joint Commission has federal deeming authority for ambulatory surgery centers, critical access hospitals, durable medical equipment suppliers, home health organizations, hospices, and laboratories.

A look at The Joint Commission

CMS approves continued deeming authority

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Intimate partner violence (IPV) is a serious, yet preventable, public health problem in the U.S. IPV exists on a continuum that ranges from episodic violence (single or occasional occurrence) to battering, which is a more frequent and intensive situation involving one partner maintaining control over the other. IPV includes four types of behavior: physical violence, sexual violence, threats, and emotional abuse. Each year in the U.S., women experience approximately 4.8 million intimate partner-related physical assaults and rapes, while men are the victims of 2.9 million intimate partner-related assaults. In 2005, IPV resulted in 1,510 deaths, of which 78 percent were female and 22 percent male. In 2003, the medical care, mental health services, and lost productivity due to IPV amounted to $8.3 billion. (http://www.cdc.gov/violence_prevention/pdf/IPV_factsheet-a.pdf).

In order to examine the occurrence of IPV 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 E967 (domestic abuse) and an age range greater than or equal to 18 years of age. 697 incidents matched this E code and age range; 516 records had discharge status recorded, including 465 discharged to home, 32 to acute care/rehab, 8 sent to nursing homes, and 11 died (these data are depicted in the Figure on this page). These patients were 72.3 percent female, and, on average, 37.1 years of age; they had an average length of stay of 3.8 days, and an average injury severity score of 7.7.

Looking at these data supports the observation of the underreporting issue with IPV. In our trauma center alone, we see several cases each month that are a result of IPV. IPV is an underreported problem that exists not only in the U.S., but also in many countries around the world. It is a complex and multifaceted problem that crosses cultures, classes, and income groups. The goal is to stop IPV before it begins. Strategies should be targeted at young people when they are learning dating skills, which
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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. He is Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.

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

New York chapters testify on needed liability reforms

On December 1, 2009, three New York State senators—representing the Insurance, Health, and Codes Committees—conducted a hearing on medical malpractice, and the New York chapters were invited to present at the hearing. William Doscher, MD, FACS (New Hyde Park Chapter), described the dire situation for malpractice insurance in the state of New York and the impact it has on patient care (see photo, right). Dr. Doscher also presented a variety of solutions, including a cap on noneconomic damages and a certificate of merit to accompany claims. These potential solutions, along with others, were a culmination of a series of conference calls among four chapters: Brooklyn-Long Island, Eastern Long Island, New York, and Western New York.

Connecticut Chapter hosts 2009 annual meeting

The Connecticut Chapter hosted its 42nd annual meeting on November 30, 2009, and more than 150 Fellows, residents, medical students, and exhibitors attended the meeting. As is the chapter’s custom, the daylong education program featured a series of paper competitions for residents and medical students, and the event concluded with the second Surgical Skills Competition, which was won by the team from the University of Connecticut School of Medicine. The competition featured eight separate skills tests in which resident teams from all eight chapter programs competed.

The winning residents of the various competitions included:

- **Clinical Oncology**: First place: Lee F. Starker, MD; second place: Murielle Brochez, MD
- **General Surgery**: First place: Sean Orenstein, MD; second place: Mun Jye Poi, MD
- **Trauma**: First place: Daniel Solomon, MD; second place: Christopher Hughes, MD

- **Specialty Surgery**: Tie: Amanda Feigel, MD; and Joseph Lin, MD
- **Plastic/Reconstructive**: First place: Michael Terry, MD; second place: Frederick Wang, MD

Honorable mentions: **Bariatric Surgery**: Erica Romblom, MS4; **How I Do It**: Seth Brown, MD, FACS; **Community Surgery**: Darren Tisher, MD, FACS; **Pediatric Surgery**: Shohan Shetty, MD

The chapter’s James Foster Memorial Lecture continued on page 54
## Chapter meetings

