MESSAGE FROM THE PRESIDENT

The year has is fast coming to an end and the leadership of the American Association for Hand Surgery are poised for another great meeting January 13-16 in Scottsdale, Arizona. First and foremost, I must congratulate and give many thanks to Chris Pederson and Michael Sauerbier and Lisa Cyr, our annual meeting Program Chairs, for what promises to be an outstanding meeting. The program is filled with the collaborative efforts of our members and members of the German Society for Hand Surgery. Our German colleagues’ participation brings a strong European influence and flare to the panels, courses and free paper sessions. I thank the German Society for all of their help and dedication in this collaborative meeting. Next year, the AAHS will join up and reciprocate with the German Society for Hand Surgery in Frankfurt at their annual meeting, where Michael Sauerbier will preside as President. AAHS annual meeting attendance continues to grow as

(continued on page 3)
FROM THE EDITOR

Thomas Hughes, MD
Editor

The Annual meeting of the ASSH has just completed and it was a successful event in many ways. There were opportunities for hands-on learning, scientific investigation, and collegiality. Like our own Association’s meeting, it is a time to refresh and recharge our interests in hand surgery. Our two organizations both help to advance the field of hand surgery and represent the majority of those practitioners involved in care of the hand.

The two groups are complimentary. They provide us with two venues to present research and share ideas. The ASSH, being the larger organization, provides certain advocacy and organizational benefits that the AAHS has only slightly become involved with. However, there is more and more cooperation between the two groups, with inclusion and coordination of educational opportunities and member services.

Our own annual meeting is shaping up nicely, and registration is open. Make plans to join us in Scottsdale for a collection of exciting educational opportunities as well as opportunities to socialize with fellow members. There is a pre-course on wide-awake surgery, hands-on courses for therapists and surgeons, and multiple paper sessions and ICL’s to round out the week. Hope to see you in Arizona!

Assistant Editor
John Fowler, MD

HAND, the official Journal of AAHS

HAND is the official peer-reviewed Journal of AAHS, featuring articles written by clinicians worldwide presenting current research and clinical work in the fields of hand surgery and hand therapy. AAHS Members have complimentary electronic access to HAND via the Members’ Only webpage.

Hand Surgery Quarterly

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Hand Surgery Quarterly is a publication of the American Association for Hand Surgery and is published strictly for the members of AAHS. This publication is designed as a forum for open discussion and debate among the AAHS membership. Opinions discussed are those of the authors or speakers and are not necessarily the position, posture or stance of the Association.

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Today the AAHS has over 1,300 surgeon and therapist members from the US, Canada and internationally. In addition, we have grown our journal affiliations to include the Brazilian Society and Argentine Society.

register early.

The Journal HAND is also growing. We are seeing more and more submissions, greater quality of papers, and a heightened awareness around the world. We made a wonderful change to a new publisher starting January 1, 2016. Our new publisher, SAGE, is very enthusiastic and brings new energy to the journals publications. Look forward to new changes this year.

At the ASSH meeting last month, Dr. Bill Seitz, President of ASSH, graciously offered podium time at the opening ceremonies for me to highlight the AAHS. Later, the leadership line from both organizations met to discuss collaborative efforts on issues we have in common such as advocacy: hand surgeons working together to improve safety and quality for our patients. It’s a great relationship we have with the ASSH. It will only grow.

Join me this year in Scottsdale for a celebration about hand surgery. A celebration of education, science, and friendship.
HAND THERAPISTS CORNER: GHANA

Gayle K. Severance, MS, OTR/L, CHT
Good Shepard Penn Partners, Philadelphia

“Akwaaba!” “You are most welcome.” This is the common Ghanaian greeting and in this deeply faithful country no conversation starts or ends without hospitable blessings and well wishes. It is a true reflection of the kind Ghanaian people I encountered during my 3-week visit there last fall for my Vargas Award trip.

