

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

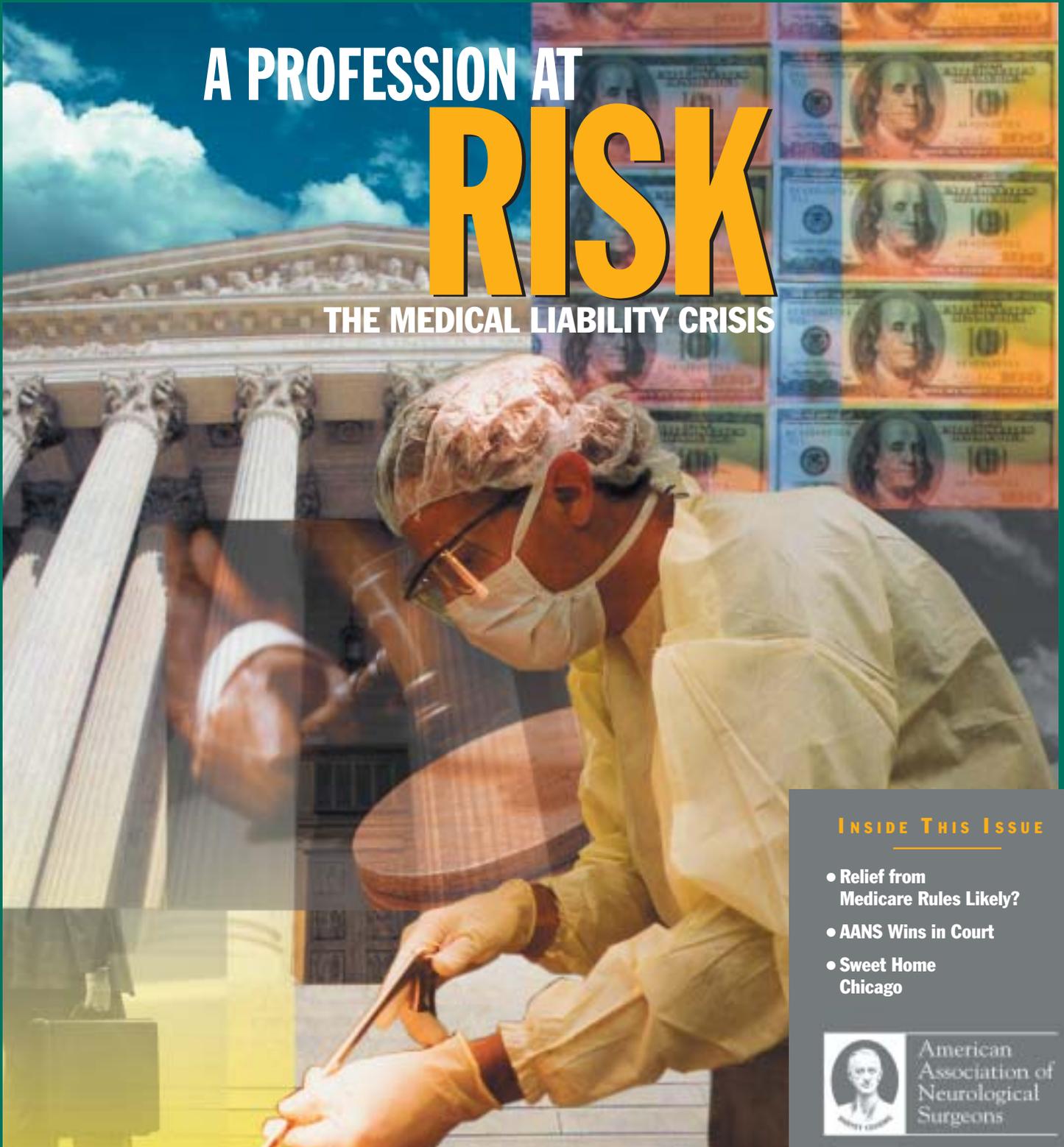
BULLETIN

The Socioeconomic and Professional Quarterly for AANS Members • Volume 10 No. 3 • Fall 2001

A PROFESSION AT

RISK

THE MEDICAL LIABILITY CRISIS



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- Relief from Medicare Rules Likely?
- AANS Wins in Court
- Sweet Home Chicago



American
Association of
Neurological
Surgeons



AANS BULLETIN

The quarterly publication of the American Association of Neurological Surgeons

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The AANS *Bulletin* is published quarterly by the AANS,
5550 Meadowbrook Drive, Rolling Meadows, IL 60008,
and is distributed without charge to the neurosurgical
community. Unless specifically stated otherwise, the
opinions expressed and statements made in this
publication are the authors' and do not imply endorse-
ment by the official policy of the AANS. The editor
reserves the right to edit copy to fit available space.

ADVERTISING SALES: Laura Wissman,
Atwood Publishing, (913) 469-1110

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With Membership Comes Responsibility

AANS Needs Your Help

Dear Colleague,

I have been disturbed over the years by the large number of our members who do not know who the president of their professional organization is and who do not seem to care. If these members get involved at all, it is usually only to ask the leaders of the organization, "What have you done for me today?" As president of the AANS, a position I am honored to hold, I wish to respond to this question, not out of frustration, but out of a true desire to involve all of you in our organization and in our important mission.

Volunteer Opportunities

There is little a professional organization can do without the active participation of its members, and unless you are willing to get involved, your voice rings hollow when you complain. Moreover, there is no reason for you not to get involved, since the opportunities for you to contribute are endless. Let me share with you some of the programs that your dedicated colleagues have initiated.

In the past, the membership process was cumbersome and time consuming. Recently, however, through the efforts of our superb Membership Committee and the AANS staff, we have streamlined that process. Now, all residents are given free membership and then asked to apply for provisional membership upon completion of an approved residency. They are then automatically approved as Active members after passing their written and oral Board examinations. This new process benefits not only North American members, but it also encourages international membership, which has resulted in our emergence as a more global organization. And the day is soon approaching when we can handle our membership application processing online.

All these improvements come directly from the work of your fellow neurosurgeons, and you, too, can be involved.

In an effort to maintain the educational and research missions of the AANS, our leadership has created the "Angel Circle Program," a new concept designed to simplify our relationships with corporate sponsors and partners. These relationships are vital in order to sustain and enhance the level of excellence we have all come to expect from our scientific programs, annual scientific meeting, journal, and the Neurosurgical Research and Education Foundation (NREF). Now, rather than

*Stan Pelofsky, MD,
is the 2001-2002
AANS President.*



being nickel-and-dimed throughout the year, corporate sponsors and partners can customize their involvement with the AANS from a menu of services and activities designed to meet the needs of all parties. Building relationships with industry raises important ethical questions, and you can be involved in determining the nature of these relationships.

Another new initiative that could benefit from your involvement and support is called "Buying Immortality: The Sharing of Knowledge." This program is every neurosurgeon's opportunity to leave a legacy to the profession by sponsoring or endowing such things as: a lectureship at the annual meeting, a fellowship, a breakfast seminar, an AANS course, a resident program or an international program. All of you should

have received information about how you can contribute to this important effort, and I am asking that you make that commitment today.

Planning the 2002 Annual Meeting offers yet another opportunity for you to be involved. Scheduled for April of 2002 in Chicago, the event promises to be exceptional both educationally and socially (See Annual Meeting preview on page 16.) You can contribute to this event by contacting the Annual Scientific Program Committee with your innovative and creative suggestions for making the meeting memorable. Your involvement is critical.

We're All Busy

I have scarcely touched upon the many ways you can make your professional organization exactly what you want it to be. We are all busy. We are all harassed. We could all make every excuse not to get involved, but the truth is that we all have a responsibility to one another to do more than that. Try not to be the critic in the wings who has plenty of time to complain about problems, but who cannot find the time to find solutions. Neither I nor the leadership of the AANS can solve the many issues that face neurosurgeons each day without your help, so I leave you with my own question: What have you done for the AANS and your profession today? Could you be doing more?

Sincerely,
Stan Pelofsky, MD
President, AANS

I shall pass through this world but once. If, therefore, there be any kindness I can show, or any good thing I can do, let me do it now; let me not defer it or neglect it, for I shall not pass this way again.

—De Grellet

NEWSLINE

NewsMembersTrendsLegislation

FROM THE HILL

STROKE BILL ADVANCES

The "STOP Stroke Act of 2001 (Stroke Treatment and Ongoing Prevention)" unanimously passed the Senate Health, Education, Labor and Pensions (HELP) Committee in August. The bill would create comprehensive stroke treatment systems, designate regional stroke centers and utilize the most advanced stroke treatment protocols. The bill is scheduled to be introduced in the House of Representatives in September. A copy of the bill is available at www.neurosurgery.org/socioeconomic.

- **Medicare Agency to Revisit Guidelines.** The Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) announced July 19 that it will work with physician groups to simplify its guidelines. CMS said it plans to work with the American Medical Association, AANS and other physician groups to ensure that the evaluation and management guidelines, the Emergency Medical Treatment and Active Labor Act and other regulatory provisions help, not hinder, the delivery of patient care. The CMS said it will stop its work on the third set of E&M guidelines to consider the input of physicians' groups.
- **Two Patients' Rights Bills Pass.** Senate and House negotiators are expected to meet in September to work out differences in their patients' rights bills. In August the House of Representatives voted 226-203 to approve H.R. 2563, the "Bipartisan Patient Protection Act of 2001." The Senate bill, passed in June, includes more lenient provisions on the right to sue health plans. The House bill passed following an 11th-hour compromise on health plan liability between President Bush and Congressman Charlie Norwood, DDS (R-GA). The AANS and CNS backed the President's compromise because it included important patient protections for neurosurgery patients such as access to specialty care, emergency room services and access to point-of-service options in health plans. Under the compromise, patients would be allowed to sue health plans in state court over denials of care, but the lawsuits must be tried under the federal rules detailed in the legislation. Further, a \$1.5 million limit is placed on damages that patients can be awarded for both non-economic (pain and suffering) and punitive damages. The Senate bill puts a \$5 million limit on punitive damages and no limit for pain and suffering. It is the second time in two years the Senate and House will try to work out a compromise on two patient protection bills.
- **AANS President Meets with President Bush.** AANS and CNS leaders, along with physicians from several other medical societies, met with President Bush on July 11 to discuss the importance of access to specialty care. Stan Pelofsky, MD, AANS President; Issam Awad, MD, CNS President; and Karl Swann, MD, participated in the private meeting, which lasted for nearly one hour. Dr. Pelofsky reinforced the notion that guaranteeing patients' access to specialty care was one of the most important aspects of the Patients' Bill of Rights legislation then being debated by Congress. He relayed a story about a University of Oklahoma professor who was denied access to specialty care and as a result became a paraplegic. Also discussed were the issues of stem cell research and malpractice reform. Following this private meeting, President Bush made public remarks to a larger group of physicians and small business owners. He reiterated his support for meaningful patient protection legislation. The President's remarks at the public meeting can be found at: www.whitehouse.gov/news/releases/2001/07/20010711-2.html.
- **AANS Backs AMA Position.** The AANS' Board of Directors approved a motion in July to adopt the AMA position statement on Contingent Physician Fees. The statement reads: If a physician's fee for medical service is contingent on the successful outcome of a claim, such as a malpractice or worker's compensation claim, there is the ever present danger that the physician may become less of a healer and more of an advocate or partisan in the proceedings. Accordingly, a physician's fee for medical services should be based on the value of the service provided by the physician to the patient and not on the uncertain outcome of a contingency that does not in any way relate to the value of the medical service. A physician's fee should not be made contingent on the successful outcome of medical treatment. Such arrangements are unethical because they imply that successful outcomes from treatment are guaranteed, thus creating unrealistic expectations of medicine and false promises to consumers.

NEWSLINE

NewsMembersTrendsLegislation

NEURO NEWS

NEUROSURGEON WINS AWARD

What does neurosurgeon Keith Black, MD, of Los Angeles, have in common with tennis stars Venus and Serena Williams, actor Samuel L. Jackson and Hans and Ivan Hageman (brothers who began in alternative school in Harlem)? He was honored with a 2001 *Essence* Award in May. *Essence* is a New York-based magazine for African-American women with a circulation of more than 1 million. Broadcast on network television, the *Essence* Awards celebrate black achievement. Dr. Black is the director of the Maxine Dunitz Neurosurgical Institute at Cedars-Sinai Medical Center. *Essence* saluted him for the “unerring skill he brings to excising brain tumors” and “unravel[ing] the mysteries of life itself.”

- **Gene Therapy Used Against Alzheimer's** An experimental surgery in California in April was the first time gene therapy was used on an Alzheimer's patient. Doctors at the University of California at San Diego injected a 60-year-old woman in the early stages of the disease with millions of her own cells. Neurosurgeons Hoi Sang U, MD, and John Alksne, MD, took part in the operation. “The patient is doing marvelously. And there has been absolutely no side effects,” said Dr. U. The medical team, led by neurologist Mark Tuszynski, MD, may not know for months or longer if the procedure will slow the disease process. A Phase I trial, the procedure was intended to make cells harvested from the women's own skin deliver more nerve growth factor where it's needed. The growth factor has been shown to prevent the death of those brain cells that use acetylcholine. Similar gene therapy is envisioned for use against Parkinson's disease and possibly Lou Gehrig's disease and Huntington's disease.
- **Paralysis Treatment Shows Promise** A clinical trial has shown success at repairing severed spinal cords, according to Israeli researchers. Melissa Holley, an 18-year-old American, regained movement in her toes and legs a year after undergoing the experimental treatment in Israel. Holley was paralyzed from the middle of her back down to her toes as a result of a car accident. Holley was the first human to receive autologous activated macrophage therapy, which uses a patient's own white blood cells drawn from skin and bone marrow to regenerate the severed nerves in the spinal cord. “We take the macrophages and put them with the wounded skin, so we educate them,” Valentin Fulga, MD, of Proneuron Biotechnologies in Israel told CBS's *The Early Show*. “We then take the macrophages, which are now more mature and hopefully more effective, and we put them into a small syringe. The neurosurgeon injects them into the spinal cord and that's all.” Dr. Fulga said Proneuron has performed the procedure on three people in the Phase I trial and wants to test it on at least five more patients. The treatment was based on the research of Michal Schwartz of the Weizmann Institute of Israel. In a 1998 study published in *Nature Medicine*, most of the adult rats whose spinal cords were cut were able to move their hind legs after macrophages were injected into their cords.
- **Link Between Computers, Carpal Tunnel Debunked** Heavy computer use does not increase a person's risk of carpal tunnel syndrome (CTS), according to a new study from Mayo Clinic in Scottsdale, Ariz. The research results, published in the June 12 issue of *Neurology*, indicate that only 10.5 percent of the study participants, all of whom used computers extensively, met clinical criteria for CTS. This was the first major study of the association between the syndrome and computer use. “We had expected to find a much higher incidence of carpal tunnel syndrome in the heavy computer users because it is a commonly held belief that computer use causes carpal tunnel syndrome,” said neurologist J. Clarke Stevens, MD, lead author of the study. Research suggests one person in 10 will develop symptoms of CTS over a lifetime. Though the workers in the Mayo study didn't develop CTS at a higher rate than the general population, they did report “a lot of aches and pains in the neck, shoulder, arm and wrist,” said Dr. Stevens.
- **More Sophisticated MRIs** More powerful MRI machines that reveal brain function will soon become part of clinical medicine, according to the *Chicago Tribune*. Several vendors are now marketing 3 Tesla magnetic scanners to clinical centers. The 3 Tesla machine produces signals much easier to read than the commonly used 1.5 Tesla machine and can monitor blood flow and not just reveal brain anatomy. The more powerful MRI is expected to be useful to surgeons in excising abnormalities and for physicians in diagnosing pathology such as Alzheimer's and Parkinson's diseases and in monitoring the progress of stroke patients undergoing therapy. The 3 Tesla machines have been used by medical researchers for several years to study the brain.

A Profession AT RISK

by Jay Copp

Medical liability crisis deepens as neurosurgeons face steeply rising premiums.

Neurosurgery is in crisis in Pennsylvania. Insurance premiums for many neurosurgeons rose by 50 percent this year and some saw triple digit increases. The profession is reeling. Twenty percent of the neurosurgeons in the southeastern part of the state have either retired or left the area, according to the Pennsylvania Medical Society.

The increase in premiums has unleashed a whole series of unfortunate events. Several trauma centers closed their doors temporarily, and a hospital near Philadelphia, unable to secure malpractice liability excess coverage, may permanently shut down its neurosurgery department (as well as its obstetrics and gynecology units). Neurosurgeons are practicing defensive medicine, ordering extra tests and avoiding high-risk cases. Teaching hospitals are having trouble recruiting neurosurgeons.

Doctors in West Virginia also are in the throes of a liability crisis. A rising number of lawsuits has led to doctors paying insurance premiums double what physicians in nearby Kentucky pay. The additional expense has forced doctors from the state. In Wheeling, the area's last neurosurgeon left because of high premiums, said the president of the West Virginia State Medical Society.

Pennsylvania and West Virginia are the flashpoints for the nation's medical liability crisis. Doctors in other states have not been hit as hard but still suffer from double digit insurance premiums increases. The situation will get worse before it gets better. Medical malpractice premiums will rise from 20 to 25 percent in some markets and as much as 50 percent in others, according to A.M. Best Company, which assesses insurer financial performance. Underwriters are scrambling to recover costs and physicians will bear the brunt of the recovery. "These estimated price increases only help return to a break-even underwriting operation; additional increases will be needed to meet insurers' cost of capital," an A.M. Best analyst recently wrote.

