

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

BULLETIN

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MANAGING THE MESSAGE

THE NEUROSURGEON AS

ADVOCATE

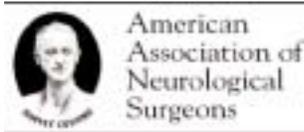


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American Association of Neurological Surgeons



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VOLUME 11 NO. 3

AANS MISSION

The AANS is dedicated to advancing the specialty of neurological surgery in order to provide the highest quality of neurosurgical care to the public.

AANS BULLETIN

The official publication of the American Association of Neurological Surgeons, the *Bulletin* features news about AANS and the field of neurosurgery, with a special emphasis on socioeconomic topics.

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Submit a story or a story idea to the *Bulletin*. Writing guidelines are available at www.neurosurgery.org/aans/bulletin.

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We Are Making a Difference

Neurosurgery's Personal Messengers Are Doing Important Work

With reimbursement for medical services declining, the cost of running our practices increasing, and government regulatory activities strangling us, it sometimes is difficult for neurosurgeons to see the value of the large investment in lobbying activities that our national organizations make through the Washington Committee. Yet, small victories have been won and incrementally, they can be important. Unfortunately, some of these "victories" in Washington are typically incremental and take years to fully implement; thus, they go unnoticed. Sometimes, the victories are defined in terms of "minimizing losses," which makes it difficult to identify the "win." Let me give you just a couple of recent examples of how we make a difference when we get involved.

Action Prods Change

In 1997 the Health Care Financing Administration (HCFA) announced that it was going to implement a new system for reimbursing physicians for their practice expenses. If implemented, the original proposal would have reduced neurosurgical income in 1998 by nearly 50 percent! Working through the Washington Committee, the AANS and the CNS, along with several other medical societies, immediately launched a comprehensive lobbying strategy to prevent these reductions. As a result, Congress recognized that payment cuts of this magnitude would cause a potential crisis in Medicare patients' access to surgical services and passed legislation that prevented these dramatic cuts. This effort saved neurosurgeons from losing more than \$100 million in Medicare reimbursement in 1998 alone and reduced the proposed cuts to about 13 percent altogether over a four-year period.

More recently, in the wake of the emer-

gency room coverage crisis, the burdens of the Emergency Medical Treatment and Labor Act (EMTALA) caught the attention of federal policy makers. One of the most serious problems for us was the policy of the Centers for Medicare and Med-

Roberto C. Heros, MD, is the 2002-2003 AANS president. He is professor, co-chairman and program director of the Department of Neurosurgery at the University of Miami.



icaid Services (CMS, formerly HCFA) that made it illegal for a neurosurgeon to be simultaneously on call for more than one hospital at a time; violators faced fines of up to \$50,000. After CMS articulated this policy during the 2002 AANS Annual Meeting in Chicago, the alarm bells went off, and our Washington Committee immediately began an all-out campaign to reverse this policy. One of the key aspects of this campaign was encouraging our membership to send letters to key legislators. In addition, many telephone calls were made directly by neurosurgeons to their congressional representatives and key staff. A number of meetings were held in Washington and within two months we convinced CMS to reverse this policy. As a result, neurosurgeons now are able to be on call for several hospitals at one time.

Important Work to Be Done: Medicare Reimbursement and Beyond

Neurosurgery is now facing two additional major crises that have bubbled up to the top of the federal healthcare agenda: additional steep reductions in Medicare reimbursement and the professional liability

insurance crisis.

Thanks to the effectiveness of our Washington Committee and the hard work of many neurosurgeons, we are optimistic about a probable favorable resolution in the Medicare payment issue. The House of Representatives has passed a bill that would increase Medicare reimbursement to neurosurgeons by six percent over the next three years, preventing the anticipated 18 percent cuts that will take place over this same time period if Congress does not intervene.

We are less optimistic about a favorable resolution of the professional liability insurance crisis, but there may be some light at the end of this long, deep tunnel. It is very significant that the magnitude of the problem has reached the attention of the President of the United States, who recently dedicated a speech in North Carolina to this issue proposing major reforms to address the malpractice insurance crisis. Clearly, this is an issue that deserves our full attention and I know that our involvement can make a difference.

Politics Is Not a Spectator Sport: Neurosurgery's Personal Messengers

As effective as our national advocacy efforts are, we cannot achieve much without the active participation of many neurosurgeons at the local level. It is well-known that "all politics are local" and individual legislators need to hear from you—not just from our national lobbyists. This may mean writing a letter, making a telephone call, or if at all feasible, meeting with your representatives. They will hear you; policy makers do, in fact, hold neurosurgeons in high esteem and value their opinion greatly. You must be neurosurgery's personal messengers.

We are making a difference. ■

Setting the Record Straight

Past President: Excising Malignancy

It was welcome news to all neurosurgeons that Peter Carmel, MD, had been elected in June 2002 to the Board of Trustees of the American Medical Association. However, in the “Newline” article (Summer 2002, page 5) you state that this is the first time in the AMA’s 175-year history that a neurosurgeon had served on its board.

How fleeting is fame for all of us! I remember AANS working diligently and successfully to elect H. Thomas Ballantine, MD, professor of neurosurgery at Harvard and Massachusetts General Hospital, as a

trustee of AMA in 1978. He served with distinction for three years, then was a candidate for AMA president-elect.

However, it is quite noteworthy to have eight surgeons serving concurrently on a board that has been dominated by non-surgeons for so many years. Now AMA might persuade Congress to excise the malignancy of medical malpractice and the privileged class of trial attorneys from our legal system. If they need a few hints, I suggest review of *Clinical Neurosurgery*, Vol. XXV, Chapter 48.

—Byron C. Pevehouse, MD, Bellevue, Wash.

Editorial Note: As the AMA Archives confirmed, H. Thomas Ballantine, MD, now deceased, indeed served on the AMA Board of Trustees from 1977 to 1980. He was secretary-treasurer for the 1979-80 year and in 1980 was nominated for president-elect.

Dr. Pevehouse was president of the AANS from 1983 to 1984 and president of the Society of Neurological Surgeons from 1986 to 1987.

FOR THE RECORD

Readers are invited to send corrections, comments, and suggestions to the *Bulletin* at: bulletin@aans.org or AANS, 5550 Meadowbrook Drive, Rolling Meadows, IL 60008. Letters are assumed to be for publication unless otherwise specified. Correspondence selected for publication may be edited for length, style and clarity.

In the Public Eye

As Neurosurgeons, We Advocate for Our Profession and Our Patients Every Day

EMTALA, HIPAA and PLI have become as familiar to most neurosurgeons as SAH, GBM and AVM. They became part of my vocabulary during my recent tenure as chair of the AANS/CNS Washington Committee, where on the “front lines” I saw how legislation sometimes adversely affected neurosurgeons and, ironically, the patients that the legislation was intended to assist.

As neurosurgeons we cannot escape the fact that we have an obligation to both our profession and our patients to raise our voices and present our point of view, whether it be in Sacramento, Springfield, Albany, or Washington. That is not to say that all of us are completely comfortable with the idea of writing to senators, calling congressmen, or meeting with officials on Capitol Hill.

Now we are confronted by the fact that to achieve legislative reform, neurosurgery’s message must reach the public. Some medical societies are launching full-fledged public relations campaigns to inform citizens about how the professional liability insurance crisis is affecting their doctors and their own access to care. Chief among them is the American Medical Association, which allocated \$15 million to its campaign for tort reform to combat the PLI crisis, with \$12 million earmarked for the public relations effort.

In this issue of the *Bulletin*, the cover story provides an overview of the AMA’s PR campaign and details what the AANS and organized neurosurgery are doing to inform the public of these important issues. Complementary articles provide different points of view and tips on how neurosurgeons can work with the media to convey scientific information and effectively manage our message.

What About Neurosurgery?

From a personal perspective, I sometimes find it distressing that these seemingly extraneous issues intrude on my practice of neurosurgery. After all, I didn’t apply to medical school because I wanted to be a politician. I didn’t train as a neurosurgeon because I wanted to have daily interaction with the media.

I did want to help patients. I did want to marshal whatever talents, intellect, skill, and understanding I possessed toward

A. John Popp, MD, is editor of the Bulletin, president-elect of the AANS, and Henry and Sally Schaffer Chair of Surgery at Albany Medical College.



that end. From this viewpoint, advocacy is part and parcel of the profession of neurosurgery.

Those who know me know of my long-time interest in music. I have been struck by the similarities between careers in music and neurosurgery. Each requires the underpinning of knowledge, technical skill, intense concentration and a great deal of practice. Great musicians and neurosurgeons also share a passion for what they do and are able to appreciate the creativity necessary for success in their respective professions.

Both also devote themselves to careful listening: Musicians listen to other musicians and their audience; neurosurgeons listen to their colleagues, and most importantly, to their patients.

Both professions also are fraught with

stereotypes. Musicians frequently are portrayed in television and movies as difficult and eccentric individuals. Neurosurgeons probably fare much worse. In fact, consider the last time a neurosurgeon—or even a “brain surgeon”—was favorably portrayed in a popular movie or on TV.

Yet as neurosurgeons, we are most familiar with the rigorous training we undertook, the on-call schedules, the long days in surgery, and our personal pain at less-than-perfect outcomes for our patients.

How can the public not know? The answer is, the general public’s perception of neurosurgery is shaped by the popular media. Most people don’t know what we do until they or a loved one needs our services. It is then that we have the opportunity to impact their view of neurosurgery by how we interact on a personal level.

But now, when neurosurgery must impact legislation and policy that directly affects us and our patients, we do need to reach out to the public with a consistent message. We need to view the media as our ally in informing the public about what we do, how we help our patients, and how our patients are being hurt by policies that purportedly help them.

We begin with our patients. As professionals we know that effective communication underlies the physician-patient relationship. It is not a great stretch to apply these familiar principles to working with our legislators and members of the media. With the understanding of the skills that are required and some practice formulating and managing a message, every neurosurgeon can be an effective advocate, starting with how we represent ourselves and our profession in our communities every day. ■

NEWSLINE

NewsMembersTrendsLegislation

FROM THE HILL

TORT REFORM A

REALITY IN NEVADA

On Aug. 7 Nevada Gov. Kenny Guinn signed into law tort reform legislation that includes a \$350,000 cap on noneconomic damages in medical malpractice cases and puts a \$50,000 limit on damages for hospitals and physicians treating trauma patients, *American Medical News* reported. The law, set to take effect Oct. 1, follows the highly publicized closure of the state's only level I trauma center for 10 days in July because its doctors couldn't afford liability insurance.

