Welcome to CAGS Wiki Surgery!

We live in the Information Age where individuals can share information easily. Our era may someday be looked back upon as the Digital Revolution, in much the same way as we now refer to the Industrial Revolution. The rise of the computer and the Internet will very likely one day be regarded as transformative for society as the invention of the printing press. Like the printing press, the Internet may be used for many things, but its greatest benefit remains its original purpose - information sharing. As CAGS moves into the 21st century, we now focus on leading in the use of information technology to bring greater value to our members and connect with them.

There are many ways that an organization can function. The leadership can be reactive and deal with issues as they are raised by the members. The leadership can be proactive and develop initiatives to head off looming crises or anticipate needs. The greatest and rarely tapped potential of any organization lies in its ability to get the entire membership working together. Let us explore one way in which this can be achieved.

Wikipedia is a free online resource that allows any user to freely edit the material within. Launched on January 15, 2001 Wikipedia currently hosts over nine million articles in possibly hundreds of languages. The strength of Wikipedia is its millions of users worldwide. Try to do an Internet search on any topic and you will be hard-pressed not to come up with one Wikipedia article. With millions of users constantly reviewing and updating articles, the average error correction time is now down to mere minutes. The accuracy of scientific articles on Wikipedia has been shown to rival major encyclopedias.

Wiki is not the exclusive domain of Wikipedia. Wiki is a Hawaiian word meaning “fast”. Many research groups routinely establish Wikis for rapid sharing of data by a large number of users. This is one specific application of the Internet that allows groups of users to develop, share, and maintain large volumes of information.

CAGS has now unveiled an exciting new initiative, CAGS Wiki Surgery. www.cags-accgs.ca/wiki

Every year our graduating residents sit their Royal College exams. With the exception of specific expertise or years of wisdom, the average examinee is bursting with a breadth and depth of knowledge that many of us will never achieve again. With each round of exams, new rituals evolve. For the majority of residents an essential part of this ritual is digesting enormous volumes of information and preparing study notes. These notes may be on paper, flash cards, desktops, laptops, smart phones, or portable hard drives, but the one thing our residents all have in common is they all create study notes.

Our residents also often study together in groups. Many hands make light work. In some groups, specific topics are assigned to individuals who in turn are expected to perform a thorough review, condense the material and report back to the group with a synopsis of current knowledge in that area. It is a good plan. It is not necessary that every resident read every paper as long as the essential material is appropriately assimilated. This requires a
Welcome to CAGS Wiki Surgery cont’d

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A great deal of trust in ones colleagues, but the bigger the group, the more material can be covered. Some individuals do it all themselves. What could result from having all those individuals and groups working together? What could we achieve if all those study notes were shared through one central repository?

Through CAGS Wiki Surgery, our 650 General Surgery residents will have the ability to enter their study notes into one national resource. Users across the country will have access to this material and be able to contribute and correct articles. CAGS members with expertise in their respective fields will have the ability to review this material, augment it, and prune it to ensure currency and accuracy. With the entire country working together, CAGS Wiki Surgery will become the most current living textbook of surgery in existence, and a Canadian one at that.

Starting this up will be a challenge. A critical mass of initial input will be required to get this initiative off the ground. It will require a leap of faith by our residents to share their reviews and study notes with each other on a national scale. Once that “tipping point” is achieved, however, they will have created an indispensable resource. Future years will need only review, edit, and update the material.

One might correctly point out the wealth of existing online resources in the form of journals, textbooks and existing review sites. These are mostly very professional, accurate and informative. No one is impugning their value. But they do suffer a few weaknesses that CAGS Wiki Surgery will correct. The material in almost all of these resources is developed in a very top-down fashion, by an editor who relies on experts to prepare and vet the content. Like buying a new computer, this material is obsolete almost the very minute it is published. New insights are added cumulatively in subsequent editions that may be years apart. CAGS Wiki Surgery will be updated within months, days, or even hours of the availability of new knowledge. More valuable yet, the content and structure will be developed and maintained by the users themselves to meet their own needs.