The premium increases reflect soaring jury verdicts as well as years of under pricing from carriers. Contributing to the liability crisis is the lack of state tort reform. Many states that enacted laws



capping damages have seen their reforms overturned by state courts. Powerful trial bars stand in the way of reform. The public, angry at managed care and leery of medicine in the wake of the Institute of Medicine report on physicians' errors, is not exactly primed to rally around calls for liability relief.

High insurance premiums are an old story for neurosurgeons. But this time the rates have reached a staggering level and they come a time when neurosurgeons are increasingly burdened. "What is extraordinary about what's happening now is the six-digit premiums [for physicians], and neurosurgeons are at the top of the list," said Lawrence E. Smarr, president of the Physician Insurers Association of America (PIAA), an association of doctor-owned or doctor-directed liability carriers. "This comes at a time when physician income is being restrained. More regulations are placed on them than ever before. They spend more time doing non-productive administrative work, and they have to worry about fraud and abuse. On top of all this they have the larger premiums."

Astronomical Verdicts

The most obvious reason for the rising premiums is the increase in jury awards. Jury awards for medical malpractice claims rose 76

percent from 1996 to 1999, according to Jury Verdict Research. The median award from medical malpractice rose from \$454,565 in 1996 to \$800,000 in 1999. The good news is that the increase from 1998 to 1999 was a modest 7 percent—from \$750,000 to \$800,000.

The study by Jury Verdict also showed a 6 percent increase in the number of million-dollar verdicts in 1998-99 from 1997-98. Some of the awards have been astronomical. In 2000, a Pennsylvania jury awarded \$100 million to a plaintiff who sued four doctors and two hospitals over surgeries and other care for an infant born 26 weeks after gestation.

The large verdict amounts have been partly attributed to changes in how society views money in light of the multimillion dollar salaries of athletes and the quick riches of dot.com millionaires. “There’s an overall lottery mentality,” said Richard Anderson, MD, Board Chairman for The Doctors’ Company, the nation’s largest physician-owned medical liability insurer. “Juries have lost track of the value of money. It’s gotten to the point where it’s OK for a lawyer to have a million dollar fee.”

The litigation mentality has spilled over into medicine with the force of a tidal wave. “The public culture needs to be changed. People need to realize that the world isn’t perfect. Just because everything doesn’t turn out right doesn’t mean someone is at fault,” says Raymond Truex Jr., MD, a private practice neurosurgeon in West Reading, Pa.

Anger at managed care and more experienced plaintiffs’ attorneys also account for the larger verdicts, according to insurance carrier administrators. Whatever the reason, the spiraling verdicts drive up settlement costs, too, which eventually

lead to higher premiums as well.

Neurosurgeons are apparently particularly vulnerable to high verdict amounts. Jury Verdict analyzed all compensatory awards in 1999 (not just medical malpractice) for six frequently claimed injuries. The median awards were \$6,827 for cervical/lumbar strain, \$89,000 for herniated disc, \$9,000 for headaches, \$295,762 for mild/moderate brain damage, \$1.45 million for wrongful death and \$22,000 for spinal nerve injuries.

A 1999 AANS survey of neurosurgeons by the AANS found that if a respondent had claims experience, the malpractice claim(s) was most often related to spine procedures (77 percent), followed by intracranial procedures (42 percent).

The Jury Verdict study also found that the median award for medical negligence in childbirth cases in 1999, \$2 million, was the highest of all malpractice cases analyzed. The median awards for other types of malpractice: \$636,844 for medication cases, \$625,000 for diagnoses cases, \$400,000 for nonsurgical treatment cases, \$300,000 for surgical negligence cases and \$230,000 for doctor/patient relations cases.

The rise in premiums has little to do with frequency of claims. “Liability insurers from Maine to Florida, in the Midwest, in the Southwest, in California and in the Pacific Northwest, said that claims frequency is flat, stable or has declined slightly,” according to the June 20 issue of *Medical Liability Monitor*. Nor have doctors been losing in the courtroom at a higher rate. The plaintiff recovery rate has hovered around 30 or 33 percent from 1994 to 1999, according to Jury Verdict.

Neurosurgery itself is not in any more difficulty than other specialties. “There is no specific crisis involving neurosurgery,” said Dr. Anderson. “It does not face a specialty specific crisis, as did plastic surgery with breast implants, for example.” A crisis possibly could occur regarding inadvertent transmission of prion-based disease from patient to patient via inadequately sterilized instruments but that issue has yet to be subject to litigation, he said.

Besides rising jury verdicts, the premium increase is due to long-term market forces in the insurance industry. Insurance carriers are always several years behind in knowing the actual cost of claims. Their prices don’t always reflect their true costs. Physicians had benefited from “a protracted soft market,” said Phil Dyer, Vice President of Business Development for The Doctors’ Company. “There was a plethora of carriers. Everyone was in fierce rate competition. Premiums were artificially low.” The bottom dropped out when the stock market tumbled, said Dyer. Carriers overly reliant on investment income became endangered. Several insurance carriers already have closed their doors or are on the block.

The prognosis is not good for the carriers’ customers—physicians. “We’re entering a ‘hard’ market. There are fewer carriers and higher rates. It will be harder to find carriers,” said Dyer.

What happens in a state in crisis like Pennsylvania is that companies begin to fold and the ones left must raise rates so high that fewer physicians can afford them. The entire local malpractice insurance system itself shows signs of teetering.

Another factor that can drive up premiums is the general state of the economy. Like crime, litigation statistics correlate with economic indicators. “Litigation cycles tend to parallel economic cycles. If the economy turns down ...,” said Dr. Anderson.

The Pennsylvania Story

The crisis in Pennsylvania shares some of the same common roots as the rest of the nation. But a whole set of local factors has exacerbated the problem. First of all, jury verdicts have risen through the roof. The Pennsylvania Medical Society says it no longer counts mil-

Continued on page 9

“We’re entering a ‘hard’ market. There are fewer carriers and higher rates. It will be harder to find carriers.”

Continued from page 7

lion dollar awards but adds up the number of \$10 million and \$100 million awards.

“The plaintiffs’ awards in Philadelphia alone in 2000 exceeded plaintiffs’ awards in California,” says Dr. Truex.

Due to the growth of integrated health systems, attorneys are able to steer cases to Philadelphia, where attorneys are craftier and juries more extravagant with awards.

A second factor is the stress on the state’s Catastrophic Loss Fund, which pays settlements up to 1.2 million. State physicians, who must have malpractice insurance, find their own insurance coverage for the first \$500,000 of coverage. As lawsuits mount, the surcharge physicians must pay into the fund have skyrocketed.

“Plaintiffs’ attorneys are out of control. It’s lawsuit abuse.”

The Pennsylvania legislature is populated by former trial attorneys, and the laws distinctly favor the legal community. There are no penalties for frivolous lawsuits and no caps on noneconomic damages. Damages are paid in a lump sum. Plaintiffs can recover their costs more than once from verdicts and other sources such as disability payments. And witnesses need not be from the specialty under question: a pediatrician can be called to testify when a neurosurgeon is a defendant.

“Plaintiffs’ attorneys are out of control. It’s lawsuit abuse,” says Steven Barrer, MD, a private practice neurosurgeon in Abington, near Philadelphia. Dr. Barrer says he has been hit with multiple frivolous lawsuits and consequently had great difficulty this year finding insurance. His premium is a staggering \$132,000, a 130 percent increase from last year.

The legislature is considering a bill to relieve the stresses on the Loss Fund, but neurosurgeons are not optimistic full-scale tort reform is coming. “The legislature does not see this as a crisis,” says Dr. Barrer. “Nothing has changed. Babies are still being delivered. Surgeries are still being done, as far as they know. The public does not see the problem. The doctors that are left are working harder.”

Tort Reform Rollback

Physician associations perennially champion tort reform as the answer to the medical liability crisis. States that limit damages, impose a sliding scale for attorneys’ contingency fees and enact other reforms experience stable malpractice premiums, all the while allowing patients to have their day in court, according to physician associations. California is the most frequently cited example. In 1975, in response to a malpractice premium crisis, the state passed the Medical Injury Compensation Reform Act (MICRA). MICRA stipulates:

Malpractice-Related Resources on the Web

RISK MANAGEMENT

- www.thedoctors.com/rm/sb/body.cfm: More than 50 loss prevention articles published by The Doctors Company, a doctor-owned medical malpractice insurer. The articles are organized into five categories: communication, practice guidelines, litigation/claims, professional conduct and clinical issues.
- www.neurosurgery.org/aans/bulletin/spring01/neuroliability.html: A spring 2001 *Bulletin* article containing results from a study on neurosurgical claims.

MALPRACTICE LAWSUITS

- <http://me.pdr.net/me/public.htm?path=docs/mal.htm>: Dozens of well-researched stories from *Medical Economics* magazine on medical malpractice. Some sample articles: “How to Squash a Small Malpractice Claim,” “The New Rules on Informed Consent,” “Offering Medical Advice on the Web,” “How’s Your Insurance Coverage” and “I Wish I’d Fought My Malpractice Suit.”

STATE LAWS ON MEDICAL LIABILITY

- www.atra.org/issues.f1ml?id=32: A state-by-state summary of medical liability laws, compiled by the American Tort Reform Association.

ADVOCACY

- www.hcla.org: The Health Care Liberty Alliance is a group of medical organizations “dedicated to rescuing the nation’s health-care system from an out-of-control legal system.” Its Web site presents information on the problems and solutions to the malpractice crisis.

- A \$250,000 cap on noneconomic damages. (Patients are allowed to recoup all medical costs of medical malpractice.)
- Limits on contingency fees. Legal fees are set by a sliding scale.
- Periodic payments on future damages instead of one lump sum.
- Collateral sources of payment. Courts can consider already existing healthcare coverage that pays to correct a medical problem.
- A shorter statute of limitations and a reasonable statute for minors.

What has been the effect of MICRA in California? “Malpractice insurance rates are less than half [of other states],” said Dr. Anderson. “And California is an incredibly litigious state. There is no shortage of lawsuits and lawyers. The frequency of suits is nearly 1.5 times the national average.”

The difference in malpractice insurance rates in states that have and don’t have tort reform is dramatic. “There is a link between open-ended liability and no coverage or unaffordable

New AANS Guide Helps Reduce Malpractice Risk

In both frequency and severity, neurosurgery ranks among the top three medical specialties in malpractice claims. While most medical specialists experience an average of one claim every five years, actuarial data shows that neurosurgeons experience one claim every two years. Experts such as attorneys and malpractice insurance carriers emphasize reducing risk by communicating, and documenting the risks, benefits and alternatives to the procedure a patient is about to undergo. No program is risk-free. But physicians can reduce risk with a strong informed consent program documenting that patients were given information needed to make an informed decision.

To assist members in this critical task, AANS is now offering the *AANS Guide to Informed Consent*. The *Guide* explains what informed consent is, how to head off problems before they become malpractice claims, the role nurses and other staff play in the process and how to make your medical records valuable in defending a claim. The *Guide* also comes with a disk containing sample neurosurgical informed-consent documents that can be personalized for your practice. The debut edition of the *Guide* contains these sample consent documents:

Cranial

- Craniotomy for hematoma removal
- Craniotomy for depressed bone injury
- Craniotomy/craniectomy for resection of the injured brain
- Surgical placement of spinal fluid shunt

Spine/Peripheral Nerves

- Anterior cervical discectomy
- Anterior cervical discectomy with fusion
- Anterior cervical discectomy with fusion and internal fixation
- Anterior cervical discectomy (with fusion/fixation—combines all of above three)
- Cervical laminectomy for cervical stenosis
- Cervical foraminotomy
- Lumbar spine surgery
- Surgery for peripheral nerve entrapment

Tumor

- Craniotomy for tumor removal: the supratentorial tumor
- Craniotomy for tumor removal: the infratentorial tumor
- Transsphenoidal surgery for the removal of pituitary tumors

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coverage. What risk writers like least is the lack of predictability,” said Sherman Joyce, President of the American Tort Reform Association.

Neurosurgeons in states with tort reform vouch for the benefits. The situation in Michigan until laws were changed in the early 1990s was “horrible—the same problems you see in Pennsylvania,” says Fernando Diaz, MD, PhD, of Detroit, who chairs the Medical-Legal Committee for the Council of State Neurosurgical Societies. Michigan has curtailed frivolous lawsuits by not allowing a suit unless the plaintiff’s attorney obtains an affidavit from an expert witness in the same field as the accused physician. The affidavit must attest to the merits of the case.

Unfortunately, tort reform across the country has seen limited success. A number of states that have passed tort reform laws have seen courts rule them as unconstitutional. Courts in Alabama, Illinois, Kansas, New Hampshire, Oregon, Texas and Washington have struck down caps, according to the Health Care Liability Alliance. On the other hand, courts in Colorado, Florida, Louisiana, Maryland, Missouri and West Virginia have upheld caps.

States that have caps for \$250,000 or less for non-economic damages are: California (\$250,000), Colorado (\$250,000, some court discretion, total cap is \$1 million), Indiana (\$250,000 cap on total damages per provider, \$1.25 million cap on total damages), Montana (\$250,000), Nebraska (\$200,000, \$1.25 million cap on total damages) and Utah (\$250,000).

States that have caps for more than \$250,000 for non-economic damages are: Arkansas (\$400,000), Hawaii (\$375,000), Idaho (\$400,000), Louisiana (\$500,000 cap on total damages plus future medical costs), Maryland (\$500,000), Massachusetts (\$500,000, some exceptions), Michigan (\$280,000, \$500,000 maximum), Missouri (\$500,000), New Mexico (\$600,000 cap on total damages, does not apply to past and future medical care), North Dakota (\$500,000), Ohio (greater of \$250,000 or three times economic damages not to exceed \$500,000), South Dakota (\$500,000), Virginia (\$1 million cap on total damages), West Virginia (\$1 million) and Wisconsin (\$350,000).

In Florida, plaintiffs are entitled to a maximum of \$350,000 in non-economic damages if they do not opt for binding arbitration and \$250,000 otherwise. The other states do not have caps.

Premiums for liability insurance vary from state to state not only because of caps but because of urban/rural characteristics, incidence of large awards and local market conditions/performance of carriers. Neurosurgeons in Chicago and New York City are paying as much as \$200,000 for a \$1 million policy while their counterparts in sparsely populated states may be paying as little as \$30,000.

A recent survey by the Pennsylvania Medical Society shows how premiums for neurosurgeons rise the closer the neurosurgeon is to Philadelphia. The premiums are: Philadelphia, \$111,296; Buck County (near Philadelphia), \$98,273; Lackawanna County

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The High Costs of Defensive Medicine

BY RICHARD E. ANDERSON, MD

“DEFENSIVE MEDICINE”—when doctors order needless tests to establish a medical record for their defense in case they are sued—is an increasingly common practice that should concern every American.

Defensive medicine exacts huge costs, in both fiscal and human terms. Take a recent story on a University of Washington and Harvard Medical School study. Many women were alarmed to learn that nearly one-third of those who undergo annual breast cancer checkups for a decade can expect to get at least one “false positive”—that is, they will be told they may have breast cancer, when they do not.

“People always imagine the worst,” one professor of health law told *The Washington Post*. “These women go through hell.”

Easier to quantify are defensive medicine’s costs to society. The health economics firm of Lewin-VHI in 1991 estimated that doctors and hospitals spent \$25 billion on defensive medical practices.

High Wire Act

I am an oncologist, not a psychologist. While I know a false positive can create fear and depression, I am in the business of avoiding something far worse—a false negative that can kill. The reality of being a physician today is a high-wire act in which we must balance deadly health threats to our patients against real costs to them in the form of discomfort, money and peace of mind.

These judgments calls are tough. They become far tougher when a lawyer looks over your shoulder as you perform a medical examination.

What do I mean by this? Consider a simple country-to-country comparison. In Sweden, false positives are only one-half to one-fifth those in the United States, with no apparent increase in missed cancers. The reason for this disparity, according to Philip J. Arena, MD, a Boston radiologist and co-author of the study on false positives, is our malpractice system. He says fear of lawsuits puts pressure on radiologists to over-diagnose breast cancer so they won’t be blamed later for missing a nascent tumor.

In Sweden, doctors are allowed to use their judgment to determine when a test should be conducted. In the United States, legal considerations often overrun medical judgment. Medical malpractice costs increased more than 48.6 percent from 1990 to 1994, far outpacing the 16.6 percent increase in overall tort costs these same years.

The distorting effect of our liability laws on medical practice does far more harm than generate false positives and fear among women. The specter of lawsuits often denies people access to healthcare itself. Examples are legion: the “lawsuit tax” adds \$500

Federal Relief Highly Unlikely

It is almost certain that there will be no federal malpractice reform legislation, despite the support of President George W. Bush. Even so, Rep. Jim Greenwood (R-PA) recently reintroduced his malpractice reform bill in the U.S. House of Representatives. H.R. 2103, the “Medical Malpractice RX Act of 2001,” essentially mirrors MICRA, the tort reform measures in place in California.

The AANS has endorsed this bill and has sent members of Congress a letter urging them to co-sponsor the measure. Neurosurgeons nationwide can write members of Congress, especially legislators from Pennsylvania, in support of the Greenwood bill. Gaining these U.S. representatives’ attention to this issue may assist in putting pressure on state policy officials to act.

—Katie Orrico, JD, Director of the AANS/CNS Washington, D.C. Office.

to the cost of a two-day maternity stay; fear of lawsuits has forced family physicians in some states to stop delivering babies; the threat of litigation has killed the only U.S. prescription drug ever approved for morning sickness; it is keeping new and better contraceptives off the pharmacy shelves.

Drastic Rethinking Needed

I see two areas in which we need a drastic rethinking of the way law and medicine interact. In a medical practice, as in life, trade-offs between risks and costs are unavoidable. We need to reform our laws so that doctors can use their training and judgment to better manage these trade-offs. And we need to let doctors share responsibility with patients, allowing people to find their own trade-offs between risks and costs and then be responsible for making their own informed decisions.

