Riding with the Waves of Change

Despite present worldwide trends that constrict physician autonomy, diminish remuneration for surgical services, restrict capital expenditures, tighten reins on postgraduate medical education, shrink available monies for educational grants, and invade our sanctity with medicolegal conflict—the spirit and momentum of minimally invasive gynecology continue to be fully alive and well amongst the ranks of our membership. Fueled by the most highly attended annual meeting in the last decade, the recent Global Congress in Las Vegas was marked by superlative enthusiasm, invigorated collegiality, and collective purpose. The AAGL continues to be a highly vibrant organization that provides definitive education, disseminates valuable information, provides worldwide networking, and strives to empower patient advocacy in all realms of minimally invasive gynecology. Serving as the most frequently referenced resource for minimally invasive gynecology, the Journal of the American Association of Gynecologic Laparoscopists—now in its 11th year of publication—continues to embody and validate our raison d’etre. In spite of our ongoing successes and enduring leadership in the field of endoscopic surgery and minimally invasive gynecology, the future strength of the AAGL will vitally depend upon its capacity to resist the complacency of achievement; its willingness to take reasonable risks; its openness to change; and its ability to take careful stock of the demographic and practice realities of our new and prospective membership. Seventy-eight percent of our current membership is from North America. Among the 618 new members during the past year, 50% are resident physicians and 42% are from outside of North America—of whom 32% are women. Among the 435 new North American members, 52% are women and 60% are resident physicians. In the United States, more than 80% of current residents-in-training are women. Furthermore, it is widely accepted that residency programs in the United States have suffered a serious decline in both laparotomic and endoscopic surgical training due to diminishing numbers of available cases, the evolution of non-surgical alternatives and clinical pathways, the absence of capital equipment, and the paucity of experienced mentors. Unquestionably, our future viability will depend upon how well our organization serves the needs of a predominantly female membership who will inevitably practice in an environment that is

Be Careful of What You Ask For!

As the multitude of attendees at this year’s AAGL Global Congress of Gynecologic Endoscopy were enjoying scientific presentations, renewing old acquaintances, and viewing the products of vendors in the exhibit hall, much important “behind-the-scenes” work was being completed. One such task was a meeting of the AAGL Coding Committee. On November 20th, Drs. Levy, Loffer, Lucente, Melkonian, and Stanford met with myself and Linda Michels to contemplate past and future coding and reimbursement issues. Since my last report in News Scope, CMS has accepted all of the RBRVS Update Committee (RUC) recommendations for ACOG’s new codes for 2004.

These are satisfying accomplishments, since, as I have mentioned before, this process is very time-consuming and complex. It often takes years for the entire process to be complete and implemented. Briefly, a specialty society (like the AAGL) first identifies a “need” for a new code. With the assistance of ACOG, an official proposal is generated and then presented to the CPT panel. If approved there, the code will get published in the next CPT manual. The work is far from over though, as the code must be “valued” to

Andrew I. Brill, M.D.
President, AAGL

Craig Sobolewski, M.D.
AAGL Representative,
ACOG Nomenclature Committee

see WAVES on Page 4

see CODING on page 3
It is a Two-Way Street....

Recently received some very thoughtful comments about the AAGL from two members. One e-mail was related to the annual meeting, while the other one was a note suggesting ways to increase the value of membership in the AAGL. Their constructive suggestions (and criticisms) were very much appreciated.

The Board of Trustees of the AAGL and the office staff in Santa Fe Springs make every effort to anticipate and be responsive to the thoughts and needs of our membership. But it is a two way street. Much of the feedback we get from the membership comes at our request from course reviews, annual meeting ratings, and periodic questionnaires. However, it is often the unsolicited comments from a member that give us a new insight or perspective, which truly allows us to make changes beneficial to the whole organization. The Board of Trustees and staff are trying, but we need your comments.

Please contact us with your comments, suggestions and feedback. The e-mail addresses of all of our officers and staff can be found at www.aagl.org (and while you are there, please check your own listing as well under ‘find a physician’).

from the editor

Introducing the Editor-in-Chief of News Scope

As the new Editor for News Scope, I plan on making very few changes in the excellent newsletter that has evolved into the format you are reading today. I am encouraging all members to take advantage of the “Letters to the Editor” section, to submit commentary on issues affecting our ability to provide top quality care for our patients.

