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The Spine Africa Project

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Photo courtesy of The Spine Africa Project

In December 2008, Dr. Richard A. Kaul left his thriving spine practice in New Jersey to travel to Lumambashi in the Democratic Republic of Congo, an area torn by civil war and domestic unrest. Many would ask why a doctor would leave the comforts of a metropolitan lifestyle and travel 12,000 miles to a dangerous and impoverished country. In this case, Dr. Kaul was spurred by a presentation by Dr. Roger Luhiriri, a native of South Kivu in the Democratic Republic of Congo and a Resident OB/GYN at Panzi Hospital in the Bukavu Province, regarding the rampant sexual violence that had been plaguing the country.

Dr. Kaul was overwhelmed with the medical conditions in Lumambashi, which is the second largest city in the Province of Katanga. Patients had traveled from throughout the region for treatment at facilities that were, by American standards, almost archaic. Dr. Kaul found facilities that used outdated and crude instruments, as well as extremely poor hygiene and sanitary practices. A minimally invasive spine expert by trade, Dr. Kaul also came to the stark realization that spinal deformities and injuries had become a pandemic in the Congo and there were no modalities or medical measures to correct these conditions. In many instances, injuries were exacerbated by the lack of a proper injury response protocol, and thus many injuries that would be considered treatable ended up being catastrophic.

Patients had traveled from throughout the region for treatment at facilities that were, by American standards, almost archaic.

Dr. Kaul returned to Africa in 2010, this

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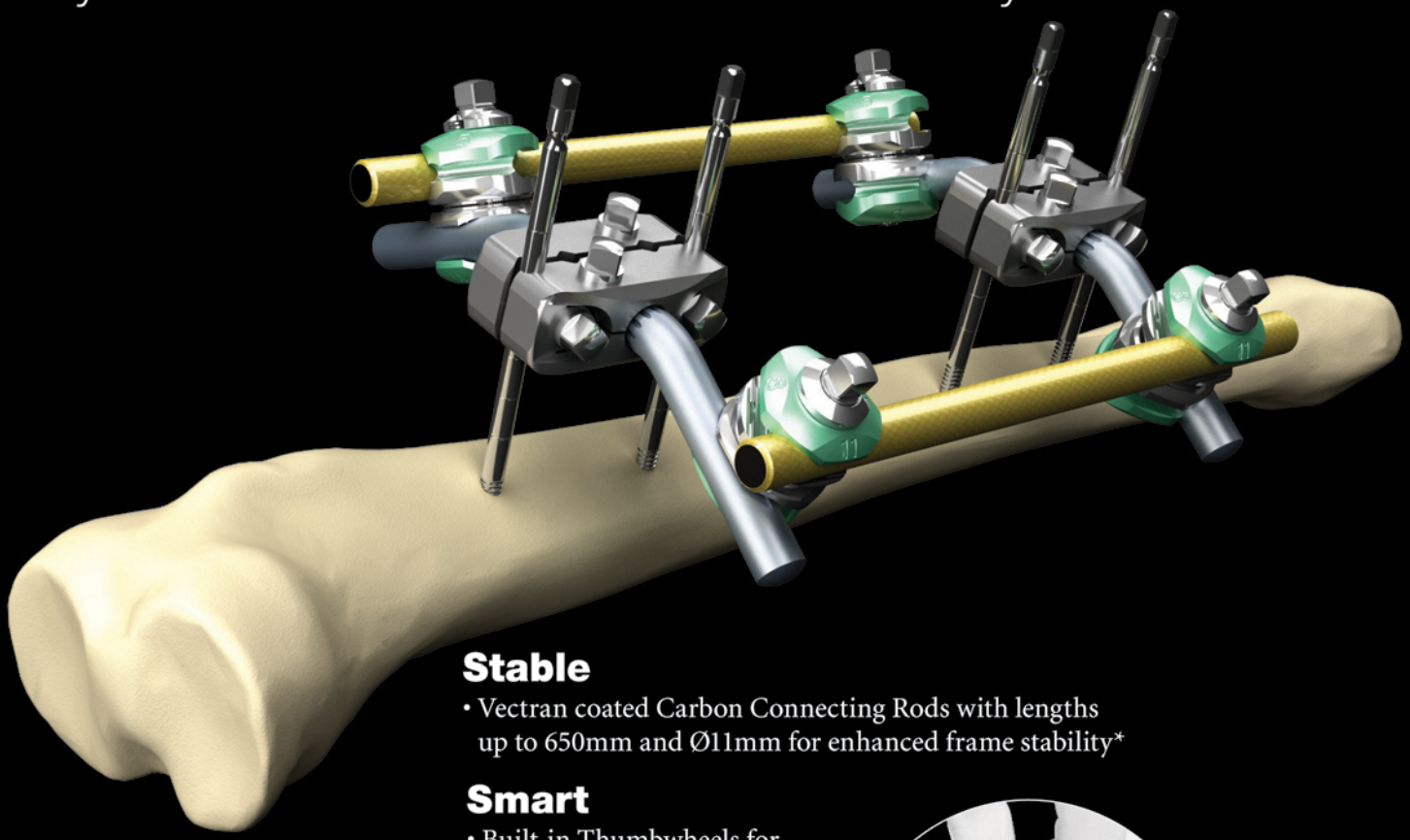