California provides a model for the first of these solutions in the form of limits on medical liability. A recent Stanford University study found that in states that adopted California-style medical liability reforms, hospitals reduced defensive medicine expenses without compromising patients’ health.

“If malpractice is inducing too much treatment, what you should do is reduce malpractice pressures,” said one of the study’s authors, Stanford economist and lawyer Daniel Kessler.

For doctors and patients alike, managing risk against cost and inconvenience is a precarious balancing act. But it is one that will work much better when the figurative presence of a trial lawyer departs from the examination rooms. ■

Richard E. Anderson, MD, is a medical oncologist, clinical professor of medicine at the University of California, San Diego, and Chairman of the Board of Governors of The Doctors’ Company.

(Scranton area), \$76,977; Allegheny County (Pittsburgh), \$56,484; Tioga County (very rural), \$54,572; Lancaster County (very rural and heavily Amish), \$54,014.

The survey also compared the highest premiums in Pennsylvania with the highest regions in neighboring states: Philadelphia, \$111,296; West Virginia, \$107,478; Ohio, \$76,715; New York (excluding New York City), \$75,232; New York City, \$166,302; New Jersey, \$74,232; Maryland, \$58,279; and Delaware, \$51,674.

The disparity in premiums leads to a host of unfortunate consequences for physicians and patients. It's quite tempting for a doctor in Philadelphia, for example, to move across the river into New Jersey or down the road a few miles into Delaware.

The court decisions overturning tort reform have led medical societies such as the Pennsylvania Medical Society to arouse its members to support judicial candidates favorable toward tort reform. Concentrated efforts also were made in Ohio and Illinois. The backed candidates didn't win, said Joyce, but positive strides were made. "Public attention was brought to the issue," he said. "Maybe judges will be a bit less aggressive."

"Our concern is that the courts have stripped the legislature of authority to make policy," Joyce added. "Our template is MICRA. What we know is that system works pretty well. That helped relieve a serious crisis in insurance and does provide a level of stability."

Tort reform is the key, said Smarr of PIAA. "Nothing has really changed over the past 20 to 30 years. There is still an upward trend in malpractice premiums except in states where there is meaningful tort reform," he said.

The legal landscape surrounding lawsuits and medicine will change if Congress passes a patients' bill of rights, which guarantees the right to sue managed care groups. Insurance groups such as the PIAA are opposed to the right to sue without tort reform because they believe that doctors would be dragged into the lawsuits.

The AANS is likewise concerned that increased lawsuits against HMOs will inevitably pull neurosurgeons into the fray as well, either as defendants or witnesses. For this reason, organized neurosurgery supports managed care reform that limits the amount of damages patients can collect from their HMOs. Unfortunately, there is not a unified position within medicine. Believing that physicians are not more likely to be sued, the American Medical Association and other some other medical groups support patient protection legislation that permits unlimited damages against HMOs.

A number of states have passed laws making insurers legally accountable for their decisions, and suits against managed care companies have been rare. Georgia, for example, passed a patients' bill of rights law two years ago that set up an external review board for patients to contest denials of coverage. Not a single person who brought his grievance through the new independent review system and was denied has filed a lawsuit, according to the Atlanta Journal-Constitution. The patients' rights bills being considered by Congress allow for an external review process.

AANS Offers Discounted Liability Insurance

AANS members can receive discounted rates on professional liability insurance through The Doctors' Company, the nation's largest doctor-owned medical malpractice insurer.

AANS members receive a 10 percent discount, additional discounts of up to 25 percent for claims-free experience, discounts up to 75 percent for physicians entering practice within three years of completing residency or military service and other discounts. Additionally, among other benefits, TDC gives a physician control over whether a claim is settled and physicians insured with other carriers can convert to TDC without purchasing costly tail coverage from their current carrier.

TDC's aggressive defense strategies resolve 80 percent of claims without indemnity payments and more than 80 percent of cases that go to court result in TDC victories.

For information, call TDC at (800) 421-2368 or visit www.thedoctors.com.

Strength in Numbers

Patients who visit Dr. Truex in his West Reading office are handed brochures outlining the medical malpractice crisis. But few family physicians are willing to distribute the literature. "The ship is dipping into the water and we're [neurosurgeons] in the forward cabin," says Dr. Truex. "The primary docs are on the other side of the ship so they're not worried."

Obstetricians and orthopedic surgeons also are in the forward cabin, but neurosurgery is more isolated in its crisis. It's a small specialty, and its services are not nearly as noticeable to the public as, say, obstetricians.

Neurosurgeons in a few states have banded together with other physicians to press for reforms, and those initiatives have at least gotten the attention of lawmakers. Hundreds of doctors in Pennsylvania closed their office and marched to the legislature in April to demand reform. In West Virginia 1,000 physicians drove to the capitol earlier this year and threatened to shut down their practices permanently and move to states where insurance is cheaper.

As AANS Past President Stewart Dunsker, MD, said at the 2001 Annual Meeting, "We need to take part in the debate not in the halls of hospitals but in the halls of legislatures. It's easy to sit back and let other physicians do the work. The more we work ... the more likely we are to change the future."

In absence of tort reform, neurosurgeons who wish to avoid the courtroom need to do what every physician presumably intends to do: practice good medicine and maintain good relations with patients. Otherwise, difficult procedures will leave neurosurgeons as well as patients at risk. ■

Jay Copp is staff editor of the AANS *Bulletin*.

How Plaintiffs' Lawyers Pick Their Targets

Editor's Note: Copyright © 2001 by Medical Economics. Reprinted by permission from MEDICAL ECONOMICS magazine, www.memag.com. This article has been edited for length.

Attorneys Jeffrey Allen and Alice Burkin are experts at suing doctors. They've been representing medical malpractice plaintiffs for more than 15 years as partners at the Boston firm Lane Altman & Owens. Unlike many personal injury lawyers, they don't solicit business through ads in the Yellow Pages. Instead, they get their clients via word-of-mouth recommendations or referrals from other lawyers. *Medical Economics* Senior Editor Berkeley Rice discussed with them which doctors get sued and why.

Choosing "good" cases and screening out "bad" ones

Q. Let's face it: Doctors generally don't have much respect for malpractice plaintiffs' lawyers. They think of you as greedy, unscrupulous ambulance-chasers who will take any case—no matter how frivolous—if there's a chance of a quick settlement.

Allen: I know doctors think that, but they're wrong. If we really did that, we'd be out of business. Given the economics of malpractice law, any lawyer who takes frivolous cases is going to go bankrupt. If you bring a weak case, the insurance companies won't settle; they'll fight you all the way, and you'll probably lose at trial. That means you'll end up losing not only your time, but also the \$20,000 to \$30,000 it costs to bring a case to trial.

Q. How do you screen prospective claims to avoid frivolous cases?

Burkin: We review dozens of claims for every one we actually accept. I spend an enormous amount of time on the phone talking to potential clients. Most of them never make it into the office.

If the case sounds promising—and only a third of them do—we invite the client in for an initial interview, which takes about two hours. Then, if the case still sounds good, we'll request medical records. Only if the records suggest negligence do we send them out for review by our medical experts.

Q. When you send the records out for review by your experts, is that mainly to determine whether negligence has occurred?

Burkin: It's much more complicated than that, because we have to prove negligence, damages, and causation. We ask our experts several questions: Was the doctor's diagnosis correct? Was the treatment appropriate? Was the plaintiff damaged? And did the doctor's negligence cause the damage? Only if our expert answers Yes to the last question will we file a suit. And that happens with only two out of every 30 potential cases.

Weighing Legal Expenses Against Potential Damages

Burkin: Because of our time investment and costs, we really can't consider a case unless we can expect a payoff of at least \$200,000 in damages, and even that's really not enough. If we end up tak-

ing the case to trial, we're probably going to spend \$20,000 to \$30,000 or more. So we have to make a business decision: Are the potential damages worth the time and expense we'll have to invest to win?

Q. Isn't that a pretty cynical way to evaluate the claim of a badly injured patient?

Burkin: I'd say it's the only realistic way to do it, even though it's one of the sad things about the economics of this business. If the damage is, say, \$50,000, that may be a big deal for many people, but it's not enough to make the case worthwhile for us.

Q. What happens to those people?

Burkin: They end up with those firms you see in the Yellow Pages.

Q. How about the plaintiffs themselves? Do they affect your decision to take the case?

Burkin: Definitely, because the plaintiff's age and economic status affect the value of the damages. That's why we're reluctant to take on elderly plaintiffs: The damages will be less, because their life expectancy is limited and there's not much claim for lost income. And yet the cost of preparing those cases may be higher if the illness has lasted for many years.

Q. I've heard that some plaintiffs' lawyers use the shotgun approach: suing every doctor involved in the case, no matter who's really to blame, hoping some will cave in and settle. One lawyer told me, "You shake the tree and see what falls out."

Burkin: Some lawyers do use that method. But our approach is to sue as few doctors as possible.

Q. Why? For economy's sake?

Allen: We don't want doctors on trial who don't belong there because it makes our case more difficult, particularly if each one has his own attorney. Let's face it: I'd much rather go up against one lawyer than four. Why have to deal with four different defense strategies? Why let your client face four cross-examinations?

It also affects our credibility with the jury. Most jurors don't want to find doctors negligent, because every one of them depends on his or her own doctor. So it's hard to convince them that one doctor was negligent, and even more difficult to convince them that two or three screwed up. If we don't convince them about one of the doctors, our credibility is damaged, which weakens our case against the others.

Settling a Case Versus Telling it to the Judge

Q. How do you decide whether to settle a case or go to trial?

Burkin: Very few of our cases actually go to trial. That's not because we're looking for quick settlements, but because we take only good cases, and we prepare every one as though it's going to trial. That way, if we do end up in court, we'll be 100 percent

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ready. The insurance companies know that, so they're more likely to settle. But they don't settle the frivolous cases. They settle the ones where there's clear liability, because they're worried about getting hit with big verdicts in court.

Q. You say you settle most of your cases. Does that mean you prefer to avoid trial?

Burkin: No, we love to try cases, because it's very exciting. After all, we are trial lawyers. But we don't gamble with our clients. If you go to trial, you risk getting nothing. So if you can get a fair settlement and avoid that risk, you have to do it. Sometimes we do struggle with the decision if the insurance carrier offers a borderline settlement when we think there's a good chance of winning more at trial. At that point, we really have to put our egos aside and ask what's best for our client.

Why Some Doctors Are More Likely to Get Sued

Q. Why do some doctors get sued more than others?

Burkin: I'd say the most important factor in many of our cases—besides the negligence itself—is the quality of the doctor-patient relationship. People just don't sue doctors they like. In all the years I've been in this business, I've never had a potential client walk in and say, "I really like this doctor, and I feel terrible about doing it, but I want to sue him." We've had people come in saying they want to sue some specialist, and we'll say, "We don't think that doctor was negligent. We think it's your primary care doctor who was at fault." And the client will say, "I don't care what she did. I love her, and I'm not suing her."

Q. It sounds like the decision to sue is based as much on perceived negligence as actual negligence.

Burkin: Exactly. You see, all of our clients have had bad medical results. The big question is: Was it just an unfortunate result, or was it malpractice? When a patient has a bad medical result, the doctor has to take the time to explain what happened, and to answer the patient's questions—to treat him like a human being. The doctors who don't are the ones who get sued.

Allen: A lot of people come to us because they want us to review their medical records and figure out why something went wrong. They'll say, "I asked the doctor, but he didn't explain anything." Now the explanation may not be simple, but you can't just ignore your patient's question, because sooner or later the truth will come out. Even if the patient doesn't get the whole story herself, we will when we review the records. That's why arrogant doctors are the ones who lose.

In one case, we found a letter the doctor had written in response to the patient's questions. He told her he couldn't tell her why her problems had occurred, and suggested she talk to someone else. Now that's sheer arrogance. He might as well have given her directions to the nearest plaintiffs' attorney.

Q. Does arrogance continue to be a factor during the malpractice suit?

Allen: Absolutely. One of the things we try to find out in a deposition is what effect the doctor is likely to have on the jury. That helps us decide whether to settle or try a case. If he's arrogant, the jury will hate him. That affects not only the amount we'll seek in

a settlement, but also how we'll try the case if it doesn't settle. In some cases, the doctor is such a piece of work that we'll call him as a witness even before we put our client on the stand. We hope he'll make the jury so angry that our case becomes relatively easy.

Q. You keep saying "he" and "him" when you talk about arrogant doctors. Is that intentional?

Allen: Well, I don't want to be sexist, but I'm afraid most of our defendants—particularly the arrogant ones—are men. And the surgeons tend to be the most arrogant of all. We once tried a case against a surgeon who sat there, expressionless, throughout the trial. One day, after court had adjourned, I asked his defense attorney, "Where's the guy's wife? How come she's not ... sitting in the front row, making him seem more human?" The lawyer said, "This guy doesn't want anybody to see his judgment questioned, particularly his wife."

Now that was a very tough trial for us, because we didn't have a strong case. But after it became clear that the jury didn't like this guy, we ended up settling for a sizable sum. I still think we would have lost that case if the doctor had been more human.

Doctors' arrogance usually becomes apparent during the deposition. Many resent being questioned or criticized, and they're angry at the legal system. But angry defendants make perfect targets for us, particularly when they're on the witness stand.

Expert Advice on How Not to Get Sued

Allen: Once you're sued, you've already "lost," no matter what the outcome. You're going to suffer emotional stress, major expense, and serious damage to your reputation. You're also going to lose income from the days or even weeks you'll spend away from your practice in depositions or in trial.

Burkin: The best way to avoid getting sued is to establish good relationships with your patients. The secret to creating those relationships is really very simple—it's not rocket science. You have to treat your patients with respect. Take time to talk with them, and even more important, to listen. When you send patients lab reports, add a personal note. Try to return calls promptly. If you can't do it yourself within a reasonable time, have someone else call. If your waiting room is backed up, why not send someone out to say, "We're sorry you've had to wait so long," and explain why you're running late? And when patients finally get to see you, offer your own apology. If that doesn't happen, patients get the message that you don't care how long you've kept them waiting.

Allen: A couple of other general rules: Write your charts as though they'll be read by plaintiffs' lawyers, not just by other medical personnel. Be accurate, and be thorough, but don't put anything in the chart that you don't want read aloud before a jury.

Finally, if you are sued, forget what you think of the legal system. Check your arrogance at the door, and follow your lawyer's advice. Remember, no matter how much you know about medicine, you're not an expert on malpractice law. Your lawyer wouldn't try to take over for you in the operating room, so don't tell him how to handle your case. And don't assume you're brighter than us plaintiffs' lawyers. Remember: once you're sued, you're in our OR. ■

Regulatory Relief Likely

Relief May Take a While But Reform Push is Strong

BY KATIE ORRICO, JD

Legislative and administrative activities seeking to minimize the regulatory burden on physicians are abundant. Significant changes have already occurred with the recent announcement by Tommy Thompson, Secretary of Health and Human Services, renaming the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS).

This “new” agency will now consist of three distinct centers. The Center for Medicare Management will be responsible for the traditional fee-for-service program (overseeing most physician payment policies and programs). The Center for Beneficiary Choices will focus on Medigap and Medicare+Choice programs. The Center for Medicaid and State Operations will have jurisdiction over Medicaid and the children’s health insurance programs.

Thompson pledged that the new agency will be significantly more responsive to the concerns of physicians and promised a series of administrative reforms aimed at reducing the regulatory hassles that physicians now face.

Congressional Pressure

The House Energy and Commerce Committee has launched a comprehensive Medicare administrative reform initiative and has been conducting oversight hearings in preparation for developing reform legislation. The House Ways and Means Committee has conducted its own hearings with the same purposes in mind. The Senate Finance Committee is likewise preparing to draft legislation along these lines.

Don Manzullo (R-IL), Chairman of the House Small Business Committee, also has been using his committee as a place to highlight the unreasonable paperwork burden placed on healthcare providers. The House Budget Committee has conducted its own set of hearings on Medicare reform, and James R. Bean, MD, an AANS member, recently testified before this committee. The Medicare Payment Advisory Commission (MedPAC) is currently working on a comprehensive report to Congress evaluating the regulatory burdens of Medicare on all providers. Finally, the General Accounting Office (GAO) has also weighed in with its own reports to Congress on this topic.

Key components of Medicare that could be reformed include:

- Requiring CMS to adequately educate physicians about Medicare’s ever-changing billing rules and procedures;
- Standardizing the timing and issuance of new rules and regulations on a quarterly basis;
- Reforming CMS’ audit process by giving physicians new due process rights, including an equitable right of appeal;

- Curtailing CMS’ use of unfair “extrapolation”—a process whereby CMS assumes that one mistake on a filing indicates the same mistake has occurred on all filings to that point;
- Eliminating random pre-payment audits, absent cause;
- Reassessing CMS’ Evaluation and Management documentation guidelines project and requiring that the new guidelines be pilot tested before they are implemented;
- Reassessing the rules and regulations of the Emergency Medical Treatment and Active Labor Act (EMTALA) to ensure that they are consistent with the original intent of the law;
- Reducing the number of carriers administering the program;
- Standardizing local medical review policies (LMRPs) to eliminate inconsistent Medicare coverage policies nationwide; and
- Streamlining and reducing Medicare’s paperwork burdens.

