

# Scope



Summer, 2002  
Volume 02, Issue 2

## MESSAGE FROM THE PRESIDENT

### The Bariatric Revolution: Can SAGES Respond?



**SAGES President  
Bruce Schirmer, MD**

#### *The Laparoscopic Revolution*

Twelve years ago, we were in the beginning of the laparoscopic revolution. We all remember those exciting times for General Surgery: new technology, new approaches for old operations, and even a few totally new procedures. While the major changes in surgical practice during the decades previously had been in perioperative care, the laparoscopic revolution was a major advance in patient care based on improved operative technology. The patient benefits and improved results were dramatic.

The laparoscopic cholecystectomy tidal wave caused most surgeons in practice to rapidly adapt and learn a new technology and develop a new set of skills. That they embraced these new procedures with overall relatively highly successful results was more a factor of their innate surgical skills rather than the fact they followed a tested, comprehensive, well-planned and proctored curriculum. Many academic medical centers were slow to embrace the new laparoscopic technology. The laparoscopic revolution was initially spearheaded by skilled individuals in private practice rather than by those in academic surgery.

Many surgical societies, particularly the more established ones, were initially skeptical of laparoscopic surgery. SAGES, however, was the exception to the rule. The leadership of SAGES in 1990 quickly recognized the enormous potential and importance of laparoscopy for the practice of general surgery. As a society already oriented toward endoscopic and minimally invasive surgical (MIS) procedures, SAGES was well positioned to assume a leadership position as a society where the practicing surgeon could learn the latest techniques and applications of minimal access surgery. This fact was quickly recognized by surgeons.

There was an explosion in SAGES membership during the early 1990's. SAGES quickly became THE society for the general surgeon to join to find training, education, enduring materials, guidelines and networking in minimal access surgery. A camaraderie and spirit along with vitality and energy unmatched by other surgical societies of its size developed and have remained the single most unique and rewarding aspect of being a SAGES member.

SAGES remains identified in most surgeon's eyes with minimal access surgery. It is also known as a venue for emerging surgical technology and application of MIS principles to other areas of surgical practice. In order to maintain such a leadership position, our society must be dynamic. *Continued on page 9.*



**Bruce Schirmer, MD, (l) incoming president, presents a plaque acknowledging the enormous contribution of Dr. William Traverso as President of SAGES 2001-2002. The plaque reads:** "Wisdom is the principal thing; therefore get wisdom; and with all thy getting get understanding." (Old Testament Proverb) "For leading with wisdom; for guiding us with understanding; for your extraordinary commitment of time, energy and ability." Presented to L. William Traverso, MD, FACS, President, April, 2001 - March, 2002.

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## 2002-2003 Committee Chair/Co-Chair List

The following individuals are the 2002-2003 SAGES Committee chairs and co-chairs, as appointed by President Bruce Schirmer, MD. Of special note is the newly formed Bariatric Task Force (see Presidential Address article for more

details), and the newly combined Standards/Credentials Committee (now called Guidelines Committee) and Membership/International Relations. Appointment letters were sent to ALL committee members in July, 2002.

### *Assets/Finance:*

**Finance Chair:** David Rattner, MD

**Assets Chair:** Barry Salky, MD

### *Awards:*

**Chair:** Wayne Schwesinger, MD

### *Bariatric:*

**Chair:** Sayeed Ikramuddin, MD

**Co-Chair:** Eric DeMaria, MD

### *By-Laws:*

**Chair:** Steven Stain, MD

### *Continuing Education:*

**Chair:** C. Daniel Smith, MD

**Co-Chair:** Daniel Herron, MD

### *Development:*

**Chair:** Steve Schwaitzberg, MD

**Co-Chair:** Mark Callery, MD

### *Educational Resources:*

**Chair:** Horacio Asbun, MD

**Co-Chair:** David Easter, MD

### *Ethics:*

**Chair:** Talmadge Bowden, MD

**Co-Chair:** Peter Crookes, MD

### *Flexible Endoscopy:*

**Chair:** Gary Vitale, MD

### *Fundamentals of Laparoscopic Surgery:*

**Chairs:** Jeffrey Peters, MD &

Lee Swanstrom, MD

**Co-Chairs:** Gerald Fried, MD &

Blair Jobe, MD

### *Guidelines (newly combined Credentials/Standards):*

**Chair:** Nathaniel Soper, MD

**Credentials Co-Chair:** David Earle, MD

**Standards Co-Chair:** Robert Fanelli, MD

### *Legislative:*

**Chair:** Aaron Fink, MD

**Co-Chair:** Daniel Jones, MD

### *Membership (newly combined with International Relations):*

**Membership Chair:** Sherry Wren, MD

**Membership Co-Chair:** Tonia Young-Fadok, MD

**Int'l Relations Chair:** Ramon Berguer, MD

### *Nominating:*

**Chair:** William Traverso, MD

### *Outcomes:*

**Chair:** William Traverso, MD

**Co-Chair:** Bruce Wolfe, MD

### *Pediatric:*

**Chair:** Steve Rothenberg, MD

**Co-Chair:** Thom Lobe, MD

### *Program:*

**Chair:** Daniel Deziel, MD

**Co-Chair:** Stephen Eubanks, MD

### *Public Information:*

**Chair:** Jo Buyske, MD

**Co-Chair:** Paul Cirangle, MD

### *Publications:*

**Chair:** Kenneth Forde, MD

**Co-Chair:** Desmond Birkett, MD

### *Research:*

**Chair:** Frederick Greene, MD

**Co-Chair:** Karen Horvath, MD

### *Resident Education:*

**Chair:** Jeffrey Marks, MD

**Co-Chair:** Ray Onders, MD

### *Rural Surgery:*

**Chair:** Nick Morris, MD

### *Technology:*

**Chair:** Mark Talamini, MD

**Co-Chair:** Scott Melvin, MD

### *Non-voting advisors to the Board:*

George Berci, MD, Tom Dent, MD, John Hunter, MD

### *2002 Membership Directory Available*

The 2002 updated membership directory is now available upon request! It includes all SAGES active, candidate, senior and honorary members from the US and abroad. Please contact the SAGES office. (Phone: 310-314-2404, Fax: 310-314-2585, E-Mail: [sagesweb@sages.org](mailto:sagesweb@sages.org)) to obtain your copy.

The SAGES members only section of the website has been updated.

<http://www.sages.org/members/>.

To obtain a password to the members only section go to

<http://www.sages.org/signup.html>.

In 2005, SAGES will meet concurrently with AHPBA and consecutively with the ACS Spring meeting. The collaborative meetings will take place at the beautiful Westin Diplomat Resort in Hollywood, Florida.

In 2006 and 2007, SAGES will continue to meet consecutively with the ACS Spring meeting, exact dates and locations TBA.

Four of SAGES long standing committees have been combined into two. The Standards of Practice and Credentials Committees have been combined to form the Guidelines Committee, under the chairmanship of Nathaniel Soper, MD. The Membership and International Relations Committees have been combined to form the Membership Committee, under the chairmanship of Sherry Wren, MD and Ramon Berguer, MD.

Our 4-year ACCME self study and re-accreditation interview were completed in July, 2002. We expect to hear formal confirmation of another 4-year accreditation from the ACCME by November, 2002.

At the April ACS Spring Meeting, Gregory Stiegmann, MD was confirmed as SAGES representative to the ACS Board of Governors. Dr. Stiegmann replaced Dr. Frederick Greene, who served us well in the same capacity for six years.

Desmond Birkett, MD has been appointed the new IFSES Secretary/Treasurer. Drs. John Hunter and Bruce Schirmer serve as SAGES official representatives to IFSES, whose main purpose is to coordinate site selection for the World Congress of Endoscopic Surgery. SAGES hopes to host the World Congress again in 2008.

The SAGES Corporate Council generously donated its project money to the Twin Towers Fund this year. SAGES Board of Governors voted to match their contribution.

Not only will SAGES meet in tandem with IPEG again at the 2003 meeting in Los Angeles, but two other changes will be visible to meeting attendees. PowerPoint will be mandated as the presentation format for all faculty and oral presenters. Discussants will also be used in the plenary room of the Scientific Session.