- **Neurosurgeon Participates in the Health Care Security Panel** James R. Bean, MD, chair of the AANS/CNS Washington Committee, participated on the Health Care Security Panel during President Bush's Economic Forum, held in Waco, Texas, on Aug. 13. The president acknowledged that the medical liability problem increases the cost of medicine and denies some people healthcare. "For a while, I thought that [reform] ought to be done at the state level," he remarked. "When I realized the cost to the federal treasury, I now believe we ought to have medical liability reform at the federal level, and I'm going to push hard for it." Regarding his participation on the panel, Dr. Bean said, "When we participate in the political process and speak with one voice, neurosurgeons' concerns will be heard and our patients will be served." The president's remarks during the Health Care Security Panel are available at www.whitehouse.gov/news/releases/2002/08/20020813-3.html.
- **HEALTH Act Needs Cosponsors** More cosponsors are needed for the HEALTH Act, HR 4600 sponsored by Rep. Jim Greenwood (R-Penn.), and S. 2793 sponsored by Sen. John Ensign (R-Nev.). The HEALTH Act (Help Efficient, Accessible, Low Cost, Timely Health Care) is a comprehensive medical liability reform package intended to help stabilize the medical liability market through tort reforms. An interactive form at <http://capwiz.com/noc/issues/alert/?alertid=194596&type=CO> allows neurosurgeons to enter their zip codes to identify their representatives in the U.S. House and Senate, customize a sample letter urging support of the HEALTH Act, and e-mail it.
- **HIPAA Privacy Rule Finalized; Compliance Date, April 14, 2003** The Department of Health and Human Services published final modifications to the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) in the Federal Register on Aug. 14. The final rule incorporates some of the more than 11,000 public comments that were received after the proposed changes were published in March 2002. The final changes specify that healthcare professionals must obtain an individual's written permission before using protected information for marketing purposes or selling it to third parties, and that healthcare professionals must provide patients with notice of their privacy rights and the provider's privacy practices. Regarding research, a single form may be used for informed consent and for authorization for use of health information. The final rule also extends by one year the deadline to change existing written contracts to prevent disclosure of protected information by business associates. The Privacy Rule is one of the "administrative simplification" regulations of the Health Insurance Portability and Accountability Act of 1996. For more information, see the HIPAA feature article in this issue. A link to the rule as published in the Federal Register is available at www.hhs.gov/ocr/hipaa.
- **Supreme Court Issues Opinion in Rush Prudential HMO Suit** The Supreme Court issued an opinion June 20 in *Rush Prudential HMO v. Moran*, affirming the Seventh Circuit's decision upholding an Illinois law that requires HMOs to provide an independent medical review when a patient's primary physician and an HMO disagree over a course of treatment. The court found that the Illinois law was not pre-empted by the Employee Retirement Income Security Act (ERISA). The ruling will allow states to help patients fight their HMOs and make it easier for patients to request a second opinion. The opinion may affect the Patients' Bill of Rights legislation pending before Congress, where, despite the renewal of recent negotiations between the White House and Congressional leaders, no compromise has been made. The only outstanding issue is whether to impose caps on damages in HMO lawsuits. The Supreme Court opinion is available at www.neurosurgery.org/socioeconomic/supremecourt07a1.html. The Seventh Circuit's opinion is at www.neurosurgery.org/socioeconomic/supremecourt07a2.html.

NEURO NEWS

E&M CODES ARE CONFUSING, STUDY SHOWS

A study published in the September issue of *Annals of Emergency Medicine* revealed that private coding firms agreed on proper coding only 15 percent of the time. The study, "Reliability of Assigning Correct Current Procedural Terminology: Four E&M Codes," found a "lack of agreement on individual records and in aggregate..." that "should not be surprising given the complexity of the process of providing emergency medical patient care, the limitations to documentation of that care, the vagueness of the definitions for CPT-4 coding, and the inherent limitation of identifying the components to meet the definitions necessary to qualify for a level of CPT-4 code on the basis of documentation."

- **Two Surveys Address Physician Compensation** In August two groups released reports based on 2001 data. In the *2002 Medical Group Financial Operations Survey*, the American Medical Group Association showed that physician groups are experiencing significant losses. The average group lost \$16,840 per physician, based on medical group financial performance on a per physician basis for all regions. Financial performance varied significantly by region, with groups in the Western region reporting declines in financial performance, while Eastern groups reported gains. It was noted that Western groups tend to have some of the highest percentages of capitated revenue, while Eastern groups have some of the lowest. In contrast, the Medical Group Management Association found in its *Physician Compensation and Production Survey* that physicians saw an overall increase in compensation in 2001. Compensation for specialists rose 2.64 percent while production increased 5.20 percent compared to a 1.21 percent increase in compensation and 11.04 percent increase in production for primary care physicians. However, the MGMA survey reported that physicians are working smarter, harder and longer to maintain compensation levels. The 2001 data used in both reports are not reflective of the 5.4 percent reduction in Medicare reimbursement that took effect Jan. 1, 2002.
- **Sunlight on the Horizon for Tumor Surgery** Trials using concentrated sunlight to burn tissues are underway in the Negev Desert. As reported in *Nature*, "sunbeams could one day shrivel away tumors, offering an alternative to laser surgery." Scientists of the Jacob Blaustein Institute for Desert Research at Ben Gurion University in Israel are conducting the research, using a curved dish that concentrates sunlight 15,000 times until it is close to the intensity of the sun. A plate-sized dish channels the light through a fiber optic cable, which could transmit the light to an operating room. Sunbeam surgery, which has been tested on chicken breast and liver, produces effects that are similar to laser burns. The technology, which is a fraction of the price of laser equipment, holds promise for developing countries in particular. The solar equipment costs about \$1,000 compared to approximately \$100,000 for a laser unit.
- **Stress Blocks Neurogenesis, Study Says** A team of researchers led by Bruce McEwen of Rockefeller University in New York reported that proliferation of neuronal precursor cells in the rat hippocampus was reduced following three weeks of "restraint stress," a chronic daily form of stress. According to *BioMedNet News* in a report from the 2002 International Congress Neuroendocrinology, in the dentate gyrus region, where neurogenesis occurs throughout life, survival of the cells was cut in half while the total number of granule cells was reduced by 13 percent and the volume of the region, by six percent. Stress also caused overall shrinkage of the rat hippocampus and reductions in the dendrites. The research showed, however, that seven to 10 days after removing the stress stimulus, neurogenesis returned to full capacity. It was unknown if the effects would be reversible following a longer period of stress. Further, McEwen said that the three-week data raises the possibility that patients with depression may experience similar effects, which may also be reversible through new drug therapy. The research team has found that the anti-seizure drug tianeptine has been shown to prevent the stress-induced remodeling of the rats in their experiment, but noted that tianeptine is not a clinical treatment for depression.

For frequent updates to news "From the Hill," check out the "Hot Topics" page at www.neurosurgery.org/socioeconomic.

Managing the Message

The Neurosurgeon as Advocate

Manda J. Seaver

The AMA's \$12 million public relations campaign and the ACOG's Red Alert campaign reach out to the public in organized bids for tort reform. How are neurosurgeons advocating for their patients and their profession?

Neurosurgeons certified by the American Board of Neurological Surgery typically have followed undergraduate education with 10 years of medical study and mastery of skills and technology needed for successful surgery of the brain, spine and peripheral nerves. Little if anything in neurosurgeons' formal training has prepared these specialists for delivering succinct and informative quotes to reporters, appearing in a television interview as competent as they are in the operating room, or communicating neurosurgeons' view of policy and legislation to state and national representatives.

Leadership qualities are second nature to neurosurgeons, many of whom are practiced at lecturing on clinical topics, leading a surgical team, and serving on committees of professional societies and academies. However for many, acting in the public arena as an advocate not only for patients, but for the neurosurgical profession, is still a new idea.

At the same time that advancing technologies promise life-altering treatment for debilitating disorders like Parkinson's and Alzheimer's disease, communications technologies like satellites and the Internet have fueled an information explosion. With breaking news beamed around the world instantaneously and the media a ubiquitous force, even the most media-shy neurosurgeons may find themselves hard pressed to avoid public comment. Yet this crossroads moment of technological advancement and information saturation also provides neurosurgeons with unprecedented opportunity to arm people with accurate information about how neurosurgeons can help them, why research is important, and what government policy and legislation can best help patients and their families.



What Do Voters Know?

As physicians' professional liability insurance premiums have increased to crisis proportions—resulting in some doctors practicing without insurance while others retire, modify or move their practices—organized medicine has sharpened Washington advocates' focus on enacting tort reform. The efforts of many have brought this escalating problem to the attention of Congress, where a liability reform package known as the HEALTH Act of 2002 is pending, and to the attention of top government officials. In fact, President Bush recognized the liability crisis as a major factor contributing to rising healthcare costs in his July 25 address on the subject and at the president's economic forum on Aug. 13.

Yet for regular citizens, who are directly affected by higher healthcare bills and insurance premiums, as well as by the dwindling availability of neurosurgeons and other specialists, the professional liability issue has scarcely scratched the surface of consciousness. Until recently the national press has barely covered the topic, although in areas where the crisis has proven most virulent, such as Florida, West Virginia and Nevada, the story has received local media coverage. But much of the coverage has cast

the problem as a “malpractice” issue, implying that doctors who are doing something wrong are the ones who are affected.

At its June 2002 annual meeting the American Medical Association moved to bring the public into the loop with the launch of a \$15 million campaign advocating tort reform. Fully \$12 million is allocated for public relations.

In a resolution presented at the AMA meeting, the Illinois delegation called for “campaign-style issues advocacy advertising—both print and broadcast—in select markets and mediums with sufficient repetitions to move an audience to action.” The delegation wanted to target key markets across the country with a focus on national newspapers—*The Wall Street Journal*, *USA Today*—selected local markets, and TV spots, complemented by an inside-the-Beltway campaign that would include advertising in print publications like *Roll Call* (a newspaper for legislators), plus radio spots.

Since June, national media interest in the professional liability crisis has intensified. Recent reports have included “Rise in Insurance Forces Hospitals to Shutter Wards” in *The New York Times* Sunday edition, and “Malpractice Costs” broadcast on National Public Radio.

Another recent article, “Ob-Gyns Feel Insurance Squeeze Too: Liability Premiums Could Drive Some Out of Delivery Business,” appeared in the *Chicago Tribune* perhaps thanks to the “Red Alert” campaign.

Red Alert Tells Public: It’s Personal

The AMA’s public relations campaign joined that of a specialty severely affected by the professional liability crisis, obstetrics and gynecology. In the May-June 2002 issue of *ACOG Today*, the American College of Obstetricians and Gynecologists announced the “Red Alert: Women’s Health Care at Risk” campaign to “support members, educate the public and the media about how this [professional liability insurance] crisis is affecting women’s healthcare, and urge federal and state legislators to adopt needed reforms.”

A Red Alert advertisement appearing in *Roll Call* featured a close-up of a baby’s smiling face and the headline, “Who Will Deliver Your Baby?” The text read:

Skyrocketing professional liability insurance premiums are crippling the nation’s health care delivery system and forcing ob-gyns to close their practices every day. Without affordable insurance, many obstetricians will no longer be able to deliver babies. High-risk patients will be hurt the most. Pregnancy is not the time to be without medical care. America’s mothers are counting on you.

The tag line “Common Sense Professional Liability Reform: Our Top Priority” and the ACOG logo concluded the persuasive piece.

Obviously, the ideas presented in the ad also apply directly to patients in need of neurosurgical care. However, a major public relations campaign to buttress advocacy efforts may be outside the scope

of the AANS, which is a fraction of the size of either the AMA or the ACOG. Even so, the association has recognized the important role public relations plays in informing the public about neurosurgery.

But I Don’t Need a Brain Surgeon

Sixty-one percent of respondents to the 1999 AANS Member Needs Survey said that AANS should allocate financial resources to cultivate media coverage of neurosurgery. Seventy-seven percent

said AANS should aggressively position board-certified neurosurgeons to the general public. This sentiment likely stemmed from anecdotal evidence suggesting that patients—and some referring physicians—think of neurosurgeons primarily as “brain surgeons” and think of other specialists for treatment of spine and nerve problems like carpal tunnel syndrome.

Osteopathic physicians were faced with a similar identity crisis. *Medical Economics* reported that when the American Osteopathic Association commissioned a survey and focus groups to gauge the depth of DO’s “perception problem,” they found that 89 percent of respondents didn’t know what a DO was,

while focus group participants often associated osteopaths with back and bone doctors. In response, AOA in 1998 launched a three-year public awareness campaign called “DOs: Physicians Treating People, Not Just Symptoms.” The campaign included video news releases, distribution of a newsletter to media outlets, briefings with reporters, editors and producers for national media outlets, and training for the association’s spokespeople.