Outlook for Reform

Regulatory reform remains a high priority for President George W. Bush and Thompson. It is clear that some sort of Medicare administrative reform will occur before the end of the 107th Congress. Perhaps the testimony of William J. Scanlon, Director of Health Care Issues for the GAO, before the House Budget Committee best highlights the challenges:

“Medicare is a popular program that millions of Americans depend on to cover their essential health needs. However, the management of the program is not always responsive to beneficiary, provider, and taxpayer expectations. CMS, while making improvements in certain areas, may not be able to meet these expectations effectively without further congressional attention to the agency’s multiple missions, limited capacity, and constraints on program flexibility.

“The agency will also need to do its part by implementing a performance-based management approach that holds managers accountable for accomplishing program goals. These efforts will be critical in preparing the agency to meet the management challenges of administering the growing program and implementing future Medicare reforms.”

Let’s hope that all parties to this debate will take heed of this message so physicians will see some meaningful change that will help them better deliver care to Medicare beneficiaries without the hassles and frustrations of the current system. ■

Katie Orrico, JD, is Director, AANS/CNS Washington, D.C. Office.

Sweet Home Chicago

Chicago to Host AANS' 70th Annual Meeting

BY JAY COPP

Chicago, a world-class city bursting with first-class attractions, is a city with many nicknames. The Windy City. The Second City. The City of Big Shoulders. Well, the City that Works will work quite well for neurosurgeons. Chicago will host the 70th Annual Meeting of the AANS, April 6-11, 2002.

William A. Friedman, MD, Annual Meeting Chairman, and Ralph G. Dacey Jr., MD, Scientific Program Chairman, are planning a blockbuster meeting. Neurosurgeons will be offered cutting-edge scientific sessions, highly relevant practical clinics and valuable breakfast seminars. The icing on the cake is Chicago itself, celebrated internationally for its museums, architecture, theatre, music, nightlife, restaurants and lakefront.

The scientific programs and exhibits will be held at the McCormick Place Lakeside Center. The headquarters hotel is the Sheraton Chicago Hotel & Towers. Other hotels included in the room block are the Best Western Inn of Chicago, Embassy Suites Downtown Lakefront, Fairmont, Holiday Inn City Centre, Hyatt McCormick Place, Inter-Continental, Palmer House Hilton and the Ritz-Carlton. Shuttle service for the scientific program will be provided from all hotels except the Hyatt McCormick Place, which is within walking distance.

The exhibit floor, larger than ever before, will include the AANS Resource Center, a Residents' lounge, poster presentations, and an area for lunches and breaks. The AANS is expecting more than 200 exhibiting companies, taking up 80,000 square feet of booth space.

The Opening Reception will be held on Sunday April 7 at the Field Museum. Start the meeting out by mingling with your friends in the shadow of Sue, the largest tyrannosaurus rex ever discovered. At the Field Museum, you can get a bug's-eye view in Underground Adventure, descend into an Egyptian tomb, watch a glowing lava



flow, be dazzled by sparkling gems, stand nose-to-nose with man-eating lions of Tsavo and learn about the world's cultures.

The plenary sessions will include the Presidential Address, special lectures and the Cushing Oration. A very special event during the plenary session on April 8 will be a celebration of Harvey Cushing's 133rd birthday. The joint sections will hold their sessions and business meetings on Tuesday and Wednesday afternoons.

The Neurosurgery Research and Education Foundation (NREF) will host a major concert fund-raiser on Monday evening in the Arie Crown Theater at McCormick Place. Music legend Ray Charles, accompanied by his 17-piece orchestra and five vocalists, will present an evening to remember. Watch for future articles in the *Bulletin* to find out how you can buy tickets to support the NREF.

Chicago is a particularly appealing destination for children. Navy Pier offers 50 acres of parks, gardens, shops and restaurants. Enjoy the towering Ferris wheel and visit the Chicago Children's Museum. Children also will delight in the Museum of Science and Industry, the Shedd Aquarium, the Adler Planetarium, Buckingham Fountain, Lincoln Park Zoo and the Sears Tower SkyDeck.

For the older set, the world-class attractions are endless: the Art Institute of Chicago, the Museum of Contemporary Art, The Second City, a host of theatres, historic architecture, outdoor sculpture, blues clubs and ethnic restaurants of every type. It's a toddling town. It's sweet home Chicago. It's yours to enjoy for six days. ■

Registration materials for the annual meeting will be mailed in December. Updated information will be available on the Web at www.aans.org.



A Risky Tool: The Phone

Careless Telephone Conversations Can Lead to Lawsuits

BY MARK GORNEY, MD, AND JOAN BRISTOW, RN, MA

Of all the instruments you use in the practice of medicine, the telephone can be the most dangerous in terms of professional liability. When carelessly conducted, phone communications can lead to diagnostic errors and misunderstandings that culminate in medical malpractice claims. Telephone conversations are inherently deceptive, because reliable communication is incomplete without facial expressions or body language to clarify and qualify what the voice is saying. Early morning phone conversations between weary attending physicians and hospital house officers are especially dangerous.

One of the most hazardous communication combinations is the phone and the ER. Emergency rooms are often staffed by personnel who are unfamiliar with the patient's problem or are unable to recognize the danger of what appears to be a superficial injury (e.g., a moonlighting medical or psychiatric resident treating a head injury). By offering medical advice on the phone, you can legally become the attending doctor of a patient you have never seen. The best way to protect yourself from such potential liability is to practice effective telephone communication.

Practical Suggestions

- Obtain as much information as possible about the patient who is calling.
- Prescribe or advise by phone only when you know the patient's medical history.
- Accept a third party's description of a medical condition only when you have confidence in his or her competence to describe what he or she sees.
- Question the caller about his or her experience with a specific medical situation.
- Insist on repeating all vital instructions to patients to help ensure comprehension.
- Be especially wary of calls concerning abdominal or chest pain, fever of unknown origin, high fever for more than 48 hours' duration, convulsion, vaginal bleeding, head injury, dyspnea, a too-tight cast, visual alterations, the onset of labor, or paralysis.
- Be particularly careful that the pharmacist understands all dosages and instructions for drug prescriptions given by phone. Insist that the pharmacist recite the information back to you. Instruct your office personnel on the dangers of automatic, routine approval of prescriptions, even if they know a patient well. If anything adverse occurs, you are just as vulnerable to a claim by patients you know well as by those you do not. (Approval of certain prescriptions, such as tranquilizers, antidepressants, or hormones,

could prove particularly hazardous without periodic examination.)

- If you take a call for another doctor, be especially on guard against telephone miscommunication if you do not know the patient. Do not make hasty decisions based solely on phone conversations. In several instances, the covering doctor has been held completely responsible for damages resulting from a telephone diagnosis, while the original physician was exonerated.

Disastrous Cases

Late one night, following a cervical laminectomy, a 52-year-old patient manifested bilateral grip weakness and tingling in his fingers. At 2 a.m., the nurse telephoned a neurosurgeon who was on call for the patient's surgeon. The neurosurgeon had never seen the patient and later contended that he was not given a complete picture of the problem. Based on the assumption that the patient had routine complaints of pain, he gave the nurse some orders. The patient's motor deficits continued, and he ultimately became quadriplegic.

Although the neurosurgeon had never seen the patient, the court ruled that a doctor-patient relationship existed because the neurosurgeon had given orders for the patient. This case resulted in a \$1.2 million verdict against the covering neurosurgeon.

Another case involved a 42-year-old male who suffered from chronic back pain following an industrial work injury. The patient had been undergoing pain management, but felt that this therapy was no longer effective. He was referred to a neurosurgeon who performed a preoperative evaluation and scheduled surgery. The procedures were as follows: L4-5 and L5-S1 bilateral discectomy and L4-5/L5-S1 interbody fusion with instrumentation.

Postoperatively, the patient developed severe back pain. Nurse A transmitted this message to Nurse B in charge of the unit before she left for the day. Nurse B called the neurosurgeon and left a message for the neurosurgeon to call back. When the neurosurgeon called back, he ordered x-rays. The x-rays showed a definite spondylolisthesis, with an expulsion of one of the cages at left L4-5.

The radiologist placed a call to the neurosurgeon, but was distracted by a patient falling in his department before he completed the call. Radiology's report went to the nursing unit where it was filed in the patient's medical record. Although the patient had been medicated for his severe back pain, he was not made aware of the failed procedure until three days later. An unplanned return to surgery was completed; however, this patient now suffers from greater-than-before-surgery pain. An expert opinion revealed additional damage resulted from the three-day delay.

Continued on page 27

Court Rules for AANS in Austin Case

Federal Appeals Court Upholds Propriety of Professional Conduct Program

On June 12, 2001, the United States Court of Appeals for the Seventh Circuit issued its opinion affirming the summary judgment which the AANS obtained in the suit brought against it by former member Donald C. Austin, MD. Dr. Austin, whose membership in the AANS had been suspended for six months for unprofessional conduct in connection with his testimony as a plaintiff's expert in a medical malpractice suit and who later resigned, sued the AANS in 1998 in federal court. He claimed that his due process rights had been violated and that his fees as an expert witness had been greatly diminished as a result of the AANS' action. He also alleged that the AANS' entire professional conduct program was biased against plaintiffs' experts and therefore was inherently unfair. In granting the AANS summary judgment in October 2000, Judge Elaine Bucklo of the United States District Court for the Northern District of Illinois ruled that "Dr. Austin received as much due process as anyone might hope for."

In appealing Judge Bucklo's decision to the Federal Court of Appeals, Dr. Austin argued that professional associations such as the AANS have no right to judge the trial testimony of an expert witness and that to do so constitutes improper intimidation of potential witnesses. Judge Richard Posner, writing for the Court of Appeals, dismissed Dr. Austin's argument as follows.

"By becoming a member of the prestigious American Association of Neurological Surgeons ... Austin boosted his credibility as an expert witness. The Association had an interest—the community at large had an interest—in Austin's not being able to use his membership to dazzle judges and juries and deflect



the close and skeptical scrutiny that shoddy testimony deserves. It is no answer that judges can be trusted to keep out such testimony. Judges are not experts in any field except law. ... Judges need the help of professional associations in screening experts."

This ruling of the Court of Appeals establishes the principal that professional associations not only have the right, but indeed the duty, to use internal disciplinary measures to identify and sanction individuals who give inappropriate or shoddy testimony as alleged experts in litigation. The Court of Appeals also ordered Dr. Austin to reimburse the AANS for its costs of the appeals.

Russell Pelton, General Counsel for the AANS, noted that the AANS has won every judicial challenge to its professional conduct program, and that this was the highest court to address and confirm the propriety of such a program.

The AANS was supported in its appeal by an Amicus brief filed on behalf of the American Medical Association, the American College of Surgeons and the Illinois State Medical Society.

Dr. Lustgarten Drops Suit

Gary Lustgarten, MD, a Florida neurosurgeon, has voluntarily dismissed his suit against the AANS that challenged the propriety of the Association's Professional Conduct program.

The suit was filed after charges of unprofessional conduct were brought against Dr. Lustgarten by Mark Gold, MD. Dr. Lustgarten's complaint alleged that the AANS' Professional Conduct program was nothing more than a conspiracy to intimidate plaintiffs' medical experts from testifying, chilled the exercise of a neurosurgeon's right to give testimony in support of plaintiffs, restrained trade in violation of the Sherman Act and tortuously interfered with plaintiffs' experts' contracts with present and future patients injured by neurosurgeons.

The suit, originally filed in federal court in Brunswick, Georgia, was transferred to the Northern District of Illinois on motion of the AANS. That transfer was critical, reported AANS General Counsel Russell Pelton, because the federal court in Chicago is bound by the decisions of the Seventh Circuit Court of Appeals. The Seventh Circuit recently upheld the dismissal of the suit brought by Donald Austin, MD, which also challenged the propriety of the Association's Professional Conduct program. Shortly after the transfer, John Vail, Senior Staff Attorney for the Association of Trial Lawyers of America, counsel for Dr. Lustgarten, advised the court that they were voluntarily dismissing the suit. ■

New Subspecialty Committee

Senior Society to Direct Fellowship Training

The Society of Neurological Surgeons (the Senior Society) overwhelmingly approved the creation of a Committee on Accreditation of Subspecialty Training (CAST) at its most recent meeting in Cleveland. This committee will be responsible for accreditation of subspecialty training (fellowships) in neurosurgery.

The Senior Society was assigned responsibility for fellowship oversight training following a 1999 summit meeting in New Orleans with representation from neurosurgery's Residency Review Committee (RRC), Senior Society, ABNS, CNS and AANS. At this meeting the following guidelines were created:

- Certification for supplemental training will be institutional.
- There will be no subspecialty certification by the ABNS.
- The RRC would evaluate fellowships only in regard to their impact on residency training. The training of fellows must not adversely affect the resident core training.
- Flexibility in regard to timing and duration of additional training should be maximized. The concept of enfolded subspecialty training into residency elective time should be preserved.

Background

The following background information is critical to understand the development of CAST:

Accreditation by the RRC is the review of training sites. Thus the present role of the RRC in regard to supplemental training (i.e. fellowships) is restricted to evaluation of any adverse impact on residency training.

Certification by the ABNS involves an examination of individuals. In order for a fellowship to have ACGME approval, the following thresholds must be surpassed:



■ The content of the fellowship must represent a "new body of knowledge." This threshold in most circumstances prohibits the creation of an ACGME fellowship in established areas (i.e., spine, peripheral nerve and pediatrics) since these activities do not represent "new body of knowledge." In contrast, the recently ACGME-approved fellowship in interventional neurosurgery did represent a "new body of knowledge."

■ An ACGME fellowship must be 12 months in duration.

CAST was created under the guidance of a series of Presidents of the Senior Society: Drs. John Van Gilder, Bill Shucart, Buzz Hoff, Howard Eisenberg and Marty Weiss. CAST consists of a Chairman (H. Richard Winn, MD), Secretary/Treasurer (David Piepgras, MD), and three standing committees:

The Program Requirement Committee, which will be responsible for the creation of fellowship requirements.

The Appeals Committee, which will be charged with evaluating and adjudicating appeals.

The Outcomes Committee, which will access the impact of fellowship training on residencies.

The actual review of the fellowships will be performed by an Ad Hoc Committee whose membership will consist of two or three Senior Society members with relevant background (i.e., members of Joint Sections). Committee members will be asked to review the actual fellowship application and, if necessary, will make site visits.

Key Points

The key points of the fellowship requirements are outlined below:

Institutional eligibility: Fellowships must remain within institutions with ACGME approved (or equivalent) neurological surgery residency training programs.

Applicant eligibility: The fellowship will commence after completion of an approved residency program or at a senior level of residency.

Duration of training: Six months at a minimum and extensions must be based on educational rationale.

Duration of program approval: Five years at a maximum; re-review will coincide with six months of the ACGME review of the sponsoring residency program.

Qualification of program director: Must possess special expertise in designated area and be appointed by the Chair of the sponsoring neurological surgery residency.

Applications and guidelines for fellowships in peripheral nerve, spine and cerebrovascular have been sent to program directors for distribution to interested individuals. Applications are currently being accepted for review. The goal of CAST is to have fellowship applications reviewed and accepted by July 2002. More information and applications will be available on the Society of Neurological Surgeons' Web site at www.societyns.org. ■

H. Richard Winn, MD, is Chairman of the Committee on Accreditation of Subspecialty Training (CAST).

David C. Piepgras, MD, is Secretary/Treasurer of CAST. **Marty Weiss, MD**, is President of the Society of Neurological Surgeons.

Learning About Leverage

Leadership Conference in Washington a Capital Idea

Under the auspices of the Council of State Neurosurgical Societies (CSNS) and the Washington Committee, the first Neurosurgical Leadership Development Conference (NLDC) was held July 21-22 in Washington, D.C. Eighty people attended this highly interactive and informative conference.

The two overall goals of the NLDC were to inform and educate participants on key current issues that significantly affect today's practice of neurosurgery and to learn how to effectively "lobby" Congress on behalf of neurosurgery.

Specifically, participants were charged with seeking support from their congressional representatives on three fronts: passing a patient bill of rights, reforming the Emergency Medical Treatment and Active Labor Act (EMTALA) and supporting the Medicare Education and Regulatory Fairness Act of 2001. Two full days of speakers, workshops, and interactive seminars prepared participants to visit Capitol Hill to meet with congressional representatives.

An Excellent Program

An Education and Practice Management Course, sponsored by the AANS Education

and Practice Management Department, was held on July 22. Additionally, several faculty members made excellent presentations. These included Stan Pelofsky, MD, "How and Why You Should Build Your Own Specialty Hospital," Greg Przybylski, MD, "RBRVS, E&M Requirements," Sam Hassenbusch, MD, "CPT Coding, PATH Audits," Kimberly Pollock, "Creating a Fee Schedule, Containing Cost and Financial Benchmarking" and John Kusske, MD,

David F. Jimenez, MD, FACS, is the Chairman of the CSNS.



"EMTALA and Other Regulatory Issues" and "Implementing and Maintaining a Compliance Plan."

Seminars were held on July 23 on grassroots advocacy, public speaking, effective communication with congressional offices and preparation for congressional visits.

Among the notable keynote speakers was Rep. Ernie Fletcher, MD, (R-KY), sponsor of patients' rights bill H.R. 2315. Additionally, congressional staffers made presentations, which served to further educate members regarding Capitol Hill visits.

Overall the program was highly successful in motivating participating neurosurgeons. Given the overwhelming success of the conference, plans are under way to consider a second NLDC next year during the hotly contested upcoming elections.

CSNS to Meet in September in San Diego

The next meeting of the CSNS will take place September 28-29, 2001, at the Marriott Hotel in San Diego. Several resolutions have been introduced and reviewed by the Executive Committee. These include: The Role of Midlevel Practitioners in the CSNS, Facilitation of the Think First Foundation, Disciplinary Actions for the AANS and CNS Members on False Testimony and Reimbursement Methodologies.