At the annual business meeting of the Society, held on Saturday, March 16 in New York, the membership approved the by-laws change, including our revised mission statement, as follows:

## *Mission Statement*

**SAGES represents a worldwide community of surgeons that can bring minimal access surgery, endoscopy and emerging techniques to patients in every country.**

*The mission of the society is:*

- ▶ **To provide education and training for gastrointestinal and/or abdominal surgeons and surgeons-in-training.**
- ▶ **To measure, on an ongoing basis, the quality and effectiveness of our educational programs and to modify them based on these measures.**
- ▶ **To identify and evaluate current and emerging minimal access and non invasive technologies and techniques in gastrointestinal endoscopy and endoscopic surgery.**
- ▶ **To serve as a forum for ideas and the exchange of information in current and emerging minimal access technology and techniques.**
- ▶ **To foster, support, and encourage clinical and basic science research.**
- ▶ **To provide guidelines for training, standards of practice and granting of privileges which promote patient safety and the best clinical outcomes.**
- ▶ **To help assure that patients are able to obtain the most effective diagnosis and treatment from qualified surgeons.**
- ▶ **To develop, maintain and provide leadership to achieve the above goals.**
- ▶ **To maintain an atmosphere which promotes diversity and collegiality among members.**
- ▶ **To define and provide tools and guidelines for measurement in assessing surgical competence.**

## *Definition*

For purposes of this document, minimal access/non-invasive technology and techniques is defined as diagnostic or therapeutic flexible endoscopy, laparoscopic surgery, endoscopic image-guided and energy-assisted modalities and thoracoscopy as they relate to gastrointestinal or abdominal disease.

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UPMC Ad

SAGES will supply artwork

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## SAGES Targets “Retired” Members for Involvement

**M**any members joined SAGES at a time when their practice and professional life were in high gear. As SAGES matures as an organization, some of our long-term members are retiring from full practice. But their expertise and experience are still valuable to us as a growing, thriving organization.

Our collective imagination and drive to provide better education and research far outstrip the available time resources of busy members. **YOU MAY NOT BE IN THE O.R. EVERYDAY, BUT YOU CAN DEFINITELY HELP WITH SAGES’ MISSION!**

Below is a list of projects or tasks that could benefit from participation by an experienced surgeon who has some time to share. Please check off all those tasks on which you might be willing to participate. (Please do not complete this form if you already responded to a similar letter.)

Someone from the SAGES office or the relevant committee will contact you shortly after we receive your form.

### SAGES Senior Member Revitalization Survey

Please complete and return to Mindy Palomo, [mindy@sages.org](mailto:mindy@sages.org) or fax 310-314-2585.

NAME \_\_\_\_\_

PHONE \_\_\_\_\_

FAX \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_  
\_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ZIPCODE \_\_\_\_\_

EMAIL ADDRESS(ES) \_\_\_\_\_

#### I would consider working on the following projects:

- Review manuscripts for SAGES’ journal
- Serve as a facilitator for the rural surgery website.  
This involves looking in on the site on a regular basis, respond, facilitate discussion, solicit responses
- Follow up potential donors for SAGES Foundation
- Serve as a lab coordinator for a hands-on course
- Serve as a lab instructor for a hands-on course
- Develop quiz questions for online CME quizzes
- Help write validated questions for Fundamentals of Laparoscopic Surgery Project
- Other \_\_\_\_\_

## COMMITTEE UPDATES

### Continuing Medical Education

The SAGES Continuing Education Committee has been working on the following projects:

#### *Improving the evaluation process for our annual meeting.*

If you attended the World Congress in New York last March, you may have noticed the evaluation forms seemed different than usual. That is due to the efforts of the SAGES CME Task Force, which determined that our evaluation process needed a major overhaul. Once tabulated, the results turned out to be very useful and are now being studied by the 2003 Meeting Course Directors!

#### *CME Accredited Video Courses.*

SAGES offers two video courses for CME credit, the *SAGES CBD Video Course* and the *SAGES Colorectal Video Course*. You were recently mailed a brochure for these courses, but if it's not handy, you may contact the SAGES office for an order form at (310) 314-2404.

#### *SAGES Endorsed Courses*

(please see the list on page 6).

### Resident Education

Due to the generosity of Ethicon Endo-Surgery, Intuitive Surgical and United States Surgical, SAGES will have the opportunity to increase their resident course offerings during the upcoming year. Please refer to SAGES website for the latest and most complete information.

SAGES' Basic courses are available to PGY 2-3 residents and SAGES' Advanced courses are available to PGY 4-5 residents. SAGES has been lenient on this policy in the past, but due to the increased availability of courses, training levels will be strictly enforced to ensure the most beneficial educational experience for the attendees.

#### *The upcoming courses include:*

Nov. 14-15, 2002	<b>Advanced Solid Organ Surgery Course</b> United States Surgical, Norwalk, CT
January 17-18, 2003	<b>Basic Endoscopy and Laparoscopy Workshop</b> Ethicon Institute, Cincinnati, Ohio
Spring 2003	<b>Advanced Laparoscopic Course</b> TBD United States Surgical, Norwalk, CT
May 2-3, 2003	<b>Advanced Foregut Surgery Course, w/ Robotics</b> Ethicon Institute, Cincinnati, Ohio

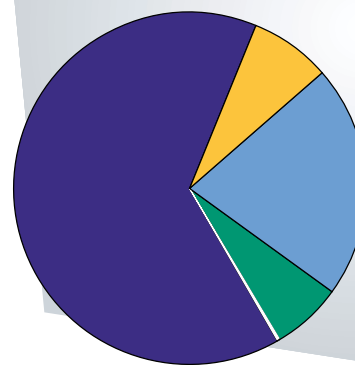
### Research

SAGES' 2003 research grant applications are now available online. At least 9 grants of \$15,000 each will be distributed in the upcoming year. These awards are available to SAGES' members only. The grant applications are posted on SAGES website at [www.sages.org/research/](http://www.sages.org/research/). The application deadline for 2003 is November 1, 2002.

The 2003 grant applications will not be mailed to every SAGES member as they have in years past. If you do not have access to SAGES' website, please call 310-314-2404 to have an application sent to you by mail. Please be sure to allow enough time for mailing. To have an application emailed to you, please send your request to [research@sages.org](mailto:research@sages.org).

### Membership

SAGES Membership Committee accepted almost 200 new members in March of 2002. Candidate membership continues to be the fastest growing category of new members. The current membership breakdown follows.



Active	2895
Intl.	315
Candidate	882
Senior	285
Honorary	21
Hiatus	9
<b>TOTAL</b>	<b>4407</b>

### In Memoriam

We acknowledge, with a sense of loss, these members of SAGES' Family who have died since the printing of our last newsletter.

#### **Mike CHANDEL, MD**

MC Kenzie, TN

Member since: October 23, 1989

#### **Charles P. HEISE, MD**

UW Hospital & Clinics

Dept Of Surgery

Madison, WI

Member since: April 1, 1998

#### **Norman ROGERS, MD**

Capitol Heights, MD

Member since: September 15, 1998

# SAGES Endorsed Courses

(As of July 31, 2002)

As a service to members, SAGES offers Course and Program Directors the opportunity to have their courses reviewed and endorsed by the Continuing Education Committee. You may find the most up-to-date list at [www.sages.org/endorsed.shtml](http://www.sages.org/endorsed.shtml).

These courses meet the guidelines established in the SAGES Framework for Post-Residency Surgical Education and Training and are endorsed by the Society of American Gastrointestinal Endoscopic Surgeons (SAGES).

**Course:** Esophageal Conference, Omaha, Nebraska

**Director:** Charles J. Filipi, MD  
**Date:** September 5 - 6, 2002  
**Contact:** Phone: 402-280-1830  
**Email:** [saoneill@creighton.edu](mailto:saoneill@creighton.edu)

**Course:** 2002 Update In Minimally Invasive Surgery, Toronto, Canada

**Director:** Joseph Mamazza  
**Date:** November 15 - 16, 2002  
**Contact:** Phone: 416-978-1617

**Course:** Endoscopic Radiofrequency Treatment of Gastroesophageal Reflux Disease, Nashville, TN

**Director:** William O. Richards, MD  
**Date:** Aug. 23, 2002; Nov. 8, 2002  
**Contact:** Phone: 615-322-6190

**Course:** Laparoscopic Bariatric Surgery (LBS) Preceptorship Program at the Alvarado Center for Surgical Weight Control, San Diego, CA

**Director:** Alan Wittgrove, MD & G. Wesley Clark, MD  
**Date:** Mon. - Thurs., Bi-monthly  
**Contact:** Phone: 303-745-0463 x225

**Course:** Advanced Videoscopic Surgery Training Course, San Francisco, CA

**Director:** Lawrence Way, MD  
**Dates:** Dates in 2002: 1/24-26, 2/28-3/2, 4/18-20, 5/9-11, 6/20-22, 9/26/28, 10/17-19, 11/21-23, 12/19-21

**Address:** Univ. of CA, Dept. of Surgery 513 Parnassus Avenue, S550 San Francisco, CA 94143-0475  
**Fax:** 415-476-9557

**Course:** Advanced Laparoscopic Suturing & Surgical Skills, San Francisco, CA

**Director:** Zoltan Szabo  
**Dates:** Check with MOET Institute  
**Address:** Phone: 415-626-3400

The courses sponsored by these institutions meet the guidelines established in the SAGES Framework for Post-Residency Surgical Education and Training and are endorsed by the Society of American Gastrointestinal Endoscopic Surgeons (SAGES).