Komfo Anoke Teaching Hospital (KATH) in Kumasi is a 1000 bed hospital in the 2nd largest city in Ghana. There are 26 million people in Ghana, but recent estimates suggest a deficient number of some 20 Orthopaedic surgeons in the country. Rehabilitation programs are relatively new to Ghana Universities; they graduated the first Physical Therapy (PT) class of 13 in 2005 and recently opened an OT program.

Despite these massively unbalanced numbers, KATH is fortunate to have a staff of 20 PT/PTA’s treating on the hospital wards and in their outpatient therapy building (approx. 2000 sq. ft). Still, the therapists are overwhelmed in both numbers and needs of their patients. Access to educational material and the Internet are limited and unreliable, but they are eager to learn and enthusiastic to improving their skills. To a Ghanaian, doing well for others is to do well for oneself.

My travel partners, mentors, friends on this journey were Heather Wood an OT / CHT from Florida and Peter Trafton a Trauma Surgeon from Rhode Island, who, in his role as an HVO Orthopaedic Program Director, has made multiple trips to KATH. Heather and I were fortunate to be the first hand therapist to travel to KATH and our objectives were slightly different than the typical Vargas Trip or HVO experience. We were charged with 2 objectives. First, assessing the Ghanaian hospital for its potential opportunities and obstacles as a HVO hand therapy project site. Second, fulfilling the purpose of the Vargas Award — outreach and exchange of educational ideas.

Initially, I was worried about traveling without an AAHS surgeon. However, we were able to turn this to our advantage. We worked closely with the Ghanaian therapists seeing patients from Ghanaian surgeons and this gave us a genuine perspective of how things are managed at KATH. Surgeons and therapists could not have been more attentive and responsive to our roles and all were eager to collaborate.

Michael Kissiedu, our delightful PT liaison, guided us

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through our eventful days. Time was spent in Trauma rounds and the “Consulting Rooms” with either one of the 2 hand surgeons, Dr. Saani from Ortho and Dr. Owanso Danso from Plastics. We rounded the Wards and work in the PT building with the KATH therapists consulting on hand therapy cases - tendon lacerations from machete’s, fractures and amputations from “Roadside accidents”, burns, nerve injuries including several fracture related radial nerve palsies, and yes, as it so happens, trigger finger and CTS!

Our greatest challenge on this trip was respectfully navigating our way through the Ghanaian culture, trying to understand the MD – therapist relationship, the rehab evaluation and treatment procedures, their baseline knowledge/skill level, and their needs and goals for developing an HVO / AAHS Hand Therapy training program.

Ultimately, we recommended KATH as excellent site for HVO. There are benefits of treatment space, a committed group of young therapists, receptive Orthopaedic and Plastic Surgeons, a population in need, housing, transportation, and it is in a safe, stable, English-speaking nation. We are proud to have helped HVO and KATH develop a contract for a Hand Therapy Program and the next Vargas Awardee will be going this fall. For Heather and myself, we will continue our relationship with KATH as HVO site co-coordinators.

“In the moment of need, the wise build bridges”. – African Proverb, Accra Airport.

Thank you AAHS, Dr. Don LaLonde, HVO and KATH for paving the way so that I, and others can contribute to building this bridge.
During the last month of my fellowship, I had the privilege of participating in the Touching Hands mission trip in Trinidad led by Dr. Scott Kozin. It was the culmination of all my years of training, and gave me the opportunity to use everything I had learned to give back to a small country that desperately needed the services of a pediatric hand surgeon. It was also an opportunity for me to meet and work with like-minded people who shared my passion for global outreach.

After brief introductions before boarding our plane, we arrived late at night in Trinidad and were welcomed by our gracious hosts, who drove us to the cottage where we would be staying for the week. Despite not getting much sleep, we all woke up early the next morning, excited to see our new surroundings in the daylight and meet the kids on whom we would be operating on our first day. My first impressions were that this was a beautiful country with a lush, green landscape and impressive hills, and its beauty was only surpassed by the people, who were incredibly warm, genuine, fun-loving, and witty.

