ASCRS News

85 West Algonquin Road • Suite 550 • Arlington Heights, Illinois 60005 • (847)290-9184 • Fax: (847)290-9203 • http://www.fascrs.org/ *Winter 2007*

All-new Website to launch in early 2008

ASCRS will launch an all-new Website in early 2008!

It is a total redesign that offers dedicated pages for Society committees, a greatly expanded online career center for members, improved search features for the public, and a range of other user benefits, Website Committee Chair Dr. **Scott M. Browning**, Portland, OR, reports.

"We set out to create an Internet resource that professionally represents the Society," Dr. Browning explains. "The new Website will improve our ability to provide useful information and services to our membership, and allow us to effectively communicate with the public on colorectal disease."

The completely redesigned ASCRS Website will help execute the Society's mission of offering expert, up-to-date information on colorectal disease.

Improved search features built into the Website will help patients and the public access educational information about colon and rectal disease. Users will also easily find office locations of surgeon specialists available to treat them.

"Effective Internet communication is key to executing the Society's mission of offering the public expert, up-to-date information on colorectal disease," says Dr. **Deborah A. Nagle**, Boston, MA, who chairs the Website Redesign Subcommittee. "Our goal is to educate and help the public connect with the best physicians when they are needed."

An essential component of the redesign project includes creation of Web pages dedicated to each ASCRS committee. Located in the "Members" section, these pages will enable committee members to upload and share documents, post upcoming event schedules, and communicate with committee members via e-mail.

The new online Career Center allows ASCRS members to post job openings or resumes, view job openings and look for other career opportunities. The ASCRS Career Center will link up with hundreds of other professional career sites, exposing members seeking new opportunities to employers nationwide and increasing traffic flow to the Society's Website.

Other features of the redesigned Website, **www.fascrs.org**, include:

- **Complete redesign** that provides greater user efficiency and multiple added features.
- **New "Industry" section** for corporate supporters and sponsorship opportunities.
- **One click access to *Diseases of the Colon & Rectum*** for member subscribers.
- **Online store** where members may purchase CARSEP VII, patient education brochures, and other materials.
- **Online donation section** for members and the public to contribute to both the Society and Research Foundation. The section will allow for anonymous or "in honor/memory of" donations.
- **Improved Listserv** for subscribers.
- **User-friendly membership renewal section** for dues payments.
- **Membership profiles** for the ASCRS online & print directories. Members may update their profiles through the Website.

Dr. Browning says that future Website updates will provide online educational opportunities for members, including online certification for MOC. ❋

In this issue…

ASCRS welcomes UK, Australian Societies for landmark 2008 Tripartite Meeting. . . 2
President's Message 2
Nominations for Community Impact Award Due March 15 4
National Media Awards to recognize excellence in colorectal disease reporting . . . 4
ASCRS members respond to Delphi questionnaire, identifying major colorectal research questions 5
Traveling Fellow Report: Dr. Rocco Ricciardi 6
International Scholar Report: Dr. Ashok Kumar 7
Washington Update. 8

ASCRS welcomes UK, Australian Societies For landmark 2008 Tripartite Meeting in Boston

ASCRS will host a Tripartite Meeting with colorectal medical organizations from the United Kingdom and Australia, June 7 – 11, 2008, at the Sheraton Boston Hotel and Hynes Convention Center.

The combined meeting will feature the Association of Coloproctology of Great Britain and Ireland; the Section of Coloproctology of the Royal Society of Medicine; the Section of Colon and Rectal Surgery of the Royal Australasian College of Surgeons; the Colorectal Surgical Society of Australia and New Zealand; and ASCRS, in collaboration with the European Society of Coloproctology.

"We look forward to the 2008 Tripartite Meeting as a landmark event for the advancement of knowledge on surgery of the colon and rectum. Adding the resources of colleagues in the British and Australian Societies allows us to feature international speakers recognized worldwide as the leading experts in colorectal surgery and related fields," ASCRS President Dr. **W. Douglas Wong**, New York, NY, explains.

Busy surgeons planning to attend the Tripartite Meeting should mark their calendars for the **Tripartite Gala Reception and Dinner Dance**, which will take place Tuesday evening, June 10.

In addition, the receptions for affiliated groups will be held Monday evening, June 9.

Complete scientific program and registration information for the 2008 Tripartite Meeting will be posted on the Society's Website, **www.fascrs.org**, in March. Additional reports on the meeting's scientific offerings will be featured in upcoming issues of *ASCRS News*. ❋

PRESIDENT'S MESSAGE

Tripartite Meeting will draw from five continents

By W. Douglas Wong, M.D.

The upcoming Tripartite Meeting in Boston, June 7-11, is expected to draw many colleagues from Europe, Australia, Asia, and the Americas, making it one of our largest meetings. Program Chair Dr. **Martin Weiser**, New York, NY, and Vice Chair Dr. **Najjia Mahmoud**, Philadelphia, PA, have been working very hard to make the program our best.

