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Because the ACS is committed to ensuring that all patients who are suffering from trauma, emergency, or critical conditions receive high-quality care from appropriately trained surgical professionals, we are proud to sponsor the Point/Counterpoint Course for Acute Care Surgery.

A growing need

One explanation for the surgical workforce crisis—particularly as it is playing out in the nation’s emergency departments (EDs)—is that many general surgeons are limiting their practices to advanced laparoscopic surgery, bariatric surgery, breast surgery, and so on. Likewise, some surgical specialists, such as orthopaedic and neurologic surgeons, are opting to center their practices on highly skilled elective procedures. An unfortunate consequence of a more specialized surgical workforce is that fewer surgeons have the experience needed to treat the conditions that are typically treated in EDs.

Acute care surgery has evolved as a response to the growing need for surgeons who can provide comprehensive general and trauma surgery care and who are available for emergency call. The development of an acute care surgery specialty has been the source of considerable controversy throughout the past decade. This sort of debate often has erupted when a new specialty has sought to establish its legitimacy, and the fact of the matter is that, as long as some practicing surgeons are unable or unwilling to take emergency call, acute care surgeons will become increasingly important members of the profession.

Point/Counterpoint course

In order to provide optimal care to surgical patients, acute care surgeons must undergo the same rigorous training expected of other specialists, and the ACS is committed to ensuring that they have access to continuing medical education (CME) resources and programs. Three ACS luminaries—Immediate Past-President L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon); Donald Trunkey, MD, FACS; and David V. Feliciano, MD, FACS—were trailblazers in this area, authoring the seminal textbook *Acute Care Surgery Principles and Practice*, published in 2007.

In addition, Dr. Britt chose to make acute care surgery the focal point of the Point/Counterpoint trauma meetings on the East Coast when he took over as course director several years ago. The Point/Counterpoint program just celebrated its 30th anniversary and was the brainchild of the late Charles C. Wolferth, Jr., MD, FACS, a key figure in the history of trauma system development. The ACS sponsors this

Looking forward
CME program, which was most recently presented June 12–15 at the Gaylord National, National Harbor, MD.

I participated in that meeting and was duly impressed with the breadth of the program and how much information was presented in only two-and-one-half days. The course included a comprehensive review of state-of-the-art management paradigms, ongoing controversies, and cutting-edge innovations that cover the full spectrum of acute care surgery.

The first day of the conference focused on hemorrhage in the emergency setting, along with the acute abdomen and the management of surgical complications. The second day was dedicated to interventions, innovations, and controversies in trauma management. Andrew Peitzman, MD, FACS, immediate past-president of the American Association for the Surgery of Trauma (AAST), provided the Wolferth Memorial Lecture. The final half day centered on diagnostics and therapeutics in the intensive care unit setting.

As the phrase Point/Counterpoint implies, for each topic covered in the meeting, a presenter made a case in favor of a specific treatment option, while another offered the evidence against it. The audience members then voted for the preferred treatment modality and discussed why that approach is more appropriate. Dr. Britt says that this teaching style is highly effective because students are provided with the best possible information available for each treatment strategy and are actively participating in the discussion and processing the data offered.

The more than 100 course attendees represented all health care professions involved in this level of care, including surgeons of all specialties, emergency physicians, intensivists, nurses, and paramedics. The course has been extremely well-received, and the next program will take place June 11–13, 2012, in National Harbor, MD.

Educating acute care surgeons

Because the ACS is committed to ensuring that all patients who are suffering from trauma, emergency, or critical conditions receive high-quality care from appropriately trained surgical professionals, we are proud to sponsor the Point/Counterpoint Course for Acute Care Surgery. Importantly, all proceeds from this program are directed toward the College’s trauma papers competition, so it contributes to surgical education on several levels. In addition, we presented a Postgraduate Course titled Trauma and Acute Care Surgery Update during the Clinical Congress last month.

The AAST also recognized the heightened stature of acute care surgery by presenting the inaugural Clinical Congress for Acute Care Surgery during its annual meeting this past September. As most Fellows know, the Clinical Congress for Surgeons was the precursor to the ACS, so this adjunct to the AAST meeting may signal that acute care surgeons are becoming more organized and unified.

As EDs throughout the nation struggle to ensure that they are adequately staffed to care for the broad range of patients to whom they provide care, the specialty of acute care surgery will be increasingly relevant. We owe it to our patients to make certain that the surgeons in this fledgling specialty are properly trained and credentialed.

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If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
The past year in state politics was one of unprecedented changes and challenges. From the beginning of this year, implementation of the Affordable Care Act (ACA) at the state level, a continuously weak economy and budget crises, and a historic political turnover in statehouses in the November 2010 elections were among the major forces and factors in policymaking in 2011.

Perhaps the greatest influence on legislation this year was the political turnover in the midterm elections. Republicans replaced Democrats as the dominant party in many state governments in 2010. The most prominent Republican state legislature and gubernatorial increases occurred in the western and midwestern parts of the country. Prior to the 2010 election, Democrats controlled both the House and the Senate chambers in 27 state legislatures; the GOP controlled 14 states, and eight states were divided between Democratic and Republican control. After the election, Democrats control 16 state legislatures, while Republicans now control 25 statehouses.* This marked shift in ideology and political make-up influenced the types of bills that the College tracked, and presented a new set of challenges and opportunities in advocating for the American College of Surgeons’ (ACS) state-level legislative priorities.

Across the country, states introduced more than 130,000 bills from January through July 2011, and the College tracked 1,099 health care-related bills. The majority of these bills pertained to the following five legislative priorities:

- Medical liability reform
- Trauma
- Scope of practice
- Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) model legislation
- The Uniform Accident and Sickness Policy Provision Law (UPPL)

The following article highlights a few of the important issues and bills tracked this year by ACS State Affairs staff.

Medical liability reform

The number of medical liability reform bills introduced and passed at the state level substantially increased this year. With the Republican Party in control in many states, and states continuing to face extreme budget crises, the climate was favorable for passing medical liability reform. Many states

by Alexis Macias
and Charlotte Grill
considered medical liability reform as a means of ensuring affordable access to health care for their citizens. With more than 30 new tort reform laws passed in 2011, it was a banner year for this type of legislation. ACS State Affairs staff tracked 63 medical liability reform-related bills—a much higher number than previous years. This extraordinary activity generated many big wins in states such as Alabama, North Carolina, Oklahoma, South Carolina, and Tennessee.

Alabama considered its first medical liability tort reform bills since 1999, when the state placed a cap on noneconomic damages. This year, Gov. Robert Bentley (R) signed two bills related to medical liability reform: the Wrongful Death Venue Reform Law, which requires that a lawsuit may only be brought in the county where the decedent could have filed suit; and the Foundation of Expert Testimony Act, which updates the standards for expert testimony in civil cases and major criminal cases to reflect the standards used in the federal court system.

The North Carolina state legislature overturned Gov. Bev Perdue’s (D) veto of S.B. 33, a bill that caps noneconomic damages at $500,000. The governor vetoed the bill on June 24, but the Senate overrode the veto on July 13, followed by the House on July 25. The North Carolina medical community views passage of the bill as a huge success, because it also strengthens pre-litigation expert review of medical malpractice claims and requires that any liability claim arising from the treatment of an emergency medical condition be proven by clear and convincing evidence.

Gov. Mary Fallin (R) signed Oklahoma Tort Reform (H.B. 2128) into law on April 5. The law places a $350,000 cap on noneconomic damages in civil liability cases arising from alleged bodily injury. The ACS worked alongside the Oklahoma State Medical Association to ensure that as many physicians as possible were engaged in the grassroots advocacy process.

South Carolina Gov. Nikki Haley (R) signed legislation that places a $500,000 cap on noneconomic damages, with the following caveat: the cap is lifted if the defendant intended to cause harm, was guilty of a felony tied to the incident, or was under the influence of drugs or alcohol.

On July 21, Tennessee Gov. Bill Haslam (R) signed the Tennessee Civil Justice Act (H.B. 2008/S.B. 1522) into law. This legislation addresses various components of civil justice and places a $750,000 cap on noneconomic damages in medical liability cases. Exceptions to the cap may be made for certain catastrophic cases. For example, the cap would be $1 million for spinal cord injuries leading to paraplegia/quadriplegia, significant burns, loss of limbs, or the death of a parent of a minor.

Many states continue to have to defend their medical liability reforms in court. In a positive decision from the West Virginia Supreme Court, the court ruled that the state’s $500,000 cap on noneconomic damages was constitutional and voted to uphold the cap. In Florida, a Circuit Court of Appeals upheld a $500,000 cap on noneconomic damages in medical liability lawsuits. The court rejected the argument that the cap violates both the Florida and U.S. constitutions. In Kansas, the state Supreme Court was expected to reach a decision on whether their caps were unconstitutional; at press time, however, that goal had not yet been accomplished.

Trauma

As in previous legislative sessions, bills related to various trauma issues were high on the College’s list of priorities in 2011. More than 220 bills pertaining to trauma issues were introduced in the state legislatures this past year. Most of these bills addressed injury prevention issues, such as graduated driver’s licenses, requirements for operating all-terrain vehicles, and seatbelt and helmet use, while a small number of bills focused on trauma systems and funding.

One of the most significant legislative trends in 2010 centered on addressing the problem of distracted driving, with more than 31 states introducing distracted driving-related bills. This year the trend continued, with more than 70 bills introduced in 28 states. However, momentum on this issue is beginning to fade, as only five states—Indiana, Maine, Maryland, Nevada, and Oregon—passed distracted driving laws in 2011, compared with the 16 states that passed bills in 2010. With the passage of distracted driving bills during the 2011 session, 34 states now have, at the very least, a texting ban in place, if not a full ban on the use of cell phones while driving.

The hot new issue for 2011 was student athlete concussion prevention legislation. Numerous organizations, including the ACS, the National Football League, the American Medical Association, and the American Academy of Pediatrics weighed in on
this issue. In fact, 24 states introduced legislation to protect student athletes from concussions by mandating the following guidelines:

- Inform and educate youth athletes, their parents, and guardians, and require them to sign a concussion information form
- Remove a youth athlete who appears to have suffered a concussion from play or practice
- Require a youth athlete to be cleared by a licensed health care professional trained in the evaluation and management of concussions before returning to play or practice

Student athlete concussion laws were passed in 10 states this year: Alaska, Arizona, Colorado, Illinois, Indiana, Maryland, Nebraska, South Dakota, Utah, and Wyoming. These states join the seven others that have already passed concussion laws.

Both the 2009 and 2010 legislative sessions brought big successes for trauma system funding. For example, Georgia passed the “Super Speeder Law,” which adds an additional $200 fine for driving more than 85 mph anywhere in the state, and for driving 75 mph or more on a two-lane road. Revenues generated through these fines are redirected toward trauma system funding.

Unfortunately, because a number of states still face severe budget cuts, the 2011 legislative sessions resulted in less trauma funding success than in past years. For instance, Illinois’ trauma system was dealt a major setback when Gov. Patrick Quinn (D) signed a bill (H.B. 1391) that redistributes scarce trauma funds from trauma centers to non-trauma center hospitals in emergency medical system regions without non-designated trauma centers. The Illinois trauma community responded with more than 100 letters and phone calls transmitted through the Surgery State Legislative Action Center (SSLAC) to the legislature as well as the governor’s office, but to little avail.

Minnesota’s trauma systems endured an additional blow with the introduction of a bill (S.F. 557) that would completely eradicate the trauma system in the state. Fortunately for the state’s trauma community and patients, the bill saw little movement and died upon adjournment.

**Scope of practice**

Nonphysician health care providers are becoming increasingly aggressive in their efforts to expand their scope of practice to include treatments, procedures, and authority inconsistent with their education and training. Commonly, scope-of-practice expansions include independent prescriptive authority, independent practice, diagnostic and/or surgical authority, and other care privileges for which a nonphysician provider may be inadequately educated or trained.

Early in the 2011 legislative session, optometrists introduced a bill in Kentucky (S.B. 110) that would significantly expand their scope of practice. The bill would grant optometrists the authority to perform the following:

- Laser glaucoma surgeries and some forms of laser vision correction
- Eyelid operations and procedures involving needles and injection
- All methods of administering pharmaceutical agents, including injection procedures, except schedules I and II
  - Local and regional anesthesia
  - Emergency inoculations, as requested by the commissioner of health

S.B. 110 was introduced in the Kentucky Senate in early February and was signed into law two weeks later, after passing both the Senate and House with only one legislator opposing the bill. Proving the effectiveness of grassroots advocacy, the Kentucky optometric community distributed more than $400,000 in campaign donations to the governor and every member of the legislature—except the one dissenting state legislator, who also happens to be a physician. The College joined with many surgical specialty societies to continue efforts to uphold patient safety and quality surgical care by submitting comments on draft rules implementing the legislation to the Kentucky Board of Optometric Examiners.

New York saw other nonphysician providers, such as podiatrists and dentists, continue to push for scope expansion. The podiatrists introduced S. 2662, which would allow podiatrists to treat the ankle and all soft tissue structures of the leg below the knee. Single-degree dentists (DDS) pushed A. 2820/S. 3059, which would allow podiatrists to treat the ankle and all soft tissue structures of the leg below the knee. Single-degree dentists (DDS) pushed A. 2820/S. 3059, which would allow podiatrists to treat the ankle and all soft tissue structures of the leg below the knee. New York physicians successfully defeated both pieces of legislation. Similar legislation has been introduced throughout the past legislative sessions in New York, and the ACS anticipates seeing these issues again in 2012.
UEVHPA

UEVHPA is model legislation that responds to a serious problem caused by a lack of uniformity in state laws, as was revealed during the horrific hurricane season of 2005. Passage of UEVHPA allows state governments to give reciprocity to other states’ licensees who are emergency service providers, so that covered individuals may provide services without meeting the disaster state’s licensing requirements. It uses a national registration system to confirm that physicians and health care practitioners are appropriately licensed and in good standing in their respective states, so that their licensees can be recognized as volunteers for the duration of emergencies in other states.


UEVHPA was signed into law in Nevada on June 2. This bill was almost unanimously passed by both state chambers, with only one “nay” vote from the House. In 2011, UEVHPA also was introduced in Connecticut, Mississippi, and Texas. While UEVHPA did not move very far along in these states’ legislatures, it is anticipated that the bill will be introduced again in these states next session.

Repeal of UPPL

The Uniform Accident and Sickness Policy Provision Law (UPPL) is a state law that allows health insurers to deny reimbursement for services provided to patients for injuries incurred when an accident is a result of the insured’s drug or alcohol use. California, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Iowa, Maine, Maryland, Nevada, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, and Washington have successfully repealed the UPPL. Some states have never enacted UPPL, but their courts have ruled that insurance companies can use alcohol/drug exclusions in states that are silent on alcohol exclusion laws. Those states that by default still uphold alcohol exclusion laws are Massachusetts, Michigan, Minnesota, New Mexico, New Hampshire, Oklahoma, Utah, Vermont, and Wisconsin. None of these states, or the other states that have not yet repealed the UPPL, introduced or enacted legislation in 2011.

Firearms and clinical care

In early 2011, the Florida legislature considered a bill known as the “Privacy of Firearm Owners” bill (H.B. 155). Sponsored by the National Rifle Association (NRA), the legislation originally would have prohibited any health care professional from asking patients or guardians, in the cases involving children, if firearms were present in the home. The bill also would have prohibited health care professionals from inquiring about the safety and storage of firearms in the home. When first introduced, the bill made asking about firearm ownership a felony offense punishable with up to a $1 million fine or five years in jail. The bill eventually was amended to make a violation a reported offense to be addressed by the Florida Board of Medicine. The bill also was
amended to allow health care professionals to ask patients about firearms if there is a medical basis for doing so. After the bill was signed into law, a group of physicians, along with the Florida Pediatric Society, the Florida chapter of the American Association of Family Physicians, and the Florida chapter of the American College of Physicians filed a lawsuit claiming that H.B. 155 infringes upon the First Amendment rights of physicians and patients. In September, a federal judge in Florida issued a preliminary injunction against H.B. 155 on the basis that the law is unconstitutional.