One might also question whether our trainees will trust each other enough to share their notes. There will be concerns of accuracy and fears of competition. Accuracy will be addressed by multiple users in the true Wiki spirit and perhaps by specifically invited visits from content experts. Competition shouldn’t be a concern. The Royal College exams are not bell curved. If as a result of this initiative our trainees improve their overall pass rate then that will be the ultimate measure of success of this program.

CAGS Wiki Surgery could become the most reliable study resource for residents from UBC to Memorial. More than that, CAGS Wiki Surgery will be available to all CAGS members and will serve equally well as a resource for practicing surgeons. Possibly the most attractive aspect of CAGS Wiki Surgery is that for CAGS members it is entirely free. All it needs is your time – so check it out and contribute to CAGS Wiki Surgery today!

Dr. Christopher Schlachta
CAGS President

www.cags-accgs.ca/wiki

The Canadian Association of General Surgeons gratefully acknowledges the support of this newsletter’s production by Covidien and Ethicon Endo-Surgery Division of Johnson and Johnson.
As was my experience during my visit last year, the Lacor hospital has been most gracious in their hospitality. I was met at Entebbe airport by the driver from Lacor and taken to the Lacor guesthouse in Kampala to rest up. They then drove me up to Lacor/Gulu the next day with some other passengers.

For new visitors you must remember to have US$50 cash payable at the immigration counter at the airport for the visa into Uganda. Usually we (surgeons/medics) would bring lots of equipment as part of our luggage but that's not a problem. We just haul it all onto a trolley available at the luggage carousel and push it by the green "nothing to declare" passage and your driver will take over from there-on.

It's best to change your money in Kampala as the rates are better. Your driver will know where to take you. Usually it's best to bring $100 US bills as the exchange rate is lower for smaller denominations, or sometimes they won't accept anything smaller than $100 bills. You probably need about $300 to $400 for a six-week period unless you are big on shopping. This would cover most incidentals including beer and pop. You might want to pick up some comfort food at the supermarket in Kampala prior to departure from Kampala.

The trip from Kampala to Lacor/Gulu used to be a grueling 360 km of pot-holed road and would take upwards of six hours. It used to take a toll on your back, not to mention the bumps on your head. Thanks goodness due to a loan from the world bank Uganda has gone on a road improvement program and now there is an almost completed highway from Kampala to Gulu and the trip now takes a pleasant 4 to 4.5 hours.

As a CAGS visitor you will be put up in the St. Mary's hospital guesthouse. This a clean and comfortable building with single and double rooms, each is complete with your own shower and toilet and bed with mosquito nets. Since we are in Malaria country, it's highly recommended that you sleep under the nets. You have three meals a day provided and meat once a day. It's not exactly haute cuisine but it's adequate. You do get laundry service. As a CAGS visitor, the St Mary's hospital looks after your board and lodgings. If you come with a companion they may have to pay about US$20 per day for the same privileges.

Gulu is the biggest town in Northern Uganda. Gulu has a population of 115,000 and Gulu district of 340,000. Gulu Government hospital has 250 beds and is supposed to be the regional referral hospital. However, St. Mary's hospital in Lacor in reality is the main referral hospital. St. Mary's Hospital Lacor is a private non-profit Catholic-based hospital with 476 beds. It is situated 6 km from Gulu along the highway to Sudan. The hospital on average has 600 in-patients and sees about 500 out-patients per day. It serves the poorest segment of the population with average income of <$0.50 per day, way below subsistence level. In fact more than 2/3 of the population cannot meet their basic needs. There are numerous NGOs, including the World Food Program, which does help, but one does wonder if all the food goes where it is supposed to go. It is in this environment that a CAGS visitor is working. The hospital has what I call an elastic bed census. They do not turn anybody away so some are on the floor and in the corridors. Having been here before I find it easier to fit in. There is no orientation so you are on your own to find out what you want to do.

