Issue No. 34 | 18 Years of Service | 2013

The Cutting Edge

A Voice for Ontario's General Surgeons
ONTARIO ASSOCIATION OF GENERAL SURGEONS
(OMA Section on General Surgery)

New OAGS President at the helm

Section needs member input for next negotiation round in 2014

By Dr. Jeff Kolbasnik

Dear Colleagues,

It is my pleasure to write this final article as the outgoing President of the OAGS. It has been a true privilege and honour to lead this organization over the past 5 years. I have appreciated the support that the membership displays for the organization, and I have appreciated the personal support and encouragement I have received from many of you. I hope to continue to contribute in a leadership capacity for our specialty, both on the OAGS Board as Past-President and at the OMA level as the current Chair of the Section on General Surgery.

Earlier this year during an OAGS Board meeting, the Board elected a new executive, with **Dr. Chris Vinden** from London elected as President and Dr. Alice Wei from Toronto elected as Vice-President. I have gotten to know both individuals well over the past few years and know the organization's future is in excellent hands. Chris and Alice have been active members of the OAGS Board for many years and have displayed great knowledge, expertise, critical thinking and leadership skills during that time. I would also like to express gratitude to Dr. Angus Maciver for his many years on the OAGS Board, including in the capacities of Vice-President, President, and for the past 5 years as Past President as well as Chair of the OMA Section. Angus has provided thoughtful insight for the organization and has worked diligently and tirelessly to advance our interests.

There have been many developments over the past year, most significantly the OMA-Ministry negotiations and the evolution of health system funding reform and its impact on hospitals.

As you know, negotiations broke down last spring and the Ministry imposed a number of fee reductions on the profession. Ultimately, negotiations resumed, and although the final agreement was still a "negative" agreement resulting in overall fee reductions for physicians, the final agreement was an improvement over the terms which government threatened to impose on the profession.

We lobbied aggressively to reverse some of the most egregious changes, including the reduction in after-hours premiums and laparoscopy premiums and the elimination of the C101 code, and we are proud that our efforts were successful in reversing these imposed changes. I wrote to you both in my capacity as OAGS President and then in my capacity as Interim Chair of the OMA Surgical Assembly urging members to vote in favour of the agreement. Despite the many negative aspects, there were a number of positive aspects as well, including agreement to continue government subsidy of CMPA premiums, negotiation of a dispute resolution mechanism, and establishment of bilateral committees to further physician contributions to the management of the health care system and to re-establish a working relationship with the government. During the referendum, 88% of general surgeons and 81% of all physicians who voted supported the agreement. Implementation is well underway.

However, this agreement is short. Yet, it sets the stage for negotiations on the next agreement, due to be completed less than a year from now (March 31, 2014). There will continue to be significant pressures to reduce the physician funding envelope, and we will need to participate in efforts to find health system savings. I expect the next negotiations to more directly involve specialty sections from the OMA in order to identify opportunities for savings. We as a specialty will need to develop a mechanism to identify such savings and potentially even participate in identifying fee decreases. Such a mechanism will need to be inclusive and broader than just the Board of the OAGS. We will need member participation, input, and feedback. Proper communication will be paramount.

It is also instructive to compare the province's financial situation to that of the early 1990's, when Rae days, ceilings, clawbacks, and major wage restraints were introduced. Nearly all the current financial indicators are similar or worse now than in the 1990's, except the interest rate on government borrowing costs, which is less than half of what it was then. An uptick in the interest rate is unlikely but would throw provincial plan

See "President" on page 10

INSIDE

NOTICE: OAGS 2013 MEMBERSHIP DRIVE (Jan-Dec, 2013)

Please be reminded that the OAGS is still collecting annual dues for the current fiscal. If you've already renewed, a receipt will be enclosed. Otherwise, a final invoice reminder may be included. For more details or to pay online, please visit our website: www.oags.org/join.htm . If uncertain of your membership status, feel free to call our office: 1-877-717-7765.

19TH OAGS ANNUAL MEETING: Saturday, November 2, 2013

OAGS Board of Directors, President Dr. Chris Vinden and Annual Meeting Committee Chair Dr. Angus Maciver would like to thank all those who attended last fall's Annual Meeting and invite all General Surgeons to this year's 19th OAGS Annual Meeting on Sat., Nov.2, 2013 at the Sheraton Toronto Airport Hotel, 801 Dixon Rd. For more details: www.oags.org. (Free admission to OAGS members.)

Editorial...

By Dr. Ciaran Kealy

The OAGS held its previous Annual Meeting on November 3rd, 2012. It has come a long way since the organization was set up in May 1995 to give the General Surgeons of this province a voice to articulate its concerns as an independent body, distinct from the OMA. It held its inaugural annual meeting in the Prince Hotel in Toronto and had an excellent turnout.

Over the course of the last 18 years, the OAGS has clearly articulated the concerns of its members and the needs of the patients of this province. In 1995, many groups were concerned with government actions that infringed on the freedom of the profession and set up splinter groups distinct from the OMA/Sections. We, being one of these groups (OAGS), were told by "The Establishment" that we were wasting both our time and money and would quickly fade into oblivion. Thankfully, due to the efforts of our executive and members, this did not occur and we have more than justified the faith put in us by you – our members.

We were able to take on various organizations (and media) using badly interpreted "evidence-based data"[1] to analyze our profession, and I refer to one study in particular published by ICES with respect to laparoscopic bile duct injuries that resulted in a ruling by the ombudsman and a full retraction in the prominent newspaper involved [2].

We pioneered and obtained paid on-call for our members. We promoted guidelines with respect to resources for our members, which advocated and, for the most part, obtained 1-1.5 days of major OR times per week, 1 day of endoscopy, 1 day of minor surgery and also a half to 1 full day for surgical clinic.