Neurosurgeons: More Than “Brains”

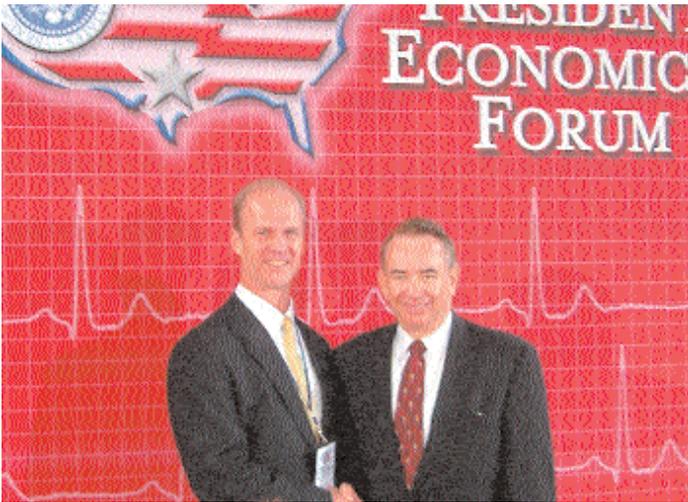
Many of these elements and more are part of the AANS public information armamentarium. Primarily through its Public Relations Committee, chaired by Ron Warnick, MD, AANS has worked aggressively to position neurosurgeons in the public eye as physicians of choice for disorders of the spine and peripheral nerves, as well as the brain.

“The most direct and cost-effective way to educate the public about what neurosurgeons do is through public relations initiatives,” said Dr. Warnick. “Not only does positive public opinion help to generate referrals for a member’s practice and educate the pub-

Continued on page 10

“The AANS has been laying the groundwork that helps neurosurgeons represent their profession in their communities, in their states, and in their nation’s capital.”

AANS PRESIDENT
ROBERTO C. HEROS, MD



James R. Bean, MD, (left) chair of the AANS/CNS Washington Committee, and Tommy G. Thompson, secretary of the Department of Health and Human Services, meet during the President's Economic Forum in Waco, Texas, Aug. 13. "It is a privilege to represent neurosurgery at the highest levels of government," Dr. Bean stated. "When we participate in the political process and speak with one voice, neurosurgeons' concerns will be heard and our patients will be served."

Continued from page 9

lic about the specialty, but it assists in passing important legislation affecting our members and the patients they treat."

AANS produced an insert in *USA Today* that reached five million readers, generated hundreds of media inquires, and thousands of hits on the AANS Web site, taking direct aim at the stereotype of neurosurgeons as "only " brain surgeons in its headline, "Neurosurgery Today: It's Not Just Brain Surgery," and lead story on low back pain. It also attacked preconceived notions that neurosurgeons are distant or uncaring by following a real neurosurgeon throughout one day. The piece, which covered James R. Bean, MD, during one of his "operating room" days, revealed the neurosurgeon as an incredibly skilled and caring individual. "You never forget that this is someone's son, wife, or grandfather," he said.

The article captures Dr. Bean checking on a trauma patient he had admitted while on call the previous evening; operating on an aneurysm; talking three patients through myelograms; driving to another hospital to perform a surgical spine procedure; checking on angiograms and more patients; and stopping by his daughter's dance recital—after missing dinner, but before seeing yet another patient. The piece depicted the diverse demands that come with the territory and suggested the attendant personal sacrifice.

Released in the summer of 2000, the *USA Today* insert still generates interest in neurosurgery and provides valuable information to the public at www.neurosurgery.org/aans/nstoday. It is worthy of note that on Dec. 1 the same year, CNN.com published a "day in the life" story on another AANS member, Richard Corales, MD, head-

lined "A Rewarding Grind: Richard Corales, Neurosurgeon." A complementary public opinion poll showed that 61 percent of respondents viewed neurosurgery as a "genuinely demanding" field that carries heavy responsibility; nine percent said it "has a lot of mystique and flash," and 30 percent said "it's honored for its sophistication but...it's a lot of work, too."

Another AANS publication that debunked the "brain surgeon" perception is the National Neurosurgical Statistics report. The report told the neurosurgery story scientifically, by detailing which procedures were performed in 1999 and how often. Out of seven types of procedures, spine and cranial topped the list, with spine performed more than twice as often as cranial. AANS physician and practice profiles, as well as demographic information and a glossary of terms, completed the picture. Available to media and the neurosurgery community beginning in 2001, the report provided solid data for use in articles while generating interest in neurosurgery.

Public Service Is Central to the Message

Bike helmet safety, when to see a neurosurgeon and pediatric epilepsy—subjects that connect with the general public—were the topics of recent public service announcements produced in mat release format. These camera-ready releases, which cover general topics relating to neurosurgery and public health, are attractive to daily press because they are both informative and designed to be plugged into available space on a moment's notice. Like the *USA Today* piece, mat press releases are useful for a year or more.

"We're still receiving clips of published mat releases that were sent to local and national press two and three years ago," said AANS Director of Communications Heather L. Monroe. She added that besides providing useful information about the nervous system, its disorders and prevention, they create awareness and a positive impression of AANS and AANS members, as well as direct readers to more information on www.aans.org.

Bike helmet safety also was the topic of a public service announcement produced as part of a cooperative campaign between AANS and Think First National Injury Prevention Foundation. These advertisements will be seen by millions on the big screen in AMC movie theaters and in national publications including *Ladies' Home Journal* and *Good Housekeeping*. The AANS logo and Web site appear prominently in these pieces.

The World Wide Web is key among AANS' public outreach efforts. The AANS Web site and the **NEUROSURGERY://ON-CALL®** site, which AANS cosponsors with the Congress of Neurological Surgeons, support AANS' public relations projects and help keep AANS and neurosurgery accessible to the public. For example, "A Patient's Guide to Neurosurgery," one of the AANS' patient education brochures, is designed for physicians to provide as a "take home" for their patients, reinforcing physician-patient discussion about what neurosurgeons do and how neurosurgery may help

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Bridging the Gap Between Science and the Media

DOUG LEVY

Every one of us knows someone who claims they were misquoted, or who is afraid to talk to reporters out of fear that their work will be taken out of context or somehow misconstrued. Certainly caution before speaking publicly is important, but the public's misunderstandings about science will only grow if scientists avoid their role as sources of knowledge and explanations.

As a health and science reporter, I was constantly seeking scientists who not only were doing interesting work themselves, but also closely followed the work of other scientific leaders. When writing about neuroscience or any other medical topic, the experts I quoted needed to be:

- scientists whose peer-reviewed work was related to the topic about which I was writing;
- individuals who knew the difference between talking to scientific peers and chatting with their neighbors about something exciting;
- people who believed that the public not only has a right to know what scientists are studying with public funds but also will gain understanding and other value from such information.

Now that I am on the other side of the fence, as a public relations consultant working with scientists and corporations on healthcare and science issues, I am getting a new view of the gap between the media and scientists. One thing that has become crystal clear to me is that the most frequent media "mistakes" as perceived by scientists could be averted if they approached an interview a bit differently.

Preparation Is Key

For example, after weeks of working with one very senior biologist, helping him understand how to boil-down his work into three or four "key messages," both of us were frustrated when one of the first news clips about his work misstated the affiliation of his laboratory. Of course the reporter, in this case a very junior reporter at a college publication, was responsible for the error. But had the scientist used his "key messages" during the interview, the affiliation would have been clear, since that was one of the key points we wanted to get across.

Other times I have seen scientists frustrated at how little a reporter understands about their work—or vice versa. Few things were more annoying to me as a reporter than a scientist who lectured me about a topic on which I had been writing for a decade. No, my skills and understanding did not qualify me to treat patients or conduct laboratory studies. But I did have a clear understanding of scientific methods and a pretty good



sense of current research in the topics that I regularly covered.

What this all means for neurosurgeons is that spending a few minutes, or longer if possible, to prepare before doing an interview is most likely to yield favorable results. A few simple things to keep in mind if a reporter ever calls:

- Find out how much the reporter knows about science and your work.
- Identify your goal for the interview—what message do you want to get across?
- Prepare for likely questions, including those touchy questions that you may dread.

Putting this into action means anticipating what reporters are interested in—and identifying how best to relate your work or your knowledge to the journalists' audience. If you get a call from *New Scientist*, you are going to get a different series of questions than when you get a call from the *Chicago Tribune*, even if the reporters asking the questions have similar levels of scientific understanding. Think more about the reporters' audience than the reporters themselves, keeping in mind that translating neurospeak into layman's terms is good communication, not "dumbing down" the work. And remember: Journalists are looking for quotes, not only information.

Interacting with the media is not always a part of science, but helping the public understand what science is all about is crucial to continued support of basic and applied research. The more that scientists take their public information role seriously, the more likely we are to have adequate public funding, support from commercial interests, and long-term scientific capabilities. There's no need to be afraid of the media. The right combination of caution and preparation is all that's needed to bridge the gap safely. ■

Doug Levy is a vice president at Fleishman-Hillard public relations in San Francisco. He covered health, science and technology for *USA Today* from 1993-1999, and previously was science editor for United Press International and part of the public affairs team at The Johns Hopkins Medical Institutions. He studied science journalism at Northwestern University and has a law degree from the University of Maryland.

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This AANS/Think First public service announcement will appear in AMC theaters and national magazines.

them. This informative piece also is available online to the public at www.neurosurgery.org/health/whatis/guide/index.html. In addition, partnerships with other neurosurgery-related Web sites, including Spine Universe and Medem, extend AANS' outreach by including AANS articles on neurosurgical topics and links to www.aans.org.

AANS Works With the Media

Shining a positive light on neurosurgeons by helping

the public understand what they do and how they can help patients and their families is a foundation-building activity in which the media is a powerful ally.

The article "Helping the Media Get the Message: AANS Media Campaign Promotes Meeting's Scientific Research" in this issue details how scientific studies presented at the 2002 AANS Annual Meeting reached more than 27 million people around the world. Actually getting an article published greatly depends on making experts available to reporters for comment and clarification. Public relations consultant and former reporter Doug Levy elucidates the

reporter's viewpoint in "Bridging the Gap Between Science and the Media" in this issue.

The experts AANS depends upon to represent the association's viewpoint are the members of its Executive Committee. To answer general media inquiries and to serve as experts for the association's public education and outreach, AANS additionally counts on its Media Information Network, a group of nearly 50 members representing various types of practices and subspecialties who have agreed to be "on-call" when a reporter contacts AANS.

Because an organization's spokespeople are the cornerstone of effective media relations, it makes sense to provide them with education and practice: media training. AANS conducts a media workshop at every annual meeting. "Media Trainer's Advice" in this issue discusses some steps to becoming media savvy, information that is presented during media workshops at the AANS annual meetings and, most recently, at the Neurosurgical Leadership Development Conference held in July.

NLDC: Integrating Media and Advocacy

The second NLDC, presented by the Council of State Neurosurgical Societies, took the direct approach to educating neurosurgeons on effective grassroots leadership skills. The conference, which featured sessions like "Grassroots Advocacy Training," "What's Happening on the Hill" and "Update on Neurosurgery's Key Issues" and culminated with congressional visits, clearly aimed to provide every neurosurgeon in attendance with the tools needed to become a neurosurgeon-advocate.

"To transform the future of neurosurgical care, we must implement change in the healthcare legislative and lobbying processes," stated CSNS Chairman David F. Jimenez, MD. "It is imperative that we continue to expand our influence on Capitol Hill as critical issues in medicine such as EMTALA, HIPAA and professional liability insurance culminate in nothing less than crisis situations."