Alabama, Minnesota, North Carolina, Oklahoma, and West Virginia all debated similar NRA-sponsored legislation during their 2011 legislative sessions, but none of those were enacted. However, it is anticipated that a number of states will introduce similar legislation during the 2012 legislative session.

Cosmetic surgery taxes

Many states have been facing severe budget shortfalls since 2008 and have been exploring new revenue options, such as a tax on cosmetic procedures. The cosmetic sales tax was introduced in Connecticut, Minnesota, and Washington this year.

The Washington bill (H.B. 1847/S.B. 5816) would have taxed all cosmetic medical procedures including, but not limited to, breast reduction surgery, surgery following reconstructive care to improve the appearance of accident victims, and surgery to remove excess flesh after gastric bypass surgery. Washington surgeons were encouraged to contact their legislators via the SSLAC. More than 120 letters were sent to legislators, and the bill was successfully defeated for the fourth time.

The proposed cosmetic tax in Connecticut was introduced in the governor’s budget package. The College and the ACS Connecticut Chapter, in conjunction with the Stop Medical Taxes Coalition, worked diligently to defeat the proposed tax but were unsuccessful in their efforts, and the tax went into effect July 1.

The Minnesota House introduced H.F. 567, which would place a sales tax on cosmetic procedures including, but not limited to, medically unnecessary cosmetic procedures, cosmetic injections, and cosmetic dentistry. H.F. 567 saw little movement during the 2011 session and died upon adjournment of the legislature.

State grassroots advocacy

The State Affairs staff in the Division of Advocacy and Health Policy is always available to surgeons and ACS chapters when state-level legislative or regulatory issues arise. The State Affairs Web page is accessible at http://www.facs.org/ahp/statelegislation.html and features useful information related to various aspects of state grassroots advocacy and state legislative resources. For more information on the legislation discussed in this article, contact Charlotte Grill at cgrill@facs.org or Alexis Macias at amacias@facs.org.
Surgical volunteerism in Vietnam:

Surgeons and educators strengthen the U.S.-Vietnam relationship

by Quyen D. Chu, MD, FACS; Gazi Zibari, MD, FACS; and Hung S. Ho, MD, FACS
Vietnam is a developing country in Southeast Asia with a population of approximately 84 million people. It is a beautiful country with many breathtaking landscapes. Socio-economically, Vietnam is mostly agrarian, although it is moving from a centrally planned economy to a market economy.

In 2010, U.S. Secretary of State Hillary Clinton visited with Vietnam Deputy Prime Minister Pham Gia Khiem to celebrate the 15-year anniversary of the normalization of Vietnam-U.S. relations. The importance of this relationship was further highlighted by President Barack Obama's April 2010 meeting with Prime Minister Nguyen Tan Dung at the Nuclear Security Summit in Washington, DC.

As part of its improving relationship with Vietnam, the U.S. has provided a significant amount of medical assistance to the nation, and is the largest donor in the fight against pandemic and avian influenza. The U.S. also provided more than $46 million in aid for Vietnamese citizens with disabilities. In addition to these efforts, under President George W. Bush, Vietnam received approximately $420 million in assistance from the president’s Emergency Plan for AIDS Relief.

In addition to bolstering Vietnam's economy and enhancing its health care infrastructure, the U.S. has been assisting Vietnam in its efforts to strengthen its educational system. Currently, more than 13,000 Vietnamese nationals are studying in the U.S., a figure that far exceeds the 800 students accepted before the normalization of relations between the two countries.

**Genesis of the VEF**

One organization that is playing a key role in this important educational endeavor is the Vietnam Education Foundation (VEF), an independent establishment under the purview of the executive branch of the U.S. federal government. The Vietnam Education Foundation Act of 2000 (U.S. Public Law 106-554) was established by Sen. John Kerry (D-MA), Sen. John McCain (R-AZ), Sen. Bob Kerrey (D-NE), Sen. Chuck Hagel (R-NE), Sen. Charles Robb (D-VA), Sen. Max Cleland (D-GA), and Reps. George Miller [R-CA] and Lane Evans [D-IL]. The U.S. Congress passed the legislation on December 20, 2000.

The genesis of the VEF can be traced back to the normalization process that was started by then-Secretary of the Treasury Robert Rubin, in 1997. Just before the Vietnam War ended, the Republic of Vietnam (South Vietnam) had borrowed hundreds of millions of dollars from the U.S. government for its war effort. As part of the agreement for normalization between the two countries, the current Socialist Republic of Vietnam agreed to assume the wartime debt of its former enemy, the defunct Republic of Vietnam, and thus repay the $146 million debt to the U.S. In return, the U.S. afforded Hanoi financial incentives, such as international borrowing. The two nations subsequently signed the bilateral trade agreement, which further strengthened their bond. Soon thereafter, Hanoi became a member of the World Trade Organization, and the U.S. conferred to Vietnam the permanent normal trade relations status on December 29, 2006.

**VEF’s educational mission**

Of the millions of dollars transferred annually from Vietnam to the U.S. Treasury, $5 million are earmarked for the VEF. The mission of the VEF is to establish an international fellowship program under which Vietnamese nationals can undertake graduate and postgraduate level studies in the sciences (natural, physical, and environmental), mathematics, medicine, and technology in the U.S. Another component of the VEF allows U.S. citizens to teach in these fields in Vietnam’s academic institutions. The VEF’s purpose is to further promote the process of reconciliation between the U.S. and Vietnam, and the building of a bilateral relationship serving the interests of both countries.

As part of its mission, the VEF has several programs, one of which is the U.S. Faculty Scholar program. The goal of this program is to select U.S. faculties to teach courses in English at Vietnamese universities either on-site in Vietnam or by interactive, real-time videoconferencing from the U.S. In order to select the scholars, the VEF engages the U.S. National Academies to identify and select qualified American faculty.

**Role as a VEF U.S. faculty member**

In 2009 and 2010, Hung Ho, MD, FACS (co-author of this article), and I (Quyen D. Chu, MD, FACS) were selected to be two of the three faculty members to teach English at Vietnamese universities in either on-site in Vietnam or by interactive, real-time videoconferencing from the U.S.
members (the third faculty member was civil engineer Findlay Edwards, PhD, from the University of Arkansas, Fayetteville) to receive the VEF U.S. Faculty Scholar award. As a joint effort between the Louisiana State University Health Sciences Center-Shreveport and the University of California-Davis School of Medicine, Sacramento, our course, Fundamentals of Clinical Surgery, was delivered to students at Thai-Binh Medical University (TBMU), Thai-Binh, Vietnam, via real-time videoconferencing. The course allowed for the delivery of didactics on basic surgical principles while allowing us to interact with, and learn from, the students and faculty members at TBMU.

In addition, Dr. Ho and I felt obliged to assist Vietnam with building the capacity of its medical education. Consequently, we had the book, Surgical Care at the District Hospital, which was published by the World Health Organization, translated into Vietnamese.

A patient from a rural region in Vietnam with a locally advanced breast cancer.
namese. A total of 100 hard copies of this 600-plus page book were printed and more than 100 compact disc versions of the book were created and donated to the Vietnamese government, to be distributed freely to the hospitals and medical schools throughout the country. We also granted permission for not-for-profit organizations, such as VEF and Global Help, which provides free health care information to developing countries, to obtain the PDF version of the translated book. This text was then made available on the organizations' websites.

**Surgical volunteering mission**

In October 2010, Gazi Zibari, MD, FACS (a co-author of this article) and I decided to go to Vietnam to present our first annual International Vietnam-American Surgical Symposium. What prompted this decision was the realization that the pace of novel surgical paradigms and techniques is quite rapid in the U.S., and health care professionals are able to stay informed of developments by attending societal meetings, workshops, and symposiums. Unfortunately, for individuals in the developing nations, such an endeavor can be cost prohibitive, especially if it requires the participants to cross oceans to attend. Therefore, we decided to bring the symposium to Vietnam. The theme was Maternal Health and Capacity Building and the meeting took place at Vietnam National Obstetrics and Gynecology Hospital in Hanoi. Five U.S. surgeons participated in the half-day event: Dr. Zibari; Dr. Chu; Ari Halldorsson, MD, FACS; Robin Lacour, MD; Marc Dean, MD; and Carolina Escobar, MD. Each gave a 30-minute lecture. Approximately 100 participants were present at the symposium, including some from Cambodia and Laos. This program was made possible with the support of pivotal organizations, such as the VEF, the Vietnam National Obstetrics and Gynecology Hospital in Hanoi, the International College of Surgeons, and such pharmaceutical companies such as Ethicon and Covidien.

Following the symposium, we spent several days visiting different hospitals in Hanoi—Vietnam National Obstetrics and Gynecology Hospital—Hanoi, the Vietnam National Cancer Institute-Hanoi, and the Vietnam Ear, Nose, Throat Hospital. At the Vietnam Ear, Nose, Throat Hospital, we witnessed some amazing, eye-opening cases. There were two cases of minimally invasive thyroidectomies that were performed by a surgeon who has done more than a thousand of these cases. Two small incisions near the axilla were the only incisions required for the operation. Witnessing this procedure were sev-

At Vietnam National Obstetrics and Gynecology Hospital-Hanoi. Left to right: Dr. Hao Pham, a Vietnamese surgical colleague, with U.S. surgeons Dr. Lacour, Dr. Chu, Dr. Zibari, Dr. Halldorsson, and Dr. Dean.
eral surgeons from various Southeast Asian nations who were there specifically to learn how to perform this procedure.

**Vietnam’s surgical infrastructure**

We were amazed at what our Vietnamese counterparts could accomplish with limited resources. They had modern laparoscopic equipment, which had been donated by a variety of international governmental and non-governmental agencies, and we found the surgeons to be quite facile in their laparoscopic skills. Unlike what is typically found in U.S. hospitals, the operating trays had only a handful of instruments. The Vietnamese surgeons only used what was needed and recycled many of the instruments that we would normally discard after a single use. Many of the surgeons performed instrument ties rather than hand ties so they could maximize the use of a stitch.

After scrubbing our hands, we were told to dip them in a bowl of alcohol and dry them on cloth towels. We were not so sure about the use of the alcohol, but according to our hosts, this practice cuts down on the infection rate. Prophylaxis antibiotics are rarely used, and we really don’t know their postoperative infection rate. One thing we did note is the paucity of obesity in Vietnam, which certainly might contribute to the low infection rate.

The lighting in the operating room (OR) was another area of interest. Some hospitals had only one standard overhead OR light. Additional lighting was supplemented by what appeared to be reading lamps. Our scrub nurse had to constantly maneuver herself and the lamps to give us adequate lighting.

Overcrowding seems to be a universal issue. We saw two bed frames pushed against each other to accommodate three or more people, many of whom had terminal cancer. There were no bed cushions, just straw mats on top of the frames.

Vietnam does not have the infrastructure to care for the terminally ill. Most are sent home to die and be cared for by their loved ones. A palliative care program is more of a wish list item than a reality.

The country is in dire need of medical assistance. Hue College of Medicine and Pharmacy, Hue, Vietnam, cares for a population of more than 20 million
people and is considered to be one of Vietnam’s major medical schools. It diagnoses about 70 new cancer cases per month, and yet, it does not have a linear accelerator.  

As the medical team wrapped up the trip, we realized how fortunate we are to be living and practicing in the U.S. Somehow, issues such as the health care debate or the concerns of medical reimbursement all seemed so far removed from our minds. All of us felt a sense of sympathy, and we pondered what more we could do to alleviate the sufferings of others. This feeling transcends race/ethnicity, socioeconomic class, and politics. It dawned on the medical team that surgical volunteerism is one of the things that defines our profession as a noble one.

**Future efforts**

We are motivated to continue our effort in assisting Vietnam with its medical education. I recently received another VEF grant to begin a course titled The Management of Breast Cancer. The goal of this course is to assist the local surgeons at TBMU to establish a multidisciplinary approach to managing breast cancer. Part of this effort will be addressed in a small handbook introducing and discussing the basic principles of breast cancer. In addition, Dr. Zibari and I have created a 501(c)(3) not-for-profit organization to sustain the effort.

Regardless of the limitations and challenges outlined in this article, we had a wonderful time with our hosts, exchanging jokes and sharing our “war stories.” The people in Vietnam are some of the most gracious and industrious individuals that we have ever encountered. Despite the differences in culture, we felt a sense of camaraderie among our surgical colleagues. We shared many things in common and, overall, we all felt a sense of accomplishment, even in conditions to which we were not normally accustomed.

**Conclusion**

After 15 years of normalization, Vietnam has become the U.S.’s strategic Southeast Asian ally. This important relationship is underscored by Secretary Clinton siding with Vietnam in the 2010 Vietnam/Chinese disputes over the Spratly Islands in the Southeast Asia Sea. Approximately 85 percent of the
hips carrying oil for China, Japan, and South Korea pass through this area.\textsuperscript{11,12} This area is also abundant with oil and natural gas; there are approximately 213 billion barrels of oil and 900 trillion cubic feet of natural gas.\textsuperscript{13} Naturally, hegemony of this abundant natural resource by any one nation in this region could potentially complicate the world’s geopolitical landscapes.

Surgeons have a role that can further strengthen the relationship between the U.S. and Vietnam, and this is paramount to the posterity and prosperity of both nations.

\textbf{References}


Surgical training is fraught with many challenges as one learns vast amounts of medical knowledge, becomes nimble at challenging operative techniques, models core professional competencies, and develops clinical acumen. Perhaps the greatest challenge, however, is that of losing a patient.

While palliative care has been making inroads in surgical practice in recent years, as evidenced by the College’s Palliative Care Task Force and the recent option of board certification in Palliative Care from the American Board of Surgery, the surgical profession remains enamored with a culture of cure and rescue. Thus, the concepts of symptom management and a graceful approach to the end of life that are the crux of palliative care sometimes seem foreign to surgeons.

Yet the reality is that despite our greatest efforts and the best that modern medicine can offer, sometimes we will have to watch our patients die. They may die fighting for cure or they may die having decided to pursue palliation. In either circumstance, it is difficult to accept; often the experience of losing a patient can be a personal or professional turning point, in particular for those early in their career.

The topic of the third annual Resident and Associate Society (RAS-ACS) Essay Contest was “My experience with a dying patient.” Trainees across surgical specialties submitted 500-word essays on how the death of a patient has affected them. Essays were blindly judged using a set of uniform criteria. We are pleased to share the top 10 essays with the readers of the Bulletin.

*Dr. Santry* is assistant professor of surgery, trauma, and surgical critical care, University of Massachusetts Medical School, Worcester. She is Chair of the RAS-ACS.
During night float rotations, endless streams of patients seem to run together. Motor vehicle crashes, every kind of “-itis,” and gunshot wounds all become thrown into the melting pot of cumulative clinical experience. Some patients are treated without realizing it. Others have an operation and go home. However, a few stand out in a subtler way. My essay centers on the families, not the patients. Sometimes loved ones need palliative care. The subject of the conversation is similar to traditional end-of-life discussions, but much more acute.

Recently, I admitted a high-speed motorcycle crash victim. He had an upper extremity amputation, a shattered leg, and a devastating head injury. In the operating room, we stopped the hemorrhage from his arm. Still, I knew his head injury would likely be fatal. I sequestered myself in the intensive care unit (ICU), waiting for his inevitable decline or the next red trauma alert. In the middle of the night, the nurse informed me that his family had arrived. They knew nothing of his condition. Although I had been present for many family conferences—and had even led a few—I felt very uneasy; I hope I always will.

I was going to be the one delivering the news, and with this patient, it was primarily the family that would need help. The phrase “work the crowd” enters my mind as I reflect on this experience. It seems trite as it is typically used with politicians, but each family member who comes to the discussion will have varying degrees of medical knowledge and different levels of connection to the patient. These factors are critical as you embark on such a conversation. I wanted to provide the medical information in a way that anyone could understand. I do not believe in false optimism, preferring to tell it how it is. In my limited experience, I think honesty is appreciated, even when brutal.