We worked at the Princess Elizabeth Centre for Handicapped Children, which functioned as a hospital with a clinic, a single operating room, and a dormitory for kids who stayed there around the year for specialized care. During our time there, many of the kids were away for the summer, so we came to know most of the kids who were still there quite well. We all quickly grew fond of our small, but cozy hospital, and spent most of our time there. It felt less like a hospital and more like retreat where we could spend time casually chatting and playing with the kids, and walk over to the clinic or the operating room whenever we needed to see patients or operate.

We operated on three days, had one full day of clinic, and one day of clinic with multidisciplinary, case-based teaching led by Dr. Kozin and attended by local physicians, nurses, and therapists. One of the most valuable aspects of the trip for me was being exposed to an unprecedented volume and variety of pediatric upper extremity pathology in just one week because our host orthopaedic surgeon had arranged for all of his complex pediatric hand surgery patients from the past several years to be seen by us in clinic or operated on by us during our week there. Therefore, it reinforced and supplemented my exposure to pediatric hand surgery in fellowship.

Some of our interesting cases included excision and reconstruction for complex thumb polydactyly with triphalangism, chondrodesis for severe clasped thumb, debulking of a distal ulnar osteochondroma and distraction lengthening of the ulna to reduce a chronically dislocated radial head, excision of extensive tumoral calcinosis in the forearm, wrist, palm, and fingers, creation of a one-bone forearm in a teenager with pan-plexus palsy......

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Michael Francis Callaghan October 4, 1932- May 26, 2015

Michael Francis Callaghan was born on October 4, 1932 in Omaha, Nebraska to Dr. Ambrose James (AJ) Callaghan and his wife Margaret Fitzgerald Callaghan. He was the youngest of 4 children.

Michael graduated in 1950 at age 16 from North Platte High School and then went on to Creighton University in Omaha, Nebraska. Upon graduation from Creighton Medical School and went on to complete his orthopedic training at the Mayo Clinic in Rochester Minnesota in 1963 and then completed a preceptorship at USC with Dr. Joseph Boyes in hand and microvascular surgery before starting his own private practice in Tustin, California. In 1962 Mike met Monique Jeanine Bouchard who had just moved to the U.S. from France and they were married in August 1962 and together they had five children: Colleen, Maureen, Michael, Sheila and Bridget. Mike loved his children very much and enjoyed sharing the value of education and travel with each one over his 82 years of life.

Mike always took pride in his work and stayed up to date on all the latest developments and attended the annual ASSH meetings and was one of the earliest members of ASSH. In 1972, he volunteered with the World Health Organization and delivered orthopedic care to the under served population in Indonesia for 6 weeks. After retiring, he completed a medical mission with his Creighton alma mater in the Dominican Republic. Michael is survived by his son Michael Francis Callaghan of Laguna Niguel, California and his daughters Colleen Yvonne Callaghan of Lake Forest, California, Maureen Callaghan Kinney of Lake forest California, Sheila Callaghan Elliott of Palos Verdes, California and Bridget Callaghan Zaro of Bainbridge Island, Washington and his nine grandchildren Michael Francis Callaghan, Jordan Riley Callaghan, Sean Michael Kinney, Aidan Robert Kinney, Shannon Rose Kinney, Beau Callaghan Elliott, Brooke Bouchard Elliott, Aubine Zaro, and Camille Bouchard Zaro.

Mission Trip (continued from previous page)

I learned new techniques I had not seen in residency or fellowship, and formed close bonds that will last a lifetime. As I reflect on our trip today, it was undoubtedly the single best experience of my medical career. I formed so many great memories and close bonds that I will carry with me forever, and the entire experience reaffirmed my strong commitment to global outreach in the future. I am forever grateful to the AAHS and the Hand Surgery Endowment for supporting me with a scholarship to make this trip possible, and I hope more fellows will take advantage of this tremendous opportunity in the future.
This edition of the Coding Corner will focus on coding guidelines for physicians who work at teaching hospitals and supervise medical students, interns, and residents in the delivery of medical care. As we all know, physician practices are poorly leveraged entities: Physicians are compensated well for services rendered, but little to no compensation is generated during vacations or meetings. While private practices can benefit from the use of physicians extenders, such as physician assistants or nurse practitioners, those of us positioned at teaching facilities benefit from working alongside interns, residents, and fellows. The Centers for Medicare & Medicaid Services (CMS) has developed specific rules for payment of physician services in this setting. While most third-party payers will follow these guidelines, some third-party insurers may have their own guidelines and may not pay when a resident has seen a patient and provided medical care.