Given what had transpired recently, however, this could be referred to as the good old days. These days appear to be gone. Our system is collapsing around our ears. Under the present government, it is "all take and no give". We have our resources cut back drastically, but yet have to provide seamless coverage when it comes to the provision of emergency care to our patients. Nobody would advocate job actions that would strike at our patients, but somehow the cynic in me wonders whether cutbacks both at the federal and provincial levels are a softening up process that will, by public demand, lead to the privatization of the health care system.

We have come a long way in the last 18 years. A lot of hard work has been done by the executives in that time. We would particularly like to acknowledge Dr. Phil Barron, Dr. Jim Forrest and Dr. Jack Long, who have made significant contributions to our organization as board members over the last 18 years and have recently stepped down from the executive. We would also like to thank Dr. Julie Ann Van Koughnett, our former Resident Representative who is now pursuing further postgraduate work in the United States. We welcome Dr. Kellen Kieffer in her place, who comes to us from NOSM, PGY3.

We currently have a strong board representing the interests of both our patients and our members who count on you to support them in these new and interesting times.

1. Priest L. The low-scar surgery with a high risk. Toronto Star 1997 Sept 21; Sect A:1,14,15.
2. www.oags.org/cuttingedge_05.pdf; www.oags.org/cuttingedge_06.pdf .

- Dr. Ciaran Kealy, OAGS board member and newsletter editor, is on staff at Health Sciences North, Sudbury. He was also the founder of the OAGS.

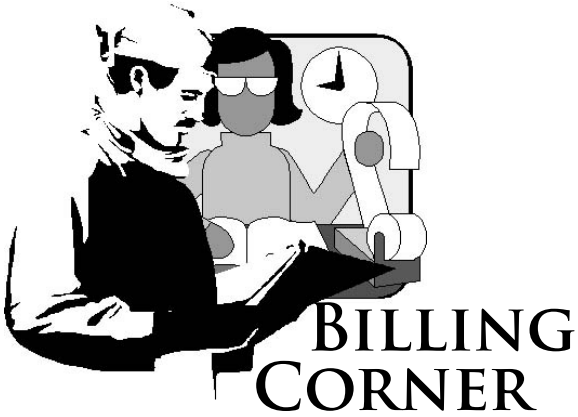
The Cutting Edge newsletter is a bi-annual O.A.G.S. publication written by General Surgeons for General Surgeons. It is in its 17th year of existence. It has a circulation of over 500 General Surgeons and General Surgery Residents within the province of Ontario. Any comments related to the contents of this publication or General Surgery issues can be emailed to: info@oags.org ...or faxed to 705-745-0478.

Chief Editor: Dr. Ciaran Kealy
Editor/ Design & Layout: Lori Quilty

Upcoming CME Events

DATE	EVENT
July 11, 2013	Harvard Med School - Breast Cancer New Horizons Marriott - Long Wharf, Boston, MA Web: www.cme.med.harvard.edu
Aug.25-29, 2013	International Surgical Week ISW 2013 Helsinki, Finland Web: www.isw2013.org / Email: surgery@iss-sic.ch
Aug.28-31, 2013	22nd SLS Annual Meeting and Endo Expo 2013 Hyatt Regency Reston, Reston, Virginia, USA Web: www.sls.org / Email: Conferences@SLS.org
Sept. 6-7, 2013	UofT Canadian Bariatric & Foregut Surgery Summit Li Ka Shing International Healthcare Education Ctr. St. Michael's Hospital, Toronto, ON Website: http://www.cepdtoronto.ca
Sept. 13-14, 2013	Canadian Society for Vascular Surg. '13 Annual Mtg. The Westin Edmonton, Edmonton, AB Web: www.canadianvascular.ca
Sept. 14, 2013	Harvard Med School - Acute Pain Mgmt. Symposium Seaport Hotel Boston, Boston, MA Web: www.cme.med.harvard.edu
Sept. 19-22, 2013	Canadian Surgery Forum 2013 Westin Ottawa Hotel, Ottawa, ON Web: www.cags-accg.ca
Sep. 27-29, 2013	Nova Scotia Surgical Section, Fall Classic Cabot Links Golf Course, Inverness, NS Email: Emily.Rendell@cdha.nshealth.ca
Sep. 27-29, 2013	Symposium on Advanced Wound Care (SAWC) Las Vegas, Nevada Web: www.sawcspring.com
Oct.6-10, 2013	American College of Surgeons Clinical Congress Washington, DC Web: www.facs.org/clincon2013/index.html
Oct.9-11, 2013	26th International Course on Therapeutic Endoscopy The Fairmont Royal York Hotel, Toronto, ON Web: www.thera-endo-toronto.com/
Saturday Nov. 2, 2013	**19th OAGS Annual Meeting** **Sheraton Toronto Airport Hotel & Conference Ctre.** **Toronto, ON** **Web: www.oags.org ; Email: info@oags.org**
Nov.7-10, 2013	19th Annual Canadian Assoc. of Wound Care Conf. Sheraton Wall Centre, Vancouver B.C http://cawc.net/index.php/conference/
Nov. 22-23, 2013	UofT Update in Minimally Invasive Surgery Marriott Toronto Bloor-Yorkville, Toronto, ON http://events.cepdtoronto.ca/website/index/SUR1318
Dec. 3-5, 2013	European Colorectal Congress 2013 Olma Messen St. Gallen, Switzerland Web: www.colorectalsurgery.eu/

For the complete listing of CME events, check our website: http://www.oags.org/events.htm
For a listing of national and international CME courses: http://www.doctorsreview.com/meetings/



Billing Corner

By Dr. Alan Lozon

For this issue's instalment of the Billing Corner, I thought I'd review some of the questions presented at last year's AGM along with some of the changes that would be made to that presentation based on the recent agreement.

Colonoscopy

The recent change in colonoscopy codes has caused significant consternation and difficulty for the membership. OAGS recommended that colonoscopic intervals be determined through education, while OHIP prefers to do this through new billing codes. The result has been more new colonoscopy codes, which OHIP hopes to use to contain colonoscopy costs.