With more than a dozen people crammed into a small ICU conference room, the atmosphere was tense. We all handle tragedy differently and this group was certainly no exception. I meticulously went through the injuries, trying to explain that the patient’s remaining time was on the order of hours, not days. There was praying, crying, and above all, lots of questions.

I led them back to the ICU in groups of two, trying to make sense of all the tubes, lines, and incessant beeps. Viewing the vast array of interventions employed to maintain his life helped them conceptualize letting it go. My efforts seemed to be appreciated. They were all so gracious and kind, as if they could sense my insecurity. Although different than a handshake after a “great save,” getting a hug from a grieving mother after her son passes is just as meaningful. I questioned if she received the attention she deserved because the reality of a busy night of call can provide incessant untimely interruptions. Somehow, that night, my pager lay on my hip, silent—exactly as it needed to be.

Dr. Dehmer is a PGY-5 resident, University of North Carolina at Chapel Hill.
I was an intern on the hepatobiliary service. At age 32, her cholecystectomy specimen during the second trimester of pregnancy revealed T2 gallbladder carcinoma. Deferring treatment until after delivering her child (a healthy baby boy), Mary came to us to discuss her options. Ultimately, hepatic resection was performed. Despite initial complications, she recovered well from surgery and spent more than two years at home with her family without further evidence of malignancy.

From the beginning, I had admired Mary’s courage to preserve the health of her baby at the risk of harming herself. The compassionate rapport established by her surgeon, Andreas Karachristos, MD, FACS, was also a great lesson for a young resident. Afterward, he would periodically update me on her outpatient progress. Now, while rounding on the trauma service, I saw Mary again. By this time, the cancer had resurfaced and invaded most of her liver. A biliary stent could not palliate the inevitable sequelae of ascites, malnutrition, and gastric bleeding. Nonetheless, Mary manifested the same joy and faith in God that characterized her at the first clinic visit.

Surgical residents thrive on the management of acute surgical problems, yet they often feel at a loss when relating with patients to whom modern medicine has little to offer in terms of treatment. There were times when the awkwardness of her terminal diagnosis dissuaded me from entering her room, but usually the bond of shared humanity overcame my sense of powerlessness as a physician. Mary was always grateful for a brief visit, and I felt rewarded each time.

Despite understanding her prognosis and what that would entail, Mary and her family declined home hospice arrangements, perhaps perceiving hospice as giving up. So, our hospital became her hospice. When my responsibilities on the trauma service were completed, I would visit Mary. We chatted about her two vibrant children. We listened to music in her native language. We prayed. As her condition deteriorated, our conversation decreased. I would just sit for a while or help her drink some juice that she was too weak to hold. The lesson from medical school remains true—a dry mouth is often the most vexing of symptoms in the terminally ill. Even with the technological advances of modern medicine, it should not be beneath physicians to treat, with equal efficacy, such basic needs.

Mary soon left this life, just before dawn and with little fanfare. Her nurses remained attentive to her comfort until the end. Major surgical interventions improved her quality of life at the time of diagnosis, while nonsurgical approaches were needed when her story came to a close. With time and experience, I hope to become highly skilled in the provision of both types of care. Most terminally ill patients encountered in residency leave the hospital before their last days. Mary’s case reminded me that I entered a career in medicine and surgery specifically to be present in the midst of suffering, and to alleviate whatever proportion I can, large or small.

Bond of shared humanity
by Stephen M. Doane, MD

Dr. Doane is a PGY-4 resident, Temple University Hospital, Philadelphia, PA.
My father died on July 5, 2010. It was messy and sudden, though not completely unexpected. After spending the week at home with the rest of my family, I returned to work on July 12. In addition to operating and supervising the junior residents, my responsibilities included caring for the intensive care unit (ICU) patients.

One of our patients was an elderly lady who had been in the hospital for more than two months. During my week away from the hospital, she had deteriorated and returned to the ICU. I spent a lot of time with her over the next several days, and it became clear that her condition was not going to improve.

Her husband and son visited constantly. They were obviously dedicated to her, and her decline was difficult for them to watch. We spoke daily about her chances for recovery, and they realized that her condition was causing her pain. At that point, we discussed the future.

We talked about options, and I stressed that there are always choices to be made. Even if the decision was to change the focus from treatment to palliation, there are many ways to do that. I told them they should not feel guilty because they already knew the patient’s wishes.

In the following days I watched them struggle with their decision. We spoke daily. I answered their questions about her condition as best I could and in a way they would understand. After long deliberation, they decided she would not want to live in her current condition. They elected to concentrate on comfort instead of cure.

I was on call on Thursday, July 15. In the morning, as my shift was ending, the family called to say they were on their way to the hospital and had made a decision. They wanted to discuss it with me.

So, I stayed.

The patient’s husband and son arrived, and we went to the family room where we had spent many hours over the last week. They told me they could not continue to watch her suffer, and wanted to withdraw care. I explained how we would do that and promised that she would have no pain.

They took turns saying goodbye; together at first, then individually. Her husband asked me how to say goodbye to someone with whom he had spent more than 50 years. I told him to hold her hand and tell her he loved her.

When they were ready, we started the process. The morphine and versed were turned on, and the Levophed and vasopressin were turned off. She was extubated and made comfortable. Then the family went inside the room so they could be with her. They asked me to stay.

So, I stayed. And my already broken heart shattered a little more.

In less than an hour, her breathing slowed down, then stopped completely. She became bradycardic, then asystolic. She died peacefully in the presence of those who loved her. After she was pronounced dead, I left the room to give her family time to grieve. Her husband and son came outside when they were ready and said thank you. Her son gave me a hug and told me that was exactly the way they wanted it to be. Then they left.

And I stayed.

I sat alone in the family room where I had recently spent so much time and thought about the events of the previous week. I thought about our conversations and about how I really believed everything I said to that family. I thought about the similarities to my own family tragedy. And I cried.

And then I began to heal.
Death is ubiquitous and, even, commonplace in a hospital. I have seen many people die for many reasons, some preventable, some self-induced, all inevitable. By my second year of surgical training, I imagined myself immune to death’s sorrow. Having seen so many people meet their final moments, I had come to accept the inescapability of death.

During a routine night on call, I met “Mr. L.” He was lying motionless in his emergency department bed, a bucket in one hand and his partner’s in the other. Quickly reviewing his medical record, I discovered he had stage IV lung cancer. His brain and bones were affected, so he had been receiving whole brain irradiation, as well as chemotherapy. Mr. L was so immunosuppressed that we didn’t immediately realize he had an acute abdomen with a large amount of intra-abdominal free air. The radiographs that revealed his diagnosis changed everything. Before Mr. L had walked into the emergency department that evening he had been dying, but death seemed far off, with time to enjoy the upcoming holidays, to plan a trip with his partner, and to cross things off his bucket list. Now, he was dying imminently—and suddenly, an impossible situation became even more unfair.

Mr. L faced a difficult decision—a question of quality of life versus quantity. The answer to that question was one only Mr. L and his partner could offer; I had never envied someone less in my life. In the end, Mr. L and his partner chose to decline surgical intervention. They agreed they would rather meet death now, cognizant and as comfortably as morphine would allow. Mr. L was transferred to hospice care, and he died a few days later.

Our conversations that night required all of my knowledge and my courage, and despite the fact that Mr. L was so far beyond medicine’s reaches, I felt that I had cared for him and his partner when they truly needed it. Mr. L chose to die, demonstrating an understanding of death beyond mine. I was powerfully confronted with his humanity and his dignity, and it overshadowed his fatal disease to show the man instead of his maladies.

Mr. L helped me understand the incredible opportunity we have as surgeons. More than in any other profession, patients put their lives directly in our hands and trust us to care about more than their outcomes. My bond with patients and their emotions is my connection to the human experience. There is an almost subconscious divide between us and our patients, an impetus to remain stoic and reserved, subtly reinforced through the generations. As a caregiver, sometimes the most important and only way I can truly give care is by breaking down traditional barriers to find the person inside the patient, by seeing Mr. L as more than a lost cause.
A cerulean mug sits alone on a shelf in our endoscopy suite—the ceremonial cup. The iconic vessel is offered after stenting across an obstructing esophageal tumor. Water soothes the weary patient and assures me that the stent is functioning. Here, in remote Africa, I stand against a continuous stream of terminal patients with a scope and the ceremonial cup.

A stent holds the power to change one’s death. Without one, countless people in this region die miserably, spitting in a cup, unable to swallow their own saliva. As a young surgeon, I experience the stress and exhilaration of providing this aggressive palliation for dying patients.

Today, my eagerness would be tempered by Mary, for whom there would be no ceremonial cup. When she first arrived, her tumor was nearly completely obstructing her esophagus. After forfeiting a lump sum of this organ for endoscopy, nothing remained for a stent—that 12 centimeters of steel and silicone that could provide a dignified death. Typically, we find donors to cover the cost of caring for these patients, but she eluded follow-up, and her medical record went silent for the next six months. Mary’s cancer grew unbridled, and in a haze of starvation, she dwindled to a mere 62 pounds. Finally she returned, weary and clinging to existence. As I gazed upon her wasted body, I desperately wanted her to swallow again. With great hope, I undertook to set Mary free from a small piece of her suffering.

I passed a thin wire past the tumor, whereby I could lay a metal bridge across the cancer wasteland. That wire is how I beat this cancer day in and day out. But Mary’s chest was obliterated with tumor, and the wire eventually led me to unwelcoming structures outside of the esophagus. The senior surgeon came to help. Then—in one of my most humbling moments—I helped anesthesia get Mary off to sleep, unsure if she would awaken again; she did not. We worked for hours without success—she was too weak to survive a large operation, and the cancer was too progressed to place a stent. No ceremonial cup, no stent, no goodbyes.

One of my surgery attendings has talked about the chain of souls we acquire as surgeons. Although we are always striving to save lives or alleviate suffering, there are those patient deaths for which we feel directly responsible. Mary belongs to the chain of souls to whom I will always be bound.

My surgical mentors assured me her disease was too advanced and that I made the right decisions. Their words eased the difficulty of the situation for me, and were crucial in preventing despondency. At the same time, they had not the power to unlink Mary from my chain. Her memory will always remind me of the delicate nature of interventions at the end of life. I now remember to proceed cautiously and to never take for granted each time I have the opportunity to offer a patient the ceremonial cup.

Dr. Hedges is a PGY-6 resident, University of Colorado at Denver.
Her toothpick-thin limbs jutted out unexpectedly from the sea of white cotton that enveloped her body. She was more pajama than woman, sitting upright in an oversized hospital bed. Her skin delicately covered her body like tea-stained rice paper, and it was almost as if each red blood cell could be seen racing sluggishly across her very bones. Yet beneath the cotton abyss, the wrinkled skin stretched taut across an abdomen bloated with the pregnancy of cancer. She examined me through regal eyes, weakened and defiant. I was three months into my internship, just beginning my surgical life, and she was a 70-year-old woman nearing the end of her life.

I met her cancer before meeting her. I was placing her hard films up to the light box, and even my untrained eye could see the large mass invading every frame of the abdomen. The chief pointed out how the tumor’s legs were encasing the aorta. It was inoperable. She had three, maybe four, months to live, if that. The plan was to discharge her in the morning. The morning turned into a month, and here is where our lives became entangled.

Our first encounters resembled the systematic questioning and answering of a robotic assembly line. Somewhere along the line the robot broke down and I became curious about her, about the woman she was before the cancer, the woman she is in spite of the cancer. I soon found myself listening to her at her bedside as she released snapshots from her vibrant life. My favorite stories were from her days as an airline stewardess in the 1950s. In a time when most women never ventured farther than 10 miles from their front door, she was traveling the globe, connecting with the world. She had been independent her whole life, and even then I could feel her strength as she recounted her adventures. In between the stories of her life, she would dispense tiny packets of wisdom wrapped with the common thread of “live your life.”

Sometimes she spoke volumes with her eyes. She knew that her body was dying, even though her brother had insisted that we not disclose the diagnosis to her. Her inevitable death was not the big secret that we all thought that it was. Right or wrong, the walls of the physician-patient relationship came crumbling down, and we became friends. We formed a bond. I stopped relating to her as a patient and began caring for her—one human being to another. Although she is gone now, and many years have passed since our interaction, her memory is sutured into my brain, subconsciously affecting every living and dying patient with whom I interact. With every patient, I try to see beyond what my eyes reveal, focusing not only on my patients’ diseases or labels, but treating them like family—healthy, living, breathing family.

She irrevocably shifted the tectonic plates of my professional and personal life, and for that I am eternally grateful.

Editor’s note

Dr. Lamb’s was the the highest-scoring essay in this year’s competition. Dr. Lamb received special recognition and an award at the Resident and Associate Society annual business meeting during last month’s Clinical Congress in San Francisco, CA.

Dr. Lamb is a PGY-3 resident, St. Elizabeth’s Medical Center, Boston, MA.
Practical Hippocrates

by Kimberly M. Lumpkins, MD

“If you’re coming to see us before we’ve even checked in, it can’t be good,” said the grizzled middle-aged man at the trauma reception desk. I cringed inside at his accurate assessment of the situation. I shook his hand and offered some inconsequential words of greeting as I ushered him and his wife into the small consultation room. “This part of the job never gets easier,” I thought, as I prepared to employ my usual strategy for breaking bad news.

Step one, establish what the other person knows. In this case, the couple knew that their son had fallen off of a roof at work. No, they didn’t know how bad it was. Step two, convey information as plainly as possible: “Your son’s head injury is devastating; there is no chance for survival.” Step three, remain silent, and listen. They were losing their only son, and they had questions, such as, “How could this happen?” “Why did this happen?” I had no answers.

As the parents entered the trauma unit, their lethally injured son’s heart was failing. In their grief, they were not yet ready to discuss a do not resuscitate order. Although we knew our care was futile, we felt obligated to initiate chest compressions and administer blood products to keep up with the patient’s blood loss while his parents wept at his bedside.

The roof worker’s plight illustrates the complex and often contradictory obligations physicians face when providing end-of-life care. In medical school, we recite the Hippocratic oath, satisfied in our theoretical commitment to primum non nocere. In practice, it is naive to think we bear a duty only to our patient. We also have a duty to the patient’s family in their time of need. We have a duty to the community, as the custodians of precious and valuable resources such as blood products. We must ensure the effective and just distribution of these resources, and therefore we must assess whether we are justified in prolonging the life of a fatally injured patient. When these obligations are in conflict, there are no easy answers.

In the end, I guided the family to sign a do not resuscitate order that allowed us to bring the patient’s suffering to an end. I was left with the unpleasant feeling that I hadn’t fulfilled any of my duties adequately—not to the family, not to the community, and definitely not to the patient, whose suffering was prolonged beyond that which was necessary. Unfortunately, our professional duties to reduce the suffering of our patients and to protect precious resources for the community can stand in clear opposition to our moral duty to give families time to cope with the grief and sudden shock of losing a loved one. Only through caring for patients in complex circumstances, such as the ones described here, can we learn to balance our professional duties.

Dr. Lumpkins is a PGY-7 resident, University of Maryland Medical Center, Baltimore.
It was a night not dissimilar to the mundane dreariness of winter, yet in retrospect, it would be a night that would test my emotional endurance and embed an experience in me that I would never forget—an experience that reinforced to me the Hippocratic oath and the very ethos of medical care.

That particular night, while completing evening rounds on my service, I recognized a family member of one of our previous patients who, years ago, underwent a hemicolectomy for colon carcinoma with concomitant wedge resection of a liver mass. As far as I had known, the patient had done well in follow-up.