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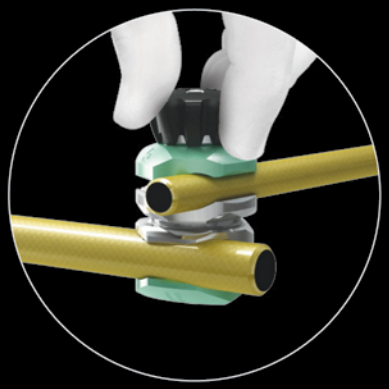

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*White Paper (NL11-NA-TR-2465): Comparison between the Hoffmann II MRI and the Hoffmann 3 Systems: The mechanical behavior of the connecting rods and a monoplanar bilateral frame. E. Wobmann, MSc; M. A. Behrens, MSc; S. Brianza, PhD; T. Matsushita, MD, DMSc; D. Seligson, MD. Based upon Biomechanical Test Reports from Stryker Trauma AG, Selzach; BML 11-072 and BML 11-059.

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Don't Let Your Board Certification Lapse!

Many surgeons are already familiar with the acronym MOC. However, if you are not, MOC stands for Maintenance of Certification. All orthopaedic physicians who are diplomats of the American Board of Orthopaedic Surgery (ABOS) must abide by the MOC process in order to maintain their primary certificate in orthopaedic surgery.

Beginning in August 2012, the ABOS and the American Board of Medical Specialties (ABMS) will publish the names of diplomates who have registered to participate in MOC on their websites. This information will be available to the public, hospital administrators, and state officials. If your licensure or credentialing requires MOC participation, your name should appear on that list. If it doesn't, visit the ABOS website at www.abos.org to register.

MOC Steps

1. **NOW!** – Register for MOC at **https://abos.org/**
2. **Years 1-3** – Complete 120 total Category 1 CME Credits, 20 of which must be SAE credits
3. **Years 4-6** – Complete 120 total Category 1 CME Credits, 20 of which must be SAE credits
4. **Year 6** – Enter all CME/SAE credits into CME Summary Sheet at **www.abos.org**

Option 1: MOC Computer Exam

5. **Year 6** – By the end of the year, enter case list data for 3 months of surgical cases (limit 75 cases)
6. **Years 7-9** – Apply to take MOC Computer Exam
7. **Years 8-10** – Take the MOC Computer Exam

Option 2: MOC Oral Exam

5. **Year 7** – Apply to take MOC Oral Exam
6. **Years 8-9** – Submit a 6-month case list of surgical cases
7. **Years 9-10** – By May, candidates will receive 12 cases selected by the ABOS based on the submitted 6-month case list. Candidates will need to bring 10 of the cases and related materials for presentation in July.

If your certification expires in 2019 or 2020, you should be in the process of earning the requisite CME for the first three years of your current MOC cycle.