Dr. Douglas Wong

The European Society of Coloproctology has been invited to submit abstracts and participate fully in our program. They will join our co-hosts: the Association of Coloproctology of Great Britain and Ireland; the Section of Coloproctology, Royal Society of Medicine; the Section of Colon and Rectal Surgery, Royal Australasian College of Surgeons; and the Colorectal Surgical Society of Australia and New Zealand.

The Boston venue has strong appeal as the site of important historical events such as the Boston Tea Party, Paul Revere's ride, and the Battle of Lexington and Concord. Now it is the home of the World Champion Boston Red Sox and the world renowned Boston Pops Orchestra. Our 2007 meeting was held in the home of the World Champion St. Louis Cardinals. In 2009, we go to Hollywood, Florida, which establishes the Florida Marlins as odds-on favorites to win baseball's World Series next year.

We have decided to bring back the practice of organizing tours during the Boston meeting to provide an additional attraction for visitors, members and their families. Local Arrangements Chair Dr. **Larry Rusin**, Burlington, MA, and his committee are still working out the details, but be ready to enjoy the sights and sounds of Boston and its environs, perhaps including the Newport (R.I.) mansions, the John Adams house in Quincy, MA, a tour of the site of the famed Salem witch trials, Lexington and Concord. This is a meeting with so much going for it, we recommend making reservations early.

> ***"We have made excellent progress in establishing our priority on surgical quality."***

By the way, another change in Boston will be moving the Annual Dinner Dance from Wednesday to Tuesday. We know many members are eager to get back to their practices, but the Society's Dinner Dance is a once-a-year opportunity to enjoy the company of your colleagues and their families in a friendly social setting. We promise you'll be very glad you didn't miss it.

Collaboration with American Cancer Society

The Executive Council has placed a high priority seeking opportunities to build, maintain and develop relationships

…continued on next page

with other organizations. In this regard, we have taken the first steps toward developing a collaborative relationship with the American Cancer Society (ACS, not to be confused with our good friends, the American College of Surgeons). Conquering colorectal cancer is one of the American Cancer Society's primary goals. In Boston, we are exploring the possibility of joining ACS in organizing a media event to promote colorectal cancer awareness and screening. Public Relations Committee Chair Dr. **Deborah Nagle**, who now lives in Boston, is leading this effort. In the future, we hope the collaboration may include gala fundraising events under a joint ACS-ASCRS banner.

Priority on surgical quality

We have made excellent progress in establishing our priority on surgical quality. The first phase of the Delphi research project, headed by our Quality Assessment and Safety Committee Chair, Dr. **Nancy Baxter**, has brought 700 responses. We are well on the way to setting the research agenda for diseases of the colon and rectum.

At the American College of Surgeons meeting in New Orleans, we made progress on another quality initiative—drawing guidelines for a collaborative effort with the College and other interested societies to establish centers of excellence in rectal cancer. This would provide a path by which medical institutions could demonstrate their commitment to, and expertise in, serving rectal cancer patients.

Dr. **David Rothenberger** and an ad hoc committee are reviewing some guidelines drawn for the Canadian health care system. Also, we have approached the Society of Surgical Oncology (SSO) and its current President, Dr. **Nicholas Petrelli**, to join us in establishing centers for excellence in rectal cancer. Our goal is to encourage centers to form multidisciplinary teams devoted to rectal cancer treatment. By their breadth of experience and depth of expertise, we believe they will be able to offer patients the likelihood of much better outcomes.

Need to keep our voice in the AMA

In our last newsletter, we spoke of the importance of maintaining our seat in the House of Delegates of the American Medical Association, so that our voice can be heard in determining the specifics of what goes into CPT codes, RUVs and all the other requirements that have such a profound effect on how we conduct our practices. Our AMA Representative, Dr. **Clifford Simmang**, has made an excellent case for AMA membership. To keep our seat, 35 percent of our Fellows must hold AMA membership. We are at 32 percent. Members of the Executive Council are behind this effort and are now calling individual Fellows to ask for their support. It is critical that we respond by increasing our membership in the AMA in order to maintain a relationship that dates from the founding of our Society in 1899.

Propose meeting collaboration with WOCN

Another relationship with great potential for our future is with the Wound, Ostomy and Continence Nurses Society (WOCN). I have approached WOCN's President, **Janice C. Colwell**, MS, RN, CWOCN, with an invitation to explore the possibility that ASCRS hold its annual meeting in close proximity, in conjunction, immediately preceding or following the WOCN annual meeting. A precedent for this – familiar to many of us – is Digestive Disease Week, in which four medical organizations with a common focus on gastrointestinal disease (AGA, ASLD, ASGE, and SSAT) meet together. WOCN is a professional, international society of 4,500 nurse professionals who are experts in the care of patients with wound, ostomy and continence problems. WOCN members manage conditions such as stomas, draining wounds, fistulas, vascular ulcers, pressure ulcers, neuropathic wounds, urinary incontinence, fecal incontinence, and functional disorders of the bowel and bladder.