I approached the room to give my regards, and I slowly realized that the complete family was gathered by the bedside. The patient’s daughter then shared with me that the cancer had recurred with multiple lesions in the liver despite chemotherapy. They had been battling it for a while and there was nothing more that could be done. Her father had decided that he did not want any further interventions and that “he was ready.” Having had a close rapport with the family from previous hospitalizations, the daughter asked me if I would stay with them during this difficult time. I could not have imagined being anywhere else at that moment—I would be present for him and for them. And I remained so, until the late hours when he succumbed to his illness comfortably.

Reminiscing about that night evokes emotions of disbelief, frustration, and even anger that our current medical therapies were unable to save him. As surgeons, we are intimately involved in patient care; in fact, we reach our hands into patients to remove pathology. Therefore, does this individual’s demise mean that we failed in our duty to him? Were we just not good enough?

The truth is, death is not a professional failure. We must learn to accept its existence and understand that we are in a position to not only help cure patients through operations, but also to be steadfast and provide guidance and support in those instances where a cure is unavailable. All too commonly we try to hide or stay protected behind our specialty; if the disease is incurable, then we request to transfer care. “It’s not a surgical condition,” we say. Well, the pride of being a surgeon comes from our utmost sense of responsibility to our patients. The duty to our patients transcends the specialty, and it reminds us that empathy and compassion are not functions of our occupations, but rather, are characteristic of our essence, of our existence as people.

The time-honored physician-patient relationship is a sacred bond. And although I will forever remember that night for teaching me about death, my real gratitude is to that patient for allowing me the privilege of being his physician—surgeon or not—and the honor of being by his bedside in his final moments.

Dr. Mouawad is a PGY-4 resident, St. Joseph Mercy Health System, Ann Arbor, MI.
couple of decades before my grandfather died of colon cancer, a photograph was taken of him that now rests on my mother’s desk. The photo shows him dressed in a suit, his wide tie loosened at the neck, with an arm casually draped around my grandmother. He’s home from his job as a thoracic surgeon, a tiring but rewarding career, and he wears the look of a man not yet ready for retirement but starting to think about it. He’s looking forward and down, his eyes focused on the grass that he planted and cared for, and he’s smiling. My grandma, cradled in his arms, is grinning up at him with absolute adoration; they love each other. On that afternoon, some time in the mid-1980s, one glance from my grandmother, captured by my aunt’s camera, hints at a relationship that survived an economic depression, a world war, a bullet through the neck, surgical residency, five children, and eventually metastatic cancer, the last of which ended their physical connection.

I visited my grandfather at his home in his last week of life. He lay in bed, his body wasted from cancer, his mind confused by drugs. In a rare lucid moment, he asked me how college was going. I told him I had a biology test coming up. He nodded and told me to study hard. That night, as I sat reading at his kitchen table, I could hear him in the bedroom gasping and moaning. Then I heard my grandmother wake up and in a soft voice repeat, “Shh. It’s okay, Jim. It’s okay.”

I thought about this scene recently while rotating through the intensive care unit. I was asked to place an emergency dialysis catheter in a 97-year-old retired otolaryngologist with worsening renal failure. He arrived in disarray—eyes frantic, speech incoherent, his hair a mess. However, his thin white mustache was impeccably trimmed—a sign of attentiveness despite impending death, a sign that someone still cared. Delirious, he refused the procedure and threatened us aggressively. We called his son, who had signed the consent form and probably trimmed the mustache, and explained the situation. There was a silence on the other end of the phone, and then a slow, exhaled breath, and then, “Okay. It’s okay.”

Death is unglamorous, and as medical professionals, we often see its ugliest aspects. We are trained to view illness as a pathological nuisance, an intruder to rid from our neat, scientific universe. Thus, it’s frustrating when our efforts are unsuccessful or our patients refuse them. Yet, caring for the dying has also revealed to me the part of life unsusceptible to disease. Occasionally, if we pay attention, we can witness in the trimming of a mustache or the gentle whispers of a spouse, the type of love and respect that persists long past the time when we need to say, “Okay. It’s okay.” And both as health professionals and as people, that’s a pretty awesome privilege.
Death is not failure
by Allison L. Speer, MD

It was Thanksgiving weekend, and I was on call again. The day had gone by quickly, and as I walked down the burn ward, my eyes turned to a new gurney in the hallway. I glanced up and down the hallway, but it was empty. Apparently, the emergency department had dropped off this patient without a warning or even a phone call. I introduced myself and asked the man his name, but he just kept moaning. He was approximately 70 years old, and reeked of burnt cooking oil. His airway was patent, his breathing unlabored, and he had a palpable pulse. I moved him to the intensive care unit. He was confused and continued to moan as I assessed his burns, the majority of which were third-degree across his entire chest and portions of his back, arms, scalp, and face. The gravity of the situation hit me. This man was going to die.

So, I did what interns do best—I calculated. I calculated his total body surface area (TBSA) burn: 18 + 9 + 4.5 + 4.5 = 45%. I calculated his fluid requirements using the Parkland formula: 45% x 70kg x 4mL = 12.6 L. I also calculated his caloric requirements: (25kcal/kg/day x 70kg) + (30kcal x 45%) = 3100 kcal. And I calculated his mortality rate using the Baux score: 45% + 70 = 115%. I thought to myself, “I can’t let him die on my call, I refuse to fail.”

I placed a central line and began resuscitation. I knew that the patient would require intubation, but held off as a nurse was finally able to translate our intentions in his native language. We were horrified to learn that “Mr. D” was blind and someone had poured oil on him while he was sleeping in his home and then set him on fire. He desperately asked to speak with his daughter.

Mr. D’s daughter was a detective with the local police force. She informed us the next morning that his estranged wife had doused him in oil, set him on fire, and then jumped 10 floors to her death. The patient’s daughter asked about her father’s prognosis, and we were honest: considering her father’s age, the 45 percent TBSA burn factor, and a likely inhalation injury, his mortality rate was high. Even if he eventually recovered, it would be a long road, fraught with multiple skin grafting operations, prolonged ventilation requiring tracheostomy, and potential secondary infections, sepsis, and multiple organ failure. She acknowledged this information with a nod, walked over to her father, and held his hand. Tears streamed down her face as they spoke. When she returned to us, she explained that they had decided it would be best to withdraw care. Her father wanted to die with dignity and without any more suffering.

Over the next 72 hours, I watched as Mr. D lost function of every organ system, but he never lost his dignity. He passed peacefully with his daughter by his side. I learned an important lesson that day: I realized that death does not equal failure. Now, when confronted with death, I think of Mr. D, and I remember that death with dignity is possible in the hands of a compassionate surgeon.

Dr. Speer is a PGY-4 resident, University of Southern California, Los Angeles.
Socioeconomic tips

Sentinel lymph node mapping and its relation to biopsy

by Linda Barney, MD, FACS; Mark Savarise, MD, FACS; and Eric Whitacre, MD, FACS

Sentinel lymph node (SLN) analysis has become the standard of care for initial regional lymph node assessment of breast malignancies and melanoma, replacing complete regional lymph node dissection for most patients. Although Current Procedural Terminology (CPT)* codes 38500–38780 serve to identify lymph node biopsy, complete regional dissection procedures, and formal lymphadenectomy procedures, these codes were developed before the widespread acceptance of SLN mapping.

Surgeons now have a code for accurate reporting of sentinel node mapping and identification. New add-on CPT code 38900, Intraoperative identification (eg, mapping) of sentinel lymph node(s), includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure), is reported in conjunction with 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745. Approval of this add-on code marked the first opportunity for surgeons to capture the important work of identifying and mapping sentinel nodes as an integral part of SLN targeting for diagnostic sampling. Because of the complexity associated with breast cancer treatment options, a single stand-alone code insufficiently addressed the wide spectrum of uses for SLN mapping and biopsy.

When performing SLN mapping in the operating room, it is the surgeon who commonly injects the vital blue dye. This procedure is considered inherent in the mapping code, although radioactive tracer injection has a much wider spectrum of applications and clinician uses. Tracer may be injected remote from the immediate operating room and surgical procedure. CPT code 38792, Injection procedure for identification of sentinel node, is reported to identify the work associated with the injection of radioactive tracer and is separately reportable, when performed.

The following scenarios address the appropriate use of the various codes now available to capture the work component of SLN mapping and biopsy.

A 55-year-old female recently diagnosed with cancer of the right breast undergoes right deep axillary SLN biopsy at the time of her partial mastectomy.

The reportable procedures in this case are as follows:

19301, Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
38525–51, Biopsy or excision of lymph node(s); open, deep axillary node(s)
+38900, Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of nonradioactive dye, when performed (List separately in addition to code for primary procedure)

Partial mastectomy for excision of the tumor is reported with CPT code 19301. The removal of the deep axillary SLNs is reported with CPT code 38525, based on the depth of the node excised. Level I nodes can be deep or superficial depending on depth, patient habitus, and the extent of required dissection. According to CPT, Level II and III nodes are considered deep nodes, appropriate for the use of code 38525. To report the work associated with the intraoperative identification of the sentinel node, report add-on code 38900. This code accounts for the work of blue dye injection, use of the handheld gamma probe, and the dissection of the axilla to identify the sentinel nodes.

If the surgeon injects a radioactive tracer, report 38792. It may also be appropriate to append modifier 51 to account for the multiple procedures performed.

A 55-year-old female recently diagnosed with cancer of the right breast undergoes right deep axillary SLN biopsy followed by a completion axillary dissection at the time of her partial mastectomy.

The reportable procedures in this case are as follows:

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2010 American Medical Association. All rights reserved.
19302, Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
+38900, Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)

Partial mastectomy with axillary dissection is reported with CPT code 19302. Biopsy or excision of lymph node(s) is an inherent part of CPT code 19302. To report the work associated with the intraoperative identification of the sentinel node, report add-on code 38900.

The National Correct Coding Initiative† edits prohibit the use of any axillary SLN biopsy code (38500 or 38525) as an inherent part of the more complex operation of ipsilateral axillary dissection. SLN mapping and injection of radioactive dye are distinct and separately reportable services not routinely included in 19302. If SLN biopsies of ipsilateral internal mammary nodes (38530) or contralateral axillary nodes (38500 or 38525) are performed at the same operative setting, both the sentinel node and axillary dissection codes are separately reportable.

A 68-year-old female recently diagnosed with cancer of both breasts undergoes bilateral superficial axillary SLN biopsy at the time of her bilateral total mastectomy.

The reportable procedures in this case are as follows:

19303–50, Mastectomy, simple, complete
38500–50–51, Biopsy or excision of lymph node(s); open, superficial
+38900–50, Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)

Total mastectomy is reported with CPT code 19303. The biopsy of the superficial axillary SLNs is reported with CPT codes 38500, based on the depth of the node excised. To report the work associated with the intraoperative identification of the sentinel node, report add-on code 38900. Modifier 50 is added to all

† All specific references to National Correct Coding Initiative Coding Policy Manual for Medicare Services are © 2011 Centers for Medicare & Medicaid Services. All rights reserved.

of the codes because all of the procedures were done bilaterally.

A 68-year-old female recently diagnosed with cancer of the breast undergoes unilateral superficial axillary SLN biopsy and completion axillary dissection at the time of her total mastectomy.

The reportable procedures in this case are as follows:

19307, Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle
38900, Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)

A modified radical mastectomy (total mastectomy with axillary dissection) is reported with CPT code 19307. CPT codes 38500 and 38505 are not separately reportable as the biopsy and excision of lymph node(s) is an inherent part of code 19307. Add-on code 38900 is separately reportable and appropriate to describe the work of sentinel node identification.

A morbidly obese 60-year-old female with locally advanced unilateral breast cancer is referred for SLN biopsy before undergoing neoadjuvant chemotherapy.

The reportable procedures in this case are as follows:

38525, Biopsy or excision of lymph node(s); open, deep axillary node(s)
+38900, Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)

To report the removal of the deep axillary SLNs, use code 38525. To report the work associated with the intraoperative identification of the sentinel node, report add-on code 38900. A lumpectomy or mastectomy was not performed at this time and is not reportable. In this case, code 38740 is inappropriate for sentinel node biopsy; this code is for a complete axillary lymphadenectomy and requires removal of all superficial axillary adipose tissue and all lymph nodes contained in this tissue.

If a port is placed at the time of the aforementioned
A 52-year-old female undergoes a left partial mastectomy with SLN mapping and biopsy. Her intraoperative node analysis is negative, but the final pathology report reveals two lymph nodes are positive for cancer. She also has a positive inferior margin on her lumpectomy specimen.

The reportable procedures in this case are as follows:

19302-58, Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy

A staged procedure within the global postoperative period is reported with modifier 58. This modifier indicates that the procedure was planned or anticipated at the time of the first procedure, rather than an unexpected procedure or a complication.

A partial mastectomy (19301), excision of deep axillary lymph node(s) (38525), and SLN mapping (38900) are performed. Two days later, the final pathology report reveals two lymph nodes are positive for cancer and a positive inferior margin on the lumpectomy specimen. Report the re-excision of a previous lumpectomy with axillary dissection with code 19302-58.

A completion simple mastectomy after lumpectomy would be coded 19303-58, Mastectomy, simple, complete.

A completion axillary dissection alone would be coded either 38740-58, Axillary lymphadenectomy; superficial, or 38745-58, Axillary lymphadenectomy; complete, depending on the extent of dissection.

Superficial axillary lymphadenectomy (CPT code 38740) requires removal of all superficial axillary adipose tissue with all lymph nodes in this adipose tissue. 38745 is used to imply a more complete deep axillary dissection, which infers an axillary clearance of intervening fat and nodes from levels I-III.

The surgeon performs his/her own injection of radioactive tracer before any sentinel node biopsy.

The injection of radioactive tracer is excluded from the sentinel node identification code (38900) because it is frequently done by another health care professional.

continued on page 59
Fire is the fifth leading cause of unintentional injury and the third leading cause of fatal home injury in the U.S. Approximately 450,000 burn injuries receive medical treatment each year, and roughly 3,500 people die in fire-related accidents each year. Burn center care, similar to medical services delivered at trauma centers, has been associated with improved survival, decreased hospital costs, and shorter lengths of stay.2,3

Burn centers are staffed by highly trained health care professionals of various disciplines who work together to ensure the best surgical, therapeutic, functional, and psychosocial recovery for burn victims, as well as for patients with severe skin disorders. Advances in critical care, skin substitutes, reconstructive surgery, and therapy are now making it possible for patients to survive burn injuries that previously may have been fatal. Of concern to health care professionals are the following issues: there has been a steady decrease in number of burn centers over the last several decades; most burn victims are not treated in burn centers; burn discharges have remained constant since 1993; and there may be a shortage of burn surgeons in the U.S. As a first step in addressing some of these issues, this article briefly describes the number and distribution of burn centers in the U.S. and provides an explanation of the verification and referral process for burn centers.

Distribution of burn centers
Of the 5,795 total registered hospitals in the U.S.,4 there are only 123 burn centers today, down from 180 burn centers in 1976. Of these burn centers, 60 are verified by the American College of Surgeons (ACS) and the American Burn Association verification criteria, and 63 are non-verified burn centers6 (see Figure 1, page 34). Only 37 burn centers in the U.S. are verified to care for both adult and pediatric burn patients. For a facility to be recognized as a verified burn center, it must demonstrate competence in all aspects of patient care, from the pre-hospital setting through post-discharge rehabilitation. Centers also must have dedicated burn staff, treat a minimum number of patients per year, and maintain involvement in burn-related research.7,8 More than 80 percent of the U.S. population lives within two hours (by ground transport) of a verified burn center.9 Most burn patients can safely be transported via ground to a specialized burn center for their care. For those patients who may be too unstable to travel long distances, referring facilities can work with the burn center to stabilize the patient and prepare them for a safe transfer (see Figure 1).

To help health providers in non-burn facilities appropriately refer patients who are most likely to benefit from the multidisciplinary care offered at specialized burn centers, the ACS Committee on Trauma and the American Burn Association jointly developed burn injury referral criteria (see table,
Figure 1. Distribution of verified and unverified burn centers, 2011


Notes: Burn centers are mapped to the ZIP code centroid, and include ABA/ACS verified and unverified burn centers. Four burn centers were missing number of designated burn beds.