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

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

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<th>Date/time</th>
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| March 19, 2010 - March 20, 2010 | Metropolitan Washington DC (CS) | Location: Georgetown University Hotel & Conference Center, Washington, DC  
Contact: Brad Feldman, MPA, CAE, IOM (614) 221-9814  
e-mail: brad@executive-office.org |
| April 18, 2010 | Connecticut                  | Location: Saint Mary’s Hospital, Conference Center, Waterbury, CT  
Contact: Chris Tasik (203) 674-0747  
e-mail: info@CTACS.org |
| April 20, 2010 - April 27, 2010 | New Jersey                   | Location: Rome, Italy  
Contact: Andrea Donelan (973)539-4000  
e-mail: nsurgeons@aol.com |
| April 23, 2010 - April 25, 2010 | Virginia (CS)                | Location: Hotel Roanoke, Roanoke, VA  
Contact: Susan McConnell (804) 643-6631  
e-mail: smcconnell@ramdocs.org |
| April 30, 2010 - May 01, 2010 | Indiana (CS)                 | Location: University Place Conference Center, Indianapolis, IN  
Contact: Carolyn Downing (317) 261-2060  
e-mail: cdowing@ismanet.org |
| April 30, 2010 - May 01, 2010 | North Dakota & South Dakota (CS) | Location: Holiday Inn City Center, Sioux Falls, SD  
Contact: Terry Marks (605) 336-1965  
e-mail: tmarks@sdsm.org  
ACS Representative(s): Mr. Jon Sutton |
| May 01, 2010 | New York (CS)                | Location: Great Escape Lodge, Lake George, NY  
Contact: Amy Clinton (518) 283-1601  
e-mail: NYCoFACS@yahoo.com  
ACS Representative(s): Karen E. Deveney, MD, FACS |
| May 06, 2010 - May 08, 2010 | West Virginia (CS)           | Location: The Greenbrier, White Sulphur Springs, WV  
Contact: Sharon Bartholomew (304) 293-1258  
e-mail: sbartholomew@hsc.wvu.edu  
ACS Representative(s): Andrew L. Warshaw, MD, FACS |
| May 07, 2010 - May 08, 2010 | Ohio (CS)                    | Location: Hyatt Regency, Columbus, OH  
Contact: Brad Feldman, MPA, CAE, IOM (877) 677-3227  
e-mail: brad@executive-office.org  
ACS Representative(s): David B. Hoyt, MD, FACS |
| May 07, 2010 - May 10, 2010 | Chile                        | Location: Santiago, Chile  
Contact: Juan Eduardo Contreras, MD, FACS (562) 212-0426  
e-mail: jec@rdcl.org |
| May 15, 2010 | Northern California (CS)     | ACS Representative(s): David J. Winchester, MD, FACS  
Location: Marines Memorial Hotel, San Francisco, CA  
Contact: Annette Bronstein (650) 992-1387  
e-mail: abronstein230@aol.com |
was presented by H. David Crombie, MD, FACS, editor of Connecticut Medicine. Dr. Crombie chronicled the history of physicians as writers. Finally, the chapter presented its Distinguished Service Award to Anthony Morgan, MD, FACS (see photo, page 52), and its first Legislator of the Year Award to Rep. James Shapiro.

Chapter execs convene in Chicago

On December 7, 2009, chapter executives convened at College headquarters for a daylong education program. In addition to a review and discussion about state legislative activities, Paula Goedert, Esq., the College’s legal counsel, reviewed hotel contract concerns.

In addition, through the efforts of Janna Pecquet, the Chapter Executive for Louisiana and South Texas Chapters, Thomas R. Russell, MD, FACS, the College’s retiring Executive Director, was presented with a gift certificate and a $700 contribution to establish a special scholarship fund for young surgeons (see photo, this page).

The chapters that contributed to Dr. Russell’s gifts included Arkansas, Connecticut, District of Columbia, Florida, Hawaii, Indiana, Iowa, Kansas, Louisiana, Metropolitan Chicago, Michigan, Minnesota, Ohio, South Carolina, South Dakota, South Texas, Southern California, Tennessee, Virginia, Western New York, and Wisconsin.

Chapter anniversaries

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