> ***"We see significant advantages for both societies in meeting collaboration."***

We see significant advantages for both societies in meeting collaboration, including:

- Increased membership,
- Increased meeting attendance,
- Improved attractiveness for advertisers and sponsors,
- Improved rates for meeting venues,
- Improved public awareness due to increased meeting size.

We propose that ASCRS and WOCN start by holding their annual meetings at the same times, in the same city and venue, beginning in 2013.

As mentioned in the last edition of *ASCRS News*, we are also building a relationship with The Chinese Association of Colorectal Surgeons and new groups elsewhere. The Chinese and other groups look to the U.S. for guidance on developing better training programs and growing the specialty. Many of them don't yet have formal accrediting boards. Our goal is to promote colorectal training worldwide. We will continue to execute the ASCRS Strategic Plan and fulfill its goals for education and research, fiscal stability, and partnership with other organizations that share our vision.

I am pleased to report that ASCRS continues to enjoy solid fiscal stability. We have been concerned, as you know, that changes governing relationships between professional organizations like ours and industry could put pressure on our budgets for the Annual Meeting and other educational activities. So far, we remain on solid ground.

Please let me have your ideas and let us know how we're doing. I look forward to hearing from you by e-mail at **wongd@mskcc.org.**

Nominations for 2008 Community Impact Awards due March 15

ASCRS is accepting nominations for the 2008 Community Impact Awards, which recognize important volunteer work by Society members in their communities, ASCRS President Dr. **W. Douglas Wong**, New York, NY, announced. Nominations for the awards, one to recognize a U.S. member, the other an international member, must be submitted by March 15.

The Society welcomes nominations from the general membership, ASCRS regional societies and affiliated International Societies. Nominees must be an ASCRS member or Fellow in good standing.

The Public Relations Committee will review all submitted nominations and select one nominee as recipient of the Community Impact Award. Nominations will be graded on the following criteria:

- Community impact;
- Humanitarianism;
- Long-term effect;
- Number of people served;
- Length of service;
- Organizational leadership;
- Frequency of service.

Submit nominations electronically to **ascrs@fascrs.org** by March 15. Nominations should include the nominee's name and address, the name of the person/organization submitting the nomination, and a one-page summary of the nominee's community service activity.

The summary should include the:

- Name and mission of the organization served by the nominee;
- Nature of the activity;
- Nominee's role in the organization;
- Length and frequency of service;
- Location;
- Scope and number of people served;
- Funding sources;
- Relation to ASCRS and other professional or charitable organizations.

Winners will be announced at the Annual Meeting in Boston. The award recipient will receive a commemorative plaque and a $1,000 donation by the Society for the physician's charity of choice.

The Society will develop a news release announcing the award winner and distribute it to media professionals in the winner's local market.

Dr. Dennis Fried

Dr. Peter Cataldo

Dr. **Dennis A. Fried**, Charleston, SC, won the Society's first Community Impact Award in 2006 for his role in establishing a colorectal surgery clinic in Belize, and for performing colorectal surgery on patients from Belize in Charleston. Dr. **Peter A. Cataldo**, Burlington, VT, won the 2007 award for his leadership in establishing a free surgery clinic that serves many of Burlington's most impoverished residents.

National Media Awards to recognize Excellence in colorectal disease reporting

Society members who know of journalists contributing to a greater public understanding of colon and rectal disease may encourage them to submit an entry for the 2008 National Media Awards or submit one on their behalf. The deadline to submit entries for the competition is March 31, 2008.

ASCRS will present $1,000 awards honoring the best work in three major media categories:

- **Print** (newspaper or magazine),
- **Broadcast** (television or radio), and,
- **Internet** (including news reports, features, discussion programs, documentaries or multimedia presentations).

Winners will receive an expense-paid trip to Boston, MA, for an awards ceremony during the 2008 Annual Meeting, June 7 - 11.

Media professionals and members of the ASCRS Public Relations Committee will judge the entries for the 2008 program. Each entry will be evaluated on the basis of writing quality, excellence in production, research, accuracy, message, impact and originality.

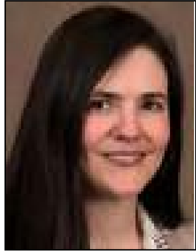
Entry forms and brochures detailing the ASCRS' 2008 National Media Awards program are available on the ASCRS Website (**www.fascrs.org**), or by calling ASCRS Public Relations at 847/934-5580.

The American Society of Colon & Rectal Surgeons
National Media Awards 2008
Call for Entries
The American Society of Colon and Rectal Surgeons ASCRS 1899
Excellence in Communication
Honoring excellence in communicating a better understanding of colon and rectal disease.
Three Categories: Print, Broadcast & Internet
Winners will receive:
- $1,000 Award
- Personally engraved plaque
- Expense-paid trip to Boston, MA, for the ASCRS Annual Meeting, June 7-11 2008

Deadline for receipt of entries: March 31, 2008

ASCRS members respond to Delphi questionnaire, Identifying major colorectal research questions

ASCRS members have responded in large numbers to an open-ended questionnaire asking them to identify three to six major research questions in colorectal surgery.