New for neurosurgeons attending the NLDC this year was a media workshop. "The heart of effective advocacy is building and delivering a clear and persuasive message," said Katie Orrico, JD, director of the AANS/CNS Washington Office, who moderated the conference's sessions. "The media workshop is extremely useful in honing focus on neurosurgery's message and providing practice in delivering it before it really counts: live on camera or in a meeting with a legislator.

Washington Committee: Neurosurgery's Advocacy Nexus

Throughout the year neurosurgery's advocacy efforts are focused in a cooperative effort of the AANS and CNS, the Washington Committee, chaired by Dr. Bean. Together with the Washington Office, the committee has achieved remarkable success. AANS President Roberto C. Heros, MD, highlights recent accomplishments on the legislative front in his President's Message in this issue.

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NEUROSURGERY'S ADVOCACY RESOURCES

Direct links to advocacy information for neurosurgeons

- **AANS Bulletin**
www.neurosurgery.org/aans/bulletin
- **AANS E-News**
www.neurosurgery.org/aans/membership/eblast
- **AANS Position Statements**
www.neurosurgery.org/aans/media/position.asp
- **AANS Media Center**
www.neurosurgery.org/aans/media
- **"Hot Topics" Washington News**
www.neurosurgery.org/socioeconomic
- **Council of State Neurosurgical Societies**
www.neurosurgery.org/csns
- **AANS Communications Department**
Heather L. Monroe, director, (888) 566-AANS, hlm@aans.org
- **AANS/CNS Washington Office**
Katie Orrico, director, (202) 628-2072, korrico@neurosurgery.org
- **AMA Talking Points on Professional Liability Insurance Reform**
www.ama-assn.org/ama/pub/article/6282-6003.html

Helping the Media Get the Message

HEATHER L. MONROE

AANS Media Campaign Promotes Meeting's Scientific Research

Reporters seek to generate stories that will interest their audience. They want to obtain all of the facts in a timely manner, to best tell their story and create a clear message for their readers. When writing about neurological disorders and research affecting them, it is critical that reporters turn to neurosurgeons for their information. However, that is not always the case. Since neurosurgeons are not the only medical professionals treating these disorders, other specialty areas including orthopedics and plastic surgery are often cited in articles as experts.

AANS members know what they do for patients and to advance the neurosurgical specialty, but does the public really know about the disorders neurosurgeons treat?

For years the neurosurgery profession has been a source of fascination, mystery and intrigue for the general public and reporters alike. Nearly everyone has a friend, family member or acquaintance that has suffered from a neurological disorder. In an effort to better understand the disorder, they reach out to their physician, friends, family, the library, the Web and even the national association, to learn more. The AANS is dedicated to making neurosurgery less of a mystery to the public.

"Through dissemination of effective messages, we have been able to position AANS and its members as authorities on treatment of disorders affecting the brain, spinal cord and peripheral nerves," said AANS Executive Director Thomas A. Marshall. "Through these efforts AANS will continue to be an important information resource for the general public."

AANS Media Campaign Brings Science to Millions

One of the ways AANS brings neurosurgical research to the public is through a proactive public relations campaign surrounding each annual meeting. Reporters from across the country and around the world flock to the AANS press room for more information on the latest advancements in neurosurgery.

Highlights of the 2002 AANS Annual Meeting in April, and scientific advancements made by AANS member neurosurgeons reached a combined audience (print, radio, online publications, television) of over 27 million people around the world. Media outlets in France, China, England, Italy and here in the United States, took notice of the neurosurgery profession, featuring stories in prominent publications and on national and international television and radio programs.

An AANS scientific news release on Parkinson's disease treatment generated unprecedented media interest as evidenced by approximately 40 articles to date published by national and international media outlets. The release focused on a study by AANS member Michael F. Levesque, MD, and Thomas Neuman, PhD, that explored autologous transplantation of adult human neural stem cells and differentiated dopaminergic neurons for treatment of Parkinson's disease.

"Through dissemination of effective messages, we have been able to position AANS and its members as authorities on treatment of disorders affecting the brain, spinal cord and peripheral nerves."

*AANS EXECUTIVE DIRECTOR
THOMAS A. MARSHALL*

Developing the Message

The first step in developing this release and seven others involved review of over 1,200 abstracts of studies submitted by AANS members in all areas of expertise, including spine and peripheral nerves, tumor, neurotrauma, cerebrovascular surgery, pediatric neurosurgery, pain, history, and stereotactic and functional neurosurgery. The AANS Public Relations Committee selected studies that would be of significant interest to the public for development into news releases.

Once studies were selected, the releases were drafted with an eye to maintaining the clarity and continuity of each study,

while educating the public in everyday language, avoiding use of "doctor-ese" or neurosurgery jargon. The releases noted the importance of each study and emphasized that although results were promising, further research would be needed to be obtained before determining any type of definitive cure for the disorders.

Once the releases were reviewed and approved by key AANS members and the authors of the studies, AANS distributed the releases to approximately 2,400 health and medical reporters nationwide using an online distribution service and posted them in the Media Center on the AANS Web site.

Every Story Needs a Quote

Key to getting the scientific information published in the media was the availability of each study's author(s) to interested reporters. These neurosurgeons served as media resources, helping reporters craft their stories over the telephone or through face-to-face meetings in the AANS press room.

In addition to the study highlighting stem cell treatment for Parkinson's disease, topics for the scientific releases included: International Internet-Based Patient Consultations; Direct Cortical Interface for Motor Restoration; Stereotactic Radiotherapy for Treatment of Acoustic Neuromas; Outpatient Craniotomy for Tumor Resection; Comparison of Endovascular and Surgical Management of Apex Aneurysms; Neuronal Progenitor Cells Restore Barrel Cortex Function After Focal Injury and Prevention of Alzheimer Plaque Formation in a Transgenic Mouse Model.

The news release on treatment of Parkinson's disease and all releases are available in the Media Center at www.aans.org.

Heather L. Monroe is the AANS director of communications.

A Media Trainer's Advice: Delivering From Square One

MANDA J. SEEVER

The media has always played an important role in politics, informing a mass audience and shaping public opinion. But ever since the televised Nixon-Kennedy presidential debates of 1960 showed a five-o'clock-shadowed Nixon, perspiring and uncomfortable under the studio lights, contrasted with the groomed-for-TV JFK, already polished and plenty media savvy, one message has been clear: Be prepared.

But where to begin? Learning from others' mistakes often is a good place to start. "One of the biggest mistakes I've seen neurosurgeons make is to say 'I've been a neurosurgeon for 25 years, I'm ready for this,'" related veteran media consultant Pat Clark, who has conducted several media training workshops for AANS and other national medical specialty societies as well as worked with the AMA and state medical societies.

Successfully negotiating the different types of media often differs from the skills needed for a particular profession such as neurosurgery. "My premise is that the chance of today's doctors getting through their careers without talking to media is slim to none," said Clark. "Doctors need to be prepared to work with the media and put their best foot forward for themselves and their specialty."

So after admitting that some coaching could help, what's next? *Understanding the media*. "Doctors need to understand what the media is, and is not," Clark said. "The media is a tool, and like any tool you use *it*, you don't let it use *you*. Ask, How can I use this interview to tell our story?"

Making the Message

"Of course, the message is the crucial element," she stressed. "Doctors know so much, they unfortunately tend to want to share it all. To avoid this trap, it helps to do some thinking about the particular information that needs to be communicated."

To help "separate the wheat from the chaff," Clark uses *The Message Box*. She draws a square box and completes the four sides with one key thought and three supporting thoughts. For example, a neurosurgeon's message on bike helmet safety might include these points:

- Neurosurgeons care about injury prevention.
- Wear a bike helmet and wear it properly.
- Ensure that your helmet meets safety standards.
- Bike helmets are inexpensive compared to cost of injury.

In preparation for an interview, one or two supporting facts for these talking points might be added. For example, the fact that a non-helmet wearing bicyclist hospitalized with a head injury is 20 times as likely to die as those wearing helmets could be stated in support of the second point. During the actual interview, use the message box by answering questions in ways that bridge back to one of the four talking points.

"Focusing on four points sounds like it would be repetitive, but an average person needs to hear a message 12-14 times before it

sticks," Clark said. "Using talking points will help keep your message consistent, and a consistent message is paramount."

Tailoring the Message to the Audience

During an interview, you are talking not only to a particular reporter, but to the particular audience who reads the science section or who tunes in for the "health beat." To tailor a message to the audience, it helps to have a conversation with the reporter, clarifying: What is the publication or program? In what section will the story appear? Who is the audience/What is the demographic? What is the story topic? What is the reporter looking for (just a quote or the whole story)? What is the reporter's deadline? When will the story run?

Clark cautioned: "Don't do an interview with a reporter who calls cold. Get as much information as you can and tell the reporter you will call back in 20 minutes." During those 20 minutes, check with communications staff at your professional association for background information. Create your message box, tailoring it to the audience, and return the reporter's call.

"Remember, the quicker you get back to the reporter, the better your chance of helping to shape the story," she said. "If a reporter calls at 9 a.m. and has a 3 p.m. deadline, if you wait until 2:30 to call back, the story will be done and you'll get a 'yeah, but' paragraph in a story that probably won't convey your message."

And when the story comes out and it's good—"on" your message—Clark advised, "Don't pick: If there is one thing wrong that isn't crucial to your message, let it go. Keep it in perspective because what you want is a long-term relationship with the reporter."

In the interest of managing the message, it might be tempting to ask to see the story before it is printed. Instead, "Think of the reporter as a partner in putting together information for the audience," said Clark. "Say, If I didn't make something clear, don't hesitate to call me back and I'll be happy to clarify it for you."

And if she could leave neurosurgeons with just one message? "It may sound self-serving, but get media training."

Manda J. Seever is staff editor of the *Bulletin*.

ON-CAMERA DO'S AND DON'TS

- Add enthusiasm to your voice—TV and radio take personality out of it.
- Dress as simply as possible: plain navy suit, red tie.
- Take make-up when it's offered.
- Big shows will have a producer do a practice interview—treat it like the real interview or risk being cut from the program.
- Don't give strictly yes or no answers.
- Don't wear short (below the calf) socks with trousers.
- Don't wear eyeglasses, or get "TV glasses" with no frame or tinted lenses.
- Don't say, "This is off the record." Everything is on the record and if you don't want it repeated, don't say it.

Speaking for Neurosurgery

MANDA J. SEAVER

Peter Carmel, MD, Elected to the AMA Board of Trustees

The June 18 election of AANS member Peter Carmel, MD, to a four-year term on the American Medical Association Board of Trustees occurred at a felicitous moment for neurosurgery.

The professional liability insurance crisis is intensifying—particularly for specialties—while at the same time Medicare reimbursement is declining, combining in what some have termed medicine’s “perfect storm.” Dr. Carmel’s election amplifies neurosurgery’s concerns within the voice of medicine and adds considerable ballast to neurosurgery’s endeavor to right the ship and reverse the trend of declining patient access to specialty care.

“The liability crisis is our number one priority,” he stressed. “We need to get that message out. We need to tell the public that their medical system has been corrupted... If patients see that the liability crisis affects them, then they will be willing to be our allies.”

Dr. Carmel cited the turnaround of HMO proliferation in the 1990s, fueled by public opinion and the negative experiences of many individuals, as an example of how “the public is always medicine’s best ally.” On a related note, he acknowledged the role of the media in the process. “The media can be our friend if we give them the right message,” he said.

His election concludes his 17 years of advocacy in the AMA’s House of Delegates and heralds a new day at the AMA.

“I believe the AMA will evolve in the next five years into an organization of organizations,” said Dr. Carmel. “If that happens, the AMA will start to represent a majority of America’s doctors.”