Firstly, it is important to understand the definitions of the medical staff as they pertain to coding and billing. A teaching physician is a physician who involves residents in the care of his patients as part of an accredited residency program. Through medical schools, teaching hospitals, and health systems, the Association of American Medical Colleges (AAMC) represents approximately 128,000 teaching physicians and 110,000 resident physicians. A teaching hospital is defined as any institution that has an approved Graduate Medical Education (GME) program for residents. An intern or resident is a physician who participates in an approved GME program or a physician who is authorized to practice only in a hospital setting, possibly with a temporary license or as an unlicensed graduate of a foreign medical school. A student is an individual who participates in an accredited medical school that is not an approved GME program and who is not considered an intern or resident. Medicare does not pay for any services rendered solely by medical students.

Medicare reimburses for services furnished in teaching settings through the Medicare Physician Fee Schedule if the services are (1) personally rendered by a physician who is not a resident, (2) rendered by a physician who is not a resident, (2) rendered by an intern or resident when a teaching physician is physically present during the critical or key portions of the service, or (3) rendered by an intern or resident under a primary care exception within an approved GME program. The primary care exception allows residents to work independently of a teaching physician but would obviously not apply to hand surgery practices. Teaching physicians in family practice, internal medicine, geriatric medicine, pediatric medicine, and obstetric practices only can bill for low-level Evaluation & Management (E/M) visits under specific guidelines.

Unfortunately, CMS does not clearly define what it considers to be “critical” or “key portions” of the services provided. This is left to the judgment of the teaching physician and is highly subjective. For surgery, the teaching physician must be immediately available during the non-critical or non-key portions of the procedure and cannot be performing a procedure on another patient. For hand surgeons that operate from two surgical suites, this may preclude the start of one surgery when another surgery is being completed under strict Medicare guidelines.

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CODING CORNER: Supervising Physicians (continued from previous page)

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Documentation of a service or procedure provided by the resident only is not sufficient to establish that the teaching physician was present and to bill for services rendered. If the resident provides the documentation, the teaching physician is required to personally state that he performed the procedure or was physically present during the critical or key portions of the service. A countersignature by the teaching physician is insufficient for both documentation and billing purposes. At a minimum, the teaching physician must state that he was “present with the resident during the history and physical examination” and that he “discussed the case with the resident and agreed with the findings and plans as documented in the note.” This holds true for operative reports and inpatient procedures, such as bedside incision and drainage procedures for abscesses or closed reductions of fractures.

When coding or billing for teaching physicians, CMS requires the use of modifier –GC, which describes services that have been performed in part by a resident under the direction of a teaching physician. Using this modifier essentially certifies that the teaching physician was present during the critical portions of the service and was immediately available during the other parts of the service. Modifier –GE is used to describe services provided by a resident without teaching physician supervision under the primary care exception. The use of these modifiers do not increase or decrease the payment to the teaching physician.
Panel Discussion: Resident/Fellow Education in the 21st Century

Asif: Thank you for participating in this panel discussion. You’ve been selected because of your experience and involvement in resident and fellow education. We are going to start first by focusing on some generic issues relative to the changes in residency education. Then we’re going to shift into hand surgery training specifics and look at some of the nuances for hand surgery fellow education. I’m also open to ideas or topics of discussion that any of you think are particularly salient to the audience and to our panel.

Asif: How have residencies adapted to the 80 hour resident work restrictions?