Dr. Nancy Baxter

The ASCRS Research Foundation asked all Society members to participate in this new survey developed using a modified Delphi process. Member responses to a series of questionnaires will outline in detail the specialty's top research priorities.

"Research relating to colorectal surgery is broad, comprising the efforts of hundreds of scientists and involving biomedical engineering, basic science, clinical research, and health services research. The myriad potential research endeavors represent a challenge to research funding organizations and directors of research programs, who want to identify the most promising, innovative proposals most likely to make important contributions to the field," says Dr. **Nancy N. Baxter**, Toronto, ON, Canada, who heads the Foundation's Delphi Taskforce.

"Until now, we have had no organized, systematic approach to establishing research priorities. We've had a sense of what's really important, but we haven't really known what specific research topics the experts in this field, practicing colorectal surgeons, consider most important," Dr. Baxter says.

Features of the Delphi method, developed by the RAND Corporation to assess long-term trends in science and technology, include:

- Anonymity, through use of anonymous self-administered questionnaires;
- Iteration, through completion of a series of questionnaires in "rounds";
- Controlled feedback;
- Statistical aggregation of the group response.

"The Delphi process avoids the common situation where a group of experts in a room might agree to follow an influential person's recommendation, even when that person may not be expressing everyone's true opinion," Dr. Baxter explains.

The first step in the Research Foundation's application of the Delphi process was selection of the ASCRS membership as the expert panel and appointment of a Delphi Taskforce, representing a range of perspectives consistent with the membership, to guide the process. In addition to Dr. Baxter, members of the ASCRS Delphi Taskforce are Drs. **Robert Cima**, Rochester, MN; **Julio Garcia-Aguilar**, San Francisco, CA; **Jose Guillem**, New York, NY; **Walter Koltun**, Hershey, PA; **Charles Littlejohn**, Stamford, CT; **Robert Madoff**, Minneapolis, MN; **Najjia Mahmoud**, Philadelphia, PA; **Rocco Ricciardi**, Burlington, MA; **Howard Ross**, West Long Branch, NJ; **David Rothenberger**, Minneapolis, MN; **Clifford Simmang**, Dallas, TX; and **Larissa Temple**, New York, NY.

> ***"Until now, we have had no organized, systematic approach to establishing research priorities."***

An open-ended questionnaire asked ASCRS members to identify three to six research questions. The Delphi Taskforce is now reviewing the questions members have identified, organizing them into themes. In some cases, questions are rephrased. A second survey will ask members to rate this list of questions on a nine-point scale. The Taskforce will then identify the top 40 questions, and members will have another opportunity to rank them. Results will be presented to the Research Foundation for drafting of the final analysis and conclusions.

The Taskforce plans to send an abstract for possible presentation of the results at the 2008 ASCRS Annual Meeting in Boston. Results will also be posted on the Society's Website, **www.fascrs.org**, and a summary will be included in *ASCRS News*.

"We will also send a report of our findings to the editors of surgical and gastrointestinal journals, and to research funding agencies," Dr. Baxter says.

"The goal of the project is to generate a set of clearly defined topics that constitutes a research agenda for colorectal surgeons for benign and malignant diseases," she says.

The research agenda may be used for several purposes, including:

- To guide requests for ASCRS research applications, assist with the ASCRS grant application process, direct grant applicants to key research areas, and inform requests for proposals.
- To guide government funding agencies in developing requests for proposals and/or determining the perceived clinical importance of a grant submission.
- To provide editors and peer reviewers with information about key research questions to better understand the importance and impact of original research reports.
- To raise the profile of research in colorectal surgery.
- To identify key gaps in current knowledge in colorectal surgery.
- To help clinical investigators identify the most relevant research opportunities in developing their research programs.

"The development of a research agenda promises many potential benefits, all of which may ultimately lead to improved patient care," Dr. Baxter says. "Active participation of the ASCRS membership will be the key to success of this project."

A Fellowship of sharing and professional growth

By Rocco Ricciardi, MD, MPH, 2007 Traveling Fellow

It was with excitement and great anticipation that I accepted the American Society of Colon and Rectal Surgery's 2007 Traveling Fellowship to the United Kingdom. Prior to the trip, I fully expected to discover varying practice patterns, absorb pearls of wisdom, and meet some of the leaders in our field while taking in some British culture. I had just over three weeks to accomplish my goals, and I planned to make the most out of this experience.

My wife and four-month-old daughter were able to take the trip to the United Kingdom and spend 8 days in Cambridge and Oxford. You might imagine that my wife and I were apprehensive about making an overseas trip with a four-month-old, as we imagined hours of crying and fussing in cramped hotel rooms and lifts. But instead of cramped rooms and strange surroundings, we were welcomed into the homes of our English hosts and treated like family. After landing in London, our trip began at Addenbrooke's hospital in Cambridge.