We have been informed that these codes are effective January 1st , 2013 and are NOT retroactive. If a Z555 was billed 3 years ago and billed again now, it will be paid. If a Z555 was billed Jan. 2nd, 2013 and a repeat colonoscopy done Feb.2, 2013 for a poor prep and billed as a Z555, it would not be paid.

We are told that these code payment conditions, AS OF CURRENT, are provider-specific. Therefore, if a surgeon sees a patient who received a colonoscopy from another provider and a Z555 was billed by them, Z555 could also be billed by the current surgeon. My personal opinion is that this is likely to change and become provider nonspecific.

It is also from my perspective that these codes are easily tracked by computer and that at some point (if it hasn't already occurred) payment refusal will be computer-generated automatically. This is a very good reason to be diligent about your billings.

Some surgeons have considered simply billing all colonoscopies as Z496 (symptomatic); while, if a patient does have symptoms, then this is the preferential billing code. We cannot recommend its use for routine or surveillance colonoscopy. Routine billing of only Z496 could put a surgeon in a difficult position in the event of an audit. Billing of a large number of only Z496 could also be programmed into OHIP billing software to trigger a review/audit.

Chris Vinden and I have put together a review sheet/card to place in your office and endoscopy suite to help in billing. We will try to get cards made up for the next AGM as we had done several years ago following the first set of new C-scope codes. *(See **page 10** for easy reference table.)*

To ease the burden of tracking these indications and intervals, I've taken to dictating the indication and time interval into my notes to make it clear to myself what to bill when I do the procedure. So, when I'm busy in the endoscopy suite without copious notes, I have already determined what I will bill in order to insure my interval is appropriate and that I get appropriate reimbursement.

We have also received numerous queries regarding how to bill for surveillance post-colon resection for carcinoma. The recommended surveillance intervals for this (at 1, then 3 and then 5 years) do not match the intervals recommended by OHIP for surveillance (Z498). We have been informed that OHIP will pay Z498 for surveillance post-colon resection for carcinoma at the 1,3,5 year intervals. Remember, that's within 1 year of resection, then 3 years later (4 years from resection), then every 5 years thereafter, as per standard guidelines.

Laparoscopy

When billing for a laparoscopic-assisted procedure, the question arises as to whether it is better to bill the laparoscopic premium (E793) or the laparoscopy before open procedure code (E860). Before the unilaterally imposed agreement, the laparoscopic premium of 25% was almost always the best method for billing laparoscopic procedures that had an open component. Since E860 only pays $131.45, any laparoscopic procedure with a basic fee of greater than $524.60 would pay more than the E860 code ($524.60 x 25%=131.45). With the laparoscopic premium of 10% after the imposed agreement, the fee code has to be greater than $1,314.50 for the premium to pay more than the E860.

We now know that the laparoscopic premiums have returned to 25% but are supposed to be re-evaluated. With these codes (for now) at 25%, the basic fee to make E793 more lucrative than E860 returns to $524.60.

As mentioned previously, the laparoscopic fee codes are to change based on the procedure. To determine the best way to bill a laparoscopic procedure, use the following equation. Ultimately, if the total for the lap premium is greater than $131.45, then bill the lap premium. If less, then bill E860...

$Fee Code x Lap Premium(E793) > $131.45 (E860)

Remember, you can only bill E860 for a laparoscopic procedure converted to an open procedure. So, the procedure must have an open component (i.e... be lap-assisted), in order for this type of billing to be defensible. If there is no open component to the procedure, you are stuck billing E793 and taking whatever OHIP decides to give you. Overall, I suspect (and hope) OHIP will neglect to re-evaluate these codes or determine that 25% is an appropriate premium and this will remain a nonissue.

Recall Patients

One of the questions Billing Corner received was whether it was appropriate to bill a consult (A035) on recall patients (i.e. yearly cancer F/U or 3/5 year repeat colonoscopy) or if a specific assessment should be billed.

In order to bill a consult, a written consult request has to be provided. If you are calling a patient back without a written request from a referring physician, then you can only bill a specific assessment (A033). If you have a written request for consultation, then you can bill A035/6 appropriately. Referral physicians, who send you a request for consultation before you call the patient back, are good referral physicians and should be kept.

Surface Pathology Billing

Surgeons should be aware of the Z116 billing code; this is for biopsy with suture. It pays $29.60, which is more than the billing for a nevus excision ($20) or any benign skin lesion, and should be billed instead of nevus or Type 1 skin pathology. Cysts, lipomas and other deep pathology should continue to be billed as usual.

Intersphincteric Abscess

Another question we received was how to bill for an intersphincteric abscess done under general anaesthetic. There is no specific code for an intersphincteric abscess drainage. The options for billing this would be to bill it as a peri-anal abscess drainage (Z105-$66) or as an Ischiorectal abscess drainage (Z107-$108). Many surgeons (author included) feel the difficulty of finding and draining the intersphincteric abscess warrants the higher billing code, and this is most representative of the procedure done.

The second part of that question was how to bill it if you couldn't find the abscess. Again, many surgeons would feel it appropriate to bill as the intended procedure. We often spend more time and frustration on an abscess that cannot be found than on an abscess that is easily drained. Personally, I would highly doubt that OHIP would challenge any ischiorectal abscess drainage, and even if they did, this should be easily defensible as appropriate. That's all for this issue. Happy Billing. - Al

- Dr. Alan Lozon, O.A.G.S. Board Member and OMA Section Tariff Chair, is on staff at the Grey Bruce Health Services, Owen Sound.