If your certification expires in 2017 or 2018, you should be in the process of earning the requisite CME for the second three years of your current MOC cycle.

If your certification expires in 2016 or sooner, the ABOS has customized a schedule for you to follow to earn the requisite CME within an abbreviated cycle of re-certification. Contact the ABOS at 919-929-7103 or view your MOC timeline at the ABOS website (www.abos.org) to learn about your specific requirements.

Not sure how to begin fulfilling your MOC requirements? Join a regional association! The Western Orthopaedic Association (WOA), the Eastern Orthopaedic Association (EOA), and the Southern Orthopaedic Association (SOA) can help you navigate through all of the necessary educational requirements to satisfy your MOC obligation and prevent your certification from lapsing.

Through membership and participation in one of these regional associations, the first six years of the MOC requirements may be satisfied. In years 1-3 and again in years 4-6, you need to obtain a total of 120 Category 1 Continuing Medical Education credits, 20 of which are Self-Assessment Exam (SAE) credits in each 3 year period. The Associations provide over 50 CMEs **per year** to their memberships through their Annual Meetings and FREE CME journal *(Journal of Surgical Orthopaedic Advances)*.

A secondary component of the CMEs is the SAEs. The Associations can assist with this piece as well. Each year, a 10-credit SAE program will be offered at their Annual Meetings. Membership and active involvement in one of these associations, WOA, EOA, or SOA, is designed to help make the MOC process a less burdensome responsibility.

For more information about joining the association in your region, visit the association website:

WOA – www.woaassn.org
EOA – www.eoaassn.org
SOA – www.soaassn.org

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Did You Know?

Between January and April 2012, a total of 16,199 cases and 1,398 deaths from meningitis were reported by 16 WHO Africa countries. 11 of those countries crossed the epidemic threshold for meningitis.

Reliefweb.int

A Rainbow of Hope

In the spring of 1978, Operation Rainbow founder Dr. William B. Riley, Jr. found himself outside a rural hospital in the Philippines. After operating on fifteen children over the next two days, Dr. Riley departed with the image of all those faces, all those unanswered prayers emblazoned on his memory. He knew that he would be unable to forget what he had seen and experienced.

On the long flight home to Houston, Texas, Dr. Riley resolved to ask some of his colleagues to join him the next year: Operation Rainbow was born.

In 1989, Operation Rainbow realigned its mission to focus mainly on orthopaedic surgical intervention — addressing growing unmet needs in developing countries.

Operation Rainbow continues its mission throughout the world by leading 6-9 humanitarian medical missions each year, which provide much-needed orthopaedic intervention for children and young adults. Operation Rainbow also focuses on training doctors, nurses, and other staff at host hospitals, enhancing their capacity for early diagnosis, treatment, and orthopaedic surgical intervention among the vulnerable populations they serve.

Luis' Story (as told at OperationRainbow.org)

In November of 2006, Operation Rainbow had its first mission to Quito, Ecuador, to a charity hospital named Fundación Tierra Nueva. With the support of the local social workers, doctors, nurses, and technicians, life-changing surgeries for children ranging in age from 5 1/2 months to 16 years were performed. All of the children, for one reason or another, touched physicians' hearts, but oddly enough, it was one of the few adult patients treated who really impressed with his strength, determination, and good humor. Heriberto Luis Colorado ("Luis") lives six hours from Quito in an agricultural co-op where he works the fields from 6 a.m. to 3 p.m., planting corn and other grains. He is married and has two daughters aged 11 and 13 years, who he supports on a wage of $5 a day. When Luis was 17 years old, he was injured playing soccer.

After his injury, he continued to feel pain, and with time and perhaps as a result of the work he does, both his hips progressively became completely ankylosed in a bad position. His right leg was permanently rotated 45 degrees outwards and hyper extended, giving him a cross-legged stance, and a sideways gait resembling that of a crab. Walking was very difficult and painful for him, yet he lived this way for over 20 years and continued working in the fields supporting his family.