World-Class Facilities

The Cambridge Colorectal Unit provides comprehensive specialist services for patients with colorectal disorders and is led by a generous and warm group including Mr. Richard Miller, Mr. Nigel Hall, and Ms. Nicola Fearnhead. My family and I stayed with Mr. Miller and his gracious wife at their beautiful cottage on a spacious estate with spectacular English gardens. The Millers were wonderful hosts to my family and made us feel quite at home.

During my time in Cambridge, I spent several days touring the world-class facilities and meeting thoughtful and outstanding individuals dedicated to the care of patients with colorectal diseases. I was welcomed into the operating theatre, visited their top-notch endoscopy center, observed patient care in clinic and came to understand the vision and priorities of this talented group of individuals.

In addition, despite my concern about my family's enjoyment during my time in the hospital, Ms. Fearnhead and her colleagues in Cambridge were kind hosts. They organized trips along the Cam and down to the charming city centre for my wife and child. We had a wonderful time in this enchanting town and were well looked after by a great team of specialist surgeons.

Oxford's 'Visionary Team'

We then headed to Oxford to meet Neil Mortensen and his visionary team. Every year the John Radcliffe Hospital treats over 500,000 outpatients and 100,000 inpatients, while boasting a large and comprehensive practice in coloproctology.

I was particularly impressed with the vision and innovation that Prof. Mortensen's team demonstrated in advancing the field of colorectal surgery. Their interest spanned a breadth of colorectal diseases and techniques, including pelvic floor disorders, advanced surgical techniques, and quality control.

Dr. Rocco Ricciardi (front, center) enjoys a sail down the River Cam with his wife Jen (bottom left), Richard Miller (bottom, right), Nicola Fearnhead and Nigel Hall.

I particularly enjoyed my time learning about outcomes tracking in the United Kingdom with Prof. Mortensen. The outcomes tracking system, which allows real time tracking and reporting, was not only comprehensive and cutting edge, but user-friendly and easily accessible to clinicians.

Next, we left Oxford and went to London for the weekend. At this time my wife and daughter returned to Boston and I went on to Basingstoke to meet Brendan Moran and his team. I stayed with Mr. Moran and his wife at their lovely home and was well looked after. Brendan and his family made me feel very much at home and we had a wonderful time discussing politics, medical practice and life in our respective countries.

In addition, I was able to meet and chat with Prof. Heald and Mr. Cecil. I toured the Pelican Center, a world class facility established by the Department of Health to improve survival and quality of life of patients with cancer through the education and development of multidisciplinary cancer teams. The Pelican Center is a 'centre of excellence' for sharing life saving, life enhancing knowledge and skills to future generations of surgeons and cancer teams.

I was particularly impressed with the National Center for Pseudomyxoma Peritonei, one of only two centers in the United Kingdom designated by the National Specialist Commissioning Advisory Group of the Department of Health. This thoughtful and dedicated group of surgeons and medical personnel provided quaternary care for a difficult and morbid condition.

Next I traveled to St. Mark's Hospital, just North of London, to observe the inflammatory bowel disease, intestinal failure, and proctology services at this world-class facility. I spent a considerable amount of time sharing thoughts and ideas with Professor Robin Phillips, Professor John Northover, Professor John Nicholls, and Miss Sue Clark.

Fueling Innovation

The clinical, educational, and research facilities at this institution are fantastic. They are all intertwined to permit collaboration while fueling innovation. My stay at St. Mark's

…continued on next page

Travelling Fellow ...continued from previous page

was highlighted by research presentations, observation of multidisciplinary conferences, trips to the operating theatre and a wonderful dinner with the staff overlooking Hyde Park and all of London from the 28th-floor of the Hilton on Park Lane.

As my trip came to an end, I joined new and old friends in Glasgow for the Annual Meeting of the Association for Coloproctology of Great Britain and Ireland. It was great to see all of my new overseas friends as well as some old friends from my days in Minneapolis. The meeting showcased some exceptional work with papers from around the country, Europe, and Australia. In addition, I was invited to council dinner and presented our paper at the British Journal of Surgery opening session. This meeting was well-designed to optimize learning and sharing of ideas.

In closing, it is difficult to completely describe the meaning of such a trip to my professional development as a student of surgery. My experiences abroad have taught me so much about varying practice styles, quality control and outcomes, and specialized care of colorectal diseases.

The trip was not only rewarding on a professional level, but also on a personal level. It taught me about generosity and thoughtfulness from our colleagues across the Atlantic.

Today, as I reflect on the experience, I have come to the realization that my "traveling fellowship" was part of a larger professional fellowship of surgeons and medical professionals. This "surgical fellowship" is founded on shared experiences, education, the pursuit of scholarly work, and a mission to reduce disease burden. I was truly inspired by those I met, and by their commitment to this purpose and to advancing our chosen field of medicine. I can truly say that this experience has been one of the most significant professional experiences of my lifetime.