With 2004 being a Presidential election year in the United States, members need to look closely at how candidates stand on issues relevant to the practice of medicine. President Bush advocated tort reform and the elimination of frivolous suits when he delivered his State of the Union Address this year, yet a number of members of congress neither applauded nor stood up for these issues. I want you to be aware when you vote this year that you are voting for your future ability to practice in a more sane environment.

We also must convince the federal government and insurance companies that minimally invasive gynecology is best for our patients and should be reimbursed as such. I have been an outspoken advocate for the rights of patients and physicians to receive and practice medicine in the most optimal manner and this will be reflected in my editorials in future issues of News Scope.
Save Your Own Neck!

When Dr. Gimpelson asked me to write a commentary for News Scope, I told him I would be happy to, but that I had to work around my upcoming neck surgery: a 3-level cervical spine fusion, with a bone graft from the hip. While considering which aspect of endoscopic surgery to write about, I realized that risks of injury to the surgeon performing this type of surgery have been largely ignored.

The first time I became aware of this was after a laparoscopic myomectomy years ago. The WISAP morcellator was a manual version of today’s electronic morcellator. It was rotated by grasping a relatively sharp collar and manually turning it back and forth. It took over an hour to morcellate a large fibroid. Immediately after completing the case I noticed numbness in my right thumb in the distribution of both digital nerves. After six months, numbness changed to pain and hyperesthesia, which lasted over two years.

A recent questionnaire by the Society of American Gastrointestinal Endoscopic Surgeons showed that 8%–12% of 199 responding surgeons reported frequent pain or numbness in the arms, wrists, or hands following laparoscopic surgery. There are numerous reports in the literature of digital nerve injuries to surgeons from laparoscopic instruments, but instrument design remains essentially unchanged.

Lateral epicondylitis of the elbow can also result from the repetitive stress of manipulating laparoscopic instruments. And I am not the only laparoscopic surgeon in Los Gatos whose “laparoscopy elbow” has required open surgery.

But the worse was yet to come. How many of us spend hours doing hysteroscopy or laparoscopy while watching a monitor way off to one side, high above eye-level? The result in my case: severe multi-level degenerative disease of the cervical spine. The disks are gone. Bone spurs shown pressing on nerve roots on MRI correspond exactly to where the paresthesias are felt. Physical therapy and nine cervical epidural steroid injections brought temporary relief. But now it is time for “definitive treatment.” I’m not looking forward to it.

A tremendous amount of effort has gone into improving ergonomics in industry to reduce the incidence of injury. Visit the OSHA web site on ergonomics (www.osha.gov/SLTC/etools/computerworkstations/checklist.html). Here are three of many guidelines for computer workstations that we can learn from:

1. Head and neck to be upright, or in-line with the torso (not bent down/back).
2. Head, neck, and trunk to face forward (not twisted).
3. Top of the monitor screen is at or below eye level so you can see it without bending your head or neck down/back.

Improved technology, such as flat panel displays are simplifying monitor placement, but even with conventional monitors it is possible to place them so as not to require straining your neck to see them. It takes time to reorganize the carts we’ve been using for years so you don’t have to twist your neck to see the monitor. Hospitals, surgery centers and office endoscopy suites need to be designed to avoid this serious and potentially permanently disabling risk to the health of all of us who perform endoscopic surgery. So if the O.R. crew gives you a hard time about doing so, just show them the pictures of my neck, and tell them you don’t want yours to look like that! Remember—the neck you save may be your own!

coding from page 1

determine reimbursement. To do this, we ask for your help to “survey” the code. This is where you as individuals can make an important difference (Please see, www.aagl.org/content/PDF/mscp0402.pdf). In this April-June 2002 issue of News Scope, the Coding Corner article can be found on page 4). The recommended RVU for the new code as determined by your surveys then gets presented at the RUC. Finally, the RUC proposals go on to CMS, which then determines whether or not to accept the RUC recommendation and publish it in their fee schedule. WHEW…