As a delegate Dr. Carmel worked within the AMA to give specialties like neurosurgery an equal voice. “Neurosurgeons in general have had a jaundiced view of the AMA, perceiving it as a captive of medical types,” he explained. His work to modify the AMA’s structure, particularly on the Specialty and Service Society and as chair of the Council on Long Range Planning and Development, helped “create parity in representation for specialty societies and

states” and “set the stage for change in the AMA.”

He credited the facts that a neurosurgeon was elected to the board and that he is the eighth surgeon and the eleventh proceduralist of 19 board members as further evidence of a changing AMA.

Dr. Carmel’s election also celebrates the spirit of advocacy awakened in neurosurgeons. In an open letter thanking organized neurosurgery and individual neurosurgeons for their support in achieving his election, he said:

The CNS and the AANS provided the bulk of the financial resources and this was generously supplemented by the CSNS. The Senior Society members were extremely effective with their phone calls to delegates, as well as calls made by members of the CSNS and other neurosurgeons around the country. This sort of direct local contact was a unique experience for most of the delegates.

Dr. Carmel praised the leadership of the AANS through the Washington Committee as being increasingly effective in lobbying and forming coalitions for neurosurgery in Washington, D.C.

“Neurosurgery has become more politically sophisticated and more proactive over the last 25 years,” he said. “We really have come light years through the Washington Committee, brought along by the leadership provided by AANS.”

The first neurosurgeon in more than 20 years to serve on the AMA Board of Trustees, Dr. Carmel brings a perspective as a practicing pediatric neurosurgeon to the table. He is professor and chair of neurological surgery at New Jersey Medical School.

“Neurosurgery has so much to give medicine,” Dr. Carmel summarized. “The AMA must have a different attitude toward policy and what it speaks out on; neurosurgeons have to look at the AMA as a vehicle to carry forth neurosurgery’s concerns.”

Manda J. Seaver is staff editor of the *Bulletin*.

Continued from page 12

With the June 2002 election of AANS member Peter Carmel, MD, to the AMA’s Board of Trustees, neurosurgery gains yet another foothold in the effort to inform policy makers and the public of neurosurgery’s point of view. In “Speaking for Neurosurgery” (above), Dr. Carmel discusses his aspirations for advocacy in neurosurgery.

Neurosurgeons: We Must Represent

From a public relations perspective, every public contact can be thought of as an opportunity to enhance the public perception of neurosurgery. The neurosurgeon is always an advocate for the pro-

fession, whether working with an individual patient, the patient’s family, or with a member of Congress.

“The AANS has been laying the groundwork that helps neurosurgeons represent their profession in their communities, in their states, and in their nation’s capital,” stated AANS President Roberto C. Heros, MD. “It is in the interest of our patients and our profession that every neurosurgeon is prepared to work for neurosurgery, sometimes through the media and sometimes on Capitol Hill.” ■

Manda J. Seaver is staff editor of the *Bulletin*.

Advancing the Specialty

Neurosurgery Research and Education Foundation
2001-2002 Campaign Results

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

The 2001-2002 NREF Campaign ran from July 2001 through June 2002, which included extraordinary philanthropic gifts made by Dr. and Mrs. Merwyn Bagan and Dr. Albert Rhoton, Jr.

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

Cushing Scholars Circle
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Privacy Rules

Second HIPAA “Administrative Simplification” Compliance Date Nears

BY JOHN A. KUSSKE, MD

Standards for Privacy of Individually Identifiable Health Information (Privacy Rule), one of the “administrative simplification” provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides comprehensive federal protection for the privacy of health information. It creates national standards to protect individuals’ medical records and other personal health information.

In anticipation of the April 14, 2003, compliance date for the Privacy Rule, the Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) published *Guidance for the Privacy Rule* on July 6, 2001 (www.hhs.gov/ocr/hipaa). According to this document, the Privacy Rule sets boundaries on the use and release of health records by establishing safeguards that healthcare providers and others must achieve to protect the privacy of health information. It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients’ privacy rights.

IMPORTANT DATES FOR HIPAA IMPLEMENTATION

Aug. 21, 1996 HIPAA becomes law.

Dec. 28, 2000 Final rule “Standards for Privacy of Individually Identifiable Health Information” (Privacy Rule) is published in the Federal Register.

Dec. 27, 2001 The Administrative Simplification Compliance Act becomes law, providing a means by which the administrative simplification provisions of HIPAA may be extended by one year.

April 14, 2001 Effective date for the Privacy Rule.

March 27, 2002 Health and Human Services proposes changes to the Privacy Rule (www.hhs.gov/ocr/hipaa/propmods.txt).

March 29, 2002 CMS issues a model compliance plan for filing a one-year extension to comply with the rule governing electronic health care transactions (www.cms.hhs.gov/hipaa/hipaa2/ASCAForm.asp).

July 6, 2002 The HHS Office for Civil Rights publishes “Guidance for the Privacy Rule” (www.hhs.gov/ocr/hipaa).

Aug. 14, 2002 Final Rule “Standards for Privacy of Individually Identifiable Health Information” (Privacy Rule) is published in the Federal Register (www.hhs.gov/ocr/hipaa/finalreg.html).

Oct. 15, 2002 Date by which a compliance plan for a one-year extension must be postmarked or filed electronically.

Oct. 16, 2002 Original compliance date for Electronic Health Transactions and Code Sets.

April 14, 2003 Compliance date for the Privacy Rule.

Oct. 16, 2003 Compliance date for Electronic Health Transactions and Code Sets for those with a compliance plan filed by Oct. 15, 2002.

The final rule was published in the Federal Register on Aug. 14, 2002, and a fact sheet summarizing the rule was released on Aug. 9. Both documents are available at www.hhs.gov/ocr/hipaa.

Neurosurgeons Share Patients’ Concerns

Right or wrong, the public sees patient data stored on paper as good for privacy and patient data stored on computers as bad for privacy. Today, a large majority of adult citizens in the United States lack confidence that their medical records are safe from unauthorized disclosure or use. They have reached that conclusion because they know that, without their consent, their personal health information easily and legally can be passed around for non-healthcare reasons to people who aren’t physicians.

The implications are sobering for neurosurgeons. As discussed in *HIPAA Compliance for CMA Members*, published in 2001 by the California Medical Association, if patients are worried that what they tell their physicians may fall into wrong hands, they may withhold information needed to reach the correct diagnosis. Also, if patients lack confidence that their personal physician can no longer protect their privacy, then the cornerstone of the practice of medicine—the trust-based patient-physician relationship—is in serious jeopardy.

Privacy Rule Provisions

Following are some provisions of the rule as described in *HIPAA-Clinician/Senior Management Education and Training Materials* produced by the California Healthcare Foundation in 2001. It is clear that individually identifiable health information may not be used or disclosed unless specifically approved by the patient or explicitly permitted under HIPAA. Further, patient consent will not be required for the use or disclosure of information for three purposes: treatment, payment and other healthcare operations (TPO).

The Privacy Rule requires most covered entities to provide individuals with adequate notice of the uses and disclosures of protected health information that may be made by the covered entity. This privacy notice must include the explanation of the individual’s rights, and the covered entity’s responsibilities with respect to covered health information. “Covered entities” include health plans, healthcare clearinghouses, and healthcare providers. The Privacy Rule also refers to patient consent and authorization. Patient authorization is disclosure of information for non-treatment purposes such as employers, underwriters or researchers. The rule also states that the use of health information for non-treatment purposes must be limited to the “minimum necessary.”

A written agreement must be in place that provides for appro-

appropriate safeguarding of health information with all “business associates.” These include practice management consultants, collection agencies, malpractice insurers, and accountants, among others. Each practice must designate a privacy officer, develop privacy policies and procedures, and provide staff training to ensure that health information is protected. Small offices do not have to develop elaborate systems, just basic protections and the office manager can be the privacy officer.

Consent is not required for sharing a patient’s medical record with another physician when referring the patient to that physician or when billing a patient referred for a specialty consultation. Privacy regulations will require authorization for disclosure of identifiable information in all cases when used for ancillary purposes such as research, either clinical or market. “Data mining” by which protected health information (PHI) is often sold for marketing will be effectively stopped unless authorized by the patient; legitimate research will not be affected.

Authorization will also be required for information given to employers or for employer group use. The Guidance for the Privacy Rule document indicates that treatment cannot be refused for failure to sign authorization. Authorizations must be written in specific terms and must identify the information to be disclosed, persons authorized to make the disclosure, persons authorized to receive the information and the “expiration date” of authorization.

For records that are subpoenaed for court use, the bottom line answer is that a properly issued records subpoena will generally be valid, and a physician who releases records under such a subpoena will be protected. This is explained in the Code of Federal Regulations 45:164.512(e).

Physicians must provide a “Notice of Privacy Practices” to each patient no later than the date of the first service after the compliance date, which is April 14, 2003. If the notice is revised, it must be provided to the patient at the first visit after revision. Patients have the right to inspect and receive a copy of their medical records and to request amendments to their medical records. Though providers have the right to deny inclusion of an amendment, that patient has the right to file a “Statement of Disagreement” which becomes part of the record. The provider can file a rebuttal to the Statement, should he/she so choose. Patients also have the right to receive an accounting of disclosures of protected information not related to TPO. Individuals may request restrictions on the use and disclosure of information that go beyond those provided in rule, but providers are not required to comply with these requests.

The Security Regulation

The companion to the Privacy Rule is the Security Regulation. The Security Regulation, which has not yet been finalized, will provide for physical and electronic protection of PHI in order to prevent unauthorized access. Spokespersons for HHS indicate the substance of the regulation will not change much in its final form. It is essential

to understand and implement the Security Regulation in order to effectively implement the Privacy Rule. The following summary is taken from *HIPAA-Clinician/Senior Management Education and Training Materials* published in 2001 by the California HealthCare Foundation.

Security Standards for all patient-specific information can be grouped into four categories. These include administrative procedure safeguards; comprehensive security policies and procedures; physical safeguards, including data integrity, backup, access, workstation location and security training; and a technical security mechanism to guard against unauthorized access to data. Technical security services need to be in place in order to protect patient information and control, monitor and audit individual access to information. The security standards do not specify particular technology requirements. Each practice must assess its own risk and develop security measures accordingly.

Neurosurgeons must develop written security policies and procedures for their practices and employees must receive training on those policies and procedures. Access to data must be controlled through appropriate mechanisms such as passwords, automatic tracking of when patient information has been accessed, reviewed, created, modified, or deleted and by whom. Security systems must be certified to meet the minimum standards.

Security and privacy requirements are scalable. Thus, in a small office every staff member will need access to all medical records. This is permitted, while in large organizations with staff that has differentiated tasks, such unlimited access would not be permissible. The techniques will also depend on the size of the organization. While a large multi-specialty group with 100 staff might use biometric identification and smartcards with passwords, a four-person office might not do so.

It appears that most physicians, not only neurosurgeons, are woefully behind in preparation for HIPAA. Speaker after speaker at national meetings have enunciated this problem. It has been stated by many that Congress will repeal HIPAA, but no, it won’t. Some have said it is a Clinton program and with a new president it will go away. No, it hasn’t. Still others say there will be no HIPAA enforcement for many years. This is incorrect also; there will be. It is time to put anger and denial behind us and to get to work on compliance. ■

John A. Kusske, MD, is chair of the Department of Neurological Surgery at the University of California-Irvine, chair of the AANS Professional Liability Committee, and a member of the AANS/CNS Washington Committee.

HIPAA Resources

- AANS HIPAA Manual on CD-ROM is available in the AANS Online Marketplace at www.aans.org or call AANS at (888) 566-AANS.
- “The HIPAA Train Is Here: Getting on Board Now May Benefit Your Practice,” John A. Kusske, MD, *Bulletin*, Summer 2002, pages 30-31, www.neurosurgery.org/aans/bulletin.