I'll end by thanking the American Society of Colon and Rectal Surgeons for allowing me to represent the Society in this once-in-a-lifetime trip. In addition, I wish to thank Ms. Anne O'Mara for coordinating the entire trip, as well as the Association of Coloproctology of Great Britain and Ireland for supporting me and making this experience truly unforgettable. ❋

U.S. visit provides opportunities for Meaningful discussion, future collaboration

By Dr. Ashok Kumar, Lucknow, India – 2007 International Scholar

It was indeed a great honor to be selected as the 2007 International Scholar of the ASCRS and International Council of Coloproctology. The opportunity allowed me to present a scientific paper at the reputed ASCRS Annual Meeting and visit two prestigious colorectal centers in the United States.

Over the course of one month, I was fortunate to attend the ASCRS Annual Meeting in St Louis, then visit the Division of Colon and Rectal Surgery at Washington University, St Louis; and the Department of Colon and Rectal Surgery, Mayo Clinic, Rochester, MN.

Dr. Ashok Kumar (left) meets with Dr. James Fleshman in St. Louis.

Upon my arrival in St. Louis, I was introduced to members of the International Council of Coloproctology. This encounter allowed me time to speak on colorectal surgery in India. During the Annual Meeting, there were many interesting guest lecturers, panel discussions and symposia.

The presentations that most appealed to me covered topics such as radical resections for rectal cancers, biologics in colorectal surgery, laparoscopic colectomy, colorectal surgery complications, and hemorrhoids and fissures. The range of speakers and topics featured during the meeting was very impressive.

It was also a great opportunity to listen to, and interact with, experts in the field of colorectal surgery to exchange thoughts on various topics. The Meeting's scientific papers – both oral and posters – were another great source of information. They enabled me to learn about many new things happening in the specialty.

My podium presentation, "The comparative study of morbidity and mortality of APR vs. LAR: The Experience from a department of Surgical Gastroenterology," provided me another forum in which to interact with surgeons during the meeting. Their questions, comments and follow up discussions with me afterwards were very valuable and rewarding.

Of all the colorectal meetings I have attended, the ASCRS Annual Meeting was, by far, the largest. All in all, I was impressed by the meeting's structure and organization. It incorporated a variety of topics – from simple to complex, from the basics to the latest advances.

Following the Annual Meeting, I had the privilege of spending almost two weeks at the Washington University School of Medicine's Division of Colon and Rectal Surgery.

...continued on next page

International Scholar *...continued from previous page*

There, I had opportunity to attend outpatient clinics, observe surgeries and consult with fellow colleagues. I observed many colorectal surgical procedures both for benign and malignant diseases.

Some of the interesting procedures I observed were hand assisted laparoscopic colectomies, and surgeries for anal fistula and rectal prolapse. During my stay, I had meaningful discussions on a variety of topics with Dr. **James W. Fleshman**, his colleagues and fellows.

I also had the good fortune to attend some of their conference presentations, meet with other visitors, and discuss the possibility of future collaborations. All the faculty and staff members were very friendly and supportive.

My travels then took me to the Mayo Clinic, and although my stay was a short one, I was able to observe many laparoscopic colectomies, anterior resections for carcinomas, and procedures for benign diseases such as ulcerative colitis and rectal prolapse.

At Mayo's outpatient clinic, I observed many colonoscopies being done on an OPD basis. This is in contrast to India, where OPD colonoscopy is not practiced. I also attended several departmental conferences. One featured a guest lecture by Dr. **Anthony J. Senagore**. I enjoyed a good relationship with Drs. **Bruce G. Wolff** and **Eric Dozois**, and their colleagues.

In addition to the obvious benefits of participating in the clinical and scientific realms, my visits to both institutions helped me learn more about dedicated colorectal care centers and how they function. I firmly believe knowledge I gained as a result of these visits will help provide care to our patients in India who would otherwise be deprived.

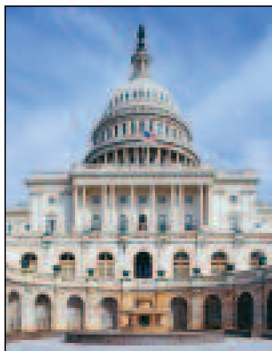
This visit will serve as a guide to creating a division/subspecialty of colorectal surgery to provide a better colorectal care. I sincerely hope my interaction with faculty during the Annual Meeting and at both centers will result in future collaboration with these institutions as we continue to establish the colorectal specialty in India.

My thanks to ASCRS for the opportunities afforded me by the International Scholarship. I look forward to productive collaboration in the future.

WASHINGTON UPDATE

CHAMP Act passes the House, but later vetoed

This report includes the federal legislative and regulatory activities that have occurred since the last meeting of the legislative committee of the American Society of Colon and Rectal Surgeons. The Advocacy and Health Policy Division of the American College of Surgeons (ACS) compiled the information in this report.