Kevin: There are a couple of perspectives that one could look at in that regard. One is the business side of clinical operations, and I think departments, meaning residency training programs, have hired many more advanced practice clinicians to provide support services that residents couldn’t perform previously. When I say support services it doesn’t mean that it’s not educational, but residents historically have seen patients in clinics and could help with the flow of the clinics, and it’s important for them to be there. I think the vast majority of departments, at least I suspect, have hired increasing numbers of APCs. From the resident education perspective, I think it’s forced departments to focus to a greater degree on what is truly valuable in resident education, because they are not there as much as before and activities that are not of value to them relative to their ultimate education I think have had to be eliminated.

Dawn: From a cost perspective, many departments have hired midlevel providers to help decrease and optimize resident duty hours and the burden of call. The residents, however, have to take some call because it offers important high yield learning opportunities. I think a number of programs struggle about pros and cons of having a night float system, which in a smaller program may be the only way to make call coverage work for the residents. The concern is that night float residents are missing out on clinic time and elective surgeries versus those in a regular night call system. The resident goes home the following day so they miss out on one day for every call day that they are there. I think it’s a bit of a juggling system to make call coverage work. Another thing to make the
resident education time highest yield, is a focus or emphasis on motor skills teaching with simulators, and giving the residents an opportunity for practice outside of the operating room and outside of the clinical hours so that they’re still getting a hands-on experience, even though the actual time in the OR may be a little more limited.

**Peter:** Can I just raise another question? I’d like to ask the panel what they think the impact of the 80 hour work week has been on patient and resident safety. More fundamentally, is the resident losing out on educational opportunities, both in the clinic and in the operating room

**Rafael:** There’s a lot of data that has shown that it hasn’t made either patients or residents safer. I think in general what has happened is a lot of residents pass on the baton and don’t have ownership of the individual patient anymore. In addition, the extra time hasn’t led to extra sleep, which leads to resident safety; it leads to more time to do other extracurricular activities which isn’t necessarily what the point was.

**Glenn:** One other point, I think it seems like the residency programs have reached into the internship year to provide additional support to the coverage. With the night floats, the internship year is added as additional time and resident manpower or womanpower to the programs.

**Asif:** Let’s discuss more about the intern year specifically. When I was a Residency Director a few years ago the rules governing intern call changed mandating that they could no longer take call by themselves. Any comments on the restrictions, on the intern specifically, and then how that subsequently affects resident training in general?

**Dawn:** Intern duty hour regulations are different than every other year in training. They can’t work more than 16 hours in a row so they certainly can’t take a call from 6 or 7 A.M. until the next morning. That’s a real limitation that comes from the ACGME rules. I don’t know if there’s a firm rule that they can’t take call, although we don’t have our interns take call on their own. Are other people doing that?

**Rafael:** I think the ACGME requires a senior resident in house, but the exact wording on whether or not senior resident, or whatever that constitutes, depends on the residency, because ultimately a senior resident in medicine versus a senior resident in surgery may be a fourth year.

**Asif:** Let’s dovetail this conversation to the utilization of surgical simulation in residencies and fellowships. What are the panel members thoughts on surgical simulation for residents and fellows?

**Peter:** Very little experience. I will share a couple thoughts. It’s my understanding that the orthopedic world is somewhat behind other disciplines in the development of simulators. I believe that general surgery, OB/GYN, anesthesia, and urology are much further ahead, and I think that we need further develop simulation tools. When I served on the ABOS we spent a lot of time discussing simulation, talked with a number of companies that had simulators, specifically for arthroscopy, and there were discussions of using it as a tool for the Part 2 ABOS examination, but that has not come to fruition.

I think we are doing a much better job in terms of surgical skills. In the orthopaedic internship year, every resident has to spend a month learning basic surgical skills. So that’s been a plus. In addition to that I think most residency programs have laboratories, microscopic, arthroscopic etc. Thus, although simulators specifically have not risen to the top, other methods of procedural education outside of the operating room are much improved.
Glenn: I know that Mark Baratz has worked hard in developing a cadaver lab to simulate tendon transfers and CMC arthroplasties and other procedures that I know the fellows have felt were extremely beneficial. The hope is that we would build on that and develop, as you said Peter, arthroscopy simulators and other simulators useful in the fellowship education.