Here are some useful hints: you probably will be asked to give some lectures to the medical students in either 5th year or 3rd year. It would help if you ask for the topics ahead of time so at least you can be prepared.

The contact person is either Mr. Tom Okello or Mr. Martin Okwanga. They are both the only general surgeons they have. Having been here before I find it easier to fit in. There is no orientation so you are on your own to find out what you want to do.
Continued from page 3

Do not pre-judge and you might have to relax your standards a little, as I think they may be lagging behind that of Canada quite a bit. The OR organization may drive you nuts, but this is Africa so go with the flow. I do.

ESS Gulu

While I was in Lacor, it coincided with the teaching of essential surgical skills (ESS). Nearly all the credit must go to Dr. Ron Lett. Ron is president of the CNIS (Canadian Network for International Surgery). He has been tirelessly working at introducing this course mostly for the African Nations. I believe it is being taught in eight different countries including Uganda, Kenya, Tanzania, and Ethiopia, to name just a few of them.

It teaches numerous emergency skills and is primarily aimed at medical students, but does include other health workers. Skills taught include intubation, cricothyroidotomy, c-section, venous cut-down, laparotomy, bowel anastomosis, reducing fractures, and amputations, to name some of the skills.

It is a one-week course taught by certified instructors, which include the local faculty. Should any CAGS member be interested please contact Ron Lett or office@cnis.ca. The feedback from the students has been extremely positive. The ESS has been funded by CIDA. Ron is in the process of writing a proposal for funding for the next five years. Let’s hope it continues.

Murchison Park

It’s not all work and no play. Murchison park is only a 2-hour drive from Lacor. It is a national reserve right alongside the Nile river. There is a lot of game like antelopes, giraffes, and elephants. If you are lucky you might see lions. A Nile cruise is highly recommended. You will see the large Nile crocodiles, hippos, elephants, weaverbirds, and all kinds of migratory birds. Set aside $150-$200 US for the trip depending on your accommodation. You can also do it all in one day if you start early enough. There are usually other guests at the guesthouse in Lacor from which you can gather a group to go with.

I mustn’t fail to mention that speaking Italian is a real asset.

Lacor and Gulu University has a co-Chancellor from the University of Naples. So Naples sends a lot of lecturers over to teach and of course they all speak Italian. Throughout the year there will be various Italian teams that come. A pediatric surgery team comes over to perform like pull-through for Hirschsprung’s, surgery for ambiguous genitalia etc. There are plastic teams and urology teams from Bolzano, Italy.

The latest exciting development is that they now have a pathologist on-site. The outfit that runs it is the equivalent of Pathologist Without Frontiers based out of Italy. Of course we have our CAGS surgeons representing Canada.

So those of you with a thirst for adventure should sign up to go to Gulu. Dr. Brian Ostrow is the one running the CAGS-GULU show. You can contact him at brian@bookshelf.ca. As traveling there already takes up the better part of a week, to be really worth while one should consider a minimum of six weeks. I assure you that it will be a memorable experience and you will probably learn more than you teach.

For more details contact Dr. Ostrow or myself at tghwang@shaw.ca, I would be delighted to fill you in on the details.
As visionaries in soft tissue repair, with more firsts than anyone, we work hard to bring you optimal mesh, biological implants, fixation and dissection solutions for hernia and abdominal wall repair.

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I've been back from the Congo for almost a month from my 10th mission with DWB all short (3-10 weeks). When you get back the first time, you are excited to talk to people about what went on, and they are interested to listen to you. After awhile though I find I have less to say. The differences in Africa are so profound that it makes for a huge disconnect with health care here.

I spent 5 weeks in Kayna in the North Kivu region of the Congo. It is a small hospital, but is the surgical hospital for the region. When DWB arrived they went from about 10 surgical patients to over 30 in three weeks, which puts a strain on the resources, although DWB is supplying all the materials and paying the staff extra. When DWB is not there the surgery is done by national doctors with no specific surgical training, or a nurse who has worked in the OR for many years.