At our November Coding Committee meeting we discussed the fact that several Association members have been inquiring about a code for Laparoscopic Supracervical Hysterectomy (LSH). If you take this through the process above, you may appreciate why the Committee has been recommending against this. If this procedure gets a new code, it will then have to go through the survey process. The new code will get compared against existing codes, in this case 58550 (LAVH). Since the new code does not involve removing the cervix, it will most likely be valued at less than the RVU’s for an LAVH (as is true of the codes for a TAH vs supracervical hysterectomy done via a laparotomy). The alternative, is to code an LSH using the LAVH code (58550) with a -52 (reduced services) modifier. While Medicare must recognize the modifier, many private insurers do not and this works to our reimbursement advantage.

So, if you’re one of the members who have been wishing for an LSH code, be careful of what you ask for!
During operative laparoscopy, the surgeon suspected a possible urinary tract injury after gross blood in the urine was reported by the circulating nurse. He injected indigo carmine intravenously and observed the operating field for the next 15 minutes. No dye spilled into the abdomen, however, the circulating nurse advised him that there was no dye in the Foley catheter drainage system. She asked if he wanted a urological consultation (an urologist was in the next O.R.) to come in for consultation. The surgeon felt it was not necessary and he terminated the procedure. He left orders to be called should any blood be seen in the Foley bag. After the patient reached the recovery area, the nurses observed and recorded a small blood clot in the Foley bag. That evening the Foley catheter was removed and the patient sent home.

Within 48 hours, the patient called with increasing abdominal pain and was instructed to visit the emergency room. The surgeon called the ER doctor, stating that he was concerned about a possible bladder injury, and suggested an IVP. The ER doctor ordered and reviewed the IVP films and reported them as normal. The patient became progressively febrile and toxic and was treated as having a pulmonary infection. The next day, he reviewed the IVP films and reported them as normal. According to the circulating nurse, she advised him that there was no dye in the Foley bag. When the IVP films were reviewed, there were only two films taken, neither showing the entire bladder. The ER doctor said that the primary surgeon had ordered it that way, but the surgeon denied that statement and claimed he assumed an ER physician, given the surgical history, would have ordered a full IVP set of films.

As the deposition process came to a close, the three defendants — the hospital, the ER physician, and the laparoscopic surgeon — were all declaring the others had fallen below the standard of care. At this point, the plaintiff’s attorney asked for a $5,000,000 settlement which was refused by each malpractice insurance company.

At trial, all of the above points were presented to a jury while each defendant pointed a finger at the other. An award for the plaintiff was $18,000,000 which, after appeal, was reduced to $17,000,000.

Lessons learned:
1. Diagnostic tests, chosen to rule in or out a suspected complication, must be comprehensive, properly performed to completion and correctly interpreted.
2. When in doubt, get consultation.
3. Another example for the need to document pathways of communication.
4. Given the suspicion, cystoscopy would have been an innocuous procedure of great diagnostic value.
5. If defendants start blaming each other, settlement is the first consideration.
6. Should an insurance carrier refuse to settle, a prudent defendant might consider personal counsel.

What Were They Thinking?

medical legal corner

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primarily obstetrical and that encourages preventive services, office practice, non-surgical alternatives, and less invasive gynecology.

In recent years, the Board of Trustees has actively debated the concept of a name change for the organization. Proponents for change have argued that we are an international organization that has reached well beyond laparoscopy, and that our present mission embraces all aspects of minimally invasive gynecology. Vocal opponents have argued that the present name has immeasurable value, and that the potential outcomes from changing the name have been inadequately researched. One of my foremost responsibilities as President is to fairly integrate all concerns into any discourse concerning a name change. As you are aware, the Board initiated a process of due diligence by recently mailing a directed survey to the membership. Approved by the Board of Trustees, the AAGL is moving forward to formally incorporate a tagline entitled: Advancing Minimally Invasive Gynecology Worldwide. Once appropriate trademark research has been completed concerning several potential names, you will be receiving an Executive Summary and FAQ document that will explain the proposal for a name change in greater detail. Ultimately, you will have the opportunity to voice your opinion by ballot as ordained by our bylaws. Then, and only then, will a final decision be made concerning a name change.