Kevin: I think a fundamental principle that we should all adhere to is the fact that if something can be learned outside of the operating room or prior to the resident actually interacting with the patient, it is certainly preferable to do that. None of us would get on an airplane if the pilot had not spent significant hours in a simulator. No matter how experienced the other pilot might be, I want the other guy to have had significant hours of practice before he’s landing that plane. I feel the same way about residents and procedures. I agree completely with Peter that we have been behind the curve in doing that, but I think we are making progress in catching up. The only other thing I would add is that simulation is not just for surgical procedures. So it can simulate situations, much like cardiac arrest or codes are simulated. We can and I think we should be thinking about how to simulate handoffs. That’s particularly relevant to what we were speaking about with resident duty hours. I think we should have residents show us that they know how to put fracture cables together. Those are all very reasonable things that residents should be demonstrating proficiency in before they actually have to do it in the operating room.

Asif: From a plastic surgery perspective, what is the panel noticing among the plastics residents in terms of the use of digital media?

Rafael: I think there’s a lot in the digital media world in plastic surgery, but I think somewhat short of what Dr. Laporte was looking for. In addition to trying to have a high-quality reading list with the access to these resources for the residents, we also tried to break out separate readings for the intern year. We don’t have something that provides immediate feedback on evaluations. A number of programs are trialing iPhone apps for immediate feedback after cases, and I think that that is a trend for the future, too. The residents are getting the motor skills and clinic feedback right away instead of every three months at the end of a rotation.

Dawn: We’re actually trying to keep up with the residents and it is really difficult. Our feedback from the residents is that they want it now, or you know, five minutes ago. They want it at their fingertips. They want to access it between cases and walking in the hallway. We’ve tried to make sure that all of the book resources that we think are important are available electronically to the residents, because that seems to be the way most of them are going to access it. Many more residents seem to be watching surgical videos; I guess one point of concern is that there are a lot of videos out there that are not quality controlled. I’m not sure what the best resource for that is. There are some really good videos on YouTube and VuMedi, but there may be a better way to direct them to those. We tried to have our faculty put up videos that we think are high-quality by sub-specialty on our password protected resident education website.

For questions, our residents are using Orthobullets, which isn’t necessarily bad. I think having a more standardized approach for that and for board review could be good too. I think a lot of web access to education is important because that’s what they’re

We’re actually trying to keep up with the residents and it is really difficult. Our feedback from the residents is that they want it now, or you know, five minutes ago.

- Dawn LaPorte
saying, it’s not necessarily from the best resources. Essentially, anyone with a camera and a YouTube account can post something. They’ve been trying to create an electronic video archive through the American Society of Plastic Surgeons so there’s better quality control guides for surgical procedures. But there’s still a lot of stuff out there that doesn’t necessarily meet our best quality.

**Glenn:** One other simple use of some new technology of course is FaceTime. In the case of our fellows who aren’t able to attend a lecture, in a different location or city, they’ve used FaceTime to dial-in to the lecture so they can be part of the lecture even though they’re not physically present. That’s been a simpler way of having all the fellows experience a lecture on Dupuytren’s contracture or other topics.

**Asif:** I want to change the topic to surgical milestones. This is something relatively new that both residencies and fellowships have to manage. This has been put together recently and, from an orthopedic point of view, there’s just two or three surgical milestones for the residents specific to hand surgery. What are your thoughts on surgical milestones in general?

**Peter:** I was involved from the get-go on the development of the milestones for both orthopedics as well as for the three hand surgery disciplines: general surgery, orthopedics and plastics. The milestones are well intended......

- Peter Stern

**Kevin:** I think Peter sums up my sentiments about it really quite well. I do think that conceptually it makes good sense to have milestones that you would expect a graduating resident to demonstrate a certain level of competency. I think the milestones are limited in that it focuses on specific areas, but if we were to develop more milestones I think it would really push residency educators a little bit over the edge, because of the amount of work that is required. Peter alluded to the fact that many people are just filling out the dots, and I think this really takes a tremendous amount of time. Conceptually, it makes perfect sense to me. I don’t know that I would throw out the idea of doing this, maybe it needs to be refined somehow.