**Institution:** Legacy Health System, Portland, OR

**Course:** Lee L. Swanstrom, MD  
**Directors:** Paul Hansen, MD and Emma Patterson, MD  
**Contact:** Phone: 1800 896-6275  
**Courses:** October 3-4, 2002

**Gastroesophageal Reflux Disease: A to Z**  
 November 4-8, 2002  
**Updates: Minimally Invasive Gastrointestinal Surgery** Honolulu, Hawaii

**Institution:** Minimally Invasive Surgery Center - Univ. of Pittsburgh, Pittsburgh, PA

**Course:** James Luketich, MD  
**Directors:** Philip Schauer, MD  
**Contact:** Phone 412-647-2845  
**Courses:** Contact institution for upcoming courses.

**Institution:** The Ohio State University, Columbus, OH

**Course Dir:** Scott Melvin, MD  
**Contact:** Phone 614-293-7399  
**Courses:** November 8, 2002,

**Minimally Invasive Bariatric Surgery**

**Institution:** Emory University School of Medicine, Atlanta, GA

**Course Dir:** C. Daniel Smith, MD  
**Contact:** Phone 404-727-1540, [www.emoryendosurgery.org](http://www.emoryendosurgery.org)  
**Courses:** Aug 2, 2002, **Introduction to Laparoscopic Bariatric Surgery**; Aug 9, 2002, **HALS (handoscopy)**; Oct 18, 2002,

**Modern Day Hernia - Inguinal**; Oct 25, 2002, **Laparoscopic Ventral Hernia**; Nov 1, 2002,

**Introduction to Laparoscopic Bariatric Surgery**; Nov 15, 2002, **HALS (handoscopy)**; Dec 6, 2002, **Laparoscopic Colon/Bowel**

**Institution:** Carolinas Laparoscopy & Advanced Surgery Program "CLASP", Charlotte, NC

**Course:** Frederick Greene, MD & B. Todd Heniford, MD  
**Director:** B. Todd Heniford, MD  
**Contact:** phone: 704-355-4823  
**Courses:** Sept 6, 2002, **Lymphatic Mapping & Sentinel Node Biopsy**; Sept 20, 2002, **Laparoscopic Nephrectomy & Prostatectomy**; Sept 27, 2002, **Laparoscopic Colorectal (Residents)**; Nov 1, 2002, **Laparoscopic Ventral & Incisional Herniorrhaphy**; Nov 8, 2002, **IVC Filter**; Nov 15, 2002, **Laparoscopic Colorectal & Solid Organ**; Dec 6, 2002, **Lymphatic Mapping & Sentinel Node Biopsy**

**Institution:** Southwestern Center For Minimally Invasive Surgery (SCMIS), Dallas, TX

**Course Dir:** Daniel B. Jones, MD  
**Contact:** phone: 1-800-688-8678  
**Courses:** Aug. 25 - 30, 2002, Nov. 3 - 8, 2002, Feb. 23 - 28, 2003, April 20 - 25, 2003, June 22 - 27, 2003, Aug. 24 - 29, 2003, Oct. 26 - 31, 2003, **Laparoscopic Bariatric Surgery Mini-Fellowship**; Sept. 27 - 28, 2002, Jan. 24 - 25, 2003, May 30 - 31, 2003, Sept. 26 - 27, 2003, **Laparoscopic Bariatric Surgery**

**Institution:** Medical Training Worldwide (U.S. non-profit organization)

**Course:** Ramon Berguer, MD  
**Director:** (President and Executive Director)  
**Contact:** Phone 415-892-1550

Medical Training Worldwide will be conducting laparoscopic cholecystectomy courses in developing countries. The training is endorsed by SAGES. Volunteers are welcome and used laparoscopic equipment is needed.

For more information, contact us at [www.med-training-worldwide.org](http://www.med-training-worldwide.org).

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SAGES will supply artwork

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POSTGRADUATE COURSES AND  
SCIENTIFIC SESSION

HOSTED BY SAGES

MARCH 12 – 15, 2003  
LOS ANGELES, CA USA



## Highlights of the SAGES Meeting

W. Stephen Eubanks, MD, Program Chairman—Complete printed program will be mailed in November.

### Hands-On Courses

*Laparoscopic Colon Surgery—Animate*

Chair: R. Larry Whelan, MD, Co-Chair: Morris Franklin, MD

*Flexible Endoscopy—Animate*

Chair: Jeffrey Marks, MD, Co-Chair: William Richards, MD

*Laparoscopic CBD—Inanimate*

Chair: David Rattner, MD, Co-Chair: Juan Pekolj, MD

### Postgraduate Courses

*Re-operative Laparoscopic Surgery*

Chair: Mark Talamini, MD, Co-Chair: Michael Holzman, MD

*Laparoscopic Hernia Repair*

Chair: Adrian Park, MD, Co-Chair: George Ferzli, MD

*Digital Editing*

Chair: Steven Schwaitzberg

Co-Chairs: Alex Gandsas, MD and Daniel Herron, MD

*Bariatric Surgery in the  
Adolescent Patient*

Chair: Philip Schauer, MD (SAGES)

*Joint Course with IPEG*

Chair: Steven Rothenberg, MD (IPEG)

### Additional CME Offerings

#### Appropriateness Forum:

*Optimal Management of the  
Morbidly Obese Patient*

Chair: Daniel Jones, MD, Co-Chair: John Hunter, MD

*Resident & Fellow Scientific Session*

Coordinators: Leena Khaitan, MD and Gretchen Purcell, MD

*MIS Nurse & GI Assistant Course  
Storz Lecture in New Technology:*

Samuel Wells, MD

*Gerald Marks Lecture:*

Scott Jones, MD

*Presidential Lecture:*

Bruce Schirmer, MD

*Invited Panel Lectures on:*

**New Technology, Robotics, Surgical Residency,  
High Volume Surgery, Flexible Endoscopy and more**

You can find additional information on-line at:

[www.sages.org/03program/](http://www.sages.org/03program/)

After October, 2002, you may register on-line at:

[www.sages.org/registration](http://www.sages.org/registration)



# SAGES' Outcomes Initiative

**S**AGES' Outcomes Initiative was created as a vehicle for surgeons to prospectively record their own cases and have the ability to compare their own data to national norms (as established by all participants in the database). This allows surgeons to define their own benchmarks, justify what we do as surgeons and improve our own practice by self-assessment.

## Web Site Updated

Surgeons now have several ways to record their own data and maintain their own surgical log. Data can be entered directly into the website following a case, it can be recorded manually on standardized forms and then entered into the website, or it can be entered via a Palm-based Handheld device. All data is maintained in an Access database. Each user can generate his/her own Access database at any time.

## Core Database Under Development

The most exciting data entry method, which is currently being evaluated, is the Core Database. SAGES provides users with an Access database with the pre-established fields maintained in the SAGES' Outcomes Database. Users can incorporate this table into their existing Access databases and add fields to gather additional information that may be of more interest to the individual. Then, with one click, the core data for the SAGES database is emailed to a central database. By collecting data once, one can keep one's own record as well as contribute to the national database.

Currently, the following forms are available: general SurgLog

form, Gallbladder form, GERD form, Hernia form, and the new Morbid Obesity form. Forms for Colorectal surgery and Pediatric Surgery will be available very soon.

## Why Participate?

It is important for surgeons in academic and rural settings to record their outcomes. There are already many organizations collecting data on all of us. Patients can go to websites to compare performances of surgeons at different centers. Most often the surgeons are not providing this data. We as surgeons need to take charge of our own information.

The information gained from the Outcomes Initiative can be an excellent way to evaluate current issues such as the relationship between provider volume and clinical outcomes. The participants in the database come from several practice settings and therefore, the information gained will be more reflective of "true practice" than the reports that come from single institutions. The SAGES Outcomes Database provides every general surgeon a way to maintain such a record. The added benefit is that the information also goes to a national database to better establish national norms and it allows each surgeon to compare his/her own results to those of all of his peers.

If you have not signed up yet, please call the SAGES Office at 310-314-2404 and ask for Jason. Signing up requires only a five-minute phone call. All information is completely secure and in compliance with HIPAA regulations. Good luck!!