With the help of a doctor at a local copper mine, Luis was able to make the 6-hour trip with his wife to Operation Rainbow's clinic in Quito. Doctors performed a realignment osteotomy on the second day of surgeries, and the transformation was amazing. The day after his surgery, and with crutches provided by Operation Rainbow, Luis was up and walking the hallway. He was smiling from ear to ear, even though he must have been in serious post-op pain. He walked so much that his leg started to swell, and he was forced to rest in bed for the remainder of the day. Luis's stance is now much improved, his legs no longer crossed.

Luis still needed a total hip replacement on the left side, and on a return mission to Cuenca, Ecuador, Operation Rainbow performed that operation. Luis is now able to live pain free and to walk with a much better gait.

For more information on Operation Rainbow, visit their website at OperationRainbow.org.

The Spine Africa Project

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time to Ethiopia. Similarly, he found that even in the most advanced hospitals in the city of Addis Ababa, proper spine care was virtually non-existent. Doctors were performing overly-invasive and often incorrect spine surgeries. This compounded with the poor sanitary conditions resulted in an astronomical rate of post-operative infection and death. One study indicated that the life expectancy of a victim of spinal injury was less than two years.

When the survival of a family is predicated upon all members' ability to work, injury is not something that family can afford. Almost all of the labor in these provinces is manual labor. Non-existent safety protocols and exhausting working conditions have led to thousands of spine injuries in both countries. "These are countries where a family's entire existence is determined by their ability to work. A spinal injury is basically the 'Kiss of Death'," explains Dr. Kaul.

Dr. Kaul has spent time treating patients throughout both of these countries who were afflicted with spinal conditions. "A large population of those spine conditions occurred in children. Malnutrition and inadequate pre-natal care had led to children developing severe spinal deformations," recalls the doctor. "These children's life expectancies were significantly shortened because of the inability to properly treat them."

While in Lumambashi, Dr. Kaul was introduced to Noella, a Congo native model, actress and political and educational activist. After discussing the medical conditions with her and explaining that there were so many ways he felt he could use his expertise to aid the injured, she introduced him to the Governor of the Katanga Province, MoÔse Katumbi Chapwe. The doctor met with Chapwe several times, stressing the need for more modern medical care. After months of communications, Chapwe convinced the government to appropriate the funds to build a new hospital in Katanga on the contingency that Dr. Kaul would return to train the medical staff in his pioneering technologies.

As of August 2011, Dr. Kaul has returned to both Ethiopia and the Congo. While there, he will be continue his mission to treat patients as well as educate doctors on how to perform his pioneering procedures. This will also be the first time he will see the hospital in the Congo that he helped inspire.

Dr. Kaul will also document his experiences in both countries so that people can see a firsthand view of the conditions. Armed with this documentation, he intends to hold a series of fundraisers throughout America to help these facilities update their equipment and modalities. "The permeating debate in America is healthcare and what our options are. But imagine living in a country where you had no options at all?"

Dr. Richard A. Kaul is a Board Certified Minimally Invasive Spine Specialist. His area of expertise is the diagnosis and treatment of spinal conditions using Minimally Invasive Techniques. Dr. Kaul has been at the forefront of Minimally Invasive and Percutaneous technologies since its advent almost a decade ago. He has received numerous Certifications regarding this specialty dating back as early as 2002, when this discipline was still in its infancy. Presently, Dr. Kaul is the president and lead physician at New Jersey Spine and Rehabilitation.

For more information about the Spine Africa project, please contact:

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973-248-8818 ext 204

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Did You Know?

Between January and April 2012, a total of 25,856 cases and 538 deaths were reported from cholera in WHO member African countries.