We took him to the OR to resuscitate him for an hour before surgery. His Haemoglobin was only 6 so we found a blood donor and started transfusing him. He was very quiet throughout and only became agitated when he needed to pee. We gave him a little basin to use, and then he was quiet again. His urine was quite dark, and with the jaundice the Congolese doctors thought he likely had intoxication from being given traditional medicine. We saw this quite often in CAR, and they often developed liver failure, a coma and die.

At the laparotomy he had a small bowel perforation, but not much spill or signs of infection. His gall bladder was distended and his liver was large. The Congolese doctor who was assisting me thought this was further proof of intoxication. I patched the hole and another area that was questionable; we washed out with warm fluids and closed. The operation didn’t take that long, and all seemed fine. I was just cleaning up the instruments after putting on the dressing when the anaesthetist found he wasn’t getting a pulse. And that was where this story started.

After cleaning up the child we brought him into the recovery room and got his Mom. She admitted that she had given him some traditional medication that morning and perhaps before as well. She was clearly upset by the death, but left without touching the child. The nurse told me that because she is alone here the mourning will wait until she brings his body home and she is with her family. DWB will take her and the body home tomorrow, but for tonight she will stay at the hospital on her own.

I’m sure there is some message about how precious life is when you see it pass away so suddenly, but I don’t know that I am feeling it right now. Like practice at home the hardest thing to deal with is the patient who doesn’t fare well, but here there is an extra stress of not knowing why they died and if anything would have made a difference. Why is it so much easier to remember our failures rather than our successes?

Tomorrow will be another day, and I hope a better one.”

Barbara LeBlanc FRCSC
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One of the exciting collaborations that has developed from the CAGS surgeons visiting Guyana has aimed at decreasing diabetes-related amputations. The Guyana Diabetic Foot Project spearheaded by Dr. Brian Ostrow is a collaboration between Canadian and Guyanese health professionals, aimed at creating a comprehensive diabetic foot care clinic at Georgetown Public Hospital Corporation (GPHC), the national referral and training hospital in Guyana, South America.

At the 2006 Bethune Roundtable, Dr. M. Rambaran, Director of Medical and Professional Services at GPHC reported that 30% of surgical admissions at his hospital were due to diabetic foot infections and complications, and 42% of these patients went on to have an amputation.

As part of CAGS’ mentorship program, Dr. Brian Ostrow visited GPHC and carried out a needs assessment on diabetic foot care in January 2007. He interested Dr. Gary Sibbald, Professor at the Dalla Lana School of Public Health in Toronto, and a world authority in wound care. After a year of planning, in February 2008, GPHC was awarded a $97,460 grant from CIDA through the Canadian Caribbean Cooperation Fund for an 18 month project.

The project uses education strategies to create an evidence-informed, interprofessional, patient-centred diabetic foot clinic at GPHC. Three Canadian expert visits modeling interprofessional care have taken place. Four Guyanese key opinion leaders, including CAGS-Guyana Diploma in Surgery graduate Dr. Carlos Martin, are completing the International Interprofessional Wound Care Course from the University of Toronto. The project has trained over 30 Guyanese health professionals in applying the Best Practice Recommendations of the Canadian Association of Wound Care to their local setting.

The Diabetic Foot Centre (DFC) opened in July 2008. Over a thousand persons with diabetes have been screened. Over 800 high risk and ulcer patients have been seen in the centre. In the first 11 months of DFC operation, the number of patients having diabetes-related major amputations was reduced by 56% compared to the three previous years!

CAGS has recently submitted an ambitious proposal to the Voluntary Sector Fund of CIDA, for a 3 three year $840,000 project to regionalize diabetic foot care. This project may serve as a model for other collaborations between Canadian and international health professionals.


Other news from the International Surgery Committee:

See the CAGS website for updates on the ongoing CAGS-Uganda and CAGS-Guyana projects. Volunteers are welcome to contact the coordinators.

Requests have been received from The Gambia and Zimbabwe requesting surgical teaching visitors. If you are interested in visiting either of these countries contact Dr. Brian Cameron at cameronb@mcmaster.ca for more information.