– Leena Khaitan, MD, MPH, Outcomes Editor

## President's Message continued from page 1.

We must pay close attention to minimal access surgery as it is applied to new operations. This is particularly true if such procedures lie within the scope of practice for our members who are primarily general surgeons.

## The Bariatric Revolution

In fact, there is now another revolution in an area of General Surgery that SAGES cannot and must not ignore. It is the Bariatric Revolution. Bariatric, or weight reduction surgery, had its birth as a recognized area of General Surgery over 30 years ago. During its first 25 years, bariatric surgery encountered setbacks and was viewed skeptically by many in the medical and lay communities. Today bariatric surgery is enjoying a deserved rapid increase in popularity, as a result of several factors:

- ▶ An underserved patient population
- ▶ Increased awareness, acceptance, and demand for the procedures by that patient population
- ▶ An increased willingness of physicians to refer patients for bariatric surgery

- ▶ An increased interest in surgeons to perform the procedures.

Of these factors, only the first has not been amplified by the introduction of laparoscopy to bariatric surgery.

It is estimated that at least 3% and perhaps as many as 5% of the adult U.S. population is severely (or morbidly) obese (having a body mass index of over 40 kg/m<sup>2</sup>). This translates, by conservative mathematics, into 8 million or more individuals. The incidence among adolescents is skyrocketing. Obesity is currently estimated as being the second (after tobacco use) most costly preventable cause of health care dollar expenditures. In Canada the national health care budget showed a direct expenditure of over 4% for costs related directly to obesity, in addition to the costs of other conditions that are increased or created by obesity. That number did not include the billions of dollars spent on usually unsuccessful dietary therapies. Despite the recent increase in publicity and demand for bariatric surgery, in 1999 it was estimated only 20,000 bariatric operations were done in the U.S. This would represent about 0.25% of the individuals eligible for such surgery. Clearly this patient population is underserved, especially as demand now *Continued on page 16.*

# Proposal for Medicare Funding in 2003

Aaron S. Fink, MD, Co-Chairman, Legislative Committee

In its proposed rule published on June 28, 2002, the Centers for Medicare and Medicaid Services (CMS) outlined the likely changes in Medicare funding for calendar year 2003. Most of the ruling addresses changes relative to practice expenses for the “zero work pool” – medical services involving no physician work. These changes have little impact on Surgical specialties and will not be reviewed here. In the discussion which follows, I briefly review those changes of primary import to Surgical specialties.

In 2002, although General Surgery achieved substantial gains in RVU values (4%) as a result of the second “five year review”, the gains were lost due to the decrease (-5.4%) in the Medicare fee schedule conversion factor. The latter, which is used to convert RVUs into payment levels, is adjusted annually according to a complex formula. Two major adjustors are included in the formula: the Medicare Economic Index (MEI) and the Sustainable Growth Rate (SGR) adjustments.

In the method currently used to adjust the MEI, the labor portion of the MEI is adjusted by the 10-year moving average change in private nonfarm business applied only to labor productivity. Based on their research, CMS proposes that the MEI adjustment used for the 2003 physician payment update apply the same moving average change to the entire index.

CMS proposes to make this change because:

- ▶ It is theoretically more appropriate to reflect the productivity gains associated with all inputs (both labor and non-labor);
- ▶ The recent growth rate in economy-wide multifactor productivity appears more consistent with the current market conditions facing physicians; and
- ▶ The MEI still uses economy-wide wage changes as a proxy for physician wage changes.

CMS believes that this change will produce a stable and predictable adjustment which is more consistent with the moving-average methodology used in the existing MEI. CMS currently estimates that the MEI will increase 3.0 percent in 2003, about 0.7 percentage points more than it would have using the existing methodology. Since the current estimate of the MEI increase for 2003 is based on incomplete historical data, it may change slightly before the final announcement.

The SGR is intended to restrain the growth of Medicare spending for physician services by linking physician payments directly with the health of the nation’s economy. The SGR update for any year is mandated to be equal to the MEI

increased or decreased by an update adjustment factor determined using a statutory formula that takes into account growth both in Medicare physician spending and in the general economy. The statute limits the update adjustment factor to between +3.0 and -7.0 percentage points. In March, 2002, CMS estimated that the update adjustment factor would be -13.1 percent. Since the statute limits the update adjustment factor to -7.0 percent, CMS expects the 2002 physician fee schedule update to equal the MEI reduced by 7.0 percentage points.

As you can see below, the impact of the above two factors, plus a minor “legislative adjustment”, **result in a update factor of 0.956, a -4.4% further decrease to the already diminished conversion factor.**

MEI	3.0%	(1.030)
SGR	-7.0%	(0.930)
<u>Legislative</u>	<u>-0.2%</u>	<u>(0.998)</u>
Update	-4.4%	(0.956)

[NOTE: It must be remembered that the formula is multiplicative, in lieu of additive. Thus, for example, the 3.0% MEI adjustment is recorded at 1.030 and is multiplied by 0.930 (corresponding to -7%). Serial multiplication results in the figure of 0.956].

Unfortunately, in contrast to last year, there is no substantial RVU update to counteract the proposed further decrease in the conversion factor. Given an additional anticipated 1% decrease in practice expense compensation resulting from methodological adjustments, **it is estimated that the overall impact of these factors will be a further 5.0% decrease in average General Surgical payments.**

While substantial efforts to defer these actions continue, it is unclear what the final outcome will be given the increased economic burden for the anti-terrorist initiatives, as well as Homeland security. Clearly our support remains vital. I encourage you to take avail of the ACS’s Legislative Action Center, which can be accessed via the internet at <http://capwiz.com/facs/issues/alert/?alertid=63328&type=CO>.

With appreciation to Cynthia Brown, Director, ACS Division of Advocacy and Health Policy, for her invaluable assistance with this article.

This section of SCOPE explores the science and ethics of surgical endoscopy and attempts to address some controversial questions.

Your thoughts and comments will be enthusiastically received. Letters to the editor will be published on a space-available basis.

## The “Six Competencies:” A Laparoscopic Surgeon’s View

**Peter F Crookes MD**

Every patient who has elected to undergo a surgical operation must have wondered, hoped, or prayed, that the surgeon is competent. For simple routine clinical problems with more or less predictable outcome, the issue of competence may perhaps be a minor one, and patients may vocalize more concern over such matters as hospital food, or rapidity of nursing responses to pressing the call button. But for major surgery, for serious or unusual diseases the issue of their surgeon’s competence must be in the foreground of their thoughts. Literature is full of incidents where the patient is referred to a surgeon who is simply described as “the best.” Trusting patients in the past were often comforted by these reassurances, but the grounds for the reputation was rarely or ever discussed.

Recently the issue of competence has emerged as a leading theme in current medical practice. It is of concern not just to residents, and those who train them and those who examine the results and offer the public the reassurance that they are satisfactorily trained, but to all practicing doctors because the rapidity with which advances are absorbed into standard practice demands that regular updating and re-education are built-in to every doctor’s lifestyle. Academics with interests in the educational process have been quietly working behind the scenes to analyze what constitutes competence and how it can be measured, and in the past few years the issue has been the focus of attention by some of the major certifying bodies in the nation: the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) – the body which includes the American Board of Surgery – have endorsed a position which enumerates general competencies which are applicable to every practicing physician regardless of individual specialty. These were adopted in 1999, with the expectation that by mid-2001 all residency programs would incorporate the concepts into the structure of their educational efforts. They have since become known as the six competencies and are listed below.

Does this represent a real advance in assessing competency of physicians, or is it merely window dressing? At first blush, the six competencies seem merely to be dividing perfection into six subgroups. Does this system of stratifying competency have any real merit, or is it merely going to degenerate into more repetitive and meaningless paperwork such as, for example, the lengthy handwritten lists and care plans our nurses have

to fill out for every patient coming into the operating room?

One of the most remarkable things that our society membership will notice about the six competencies is the complete absence of any recognition of the importance of technical ability. It is undeniable that the six competencies are intended to apply to all physicians, whether or not they perform surgery. But increasingly, physicians in a wide range of non-surgical specialties are expected to be trained in, and perform, interventional procedures, and the range of such procedures is expanding daily. Pulmonologists, cardiologist, gastroenterologists, nephrologists, radiologists, all perform invasive procedures demanding manual skill. Many people faced with the need to implement training and assessment exercises based on the six competencies will wish that the ACGME had included measures of technical skill in their deliberations.