In August, the House of Representatives passed the Children's Health and Medicare Protection Act (CHAMP Act). This legislation includes both the reauthorization of the State Children's Health Insurance Program (SCHIP) and also a short-term fix to the Medicare physician payment system. Following the House vote, the Senate took up legislation that only addressed the SCHIP reauthorization. The House eventually passed the Senate bill and this legislation (SCHIP reauthorization only) was vetoed by President Bush. Congress was unable to override this veto. The original House CHAMP Act is still pending, and everyone is waiting for the Senate to address the Medicare physician payment issues.

This CHAMP Act would reauthorize SCHIP and replace projected Medicare physician payment cuts in 2008 and 2009 with positive payment updates of 0.5 percent in both years. In addition, the legislation takes steps toward long-range Medicare payment system reforms by replacing the sustainable growth rate (SGR) with a new system of six separate expenditure targets and fee schedule conversion factors for various categories of physician services: primary care, other evaluation and management services, imaging, anesthesia, major procedures, and minor procedures.

The proposed new expenditure targets and conversion factors are consistent with a proposal that the American College of Surgeons and the American Osteopathic Association have advocated. This new methodology holds promise of ending the current problem of across-the-board payment reductions being imposed on service categories, such as major procedures, that have experienced relatively low levels of volume and spending growth. These and other provisions would be financed through a tobacco tax increase of 45 cents and a five-year phase-out of overpayments made to Medicare Advantage plans.

Below are some salient details of the CHAMP Act:

Physician Payment Updates – the legislation would stop the 10% cut in Medicare physician payments that are scheduled for 2008 and also stop the 5% cut that is scheduled for 2009. In both years, the cuts would be replaced by a 0.5% positive update. The bill freezes payment updates in 2013 and subsequent years. In addition, the bill would lower the floor to MEI –14% instead of MEI –7% in 2010 and 2011. Lowering the floor helps reduce the overall costs

...continued on next page

CHAMP Act *...continued from previous page*

of the bill and House Democratic Congressional leaders have assured us that they will work with us to make sure that the cuts in 2010 and 2011 do not go into effect.

Separate Conversion Factors – the legislation would replace the current SGR with six separate expenditure targets that include primary care/preventive services, other E&M services, imaging services, major procedures (10 or 90 day global services), anesthesia services, and minor procedures/ other services. The growth would continue to be measured by GDP, with a GDP + 2.5% target allowance for primary care/ preventive services. This section of the legislation was included at the request of the American College of Surgeons and is very similar to a proposal that was created by the ACS and endorsed by the American Osteopathic Association.

Expert Panel – the legislation would require the Secretary of HHS to establish an "expert panel" to identify, through data analysis, physicians' services for which the relative work values are potentially misvalued (particularly those services that may be overvalued) and determine if they need review by the RUC. The panel is required to conduct a 5-year review of physicians' services in conjunction with the RUC 5-year review. The 5-year review will look particularly at services that have experienced substantial changes in length of stay, site of service, volume, practice expense, or other factors that may indicate changes in physician work. In addition, the review would identify new services to determine if they are likely to experience a reduction in relative values over time as the new technology is more broadly disseminated. Membership on the panel would include individuals with expertise in medical economics and technology diffusion; members with clinical expertise; physicians, (particularly those who are not directly affected by changes in the physician fee schedule); carrier medical directors; and representatives of private payor health plans.

Medicare Efficiency Bonus Payments – the legislation provides a 5% Medicare bonus payment for physicians practicing in counties in the lowest 5th percentile of per capita spending for services provided under Part A and Part B for 2009 and 2010.

Payment for Imaging Services – *[special note – much debate has ensued over the exact meaning of the language in this section]* - the legislation establishes an accreditation process for facilities that provide diagnostic imaging services (including MRI, CT, PET, nuclear medicine procedures, x-rays, sonograms, ultrasounds, echocardiograms and emerging diagnostic imaging technologies specified by the Secretary of HHS); effective date is January 1, 2010, except for ultrasound services, which has effective date of January 1, 2012. The payment amount for the technical component and the professional component shall be zero if the services are not furnished in an accredited facility. The previous sentence shall not apply to the technical component if the imaging equipment meets certification standards and the professional component of a diagnostic imaging service that is furnished by a physician.

Single National Entity to coordinate the development of health care measures – the legislation requires the Secretary to designate a single national entity (such as the National Quality Forum) to coordinate development of health care measures.

Never Events – the legislation requires the Secretary to develop a plan to identify steps needed to implement a system to prohibit Medicare payment for "never events." The Secretary shall provide a report to Congress by June 1, 2008, that details this plan. The Centers for Medicare and Medicaid Services (CMS) has identified several "never events" such as object left behind in surgery, hospital acquired infection, blood incompatibility, and air embolism for which it will not pay a higher DRG to compensate the hospital for the complication. In other words, the hospital will still be paid for the care associated with the original diagnosis (e.g., taking out the gallbladder), but it will NOT pay to cover the costs of treating the complication (e.g., reoperating to take out the sponge left behind). Physician payments at this point are not affected. The American College of Surgeons has urged CMS to not include infections, since the coding system is not quite refined enough to capture all the risks accurately.