The Branch for International Surgery at UBC is offering an online graduate-level course: Surgical Care in International Health, starting September 2009. Contact their office for more information: http://www.internationalsurgery.ubc.ca/

The upcoming Canadian Surgery Forum includes several sessions of specific interest to internationally-minded surgeons:

Postgraduate Course: Catastrophe Surgery for Victims of Disaster, Terrorism or War.

Gallie Lecture: Dr. S. Pirani, founder of the Ugandan Club Foot Project CAGS Residents symposium: International Surgery Experiences During Residency.
Evidence Based Reviews in Surgery (EBRS) Update

Uncertain about whether nuts, corn, and popcorn consumption really are associated with an increased incidence of diverticular disease? There are a lot of ways to manage pilonidal sinus but do you know what the evidence is to support those treatments? Should you prescribe steroids in patients in septic shock? What about beta blockers in patients undergoing non-cardiac surgery?

If you do have uncertainty about what to do in those situations, we invite you to participate in Evidence Based Reviews in Surgery. It is free to all members (including residents) who are members of the Canadian Association of General Surgeons. You can access EBRS by going to the CAGS website. If you want to participate in the listserv discussion and receive Maintenance of Certification credits, then you can register with Marg McKenzie by emailing her at mmckenzie@mtsinai.on.ca.

The topics for 2009-2010 are the following:

- Use of the WHO checklist
- Management of biliary tract disease in pregnant females
- Use of CT for cervical spine clearance in trauma patients
- Association between nut, corn, and popcorn consumption, and diverticular disease
- Management of pilonidal sinus
- Use of beta-blockers in the peri-operative period in patients undergoing non-cardiac surgery
- Efficacy of hydrocortisone in patients in septic shock.
- Value of MRSA screening of surgical patients

In addition, there will be also four packages on colorectal surgery topics in 2009-2010:

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

EBRS will resume in October of 2009. The schedule for the year is posted on the CAGS website now.

Some things which you may not know about EBRS, but which we hope will add value to the EBRS program:

- We have two listserv discussion groups: one for the general surgery topics and one for colorectal surgery topics. All members are invited to participate in both.
- At the end of the listserv discussion, members can complete five multiple choice questions pertaining to the methodological and clinical papers and reviews. When you do, you will receive feedback from the pertinent part of the articles, or reviews that support the correct answer.
- Our clinical and methodological reviews are completed by some of the national and international experts on these topics. Each article has a clinical review written by both a Canadian and an American expert - so two different perspectives on the issue are often obtained.
- We have an “Archives” section which is indexed by clinical and methodological topic. We now have almost 100 packages, which have been reviewed over the past 10 years and can be used as a resource by members interested in a particular topic.
- Members can also access online some of the most widely read journals, including the New England Journal of Medicine, CMAJ, JAMA, and Annals of Surgery, and use them for you’re own reading. Just go to the EBRS website and look for “Journals”.
- We have added a section called “Evidence Based Medicine”. Here you will find a glossary of terms and links to other websites that may be of value to members.
- All of the EBRS reviews are published, and to date almost 50 articles have appeared in the Canadian Journal of Surgery, Journal of the American College of Surgeons, and Diseases of the Colon and Rectum; a new link is available with access to all of the review articles.
- All general surgery and colorectal surgery programs should have received a schedule of the topics for 2009-2010 already. The complete packages will be sent in early September.
- For individuals planning to attend the ACS Clinical Congress this year, we invite you to attend the EBRS symposium entitled “What is the Evidence for Antibiotic Prophylaxis in Mesh Inguinal Hernia Repair: Let’s Do Journal Club” October 12, 2009, 4:15 pm – 5:45pm. We will have touch pads, so audience participation will be encouraged.