What will it mean to us in practice? To those in academic centers with residency programs, it will mean some extra paperwork and a change in emphasis as we are forced to assess in more detail how our residents are progressing. One of the underlying principles guiding the analysis of competency was that whatever we can measure we can improve. In our efforts to comply with the guidelines regarding these six competencies, we must not forget the importance of teaching and assessing technical skills. In the past ten years, laparoscopic surgeons have been in the forefront of this kind of work. Laparoscopic surgery is ideally suited to the analysis of operative skills, through such initiatives as the development of simulators which can measure the speed and accuracy of a wide range of maneuvers and provide accurate and timely feedback to the trainee surgeon. Some of the most innovative and elegant examples are on display in the SAGES learning center every year. Make sure you visit the center when you come to Los Angeles in March.

### *Six Competencies:*

- ▶ **Patient Care**
- ▶ **Medical Knowledge**
- ▶ **Practice Based learning and improvement**
- ▶ **Interpersonal and communication skills**
- ▶ **Professionalism**
- ▶ **Systems-based practice**

*8<sup>th</sup> World Congress draws 3,000 surgeons, exhibitors and guests. Surgeons from around the world say a resounding "Yes!" to New York!*



From the first minutes of registration through a week of extraordinary exhibits and lectures, the 8th World Congress brought Education and new technology to more than 1,500 surgeons.



*Opening ceremonies evoke world harmony and solidarity with New York.*



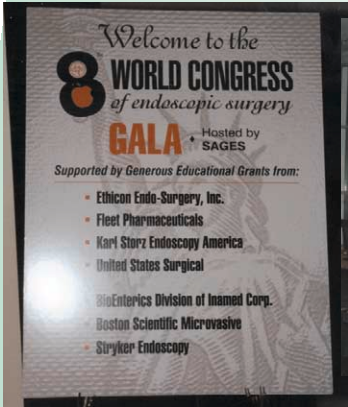
Representatives of all the IFSES member societies participated in emotional opening ceremonies that celebrated our unity and commemorated the brave firefighters, emergency medical personnel and police of New York City.



# Nights out in the Big Apple



Dr. and Mrs. Bruce Schirmer and Dr. and Mrs. Dennis Fowler lead guests into United Nations Delegates Dining Room for a Faculty Dinner where the international leaders were congratulated on a superb program.



The World Congress Gala, with more than 700 guests, was a candle lit evening at Chelsea piers with a spectacular view of the New York City skyline, fabulous food and great entertainment in the form of the International Sing-Off. Which included 10 groups from 4 continents and a fabulous duo from Ethicon Endo Surgery who braved the stage in their debut performance. Capping off the evening President Bill Traverso presented each SAGES staff member with a tribute and a rose.



## Highlights and Honorees



▲ John Coller (2<sup>nd</sup> from right) was honored with the SAGES Distinguished Service Award. John's Family showed up with dozen's of John Coller "fan" signs. The SAGES leadership quickly appropriated these. (L to r) Bill Traverso, Wayne Schwesinger (hiding!) Dr. Coller and Lee Swanstrom.



▲ The Program Chairman and a host of SAGES presidents gather to pay tribute to Professor Paul Swain, the Karl Storz Lecturer in Innovative Technology. (L to r) Drs. Bruce Schimmer, Dr. Swain, Lee Swanstrom, Bill Traverso, Nat Soper, Jeff Ponsky and George Berci

### The Blue Ribbon panel. ►

These poster presenters were awarded a blue ribbon for best poster in their category. These 14 represent the best of more than 600 posters presented at the 8th World Congress.



▲ This gathering might be entitled "The Three!" Taking a well-deserved breather are: PG Course Chair Nat Soper; International Program Co-Chair; Antonio Lacy and Program Chair Lee Swanstrom.

## 8<sup>th</sup> World Congress Webcast

SAGES is proud to present the free webcast of the Scientific Session from the 8th World Congress of Endoscopic Surgery. Over 50 presentations have been selected for the webcast. All presentations feature the full audio, video and Powerpoint from the original talk. Any presentation available from the 2002 Webcast may be purchased on CD for archival viewing. Please call David Schlamme at 215-638-9700 or send e-mail to [dschlamme@vioworks.com](mailto:dschlamme@vioworks.com) for more information on CD orders.

### View the Webcast at:

<http://www.vioworks.com/logon/ConferenceMainEntrance.asp?ConfSkey=80>

In order to continue to meet your needs, SAGES has included a banner and link to a short survey at the bottom of each presentation and we have also included it below.

If you have visited the 2002 Webcast, please take a minute to fill out the survey: <http://www.vioworks.com/clients/sg051002/>



▲ The Circon Golden Scope is presented to the winner of the Young Researcher Award, Ninh Nguyen, MD. Left to right, a representative from Circon, Ninh Nguyen, MD, and Jeff Marks, MD, SAGES Resident Education Chair.



▲ Professor Kurt Semm (2<sup>nd</sup> from right) was honored as the Pioneer in Endoscopy. Congratulating him on "showing us horizons we had not noticed and helping make it possible for surgeons to embrace endoscopic surgery" are (l to r) Drs. Rick Greene, Lee Swanstrom, Dr. Semm and Bill Traverso.

*Best Presentation during the 8<sup>th</sup> World Congress by a Resident or Fellow*

- 1<sup>st</sup> Place** **Hugh Houston, MD** Vanderbilt University
- 2<sup>nd</sup> Place** **Paul Ridgeway, MD** Imperial College of Science, Medicine and Technology
- 3<sup>rd</sup> Place** **Lily Chang, MD** University of Washington

**2002 Research Grant Award Winners**



**Mohamed R. Ali, MD**, "Intracellular Cytokine Expression By Peripheral Monocytes And Lymphocytes During Laparoscopic Surgery," Medical College Of Virginia, Virginia Commonwealth University, (l) Support: United States Surgical, presented by John Hart (r).



**Kristi L. Harold, MD**, "The Effects Of Prolonged, High-pressure (15mmHg) Carbon Dioxide Pneumoperitoneum In A Porcine Sepsis Model," Carolinas Medical Center, (r) Support: Ethicon Endosurgery, presented by Bob Honigberg, MD (l).

**H. Jaap Bonjer, PhD, MD**, (not pictured) "Laparoscopic Versus Open Live Donor Nephrectomy: A Prospective Randomized Trial Regarding Quality Of Life And Costs," Univ. Hospital Rotterdam, Support: United States Surgical



**Brian J. Dunkin, MD**, "The Impact Of A Virtual Reality Simulator Curriculum On Mastery Of Colonoscopy During Fellowship Training," University Of Miami School Of Medicine, (r) Support: CB Fleet.



**Hugh L. Houston, MD**, "Prevalence Of Non-Acid Reflux Following Medical And Surgical Treatment Of Barrett's Esophagus," Vanderbilt University Medical Center, (r) Support: Ethicon Endosurgery, presented by Bob Honigberg, MD (l).



**Jason B. Fleming, MD**, "Evaluation Of Vascular Endothelial Growth Factor (VEGF) In Peritoneal Washing Specimens Obtained At Staging Laparoscopy In Patients With Upper Gastrointestinal Malignancies," University Of Texas - Southwestern Medical Center At Dallas, (l) Support: United States Surgical, presented by John Hart (r).



**Blair A. Jobe, MD**, "The Effect Of Neoesophagus Vascular Augmentation And Delay Phenomenon On Esophago-gastrostomy Stricture Formation," Oregon Health Sciences University And PVAMC, (l) Support: W.L. Gore, presented by Angela (r).

Support: United States Surgical, presented by John Hart (r).



**James Fleshman, MD**, "Does Antisense To Beta-Catenin Reduce Port Site Implantation In Colon Cancer?" Washington University School Of Medicine, Support: Karl Storz Endoscopy America. Award accepted on Dr. Fleshman's behalf by Emily Winslow, MD (r), presented by



**Edward Lin, D.O.**, "Laparoscopic Living Donor Hepatectomy and Graft Preservation," Emory University School Of Medicine, (l) Support: United States Surgical, presented by John Hart (r).

John Davis (l).

**Harrison S. Pollinger, MD**, (not pictured) "The Effect Of Co2 Pneumoperitoneum And Wound Closure Technique On Tumor Implantation," Carolinas Medical Center, Support: Ethicon Endosurgery



**Tonia M. Young-Fadok, MD**, "Patterns of Hormone Flux and Fluid Mobilization Associated with Laparoscopic Colorectal Resection," Mayo Clinic, Rochester, (l) Support: Stryker Endoscopy, presented by Kevin Unger (r).

exceeds supply.