NOTE: Please note that the opinions expressed above are those of the author and do not necessarily represent OMA or OHIP Policy. We are always looking for ideas or "tips/tricks", so members are MOST encouraged to send us your questions or suggestions, especially for our Annual Meeting interstitials. Ideas can be sent via email (info@oags.org), fax or mail.
Further information can be found on the MOHLTC/ Schedule of Benefits website: http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html .

Resident Rostrum

By Dr. Kellen Kieffer
O.A.G.S. Resident Representative

In Defence of the Generalist

There was a time when a general surgeon would be the go-to person for all your surgical needs. Needed a hip pinned? Get the general surgeon. Aortic aneurysm? The general surgeon will handle it. Caesarean section? You guessed it. There are some places in the world where this is still the model of care – and, in fact, some places in our country and our province. However, in the vast majority of cases over the past six decades, we have seen a continuous trend towards specialization and narrowing of focus in surgery and in medicine as a whole.

The common opinion seems to be that this is driven by public demand. As the depth of our knowledge expands, individuals need to narrow their focus in order to retain the standard of "expert". And these days, the public demands the best and so we must subspecialize in order to deliver it. Interestingly though, there is no evidence that the public or its demands played any part in the changing structure of the medical field. Alternately, it seems to be something coming directly out of the academic centres. Specialists with deep expertise have ruled the roost in the last 60 years – not only in medicine and surgery, but in most professional domains such as academia, law, finance, and economics. In order to advance one's career, it was most efficient to specialize. In other professions and in the business world especially, we have more recently seen a backlash against "domain expertise" in favour of generalists who are better able to deal with a complex global economy and are proving to be more effective. We have not seen the same thing in surgery, but would it be the better way to go?

There is evidence to support specialization in medicine. But there is also fairly robust data to support the generalist, both within medicine and more abstractly. Several studies have shown that generalists are better at navigating uncertainty, which is still important in modern medical care, despite advancements in knowledge and technology. The largest of these studies was performed by Philip Tetlock over a 20+ year period. He tested the ability of professional forecasters in many domains to predict occurrences within and outside their area of expertise. He found that generalists vastly out-performed specialists, even within their area of specialization. He concluded that specialists tend to get very focused and efficient with the usual presentation but don't perform as well when things deviate from the norm. From the medical literature, generalists tend to be better diagnosticians. They tend to be more resourceful problem solvers and produce more innovation, and they are more cost-effective in both single-payer and private health care systems.

More practically, general surgery in rural and remote places not to mention many community centres, is a generalist practice. Case logs from these practices indicate that the workload has not changed as compared to a decade ago. These surgeons are still performing many of the common cases such as carpal tunnels and ganglion excisions, saving their patients from year-long wait lists at tertiary centres.

In Canada, surgeons are not being trained as generalists any more. This is certainly illustrated in a survey of 5th-year residents across Canada which just came out in the American Journal of Surgery recently. Comfort levels were extremely low for procedures not normally performed by general surgeons in teaching hospitals (lower limb fasciotomies for example) but which would be expected of a general surgeon outside of the city. And further down the page you read that over 50% of these graduating residents intend to practice in the community and 25% in rural centres![1]

Surgical education is at a crossroads right now. As people are realizing that the traditional models of training may not be well suited in today's environment, changes are on the horizon and particularly the move to a "competency-based curriculum". For those of you not familiar with the concept, competency-based training aims to define a specialty by a discrete number of observable abilities, termed competencies. A resident's training will be deemed complete when he or she is able to demonstrate a minimum standard in each of the competencies in his or her specialty. The problem in general surgery is, how do you define the specialty when it varies so much from setting to setting? There is a danger of establishing a narrow set of competencies based on the work common to all general surgeons, rather than a wide set of competencies based on the true breadth of the specialty.

I believe that general surgery suffers as we gradually drift away from our generalist roots. The surgeons practicing today have benefited from a strong, well-rounded residency which prepared them to practice in any setting. Those who have subspecialized after residency have also benefited from this solid grounding. Certainly, this has provided them with the skills and versatility needed to deal with complex cases and unexpected intraoperative situations that inevitably come up even in their focused practices. If we must transition to competency-based training, I would urge the schools to establish a broad range of competencies for general surgery residents. I hope this would include things like skin grafts and vascular anastomoses that would normally fall under the domain of another surgical specialty. And I believe it's not just those ending up in rural practice who would benefit, but all of us.

If they're going to call us "general surgeons," let's make sure it continues to be for a good reason.

As always, if there are any resident related issues you would like to be brought to the OAGS or discussed here, please contact me or the OAGS at info@oags.org or contact your local OAGS Resident Liaison. (see below)

[1]*Gillman LM, Vergis A.- General surgery graduates may be ill prepared to enter rural or community surgical practice, Am J Surg. 2012 Jul 30. [Epub ahead of print]*

Kellen Kieffer, OAGS Resident Representative
PGY 3, General Surgery, Northern Ontario School of Medicine (NOSM)

New Resident Representative

The Ontario Association of General Surgeons would like to welcome Kellen Kieffer PGY 3, Northern Ontario School of Medicine (NOSM) as our new Resident Representative, succeeding Dr. Julie Ann Van Koughnett when she graduated last summer. We look forward to working with him on resident issues for the duration of his term.

Kieffer: "*Surgery residents are generally underrepresented in political groups such as PARO and the OMA....I feel it's a natural role for the OAGS resident liaisons and representative to advocate for Ontario's surgery residents among the resident population, just as OAGS lobbies for surgeons within the OMA.*"

We also have a few new Liaisons this year:

- McMaster U - Karina Roth Albin, PGY5
- U of Ottawa - Amber Menezes, PGY4
- Queen's U - Mike Rizkalla, PGY2
- UofT - Debbie Li, PGY3
- UWO - Sami Chadi, PGY4

2013: New OAGS President

Dr. Chris Vinden

As of January 26, 2013, Dr. Chris Vinden of London, ON has succeeded Dr. Jeff Kolbasnik as OAGS President. Dr. Vinden is Associate Professor, UWO, Division of General Surgery and also on staff at Victoria Hospital, London Health Sciences Centre (LHSC).