**Glenn:** I asked one of our fellows to comment, and his feeling was that it does level the playing field to make sure that all the fellows develop some core skills. The difficulty he saw was you may do only one of a specific procedure so it’s hard to get an attending to sign off on the fellow’s ability to do the procedure with minimal supervision. So I think that there are certainly pros and cons, even at the fellowship level. On a personal level, I’ve used the CMC arthroplasty as my technique and surgical skill evaluation of the fellows. The procedure involves a number of steps, and I do a number of them over the timeframe I’m with a particular fellow. So by the end of
the rotation, they independently do the procedure and I can judge their surgical skill in doing that particular operation.

**Peter:** When the milestones for residency programs were being developed, it wasn’t clear whether a resident only needed to know distal radius fracture, carpal tunnel release, pediatric supracondylar fracture, and fixation of a distal humerus fracture. The idea was that a milestone would be a biopsy of both technical/care competencies, as well as patient care. The committee felt that these diagnoses were a representative ‘biopsy’ of wrist and elbow disorders. I believe that the hand fellowship milestones are a better biopsy of all aspects of hand surgery. They cover most domains. We had our fellows self-evaluate with milestones and we found that was that we were weak in congenital so I’ve modified our fellowship program so that our fellows have more exposure to hand at our Children’s Hospital.

**Asif:** Let me talk a little bit more about hand surgery fellowships specifically. One of the issues that various fellowships are having is the changing demand for and opportunity to train in microvascular and soft tissue coverage cases. What is your thought in terms of fellow training both in the importance of these cases in terms of fellow expectation and needs.

**Rafael:** I agree that our safety has reduced our injuries. And there are things like negative pressure wound therapy and Integra that make certain defects that before needed transfer that you can get away with a less invasive procedure. I do mostly hand. I do have a kind of general practice. I do welcome the fellows to do lower extremities re-flaps. It may not be part of their fellowship but freezing of free flap is really based on technique. Where you’re putting it, whether it be on the top of the head or on the ankle or on the hand, the techniques are the same and so I think there are still options out there to try and maximize those skill sets as long as you’re willing to have those parts your practice available to the fellows.

**Glenn:** I think it’s totally changed through the years. I can remember back 30 years ago when I started that we were doing many more replants and had many more traumatic injuries. I think the microvascular experiences are supplemented in the laboratory. I know we’ve tried to run a laboratory experience for each of the fellows to work on microvascular techniques. But it depends on each of the individual hand surgeons practices. In our case the hand trauma surgeons are probably providing most of that experience with microvascular work with traumatic hand injuries replantation and revascularization.

**Peter:** The micro experience is very fellowship dependent. I think the two areas in general that hand fellowships can be deficient are in micro and pediatrics-congenital. We send our fellows within their first three weeks to a micro lab at Indiana University to acquire micro skills. I believe our program’s micro experience is OK; not exceptional. Generally, I believe a fellowship should be based out of a level one trauma center. In terms of pediatrics we’re very fortunate. We’ve got two full time pediatric hand surgeons to which the fellows traditionally have not had enough exposure but that’s increasing.

**Asif:** The last topic will be shoulder and elbow experience during a hand surgery fellowship. What are the panel’s thoughts on incorporating shoulder and elbow surgery within the hand surgeon fellowships?

**Dawn:** I think that it’s great for hand and upper extremity fellows to be exposed to shoulder, but as I work with fellows in a combined orthopaedic and plastics fellowship, I see that the orthopedic fellows love doing...
the shoulder and elbow cases and the plastic surgery trained fellows typically are not interested in the shoulder arthroscopy cases. I think it’s a difficult question. In a mixed fellowship which is a nice educational setting, many fellows are interested in the concept of being able to treat the whole upper extremity. I think some fellows are looking for that. The flip side is that it’s difficult to adequately cover the classic hand and upper extremity areas like Dr. Stern was just saying including micro and congenital. To add in shoulder and elbow is not something that you can touch on in a cursory fashion. I know that the hand society has actually piloted programs to expand on those but my understanding is that it has not been very popular to add a second year. So I think it’s a good thing but I think it’s definitely controversial.