The last half of the 1990's saw the application of laparoscopy to bariatric surgery. The delay in using laparoscopy for bariatric surgery was undoubtedly due to the technical difficulty of such procedures as well as equipment limitations. The performance of a laparoscopic gastric bypass was viewed as an almost insurmountable technical challenge by bariatric surgeons in the year 1994. Within five years some centers had not only conquered the challenge but also accumulated large series of procedures. There emerged a new perception of bariatric surgery as a highly difficult, technically challenging operation that could only be performed with excellent advanced laparoscopic skills. It became more attractive as a field for the budding laparoscopic surgeon. Internationally, laparoscopy revolutionized bariatric surgery through the rapidly developing popularity of the laparoscopically placed adjustable gastric band for weight loss. The adjustable band is now poised to make its mark on the U.S. population after FDA approval last year.

Patient interest in bariatric surgery exploded in the 1990's. As the procedures became more widespread, patient and referring physician acceptance increased and the popularity of the procedures increased. Rapid communications, the Internet, mass media coverage of stories about bariatric surgery, and even televised procedures all brought more recognition of the field to the lay public.

However, the potential for having bariatric surgery performed laparoscopically has done to bariatric surgery what the option of laparoscopy did for antireflux surgery five to seven years ago. Patient interest is now overwhelming. Physician referrals have increased several-fold. Waiting lists for many established bariatric surgeons are six months or longer. These factors combined have increased the number of bariatric operations done in the U.S. from about 20,000 three years ago to an estimated 70,000 this past year.

### *Surgeon Training...where and how?*

Meanwhile, there is an urgent demand by surgeons seeking to perform laparoscopic bariatric surgery for adequate educational, tutorial, and proctoring experiences. Where are surgeons turning for these educational opportunities? One obvious choice has been the American Society for Bariatric Surgery. This society has more than quadrupled its membership in the last few years; it is the fastest growing surgical society in the U.S. In June the ASBS meeting attracted over 1700 registrants.

While ASBS is the society with bariatric surgery as its focal point, the huge demand for training and education in laparoscopic bariatric surgery presents both an opportunity as well as an obligation for SAGES. As the fastest growing area in general surgery, laparoscopic bariatric surgery should become a focal point for SAGES over the next few years, until the demands for adequate training and educational opportunities by practicing

laparoscopic surgeons are met. These demands extend to the resident years as well. Fellowship opportunities for this discipline are also in high demand. Residents in only a few medical centers actually perform any significant number of laparoscopic bariatric operations. As with many areas of advanced laparoscopic surgery, we cannot say that we are preparing our residents adequately to perform these operations.

### *SAGES' Role*

Laparoscopic bariatric surgery is a topic addressed at SAGES' annual meeting for the past several years. In Los Angeles (March 2003), registrants may participate in

- ▶ An appropriateness conference
- ▶ A postgraduate course on bariatric surgery in the adolescent
- ▶ The Scientific Session, including oral, video and poster presentations.

However, in my opinion this is not enough to meet the current educational and training needs of American surgeons. SAGES must become more responsive to this demand. I have authorized the creation of a Bariatric Task Force, which will develop and implement those ideas that will make SAGES a society that supports practicing and prospective laparoscopic bariatric surgeons. New bariatric surgeons will undoubtedly benefit from application of the vast experience of SAGES in other areas of MIS to their practices in laparoscopic bariatric surgery. Hopefully those surgeons will join our ranks as well, if they have not done so already.

SAGES has, if anything, proven that being a dynamic society, responsive to the changing needs of surgeons in practice and in training, creates a win/win situation for all involved. From its flexible endoscopic roots through the laparoscopic revolution with its progressive inclusion of an increasingly larger number of operative procedures and areas, SAGES has maintained a forward-looking perspective. Emphasis on safe application of new technology and procedures has been a highlight of our educational mission. We now have another vital area to which we must, for the benefit of our patients and their surgeons, devote greater attention. Regardless of our own personal opinions about bariatric surgery, perhaps based on experiences now of historic importance only, I encourage all of the SAGES community to assist in meeting this new demand to provide safe and effective minimally invasive surgical therapy for a segment of the population desperately in need of it.

Through the efforts of the newly established Bariatric Task Force, the vision and support of the SAGES leadership, the efforts of our dedicated staff, and most importantly through the support and enthusiasm of you, the members of SAGES, I hope that by next year we can answer an affirmative "Yes" to the question posed by the title of this article: "The Bariatric Revolution: Can SAGES Respond?" We will be doing a great service to an underserved and long overlooked group of patients.

– Bruce Schirmer, MD



A group of SAGES and EAES leaders and Publication Committee members convened in New York last January for an in depth discussion and review of the journal, our publications with Springer, and how we work together. The group determined that the focus of the journal would remain minimal access surgery and new technologies. The retreat was very productive, rewarding, and resulting in several dramatic improvements in the journal, detailed below.

### *Editorial Board Re-Structured*

The *Surgical Endoscopy* Editorial Board has been re-structured by the Editors-in-Chief, including three associate editors from SAGES and EAES, one technical editor, and 50-60 editorial board members. Each term limit will be 1-3 years in length, with an option for re-appointment.

### *Formation of Jt. Journal Oversight Committee with EAES*

A Joint Journal Oversight Committee was formed to govern the financial and business aspects of the journal. The SAGES and EAES Boards approved the structure of that Committee to include the Editors-in-Chief, Treasurers, Presidents, the Publications Committee Chairmen, and the Executive Directors ex officio. The Joint Committee will first meet at ACS this Fall.

### *News from Springer*

Most members know that they can access the journal online. You may not know, however, that SAGES members receive a discount on other Springer publications when ordered online. You may also not know that with Online First most articles are published electronically months before the print version is available, even before the issue and page numbers have been assigned. Publication of an article in a print journal usually takes several months. Even when peer-reviewing, revisions, final acceptance, typesetting and proof-reading have been completed, the paper cannot be printed immediately, but must wait until the "next available issue." For technical reasons, a printed journal has to have a minimum number of pages, and issues are also published according to an annual schedule. However, with the Online First articles, the official date of publication is the on-line publication date. The article can be cited by the digital object identifier (DOI). This means that the online first article is available in PubMed days after electronic publication.

Among the many exciting changes occurring at the journal is fast progress towards the electronic submission and review of manuscripts. *Surgical Endoscopy* is currently converting its manuscript submission, review and decision processes from one of paper copy to the quicker, more efficient web based on-line article submission, peer review system called Manuscript Central. Manuscript Central will enable authors to submit their manuscripts to the journal electronically and will greatly facili-

tate the review process, and will be available by the end of the year.

#### **The benefits for Manuscript Central include:**

- ▶ Easier and quicker submission of manuscripts
- ▶ Reduction in time from submission to first decision
- ▶ Significant improvement in communication between authors, editors and reviewers
- ▶ Reduction in administrative and postage expenses

The 2001 ISI Journal Citation Report shows *Surgical Endoscopy* having an increased impact factor, from 2.056 in 2000 to 2.374 in 2001. This ranks our journal 17th out of 139 titles listed in surgery. Congratulations, *Surgical Endoscopy*!

### *SAGES Manual Update*

There is now a PDA-version of the SAGES Manual available, created by Skyscape ([www.skyscape.com](http://www.skyscape.com)). The outline-based content of The SAGES Manual lends itself perfectly to handheld devices. Skyscape's version is \$64.95 and can be purchased directly from Skyscape by downloading from their website or by purchasing a CD-ROM. Users can choose either the Palm operating system or the Windows CE/Pocket PC system.

The product is "beam-locked," i.e. one user cannot beam it to another user's Palm Pilot. When you download a Skyscape product, you have a unique serial number attached to the download. Skyscape's system also captures the device ID unique to the user's handheld. Together, these numbers "unlock" the product and keep it secure to that specific handheld device.

You can visit Skyscape at [www.skyscape.com](http://www.skyscape.com). Search "Products" under "Surgery." Skyscape currently has two surgery products so you will see *The SAGES Manual* immediately.

The current SAGES Manual is also undergoing revision, once again under the Editorship of Carol Scott-Conner, MD. This 2nd edition should be available by SAGES 2004 Annual Meeting.

A new manual has been in development for more than a year, under the co-editorship of Larry Whelan, MD and James Fleshman, MD. All the chapters are complete, and have been reviewed by an Editorial Advisory Board. The new manual will be entitled *The SAGES Manual of Peri-Operative Care in Minimally Invasive Surgery*, and will hopefully be published in mid-2003.

**Access Surgical Endoscopy online at**  
**<http://www.sages.org/members/springer.html>**

#### **Springer's Contact Information:**

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## Viruses and SAGES

Normally this space is reserved for announcements about the SAGES web site and our continuing efforts to provide you with high-quality services and educational products. However, recent events have compelled me to use this space to address a slightly different topic: Email viruses coming from sages.org email accounts.