The OAGS held its board election during the 18th OAGS Annual Meeting last fall on Nov. 3, 2012. As it was a staggered year, only half of the 14 board members were up for re-election along with 2 new nominees, which necessitated a private vote. As a result of the vote, the following seven candidates were elected: **Drs. Jeff Kolbasnik, Alan Lozon, Angus Maciver, Harshad Telang, Eric Touzin, Alice Wei, and Dr. Peter Willard.** (The other 7 board members will be up for re-election at the next annual meeting this fall.)

Also in December of last year, Dr. Philip Barron resigned his position on the board. According to the bylaws, the board is permitted to appoint a member to fill the vacancy until the term ends. Given his interest in becoming more involved and having run in the recent election, **Dr. Timothy Jackson** was invited to take over Dr. Barron's term until Nov., 2013.

Subsequently during a board meeting on January 26, 2013, the board also appointed the new officer positions and committee members. (See back page or our website: www.oags.org.)

Currently, the OAGS Board looks like this:

1. **President: Dr. Chris Vinden, London**
2. **Immediate Past President: Dr. Jeff Kolbasnik, Milton**
3. **Vice President: Dr. Alice Wei, Toronto**
4. **Treasurer: Dr. Dennis Desai, Ottawa**
5. **Secretary: Dr. Harshad Telang, Thunder Bay**
6. **Member-at-Large: Dr. Frank Baillie, Toronto**
7. **Member-at-Large: Dr. Suru Chande, Ottawa**
8. **Member-at-Large: Dr. Ian Chin, Oshawa**
9. **Member-at-Large: Dr. Timothy Jackson, Toronto**
10. **Member-at-Large: Dr. Ciaran Kealy, Sudbury**
11. **Member-at-Large: Dr. Alan Lozon, Owen Sound**
12. **Member-at-Large: Dr. Angus Maciver, Stratford**
13. **Member-at-Large: Dr. Eric Touzin, Sioux Lookout**
14. **Member-at-Large: Dr. Peter Willard, Welland**

New Board Members (L-R): *Dr. Eric Touzin, Sioux Lookout and Dr. Timothy Jackson, Toronto.*

In Memoriam

Dr. Charles Olayiwola Omole, Wingham & District Hospital - July,2012
(OAGS Member: 1999-2012)
Dr. A. Kent Sorsdahl, Stratford General Hospital, HPHA - May 23,2013
(OAGS Member: 2008-2013)
Note: Let us know of any other colleagues who should be remembered: info@oags.org

OMA Section Election 2012-13

Dr. Jeff Kolbasnik

Please note that the OMA is now facilitating the elections of all individual sections. Although the OAGS and OMA Section on General Surgery executives are separate entities and will now hold their elections at different times, the two bodies continue to work together as one unit in an effort to represent all General Surgeons throughout Ontario.

Section Election Report: The final day of the Section Election for 2012 was set for December 17, 2012 - several weeks following the 18th OAGS Annual Meeting. Initial notification and a call for nominations was disseminated 2 months before the election date by the OMA. Because there were no new nominations, the roster of Section executive candidates that was submitted ended up being acclaimed on November 7, 2012. Terms will end in December, 2013. The current Section Executive will set the date for the next Section Election in the coming months. The Section must notify the OMA (and in turn the Section membership) in advance of 2 months before the intended election date while also submitting its roster of candidates at the same time. Nominations amongst the membership will be invited as well.

The current **Section Executive** began their 1-year terms as of Dec.17/12:
1) Chair - Dr. Jeff Kolbasnik, Milton
2) Vice Chair - Dr. Chris Vinden, London
3) Secretary - Dr. Alice Wei, Toronto
4) Tariff Chair - Dr. Alan Lozon, Owen Sound
5) Member-at-Large - Dr. Frank Baillie, Toronto
6) Member-at-Large - Dr. Harshad Telang, Thunder Bay
(Note: As Past Chair, Dr. Angus Maciver was automatically acclaimed as well.)

The following were also acclaimed for 1-year terms as **OMA Council Delegates and Alternates**:
1) Delegate - Dr. Jeff Kolbasnik
2) Delegate - Dr. Chris Vinden
- **Alternate** - Dr. Frank Baillie
- **Alternate** - Dr. Angus Maciver
- **Alternate** - Dr. Alan Lozon
- **Alternate** - Dr. Alice Wei

For more details: www.oags.org/election.htm

Thank You

We would like to take this opportunity to thank **Dr. Phil Barron and Dr. Jack Long** for their tireless efforts in serving both the OAGS and Section on General Surgery for the past 15+ years. During his term, Dr. Barron served as OAGS President (1998-2003), OMA Section Chair (2003-08), and strove to improve the issue of relativity along with building the Annual Meeting to the status it enjoys today. Dr. Long has been with the OAGS since its inception (1996 and earlier with the Section) and devoted many years early on as our stalwart Tariff Chair. We very much appreciated their imparting experience and wisdom to the board/executive over the years and wish them all the best in their future endeavours.

Dr. Philip Barron

Dr. W.J. (Jack) Long

18th Annu

Saturday, November 3, 2012 -

9th Annual OAGS International Lecture Keynote Speaker Dr. Philip H. Gordon (Dir., Div. Colon & Rectal Surgery, Jewish General Hospital/McGill University) spoke on "Evolution of Colorectal Surgery", "Evaluation & Mgmt. of Rectal Carcinoma" as well as a bqt talk about writing a textbook.

By Dr. Angus Maciver

The 18th OAGS Annual General Meeting again exceeded expectations both in quality and attendance.

Our keynote speaker, Dr Phil Gordon, provided us with an illustrative journey of the evolution of colorectal surgery in the country, no less than a primer on cancer of the rectum, and finally at the banquet, an engaging discussion about writing a textbook, including the personal sacrifices one makes.