**Asif:** How about from a plastic surgery fellowship, how does the panel see shoulder and elbow requirements or electives effecting prospective plastic surgery applicants? I would be inclined to think that this is not something that a plastic surgeon is looking for, but perhaps not?

**Rafael:** If you look around at different fellowships, every fellowship has a little bit of a different flavor and I think that if you’re really hard against being involved with a fellowship that has elbow and shoulder, you should find a fellowship that won’t have much at all. I think that as a plastic surgeon who did a fellowship with shoulder and elbow, I actually wanted that. So when I was looking at fellowships I knew that I was very comfortable at micro. I’ve done 70-80 free flaps as a resident and I wasn’t worried about trying to get micro surgical experience as much as I wanted to feel comfortable with the upper extremity and ultimately even if I wasn’t going to have a shoulder and elbow practice. Often times people come in with one complaint and have another additional one that maybe something you don’t want to manage long term but you know whether or not something that you’ve used to put injection on and do a good physical exam and realize they’re fine. And it’s just impingement or concern for rotator cuff injury and you can plug them into somebody who does shoulder and elbow. So it depends on what you want out of it.

**Glenn:** I know we have a number of plastic surgery fellows that enjoy the shoulder work and some that do not. As a full upper extremity fellowship program, we want to be careful not to over emphasize the shoulder and elbow and take away the hand and wrist work. We want to ensure that the basic principles of hand surgery are covered during the training year. I’d say, just as an overall percentage, that the program offers about 20% of its work in the shoulder and elbow area.

**Asif:** I’m going to finish up with Dr. Stern, you’ve been involved in fellow education for a long time and have much more perspective on this. Have you noticed a trend towards increasing shoulder and elbow experience in hand surgery fellowships and do you think that this is a healthy trend and / or a natural trend?

**Peter:** I agree with what you’ve said that there is an increased interest in the entire upper extremity but one has to consider requirement for receiving subspecialty certificate in hand surgery. For ABOS and the ABPS, none of that includes shoulder and the only elbow is soft-tissue. So really from a certification standpoint, shoulder doesn’t count. From a practical standpoint, particularly for an orthopedic surgeon, I think it can be very helpful and Dawn alluded to it. Bob Szabo...
when he was the ASSH president, wanted to see a two year fellowship that embraced the entire upper extremity. From a practical standpoint that’s not happened, I don’t see it happening and I don’t think the Boards have an interest in going in that direction. There are too many political controversies and problems.

Asif: Are there any topics that you think that are particularly salient to this discussion that you think we should touch upon briefly that we can share with the membership of the AAHS?

Kevin: I suspect I’m the only non-hand surgeon in the group. But I think that the fact that we’re just having this discussion is a great thing and if you turn the clock back 15-20 years, I don’t think discussions of this level would have occurred. And the fact that we’ve tried some things such as the milestones and they haven’t worked out like we had hoped - that’s ok. Not everything is going to work out the first time and I give the people who worked on the milestones tremendous credit for all the thought that went into it. I would also add, in regards to your last question, the conflict about shoulder surgery and hand surgery is a really complicated one and it brings in two really interesting areas. One is, how individuals practice and their degree of specialization. And questions about those are: Does our training align with what we are really doing and the fact that we still live in a time based residency or fellowship. I could have been in a hand fellowship for 10 years and I never could have done microvascular surgery. I just don’t have those kind of skills. I think these are just great discussions to have and I know we’ll have them for a long time. I congratulate you and AAHS for doing this.

Asif: This has been an excellent panel discussion with some fantastic discussion on various evolving issues on both general training requirements as well as the demands specific to hand surgery fellowships. Thank you for your time participating on this panel as well as your ongoing commitment to resident and fellow training.

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Thanks to the generosity of AAHS members, the Hand Surgery Endowment is now less than 10% away from its fundraising goal of $1,000,000.

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