In the last three months, there has been an explosion in the number of virus-infected messages received by the SAGES office. This is especially notable because almost all the messages are being generated by a variant of the same virus... W32.Klez.gen@mm, aka "Klez."

What makes this worm particularly virulent is that it will use random email addresses on the infected computer for both the sender and the recipient, which causes the worm to appear to be coming from a trusted source which leads me to the main point of this article. The SAGES office sends out tens of thousands of emails each month, with the vast majority of those coming from the webmaster account of sagesweb@sages.org. This means that there is a very high probability of a sages.org address being present in the Microsoft address book on an infected computer or network and therefore a high probability that you may receive a message from a sages.org account that contains a virus.

First, please be assured that the SAGES Office is and will remain virus-free. Second, the SAGES administrative staff never sends attachments that have the following extensions: .bat, .exe, .pif or .scr. The only exception to this is our Outcomes PDA software that can be downloaded from the SAGES web site and does have the .exe extension. If you do receive an email that appears to originate from a sages.org address and contains an attachment ending in the above extensions, it is most likely a virus; delete the message without opening or previewing it. Finally, everyone should follow safe computing practices. At a minimum, this means installing anti-virus software that loads

when your computer is booted, scans all incoming email attachments, and has a mechanism for updating the virus definitions in order to catch the newest virus threats. Home computer users should also consider obtaining a software or hardware firewall that can detect both inbound and outbound internet traffic and alert you if your computer is sending email without your permission or knowledge.

I am more than happy to discuss security in greater detail with you by email. Send your messages to sagesweb@sages.org. Finally, I have included a brief list of anti-virus and firewall products below.

Sincerely,

The SAGES Webmaster

### *Anti-Virus/Firewall Suites:*

#### **Norton Internet Security**

[http://www.symantec.com/sabu/nis/nis\\_pe/](http://www.symantec.com/sabu/nis/nis_pe/)

### *Anti-Virus Software:*

#### **Norton Anti-Virus**

[http://www.symantec.com/product/index\\_ns6.html](http://www.symantec.com/product/index_ns6.html)

#### **McAfee Virus Scan Online**

<http://www.mcafee.com/myapps/vso/default.asp>

### *Personal Firewalls (software based):*

#### **McAfee Personal Firewall+**

<http://www.mcafee.com/myapps/mpfp/default.asp?cid=3232>

#### **Norton Personal Firewall**

[http://www.symantec.com/product/index\\_ns6.html](http://www.symantec.com/product/index_ns6.html)

#### **ZoneLabs ZoneAlarm**

<http://www.zonelabs.com/store/content/home.jsp>

#### **Blackice Defender**

[http://www.iss.net/products\\_services/hsoffice\\_protection/blkice\\_protect\\_pc.php](http://www.iss.net/products_services/hsoffice_protection/blkice_protect_pc.php)

## SAVE THE DATE

## SAGES & IPEG to Meet in Tandem Again in '03

SAGES and IPEG (International Pediatric Endoscopic Surgery Group) will once again join their annual meetings in March 10-15, 2003 in Los Angeles, CA. After their first successful tandem effort in Atlanta in March of 2000, the groups have determined to have joint meetings when IPEG meets in the U.S. As in the previous collaborative effort the two groups will meet "back-to-back" not concurrently, giving surgeons and opportunity to participate in both meetings. There are several overlapping educational programs.

*Some of the highlights of the joint schedule include:*

- ▶ **Minimally Invasive Surgery in Adults & Children**
- ▶ **One Exhibit Hall**
- ▶ **5 Postgraduate Courses**
- ▶ **3 Hands-On Courses w/Labs**
- ▶ **Expert faculty in Minimally Invasive Surgery and New Technologies**

## SAGES PROSPECTIVE EGD STUDY

*You are invited to participate in the most significant EGD-by-surgeons study ever undertaken! Join the 200 other surgeons who have already signed up to participate!*

**TITLE: SAGES Prospective Esophagogastro-duodenoscopy (EGD) Outcomes**

**PRINCIPLE:** John W Kilkeny III, MD and

**INVESTIGATORS:** William Reed, MD

**CO-INVESTIGATORS:** 200 - 300 surgeons

### **SPONSORED AND OPERATED BY SAGES**

Very little data exists regarding the efficacy or procedural complications (intra and post) for surgeons performing diagnostic or therapeutic EGD. A prospective study is in order to define these parameters.

**Study Hypothesis:** For the last two decades, SAGES has been involved in a continuous dialogue regarding the criteria for granting privileges to perform flexible gastrointestinal endoscopy. Formal requests for such documentation have been frequent. Some guidelines have been published by nonsurgical organizations regarding the safety and appropriateness of performing EGD studies along with the minimum number of procedures endorsed to achieve this competence. Although these recommendations can vary in specifics, the commonality that exists is that they are promoted by either group consensus or literature reviews. SAGES, therefore, proposes to undertake a prospective data analysis to formulate outcome-based guidelines addressing the safety and appropriateness of surgeons performing diagnostic and therapeutic EGD procedures.

**Study Ends December 1<sup>st</sup>. Sign Up Today!**

**Goals:** To assess the safety and efficacy of EGD performed by surgeons. Measurements would include procedural morbidity, along with correlated findings and any therapeutic interventions. Correlative relationships between these parameters and case volumes would also be analyzed.

**Your Participation Will Make This Possible:** SAGES is seeking surgeons to voluntarily submit a minimum of ten (10) and a maximum of two hundred (200) **consecutive EGD procedures.**

Any surgeon willing to submit the minimum of 10 cases may participate. A sample of the data collection sheet will be faxed or emailed to you, if requested, to demonstrate the minimal amount of time required to complete each form.

**YES**, I would like to join this collaborative effort.

**YES**, I would like to join, but send a sample data collection sheet first.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

# PRIOR EGDs: \_\_\_\_\_ CURRENT # ANNUAL EGDs: \_\_\_\_\_

# YEARS IN PRACTICE: \_\_\_\_\_

### **REPLY ASAP TO SAGES:**

FAX to: 310-314-2585; E-MAIL to: [egd@sages.org](mailto:egd@sages.org)

**Thanks to Olympus-America, Inc., for the generous educational grant to support this study in part.**

## JOB CORNER

### **SAGES Unveils Redesigned Job Board on Website**

**D**ue to the increased demand for the online SAGES Job Board, it has been redesigned as a searchable database of jobs with many new features for both the job seeker and the recruiter.

#### *Job Seekers:*

As mentioned above, you may now search the database of available jobs to more quickly find an opening. Furthermore, the new Job Board simplifies the process of contacting a recruiter or notifying a colleague about an opportunity. At the bottom of each listing are links to contact the recruiter or forward the listing to another person.

#### *Recruiters:*

The online Job Board gives recruiters more flexibility and control over their listings. Recruiters can now set the length of time a listing will appear on the Board, will be notified by e-mail when a listing is about to expire and will be given the opportunity to automatically renew the listing up to three times. Additionally, recruiters may now set a password for their listing upon submission that will allow you to edit or delete your ad at any time.

SAGES provides the online Job Board as a service to our members and the surgical community. There is no fee to place an ad or to browse the available listings. Please visit the Job Board at: <http://www.sages.org/jobboard/index.php>

# More from the President...

Five months have passed since we last convened in New York for the 8th Annual World Congress of Endoscopic Surgery. For those of you in attendance, you know that the meeting represented a true testimony to the resiliency and spirit of not only the host city, but of the international community of endoscopic surgeons. Faced with significant concerns prior to the meeting that attendance would be slashed by the events of September 11, there was, at times, debate among the SAGES leadership as to whether cost-cutting measures needed to be enacted to avoid a potential financial disaster.

Instead, March 13-16 saw an unprecedented attendance record set for a World Congress held in the U.S. Thanks for this support goes to many sources: to our international colleagues who showed up in strong numbers from all corners of the world, to our SAGES staff who did an extraordinary job of promoting and preparing for the meeting, to our surgeons in the Northeast and especially greater New York area, who made the on-site registration numbers significantly increase the total number of registrants. Lee Swanstrom, Program Chair, deserves a huge acknowledgement of appreciation by SAGES for his and all his committee's work to put the program together. Barry Salky, local arrangements, Ken Forde, Honorary Chair, Antonio Lacy, International Co-Chair, and a long list of others also deserve special thanks.

My purpose in writing this column is really quite simple: it is eminently clear that most of us in SAGES do not know of the vast amount of work our colleagues are doing to promote our mission. Highlights of selected projects will be described in this column to improve that awareness.