There are plans for further presentations and leadership development, particularly at the state level. Presentations on how to become involved with your state medical society and on how to effectively lobby at the state level for neurosurgical issues also will be made.

The Council continues to be very productive and an excellent venue for grassroots neurosurgical initiatives. If you have any innovative ideas, issues or concerns that affect the way you practice neurosurgery, you can have them addressed by contacting your state delegate. Or you may e-mail me at JimenezD@health.missouri.edu or send a fax to me at (573) 884-5184. ■



Rep. Ernie Fletcher (R-KY) speaks at the NLDC conference on the Patients' Bill of Rights legislation.



Rep. John Cooksey (R-LA) gives the luncheon keynote speech.

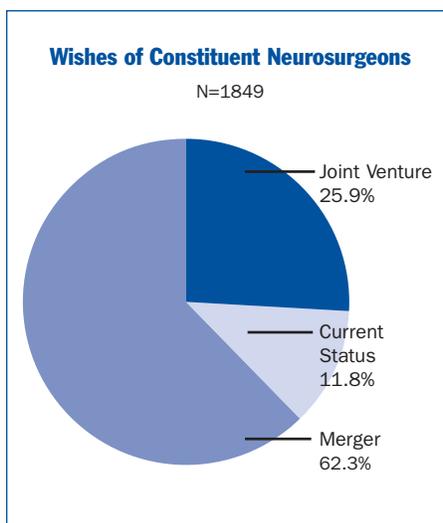
To Merge or Not to Merge

Neurosurgeons Prefer Combining AANS and CNS

At the March 2000 Executive Committee meeting of the Council of State Neurosurgical Societies (CSNS), a resolution was proposed to poll AANS and CNS members on merging the infrastructure of the two organizations. The resolution was presented to the CSNS Assembly at the Plenary Session of the April 2000 CSNS meeting. It was passed with a modification that required the survey tool be given to the AANS and CNS leadership for review and comment prior to dissemination. The development of the survey was assigned to the Medical Practices Committee of the CSNS.

The Yale School of Medicine Biostatistics Section was consulted for assistance in developing the initial survey. Once completed, the survey was submitted for review to the AANS and CNS leadership. The survey instrument was then presented to the CSNS Executive Committee meeting in August 2000. The CNS was represented by Dan Barrow, MD, and the AANS was represented by Stan Pelofsky, MD. After extensive discussion, the survey was revised and simplified. The emphasis on merger was changed to levels of integration: merger, joint-venture or no change in current status. The abridged survey was then presented to the membership of the CSNS with the leadership of the AANS and CNS in attendance. After intensive criticism and eloquent discourse, a final survey document was adopted.

The survey was distributed during November 2000. A total of 5,809 questionnaires were mailed to AANS members (Active, Senior, Provisional, Lifetime and Candidate) and to CNS members (Active, Senior, Transitional and Resident). A total of 1,849 surveys were returned, a 32 percent response rate. (Forty-one surveys were returned as undeliverable by the U.S. Postal



Service.) The replies were collected, tabulated, and analyzed employing Chi-Square methodology. The statistical analysis was performed at the University of Nebraska School of Medicine.

In summary, the survey respondents favored change. A merger of the two organizations infrastructure was favored by 62.3 percent. A joint-venture that would maintain the individual organizations but integrate aspects of leadership, meetings and mission was favored by 25.9 percent. The maintenance of the current status was preferred by 11.8 percent.

The demographic profile of the respondents corresponded quite well with those of the parent organizations. For respondents with an AANS affiliation, there were 894 active members, 64 lifetime members, 72 provisional members, 27 candidate members and 28 resident members. For respondents with a CNS affiliation, 832 were active members, 12 transitional, 70 senior and 43 resident. The median age of the respondents was near 50, with those 50 and above numbering 989 and those younger than 50 numbering 860. Male respondents

numbered 1,755, while females numbered 84. As for practice affiliation, 1,164 respondents were in private practice, 468 were in full-time academics and 145 were in neither category (retired, residents, etc.).

A cross tabulation between demographic subgroups and opinion responses was evaluated by employing Chi-Square analysis. Comparison of AANS membership categories failed to show significant subgroup differences.

However, if the subgroups were manipulated by combining the Provisional, Candidate and Residents, there was a significantly smaller majority favoring an organizational merger. Analysis of the CNS membership also failed to demonstrate significant differences of opinion across membership categories.

Dividing the respondents at age 50 also failed to demonstrate significant differences of opinion. Gender analysis also showed a near congruence of respondent distribution.

Analysis of practice affiliation did demonstrate a significant difference among the subgroups. The difference being that a greater percent of private practice favored merger than their counterparts in academia. Nevertheless, the academic respondents favored merger by greater than 50 percent.

The issues surrounding organizational integration between the AANS and CNS are numerous. Although this survey may have design or analytic flaws, it does exhibit that more than 88 percent of respondents favor organizational change. The degree that organized neurosurgical leadership can work toward these ends will be followed closely by their constituents. ■

Gary M. Bloomgarden, MD, is Chair, Medical Practices Committee, Council of State Neurosurgical Societies.

EMTALA: Where We Stand

GAO Unable to Measure Overall Impact

In a new report, the General Accounting Office (GAO), Congress' watchdog agency, generally stands by the Department of Health and Human Services' (HHS) interpretation of the Emergency Medical Treatment and Active Labor Act (EMTALA). The GAO also places faith in the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) to clarify provisions that bedevil providers.

The medical community is concerned that EMTALA creates burdens for hospitals and physicians such as overcrowded emergency departments. EMTALA requires emergency rooms to furnish screening exams and stabilizing treatment to patients with emergency medical conditions regardless of their ability to pay. (AANS *Bulletin* Vol. 9, Spring 2000.) Hospitals must start treatment before checking insurance status, and they must follow rules when they transfer patients to hospitals that are better equipped to deal with a particular condition. The rule was expanded in 2000 to cover a main hospital campus and off-campus provider-based facilities.

Lack of Dumping Data

The GAO report, titled *EMTALA Implementation and Enforcement Issues*, states that hospital and physician representatives say that EMTALA has been beneficial in ensuring access to emergency services and reducing the incidence of patient dumping. The GAO concludes, however, that the overall impact of EMTALA is difficult to measure because there are no data on the incidence of patient dumping before its enactment. The only measure of current incidence, that is, the number of confirmed violations, is also imprecise.

Many hospital administrators and physicians with whom GAO spoke said that the implementation of EMTALA

adversely affects the efficiency and types of services provided in emergency departments and results in additional costs. Hospitals and physicians also expressed uncertainty to GAO about the extent of their responsibilities. For example, they have questions about how EMTALA applies to certain on-campus and off-campus hospital departments, known as provider-based facilities. It was asked whether walk-in patients could supplant scheduled patients by claiming their conditions are emergencies.

The extent to which providers are obligated under EMTALA to render follow-up care to emergency department patients was also discussed. The erroneous belief has

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Chair of the AANS
Managed Care
Advisory
Committee.



spread that EMTALA obligates full treatment all the way to cure. This is not so, according to CMS. Hospitals' obligations end once the patient is "stable for transfer."

CMS officials told the GAO that they were aware of the difficulty providers have encountered in implementing some aspects of EMTALA and that it plans to provide more guidance and re-establish an advisory group of EMTALA stakeholders.

Few Violations Found

The report illustrates that the numbers of EMTALA violations and fines have been relatively small, and hospital's Medicare provider agreements have rarely been ter-

minated. Since 1995, CMS regional offices have directed state survey agencies to investigate about 400 hospitals per year and have cited about half of them for EMTALA violations. The numbers of investigations and proportion of confirmed violations vary among regions. CMS is taking steps to increase consistency among regions, which could assist providers in their efforts to comply with EMTALA.

From 1995 through 2000, the OIG imposed fines totaling over \$5.6 million on 194 hospitals and 19 physicians. The majority of hospital fines were \$25,000 or less. The total number of physicians ever fined by the OIG for EMTALA violations is 28. EMTALA has resulted in only four hospital exclusions.

The study comes as the American Medical Association (AMA) drafts a proposal to stop CMS from expanding the law to provider-based facilities. AMA wants the law to apply only to hospital emergency departments, and it wants Medicare and private insurers to pay for the screening and stabilizing of patients required by EMTALA. Adding to industry concerns, the U.S. 9th Circuit Court of Appeals ruled last January that EMTALA applies to non-hospital ambulances still en route to a facility. The court said a patient who died in an ambulance headed for Queen's Medical Center in Honolulu showed up, for the purposes of the law, at the emergency department when the paramedics discussed the patient with a Queen's emergency physician by radio and was diverted before arriving at the facility.

Neurosurgeons should be aware that without much pressure from GAO, CMS seems less likely to satisfy the requests of hospitals and physicians for negotiated rulemaking to subdue EMTALA. *Medicare Compliance Alert* (July 9, 2001) reports that a CMS spokesperson says Administrator Tom Scully will review the issues before the agency convenes an advisory committee on EMTALA. Stay tuned. ■

RBRVS: A Management Tool

Fee Schedules Can Reflect Practice Costs

Although the Resource-based Relative Value System (RBRVS) is the method applied by Medicare to determine payment for physician services, the same principles can be used in your practice to establish fee schedules as well as to determine your cost in providing a particular service. Given declining reimbursement, it is particularly important for physicians to know their costs before committing to third-party payer contracts that might provide insufficient reimbursement.

The concept of RBRVS actually originated half a century ago based on median charges reported by California Blue Shield. Although a charge-based RBRVS was supported by surgical subspecialty societies, a resource-based system supported by non-procedural specialty societies prevailed.

The American Medical Association (AMA) supported a system based on resource costs as long as the payment system allowed balanced billing and reflected geographical variations in cost. Antitrust concerns precluded direct physician involvement in the development of a physician payment system. Eventually, the AMA accepted the proposal by William Hsiao, PhD, and Peter Braun, MD, of the Harvard University School of Public Health.

The Omnibus Budget Reconciliation Act of 1989 mandated a Medicare fee schedule based on RBRVS derived from the Harvard study with inclusion of physician work, practice expense and malpractice costs with geographical adjustments for each of these three components. It was estimated that physician work comprised just over half of the total RVU, whereas practice expense comprised approximately 40 percent of the service value. A conversion factor from relative value units (RVU) to dollars was used to provide a mechanism for Medicare to achieve



expenditure targets. The Medicare conversion factor for 2001 is \$38.88.

RVU as a Surrogate

The RBRVS system attempts to measure physician work on an equitable scale, such that the “value” of different physician services can be similarly measured across physician specialties. There is also an estimate of the cost (practice expense and malpractice cost) built into the RVU of each procedural code. Although practice costs are not linearly related to physician work, the RVU can serve as a surrogate. Consequently, a fee schedule can be constructed based on a “conversion” factor determined by the practice and applied to the RVU assigned by Medicare to procedural codes.

However, the appropriate conversion factor for a given practice is influenced by many factors. Certainly, one of the most important components that should drive the conversion factor is the practice cost including personnel, equipment, insurance (disability, health, malpractice) and others. The practice manager should determine the average annual RVU performed for the entire practice as well as stratified by individual physician. The RVU can be separated into E&M and procedural services. One must be careful to account for “reduced” RVU when modifiers are appended (e.g.,

–51 multiple procedure modifier reduces RVU by 50 percent) to more accurately account for the physician services performed. As a result, simply dividing the total practice (or individual physician) costs by the RVU performed during the same period provides a cost/RVU figure that reflects the expense to provide physician services.

Determination of cost/RVU is essential in negotiating contracts with third-party payers. Since many third-party payers have adopted fee schedules based on RBRVS, it is to your advantage to determine your costs similarly. First of all, your analysis of the payment schedule is more meaningful once you have determined your practice cost to provide the service. For example, I evaluated a large physician practice in which fewer than one quarter of the physicians had a cost/RVU below the Medicare conversion factor. When discussing the proposed payment schedule with insurers, one can quickly determine whether the practice can afford the terms.

Secondly, the cost analysis allows the physician to see where costs can be reduced. Finally, one can assess the time required to perform particular services. Certain services may be more economical than others, thereby allowing the physicians to focus efforts on their most efficient services.

Conclusion

The RBRVS has been a tool used by Medicare and third-party payers to create a reimbursement system in which costs are much easier to manage. Physicians should take advantage of this same system to analyze their practice costs in terms of services provided. This will not only improve efficiency and identify areas for cost containment, but will also facilitate educated negotiations so that the practice does not agree to contracts whose terms are unsustainable in this difficult health market. ■

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The Path to Great Discoveries

Absent Luck or Genius, Scientific Method is Best Bet

Great discoveries are made in many ways. Three are obvious. Luck is probably the most exciting. Discovery of gold in 1849 at Sutter's Mill in the Sierra Nevada foothills is a good example. Perhaps even more astounding is discovery that comes from the mind of a genius. Examples are Da Vinci's design of an airplane based on his observations of birds in flight and Einstein's theory of relativity and its impact on our basic understanding of matter. A third avenue to great discovery is through the scientific method. Discoveries such as penicillin, MRI, television and computers were derived by thousands of incremental steps in laboratories over decades. This third way to discovery, while less dramatic than the other two, is equally productive.

Most of us are not lucky, at least not enough to discover something important or even win the lottery. And most of us are not blessed with the mind of a genius. On the other hand, most of us are blessed with intelligence and an environment that enables us to make discoveries through the "bit by bit" method. Discovery through research requires training. The same is true for skills that must be learned through training, whether those of a neurosurgeon, a baseball star or a blacksmith. The essentials of research training for neurosurgeons are known to many, but are available only to a few, unfortunately. The essentials are: 1) protected time 2) equipment and space, 3) money and 4) mentoring. The mentor knows the scientific method and how to teach it.

A Tried and True Method

The recipe for success is simple, but its execution is often complicated. The following is a typical pathway for researchers. Research begins with a question. A tenta-

tive answer is formulated in the form of a hypothesis. The answer or hypothesis must be testable, i.e., is it true or not true? The hypothesis states the essence of the experiment and is the first building block for the project. The hypothesis must have as few variables as possible. The more variables, the more difficult to test. A protocol is derived from the hypothesis, and a sequence for the experiment is formulated. The mentor is essential throughout

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this process because he or she provides knowledge and experience to know whether the experiment is feasible or not.

Pilot experiments then follow in order to test whether the real experiment is doable or not and whether the variables are too many or not. Statistical analysis of the data stems from the pilot study. The experiment now begins with an expectation that the hypothesis stated at the beginning will be proven or disproven by the results.

Analyzing the data is the final step of the project. Then comes writing required for presentation in the scientific literature or at a scientific meeting or both. Writing skills and precise language are essential in order for the project to be interpretable by the scientific community and publishable by journals. The satisfaction derived from a successful project can be thrilling and worth frustrations that are inevitable with any research project.

Clinical research is done in the same manner. Hypothesis testing follows a good idea. Data accumulation and statistical analysis of it are essential to prove or disprove the hypothesis. Training involves population studies, epidemiologic techniques and outcomes methodology requiring meticulous follow-up, and a stringent limitation of variables. Clinical research can be difficult because many variables are inherent in any human condition that warrants study.

There are other types of research we can do. The development of surgical tools and instruments is one. Neurosurgeons became interested in spine instrumentation because it was new to our specialty, it seemed to improve our results and it was a large part of our daily experience. Collaboration with industry paid off for all neurosurgeons, stimulating new products from industry with consultation by many practitioners. The development of outcomes research has also expanded our specialty and its research opportunities. Clinical trials of drugs and other treatments, both prospective and retrospective, also contribute new knowledge.

Support Produces Results

The Neurosurgery Research and Education Foundation (NREF) has funded research training for young investigators for more than 20 years. More than \$2 million have been expended in this effort. The track record for productivity has been remarkably good with more than 50 percent of trainees supported by the NREF pursuing careers that blend research and patient care.

The NREF continues to need the generous support of all neurosurgeons in order to continue research and development of our specialty. To make your contribution to the NREF, kindly contact Bobbi Burgstone, Director of Development, at (847) 378-0540. ■

Julian T. Hoff, MD, is Chair, Executive Council, Neurosurgery Research and Education Foundation.

Advancing the Specialty

Neurosurgery Research and Education Foundation
2000-2001 Campaign Results

Each year the Neurosurgery Research and Education Foundation (NREF) conducts a charitable campaign to raise funds to award research fellowships, which are vital to the advancement of the neurosurgery specialty. Support of NREF by AANS members is greatly appreciated and critical to the success of the program.

The 2000-2001 NREF Campaign ran from July 2000 through June 2001. Extraordinary philanthropic gifts, ranging from \$50,000 to \$100,000, were given by Albert Rhoton Jr., MD, the Lester Mount Estate and Mrs. E. Laurie Bittner.

The Executive Council of NREF is pleased to acknowledge generous contributions received from AANS members, laypeople and corporations:

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Gifts of \$5,000 and up

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House of Delegates Report

AMA Acts on Issues Affecting Neurosurgeons

The American Medical Association House of Delegates considered several issues important to neurosurgery at its meeting in mid-June.

Dr. Carmel's Candidacy

Peter Carmel, MD, ran an excellent race for election to the AMA Board of Trustees but, unfortunately, was unsuccessful by just a few votes. Neurosurgery is a small organization and does not have much leverage. Nevertheless, Dr. Carmel ran a superb campaign and his excellent qualifications made him a very good candidate.

It was extremely gratifying to see the neurosurgical community come together in support of Dr. Carmel's race. So many delegates reported that they were astonished to receive personal calls from neurosurgeons throughout the country in support of Dr. Carmel. It is a great compliment to the fraternity of neurosurgery that even though our numbers are small, we do come together.

Dr. Carmel is assessing whether he will run for the Board next year. If he decides to do so, the AANS will once again call on

neurosurgeons to assist in this endeavor.