John Hagen provided his tips and tricks to make laparoscopic colon surgery less daunting. Paul Kortan shared his insights and techniques in arriving at the promised land - the end of the caecum. We were brought up to speed by Martha Louzada with the newer anticoagulants, and she imparted strategies for safe perioperative coverage.

No less of a highlight, and brought back by overwhelming popular demand, was the talk from Marcus Burnstein and Stan Feinberg (anorectal problems: part deux), which was extremely well received with ample audience interaction. David Szalay updated our knowledge in vascular surgery, certainly a field on which we must keep abreast with these changing approaches and technologies.

OAGS Sponsor Chair Dr. Ian Chin (centre) presents an award of appreciation to our Silver Level Exhibitor Ethicon and Ethicon Endo-Surgery (JJMC). We greatly appreciated having 24 exhibitors join us last year at the AGM. Without their support, our meeting would not be such a success.

This year's roster of speakers and topics drew an impressive crowd. Some of c Regional Hospital, Toronto), Dr. Paul Kortan (St. Michael's Hospital, Toronto), Dr. ilton General Hospital/McMaster, Hamilton), Dr. Arni Sekar (Ottawa Hospital & ST Toronto), Dr. Alan Lozon of the Billing Corner (Grey Bruce Regional Health Servi

Silver Sponsor Covidien receives a plaque of appreciation from OAGS Sponsor Chair Dr. Ian Chin. For more photos and information on attending next year's meeting, please visit our website: www.oags.org.

LEFT TO RIGHT: Former OAGS President Dr. Jeff Kolbasnik chaired the morning s the afternoon. OAGS Vice President Dr. Chris Vinden chaired the Business Meetir Martin Yaffe (Sunnybrook HSC), while Drs. Stanley Feinberg (NYGH) and Marcus

al Meeting

Sheraton Toronto Airport Hotel

Arni Sekar shared his experience in the establishment of self standing endoscopy facilities, with a fulsome discussion of financial viability in a quality environment. David Grant discussed blood bourne pathogens and how this has impacted our profession with regard to the CPSO and shared his personal perspective as well as outlining strategies for us all as we "go forward" in our careers. (Sorry for the Adminspeak). A great discussion with Ralph George and Martin Yaffe about what's real and what's surreal about mammographic screening was well received also.

Along with Al Lozon's Billing Corner, we feel the meeting was well balanced and directed to not just our mainstream audience, but with the additional points of interest that were well appreciated by those attending. The wine tasting, sponsored by Coyote's Run was excellent as was the fellowship at the banquet afterwards.

We will do our best to build upon the progressively outstanding quality of previous years, in acquiring speakers and topics who are most pertinent and engaging. With the help of the OAGS Program and Education Committee along with the OAGS board at large, I'm confident things will only get better and bigger.

We look forward to your joining us again this fall: Sat., November 2, 2013!

Our 18th OAGS Annual Meeting was well attended again on Nov. 3, 2012. There were over 190 attendees who enjoyed a day of academic presentations and delicious food prepared by the Sheraton Toronto Airport Hotel. We're hoping for an even larger turnout this year on Nov.2, 2013.

our guest speakers were as follows (left to right): Dr. John Hagen (Humber River Martha Louzada (London Health Sciences Centre, London), Dr. David Szalay (Ham-AR Endoscopy Ottawa Clinic, Ottawa), Dr. David Grant (Toronto General Hospital, ces, Owen Sound). Thanks to all who participated. It was greatly appreciated.

Our panel discussions garnered much discussion from the floor during the Q&A as did most of the presentations throughout the day. The 18th OAGS Annual Meeting was an accredited group learning activity as defined by the RCPSC and earned 7 CME credits (1credit /hr attended).

session. Section Chair and OAGS AGM Committee Chair Dr. Angus Maciver chaired ng. The mammography debaters were Drs. Ralph George (St. Michael's Hosp.) and Burnstein (St. Michael's Hosp.) were on the colorectal panel. (Photos by Lisa Koski)

Bronze exhibitor and CME Supporter MD Physician Services donated several items for our registration packages at that last meeting. For more details and photos on our meeting, visit our website: www.oags.org.

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19TH OAGS Annual Meeting

Ontario association of General Surgeons

(OMA Section on General Surgery)

Sheraton Toronto Airport Hotel
801 Dixon Rd., Toronto, ON
Saturday, November 2, 2013

ACCOMMODATION

A limited block of rooms is being held at the **Sheraton Toronto Airport Hotel, 801 Dixon Rd., Toronto** at a group rate of **$119 CDN** plus taxes per single/double room. The deadline is **Oct. 1st** or until the block fills. **REBATE:** Those listed under the "OAGS" block listing will also be given an OAGS rebate of $30/rm/night. A great deal at $89/night! (Note: Rebates mailed.)

To Make Reservations:

- Call the Sheraton Hotel directly at 1-800-325-3535 / 416-675-6100.
- Online: Visit www.oags.org/agm.htm to be linked directly to the hotel.

PARKING

Parking will be free for those attending the meeting, courtesy of the OAGS. Members should provide necessary vehicle details in advance or upon arrival at the OAGS registration desk before 10am. DO NOT pay the parking meter.

MEMBERSHIP DUES

OAGS 2013 annual membership dues (Jan-Dec) include benefits such as free admission to this year's 19th OAGS Annual Meeting. Visit www.oags.org/join.htm *for more details.*

RSVP & PAYMENT

How to RSVP to the OAGS Office:

- **Phone:** 1-877-717-7765 / 705-745-5621 **Email:** info@oags.org
- **Online: http://www.surveymonkey.com/s/MLHV536**

How to Pay: (1 of 2 methods)

- **Cheque** - Make payable to "OAGS" and send via post.
- **PayPal** - Major credit cards accepted online only: www.oags.org/join.htm .