Produced by: American College of Surgeons Health Policy Research Institute, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Despite these criteria, only 40 percent of all burn injuries are treated in a burn center. Of the burn patients seen in burn centers, more than 75 percent are treated at non-verified burn centers.

Burn care teams

Burn care is dependent on an integrated, multidisciplinary team of highly trained health care professionals working together in both the acute inpatient and long-term outpatient settings (see Figure 2, page 36). Burn care can be highly complex, necessitating the participation of a variety of professionals who are familiar with the unique needs of burn patients. Surgical care is just one part of the overall treatment of a burn patient; physical and occupational therapy, nutrition, pain control, and aftercare are also key components of the long-term recovery of these patients.

Looming shortage of burn surgeons

Burn surgeons seem to be in short supply. The results of a survey of burn centers conducted by Faucher and colleagues, published in 2004, showed that the majority of burn centers needed, or will need, a burn surgeon in the next five years. This same survey showed that of the 152 burn surgeons trained in the preceding 10 years, only 40 percent of those were currently practicing at the time of the survey, demonstrating a noticeable attrition of recent burn surgeon trainees. A follow-up survey, published in 2011, showed improvement in attrition...
American Burn Association referral criteria to a burn center

A burn center may treat adults, children, or both.

Burn injuries that should be referred to a burn center include the following:

1. Partial thickness burns greater than 10% total body surface area (TBSA)
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints
3. Third degree burns in any age group
4. Electrical burns, including lightning injury
5. Chemical burns
6. Inhalation injury
7. Burn injuries in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality
8. Any patients with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of mortality and morbidity
9. Burned children in hospitals without qualified personnel or equipment for the care of children
10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention

Severity determination:

First degree (partial thickness)
Superficial, red, and sometimes painful

Second degree (Partial thickness)
Skin may be red, blistered, swollen. Very painful.

Third degree (full thickness)
Whitish, charred or translucent, no pin prick sensation in burned area.

Percentage TBSA:

rates, but also a marked decrease in the total number of new burn surgeon trainees over the past 10 years (152 in 2004 versus 21 new surgeons in 2011, as reported by surveyed burn centers). 14

The training pathways for burn surgery vary. As such, total training time for a burn surgeon varies too, ranging from seven to 11 years. The American Board of Medical Specialties (ABMS) does not have a burn surgeon certification, so surgeons with certain training and practice may designate themselves as burn surgeons. Burn surgeons may have completed an ABMS general surgery (five years) or plastic surgery residency (five +/- three years). Today, most surgeons who choose to pursue burn surgery will do a one-year non-Accreditation for Graduate Medical Education (ACGME)-accredited burn fellowship in addition to an ACGME-accredited, surgical critical care fellowship. Many surgeons also will have spent some time doing research in addition to their clinical training. However, some trauma and plastic surgeons did no additional burn-specific training, but may perform burn surgery as part of their practice.

Burn admissions remain constant

Although the incidence of burns has decreased over the years, the number of burn admissions has remained relatively constant over time, with nearly 50 percent of all burn injuries occurring in the
southeastern U.S., where there have been several burn center closings in recent years.\textsuperscript{15,16} In addition to a steady number of burn admissions, burn centers also provide care for patients with extensive skin conditions, disorders, and infections, many of whom are critically ill. Studies have shown that patients with exfoliative skin disorders, such as toxic epidermal necrolysis, have better outcomes and decreased mortality when cared for in burn centers versus general hospitals.\textsuperscript{17}

\textbf{Policy implications}
Fewer burn care centers and potentially fewer burn care surgeons, compounded by the need to reduce health care spending, make ensuring appropriate burn care an increasingly difficult task. More rigorous workforce analysis is needed to predict the current and future number of burn surgeons and the implications for access to care. More research also is needed on the cost and quality of patient care in verified versus non-verified burn centers and the possible implications the regionalization of U.S. burn centers may have for access to burn care. As the trauma model has evolved, studies have shown the regionalized system improved patient access and care quality and lowered costs.\textsuperscript{18,19} Understanding the number and geographic distribution of burn centers is a first step toward determining whether regionalizing burn care might promote similar benefits.

\textbf{References}


The number of Americans who abuse prescription medication is reaching epidemic proportions. Appropriate treatment for chronic pain, therapeutic opioid use and abuse, and the nonmedical use of prescription drugs have been topics of intense focus and debate, garnering attention from the Centers for Disease Control and Prevention, the White House, the U.S. Drug Enforcement Administration, and the National Conference of State Legislatures, among other stakeholders. According to the American Society of Interventional Pain Physicians (ASIPP), Americans—who comprise only 4.6 percent of the world’s population—have been consuming 80 percent of the global opioid supply, and 99 percent of the global hydrocodone supply.*

In the U.S., retail sales of commonly used opioid medications have increased 149 percent in 10 years. Policymakers at the state level are recognizing the problem prescription drug abuse has become and are attempting to battle the problem through legislation and regulation.

Legislative efforts

Prescription drug abusers obtain drugs from a variety of sources, but according to ASIPP, 18 percent of the people who use pain relievers for nonmedical reasons report they got their drug from one physician. Federal agencies maintain that many drugs enter the illegal market primarily through “doctor shoppers.” These are people who take advantage of inappropriate prescribing practices by physicians and improper dispensing by pharmacists.*

In an effort to stop drug abusers from doctor shopping, states have implemented prescription monitoring programs (PMPs) to regulate pill mills at the state level. PMPs collect statewide data regarding prescription drugs and track their flow. These programs have three components:

1. Data collection for prescriptions that shows the physicians who wrote them and the pharmacies that dispensed them (pharmacies are required by law to report the data, and physicians are encouraged to report this information, but are not required to do so)
2. A central repository for this data
3. A protocol describing how authorities and agencies can access the data in the central repository

A total of 38 states have implemented PMPs, but there are significant differences in the manner and frequency in which the data is collected from state to state.

Some states such as Texas and Louisiana are tackling the issue of pill mills with more stringent regulation. In 2005, Louisiana passed the Pain Management Clinic Law, which regulates facilities that primarily dispense prescription drugs to treat pain. The law mandates that only physicians may own and operate a pain management clinic, and it makes it unlawful for a health care professional to assist anyone in obtaining controlled substances through misrepresentation. A violation of the law brings up to five years in prison or a fine up to $50,000.

Texas’ pill mill law went into effect in September 2010 and makes it illegal to own or operate a pain clinic without certification from the Texas Medical Board. Additionally, owners and employees of pain clinics must go through a background check before working at a pain clinic.

Some local jurisdictions in states that have not passed pill mill laws have passed ordinances restricting pill mills. For instance, the Polk County Board of Commissioners in Georgia requires licensing, application, and registration fees, and clinics must provide information on the staff to the county for background checks.

The 2011 legislative session brought about two victories in pill mill legislation. Legislators in Flori-
da tackled the issue of pill mills after realizing more than 9 million oxycodone tablets were prescribed to Floridians in just six months.† Gov. Rick Scott (R) signed into law H. 7095, which establishes standards of care for physicians who prescribe narcotic-grade pills, requires them to register with the Florida Department of Health, and increases penalties against physicians who overprescribe to a minimum $10,000 fine and six-month license suspension. The new law also bans physicians from on-site dispensing of the most abused pills, such as oxycodone and hydrocodone.

According to the Ohio Department of Health, in 2007 and 2008 there were more deaths in Ohio due to unintentional drug overdoses than to motor vehicle crashes, and four Ohioans a day were dying from prescription drug abuse.‡ In 2011 the Ohio legislature passed pill mill legislation (H. 93) to combat the prescription drug abuse epidemic.‡ The bill was sponsored by the only two health care professionals serving in the Ohio General Assembly, Reps. Terry Johnson, DO (R-Portsmouth), and Dave Burke, MD (R-Marysville). The new law requires licensure of pain management clinics, authorizes the state medical board to establish rules as to when a physician should review the Ohio Automated Rx Reporting database, severely restricts in-office dispensing of controlled substances, and establishes a Medicaid pharmacy lock-in program and prescription drug take-back program.

A number of other states have introduced legislation attempting to stymie pill mills, but no other states have had the legislative success of Florida and Ohio. (New Hampshire, New York, Pennsylvania, and West Virginia introduced various bills related to the regulation of pain clinics.) It is expected that states will continue to address pain clinic regulation through legislative avenues, introducing bills that include drug reporting programs, licensure and supervision requirements, and memorandums on pain management clinics.

With prescription opioid drug abuse continuing to rise more than 400 percent in 10 years, many states need to act now to protect their patients and physicians.§ For additional information on pain management legislation, or to discuss pill mill initiatives being considered in a state legislature, contact Alexis Macias at amacias@facs.org.


Patricia J. Numann, MD, FACS, installed as 92nd President of the ACS

Patricia J. Numann, MD, FACS, a general surgeon from Syracuse, NY, was installed as the 92nd President of the American College of Surgeons (ACS) during Convocation ceremonies that preceded the official opening of the College’s 2011 Annual Clinical Congress in San Francisco, CA. Dr. Numann is the Lloyd S. Rogers Professor of Surgery Emeritus, Distinguished Service Professor, and Distinguished Teaching Professor Emeritus at the State University of New York (SUNY) Upstate Medical University, Syracuse.


Dr. Numann also served professional surgical appointments as attending surgeon at SUNY Upstate Medical University (1989–2007), staff surgeon at Veterans Affairs Hospital (1970–2007), and as consulting surgeon at Crouse-Irving Memorial Hospital (1970–2006), all located in Syracuse. Dr. Numann is board certified by the American Board of Surgery (1971, recertified 1994).

Throughout her surgical career, Dr. Numann’s clinical and scientific interests have focused on breast disease and thyroid and parathyroid disease, a commitment reflected in the naming of the Patricia J. Numann Breast & Endocrine Surgery Center at SUNY Upstate in 2007. Moreover, she received grants and served as principal investigator or co-investigator of several studies researching various aspects of breast and endocrine disease.

Dr. Numann has also served as an author or co-author of several chapters in surgical text books as well as numerous journal articles and abstracts, many of which focus on breast and parathyroid disease. Additionally, she has served on the editorial boards of several prestigious medical and surgical journals including the World Journal of Surgery, the Journal of Surgical Research, the Journal of the American College of Surgeons, Archives of Surgery, and the American Journal of Surgery.

Known as an outstanding and motivating educator, Dr. Numann received the Distinguished Teacher Award (1983) and President’s Award for Excellence in Teaching (1990) from SUNY, where the graduating medical students have regularly asked her to serve as faculty marshal or to deliver the Oath of Hippocrates during commencement.

Dr. Numann became a Fellow of the American College of Surgeons in 1974, and she has actively contributed to the work of the College for many years. Since 2003, she has been Director of the ACS Fundamentals of Surgery Curriculum and concurrently serves as Director of the ACS Fundamentals of Surgery Curriculum.

Previously, Dr. Numann was a member of the Board of Regents’ Communications Committee (1999–2000), Graduate Medical Education Committee (1992–1994), Committee on Surgical Education in Medical Schools (1986–1996), Advisory Council
for General Surgery (1999–2002), and member (1992–1994) and Chair (1994–1995) of the Nominating Committee of Fellows. She served on the ACS Surgical Education and Self-Assessment Program (SESAP™) Committee beginning with SESAP 3 (1976) and served as a committee co-chair.

Dr. Numann next served as the College’s Second Vice-President from 1999 to 2000. In 2006, the ACS recognized Dr. Numann for her invaluable service contributions by naming her the recipient of its Distinguished Service Award, the College’s highest honor.

In addition to membership in—and service to—the ACS, Dr. Numann has been an active leader and member of several national surgical and medical organizations. She was the first woman to serve as chair of the esteemed American Board of Surgery (1994–2002), and was vice-president of the American Association of Endocrine Surgeons (1992). Dr. Numann was one of the founding members and president of the Association for Surgical Education (1985–1986), and she founded the Association of Women Surgeons in 1982, and later served as its president (1986–1987).

Throughout her remarkable career, Dr. Numann has received numerous honors and awards at the local, state, and national levels, including the New York State Woman of Distinction in Medicine Award (1994), the Nina Starr Braunwald Award of the Association of Women Surgeons (1998), and the Susan G. Komen Breast Cancer Foundation Distinguished Service Award (2001). The Carol M. Baldwin Breast Cancer Research Fund of Central New York named her Humanitarian of the Year in 2003. Dr. Numann next was inducted into the International Women Physicians’ Hall of Fame and named “Local Legend” in the National Library of Medicine’s “Changing Faces of Medicine” exhibit (2004). Earlier this year, she was awarded the prize of the International Society of Surgery/Société Internationale de Chirurgie—its highest honor.

When Dr. Numann retired from active clinical practice and as Lloyd S. Rogers Professor of Surgery in 2007, she was awarded emeritus status by SUNY. In 2009, it was announced that “in honor of her life’s work and outstanding dedication,” SUNY Upstate was creating its first endowed chair for a woman: the Patricia J. Numann, MD, Chair of Surgery.

Dr. Numann resides in Syracuse, where she continues to devote herself to many teaching and community service organizations, including the boards of the Everson Museum of Art, The Community Health Foundation of Western and Central New York, Vera House, and Hospice of Central New York.
Honorary ACS Fellowship awarded to six prominent surgeons

Honorary Fellowship in the American College of Surgeons (ACS) was awarded to six prominent international surgeons during the October 22 Convocation ceremonies that preceded the official opening of the 97th Annual Clinical Congress in San Francisco, CA. The granting of Honorary Fellowship is one of the highlights of the Clinical Congress. The surgeons who were accorded this honor practice in South Africa, England, Ireland, Italy, The Netherlands, and the People’s Republic of China and are as follows:

Kenneth D. Boffard, MB, BCh, FACS, FRCS, of Johannesburg, South Africa, is a renowned surgeon and leader in trauma and critical care and has been instrumental in bringing trauma care training to resource-poor countries. He is currently a professor and the head of the department of surgery at Johannesburg Hospital and at the University of Witwatersrand in Johannesburg.

Ara Darzi, MB, BCh, FACS, FRCS, of Denham, Buckinghamshire, England, is a surgical oncologist, the Paul Hamlyn Chair of Surgery, and chairman of the Institute of Global Health Innovation at the Imperial College of London, as well as chair of surgery at the Institute of Cancer Research in London. He previously served as Parliamentary Undersecretary of State at the Department of Health in the U.K.

Eilis McGovern, MD, DCh, FRCSI, of Dublin, Ireland, is the current president of the Royal College of Surgeons in Ireland—the first woman to hold that position in the organization’s 227-year history. She led a successful effort to reduce waiting times for elective cardiac surgery and a program to reorganize acute hospital services and improve patient safety in Ireland. She continues to teach at the Royal College of Surgeons Medical School.

Alberto Montori, MD, FACS, of Rome, Italy, is Emeritus Professor of Surgery and former chair of the department of surgery at the Università di Roma. He has a reputation as a trailblazer in innovative surgical technology for his efforts to decrease postoperative pain and recovery times and led a successful effort to develop an exchange program for Italian and American surgeons.

Cornelis J.H. van de Velde, MD, PhD, FRCS, of Leiden, the Netherlands, is head of the department of surgical oncology, gastrointestinal surgery, and health and neck/endocrine surgery at Leiden University Medical Center. He is also president of the European Cancer Organization and has attained international acclaim for initiating clinical trials in malignant disease.

Yupei Zhao, MD, FACS, of Beijing, China, is vice-president of the Chinese Medical Association and president of the Chinese Society of Surgery. He also is president of Peking Union Medical College Hospital and is the dean of that institution’s School of Clinical Medicine. He is a renowned pancreatic surgeon and scientist.

Presenting on behalf of the College were: Anthony A. Meyer, MD, FACS; Andrew L. Warshaw, MD, FACS; Hilary Sanfey, MD, FACS; Carlos A. Pellegrini, MD, FACS, FRCSI(Hon); John K. MacFarlane, MD, FACS; and LaMar S. McGinnis, Jr., MD, FACS.