Thompson Speaks

"I need your help" was the message to the House from Tommy Thompson, U.S. Health and Human Services Secretary. Thompson said that he is committed to eliminating hassles in Medicare rules that interfere with the physician's ability to care for their patients. He has changed the name of the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS) in an attempt to change the image of the department. The House gave Thompson a standing ovation when he said, "If you do your job of bringing to the forefront those things that don't make any sense with advice and suggestions on how we can improve it, we are going to change this system together."

Several Resolutions Adopted

Actions taken by the AMA House of Delegates included:

- A directive for the CPT Editorial Panel and specialty societies to develop spe-

cialty-specific clinical examples for evaluation and management codes. The panel was directed to work with CMS to refine the draft examples that CMS is currently developing. Led by neurosurgeon Troy Tippet, MD, delegates stated that the draft examples are "seriously flawed" and amount to down coding.

- A vote urging the Office of Inspector General to modify its Compliance Program Guidance for individual and small group physician practices.

- A request that the Board of Trustees decide whether the AMA should ask Congress to repeal the privacy regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA).

- A call for revisions in Medicare reimbursement rates for services provided to the same patient in the emergency room and as an inpatient.

- A study of overcrowding of emergency rooms and ambulance diversions.

- Praise for former Rep. Tom Campbell's (R-CA) efforts to secure antitrust relief so physicians can jointly negotiate with health plans.

- A requirement that AMA "take a proactive" role with all stakeholders in developing standards for digital medical management systems. ■

Mark J. Kubala, MD, a neurosurgeon in private practice in Beaumont, Texas, is the AANS delegate to the AMA's House of Delegates.

Continued from page 17

These cases display faulty communication on behalf of all healthcare providers.

The Need to Document

Disagreements about what was said are invariably a major problem when cases are tried. It is of prime importance, therefore, to obtain all of the necessary information on the phone, and if you still feel there is any area of ambiguity, we strongly advise that you visit the patient. An alternative is to have either a physician in the hospital or another nurse check the patient. The critical point is

that you must arrive at an accurate and totally reliable appraisal of the patient's condition either while you are on the phone or within a few minutes thereafter.

The information you received, what you advised, and the orders you gave need to be recorded immediately to avoid future discrepancies about what was said. This is especially important when the phone call occurs after office hours or on weekends. During office hours, take steps to resolve the caller's questions and problems. The patient's problem should be appropriately referred and

the process should be documented. Tell the caller when the physician is most likely to follow up to ensure that the questions and problems were resolved on schedule.

Effective communication is particularly important when telephone communication is involved. Physicians who are careful in their use of the telephone will reduce misunderstandings that can lead to legal action. ■

Mark Gorney, MD, a plastic surgeon, is a founding member and medical director of The Doctors' Company. **Joan Bristow, RN, MA**, is vice president of TDC Risk Management.

New Educational Products

AANS Offers Additional Resources

As the practice of neurosurgery continues to evolve, the Education and Practice Management Committee, in conjunction with the Department of Education & Practice Management (EPM), not only keeps pace but is continually offering new educational products and services to assist our neurosurgical membership in staying “one step ahead” of competition, the regulatory environment and payers. Here is a summary of the latest educational services offered by the Department of Education & Practice Management.

New Educational Offerings

Neurosurgical Practice Management: Improving Your Competitive Advantage. This new course focused on how neurosurgeons and their practice administrators can improve their competitive advantage via effective strategic planning, financial management and practice marketing. The course was designed to provide practice management strategies specific to neurosurgery that will provide an effective and immediate impact.

Beyond Residency: The Real World. For the first time, the AANS is coordinating a one-day coding and practice management course designed to assist residents in preparing themselves for the “Real World.” Topics will include basic coding, legal issues, how to evaluate a job and establish a practice, practice management and the advantages and a comparison of academic vs. private practice.

Educate Yourself and Your Practice Staff Without Leaving the Office. AANS and Economedix, LLC have partnered to present 21 of the best, most cost-effective practice management training seminars brought into your medical practice office via the online education. The seminars are

presented live from the Internet and heard via teleconference or can be accessed 24 hours a day, seven days a week through seminar-on-demand technology. Courses include: Human Resources, Compliance and Medicare, Patient Flow and Marketing, Coding and Reimbursement and Financial Management. Each course can be viewed by an unlimited number of practice employees and physicians for only \$99.

In 2002, EPM will also develop clinical courses, focusing first on spine and neuroendoscopy. Watch for upcoming course information on www.aans.org.

Bedrock Courses

The following courses form the very strong foundation of the AANS’ Education and Practice Management program. Changes and updates to these courses occur every year to ensure that the educational activity continues to meet the complex needs of our neurosurgical membership.

Managing Coding & Reimbursement Challenges in Neurosurgery: 2001. This is a new and improved advanced coding and reimbursement course that addresses issues specific to today’s complex neurosurgical practice. New course content this year includes a compliance program section and an extended length of time dedicated to practice coding sessions.

Neurosurgery Review by Case Management: Oral Board Preparation. This highly interactive course assists board candidates in becoming familiar with the mechanics of the oral exam and at the same time provides an intense review of clinical neurosurgery in an enjoyable format. This course is an intense learning experience in a group setting and breakout session format. The Oral Board Review course is considered the “must have” educational experience to assist

with successful completion of oral board exams.

Publications and Other Resources

EPM also is focused on providing the resources necessary to succeed in the current state of healthcare delivery and practice. The following are just a few of the new and updated publications that have been developed to achieve this goal:

Practice Compliance Handbook. In response to the Office of Inspector General’s “Compliance Program for Individual and Small Group Practices,” the AANS developed this binder of valuable information. The handbook reviews the seven components of a compliance program and provides the tools needed to customize a program for your practice.

A Guide to Coding Procedures for Neurosurgery. Originally published in 1998, this guide was completely updated in April. It is a collection of procedure-related information designed to facilitate the efforts of neurosurgeons and their staff in the accurate and prompt coding and processing of procedure claims.

Express Code: Quick Reference to ICD-9 Coding. This new coding resource contains over 300 codes which are frequently used in neurosurgical practices.

Neurosurgeon’s E&M Reference Card. This is an updated pocket-size guide to the basic coding and documentation guidelines for Evaluation and Management Services specific to a neurosurgical practice.

Our Mission

The EPM mission is to “assess, develop, provide, and continually evaluate appropriate and effective educational products to support its members’ educational needs.” We continually strive to fulfill the mission by developing products that exceed the expectations of our membership. For information, call Jane Ries at (847) 378-0558.

David F. Jimenez, MD, is Chair of the Education and Practice Management Committee. **Jane M. Ries, MHA,** is Director, AANS Department of Education & Practice Management.

Successful Job Strategies

Networking—the Old Standby—Remains the Best Tool

Editor's Note: Copyright © 2001 by Medical Economics. Reprinted by permission from MEDICAL ECONOMICS magazine, www.memag.com. This article has been edited for length.

Neurologist Richard M. Ransohoff, MD, of Cleveland remembers when a colleague passed along a letter from a senior medical student in Denmark who was looking for a job in the United States. Ransohoff wasn't interested in someone so junior, but since he happened to be going to a meeting in Norway, he agreed to meet the young doctor. Ransohoff was so impressed with the man that he hired him.

For physicians, job hunting conjures up thoughts of newspaper and journal ads, executive search firms, and, more recently, Internet job sites and bulletin boards. These methods of looking for a clinical position can work and should be part of any job seeker's arsenal, but the most powerful way to locate and secure challenging and rewarding jobs is through direct contact with other people. Ransohoff summarizes the process of recruiting as "a guy knows a guy who needs a guy."

William S. Beckett, MD, an internist at Finger Lakes Occupational Health Services in Rochester, N.Y., believes that searching for a job in medicine is a lot like looking for an apartment in New York City. "Everyone knows that the really cool apartments are found by word of mouth, not by looking at newspaper ads," he says. "The same is true for clinical positions in medicine."

Molly D. Shepard, president of Shepard Executive Resources in Philadelphia, concurs: "In counseling high-level executives and physicians, I have found that at least 85 percent of the really good, exciting jobs are found through personal contacts. There is no doubt that networking is the one key skill for any job hunter."

Network with Everyone

Networking serves many functions: It can lead to discovery of available jobs, introductions to influential people in your field, and priceless feedback on how well you're presenting yourself, how effective your resume is, and how realistic your goals are.

For networking to be most effective, you need to begin well before you're ready to land a job. You also need to balance the give-and-take in these relationships. As psychiatrist Gigi Hirsch observes in *Strategic Career Management for the 21st Century Physician*, "If you develop a reputation as a 'taker' rather than a 'sharer,' your ability to network will be drastically diminished." Realize that you are a potentially valuable resource for those you meet, and do what you can to reciprocate, she says.

Who's good to network with? Everyone. People you meet in the course of your day, or identify by doing Internet research, or talk to on the phone, or know as an opinion leader in your field can all help. You can never tell who will lead you to your next job, as ob/gyn Janice B. Asher, MD, learned when she moved from Chicago to Philadelphia with her attorney husband. "Three teen-age girls welcomed us to the neighborhood with home-baked brownies," she recalls. "We became friendly and had a nice talk. After I revealed my occupation, they returned to their house to tell their father, who immediately rushed over and started

recruiting me for his hospital. He was an internist who knew that the ob/gyn department desperately needed doctors."

But networking is seldom that passive. "You really have to work at not becoming insulated in your daily cocoon," says Hirsch, founder of MD IntelliNet, a firm in Brookline, Mass., that helps physicians diversify their careers. "Join clubs and associations that introduce you to people other than your colleagues in a particular specialty. Periodically take CME courses that don't relate to your specialty. Keep your feelers out."

Hirsch recalls one physician with expertise in alternative medicine who made a deliberate effort to become known to the key players of the healthcare system he worked for. As a result of his efforts, he was named director of all alternative medicine initiatives across the entire system.

Of course, your peers can be helpful, too. The colleague you schmooze with at those annual meetings may provide you with just the right information at just the right moment. That's what happened to pathologist John D. Olson, MD, when he and his family decided to leave Iowa in search of a warmer climate. "I started my search on the Internet by looking at the job bulletin board on the Web site for the American Society for Investigative Pathology," says Dr. Olson. "One listing was for director of clinical laboratories at the Uni-

NEUROSURGERY://OC IS A GREAT RESOURCE

NEUROSURGERY://ON-CALL® offers a number of networking and job search opportunities. Visit the Young Neurosurgeons section (www.neurosurgery.or/yons/index.html) for links to the AANS Young Neurosurgeons Committee, the Job Placement Service and the Young Neurosurgeons listserv. Additionally, residents, who automatically are AANS Candidate members, can subscribe to the *Journal of Neurosurgery* at a reduced price and receive discounts on meeting registrations.

versity Health System in San Antonio, and I sent in an application.”

After hearing nothing for months, Dr. Olson assumed the position had been filled. But when talking with a fellow pathologist in Arizona he had known for years, he learned the position was still available. Dr. Olson called the chair of pathology in San Antonio to express his continued interest and eventually landed the job.

Keith Pryor, a Philadelphia-based consultant and career counselor, encourages job seekers to keep in touch with a network of contacts by e-mail, and to cold-call influential leaders in a particular field. “Most people are willing to talk with a fellow professional who calls up for 15 minutes of mentoring,” he says. “Who can resist giving advice and being regarded as an expert?”

Can You Find a Position Using the Net?

Networking isn't the only job-hunting strategy, of course. In addition to scanning newspapers and professional journals, doctors are increasingly turning to the Internet to ferret out job openings. However, plum opportunities are rarely advertised on the Web, and even if they are, you'll face stiffer competition than if you learn about the job from a contact before it's advertised.

Still, using the Web may give you a slight edge in getting your CV in front of employers who advertise in medical journals if the journal routinely runs online classifieds before putting them in print. *The New England Journal of Medicine* (www.nejm.org/careerlinks), for instance, gives its registered members the option of receiving e-mail job alerts of new openings before they're listed in print or online.

If you're just beginning your search, browse the Web sites for your specialty society and the larger recruiters such as Cejka & Company (www.cejka.com), CompHealth (www.comphealth.com), Merritt, Hawkins & Associates (www.merrithawkins.com), and Weatherby Health Care (www.whcfirst.com). Also consult the *Medical Economics* Career Center site at www.memag.com or www.hospitalhub.com/medec. In addition

to job listings, you may find current physician compensation surveys, CV writing tips and other career information.

The Web can also help job seekers research specific employers, jobs, or geographic locations or obtain information on potential networking contacts.

The Value of Recruiters

Recruiters are another way to supplement job-hunting efforts. Just remember that recruiters make their money from employers, so that's where their loyalty lies—no matter what they tell you. And don't look to them for long-term career counseling or to answer questions such as, “How do I leave practice and get a job in administration?” Those questions are better addressed to a career coach or counselor.

Recruiters may have leads that you couldn't easily get elsewhere. Or they may not. “When I've engaged recruiters to find someone for my practice, they've tended to present the same candidates who contacted me after reading my ad in *The New England Journal of Medicine*,” complains pulmonologist Ira P. Krefting, MD, from Silver Spring, Md. Most recruiters work on either contingency or retainer. The contingent firms typically recruit for lower-paying positions, and they don't have an exclusive contract for the jobs they seek to fill. “Rarely do they have an opening in a prestigious practice in a metropolitan or suburban area,” says Dr. Krefting.

On the plus side, recruiters are good at providing valuable information and setting up interviews, Dr. Krefting says. They should be able to provide the information you need, for instance, to determine whether a community is right for you. Realize, too, that the quality of recruiting firms varies greatly. To size up the firm, he says, ask how many doctors the firm places annually, how long doctors stay in those positions, and whether recruiters visit a practice before advertising it. ■

Kent Bottles, MD, is a pathologist and president of a biotechnology firm in Cambridge, Mass., that has run physician workshops on career change.

Need A Job?

POINTERS ON HOW TO NETWORK

- Don't be shy. People enjoy helping enthusiastic, optimistic job seekers who are determined to help themselves.
- Start networking before you need a job. Keep in contact with your professional network by regular e-mails, telephone calls, visits, and letters. Send (via e-mail if possible) newspaper clippings of stories that might interest them.
- Don't brush off anyone. Every new acquaintance is a possible connection, even if he isn't in a medical field.
- Always have a business card handy, and remember to get a new contact's address, phone number and e-mail address.
- Write a thank-you note to those who go out of their way to help you.
- Make appointments for mentoring with opinion leaders and experts in the field you want to work in.

MORE TIPS FOR THE JOB HUNTER

1. If you're married to another physician and your spouse is in a specialty where there are very few jobs, help your spouse find a job first. Then look for something within comfortable commuting distance.
2. Young physicians who are seriously entertaining the notion of solo practice should work for a group first. This will not only provide a steady paycheck—which can speed repayment of debt—but invaluable experience. You can learn a lot about the workings of an office—and decide what you want to emulate and what you want to do differently—by working for another practice first.

Whither Healthcare?

Consumerism and Technology Likely to Reign

It's not easy to understand why the outstanding books on the future of healthcare are coming out of Denver. But since lots of good things are coming out of the West, please don't hold that against these two books.

We have come to the end of an old era and an old way of thinking. It's time to reassess and look to the future. *Beyond Managed Care* attempts to do that. The book is divided into four sections. Part I is lessons learned from the past two decades. Part II examines financial resources available to fund healthcare. Part III looks at external factors influencing the healthcare marketplace of the future. These include population and income growth, the aging of the population, the growing role of consumers, the capacity of healthcare providers and the effects of governmental regulations and laws.



Beyond Managed Care: How Consumers and Technology Are Changing the Future of Health Care by Dean C. Coddington, Elizabeth A. Fischer, Keith D. Moore and Richard Clarke. Jossey-Bass, 335 pages, ISBN 0-7879-5383-0, 2000.

Strategies for the New Health Care Marketplace: Managing the Convergence of Consumerism and Technology by Dean C. Coddington, Elizabeth A. Fischer and Keith D. Moore. Jossey-Bass, 418 pages, ISBN 0-7879-5593-0, 2001.

All of this leads to Part IV, which describes four possible healthcare scenarios of the future. Scenario I, incremental change, represents a continuation of what has been happening in the 1990s. Scenario II, constrained resources, projects serious cutbacks in payment level and drastic instability. Scenario III, technology dominant, envisions healthcare merged with Stars Wars in a future even Bill Gates cannot imagine. Scenario IV would combine a technology dominant world with unprecedented growth in consumerism. The authors enthusiastically predict that the future will involve a convergence of consumerism and technology.

This conclusion obviously demanded another book. *Strategies for the New Health Care Marketplace* is the result.

Strategies is also divided into four parts with logical sequencing. Part I deals with understanding the healthcare marketplace. Part II describes how healthcare delivery and financing systems can develop strategies that anticipate fundamental changes in the new era. Part III covers leadership and governance in positioning healthcare for the 21st century. Part IV talks about essentials for success in the new consumer oriented marketplace.

If you want to know about and influence how healthcare in the United States is going to change in your lifetime, read these books. *Beyond Managed Care* emphasizes “why” we need to change, and *Strategies* deals with “what” we need to change. I thought *Beyond Managed Care* was excellent but *Strategies* is even better.

We can all agree that the future isn't what it used to be. Now, let's do something about it. If you've read *Who Moved my Cheese?* and were wondering what you should be doing about it, read these books. Every hospital medical library ought to have a copy. ■

Gary VanderArk, MD, is a member of the AANS Board of Directors, a senior partner of Rocky Mountain Neurosurgical Alliance, Englewood, Colo., and past president of the Colorado Medical Society.