Registration Deadline:

Oct. 1st, 2013

Target Audience:

Active & Inactive
General Surgeons
General Surgery Fellows,
Residents, Med Students

CME Accreditation:

This event is seeking accreditation by the Canadian Association of General Surgeons as a group learning activity as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada.
(1 credit/ 1 hr attended)

Admission Fees (day only):

- **FREE** - Current OAGS Member
- **$450** - Non-OAGS Member
Gen Surgeon (active/inactive/O-P)
- **$ 30** - Non-OAGS Member
Gen Surgery Resident/Fellow
- **FREE** - Medical Student

Wine/Banquet Fee:

- **$50** - Member & Non-Member

NOTE: Refunds will not be issued for cancellations after the deadline.

Toll Free: 1-877-717-7765
Phone: 705-745-5621
Fax: 705-745-0478
Email: info@oags.org
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OAGS
Ontario Association of General Surgeons
Association des Chirurgiens Généraux de l'Ontario

PRESIDENT... CONTINUED FROM P.1

ning into significant turmoil.

We also know from history that such feast and famine scenarios are cyclical. I expect we will indeed climb out of our current challenges in the next few years and will see new investments and increased spending in the health care system. I am not convinced it will be accompanied by significant fee increases, but we will enhance our ability and resources to care for our patients. I am also hopeful we will improve our significant workforce challenges, where many of our excellent new graduates are struggling to find permanent positions. New resources will enhance hospitals' abilities to recruit new general surgeons.

Health system funding reform has presented both opportunities and challenges for hospitals and their physicians. In brief, these efforts are meant to better align hospital funding with the health needs of the populations they serve. It involves an element of funding relative to population base and demographics, and ideally reimburses hospitals for the care that they provide, thus rewarding efficient care and potentially making the provision of patient care profitable rather than merely a cost to hospitals.

The introduction of Quality-Based Procedures (QBP) is meant to promote high quality and cost efficient care. In principle, these are positive changes, but in practice, there have been major problems and challenges. A number of hospitals have lost substantial funding relative to their historical base (though mitigated to reduce potential negative impact), and have had to make major clinical adjustments. Some clinical services have closed or have been moved.

But most significantly, overall hospital funding has remained relatively flat and effectively decreased when adjusted for inflation and wage pressures. As such, since reimbursement to hospitals for patient care has remained within a fixed envelope, true patient-based funding has not really been implemented. Furthermore, new funding has been tied almost entirely to QBPs and other limited initiatives. Few other opportunities to realize funding for growth and true increased patient needs exist. Some hospitals have cut OR and other outpatient resources. Many others have limited necessary expansion of these services.

All of these challenges must be tackled, and debate exists regarding the best solutions. The government's initiatives to identify management plans for the 5% of patients that consume 50% of the health care spending are appropriate and necessary. Greater links of primary care providers with hospitals, including developing mutual goals and strategies, is important. Many argue that digitization and technological advances, including the need for our health care system to catch up to other industries in the use of technology, will ultimately improve care and make it more efficient. Telemedicine, with appropriate support and compensation, will grow. Bulk purchasing of supplies and government efforts to lower drug costs will help. The use of lower cost providers for some aspects of patient care will grow.

We as physicians will need to do our share, not only to propose solutions but also to ensure that the care we provide is appropriate, effective and, where possible, evidence-based. Just as we expect government and administrators to be accountable, we need to be accountable ourselves. As data gathering and data management improves, audit and feedback will become an increasing part of our professional lives.

I thank you for your help and support over the past 5 years and look forward to working with you through the challenges in the years ahead as Section Chair.

Sincerely,
Jeff Kolbasnik

- Dr. Kolbasnik, OMA Section Chair and OAGS Past President, is on staff at Halton Healthcare Services, Milton Site.

Cut Here

Ontario Association of General Surgeons
Easy Colonoscopy Billing Reference *As of Jan. 2013*

Colonoscopy Procedure Codes	Diagnostic Codes
Z491 - FU incomplete polypectomy, large sessile polyp • Or piecemeal or high grade dysplasia • Payable only within 6 months	546 - surveillance
Z492 - 5 year FU of a normal colonoscopy • Payable every 5 years after Z499	546 - surveillance
Z493 - 10 year FU of a normal colonoscopy • Payable every 10 years after Z497,Z555	546 - surveillance
Z494 - Very high risk screening - HNPCC, FAP, IBD >10 yrs • Payable within "clinical practice guidelines"(q 1-2yr)	546 - surveillance
Z495 - Repeat due to poor prep/ incomplete • No interval limit	Use Original Code
Z496 - Symptomatic • No interval limit	569 - symptoms
Z497 - FU+FOBT, +DCBE, +sigmoidoscopy, +CT • Confirmatory - no interval limit	545 - FOBT+
Z498 - Polyp Surveillance Standard Intervals 3 or 5 years • 5 yrs if 1-2 tubular adenoma • 3 yrs if 3+TA, >1cm, villous, any HGD, or Rt. SSA • <3yrs if >10 adenomas • use for colon cancer follow-up at 1, 3, 5 yr intervals	546 - surveillance
Z499 - Family History + first scope • 1st degree or 2 2nd degree relatives at 50 (or 10 yrs younger)	547 - family history
Z555 - Average Risk Screening • Payable at 10-year interval	548 - screening

CONGRATULATIONS!

We would like to take this opportunity to congratulate three very deserving General Surgeons for their service to the Ontario Section on General Surgery and the profession at large through the years. Well done to all of you!

Dr. Bryce Taylor has received the 2013 **Section Service Award** for General Surgery after a 40-year career and continuing. Dr. Taylor has provided leadership in many elements of surgical care in Toronto, including UHN Surgeon-in-Chief (99-2010) and more currently Professor and Associate Chairman in the Department of Surgery at the University of Toronto. He has been an inspiration to many other surgical leaders across Ontario (particularly hepatobiliary and pancreatic surgery and transplantation) and has been gracious of his time and advice in supporting surgical leaders. He has been a tireless advocate for patient safety and quality of care, including his participation in developing the Surgical Safety Checklist, which is in routine use at all hospitals across Ontario.