Sir Rickman Godlee, President of the Royal College of Surgeons of England, was awarded the first Honorary Fellowship in the College during the ACS’ first Convocation in 1913. Since then, 430 internationally prominent surgeons, including the six chosen this year, have been named Honorary Fellows of the American College of Surgeons.

Following are the citations presented during the Convocation.
Mr. President, it is a distinct honor to present to you Prof. Kenneth D. Boffard of Johannesburg, South Africa, for Honorary Fellowship in the American College of Surgeons (ACS). Professor Boffard is an internationally recognized leader in trauma and critical care. He is head of the department of surgery at Johannesburg Hospital and the University of Witwatersrand in Johannesburg.

Professor Boffard was born in Johannesburg in 1949. He received his medical degree from the University of Witwatersrand, Johannesburg, in 1972, and did his surgical training at several institutions including Johannesburg General Hospital, and three institutions in England, including the Birmingham Accident Hospital, the Great Ormond Street Hospital for Children, and Guy’s Hospital, with Professor the Lord McColl of Dulwich, where Professor Boffard also served as lecturer. For two of his years at Guy’s Hospital, Professor Boffard did research into the dynamics of fat metabolism following surgical thoracotomy.

In 1984, Professor Boffard returned to South Africa, where he rapidly progressed in his career, becoming chief of the Johannesburg Hospital Trauma Unit in 1985, associate professor in 1999, and professor and chair of surgery in 2001.

Professor Boffard is a fellow of the Royal College of Surgeons of Edinburgh, the Royal College of Surgeons of England, the Royal College of Surgeons of Glasgow, the College of Surgeons of South Africa, and the ACS. He holds honorary fellowships in the Association of Surgeons of Great Britain and Ireland, the Royal College of Surgeons of Thailand, and the College of Surgeons of Sri Lanka.

Professor Boffard is an accomplished pilot of both fixed- and rotary-wing aircraft. He is an honorary Colonel in the South African National Defense Force and also has an honors degree (cum laude) in aerospace medicine from the University of Pretoria, South Africa.

Professor Boffard has given invited lectures throughout the world, including in the U.S, Europe, Asia, Australasia, and Africa. His published work demonstrates his expertise in all aspects of trauma care, including blood coagulation, trauma prevention, pre-hospital care and transport, acute management, rehabilitation, and trauma system improvement. He is a global leader in the care of the injured, and has done considerable work in the fields of hemostasis, artificial clotting factors, and hemoglobin oxygen carriers.

Professor Boffard has held many leadership positions in academic organizations and serves on the Councils of the College of Surgeons of South Africa, the medical board of the Health Professions Council of South Africa, and the Association of Surgeons of South Africa. He was president of the Trauma Society of South Africa, chair of the ACS Advanced Trauma Life Support® program in South Africa, and is a previous Governor-at-Large of the ACS for South Africa. As chairman of the International Association for Trauma Surgery and Intensive Care (IATSIC), Professor Boffard developed the National Trauma Management Program for trauma training in resource-challenged countries, which so far has trained more than 6,000 physicians in India, 1,000 in Sri Lanka, and 1,000 in African countries. He was also instrumental in developing the Definitive Surgical Trauma Care Course, which is the world’s most advanced open trauma course, and the model on which the American College of Surgeons’ Advanced Trauma Operative Management® course is based. To date, 5,000 surgeons in 25 countries have been trained through this course. Professor Boffard has just completed a two-year term as president of the International Society of Surgery, which is based in Switzerland and is the world’s oldest international surgical organization.

Professor Boffard is a gracious,
welcoming man who has helped many trainees and young faculty develop their careers. He has developed a strong program to encourage women in surgery and is very pleased that 50 percent of his surgical residents are female. In conjunction with his efforts to encourage women to consider surgery as a career, Professor Boffard developed one of the first part-time training programs for surgeons. He is dedicated not only to his own patients, but also seeks to improve the care of all patients throughout the world. He is a role model for all young surgeons, especially those aspiring to be “globalists.”

Professor Boffard is equally dedicated to his family—his wife, Vee Boffard, MD, who is a general practitioner with a special interest in physical rehabilitation, and their son and daughter. He and his family enjoy the many wonders of South Africa and are proud to have been part of the democratic change since 1994 in their country.

Mr. President, Professor Boffard has made great contributions to the care of the ill and injured in South Africa and the world through his patient care, research, teaching, and leadership. I am honored to present Prof. Kenneth D. Boffard for Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Ara Darzi

by Andrew L. Warshaw, MD, FACS

Mr. President, it is my distinct privilege to present to you Professor the Lord Ara Darzi of Denham, Buckinghamshire, England, for Honorary Fellowship in the American College of Surgeons. A graduate of the Royal College of Surgeons in Ireland and Trinity College, Dublin, Lord Darzi is a surgical oncologist who is currently the Paul Hamlyn Chair of Surgery and the chairman of the Institute of Global Health Innovation at the Imperial College in London. He also is chair of surgery at the Institute of Cancer Research. Professor Darzi has been a world leader in the development of minimally invasive technologies for surgery and the use of surgical robots, virtual reality imaging, and image-guided surgery, as well as their application to teaching and measuring core surgical competencies. This work has received international recognition, including the Hamdan Award for Medical Research Excellence.

Professor Darzi first introduced laparoscopic surgery to the UK, and then described the first laparoscopic colorectal resection in 1992. He performed the first natural orifice transluminal endoscopic surgery (NOTES) cholecystectomy in the UK in 2010, and is leading the clinical trial of NOTES in the UK. His invention of gaze-contingent robotic control introduced a novel technique for manipulating an articulated robotic device through the eyes of a surgeon doing minimally invasive surgery as part of the perceptual docking framework. His invention of the “smart” Bougie endoflip—a sensor-enabled surgical dilator—won the 2006 Idea to Product European and Global competitions. Professor Darzi holds six patents for these and other inventions. He is the author of more than 600 peer-reviewed publications, and author or editor of 10 books.

Professor Darzi pioneered virtual reality simulators for advanced surgical training in the UK, allowing for training in a safe nonpatient environment. The tools used for this approach to learning include synthetic models, virtual reality simulation, motion analysis, and a virtual operating suite. He developed the majority of these instruments in-house, and they are now in use worldwide. This research alone has led to more than 100 peer-reviewed publications, extensive grant funding, and collaboration with centers of surgical
education across the globe. The training curricula that Professor Darzi developed have been shown to reduce learning errors and to improve team communication, decision making, and professionalism. Building on this work, Professor Darzi created and leads the Imperial Center for Patient Safety and Service Quality. In 2001 his group was awarded the Queen’s Anniversary Prize for Excellence in Higher and Further Education in recognition for achievements in pioneering new technologies to address training requirements.

Professor Darzi was knighted for his services in medicine and surgery in 2002. In 2007, he was introduced to the UK’s House of Lords as Professor the Lord Darzi of Denham and appointed Parliamentary Undersecretary of State at the Department of Health. In that role, his major review of the national health system led to the seminal report titled High Quality Care for All. As a government minister, Professor Darzi was responsible for shepherding the passage of health-related legislation through the House of Lords. He was instrumental in ensuring that a bill entitled Human Fertilization and Embryology—an act heralding new frontiers for biomedical scientific research—made it into the statute book.

Mr. President, Professor the Lord Darzi of Denham is a unique, innovative surgeon, educator, champion of safety in surgery, and health care leader in his country. He is most worthy of Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Eilis McGovern

by Hilary Sanfey, MD, FACS

Mr. President, it is my distinct honor to present to you Prof. Eilis McGovern of Dublin, Ireland, for Honorary Fellowship in the American College of Surgeons. Professor McGovern is the current president of the Royal College of Surgeons in Ireland. Not only is she the first woman to fill that prestigious post in the 227-year existence of the organization, but she is also the first woman to become president of any of the four Royal Colleges (Ireland, Edinburgh, Glasgow, and England) in their collective 1,000-year history. While this historic achievement is, by itself, worthy of recognition, it is the culmination of a remarkable career of accomplishments as a surgeon, a leader, an educator, and a mother that is also notable.

Professor McGovern graduated from University College Dublin Medical School in 1978, winning both the gold medal in surgery and the silver medal in medicine. She obtained a diploma in child health the following year. In 1985, she traveled on a Council of Europe fellowship to study with Prof. Alain Carpentier in Paris and later undertook a cardiothoracic fellowship at the Mayo Clinic. Professor McGovern was appointed as a consultant cardiothoracic surgeon in 1987, and shortly thereafter not only created a new cardiac surgery unit at St. James Hospital in Dublin, but also led the project to expand cardiac services in Ireland at a time when the waiting lists were so long that only emergency in-house patients received cardiac surgery. Within two years under her leadership, the national waiting list for elective cardiac surgery had diminished from a length of several years to more acceptable limits. This unit has been frequently cited by health ministers as an example of best practice. For this outstanding work, Professor McGovern was awarded a personal chair by Trinity College, Dublin.

Professor McGovern also recognized the importance of expanding the role nursing plays in the care of patients. Under her leadership, Professor McGovern’s department was the first in the country to have advanced nurse practitioners on the clinical team. In 2006, she was appointed by the Health Service Executive as project director to reconfigure acute hospital ser-
vices and improve patient safety for the North Eastern Health Board. The model she developed has since been introduced in two other health board areas across the country.

In the field of undergraduate medicine, Professor McGovern chaired the medical faculty board of the Royal College of Surgeons medical school from 2001 to 2006. She is actively involved in medical student teaching, and she is a past member of the Intercollegiate Board for Cardiothoracic Surgery. Professor McGovern currently sits on the National Medical Education Training and Research Committee and is a past chair of the Irish Postgraduate Medical and Dental Board. Under her leadership, this board produced two important reports: The first was titled Recommendations for Flexible Training in Ireland, and the second report was titled Recommendations and Principles for the Funding of Postgraduate Medical and Dental Training in Ireland. Professor McGovern has also produced national recommendations for improving maternity and neurological services, as well as guidelines for the use of blood products.

During her almost 20 years on the Council of the Royal College of Surgeons in Ireland, Professor McGovern has chaired the faculty governing body of the schools of medicine, pharmacy, physiotherapy, and nursing. Under her leadership, this board produced two important reports: The first was titled Recommendations for Flexible Training in Ireland, and the second report was titled Recommendations and Principles for the Funding of Postgraduate Medical and Dental Training in Ireland. Professor McGovern has also produced national recommendations for improving maternity and neurological services, as well as guidelines for the use of blood products.

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Mr. President, it is with great pleasure that I present Prof. Eilis McGovern, President of the Royal College of Surgeons of Ireland, for Honorary Fellowship in the American College of Surgeons.

Mr. President, it is with great pleasure that I introduce Prof. Alberto Montori for Honorary Fellowship in the American College of Surgeons (ACS). Professor Montori is emeritus professor of surgery and former chair of the department of surgery at the University of Roma, also known as Sapienza-Università di Roma or La Sapienza. In Italian, “sapienza” means “wisdom” or “knowledge.”

Alberto Montori was born in the center of Italy, the region of Marche located on the Adriatic side of the country. Ascoli Piceno is an exceptionally beautiful medieval town with many Roman architectural sites and is famous for good wine and Mediterranean cuisine.

Professor Montori received his doctor of medicine degree from the University of Perugia in February 1960, the same year he finished his military service and the year he met his wife Pauline, his lifelong companion. Professor Montori then completed his internship and residency in general surgery at the Universities of Padua and Rome.

His professional life has been characterized by a keen interest

Professor McGovern has served as a compassionate clinical surgeon, a master educator, and an inspirational role model for all surgeons for almost three decades, demonstrating her ability to pursue a successful career in a male-dominated profession while maintaining life balance as a mother to Emma and Sophie, both of whom are studying medicine, and as spouse to Joseph Duignan, MD, also a surgeon, in an era when the ability to do so was unheard of for women physicians in general, let alone women surgeons. I have been proud to call her a friend from our days in training, and I cannot think of a more worthy recipient of this recognition.

Mr. President, it is with great pleasure that I present Prof. Eilis McGovern, President of the Royal College of Surgeons of Ireland, for Honorary Fellowship in the American College of Surgeons.
in reducing the trauma of traditional operations, decreasing pain, and hastening the recovery of patients. This interest led Professor Montori to adopt endoscopic techniques from the very start of his career when only rigid endoscopes were used. He used flexible endoscopes when they became available, and then later he adopted minimally invasive approaches. Changes such as these were a departure from tradition, and brought criticism from the established surgical community. Yet, the capacity to adapt and the benefits provided by these new advances also brought fame to our guest. Thus, Professor Montori’s name became synonymous with innovation, and his department became known for its ability to change and adapt to new techniques and technologies. One such innovation was the creation of a postgraduate course titled Digestive Surgery and Therapeutic Endoscopic Surgery—the first course of its kind on surgical endoscopy to be included in a surgical program in Italy. The course continues to be offered today.

Being identified as a place of innovation and change, his department attracted the best and brightest students from his country and abroad. This successful experience led Professor Montori to create an exchange program for young surgeons between La Sapienza and Thomas Jefferson University, Philadelphia, PA, that lasted for many years. Professor Montori was recognized with the dean’s medal at both Thomas Jefferson University and his own Università “La Sapienza” for his exceptional achievements in conceiving, promoting, and implementing worldwide academic relationships.

With the thought of further promulgating the use of minimally invasive surgery to other areas around the world that have less access to resources, Professor Montori developed and directed humanitarian programs in Pakistan, India, Afghanistan, and North and South Africa.

Professor Montori has served the ACS in many capacities: as the leader of the College’s Italian Chapter, as Governor-at-Large for Italy, and as an innovator who introduced the Advanced Trauma Life Support® (ATLS®) program in Italy, and as an innovator who conducted a memorable ACS scientific meeting in Ascoli Piceno (the town of his birth)—attended by surgeons from both sides of the Atlantic.

A member of several editorial boards, a prolific author, and a leader of many endoscopic and minimally invasive surgery professional groups in Europe, Professor Montori has been the recipient of many honors during his professional life, including the Vesalius Award in recognition for his service to the European Academy of Surgical Sciences, and honorary fellowship in the Society of American Gastrointestinal Endoscopic Surgeons.

Mr. President, it is with great pride that I present to you Prof. Alberto Montori, a surgeon whose work has led to improvements in the care of patients and in the education of surgeons in Italy and beyond, for Honorary Fellowship in the American College of Surgeons.

Citation for Prof. Cornelis J.H. van de Velde

by John K. MacFarlane, MD, FACS

Mr. President, it is a distinct honor for me to present to you Prof. Cornelis van de Velde of Leiden, the Netherlands, for Honorary Fellowship in the American College of Surgeons. Professor Van de Velde is an internationally acclaimed initiator of clinical trials in malignant disease that have increased the profession’s knowledge in the surgical therapy of cancer of the stomach, breast, colon, and rectum.

Born in the Netherlands, Professor van de Velde completed his medical studies at the University of Leiden in 1975. His surgical training occurred in Holland followed by a fellowship in 1980 at the University of Texas MD Anderson Cancer Center, in Houston. Professor van de Velde returned to Leiden as associate professor of surgery, rising quickly to become clinical professor of surgery and chairman of the department of surgical oncology in 1988. He is presently head of the department of surgical oncol-
ogy, gastrointestinal surgery, and head and neck/endocrine surgery at Leiden University Medical Center, a position he has held since 1999.

Professor van de Velde has traveled extensively, and at present is the president of the European Cancer Organization. His major clinical interests include breast, colorectal, gastric, and endocrine tumors, and he serves on multiple editorial boards of Asian and European oncology journals. Professor van de Velde has published widely, and his bibliography boasts more than 600 peer-reviewed publications.