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Readers Respond

EMTALA Continues to Frustrate

Dump EMTALA

Regarding the article by our distinguished representative in Washington, Katie Orrico ("Window of Opportunity," Spring 2001), what bothers me is the language of this so-called EMTALA (Emergency Medical Treatment and Active Labor Act). We have had a great deal of difficulty in our area hospitals regarding EMTALA because practically most neurosurgeons cover more than one hospital. For a solo practitioner like myself, while I am busy in one hospital and a patient comes to an ER that is 10 or 15 miles away, I believe it is in the best interest of the patient and the best interest of the surgeon that the patient be transferred. While I'm busy, he or she will have the preliminary care, whether it is a CAT scan or an MRI or anything else.

The way I read the language of EMTALA is that physicians who are on call at two hospitals simultaneously must not request that the patient be transferred for the physician's convenience. I believe that this is nonsense. It puts an extra burden on the hospitals and the doctors and also is detrimental to patient care. When I am busy in one hospital and cannot possibly see the patient at another hospital, it may take me 15 or 20 minutes to get there after I finish up at the first hospital. What is better for patient care? To let them stay and rot or have them sent over to get the preliminary work done?

I believe Katie Orrico should clarify this issue with people in Washington. This law should be modified since it is not for the convenience of the physician. Modifying it will improve patient care and cut down red tape and paperwork as well as be less of a headache for the surgeon and hospital.

—David A. Yazdan, MD, FACS, Brick, N.J.

More Healing Across Borders

I was delighted to read in the *Bulletin* the article on healing across borders (Summer 2001). Work of this kind is essential in improving the quality of neurosurgery in areas that have not been fully developed. I have been returning to Pakistan at least three to four times a year to carry out improvement in the Neurosurgical Center in Islamabad, Pakistan's capital.

I have been made an Honorary Professor at the Al-Shifa Hospital, which is the city's best private hospital. The hospital has only one neurosurgeon, Dr. Irfan, and he

struggles at times with the lack of instrumentation, as well as the difficulty and high cost of getting shunting devices.

I am encouraging the neurosurgeons in the United States who are from Pakistan to do similar work through the Association of Pakistan Physicians in America. I will certainly get in touch with Dr. Flynn, who began the Southeast Asian Medical Aid and Teaching Foundation, and hopefully we can collaborate on this important endeavor.

—Ayub K. Ommaya, MD, Bethesda, Md.

IN MEMORIAM

Sherry Apple, MD, an Active Provisional AANS member since 1994, died suddenly in July due to injuries suffered in a boating accident. A private practice neurosurgeon in Charleston, W. Va., she was the President of Women in Neurosurgery. The following story is excerpted and reprinted with permission from the *Charleston Daily Mail*.



Dr. Sherry Apple, a pioneering Charleston neurosurgeon who handed out her trademark apple bandages, has been killed in a boating accident in Canada.

"It's a deep loss for our organization and for her patients," said Dr. Glenn Crotty, chief operating officer of Charleston Area Medical Center.

Apple reportedly was boating in a skiff with her husband in the Thousand Islands area near Upstate New York either in the

late hours Wednesday or early Thursday. The skiff caught a wave, ejected Apple and then crashed into her.

One of only four brain surgeons in the Kanawha Valley and the only female neurosurgeon in the state, the 49-year-old Apple was enamored with new and creative surgical procedures that would reduce pain and heal. She attended medical school at Tennessee State University, practiced in Arizona and Louisiana and was recruited to West Virginia three years ago by Dr. Constantino Amores, a colleague at Neurological Associates. Apple once told a newspaper reporter if the surgery was complicated, she was going to do it. In 1999, she debuted stereotactic radiosurgery in the area. In February of this year, Apple performed the first balloon vertebroplasty in the area. During that procedure, she inflated a balloon inside a spinal fracture caused by osteoporosis and injected bone cement to shore up the spine. ■

Section News

Section on Neurotrauma and Critical Care The Trauma Section has launched an initiative designed to increase neurosurgical involvement in neurotrauma care. A major component of this effort is to explore mechanisms for improving reimbursement for neurosurgeons involved in neurotrauma care.

According to a survey done in cooperation with the Council of State Neurosurgical Societies, about one in five U.S. neurosurgeons are paid a stipend for providing emergency room coverage. The current challenge is how to increase this practice of stipend payment. After much investigation, it became clear that such stipend contracts must be negotiated by the individual neurosurgeon and his or her hospital.

To aid neurosurgeons in this effort, the Trauma Section compiled an information packet that will help them not only provide the best possible neurotrauma care to patients but also help facilitate the negotiation of stipends with their hospitals. "Emergency Room Coverage: What Every Neurosurgeon Should Know" was sent to all AANS and CNS mem-

bers in July. (A copy is also available on the Web at www.neurosurgery.org/trauma.) The packet consists of an overview of neurosurgical contracts for trauma coverage, a position statement from the AANS and CNS concerning emergency room coverage, background information on EMTALA, two sample contracts and an abbreviated list of CPT and ICD-9 codes for neurotrauma procedures.

Members of the Trauma Section Executive Committee welcome feedback on the packet. For more information on neurotrauma care reimbursement, see the spring 2001 issue of the Trauma Section newsletter and the spring 2001 *Bulletin*.

Section on Tumors The abstract submission deadline is Friday, October 19, for the 2002 AANS/CNS Section on Tumors Satellite Symposium April 11-12, 2002, in Chicago. The submission form is available online. Visit www.neurosurgery.org and go to the Professional Pages Section to find the Abstract Center. For more information contact the Meeting Services Department at (888) 566-AANS or (847) 378-0500.

Immunotherapy for Tumors Task Force Holds Inaugural Meeting

ROBERTA P. GLICK, MD, AND TERRY LICHTOR, MD, PhD

The first meeting of the Immunotherapy Task Force for Malignant Brain Tumors was held in April in Toronto in conjunction with the AANS Annual Meeting. It was jointly sponsored by the Joint Section on Tumors and the National Institutes of Health (NIH). The meeting was organized in response to numerous inquiries by patients, medical physicians and other neurosurgeons regarding the role of immunotherapy for malignant brain tumors.

The meeting was coordinated by Roberta Glick, MD, of the Department of Neurosurgery, Rush University Medical Center and Cook County Hospital, Chicago, and Darell Bigner, MD, PhD, Professor and Director of the Duke University Cancer Center, Duke University Medical Center, Durham, North Carolina.

The goals of the meeting were threefold: (1) Present and evaluate the current laboratory and clinical research in the field of brain tumor immunotherapy in order to coordinate and disseminate current information and ongoing research in the field; (2) try to reach a consensus regarding what clinical endpoints and immune system monitoring parameters should be evaluated in clinical studies; and (3) evaluate the need for an immunotherapy consortium for conducting multicenter trials, both clinical and basic science.

The participants included basic scientists, clinical neurosurgeons and neuro-oncologists. Those attending functioned as a multidisciplinary focused research group, a kind of "neural environment" for facilitating communication and research.

The meeting began with an invited lecture by Darell Bigner, MD, PhD. He reviewed the basic science and early clinical immunotherapy trials as well as newer and innovative work. Dr. Bigner acknowledged Stephen Mahaley, MD, for his pioneering work in the 1960s with monoclonal antibodies and targeted therapies.

Monoclonal Antibodies

Recent clinical trials using monoclonal antibodies (mabs) have included therapies such as radioimmunotherapy, antibodies linked to radiation sources. A recently completed Phase I trial investigating the use of 131-I-81C6, an iodinated anti-tenascin mab injected into the post-operative tumor bed, demonstrated a significant increase in survival in newly diagnosed glioblastoma patients. A Phase II study is showing similar results.

Another promising area is that of immunotoxin therapy, mabs linked to a variety of toxins as a means of delivering targeted therapy. One such example is PE38-TP38, a pseudomonas exotoxin developed by Pastan and Vogelstein that is linked to an anti-EGFR mab. Such therapies can be delivered in high concentrations directly to the brain tumor via the convection technique, developed by Dr. Oldfield at the NIH. The identification of a mutated EGFR, EGFRvIII may be a truly specific and novel brain tumor sequence that can enable the further development of more specific targeted therapies, such as dendritic cell therapy.

Vaccine Approaches

Dr. Bigner discussed his work with tumor vaccines using peptides, anti-idiotypic mabs and dendritic cell technology. To overcome the problems associated with dendritic cells primed with tumor antigens, including autoimmunity and encephalomyelitis, Dr. Bigner and his colleagues have taken the novel approach of using an antigen specific for brain tumors as the target for the dendritic cells.

In particular, the peptide from the mutated EGFR (EGFRvII), present on a significant portion of brain tumors, was used as a target in preclinical studies. Such studies demonstrated the efficacy and safety of such a treatment strategy with significant potential for improved anti-tumor immunologic responses.

Research Reports

Thirteen talks were presented on dendritic cell therapy, LAK cells, cytokines, antisense, activated lymphocytes, T cell function and animal models. They were: Lois Lampson—*Heterogeneity of immune regulation in the CNS*; Habib Fakhrai—*Active immunotherapy of human gliomas with autologous tumor cells engineered to block their TGF- β secretion*; Robert Martuza—*Oncolytic herpes vectors as an “in situ” vaccine for tumor therapy*; John Yu and Keith Black—*Dendritic cell immunotherapy and allogeneic tumor cells/fibroblasts secreting GM-CSF*; Carol Kruse and Kevin Lillehi—*Alloreactive CTL for therapy of recurrent brain tumors*; Ian Pollack—*IL-4-HSV-TK autologous glioma vaccine for malignant gliomas*; Nicolas deTribolet—*Specific T cell effector function against intracerebral tumor model in the mouse*. Roberta Hayes —*IL-2 and LAK cells for malignant brain tumors: Phase I-II*; Roberta P. Glick and Terry Lichtor—*Immuno-gene therapy using IL-2 secreting allogeneic fibroblasts for intracerebral breast cancer*; Linda Liau—*Treatment of GBM with autologous DCs: Phase I study*; Antonio Chiocca—*Immuno-suppressive treatments facilitate propagation within tumors by oncolytic virus*; Andrew Sloan and Gary Wood—*Adoptive immunotherapy in patients with recurrent glioma: autologous whole tumor vaccine +GM-CSF and adoptive transfer of anti-CD-3 activated lymphocytes*; and Andrew Parsa and Jeff Bruce—*Immunotherapeutic responses in animal models*.

Roundtable Discussion

Two major questions were discussed in detail: What clinical monitoring parameters and standard endpoints are pertinent for clinical immunotherapy trials? And where do we go from here? In other words, is there a need for a consortium, multicenter trials or future conferences?

To evaluate the efficacy of clinical studies, as well as to communicate the results to patients, standard clinical endpoints are needed. These will allow comparing a particular type of therapy with another. The group came to an informal consensus that clinical studies and investigational reports need to include, at the least, information on the following endpoints when reporting their results: radiographic assessment of the tumor size before and after treatment; functional status of the patient (KPS/neurologic); survival (including overall time and time to progression); an assessment of systemic/peripheral immune or immunocytotoxic responses, for example, elispot or

chromium release; an assessment of immune responses in the CNS, for example, immunohistochemistry of the tumors for immune markers or infiltrating lymphocyte immunocytotoxic responses.

As to the need and timing of an immunotherapy consortium, this may be a future goal because, at this time, most clinical studies are single institution Phase I studies. When clinically ready for multicenter trials, the need for a consortium would be greater. Still, the development of a focused consortium for conducting immunotherapy studies may help investigative groups obtain FDA/RAC approval and necessary funding for performance of these studies. In addition, a consor-

tium may also ensure that standard monitoring parameters required by the FDA and appropriate clinical endpoints are adhered to in these studies.

Finally, the group agreed future conferences were needed in six-month or annual intervals, and expressed the need to share new information, discuss ongoing work and evaluate results of current studies.

Roberta P. Glick, MD, is Associate Professor, Department of Neurosurgery, Cook County Hospital and Rush University Medical School. **Terry Lichtor, MD, PhD**, also is affiliated with the Department of Neurosurgery, Cook County Hospital and Rush University Medical School.

New Book from the AANS Press

Just published in June, this comprehensive volume is the latest update of the standard reference for spine surgeons. Important new chapters such as “Biomechanical Testing” and “The Decision-Making Process” will help neurosurgeons decide how to treat patients with spinal disorders related to deformity, trauma, tumors, infections or degeneration based on sound biomechanical principles—principles that will influence the surgeon’s choice for the surgical approach, type of fusion and type of instrumentation.

The book was edited by Edward C. Benzel, MD, Director of Spinal Disorders at the Cleveland Clinic Foundation, where he heads a multidisciplinary team of spine care specialists in research, education and patient care. His major clinical and research interests have embraced many aspects of neurosurgery, but have focused on spinal disorders. Early in his career in the mid-1980s, he reported on the assessment of neurological outcome following spinal cord injury in a series of manuscripts written in collaboration with his mentor, Sanford Larson. During this same time, they co-wrote one of the first neurosurgery series for the management of thoracic and lumbar spine trauma with spinal instrumentation. Dr. Benzel has published multiple textbooks, including *Contemporary Management of Spinal Cord Injury: From Impact to Rehabilitation*. He also is a member of the editorial review boards of the *Journal of Neurosurgery*, *Neurosurgery*, *Spine* and *The Spine Journal*.

Since the first edition of *Biomechanics of Spine Stabilization* was published, more sophisticated diag-



Biomechanics of Spine

Stabilization Edited by Edward C. Benzel, MD. June 2001. 526 pages. ISBN: 1-879284-82-0. Order #820. Price: \$150. Member price: \$135. (Includes book and CD-ROM.) To order, call toll-free (U.S. only) (888) 566-AANS (2267).

nostic techniques and better instrumentation have been developed and the neurosurgeon’s understanding of biomechanics has advanced considerably thanks to extensive laboratory and clinical research. This updated version of the book brings all of that knowledge together. It begins with the essentials, proceeds toward the development of an understanding of biomechanical principles, and, finally, provides a basis for clinical decision-making.

Liberally illustrated, *Biomechanics* includes: physical principles and kinematics, spine and neural element pathology, non-operative spine stabilization, general principles of spine stabilization, spinal instrumentation constructs, segmental motion, stability and instability, surgical approaches and spinal fusion, as well as special concepts and concerns.

This volume includes an exclusive CD-ROM containing all of the illustrations featured in the book. Easily searchable, it allows the user to create mental images of critical anatomical, biomechanical and clinical points. This is an essential volume for any spine surgeon’s library. ■

Annual Meeting Tapes Available

Couldn’t get to all the sessions you wanted in Toronto? Couldn’t make it to Toronto at all? Don’t miss this opportunity to purchase the 69th Annual Meeting audio tapes and CD-ROMs. Choose individual tapes or CDs or tailor-made sets from more than 70 breakfast seminars, 12 scientific sessions, two plenary sessions and various special lectures. For details, visit the AANS Web site at www.aans.org and the opportunity to purchase online. Or simply print the order form and fax it.

AANS News

AANS Members Suspended

The Board of Directors has taken action against four members who are not in compliance with AANS Annual Meeting attendance by suspending their membership. The AANS' Bylaws require that members attend at least one of every three consecutive AANS Annual Meetings.

Media Blanket Annual Meeting U.S. and Canadian reporters took temporary residence in the AANS Press Room for one week during the 2001 AANS Annual Meeting in Toronto. After attending scientific sessions and interviewing many speakers and AANS members, the reporters wrote stories covering everything from stem cell therapy and radiation for glioblastomas to partial skull removal to combat stroke. One story even featured an exhibit of photos showing neurosurgeons' hands.

Notable media outlets covering the meeting included Reuters Health, Medscape, Medical Post, WebMD (Canada and United States) and the Toronto Star, to name a few.

To promote public interest in the latest neurosurgical research, the AANS staff and members of the Public Relations Committee wrote scientific news releases highlighting research reported at the meeting and distributed them to approximately 2,400 health/medical reporters nationwide. In addition, materials were posted on the AANS Media Center section of **NEUROSURGERY://ON-CALL**®.

Topics for the scientific releases included Gamma Knife radiosurgery for treatment of trigeminal neuralgia, stem cell transplantation for traumatic spinal cord injury and hemicraniectomy for stroke. The press materials also included releases featuring an overview of the AANS Annual Meeting, AANS board appointments and AANS award recipients.

This year's public relations efforts also included on-site hometown radio interviews. Approximately 50 AANS members took advantage of this media opportunity, recording one-minute interviews that were broadcast on more than 850 radio stations nationwide, reaching a combined total audience of over 35 million people.

An additional highlight of the public relations efforts included a live interactive WebMD physician chat outlining the common disorders that neurosurgeons treat. Drs. Ronald Warnick, Robert Heary and Ghassan Bejjani were the neurosurgeon experts for this interactive chat.

AANS' Bylaws Revision OK'd AANS membership has approved a complete revision of the Association's Bylaws by an overwhelming margin. Eight hundred thirty-seven of the 856 votes cast (97.8 percent) approved the revision.

Originally adopted in 1960 and amended piecemeal many times since, the Bylaws had developed a number of internal inconsistencies, in some respects no longer reflected the practical operations of the AANS and included many detailed provisions that unnecessarily impeded effective governance of the Association. The Bylaws were simplified and updated. In addition, many detailed provisions that impeded day-to-day operations of the AANS were removed and added to proposed Rules and Regulations of the Board of Directors, which can be modified at any time by a vote of the Board rather than by a vote of the Association's membership.

The ballots were cast in June and early July. Bylaws Committee members who worked on the revision were Troy Tippet, MD, Chair; Paul Arnold, MD; Robert Goodkin, MD; and William Chandler, MD.

The Bylaws can be found at www.aans.org or a copy can be obtained by calling Diana Hughes, AANS Governance Manager, at (847) 378-0507.