Cultural Connections

Global Perspectives Inform 71st AANS Annual Meeting

BY MANDA J. SEAVER

Renowned for its year-round idyllic climate, San Diego long has been a destination for travelers around the world. In addition to 70 miles of pristine beaches, the Southern California city boasts a dazzling array of attractions, including the world-famous San Diego Zoo and Wild Animal Park, SeaWorld San Diego, charming neighborhoods and communities—downtown’s historic Gaslamp Quarter, Coronado, La Jolla—and myriad sporting activities as well as cultural offerings, known as “art and sol” in a city that celebrates sun.

Against the backdrop of a city where each day’s dawn holds the promise of a glorious sunset, with endless opportunities to see and do in between, the Annual Meeting of the American Association of Neurological Surgeons is renewed in its 71st year through a fresh approach to its core attraction of scientific programs and a panoramic view of neurosurgery.

Emblematic of new vistas in neurosurgery open to exploration at this annual meeting, the theme “Cultural Connections: Bringing Global Perspective to Neurosurgery,” was chosen by AANS President Roberto C. Heros, MD.

Scientific Program: Reaching Out to the World

Scientific Program Chair William T. Couldwell, MD, said, “This year, in keeping with our meeting theme, we are making every effort



View of San Diego skyline from Point Loma.

PHOTO CREDIT: JAMES BLANK

to involve top neurosurgical colleagues from around the world. By doing so, all of us will benefit from the exchange of cutting-edge research and fascinating ideas that are being explored in North America and beyond.”

WHAT'S NEW FOR 2003

71st AANS Annual Meeting
April 26–May 1, 2003
San Diego Convention Center

Annual Meeting Chair:
Ralph G. Dacey, MD

Scientific Program Chair:
William T. Couldwell, MD

- **Cushing Orator**—Henry A. Kissinger, PhD, Tuesday, April 29.
- **Japanese-American Neurosurgical Friendship Symposium**—Japan Neurosurgical Society and AANS on Friday, April 25.

- **Kurze Lecture**—Gazi Yasargil, MD, will deliver the premier Kurze Lecture, established this summer by John J. Guarnaschelli, MD, and his wife, Martha L. Guarnaschelli, in memory of Theodore Kurze, MD.
- **Media Training Workshop**—Open to all AANS members registered for the Annual Meeting.
- **Neuroscience Courses for Nurses and Physician Assistants**—Neurosurgeons are encouraged to sponsor attendance of their nurses and PAs.

- **NREF Fundraiser**—Food, fun and dancing after the Opening Reception on Sunday, April 27.
- **Plenary Session Extended**—Three days of oral papers instead of two.
- **Point-Counterpoint**—A fast-paced exchange exploring a controversial clinical topic.



Watch for 2003
AANS Annual
Meeting updates at
www.aans.org.

He noted that the Scientific Program Committee actively solicited prominent international neurosurgeons for abstracts that would deepen the pool of excellent oral papers. In addition, the program was restructured to facilitate inclusion of various points of view. For example, this year each breakfast seminar moderator, rather than the committee, is charged with selecting their program's speakers.

Other changes involve augmenting sessions that have proven popular in recent years and adding new programs that advance science. "The plenary session is extended to Wednesday to accommodate the best oral papers," Dr. Couldwell explained. "The special courses on Thursday include world-renowned neurosurgeons focusing on aneurism treatment, a course on contemporary management of the spine, and, regarding practice management, an update on legislative issues, including EMTALA and HIPAA."

In addition, the special lectures—among them the inaugural Kurze Lecture, to be given by Gazi Yasargil, MD, and the second Rhoton Family Lecture, to be delivered by Rear Admiral James A. Johnson, commander of the Naval Medical Center in San Diego—will be interspersed with the oral presentations. A new 30-minute point-counterpoint session is intended to stimulate discussion of controversial clinical issues.

"Our goal is to make this meeting the premier neurosurgical event in the world," said Dr. Couldwell, himself a native of Canada who trained in Europe. "I think it will be." ■

Manda J. Seaver is staff editor of the *Bulletin*.

Land of the Rising Sun—City of the Setting Sun: Japanese-American Neurosurgical Friendship Symposium

Building on the success of the 2002 Francophone Symposium, AANS extends its hand in friendship across the Pacific to Japan. Members of the Japan Neurosurgical Society (JNS) will be the honored guests of the AANS in San Diego for the Japanese-American Neurosurgical Friendship Symposium, organized by Christopher M. Loftus, MD, and Kiyonobu Ikezaki, MD.

During the symposium, scheduled for Friday, April 25, from 8 a.m. to 3:15 p.m., members of the AANS and JNS will address topics concerning Japan's healthcare system, new surgical instruments, endovascular neurosurgery, molecular neurosurgery, and more. Conducted in English, the program will commence in segments of one topic illuminated by two oral papers given by Japanese neurosurgeons, followed by discussion led by two AANS members.

An evening reception will cap the program, allowing time for cultural, as well as scientific, exchange.

Henry A. Kissinger, PhD, Cushing Orator



As America confronts terrorism on home soil, honored statesman Henry A. Kissinger, PhD, will provide his truly global perspective on current world events. The 2003 Cushing Orator, born in Germany, is a naturalized United States citizen who is the recipient of the Presidential Medal of Freedom (the nation's highest civilian award) and the Medal of Liberty (given one time to 10 foreign-born American leaders).

Dr. Kissinger, America's first name in geopolitical opinion, is praised as one of the most brilliant secretaries of state in the history of our nation. World-renowned for his unparalleled skills in the art of diplomacy, Dr. Kissinger understands first-hand the delicate balance of world power and America's place in it.

Secretary of state under Presidents Nixon and Ford, Dr. Kissinger was also national security adviser for six years. He was a key negotiator of the withdrawal of American forces from Vietnam, for which he won the Nobel Peace Prize.

His recent book, *Does America Need A Foreign Policy*, debuted to critical acclaim. The American Library Association commented on the book: "Can anyone think Kissinger would answer the question posed in his book's title with a no? Of course America needs a foreign policy, and Kissinger is just the man to tell us what it is. Having spent much of the 1970s and 1980s in or near the corridors of power, practicing realpolitik at the State Department and National Security Council, Kissinger has his own analysis of the special challenges the U.S. faces in the new century."

Dr. Kissinger's previous book, *Years of Renewal*, the third and final volume of his memoirs, also received high praise. According to *The New York Times*, "Mr. Kissinger demonstrates that he is not only a formidable diplomat but an engaging storyteller as well, and he treats episodes of diplomacy as narratives, complete with interesting characters, plenty of dramatic tension, and, obviously, high stakes."

In his public appearances Dr. Kissinger shares the nuances and principles of the art of diplomacy. Drawing on his past experiences with some of the most important foreign policy leaders of our time, as well as his current work as an international corporate consultant, he advances our understanding of international relations and the resulting impact on our domestic economy and security. Dr. Kissinger expertly shares the lessons of the past—throughout time and particularly through our modern history—to summarize the strength of America's global position today.

Marketing a Neurosurgical Practice

You Don't Have Time Not to Build Your Practice

I was amused recently by a comment made by a surgeon who, somewhat disappointed that his surgical schedule wasn't as full as he wished a year or two after joining an established practice, said impatiently, "I'm 42 years old. I don't have time to build a practice."

Unfortunately, nothing could be further from the truth. Neurosurgeons are engaged in practice building every day of their practice careers. Every patient seen and treated is more than a medical service; it is an opportunity to gain another referral. Every physician and public contact is a chance to expand the sources and numbers of referrals. The correct response to this surgeon's complaint is, "You don't have time not to build your practice."

Establishing, maintaining or expanding a practice in a competitive environment is a full-time effort and requires marketing.

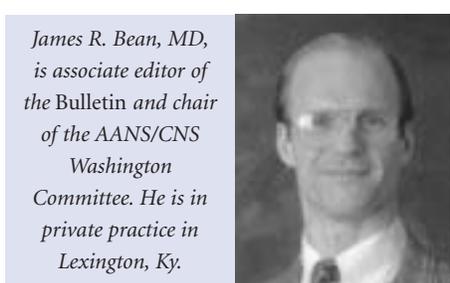
You: The Solution to a Patient's Problem

Marketing, however, is not simply advertising. Marketing is informing the public about who you are, what you do, and why people want to see you. What differentiates practice marketing from commercial product marketing (such as cars, cameras and computers), is the audience, the methods, and the consumer's motive. Commercial marketing targets the broad public, using brief images and messages that appeal to personal wants or needs to capture attention, and repetition to implant and reinforce the image in the consumer's mind, even creating demand where there was none.

Professional marketing is different. Patients see a neurosurgeon not because they want an operation, but because they have a problem. The challenge is matching their needs to your services as the solution to their problem, so when that need arises in

the few who have it, your practice becomes the destination for the patient referral.

But neurosurgeons in a busy practice do not have time to personally screen large numbers of potential patients for problems they can treat. They need a referral network



and screening process in place to ensure that numerous referrals are received, and that those referrals are appropriately screened for the practice's services.

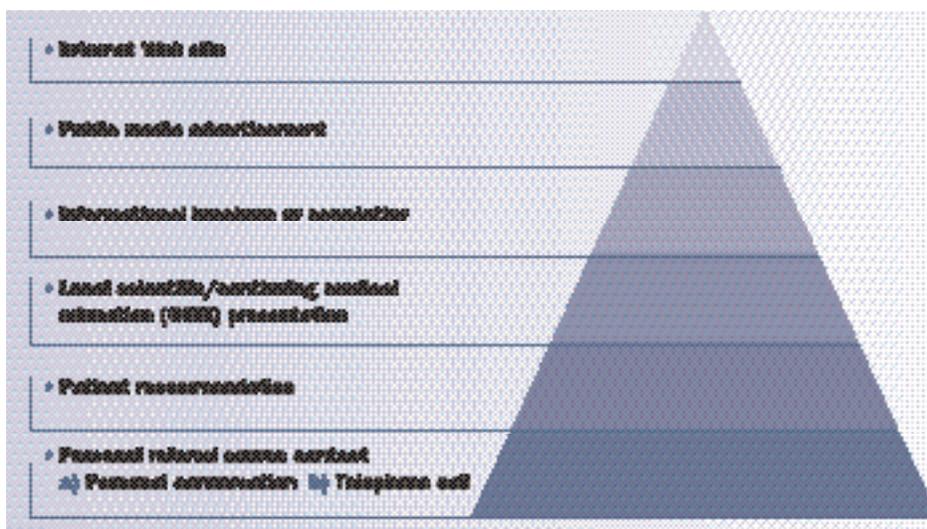
Fundamentals Count

The concept of marketing often generates images of advertising agencies and thousands of dollars of consulting and public

media costs. This is a misperception. Professional marketing for neurosurgeons is like a pyramid, with the fundamental and most effective means as the base (see figure). In fact, the most powerful and successful practices require little more than the first two levels. The methods of marketing a practice, in descending order of effectiveness, currently are:

- Personal referral source contact
- Personal conversation
- Telephone call
- Patient recommendation
- Local scientific/continuing medical education (CME) presentation
- Informational brochure or newsletter
- Public media advertisement
- Internet Web site

Personal referral source contact is the most potent and effective method of building future referrals. Most referrals



Professional marketing is like a pyramid, with the fundamental and most effective means as the base.

come from primary care physicians. Each PCP manages from 1,500 to 4,000 patients, depending on the style and popularity of practice. Each neurosurgeon needs a population base of 60,000 to 100,000, depending on the type of practice. PCPs are the fundamental leverage point in a neurosurgeon's referrals. A PCP is the neurosurgeon's reservoir of potential patients, the screening mechanism for appropriateness of referral, and the decision-maker in most cases about the desti-

must not be neglected. But for marketing purposes, they are a weaker substitute for direct verbal and visual contact. An opportunity to speak to a PCP is a potent opportunity to market the practice.