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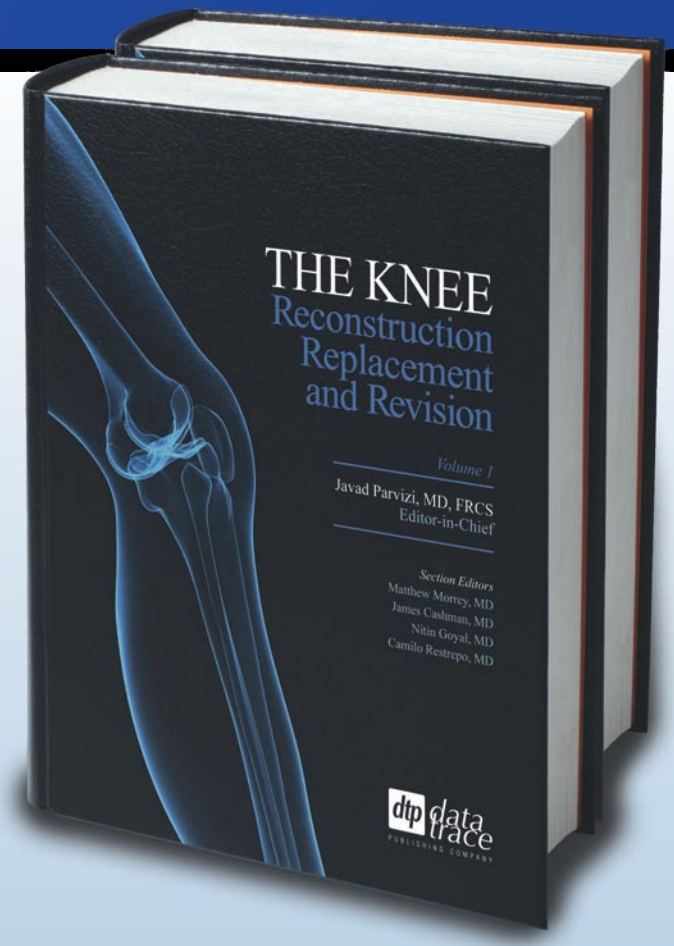

This essential, 2-volume book with more than 1,500 pages on knee arthroplasty, provides the very latest, evidence-based look at the knee from a truly global perspective. Richly illustrated, the content has been written by more than 200 international experts in the field and edited by the renowned orthopaedic surgeon, Javad Parvizi, MD, FRCS, and four Rothman Institute fellows.

Formulated to serve as a key resource for orthopaedic surgeons in the management of knee surgery complications when they occur, and to assist in performing reconstructive procedures on patients with failed TKA. It also addresses how to mitigate risk for patients with disorders such as Paget's disease, extreme limb deformity, and even bleeding disorders, and how to help prevent failures, such as infection, periprosthetic fractures, and instability.

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EHR: Consider This a Warning...

Has your hospital or office been slow to convert to electronic health records? Perhaps there are objections because of budgetary concerns or perhaps time constraints make training staff on new procedures troublesome, but consider this:

A little over a year ago, a deadly tornado tore through Joplin, Missouri, killing 161 people. The twister also heavily damaged St. John's Regional Medical Center, destroying and spreading patient files and X-rays up to 70 miles away. Fortunately, just three weeks earlier, St. John's had switched from paper to electronic health records.

As the hospital's 183 patients were being evacuated, St. John's staff accessed and printed out their records from a remote site, and sent copies with their patients to the hospitals where they were transferred. Accessing the computerized records also allowed St. John's-affiliated physicians whose clinics had been destroyed to resume care at new sites.

In contrast, after Hurricane Katrina destroyed many thousands of patient records in New Orleans and along the Gulf Coast, physicians receiving evacuees were forced to provide treatment without patients' medical histories, allergies, medications, or previous test results. However, evacuated military veterans whose records were maintained through the Veterans Health Administration's VistA system were able to receive uninterrupted care at other VA medical centers throughout the country.

Health care facilities with electronic records are proving more resilient in the face of not only natural disasters but also other unexpected dangers because they are stored in large databases that are not located on site and they can be quickly reconstituted.

Handling a HIPAA Audit

The U.S. Department of Health and Human Services has announced that it plans to carry out random audits for Health Insurance Portability and Accountability Act (HIPAA) compliance throughout 2012. Physicians may be subject to a HIPAA audit randomly or in response to a specific complaint.

The Cost of Violating HIPAA Is High

Previously, violations of HIPAA generally resulted in a warning letter. However, as a result of the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009, violations of HIPAA now result in mandatory fines. Under the HITECH Act, the least serious violations, known as first-tier violations, result in a small fine that starts at $100. Second-tier violations are $1,000 per violation. The most serious violations, described as "willful neglect," include breaches of unsecured protected health information (PHI). Medical practices found in violation of this category may face penalties of up to $1.5 million.