Among his many honors and awards, he was appointed as a member of the Royal Academy of Sciences of the Netherlands in 2000, and he has Honorary Fellowship in the Royal Colleges of Surgeons of London and Glasgow. Professor van de Velde has served many European oncologic groups either as president, a board member, or chairman, attesting to the high esteem in which he is held throughout the world of surgical oncology. His organizational skills are legendary and were nowhere better demonstrated than in the seminal Dutch Total Mesorectal Excision Rectal Cancer Trial, in which each of the participating surgeons and pathologists throughout Holland were individually proctored and certified before participating in the trial.

A consummate academic surgeon, Professor van de Velde has somehow found time to supervise more than 50 PhD theses in the department of surgery at Leiden—all the while carrying out his other teaching and administrative duties, not to mention his clinical responsibilities.

I first met Professor van de Velde in Oslo, Norway, at a rectal cancer symposium in 1995. This meeting brought together experts from all over the world to help define the state-of-the-art treatment of rectal cancer, to reach a consensus on the optimal surgical procedure, and to formulate international standards for documentation and reporting of cases. I was impressed with his depth of knowledge and passion for work. Professor van de Velde took up the challenge and subjected it to a rigorous clinical trial, which has helped to define the gold standard of therapy for rectal cancer. Since then, we have become close friends, and our families have vacationed together on the hills of Whistler Mountain in British Columbia, Canada, on several occasions. He skis like he works—swiftly and furiously.

It, therefore, gives me great pleasure to present my friend and colleague Prof. Cornelis van de Velde, a man for all seasons, for Honorary Fellowship in the American College of Surgeons in recognition of a career of immense service to international surgical oncology.

Citation for Prof. Yupei Zhao

by LaMar S. McGinnis, Jr., MD, FACS

Mr. President, it is my privilege and distinct honor to present Prof. Yupei Zhao of Beijing, The People’s Republic of China, for Honorary Fellowship in the American College of Surgeons. In one of the largest and the most populous countries in the world, there are many active, productive, and skilled surgeons. Among the 7 million health care professionals in the more than 30,000 hospitals serving China’s 1.4 billion citizens (20 percent of the world’s population), there are 1 million surgical care providers. In this group, there are only a few distinctive leaders. Professor Zhao is one of them.

Allow me to enumerate some of Professor Zhao’s distinct record of service. The largest and the oldest medical association in China is the Chinese Medical
Association, founded in 1915. This association encompasses 84 national specialty societies, has 430,000 members, and publishes 113 specialty medical journals. Professor Zhao is the current vice-president of this association. The Chinese Society of Surgery is one of 84 national specialty societies and is the largest and the oldest surgical society in China. Professor Zhao is serving his second consecutive four-year term as president, the first surgeon to be so honored. Additionally, Professor Zhao is president of the renowned Peking Union Medical College Hospital (PUMCH), established in 1929 by the Rockefeller Institute and viewed by many as mainland China’s best hospital. In addition, he is dean of the Peking Union Medical College’s School of Clinical Medicine. Professor Zhao is also vice-president of the Chinese Academy of Medicine, China’s highest medical academy, and he is a board member of the Chinese Hospital Association.

Professor Zhao is also active in other countries. He serves as immediate past-president of the Asian Surgical Association and is an Honorary Fellow of the Royal College of Surgeons of England, the International College of Surgeons, the College of Surgeons of Hong Kong, and the American College of Physician Executives. He is a Fellow of the American College of Surgeons and is the Governor-at-Large representing China-Hong Kong.

Professor Zhao’s editorial contributions have been expansive. He has served as chief editor of the *Annals of Surgery* (Chinese edition), the *British Journal of Surgery* (Chinese edition), and the *Chinese Journal of Surgery*. He also has provided editorial service for eight other scientific journals and has published 350 peer-reviewed papers.

A general surgeon, Professor Zhao has focused on pancreatic surgery and is a renowned clinical surgeon and scientist, having performed 3,000 pancreatic procedures, including 1,200 Whipple procedures and 480 insulinoma resections.

He also has trained 40 post-graduate fellows. He is the director of the PUMCH General Surgery Specialist Training Center of the Royal College of Surgeons of Edinburgh, and he has been the principal investigator for 12 major research grants.

This surgical leader has devoted himself to the improvement of surgical education and to the improvement of the quality of surgical care in China. He has been instrumental in the development of surgical guidelines and in their adoption and implementation. In fact, Professor Zhao will host the largest general surgery congress in China this year with more than 10,000 surgeons participating.

Professor Zhao is a warm, personable, likable individual with a strong persuasive ability who has been a major force in formulating governmental health policy. Being located in China’s capital city, he is sought out as the surgical consultant for China’s political leaders. Professor Zhao’s influence in this regard is best exemplified by the recently completed 300-bed hospital at PUMCH devoted to the care of those leaders.

This remarkably influential clinician, researcher, educator, administrator, and thoughtful leader also is devoted to his equally busy wife, a vice-president of a large Chinese company, and to his daughter, the program host for a famous Chinese television company. Amazingly, despite the demands of all of his professional responsibilities, Professor Zhao still finds time for his hobbies, which include Chinese writing, music, and opera, and playing both golf and tennis.

Mr. President, this surgeon embodies all of the attributes desired in our Honorary Fellows. It is now my honor to present Prof. Yupei Zhao for Honorary Fellowship in the American College of Surgeons.
Oral presentations

- Surgical Forum*
  Program Coordinator: Kathryn L. Matousek, 312-202-5336, kmatousek@facs.org
  (15 Excellence in Research Awards were given in 2011)

  Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)

- Scientific Papers*
  Program Coordinator: Kay Anthony, 312-202-5325, kanthony@facs.org

Poster presentations

- Scientific Exhibits (Posters)
  Program Coordinator: Carla Manosalvas, 312-202-5385, emanosalvas@facs.org

Video presentations

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

Submission information

- Abstracts are to be submitted online only.
- Submission period begins after November 1, 2011.
- Deadline: 5:00 pm (CST), March 1, 2012.
- Late submissions are not permitted.
- Abstract specifications and requirements for each individual program will be posted on the ACS website at www.facs.org/education/.
  Review the information carefully prior to submission.
- Duplicate submissions (submitting the same abstract to more than one program) are not allowed.

*Accepted authors are encouraged to submit full manuscripts to JACS.
A surgeon’s ability to protect his or her patients goes beyond the operating room. Every day, lawmakers on Capitol Hill make policy decisions that affect surgical practice. However, many members of Congress often lose sight of how these policy decisions directly affect the care that patients—their constituents—receive. Surgeons, though, know firsthand how potential federal legislation—including Medicare physician payment, liability reform, and surgical workforce issues—will affect surgeons and patients in their state and district; therefore, it is crucial that surgeons share their experiences in order to influence legislators in Washington, DC.

To these ends, the American College of Surgeons (ACS) will hold its first annual Advocacy Summit, March 26–27, 2012, in Washington, DC, immediately following the ACS Leadership Conference. The summit, which will replace the former Joint Surgical Advocacy Conference (JSAC), will give Fellows the opportunity to join hundreds of their colleagues, from across the country and across specialties, in attending advocacy training programs and comprehensive issue briefings. Participants will also be able to meet with their federal legislators, with the ultimate goal of preparing them to become long-term surgeon advocates.

The summit is designed to accommodate the needs of surgeons with varying levels of advocacy experience. Resident and beginner advocacy training will provide participants with an understanding of the complexities of Congress and the legislative process, what to expect in congressional meetings, and the do’s and don’ts of lobbying. For seasoned advocates, an advanced session will include a deeper look at persuasive communications techniques to use when attempting to influence legislators, provide an inside look at the political environment, and offer a framework for mentoring less experienced advocates at home. Because advocacy is an ongoing endeavor and not something that is accomplished in one day, both beginner and advanced advocates will also be armed with the skills needed to continue their advocacy efforts at home.

Summit participants will have the opportunity to hear from members of Congress and to attend an intensive briefing on pertinent issues under consideration on Capitol Hill. These sessions will enable surgeons to have informed discussions with their senators, representatives, or their health policy staff during the second, and most important, day of the summit.

Apart from legislative training, the summit will include a reception with entertainment, as well as a political event hosted by the American College of Surgeons Professional Association (ACSPA)-SurgeonsPAC (political action committee) Board of Directors to benefit the ACSPA-SurgeonsPAC.

Surgeons are not only experts on the real-world impact of health care policy in their legislators’ states and districts, but they also treat and employ constituent voters. As such, legislators want to hear from surgeons.

In order to fully participate in the Capitol Hill meetings and to successfully educate and influence their legislators, surgeons are advised to remain in Washington until 3:00 pm, Tuesday, March 27, in order to fully participate in the Capitol Hill meetings. Effective advocacy requires a sacrifice of time and resources, but a surgeon’s commitment will make a difference for themselves and their patients.

Registration for the first annual ACS Advocacy Summit will open in December, and attendees will be offered a special group rate at the JW Marriott, located between the White House and the U.S. Capitol. Fellows of the College will receive an e-mail with registration details as soon as registration has opened.

If you have any questions about the ACS Advocacy Summit, visit http://www.facs.org/ahp/summit/index.html or contact Catharine Harris in the Division of Advocacy and Health Policy’s Washington, DC, office at charris@facs.org or 202-337-2701.

Ms. Harris is Legislative Assistant with the Division of Advocacy and Health Policy, Washington, DC.
L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), was awarded honorary fellowship in the West African College of Surgeons during its 51st annual Clinical Scientific Congress held in Dakar, Republic of Senegal, June 30–July 5. Dr. Britt is the Henry Ford and Brickhouse Professor and chairman, department of surgery, Eastern Virginia Medical School, Norfolk, and the Immediate Past-President of the American College of Surgeons (ACS).

Dr. Britt is one of the three African-American Presidents of the ACS to receive the honorary fellowship designation from the West African College of Surgeons, and is the first to receive the fellowship during his tenure as President. LaSalle D. Leffall, Jr., MD, FACS, and the late Claude H. Organ, Jr., MD, FACS, were awarded the honorary fellowship a few months prior to assuming the role of President of the College.

The governing council of the West African College of Surgeons awarded the fellowship to Dr. Britt in recognition of the great contributions he has made, and continues to make, to the growth and development of the profession around the world, specifically in the area of mentoring and training of residents and fellows from the West African sub-region through collaboration on courses, workshops, and various educational programs. Many of these surgeons have since returned to West African sub-region to serve.

Following the conferment of the honorary fellowship, Dr. Britt delivered a lecture on the Challenges of Health Care Delivery in the U.S. He noted that the U.S. is still a young nation in spite of its enormous wealth, military strength, technological advances, and benchmark and clinical research. However, Dr. Britt questioned health care spending in the U.S. and discussed the health care reform debate.

More than 1,000 participants attended the 51st annual Scientific Clinical Congress.

Dr. Adebonojo is emeritus professor of surgery at Wright State University College of Medicine, Dayton, OH.
Dr. Sachdeva honored with Margaret Hay Edwards Achievement Medal

During the 2011 International Cancer Education Conference, September 8–10, in Buffalo, NY, Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the American College of Surgeons Division of Education, received the highest honor bestowed by the American Association for Cancer Education (AACE), the Margaret Hay Edwards Achievement Medal for “Outstanding Contributions to Cancer Education.”

A trailblazer in the field of cancer education, Margaret Hay Edwards, MD, for whom the award was named, established and then directed the National Cancer Institute’s Cancer Training and Education Grant Program for more than 18 years. Dr. Edwards also enthusiastically supported the AACE, a multidisciplinary national organization focused on advancing both professional and patient education.

Dr. Sachdeva, a former AACE president, delivered the association’s Samuel C. Harvey, MD, Memorial Lecture in 2006. He also served as a member and chair of the Scientific Review Group Education Subcommittee (Study Section) of the National Cancer Institute, which is responsible for a large portfolio of education and training grants that evolved from the grant program established by Dr. Edwards.

Dr. Sachdeva received his medical training at the All-India Institute of Medical Sciences, New Delhi, India. He completed a surgery residency at the Hospital of the Medical College of Pennsylvania in Philadelphia and has held specialty certification in surgery since 1981. Dr. Sachdeva participated in the Harvard Macy Institute Program for Leaders in Medical Education. Prior to joining the College, Dr. Sachdeva was the Leon C. Sunstein, Jr., Professor of Medical and Health Science Education and Professor and Vice-Chairman for Educational Affairs, Department of Surgery, at the MCP Hahnemann School of Medicine. He has also held the positions of associate dean for medical education and director of the Academic Center for Educational Excellence, and served as chairman of three successive medical school education/curriculum committees for 12 years. In addition, Dr. Sachdeva served as chief of surgical services at the Philadelphia Veterans Affairs Medical Center for more than eight years. He has received many prestigious national awards for landmark contributions to surgical and medical education. Dr. Sachdeva is an adjunct professor of surgery at The Feinberg School of Medicine at Northwestern University, Chicago, IL.

In addition to having served as president of the AACE, Dr. Sachdeva has been president of the Association for Surgical Education and president of the Alliance for Clinical Education, and currently serves as president of the Council of Medical Specialty Societies.
98% of attendees this year say they would recommend the workshops to a colleague and 97% would attend a future ACS/KZA workshop! Come see why, can you afford not to?

Optimize legitimate collections and reduce your audit risk. Break the cycle of downcoding, delays, and denials.

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These workshops are a fast-paced, dynamic two-day event that mean you’ll leave with practical skills to take home and use immediately. If you follow our advice you’ll submit more accurate, clean claims, reducing denials and claim rejections.

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Mary Ann Cross, General Manager, California Bariatric & General Surgery Associates, Arcadia, California

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BETSY NICOLETTI
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Code It Right and Get Results

SAVE THESE 2012 DATES
LAS VEGAS – February 16-17
CHICAGO – April 26-27
NEW YORK – May 3-4
NASHVILLE – August 16-17
Stephen J. Regnier, Editor of the Bulletin of the American College of Surgeons (ACS) since June 1988, will retire at the end of November. During his 23 years at the ACS, he also has been responsible for the publication of the Clinical Congress Program Book and the convention daily newspaper, the Clinical Congress News.

During his tenure as Editor, the Bulletin has grown to a circulation of more than 73,000 readers. The monthly has progressed from a two-color publication to one with full color throughout each issue. The format for the articles and columns was redesigned in the early 1990s and is currently undergoing another redesign.

Through the efforts of Mr. Regnier, the Bulletin currently employs the services of four Regents of the College as Editorial Advisors, as well as a host of secondary advisors from the Web portal communities.

Under his direction, regular contributions in the Bulletin have included the popular surgical outreach articles and the "surgical lifestyles" features, which describe the varied avocational interests of today's practicing surgeons.

Mr. Regnier was instrumental in facilitating the redesign and format of the Clinical Congress News to include full-color ads and stories and photographs from the meeting. “I’m very proud of what the Clinical Congress News has become in terms of its graphic appeal and coverage of the Clinical Congress events,” he said. “I believe it is one of the premier convention daily papers today.”

For 12 years prior to coming to the College, Mr. Regnier served as editor-in-chief of Rehabilitation Literature, a monthly resource published by the National Easter Seal Society in Chicago, IL.

Diane S. Schneidman, who has been with the ACS since October 1989, will succeed Mr. Regnier. Presently, Ms. Schneidman is Manager, Special Projects, in the Division of Integrated Communications. She assumed this position in 2005, and since then has been responsible for assisting the Executive Director and other College officials with their written communications activities. She also has written feature stories for the Bulletin, acted as the liaison between the ACS Division of Advocacy and Health Policy and the Division of Integrated Communications, and contributed to the production of ACS NewsScope and Surgery News.

From 2000 to 2005, Ms. Schneidman served as the Senior Editor of the Bulletin and was responsible for copy editing the magazine, editing the Clinical Congress Program Book, and reporting on sessions for the Clinical Congress News.

Before she began working in the Division of Integrated Communications, Ms. Schneidman held various positions in both the Chicago, IL, and Washington, DC, offices of what is now known as the Division of Advocacy and Health Policy. Her responsibilities in that division included producing a monthly newsletter on state legislative activities, writing articles for the Bulletin, managing the Metropolitan Washington, DC, Chapter of the ACS, and lobbying.