Satisfied Patients Spread the Word

Satisfied patients will augment your marketing efforts. Patient-to-patient recommendation is the next most powerful source of referrals, but it takes time to build

what you are doing that differentiates your practice from others. One of the goals of marketing is to seek and exploit a "competitive differential advantage," something that is in demand and uniquely available in the practice. Scientific and CME presentations are the best professional opportunities to leverage referrals by promoting a competitive differential advantage, whether it be a new or unique procedure, a subspecialty expertise, or simply an area of interest and experience.

Informational brochures about the practice mailed to regional referral sources can be used to promote the practice, especially when a physician is new to the region. They also can be used in combination with personal contacts; for example, when speaking at a scientific presentation, provide brochures to interested parties so they will have a reference regarding what your practice offers and how to contact you. However, the expense can be high, and the return low.

Public media advertisement is the least effective and most expensive means of marketing a practice. It has a high price tag and fails to target the audience where referrals originate. Better to spend that money on improving service in the office on patients who will spread the word for you. Or better yet, spend the time to increase physician contacts to build referrals, and clinic appointment times to receive referrals.

Finally, a growing number of practices have established Internet Web sites as information sources for current and potential patients. In fact, patient use of Internet information is becoming more and more common. It is not a substitute for good service, but it does provide an alternative opportunity for the practice to market information to the public and project the image it would like the public to see. It should include physician profiles, office appointment information, a range of services, postoperative instructions, and links to Web sites that feature medical information. ■

“Patients see a neurosurgeon not because they want an operation, but because they have a problem. The challenge is matching their needs to your services as the solution to their problem, so when that need arises in the few who have it, your practice becomes the destination for the patient referral.”

nation of referral. Depending on the practice, referrals may come from other specialists (neurologists, orthopedists, oncologists, or even other neurosurgeons), but the principle is the same. Personal conversation means face-to-face discussion, whether about a particular patient, or about professional practice in general. The important goal is personal acquaintance, so that you, as a neurosurgeon, come to mind when a neurosurgical referral is needed.

Telephone conversation is the second most effective means of securing future referrals. A personal call to the PCP after seeing a new referral, when a diagnosis or treatment decision is made, or after a surgical procedure is completed ensures that the PCP is aware of the patient's care and further cements the long-term professional relationship. Each telephone call is another brick placed in the wall that becomes the practice edifice. It is time leveraged wisely.

Finally, written letters and reports that keep referring physicians informed of each encounter are important, are the least time consuming form of communication, and

a reserve of current and former patients in the practice area sufficient to influence patient choice, particularly if it differs from the PCP's customary referral. However, once a large enough reservoir exists, it is always surprising how often a patient finds others in the community with similar problems and acts on a recommendation from a former patient. Satisfied patients and family members return more business than any public advertising campaign can. This means more marketing benefit comes from respectful care, technical competence, amenities, conveniences, and helpful responses provided to current patients than public media and mail marketing campaigns can ever generate.

Local scientific or CME presentations are solid marketing tools. From a practice perspective, more important than teaching neurosurgical colleagues new techniques is teaching referring PCPs and other specialties what you do and who needs the service. Rarely is there a similar opportunity to talk to an audience that is so concentrated with potential referrals about how you can serve their needs, or

Evaluation & Management Codes

Managing the Process, Mastering the Rules

Although neurosurgeons often assume that most of their work is performed in the operating room, more than 25 percent of a typical neurosurgical practice collects income from evaluation and management (E&M) services. Moreover, a significant portion of the physician work component of global surgical services in the resource-based relative value system (RBRVS) involves E&M services provided by the surgeon, including hospital and office visits. Finally, the perceived and occasionally real threat of practice audits to examine the appropriate usage of E&M codes has prompted a great deal of interest in mastering this often complicated set of rules. The following review of E&M coding includes the evolution of the rules governing E&M over the past decade, followed by a glimpse into the possible future format that E&M guidelines may take.

E&M Codes Debut in 1992

The current codes for E&M services were introduced into Current Procedural Terminology (CPT) in 1992 along with the adoption of the relative value system for assessing physician work. The American Medical Association's CPT Editorial Panel began to develop this revision three years earlier to improve coding uniformity. At the same time, the Centers for Medicare and Medicaid Services (CMS—at the time known as the Health Care Financing Administration, or HCFA, an agency of the Department of Health and Human Services) was charged with developing a uniform system as part of standardizing Medicare policy. Multiple factors were considered including levels of service, site of service, differentiating patient type, and the importance of time. A pilot study conducted in 1991 used clinical descriptions of typ-

E&M REVIEW	
1989	CPT Editorial Panel and CMS independently begin work to improve coding uniformity.
1991	CMS pilot study of uniform coding uses clinical descriptions of patient visits followed by field testing.
1992	CPT Editorial Panel implements E&M revisions based on history, physical examination, and medical-decision making. CMS accepts E&M revisions.
1993	CMS revises RVUs so that they increase as the level of service increases.
1995	CMS establishes guidelines for proper use of RVU codes.
1997	CMS revises 1995 RVU guidelines to include organ system-specific examinations. AMA protests "accounting" method of describing physician work.
2000	CMS drafts and revises new RVU guidelines.
2001	CMS provides the AMA with RVU guidelines derived from medical records. AMA forms the E&M workgroup to evaluate problems with RVU guidelines and make recommendations to the CPT Editorial Panel.
2002	E&M workgroup presents its findings to the CPT Editorial Panel.

ical patient visits, which were subsequently field-tested in the second phase to determine reliability in actual practice. After revising the guidelines based on these studies, the CPT Editorial Panel implemented the E&M revisions in 1992, and these were accepted by CMS. The previous levels of service were replaced with a "more precise" method of assigning codes based upon the now familiar triad of history, physical examination, and medical-decision making. Although time was included as a contributory component to help guide practitioners, CMS emphasized time as an ancillary factor to facilitate choosing the appropriate level of service.

The work relative value units (RVUs)—the value of each CPT code in the Medicare Fee Schedule—were revised in 1993 by CMS after deciding that the work per unit time should be uniform among these services and the RVU should increase linearly as the level of service increases. The assigned RVUs were reevaluated by CMS in

1998 as part of the five-year review. Concurring with the Relative-value Update Committee's recommendations, CMS increased the RVUs for E&M services based on the argument that these were undervalued compared with other physician services.

RVU Guidelines Implemented in 1995

Guidelines for proper use of RVU codes were implemented in 1995. At that time, a general physical examination was the template for the E&M service. Since specialists did not perform a general physical examination, but instead performed a comprehensive specialty-specific examination, revised 1997 guidelines included organ-system specific examinations in lieu of general physical examinations. However, the "accounting" method of describing varied physician activities in a bulleted format prompted frustration and discontent among various physician groups. The AMA responded by developing an alternative recommendation for revising the

documentation guidelines to CMS.

In June 2000 CMS issued a draft guideline that was revised the following December. CMS contracted with Aspen Systems Corporation to develop clinical examples that would serve as guides for promoting accurate coding of E&M services. Clinical examples derived from actual medical records were used and presented to the AMA in May 2001. Many specialty societies voiced concerns about the methodology and implications, prompting the AMA to write a letter to Thomas Scully, CMS administrator, describing the identified problems and requesting the opportunity for specialties to develop clinical examples. In July 2001 the Department of Health and Human Services and its agency, the CMS, agreed to work with the AMA, and the CMS brought the Aspen project to a halt. The AMA formed an E&M workgroup to

evaluate current problems and make recommendations to the CPT Editorial Panel for consideration. Neurosurgery is indebted to the efforts of Troy Tippett, MD, who served on the E&M workgroup and helped guide the process to fruition.

E&M Workgroup's Findings

In August 2002, the workgroup presented its findings to the CPT Editorial Panel. Many options were discussed by the workgroup, ranging from developing a single code to maintaining the current guidelines. Given that various clinical scenarios require different amounts of emphasis on the various key components, the workgroup felt that medical decision-making with the required clinically appropriate history and examination will drive the time and physician work required to provide a given service. The workgroup rec-

ommended moderate changes to the existing guidelines, including the elimination of some confusing service types and the establishment of new code descriptors and criteria that appropriately reflect the intensity of total physician work, particularly the importance of medical decision-making in the choice of a given level of E&M service.

While either the 1995 or 1997 documentation guidelines are being utilized currently, a newer system is likely to be implemented in the future that reflects the cognitive efforts of the physician in providing patients with appropriate medical care rather than "counting" the number of activities performed. ■

Gregory J. Przybylski, MD, is associate professor of neurological surgery at Northwestern Memorial Faculty Foundation of Northwestern University in Chicago and a faculty member for AANS-sponsored coding and reimbursement courses.

Your Handy Handheld and HIPAA

Should Patient Data on Your PDA Concern You?

Handheld computers, also known as personal digital assistants (PDAs), are being used increasingly in the clinical setting by healthcare professionals. But if you use a personal digital assistant when providing patient care, you and your PDA may be subject to the privacy and security standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for which the final regulation was published Aug. 14, 2002.

Today's PDAs Are Used for Much More Than Scheduling

Today's PDAs not only can be used for the typical scheduling and contact information tasks, they can access the Internet and carry software, including valuable clinical reference guides. They also frequently are being used as a mechanism to conveniently record and store patient-specific data. This data may later be downloaded into a healthcare provider's computer network system for inclusion in each patient's medical record. The article "A Typical Day With A PDA," which appeared in the Summer 2002 issue of the *AANS Bulletin*, described the PDA habits of a technology-savvy physician who, among other things, uses his PDA as a portable device to record patient treatment information and later, to print out these notes for inclusion in a patient's paper medical record. Another example of PDA use in the healthcare setting is provided by a new Concentra Health Services program. Concentra is a Texas-based occupational therapy group, which is conducting a pilot program in which 1,000 of its physicians and physical therapists are using wireless technology devices to electronically record patient care data and complete patients' medical notes for downloading into the provider's main computer systems.



Handy Devices Don't Circumvent HIPAA

PDAs are handy devices. HIPAA, however, requires any healthcare provider, clearinghouse, or health plan—each known as a "covered entity" under HIPAA—involved in a patient's care to take reasonable efforts to limit the amount of personally identifiable health information it uses, discloses or requests to the minimum extent needed for accomplishing the intended purpose. HIPAA also requires that:

- computers and data containing protected health information (PHI) are protected from compromise or loss;
- audit trails of access to PHI are kept; and
- electronic transmissions of PHI are authenticated and protected from observation or change.

The HIPAA privacy standards are described in more detail in "Privacy Rules" by John A. Kusske, MD, in this issue. Briefly, however, HIPAA is designed to protect PHI that could be used to identify an individual relating to his physical or mental health condition, the provision of healthcare to that person, or the payment for his healthcare. Protections are extended to PHI that is

transmitted electronically, maintained electronically, or transmitted or maintained in any other form or medium.

How Is Your PDA Used?

For purposes of assessing the privacy and security requirements imposed on the use of a PDA to store and retrieve personal health information, it is helpful to consider the use of the PDA on several different levels.