We are all in the midst of momentous change. The long-term survival of the AAGL will require the determined courage to openly accept the challenges of the future, while never failing to honor the richness of the past. I am confident that our mutual love affair with the AAGL will serve to insures its robustness and longevity as the state-of-the-art resource for minimally invasive gynecology.
LSH is going Orange!

One System. One Color. Your Complete Solution.

The PK System is all you need for every LSH you perform. As a market leader in disposable bipolar devices, we offer many instrument options with the gynecologic surgeon in mind:

- **PK System CUTTING FORCEPS**—multifunctional device for grasping, dissecting, coagulating, transecting and retracting tissue.
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www.gyrusmedical.com
It is with much excitement and anticipation that we prepare for our 33rd annual meeting to take place November 9–13 at the San Francisco Hilton and Towers. The AAGL has become the pre-eminent worldwide organization advancing minimally invasive gynecology. This fact has become even more evident to me in the past several months as I have worked with the Board of Trustees, the Continuing Medical Education Committee and the excellent AAGL staff. The incredible capabilities of many outstanding people have been focused in a team effort to bring you the best-ever annual meeting.

We have reviewed all the feedback from prior years and listened carefully to suggestions from many members. The program format will feature our acclaimed Postgraduate Courses, Expert Panels, Crossfire Debates, Surgical Tutorials, Video Sessions, Telesurgery, Roundtable luncheons and Industry Symposia—all led by the world’s leading minimally invasive gynecologists. It is absolutely impressive to see the quality and breadth and depth of expertise of our faculty. The program will comprehensively cover all aspects of our specialty and the newest innovations including laparoscopy, hysteroscopy, hysterectomy, urogynecology, pelvic reconstruction, abnormal uterine bleeding, cancer, myomas, adhesions endometriosis, infertility, sterilization, and medical alternatives. Additionally, all our members are invited and strongly encouraged to submit their work. Hundreds of their abstracts will be presented orally, by poster and video. Don’t miss out on staying up-to-date with the latest and best treatments for your patients. Please go to www.aagl.org to submit your abstract—the sooner the better!

And this great meeting will take place in one of the world’s favorite cities! San Francisco has it all—great atmosphere, cuisine and culture surrounded by Napa and Sonoma wine country, the ocean and Monterey, and Lake Tahoe in the Sierra Nevada Mountains. Join all your friends and colleagues in November for a terrific program with lots of interesting learning and a wonderful social time in a beautiful place. We look forward to receiving your abstract and seeing you in November!

An advanced postgraduate workshop for gynecologic laparoscopists who desire to master retroperitoneal and Space of Retzius anatomy and the various surgeries performed therein, is being offered by the AAGL in affiliation with the Department of Ob/Gyn and Department of Anatomy at the University of Louisville in Louisville, Kentucky.

Dr. Ronald Levine will lead an experience faculty that includes some of the most outstanding physicians in the field. Participants will operate, assist, and observe. This rotational format allows participants to learn pelvic anatomy and laparoscopic suturing skills in a meaningful manner. Faculty members will lead participants through procedures such as pelvic sidewall dissection, preparation for laparoscopic hysterectomy, uterosacral colposuspension, Burch retropubic colposuspension, and paravaginal defect repairs through the laparoscopic approach.

This year, we are including an opportunity to learn TVT and Trans Obturator Sling if desired. If not, participants may opt for additional suturing instruction or further instruction on dissection.

The workshop is limited to 28 participants, so we encourage you to register today as the course is filling fast! Visit www.aagl.org for more information.

View Streaming Videos on the AAGL’s Website— www.aagl.org

Good news! AAGL members can now access streaming videos at www.aagl.org. The new Video Library includes the top videos from the 2003 annual meeting and educational videos from the last five annual meetings. Highlight videos from recent workshops are soon to be added to the selection as well. You can find a link to the AAGL’s Video Journal on the front page of the website.
Jay Michael Cooper, M.D.
1944–2004

Remembering a Visionary and Dear Friend

Jay Michael Cooper of Phoenix died February 4, 2004; he was 59 years old. Jay moved to Phoenix in 1974 from Philadelphia. Jay was an Obstetrician/Gynecologist.