EBRS is a program of both CAGS and the American College of Surgeons, plus it is endorsed by the Canadian Society of Colon and Rectal Surgeons and the American Society of Colon and Rectal Surgeons. EBRS continues to be funded by Ethicon and Ethicon.
We re-enter an era of uncertainty in Alberta, with the dissolution of all regional health authorities and the creation of a single health board (Alberta Health Services), led by one of the architects of the Australian blended public/private system, Dr. Stephen Duckett.

We are currently seeing only the beginning of the restructuring process, with new administrative structures being created and a new strategic direction being developed by the new Alberta Health Services Board.

All middle management have been asked to re-apply for their jobs. Nurses were recently counted amongst our greatest shortages, now suddenly we have enough - or even too many. A hiring freeze was rumored, then became a hiring “cool-off”, with centralization of all approval of physician recruitment directly at the level of the provincial VP medical.

We are currently working on delivery models for acute care surgery at the provincial level. In developing this process, we are seeking the help of our colleagues in Canada in providing any information of working acute care surgery models at the hospital, city, or regional level. You can forward this information to Cliff Sample via CAGS.

Continued from page 9

Endo-Surgery Canada, and Ethicon Inc and Ethicon Endo-Surgery Inc in the USA, and we are grateful for their ongoing support so EBRS can be provided without charge to members of CAGS and the ACS.

The members of the Steering Committees include: Nancy Baxter, U of Toronto, Carl Brown, U of British Columbia, Karen Brasel, Wisconsin Medical College, Prosanto Chaudhury, McGill University, Suzanne Cutter, Cedars Sinai LA, Bill Fitzgerald, St Anthony, Harry Henteleff, Dalhousie University, Andy Kirkpatrick, U of Calgary, Steve Latosinsky, U of Western Ontario, Tony MacLean, U of Calgary, Tara Mastracci, Cleveland Clinic, Arden Morris, U of Michigan, Leigh Neumayer, U of Utah, Larissa Temple, Memorial Sloan Kettering, NY. We welcome a new representative of CAGS-R Luc Dubois and a new general surgery program director – Celia Divino from Mount Sinai, NY. Our administrative coordinator is Marg McKenzie.

New accredited program on the CAGS Website!

Dr. Ralph George, (Chair of the CAGS CPD Committee) has laboured long and hard on the CAGS Accredited Self Assessment Program (ASAP) to offer all CAGS Members a new way of acquiring MOC CPD Credits. On August 28th, 2009 visit the CAGS website and login with your CAGS user ID to earn your own CME credits. This program was designed for your busy lifestyle, where you can sign in and pursue your continuing professional development on your own time. Your credits will be automatically logged on your personal CAGS profile and tracked for you. Because this learning activity is self-directed and self-assessed, it qualifies for Section 3 MOC credits, worth twice as many hours than regular Section 1 MOC credits. Maybe the best of all is that the program will be available at no extra cost to all CAGS members. Try your hand at ASAP August 28th.

Evidence Based Reviews in Surgery (EBRS) Update cont’d

Alberta Association of General Surgeons

We re-enter an era of uncertainty in Alberta, with the dissolution of all regional health authorities and the creation of a single health board (Alberta Health Services), led by one of the architects of the Australian blended public/private system, Dr. Stephen Duckett.

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We are currently working on delivery models for acute care surgery at the provincial level. In developing this process, we are seeking the help of our colleagues in Canada in providing any information of working acute care surgery models at the hospital, city, or regional level. You can forward this information to Cliff Sample via CAGS.
Many thanks to all who answered the CAGS 2009 needs assessment. Congratulations go to our 100th respondent, Dr. Jean Tchervenkov (Montreal) and the 300th respondent, Dr. John Graham (Calgary) who have won a free CAGS annual membership.