What Triggers a HIPAA Audit?

Typically, the circumstances that would result in a physician being audited are:

- A breach or complaint of a breach of PHI. A PHI breach is an impermissible use or disclosure under the Privacy Rule that results in the security or privacy of the PHI being compromised to such an extent that it puts affected persons at significant risk of harm to their finances or their reputations. Any PHI breach that affects more than 500 individuals must be posted online.
- A complaint of a privacy or security violation by anyone. The Department of Health and Human Services is obligated to investigate all complaints of HIPAA violations.
- Filing for Electronic Health Record (EHR) reimbursement. Physicians are required to show how they comply with HIPAA and that their EHR is certified as HIPAA-compliant when they apply for Medicare incentives for "meaningful use" of an EHR system.

What to Expect If You Are Audited

Physicians who are audited will have to document their HIPAA compliance efforts. Essentially, you'll need to produce a list of policies and procedures that have been implemented to protect the confidential health and financial information in the health records of patients.

Your practice's key personnel will have to be available for the auditors. The practice owner, your HIPAA compliance officer, and the practice's IT person are considered key personnel.

If your practice does not currently designate an individual as a privacy/security officer, you should appoint one as soon as possible. That person will be responsible for regularly implementing and maintaining HIPAA compliance practices and records. Moreover, you have to be certain that your IT professional(s) is familiar with the essential requirements that HIPAA mandates for medical practices and is capable of meeting those requirements.

Seek Professional Assistance

The financial consequences of your practice failing a HIPAA audit can be substantial. Carefully review your current policies and procedures as they relate to HIPAA. You may benefit from outside professional assistance.

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Editorial: Volunteerism in Orthopaedics

A volunteer actively, willingly, and altruistically assumes responsibility for a task to promote good or to improve quality of life. The voluntary commitment to perform orthopaedic surgery is skill-based. In contradistinction, organizations such as the Peace Corp provide catalysts and general education to impact change.

Volunteer orthopaedic surgery can occur in rural and un-served areas of developed nations or in third world countries and may be in the form of direct care or education of local providers. There are significant ethical and moral issues included in providing volunteer care. Within the United States, providing non-Good Samaritan health care is regulated by licensure through Boards of Medical Examiners and hospital credentialing. This is not the case in many other countries.

It is important to provide care that is appropriate and for which you are well-trained. While there may be no lawsuits over standard of care in a volunteer situation, it is morally and ethically challenging to provide care without appropriate training or following the standards that are required at home.

Occasionally circumstances warrant non-standard of care guidelines. This may be true during a disaster, but it is inappropriate for elective surgery. The need or desire of others is not a justification for substandard care. Furthermore, residents and medical students must have appropriate oversight and perform within appropriate training boundaries.

Well-known volunteer organizations vet credentials and provide oversight in both rural areas and third world countries. They deal with local laws and customs. Examples of these are ***Doctors without Borders, SIGN Fracture Care International, Spine Africa Project,*** and ***Operation Rainbow.*** When volunteering, it is important to recognize that the resources that you have may not be comparable to those available at home. The ability to make do with "adequate" but not twenty-first century equipment is crucial. Most importantly, you "must do no harm."

Why should you volunteer? The answer is simple — because you can and want to make a difference. But do not deceive yourself; working in austere environments within an ethical and moral standard of care is not for everyone. In many volunteer organizations resources are limited, follow-up is defined by local resources, specialists may not be available to deal with complications, and operations/interventions must be tailored to the realities of these limitations which is not to condone non-standard-of-care; it is correcting for optimal benefit versus risk. The need to suspend standard of care may be mandated; non-operative, old-fashioned, and outdated care (e.g., cast-braces) may be optimal and expectant care may be unavoidable. Hopefully, such events will never come, but it is prudent to prepare — and volunteer experience can assist with such preparations.

— L. Andrew Koman, MD