Jay was loved by his wife, Joyce; daughters Jenna (Steffen Lipofsky), Jill (Matthew Lefferman) and Jessica; parents Fannie and Joseph; sisters Janice Zuckerman and Joan Cooper; brother Jeffrey Cooper; and grandchildren Maia and Joshua Lefferman.

Two funds have been established to honor the life and work of Dr. Jay Cooper. The first was established by the Cooper family and will benefit medical research, education and the arts. Tax deductible donations can be sent to the:

Jay M. Cooper Memorial Fund
12701 N. Scottsdale Road, Suite 202
Scottsdale, AZ 85254 - Ph: 480.699.1717

The second was established by the Foundation of the AAGL to provide an annual award for the fellow who submits the best paper on minimally invasive gynecology. The award will consist of a $1,000 cash prize, travel, housing, and an invitation to present their paper at both the AAGL and ASRM annual meetings. Papers are limited to fellows currently enrolled in the AAGL/SRS Fellowship in Gynecologic Endoscopy. Tax deductible donations can be sent to the:

Jay M. Cooper Endowment
Foundation of the AAGL
13021 E. Florence Avenue
Santa Fe Springs, CA 90670-4505
Ph: 800.554.2245 or 562.946.8774
Email: generalmail@aagl.org
Web: www.aagl.org

post-doctoral life stands head and shoulders above the rest of us who chose obstetrics and gynecology for a career. Jay moved to Phoenix, Arizona in 1974 to work for the Indian Health Service. In 1976, he entered private practice, but also served as Medical Director for Planned Parenthood of Phoenix, AZ and Medical Director of the Arizona Tay-Sachs Prevention Committee. Jay soon became the recognized world leader in all aspects of hysteroscopic surgery. Nearly everyone in the world doing hysteroscopic surgery today has learned something from Jay Cooper; or has learned from someone taught by Jay. In fact, there are at least two book chapters and two peer-reviewed journal articles written by him that will be published later this year.

In spite of all this professional success, Jay’s number one priority has always been his family. At one of the peaks in his professional career, he put many requests for his presence on hold to spend more time with his daughters as they grew. Eventually, his gift brought him back into the many leadership roles he has held throughout his career, including President of the AAGL. Throughout all this time, his wife, Joyce, has been a wonderful life partner.

My last meeting with Jay was in April 2003, at the International Congress on the Contemporary Management of Uterine Fibroids. Jay was the Scientific Program Chair, and he assembled all of the world’s experts on fibroids. None of us present at that meeting knew we would lose Jay within a year.

During the funeral services at Beth El Congregation and the Interment at Beth El Cemetery I thanked God for bringing Jay into my life, into the lives of the many physicians he trained, and into the lives of the many women to whom he brought comfort through his remarkable skills.

Most of all I thank Joyce, Jenna, Jill, Jessica and Fanny and Joseph Cooper for sharing Jay Cooper with all of us.

—Richard J. Gimpelson, M.D.
Secretary-Treasurer, AAGL
Editor-in-Chief, NewsScope
future meetings

AAGL MEETINGS

Advanced Workshop on Gynecologic Laparoscopic Anatomy and Surgery on Unembalmed Female Cadavers
May 21–22, 2004
University of Louisville
Louisville, Kentucky

Global Congress of Gynecologic Endoscopy
AAGL 33rd Annual Meeting
November 10–13, 2004
(Registration begins evening November 9, 2003)
San Francisco Hilton & Towers
San Francisco, California

Global Congress of Gynecologic Endoscopy
AAGL 34th Annual Meeting
November 9–12, 2005
(Registration begins evening November 8, 2005)
Chicago Hilton & Towers
Chicago, Illinois

AFFILIATED MEETINGS

11th Scientific Meeting on Chronic Pelvic Pain
August 5–7, 2004
Chicago, Illinois

3rd Workshop on Basic Anatomy and Advanced Technology in Laparoscopic Surgery (Simulators and Robotics)
September 2–4, 2004
Kiel, Germany

2004 Regional Meeting: Endometriosis — Current and Future Management Strategies
September 6–8, 2004
Capetown, South Africa