Limitation on exception to the prohibition on certain physician referrals to hospitals – the legislation eliminates the whole hospital exception so that physicians cannot self refer to hospitals in which they have ownership. Applies to all hospitals – not just specialty hospitals. Grandfathers hospitals that were in operation with Medicare provider agreements as of the date of introduction of the bill. Requires grandfathered hospitals to meet standards with 18 months of enactment to include: preventing growth, requiring disclosure of ownership, limiting physician ownership to an aggregate of no more than 40% of the facility and no more than 2% individually, and disclosing to patients if they fail to have 24 hour physician coverage.

CMS Releases Proposed Regulation on 2008 Medicare Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) has published a regulation outlining Medicare physician payment policy changes for 2008. The notice states that the 2008 Medicare fee schedule conversion factor still is slated for an estimated 9.9 percent reduction due to the effects of the SGR formula. Other provisions in the proposal that may be of particular interest to surgeons are as follows:

- The "work adjuster" that is applied to relative work values in the fee schedule would change from -10.1 percent in 2007 to -11.8 percent in 2008 (a 1.7 percent decrease

...continued on next page

CHAMP Act ...continued from previous page

in payment), primarily because of a proposed 32 percent increase in work values for anesthesia services.

- The geographic practice cost indices, which by law must be reviewed every three years, would be revised to reflect new data on resource cost differences among localities. The most significant decreases are expected in northern California where Santa Clara, for example, will see an estimated 4.63 percent reduction in payment. The largest proposed increase is estimated at 2.17 percent in Miami, FL.
- The multiple procedure payment reduction, under which payments for subsequent operations are reduced by 50 percent when performed by the same physician during the same operative session, would now be applied to Mohs surgery.
- A significantly expanded list of clinical and structural measures would be incorporated into the Physicians Quality Reporting Initiative (PQRI). However, no new measures will be used until the National Quality Forum endorses them or the AQA (formerly the Ambulatory Care Quality Alliance) adopts them. Without congressional action, no funding is available to continue this year's policy of providing a bonus payment of up to 1.5 percent to physicians who report the PQRI measures.

Informed Consent

Since 2004, the CMS Interpretive Guidelines have required that the name of the resident and the tasks he or she would be performing be in the informed consent. At the urging of a number of groups including the American College of Surgeons, CMS modified the interpretive guidelines so that the informed consent process encourages discussion in general terms about the nature of a surgical residency program and the responsibility of the teaching physician. The ACS believes that discussions held under these Interpretive Guidelines will cover what needs to be discussed regarding the resident's role in the surgery and will prove much more useful than the previous Interpretive Guidelines. The College continues to work with CMS to improve the Interpretive Guidelines.

Release of Medicare Claims Data

On August 22, 2007, the U.S. District Court for the District of Columbia issued a ruling, which will make physician-identified Medicare claims data available for use by Consumers' Checkbook/ Center for the Study of Services to assess health care quality. Specifically, the court decision requires the U.S. Department of Health and Human Services (HHS) to provide physician-specific Medicare claims data to Consumers' Checkbook for use in reporting to the public on the number and types of procedures each physician provides under Medicare and somehow translate those data into an assessment of healthcare quality. The College and a number of other physician groups have expressed concern with this ruling and have urged HHS to appeal this ruling.

Public-Private Sector Collaboration on Quality

Physician Quality Reporting Initiative (PQRI) began July 1

In December 2006, Congress passed legislation linking a 1.5 percent Medicare physician payment bonus to reporting Medicare quality data through the PRQI, an updated version of the Physician Voluntary Reporting Program. Briefly, the PQRI works as follows:

- The physician voluntarily reports on relevant quality measures for services provided between July 1 and December 31, 2007.
- Quality measures are reported on the same claim as the primary procedure or service, generally using Current Procedural Terminology (CPT) category II codes.
- A bonus payment of up to 1.5 percent of all allowed Medicare charges submitted during this period will be paid in a lump sum in mid-2008.
- Physicians who submit quality data will receive a confidential report on their performance.
- None of the reported information will be made available to the public.

Seventy-four physician performance measures are available for use in the PQRI, all of which were developed with physician involvement. Physicians who report on three performance measures for at least 80 percent of relevant procedures are eligible for the full 1.5 percent bonus payment. Understanding that not all physicians would have three relevant procedures in the list of 74, Congress and the Centers for Medicare & Medicaid Services (CMS) allowed some flexibility. If only one or two measures are applicable to a physician's practice, he or she must only meet the 80 percent reporting rate on those applicable measures to qualify for the full update. In addition, for physicians who report more than four performance measures, CMS will choose the three measures with the highest reporting rate to calculate the bonus payment.

Additional information on the PQRI, including performance measure specifications, can be found on the CMS Website at **www.cms.hhs.gov/pqri**, or on the College's Website at **www.facs.org/ahp/pqri**.