Ms. Schneidman earned a master of arts degree in writing from DePaul University, Chicago, IL, and bachelor of science degree in journalism from Eastern Illinois University, Charleston.

“I am looking forward to building on Steve’s many achievements as Editor of the Bulletin,” Ms. Schneidman said.

If you have suggestions or comments regarding the Bulletin that you’d like to share with Ms. Schneidman, please contact her at dschneidman@facs.org.
The ACS National Surgical Quality Improvement Program – a national effort to improve surgical care and cut costs run by the American College of Surgeons – is helping to prevent thousands of surgical complications each year, according to a study of 118 hospitals.

The hospitals experienced a reduction of 250-500 complications per hospital, per year. If these methods were used in every hospital in the nation, we could reduce health care costs by $13 to $25 billion every year, or $130 to $250 billion over the next decade – and help literally millions of patients avoid preventable complications.

So let’s stop focusing on the issues that divide us, and work together to make sure Congress rewards providers who deliver better care at lower costs by using measures like these.

Learn more about the ACS NSQIP® program at acnsqip.org
Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its June 10, 2011, meeting:

- Mark C. Leeson, MD, an orthopaedic surgeon from Akron, OH, was suspended from the College with terms and conditions for reinstatement of his full Fellowship privileges. This action was taken following disciplinary action by the Ohio Board of Medicine. The Ohio Board placed his medical license on probation for five years with terms and conditions following an admission by Dr. Leeson that he is chemically dependent and that he had inappropriately obtained Vicodin for his own use.

- Darshan R. Shah, MD, a general surgeon from Bakersfield, CA, had his ACS Fellowship placed on probation with terms and conditions for reinstatement of his full Fellowship privileges. This action was taken following disciplinary action by the California Medical Board. Dr. Shah’s medical license in that state was placed on probation for five years with terms and conditions following allegations that he had sexual relations with a patient.

**Definition of terms**

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

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

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

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

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

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

**Trauma meetings calendar**

- **Advances in Trauma**, December 9–10, 2011, Kansas City, MO
- **Trauma, Critical Care & Acute Care Surgery—2012**, March 26–28, 2012, Las Vegas, NV
- **Point/Counterpoint XXXI, Acute Care Surgery**, June 11–13, 2012, National Harbor, MD

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ website 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.
When lymphatic mapping and sentinel lymph node (SLN) biopsy were widely accepted, lymph node micrometastases were found and noted in pathology reports. The following is one such clinical scenario. The patient is a 55-year-old post-menopausal woman who presents with a 2 cm N0M0 right breast cancer, ER+, HER2neu negative. The physician has proceeded with lymphatic mapping, SLN biopsy, and lumpectomy. Initial hematoxylin and eosin (H+E) staining of three SLNs showed no metastasis, but on immunohistochemistry (IHC) staining, a 1 mm metastasis was present in one SLN. Oncotype DX testing showed a low risk of recurrence.

This case is presented to the hospital tumor board, which debates whether the patient should receive adjuvant chemotherapy for the positive sentinel lymph node micrometastasis. This case is a fairly common situation and, until recently, there has been considerable debate about whether to recommend systemic adjuvant chemotherapy for an IHC discovered micrometastasis in a SLN.

Lymphatic mapping and SLN biopsy have become standard of care for resectable breast cancer and this has allowed serial sectioning, IHC staining, and detection of micrometastases that, heretofore, often went undetected with routine H+E staining. When micrometastases were found, the impression was that such node positive disease should be treated with adjuvant chemotherapy. Retrospective data suggested that patients with micrometastasis had a worse prognosis. Many health care professionals argued that the clinical significance of micrometastasis was unclear and that prospective data were needed.

Two prospective clinical trials reported recently have now shed considerable light on the subject of micrometastases in breast cancer SLN. NSABP B-32 was a phase III randomized trial comparing SLN biopsy alone versus SLN biopsy + axillary dissection for SLNs that were negative for metastasis by H+E evaluation.* A secondary objective of this trial was to investigate the impact of micrometastasis detected by IHC in SLN on survival. A total of 3,887 patients whose SLN were negative for metastasis by H+E evaluation participated in the trial. SLN paraffin blocks were obtained and serially sectioned. Occult metastases were detected with IHC in 15.9 percent of cases. While the investigation reported that occult metastases were an independent prognostic variable, the difference in five-year outcomes was small (approximately 1 percent), and the report’s authors found no clinical benefit to IHC evaluation of serially sectioned SLN.

The second publication on micrometastases in breast cancer SLN was reported in July 2011. ACOSOG Z10 was an observational study of occult SLN metastases found in clinical stage I and II breast cancers.† The SLNs were serially sectioned and evaluated by H+E histology for 3,326 cases. If there was no evidence of metastasis, further SLN histologic slides were evaluated by IHC with a central laboratory pathologist and blinded to the clinician. The incidence of occult metastases detected by IHC was 10.5 percent. All patients received standard adjuvant systemic therapy based upon primary tumor characteristics and SLN nodal staging using standard H+E methods. At a median of 6.3 years, no evidence indicated that IHC detected occult metastases affected overall survival.

These two large patient trials demonstrate that IHC to detect occult metastases in breast cancer SLN has no clinical benefit in


clinical stage I and II breast cancer. These publications provide data demonstrating that examination of SLNs with IHC, as in the case described earlier in this article, is unnecessary. Recommendations regarding postoperative adjuvant therapy can be made based on primary tumor characteristics and routine H+E evaluation of SLNs. Physicians are encouraged to read these publications and decide whether to order IHC evaluation of breast cancer SLNs.

Both of these trials were supported by the National Cancer Institute (NCI). The authors also acknowledged the hundreds of surgeon investigators who participated in these trials. It is well known that NCI capitation payments do not cover the costs of these trials and that there was significant pro bono contribution by participating surgeons to answer the important question of occult nodal metastases in breast cancer. Patients and the community at large are grateful for those who supported these two important trials.

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

Dr. Giuliano is executive vice-chair of surgery, surgical oncology, department of surgery, and associate director, surgical oncology, Samuel Oschin Comprehensive Cancer Institute, Los Angeles, CA. He is co-director, Saul and Joyce Brandman Breast Center, Cedars-Sinai Medical Center, Los Angeles, CA.

Oweida Scholarship availability announced

The Board of Governors of the American College of Surgeons is pleased to announce the availability of the 2012 Nizar N. Oweida Scholarship. The Oweida Scholarship, an annual award administered by the Executive Committee of the Board of Governors, was established in 1998 in memory of Dr. Oweida, a general surgeon who practiced in a small town in western Pennsylvania.

The purpose of the Oweida Scholarship is to enable young surgeons practicing in small communities or rural areas to attend the Clinical Congress and benefit from the educational experiences it provides. The $5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees.

Applications consist of a curriculum vitae, plus a one-page essay discussing why the applicant characterizes his or her practice as serving a small community and why he or she would like to receive the scholarship.

The deadline for receipt of application materials is December 15, 2011. For the complete requirements for this scholarship, visit http://www.facs.org/memberservices/oweida.html, or contact Kate Early, Scholarships Administrator, at kearly@facs.org.

SOCIOECONOMIC TIPS, from page 32

A 50-year-old male has a biopsy-proven 1.5 mm deep melanoma.

For melanoma patients, the SLN mapping and identification code 38900 can also be used and should be paired with the relevant node basins sampled. Excision of cervical nodes (codes 38510, superficial and 38520, deep), internal mammary nodes code 38530, and deep jugular nodes code 38542 are specifically described. Due to the fact that deep and superficial inguinal biopsies are not specifically described, 38500 can be used for a superficial biopsy because other regions, such as the inguinal, do not have specific codes for lymph node excision as opposed to full dissection. It also may be appropriate to append modifier 51 (multiple procedure), if the excision and sentinel node biopsy are done in the same setting or if more than one node basin is sampled. Modifier 51 is left off of code 38900 because it is an add-on code.

Use of SLN sampling may be advancing beyond the more common breast cancer and melanoma indications. As always, when a correct coding solution is not evident, the best alternative is to use the appropriate section unlisted code.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 8:00 am and 5:00 pm MST, excluding holidays.
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The combined history of the American College of Surgeons (ACS) and The Joint Commission (TJC) goes back to the formation of the College itself, following a proposal by Ernest A. Codman, MD, FACS, to establish an "end result system of hospital standardization" in 1913. Under Dr. Codman's system, a hospital would track every patient who received care there long enough to determine whether the treatment provided was effective. If the treatment was ineffective, the hospital would then attempt to determine the reasons why. The ACS was founded in 1913, and the “end result” system became an ACS stated objective. The establishment of this goal paved the way for the long-standing collaboration between the ACS and TJC. This goal also established the foundation for the accreditation standards used by The Joint Commission to promote patient safety and quality worldwide.

In 1918, just four years after the ACS was founded, the organization developed the Minimum Standards for Hospitals and began conducting on-site inspections of hospitals. The College, eight years later, also printed the first Hospital Standards manual. In 1951, the Joint Commission on Accreditation of Hospitals (JCAH) was created through a partnership with the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association. The JCAH would later become known as the Joint Commission on the Accreditation of Health Care Organizations. Today, TJC functions as an independent not-for-profit organization whose primary purpose is to provide voluntary accreditation. The ACS officially transferred its Hospital Standards program to JCAH in 1952, and in 1953 JCAH published the Standards for Hospital Accreditation. Today, TJC and the ACS are working together in many ways to continue the original focus on which their shared history is based—quality improvement and measurement in health care.

Both organizations regularly collaborate on projects to improve patient safety and enhance quality of health care. The ACS and TJC, along with the Association of periOperative Nurses, have worked to support the annual National Time Out Day, highlighting the importance of TJC’s Universal Protocol, which requires the verification of the correct patient, correct procedure, and correct site before any operation begins. TJC is a prominent supporter of the College’s National Surgical Quality Improvement Program (ACS NSQIP®) and provides badges that highlight the hospitals that participate in NSQIP on QualityCheck.org.

One of the most important collaborative projects between TJC and the ACS began in August 2010, when TJC’s Center for Transforming Healthcare launched its fourth project, which is intended to reduce surgical site infections (SSI) in patients undergoing colorectal surgery and colorectal procedures. The ACS NSQIP surgical outcomes data are guiding the SSI project’s data collection and analysis. The ACS NSQIP data on surgical outcomes are highly regarded in the physician community as clinically valid, and show that colorectal surgery and colorectal procedures are often associated with SSIs. Proposed solutions to SSI in colon-rectal surgery are targeted for publication in fall of 2011.

The ACS also has three seats on the TJC corporate board. Other board members represent the American Hospital Association, the American College of Physicians, the American Medical Association, and the American Dental Association. In addition, the ACS has one representative on each of the following board committees:

- Executive committee
- Accreditation committee
- Board appeal review committee
- Finance & audit committee
- Governance committee
- Human resources and compensation committee
- Sentinel event subcommittee
- Achieving High Reliability in Health Care Strategic Issues Work Group
- Center for Transforming Healthcare
Healthcare Board of Directors
TJC works with the ACS through three of its advisory groups in its continuous effort to improve the safety and quality of care provided to the public. These groups provide feedback to help TJC develop and revise standards, policies, and procedures that support performance improvement in health care organizations.

One of the advisory groups in which the ACS participates is the Liaison Network. This group improves communications between TJC and health care professional groups. The Liaison Network includes more than 230 professional organizations and ensures that TJC maintains and strengthens these important relationships. The other two advisory groups are both professional and technical advisory committees (PTACs), the Hospital Accreditation Program and the Ambulatory Care Accreditation Program. Members of the PTACs include professionals from respective fields representing national associations and other health care advocates. The PTACs provide important input on accreditation standards by advising on proposed standards changes and improvements.

Through its position on the Board of Commissioners, and other integral collaborations highlighted in this article, the ACS continues to play an essential role in many of TJC’s decisions and projects.

For more information on TJC’s history, board of commissioners, Center for Transforming Healthcare, or advisory groups, visit http://www.jointcommission.org/about_us/who_we_are.aspx.
NTDB® data points

Oh, deer

by Richard J. Fantus, MD, FACS

Near the beginning of the 20th century there were approximately 500,000 white-tailed deer in the U.S. As a result of unregulated commercial and recreational hunting and poor land-use practices, including deforestation, the white-tailed deer was threatened with extinction. By the 1930s the number of white-tailed deer had dwindled to approximately 300,000. Around the same time, many state wildlife agencies were formed with a goal of conserving depleted wildlife resources. These efforts were a huge success, and now the national deer population exceeds 30 million and is rising. In rural areas, these animals may exceed 40 deer per square mile, with reports of more than 100 deer per square mile near many metropolitan areas on the East Coast. With adequate food resources, the deer population doubles every two to three years.

In parts of the country, white-tailed deer populations far exceed the local capacity and are considered by some to be a nuisance for the following reasons: economic losses secondary to cash crop damage (especially corn and orchards); prevention of successful reforestation following logging operations; impact on plants and animals in parks and nature reserves; damage to suburban landscaping; and proliferation of deer ticks, which carry Lyme disease. Lastly, deer sometimes cause serious motor vehicle collisions, including collisions with motorcycles. Motorcycles can weigh approximately 500 pounds, while adult deer can weigh between 100 to 300 hundred pounds—which can result in a significant impact (http://wildlifecontrol.info/deer/pages/deerpopulationfacts.aspx).

The National Highway Traffic Safety Administration (NHTSA) defines a motorcycle as “a motor vehicle with motive power having a seat or saddle for the use of the rider, and designated to travel on not more than three wheels in contact with the ground” (http://www.nhtsa.gov/cars/rules/import/faq%20site/pages/page3.html#Anchor-52644).

According to the Motorcycle Industry Council’s owner survey, it is estimated that in 2009, 11 million motorcycles were in use and travelled more than 27.6 billion miles. This represented a 5 percent increase over 2008 (http://www.mic.org/news042611.cfm).

According to a 2008 NHTSA Traffic Safety Fact Sheet, motorcycles made up approximately 3 percent of all registered vehicles in the U.S. in 2007, but accounted for only 0.4 percent of all vehicle miles travelled. In spite of the lower number of miles travelled, motorcyclists were approximately 37 times more likely than occupants of a passenger car to die in a motor vehicle crash and at nine times greater risk of being injured. In 2008, motorcyclists made up 14 percent of the total traffic fatalities (http://www-nrd.nhtsa.dot.gov/Pubs/811159.pdf).

In order to examine the occurrence of motorcycle versus deer collisions in the National Trauma Data Bank® Research dataset 2009, admissions records were searched using the International Classification of Diseases, Ninth Revision,
Clinical Modification (ICD-9-CM) external cause of injury E codes. Records that contained E codes 815.2 and 815.3 (injured driver or passenger of a motor vehicle crash involving collision between motorcycle and an object that would include animals, herded or unattended) were then searched by the field. In all, 2,736 records were found while 2,516 had a discharge status recorded, including 1,928 discharged to home, 288 to acute care/rehabilitation, 205 to nursing homes; 95 died. These patients were 87 percent male, on average 41.5 years of age, had an average length of stay of 6.98 days, and an average injury severity score of 16.6. Helmets were worn by 1,693 (61.9 percent) of the motorcycle drivers/passengers in this group. (These data are depicted in the figure on page 63.)

Working in an inner-city trauma center, I thought that this would be one type of traumatic event that I would not encounter. However, with the explosion in the population of the white-tailed deer, motorcycles have yet one more potential obstacle in the road that they will need to avoid, even in urban environments. After all, if you are the passenger riding on the back of the motorcycle, the last thing you want to hear from the driver is, “Oh, deer!” Throughout the year, we will be highlighting data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Report 2010 is available on the ACS website as a PDF file and a PowerPoint presentation at http://www.ntdb.org. In addition, information is available on our website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

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