Dr. Bryce Taylor

Dr. Chester Pitter has received the 2013 **OMA Life Membership Award***. Dr. Pitter practiced general surgery for most of his career at what is now referred to as Grey Bruce Health Services in Owen Sound (30yrs). During this time, Dr. Pitter served the OMA in many capacities such as Section Chair (1997-2003), Past Section Chair, Vice Section Chair, OMA Council Delegate ('96-'03), Branch Society Delegate/Secretary/VP. He was also one of the co-founding members of the Ontario Association of General Surgeons (OAGS), of which he was Vice President (1995-2003) and served on a number of committees. In particular, Dr. Pitter along with the Section/OAGS executives initiated the concept of remuneration for on-call.

Dr. Chester Pitter

Also a recipient of the **OMA Life Membership Award** is **Dr. J. Ian Macmillan** of St. Catharines, Ontario. Dr. Macmillan practiced general surgery for most of his career of 30+ years at St. Catharines General Hospital - several years as Chief of the Dept. of Surgery. Also during this time, he served as a member of the executive of both the Section on General Surgery and the OAGS from 1999-2006 in the capacities of Vice Chair, Secretary as well on a number of committees which included the popular Billing Corner. Dr. Macmillan was also on the executive of the OMA District 4, a member of the Central Tariff Committee ('02-'08), Chair of the Technical Fees Working Group ('04-'06), Chair of a General Surgery panel for the Ontario Waiting List Project of the Joint Policy and Planning Committee, a member (and President) of the executive of the Southern Ontario Surgical Society ('87-'09) and Founder/President of the Canada Nepal Medical Society. He continues to teach undergraduate medical students at the Niagara Regional Campus of McMaster School of Medicine.

Dr. J. Ian Macmillan

If you know someone that should be nominated for a 2014 OMA award, please remember to submit your nominations to us or your local district. Submissions are accepted up until September, 2013.

Locum & Job Listings

The O.A.G.S. does not offer a job placement program. We provide space in our newsletter/website for both those who are seeking and/or institutions/communities that are offering a general surgical position in the province of Ontario. Rates can be found on our website: **www.oags.org**

All candidates should be eligible for licensure in Ontario and have obtained or be eligible to obtain RCPSC specialty qualifications. Surgical credentials can be confirmed by calling the Royal College directly: 1-800-461-9598 ext.478.

ONLINE VACANCIES & LOCUMS:

- Advanced Multi-Specialty Walk-In Clinic (Mississauga)
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- Royal Victoria Regional Health Care Centre (Barrie)
- The Reimer Clinic (Kitchener/Ottawa)

For more details on the above, please visit our website at: www.oags.org/joblisting.htm

OAGS MEMBERS:

OAGS members can post an online ad for **FREE** - whether you are posting a vacancy or seeking a position.

To Place a Job Ad: info@oags.org
Download a form: www.oags.org/joblisting.htm

Other websites with job placement programs:
www.hfojobs.ca

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COMMITTEES	COMMITTEE CHAIR & MEMBERS
Economics & Tariff (MSPC)	C. Vinden (Chair). Alts: Section Chair (J.Kolbasnik), T.Jackson, A.Lozon, A.Maciver, H.Telang, E.Touzin.
General Surgery Resources (Manpower)	C. Vinden (Chair), J. Kolbasnik, E. Touzin. (Res. Consultant: K. Kieffer)
Membership	F. Baillie, I. Chin, A. Wei (Res. Consultant: K. Kieffer)
Bylaws	D. Desai (Chair), C. Kealy, A. Maciver
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Political Activity	A. Maciver (Chair), C. Kealy, J. Kolbasnik, A. Lozon, C. Vinden
(Ad hoc) CAGS	C. Maciver (Chair), C. Vinden (Alt.), J. Kolbasnik, A. Wei
(Ad hoc) Cancer Care Ontario	C. Vinden (Chair), J. Kolbasnik, A. Lozon, A. Maciver, A. Wei
(Ad hoc) CPSO	President (C. Vinden) (Chair), Section Chair (J. Kolbasnik), S. Chande, A. Maciver
(Ad hoc) Newsletter	C. Kealy (Managing Editor), President (C. Vinden)
(Ad hoc) OMA	Section Delegates: J. Jolbasnik, C. Vinden (Alts: F. Baille, A. Lozon, A. Maciver, A. Wei)
(Ad hoc) On-Call	J. Kolbasnik, A. Lozon, H. Telang, E. Touzin, C. Vinden, P. Willard
(Ad hoc) Peer Support	Board-at-Large
(Ad hoc) Program & Education (i.e.AGM)	A. Maciver (Chair), S. Chande, I. Chin, D. Desai, C. Kealy, J. Kolbasnik, C. Vinden
(Ad hoc) Sponsorship / Exhibiting	I. Chin (Chair), S. Chande, J. Kolbasnik, C. Vinden

EDITOR'S NOTE: *This is the 34th issue of The Cutting Edge. None of our work would be possible without your support. Your board members are hard-working active general surgeons, like yourselves, who are interested in improving both our working conditions and our quality of life. Although we would like to send this newsletter to every general surgeon in the province, The Cutting Edge is mailed exclusively to paid-up members due to the cost factor. If you have not yet renewed your membership, we encourage you to do so. We get very little funding from the OMA as the Section on General Surgery, and your financial support is essential to the survival of the OAGS. Thank you. - Dr. Ciaran Kealy, Editor*

Our recent Annual Meeting of 2012 was funded by the following sponsors. Their support is greatly appreciated. Thank you.

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