Online Marketplace Improved The AANS Online Marketplace has been updated and expanded. Now you can preview and order the latest publications, products and videos available from the AANS on the Web. The Marketplace is now searchable by keyword, author or topic category, making it easier than ever to find and order exactly the products you want. In addition, product listings now include much more detailed information, allowing you to make a more informed buying decision.

For quick reference, products also have been organized into the following categories: Coding & Reimbursement, Education & Practice Management, General, Getting SMART Practice Building Programs, History, Leaders In Neuroscience, Legal, Marketing & Referral Development, *Neurosurgery Today* Reprints, Neurosurgical Operative Atlas Series, Patient Education, Practice Management Resources, Reference Materials and SANS VI.

To visit the AANS Online Marketplace, go to www.neurosurgery.org/marketpl. ■

CHANGED YOUR ADDRESS?

Let us know by writing us at: American Association of Neurological Surgeons, 5550 Meadowbrook Drive, Rolling Meadows, IL 60008. Or e-mail tmz@aans.org.

Results in on *Bulletin* Survey

Readers Support Socioeconomic Thrust of Magazine

We asked for your opinion of the *Bulletin* in a survey included with the spring issue and you let us know that you value the *Bulletin* and read it on a regular basis. You also told us that you agree with the magazine's socioeconomic focus and are interested in "news you can use" as well as advice on practice management. You also indicated an interest in what's new with the AANS.

Departments or features that earned the highest interest were the cover stories, AANS News, Newline, Section News, Coding Corner, Calendar of Events, Practice Profile and Managed Care. Respondents asked for more coverage of socioeconomic issues, practice management advice, technological advances, using computers, legislative and regulatory issues, and AANS News.

We received only 81 completed surveys.

The low response could be due to the frequency of recent AANS surveys, which the AANS has decided to reduce. In any event, the survey provided a tool for gathering input as well as an opportunity for the voices of readers to be heard. To ensure that we receive as much input as possible, send suggestions and comments about the *Bulletin* to Jay Copp, staff editor, at ejc@aans.org or via fax to (847) 378-0669.

<p>1. When I receive the AANS Bulletin, I usually read 46.9%Most of it 28.4%All of the magazine 12.3% ...Some of it 9.9%About half 2.5%Not much</p>	<p>27.5%2 6.2%1 Newline 32.9%4 48.1%3 17.7%2 1.3%1</p>		<p>Membership 14.1%4 32.1%3 6.2%2 7.7%1 Governance 11.7%4 24.7%3 54.5%2 9.1%1</p>	<p>35.9%2 0.0%1 5. Should the Bulletin increase, keep the same, or decrease coverage of: General Neurosurgical News 61.4%Same 38.6%Increase 0.0%Decrease Socioeconomic Issues 52.4%Increase 45.1%Same 2.4%Decrease Practice Management Advice 50.0%Increase 45.0%Same 5.0%Decrease Technological Advances 50.0%Same 43.9%Increase 6.1%Decrease Using Computers in Neurosurgery 51.9%Same 39.2%Increase 8.9%Decrease Legislative and Regulatory Issues 57.5%Same 37.5%Increase 5.0%Decrease Profiles of Members 54.9%Same 36.6%Decrease 8.5%Increase Accomplishments of Members 53.1%Same 37.0%Decrease 9.9%Increase</p>	<p>AANS News 61.7%Same 35.8%Increase 2.5%Decrease AANS Professional Development Courses 67.1%Same 24.4%Increase 8.5%Decrease AANS Board Actions 71.2%Same 18.8%Increase 10.0%Decrease AANS Annual Meeting 77.8%Same 12.3%Increase 9.9%Decrease New AANS Programs 72.2%Same 26.6%Increase 1.3%Decrease AANS Volunteer Opportunities 70.9%Same 22.8%Increase 6.3%Decrease</p>
<p>2. After receiving the AANS Bulletin, I usually read it 72.5%As time allows 27.5%Right away 0.0%I don't usually read the Bulletin</p>	<p>Managed Care 33.8%4 37.5%3 25.0%2 3.8%1 Coding Corner 41.8%4 27.8%3 24.1%2 6.3%1 Research 13.9%4 31.6%3 48.1%2 6.3%1 Research Foundation 10.1%4 24.1%3 55.7%2 10.1%1 Computer Ease 20.8%4 32.5%3 40.3%2 6.5%1 Committee Close-up 13.3%4 24.0%3 52.0%2 10.7%1</p>		<p>International Corner 9.1%4 39.0%3 42.9%2 9.1%1 Section News 23.8%4 57.5%3 17.5%2 1.2%1 AANS News 37.2%4 53.8%3 9.0%2 0.0%1 Practice Profile 31.6%4 40.5%3 25.3%2 2.5%1 Calendar of Events 27.6%4 48.7%3 23.7%2 0.0%1 Editor's Column 23.1%4 41.0%3</p>		
<p>3. Where do you get most of your socioeconomic news about your profession? 69.6%AANS Bulletin 31.6%Neurosurgery News 26.6%Am. College of Surgeons Bulletin 25.3%Daily Newspaper 13.9%Other 11.4%American Medical News 10.1%Medical Economics</p>					
<p>4. Rate your interest in the following sections of the AANS Bulletin. (Use a scale of 1 to 4, where 1 is Not At All Interested and 4 is Very Interested.) Cover Story 38.8%4 52.5%3 7.5%2 1.2%1 President's Message 22.5%4 43.8%3</p>					<p>6. Compared with other services of the AANS, I rate the Bulletin as: 62.2%Very important 34.1%Somewhat important 3.7%Not important 8. Overall, what is your opinion of the AANS Bulletin? 39.0%Excellent 46.3%Very good 13.4%Average 1.2%Below Average 0.0%Poor</p>

A Businesslike Practice

Chicago-area Group Uses Sophisticated Strategies

West Suburban Neurosurgical Associates

Location: Hinsdale, IL

Neurosurgeons: Robert P. Kazan, MD, Daniel J. Harrison, MD, Anthony DiGianfilippo, MD, Stanley W. Fronczak, MD, JD, and Ofer M. Zikel, MD.

Neurosurgical Capability: All adult neurosurgical services including heavy concentration in skull base and acoustic neuromas; brain and spinal cord tumors; pituitary surgery; complex spine with all instrumentation techniques; radiosurgery and neuroendovascular radiology.

Practice History. Our group started 50 years ago. The founding members decided that geographical diversification was desirable not only to capture the most interesting cases but also to be on multiple hospital staffs to protect against political and economic shifts. As a result, our group provides care to a whole county as well as some of the western Chicago hospitals. One hospital (Hinsdale) is our center of excellence with full and the most sophisticated technology including a neuro ICU, a dedicated neuro floor, neurological nurses, neuronavigational and 3-D computer analysis preoperatively of aneurysms and AVMs. Members in our group traditionally work in several hospitals during the week, and emergency weekend coverage is provided to all the hospitals by doctors on call. Periodically, hospitals are dropped or added depending on how many cases they provide to the group practice.

Business Philosophy. We employ a sophisticated analysis of our practice universe. Ongoing ranking of our insurance contracts is done to determine the percentage of our time spent with each company's enrollees, how much they pay relative to the market and what is the time value of collections (30, 60 days or more).

We are also interested in ease of dealing with payers. Because we have so many contracts, if any of the studied companies reach a critical mass of negative ratings, they are dropped from the practice.

Business management requires a certain discipline that is similar to investing in the stock market. To continue to serve a medical contract that pays poorly, holds back payment (uses the float) and requires constant calling by office personnel is counterproductive. Instead of trying to do everything it is better economically to eliminate some of this exposure. The group does fewer cases but makes more money and the additional time can be spent reading, studying and preparing lectures or

Robert Peter Kazan, MD, is President of West Suburban Neurosurgical Associates.



simply by spending more time with our existing patients.

Bargaining Tools. Many neurosurgeons are “babes in the woods” compared to their counterparts in business and the insurance industries. They accept terms that other business people would deem laughable and that is why they are taken advantage of so easily. We need to understand that there are some businesses who produce products that payment is required C.O.D. (cash on delivery). No payment—no service!

As physicians we are inclined in our treatment of patients to give wide latitude to payment. We have a humanistic side. This is something we need to maintain. But we

need to remember, for our own health, that in business every advantage must be realized. If there is a way to make money from weaker, less sophisticated players, it will be done. And, anyone watching health insurance markets over the last 10 to 15 years knows that we've been “had” in many ways.

One technique that will work if a group is a major provider for an area relates to “out of network.” If a company will simply not negotiate a fair contract, a group may have to withdraw. Obviously, people from that company-insured pool will need to have emergency services. When that occurs, the “out of network” situation provides full payment by law of the neurosurgeon's listed fees. One case of this type may equal three of the cases ordinarily reimbursed under the poor insurance contract. Amazingly, some trauma surgeons have dropped all insurance contracts and operate “out of network” because of the legal requirement that they be paid on emergency cases. It won't be long before the insurance companies come back to negotiate a better fee schedule. This is leverage—a valuable tool in negotiating.

Secondly, nothing substitutes for a numerical analysis. It used to be thought that insurance companies would work with people that provide only high quality. But there are many high quality neurosurgeons in our society, so cost does become an issue. Groups with low complications, fewer reoperations and shorter length of stays will be favored, especially if they can prove it.

Future Practice. We know the science of neurosurgery will advance. All of us continue to learn new ways to better care for our patients. This is exciting and that's why we are neurosurgeons. Supply and demand is in our favor. We are in demand. Without that we have no negotiating power. Along the way, unless we fall to the inefficiencies and delays of a national health system, we must learn the rules of engagement of a competitive business world. Our prosperous future as scientists, surgeons and business operators depends on this. ■

EVENTS

Calendar of Neurosurgical Events

Congress of Neurological Surgeons Annual Meeting

September 29-Oct. 4, 2001
San Diego, California
(877) 517-1267

American Neurological Association Annual Meeting

September 30-
Oct. 3, 2001
Chicago, Illinois
(612) 545-6284

American College of Surgeons Annual Meeting

October 7-12, 2001
New Orleans, Louisiana
(312) 202-5000

RUNN 2001

October 20-27, 2001
Woods Hole, Massachusetts
(303) 806-0777

American Clinical Neurophysiology Society Annual Meeting

October 25-28, 2001
Boston, Massachusetts

North American Spine Society Annual Meeting

October 31-Nov. 3, 2001
Seattle, Washington
(877) 774-6337

Association of Military Surgeons of the United States Annual Meeting

November 4-9, 2001
San Antonio, Texas
(301) 897-8800

Society for Neuroscience Annual Meeting

November 10-15, 2001
San Diego, California
(202) 462-6688

American Heart Association Annual Meeting

November 11-14, 2001
Anaheim, California
(214) 706-1685

American Academy of Neurological Surgery Annual Meeting*

November 14-17, 2001
Palm Beach, Florida
(507) 284-2254

Society for Neuroscience Annual Meeting

November 10-15, 2001
San Diego, California
www.sfn.org

Five-day, Hands-on Radiosurgery Tutorial Course

November 26-30, 2001
UCLA Medical Center

Los Angeles, California
(310) 794-1221

2001 AANS/CNS Section on Pediatric Neurological Surgery Annual Meeting

November 28 – December 1,
2001
New York, New York
(888) 566-AANS

Cervical Spine Research Society Meeting

November 29 – December 1,
2001
Monterey, California
(847) 698-1628

American Epilepsy Society Annual Meeting

November 30 - December 5,
2001
Philadelphia, Pennsylvania
(860) 586-7505

International Conference of Lumbar Fusion and Stabilization

November 30-December 4, 2001
Cancun, Mexico City, Mexico
www.iclfs.com

California Association of Neurological Surgeons Annual Meeting

January 18-20, 2002
San Francisco, California
www.cans1.org

Lende Winter Neurosurgical Conference

February 2-9, 2001
Snowbird, Utah

AANS/CNS Section on Cerebrovascular Surgery and Society of Interventional and Therapeutic Neuroradiology Annual Meeting

Feb. 3-6, 2002
Dallas, Texas
(888) 566-AANS

American Academy of Orthopaedic Surgeons Annual Meeting

February 13-17, 2002
Dallas, Texas
(847) 823-7186

AANS/CNS Section on Disorders of the Spine and Peripheral Nerves Annual Meeting

Feb. 27-March 3, 2002
Orlando, Florida
(888) 566-AANS

American Academy of Pain Medicine Annual Meeting

February 27-March 3, 2002
San Francisco, California
(847) 375-4731

Southern Neurosurgical Society Annual Meeting

March 6-9, 2002
Savannah, Georgia
(901) 259-5321

American Association of Neuroscience Nurses Annual Meeting

March 16-19, 2001
Chicago, Illinois
(888) 557-2266

AANS 70th Annual Meeting

April 6-11, 2002
Chicago, Illinois
(888) 566-AANS

2002 AANS/CNS Section on Tumors Satellite Symposium

April 11-12, 2001
Chicago, Illinois
(847) 378-0649

American Surgical Association

April 25-27, 2002
Hot Springs, Virginia

Third Arctic Stereotactic Conference

May 2002
Svalbard, Spitsbergen, Norway
(412) 647-6782

Society of Neurological Surgeons Annual Meeting

May 12-14, 2002
Toronto, Ontario, Canada
www.societytyns.org

International Society for the Study of the Lumbar Spine Annual Meeting

May 14-18, 2002
Cleveland, Ohio
(416) 480-4833

Education and Practice Management Courses

For the first time, the AANS will coordinate a one-day coding and practice management course designed to assist residents in preparing themselves for the "real world." Topics will include how to evaluate a job and establish a practice, basic coding, legal issues, practice management and the advantages and a comparison of academic vs. private practice. This is a must attend for all residents. **Beyond Residency: The Real World** will be offered Saturday Nov. 17, 2001, in Baltimore, Maryland.

• **Managing Coding and Reimbursement Challenges in Neurosurgery**
Nov. 16-17Atlanta, Georgia

• **Neurosurgery Review by Case Management: Oral Board Preparation (Sold Out)**
Nov. 4-6Houston, Texas

For more information or to register for these courses, call the Education and Practice Management Department at (888) 566-AANS or visit www.neurosurgery.org/aans/meetings/epm/epmcourses.html.

Lemonade Out of Lemons

Personal Reflections on Medical Malpractice

I have been sued for medical malpractice only once. That single incident had a profound effect on me, my family and the way I practice neurosurgery. Hence, the cover article of this issue hits close to home and brings back old feelings that were closer to the surface than I imagined.

My “incident” involved a patient operated on by a skilled neurosurgeon in another state who came to my hospital with symptoms related to his disease. We saved his life but he was left with neurological dysfunction. Despite what I thought was appropriate care, I was sued for malpractice. One of the most trying three years of my life followed.

My own malpractice case and my knowledge of others in my “day job” as chair of a nine-division department of surgery have given me some perspective that I would like to share, particularly with residents. Three factors frame my personal perspective. First, medical malpractice does occur. Second, bad results don’t equate with malpractice and good results don’t mean that the patient has had the best of care. Finally, neurosurgery can be a “high wire” act—make sure you are fully prepared and use a safety net!

A Shocking Experience

Malpractice does occur, though certainly not with the frequency suggested by the number of malpractice suits. When one finds himself being sued, as I did, something akin to the stages of the Kubler-Ross death and dying model kicks in: denial, anger, bargaining, depression and acceptance. I was shocked when I was sued. I had spoken often and in-depth with the family of the patient and documented my plan and treatment. I believed that the cause of my patient’s problem was unavoidable (an

act of God), following an operation by another surgeon in another city who had treated the problem appropriately.

The three-year process of the lawsuit was fatiguing—frequent review of charts, meetings with lawyers and restless nights followed by canceled depositions. During this time my sensibilities as a surgeon were undermined and I was embarrassed. Fortunately, several of my associates rallied around me and helped with data review and preparing dispositions.

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Ultimately, after three years I was “dropped” from the lawsuit and the case was settled out of court. I felt great relief, but as a believer that justice would prevail, I was dismayed. Justice had not carried the day. Not only had my hospitals’ insurance company paid a settlement but also one third of the money needed by the family of an impaired breadwinner went to the plaintiff’s lawyer, who later sued the family for a greater percentage of the settlement.

Lessons Learned

What did I learn from my exposure to malpractice that I can share with you?

Be fully aware that as a practicing neurosurgeon you are on a high wire. Tighten your lines and put up safety nets—make sure that nurses, technicians and other team members understand your goals and

direction by writing legible and comprehensive orders. Always listen carefully to the patient and review diagnostic studies to make sure you have the correct diagnosis. Convey the risks to the patient and legibly document this discussion.

Bad results don’t mean that malpractice has occurred. As physicians we understand the potential inherent devastation of the diseases we treat. Unfortunately, our patients and their families do not. Furthermore, the current malpractice environment and the press coverage of medical errors have further eroded the public’s confidence in physicians.

What can you learn from my malpractice experience?

1. Develop a better understanding of why lawsuits occur and become even more attentive to the pitfalls that lead to lawsuits, many of which can be avoided by practicing good patient care—diagnosis, discussion and documentation.

2. Recognize that we do have a safety net—malpractice insurance. Although it is sometimes lacking in comprehensiveness, insurance coverage is there for a reason and should allow us to practice neurosurgery without fear.

3. Reach out to your colleagues for their advice and insight. It is a good feeling to know that you are not alone.

4. Use the resources provided by the AANS—the *Guide to Informed Consent*, stories in the *Bulletin*, CME courses—to protect yourself against lawsuits.

5. Use the lessons you learned to teach yourself and others, whether at a conference or as I did in writing a paper about the complication and presenting it at an international forum. Share your expertise, get over (but don’t forget) your malpractice experience and make lemonade out of lemons. ■