**Demographics**

My age group is:
- 25 - 34: 45.05%
- 35 - 44: 21.62%
- 45 - 54: 13.51%
- 55 - 64: 13.51%
- 65 - 74: 5.41%
- over 75: 0.90%

The population served by my medical practice is:
- 50,000: 14.19%
- 50,000 - 250,000: 23.55%
- 250,000 - 500,000: 14.84%
- 500,000+: 47.42%

Gender:
- Male: 79.42%
- Female: 20.58%

**Career Path**

My present practice can best be described as:
- University based: 42.07%
- Private practice: 31.37%
- Hospital practice: 26.57%

I am remunerated by:
- Salary: 24.36%
- Fee for service: 44.87%
- Salary + fee for service: 28.21%
- Alternative plan: 2.56%

My time in the following areas can best be described as:

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I consider myself a general surgeon:
- Yes: 90.36%
- No: 9.64%

The percentage of clinical time I spend in a subspecialty:
- none: 31.65%
- 0 - 25%: 22.78%
- 25 - 49%: 18.99%
- 59 - 74%: 8.86%
- 75 - 100%: 17.72%

**Most Common Sub-specialities**, beginning with most common to less common:
- Colorectal, Laparoscopic, Minimally Invasive Surgery, Critical Care Medicine, Surgical Oncology, Breast Surgery, Endocrine

**Specialty Supply**

Over the past five years, the role of general surgery in the provision of medical subspecialty services in my own practice community is:
- shrinking: 24.19%
- not changing: 46.21%
- growing: 29.60%

Continued on page 12
The present number of general surgeons in my own practice community is:
- too few: 44.60%
- just right: 52.16%
- too many: 3.24%

CAGS Newsletter and Correspondence
The format I prefer to receive correspondence from CAGS is:
- Print (mail): 39.36%
- Electronic (e-mail or Internet): 60.64%

I find the content of the newsletter useful:
- Yes: 92.19%
- No: 7.81%

I would like to see a feature on:
Responses focused on the following features: errors in medicine, continuous medical education in new surgical techniques, the changing face of general surgery, such as work projections, bariatric surgery, and a summary of National/International meeting dates long in advance.

Please rate the components of the CAGS Annual Meeting scientific program on a scale of 1 - 5 where: 1 = poor, 5 = excellent

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<tr>
<td>Nominations/Awards</td>
<td>2.99%</td>
<td>8.96%</td>
<td>41.79%</td>
<td>43.28%</td>
<td>2.99%</td>
</tr>
</tbody>
</table>

Please list any topics of interest that you would like to be included in the scientific program:
Comments focused on the breast, with mention of colorectal surgery, and mention of a variety of other surgical sub-specialties.

CAGS Objectives
I am satisfied with how CAGS is pursuing its redefined mission and vision:
- Strongly Disagree: 2.52%
- Disagree: 14.39%
- Undecided: 19.42%
- Agree: 57.19%
- Strongly Agree

Rate each CAGS objective by importance to you, where 1 is most important and 4 is least important:

<table>
<thead>
<tr>
<th>Objective</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Professional Development</td>
<td>62.77%</td>
<td>21.30%</td>
<td>9.61%</td>
<td>6.09%</td>
</tr>
<tr>
<td>Residents and Education</td>
<td>12.99%</td>
<td>38.26%</td>
<td>37.99%</td>
<td>10.87%</td>
</tr>
<tr>
<td>Research in General Surgery</td>
<td>3.46%</td>
<td>9.57%</td>
<td>29.26%</td>
<td>57.83%</td>
</tr>
<tr>
<td>Political and/or Public Advocacy</td>
<td>20.78%</td>
<td>30.87%</td>
<td>23.14%</td>
<td>25.22%</td>
</tr>
</tbody>
</table>

What suggestion(s) do you have for the CAGS Executive?
There was a recurring theme of strengthening political advocacy among comments given. Comments focused on the need to be more actively involved in political advocacy, to achieve positive policy outcomes related to general surgery. There were also a few comments on CAGS being the voice of the university surgeon and that more effort should be made to include the community surgeon.

Please put a check beside the CAGS Organizational Objective(s) that are of interest to you:
- Continuing Professional Development: 39.96%
- Residents and Education: 26.99%
- Political or Public Advocacy: 20.71%
- Research: 12.34%

Volunteering
103 CAGS members offered to volunteer on (at least one) CAGS objective.