The SAGES Outcomes Committee continues to make extraordinary progress in assembling an impressive database for members use. SAGES members enjoy a relatively unprecedented benefit of membership: they can submit cases to this database **free of charge**, and use it as a norm for comparison to national averages. The only other database of any society to which your President belongs is available to members only on a yearly charge basis. As the winds of change blow us closer to the era of accountability reporting and outcomes measurements as a determinant of quality of practice, it behooves all of us to become disciplined enough to enter data into such a database for short and long-term outcomes analysis. For those of you unaware to whom we owe thanks for this project, the list is relatively short: Bill Traverso and John Hunter have been the forces behind this project, with strong financial support from our corporate partner Ethicon Endo-Surgery.

The Fundamentals of Laparoscopic Surgery (FLS) Committee, now under the joint direction of Jeff Peters and Lee Swanstrom, has continued to make significant strides toward rollout of the completed, test-validated, educational

tool that hopefully will serve the laparoscopic surgical community much as ATLS has served the community of trauma and critical care surgeons. Testing at beta sites began in August. Anticipated final rollout of the project is by year-end 2002. The FLS Committee has been very busy writing backup test questions to compile a bank of such questions for future use, as well as other case scenarios for the module. Review of the beta site test results is in the immediate future, as are further efforts to secure funding from foundations and national grant sources. Finally, Jeff Peters and Gerald Fried delivered a presentation on the FLS module to the American College of Surgeons Board of Regents on June 7. I have it on good sources that the presentation was well received; the Board will potentially vote in October as to whether the ACS will enter into a joint venture with SAGES to distribute the FLS module for the potential benefit of both practicing surgeons and finishing surgical residents.

Another area that I wish to highlight in this column is the initiation of what I hope will be a strong effort, during the remainder of my Presidency, to represent the interests of the "rank and file" SAGES members. One clearly obvious area in which SAGES can help the practicing surgeon is to act on their behalf in the ongoing struggle to recognize the benefit of laparoscopic surgery and similarly the value of the laparoscopic surgeon. Currently the reimbursement from Medicare for an open inguinal hernia is higher than for a laparoscopic one. The same is true for cholecystectomy. The latter situation points out a distinct irony of reimbursement incentive: low reimbursement for laparoscopic procedures could take away the incentive for our members and other highly skilled laparoscopic surgeons from offering patients the potential benefits of a laparoscopic approach for treating their surgical disease. Clearly this is wrong.

The SAGES Legislative Committee, under the able guidance of Aaron Fink, is currently leading our efforts to address the issues of obtaining appropriate CPT codes for laparoscopic procedures, as well as the appropriate reimbursement for surgeon's efforts to perform such procedures. Eric Weiss, SAGES representative to the CPT coding committee, will soon attend a meeting to discuss these issues. The Committee urges all SAGES members to participate in any writing campaigns for which your support is asked, as well as completing any surveys of hours and effort required for various surgical procedures if you receive such surveys. It is only through the compilation of data from such surveys that the regulatory committees regarding reimbursement make decisions regarding fee schedules. The percentage of such surveys completed and returned by surgeons is abysmally low. So PLEASE, help the Committee, yourself, and your fellow surgeons if you are presented with such an opportunity.

The final subject that I shall address is the SAGES Foundation. Established in 1998, the Foundation has the long-

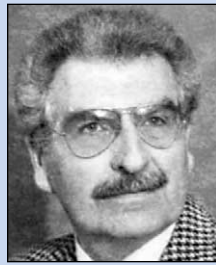
term goal of funding research and education in minimally invasive surgery through money generated from the endowment of the Foundation. The goal for the Foundation Endowment is \$10 million. To date the Foundation has received \$3 million in pledges from our corporate partners and an additional \$350,000 from individual SAGES members. The goals of the Foundation will only be met if we continue to receive ongoing support from the membership.

As a SAGES member, I urge you to consider the importance of the Foundation for the future of our mission to promote minimally invasive surgery. How valuable has minimally invasive surgery been to your practice? Is it time to “give back” something, to further the development of all the benefits to our patients and to us, which have occurred as a result of these advances in surgical technology? How much reimbursement do you receive for only one brief lap chole, and is that in any way a yardstick by which you may consider supporting the Foundation?

Consider the following: recently I have developed the habit of encouraging any fees I generate for proctoring or legal work, which I do in time away from the office, to be donated to the Foundation. The surgeons or lawyers involved have been happy to learn that their payment has been turned into a tax-deductible contribution and I lessen my estimated taxes for the next year. Consider such a donation of your time to SAGES. If we all did this in the coming year, the benefit to the Foundation would be unprecedented and set a standard for Society giving which would be unmatched in American surgery. It would send a powerful message to our corporate partners about the value we place in the Foundation. One of the great privileges of being a high-income earner is the ability to be generous.

I remain indebted to all of you for the privilege of being able to serve as your President.

– Bruce Schirmer, MD, President



*On March 13, 2002, during the Opening Ceremonies of the World Congress, Professor Jacques Périssat, President of the International Federation of Societies of Endoscopic Surgeons (IFSES), gave the following address to attendees.*

**H**ere we are, coming from every corner of the world, gathering together around the SAGES family in this city of New York so deeply wounded. This City of New York, still mourning her dead, erasing her ruins, tears on cheeks but lion courage in heart. This New York City, already on the way to recovery, always enlightening the whole world with a new source of light. Those two big blue laser beams soaring from Ground Zero, in addition to the eternal flame of Ala Statue de la Liberté, which never deserves so well to be the symbol of the permanent search, for honest people of more freedom, solidarity and brotherhood.

In 1998, The Board of International Federation of Societies of Endoscopic Surgeons approved the choice of New York City as the venue for the 8<sup>th</sup> World Congress of Endoscopic Surgery. At that time everyone was quite confident on the success of the conference. All the ingredients were put together: power of US industry, expertise of SAGES leaders, attractiveness of New York. You can imagine our concerns when IFSES met October 9, 2001 in New Orleans during the Clinical Congress of the American College of Surgeons. We understood immediately how strong was the determination of our SAGES colleagues (Ken Forde, Lee Swanstrom, William Traverso) to maintain New York City as the venue of the 8<sup>th</sup> World Congress. They asked us about the support of the other IFSES members. Our answer was immediately YES. In other words, the summary of our dialogue was: AIFSES trusts in SAGES, SAGES can trust in IFSES. You can see the result today. Almost 2,000 surgeons from the US and 50 different countries, almost 1200 corporate delegates convening in New York City for our 8th World Congress of Endoscopic Surgery. Let us congratulate them, those from the Board of SAGES and those from the International Program Committee chaired by Dr. Daniel Deziel. The New York meeting will remain an example for us. Let us learn from it for the future:

The 9<sup>th</sup> World Congress of Endoscopic Surgery will be February 2004 in Latin America, Cancun, Mexico. Viva Latina America! Viva Mexico! 10<sup>th</sup> World Congress of Endoscopic Surgery will be September 2006 in Europe, Berlin, Germany. Es lebe Europa! Es lebe Deutschland!

Take good note of these appointments, which are opportunities to learn, exchange and make more progress. Keep in mind that 80% of the world population has no access to the benefits of minimally invasive surgery. There is a huge task ahead of us.

Thank you so much for coming.

–Jacques Périssat, MD

# SAGES Education & Research Foundation

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# Save these Dates!

## SAGES' Scientific Sessions & Postgraduate Courses

**March 12 - 15, 2003**      **Los Angeles Convention Center, Los Angeles, CA**  
This is a joint meeting with the International Pediatric  
Endosurgery Group (IPEG)

**March 31 - April 3, 2004**      **Colorado Convention Center, Denver, Colorado**

**April 13 - 16, 2005**      **Westin Diplomat Resort, Hollywood, Florida**  
This is a joint meeting with AHPBA: American Hepato-  
Pancreato-Biliary Association and the ACS Spring Meeting.

### *Other Meetings of Interest*

**October 6-11, 2002**      **ACS Clinical Congress, San Francisco, CA**

**May 18-21, 2003**      **Digestive Disease Week, Orlando, FL**

**June 21-26, 2003**      **ASCRS Meeting, New Orleans, LA**

### *International Meetings*

**December 8 - 11, 2002**      **18th World Congress of ISDS, Hong Kong**

**June 15 - 21, 2003**      **1st European Endoscopic Surgery Week,  
11th EAES Congress**  
Glasgow, Scotland

**February 2 - 7, 2004**      **9th World Congress in Endoscopic Surgery, hosted  
by ALACE/FELAC**  
Cancun, Mexico

### **Society of American Gastrointestinal Endoscopic Surgeons**

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