First, the security of the data contained on a PDA itself is regulated by HIPAA, and the PDA must be guarded against unauthorized use. Generally, PHI may only be accessed and used by covered entities for appropriate treatment, payment or healthcare operations purposes. For example, physician-to-physician consultation for patient treatment purposes, such as sharing patient data stored on their PDAs, would be a valid use of PHI. Moreover, a PDA's small size makes it easy to misplace and a popular target for thieves. With respect to the security of the PHI contained on a PDA that is used and stored exclusively in the physician practice setting, there may be fewer risks of the data falling into the hands of unauthorized individuals who are not involved in the patient's care. The risk that PHI will be compromised, however, increases in a clinic or hospital setting or even in a health system that involves many people and organizations sharing PHI while providing healthcare in several geographically distinct settings.

Second, the transmission of data from a PDA to the provider's computer network is regulated. Networked PDAs carry the risk that someone may intercept a PHI data transmission while transferring PHI to the main computer system. For wireless data transmission, information may even be intercepted by someone with a rogue

wireless system outside of the health facility's walls. According to Dyane Genovese in *Computer Bits*, the greatest risk for a wireless security breach (that is not provider-controlled) can happen when data is transferred from a wireless system to a wired system. In addition, a PDA user may accidentally "beam" PHI via the PDA's infrared port to an unintended recipient or transmit more data than was intended. Thus, wireless transmission of PHI from a PDA to a mainframe should not be considered unless a secure transmission is guaranteed.

Third, the transmission of PHI from a PDA to any person other than the provider (which is the custodian of the PHI) is a transmission subject to the security requirements of HIPAA. While appropriate encryption and data set requirements can be met for PDA user transmissions, a physician using a PDA should not transmit PHI to a third party, such as a health insurance plan, unless such transmission is coordi-

nated with the provider's HIPAA compliance program.

Securing Patient Data on Your PDA

Although HIPAA does not set forth any specific requirements for PDAs, HIPAA does require that reasonable steps be taken to protect PHI in electronic form. Certain steps for securing PHI stored on a PDA include:

- Activate the password protection that comes with your PDA (or purchase the more robust password protection software sold by third-parties).
- Keep track of your PDA to ensure it is not misplaced and that unauthorized individuals do not have access to it.
- If you transmit PHI from your PDA to your facility's computer systems via a network or wireless network, ensure that proper network security measures (including device authentication and data encryption) are in place.

- Encrypt the PHI on your PDA via the included software or through third-party software.
- Ensure that the caretaker of the PHI has set in place procedures to handle the security of PHI and that software exists to create an audit trail of system activity, including login attempts, security incidents and attempts to access files containing PHI.
- When your PDA has become obsolete, use disk-wiping software to clear out or overwrite the PHI.

While PDAs seem to have endless potential to provide convenience, efficiency, improved documentation, ease of data entry, and the ability to have a portable medical record, use of a PDA, like any other medium, must comply with HIPAA requirements to protect a patient's privacy. ■

Kara M. Friedman, JD, and **Morgan G. Moran, JD,** are attorneys in the Health Care Group at Ross & Hardies, Chicago, Ill.

With PDAs, Cooperation Is Key to Maintaining Privacy

For purposes of assessing the privacy requirements imposed on the use of the personal digital assistant (PDA) to store and retrieve personal health information, PDAs can be viewed as little more than portable computer terminals. Thus, while a physician could use a PDA in a clinical setting for retrieving reference material without adhering to a standard PDA protocol imposed by the provider, if the technology is used for storing and retrieving personal health information, it is in the interest of the healthcare provider (e.g., medical practice owner, hospital or outpatient clinic) to require that the PDA's use and functionality be coordinated with the healthcare provider's health information system.

In the hospital setting, it may very well be the case that the more innovative physi-

cians on staff will solicit hospitals for their assistance in making PDA software and documentation practices compatible with the hospitals' systems. Some hospitals will be more amenable to creating wide functionality for these PDA users. In the hospital setting, however, it is the hospital itself that is regarded as the custodian of the patient's health information. Thus, most hospitals will rightly first develop hospital information systems that comply with HIPAA and then accommodate PDA use.

For example, a hospital may be urged to create a wireless interface that allows physicians to tap into the hospital's main systems without ever connecting the PDA to another computer, much as they would make a telephone call using a cell phone. Protection of information transmitted to the mainframe, however, may be suscepti-

ble to interception, and cradle transmission (as opposed to infrared transmission) may be the first step toward PDA-to-mainframe integration when the privacy of patients is a key priority. On the other hand, the probable documentation benefits of lessening the time between clinical inquiry and documentation of the information gathered based on such inquiry present hospitals with the incentive to develop the capability for full integration of PDA activities.

Before investing significant expense and energy in developing optimal clinical use of a PDA, it would be wise to approach the medical staff coordinator(s) at the hospitals to ascertain the facilities' ability and willingness to accommodate PDA users.

— Kara M. Friedman, JD, and
Morgan G. Moran, JD

Committees Move AANS Forward

International Outreach, Ethics and Values Explored

The committees of the American Association of Neurological Surgeons are the volunteer backbone of the association. Many of the AANS committees, their chairpersons, members, and links to each person's contact information are available at www.neurosurgery.org/aans/about/committees.asp.

International Outreach Committee. The AANS is expanding its international efforts. In late 2001, an International Advisory Task

Force was created, headed by Benjamin T. White, MD, of the University of Oklahoma Health Sciences Center. At its July 19 meeting, the Executive Committee officially designated the Task Force as the International Outreach Committee. The committee will be chaired by Dr. White, and includes: Christopher Loftus, MD, Diana Kraemer, MD, Daniel Kelly, MD, Russell Andrews, MD, Gail Rosseau, MD, Paul Francel, MD, and AANS President Roberto Heros, MD, as

an ex-officio member.

One of the IOC projects is to compile a list of programs that are willing to accept international visiting surgeons. The University of Oklahoma, for example, has international visitors on a regular basis. Visiting surgeons stay for periods ranging from one to three months and are self-funded. Because of licensing, credentialing and insurance reasons, the visits are limited to observational experiences.

The IOC is now compiling a list of institutions, hospitals and practices that are willing to accept international visitors. The host institution would solely determine the structure, length and content of the visiting surgeons' experience. The information compiled will be featured on the AANS Web site. If you have questions, or would like to include your organization in the directory of programs that accept international visiting surgeons, contact: Benjamin T. White, MD, Department of Neurosurgery The University of Oklahoma Health Sciences Center; benwhite@ouhsc.edu, (405) 271-4912.

The committee also will be sponsoring a competition for the Best International

Abstract submitted by a Resident or Fellow, for the 2003 AANS Annual Meeting. The IOC received AANS funding to support a \$2,000 travel scholarship, which will be used to offset some of the winner's travel costs to attend the San Diego Meeting.

Ethics and Human Values Committee. Recent headlines have spotlighted unethical and unprofessional behavior in the business and medical communities. Fraudulent accounting, obstruction of investigations, and issues surrounding informed consent have brought attention to the need for ethical behavior standards.

The AANS Ethics and Human Values Committee is an advisory committee that may make recommendations to the AANS

Board of Directors. The committee can be asked to review specific cases, or discuss general issues such as informed consents, research conduct, the ethical use of new and investigational technologies, the relationships between neurosurgeons and commercial sponsors, and the necessity of full disclosure of financial ties. The committee requests that members who have concerns submit their questions and issues to the committee's chair, Ann Marie Flannery, MD, Medical College of Georgia, 1120 15th St.; Augusta, Ga., 30912-4010; aflanner@mail.mcg.edu. ■

Susan M. Eget is the AANS associate executive director.

Actively Seeking Remuneration

AANS/CNS Coding and Reimbursement Committee Works for Neurosurgeons

The AANS/CNS Coding and Reimbursement Committee identifies and responds to coding and reimbursement issues of concern to neurosurgeons. To this end, committee membership includes a liaison from each of the AANS and CNS sections. The committee membership also includes AANS and CNS representatives and advisers to the American Medical Association Current Procedural Terminology (CPT) Editorial Panel, AMA Relative Value Update Committee (RUC), and the AMA Practice Expense Advisory Committee, which is a subcommittee of the RUC.

Through regular meetings during the AANS and CNS annual meetings, and “as needed” communications in conjunction with meetings of the CPT, RUC, and the Neurosurgical Leadership Development Conference, committee members stay abreast of current issues and developments that impact coding and reimbursement for neurosurgeons.

Cracking CPT Codes

The committee has been very active in reviewing and introducing new and revised neurosurgical codes for CPT. Suggestions for new codes typically come from AANS/CNS sections and individual AANS and CNS members. Regardless of the source of the initial request, the committee consults the appropriate section to determine if a new code is deemed necessary and of interest to the section’s neurosurgeons. If the issue proves to be of concern, the committee works with the section to propose a new code. In some cases, committee members and the Washington Office staff work with physicians and staff from other specialty societies who also perform the procedure. For example, the AANS and CNS have worked with radiol-

ogy groups on the creation of several new codes. A proposal for an intraoperative magnetic resonance imaging code will be presented at the November meeting of the CPT Editorial Panel. The code was developed in conjunction with the American College of Radiology and the American Society of Neuroradiology.

Some CPT proposals are intended simply to make the wording of the code easier to understand and more consistent with the format of the CPT book. These “editorial” changes are brought to the attention of the CPT panel by the advisers and often are

“RUC surveys are very important and a good response rate helps ensure that neurosurgical codes are appropriately valued.”

passed with little discussion. For example, at the August meeting of the CPT Editorial Panel, the AANS and CNS suggested that the wording of CPT Code 63173 *Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal space*, should be changed to add the words “or pleural space” to make the code consistent with other cerebral spinal fluid shunt codes currently listed in CPT. The CPT Editorial Panel considered this an editorial change and does not expect the code to require revaluing by the AMA’s RUC panel.

Other proposed codes submitted to CPT for consideration at the November 2002 CPT Editorial Panel meeting include new codes for epilepsy and for vertebral corpectomy with a lateral extracavitary

approach. For consideration at the February 2003 CPT Editorial Panel meeting, the committee is working with radiology specialties to submit a proposal for new codes for endovascular procedures.

Workgroup Evaluates E&M

At the November 2001 CPT Editorial Panel meeting, the panel appointed a workgroup to develop new codes for evaluation and management (E&M) services. Neurosurgery was fortunate to have Troy Tippet, MD, on this blue-ribbon panel to reorganize E&M guidelines. (The Coding Corner column in this issue discusses E&M codes in detail.)

RUC Recommends Work Values

The RUC is the body that makes recommendations to the Centers for Medicare and Medicaid Services (CMS) for relative work values for new CPT codes. Following a CPT Editorial Panel meeting, the RUC reviews the changes and sends out a memo to specialty societies asking their interest in surveying the physician work involved in the new code. In the case of revised codes, the RUC would require that the code be resurveyed if the level of physician work was significantly changed.

When a new code is to be considered by the RUC, surveys are sent to a random sample of the appropriate AANS/CNS section. RUC surveys are very important and a good response rate helps ensure that neurosurgical codes are appropriately valued. Neurosurgeons who receive an RUC survey should fill it out or pass it on to a colleague who performs the procedure in question. The survey packages always contain e-mail contact information for committee members and Washington Office staff who can answer questions about the survey. New codes valued at the RUC during 2002 include codes for neuroendoscopy, which

were approved at the February 2002 RUC meeting and codes for implantation of brain intracavitary chemotherapy agent, endovascular extracranial balloon occlusion, and four new codes for craniotomy/craniectomy for trauma, approved at the April RUC.

The RUC recommendations are important not only for Medicare payment but also for private payers who increasingly are basing their payment on the Medicare Fee Schedule. It is estimated that more than 90 percent of all medically insured people in the United States are affected by the system of relative value units (RVUs).

CCI and Medicare "Edits"

Another function of the committee is to review and respond to proposed "edits" implemented by the Medicare National Correct Coding Initiative (CCI). In May 2002, the AANS and CNS received a letter from Niles Rosen, MD, CCI director, regarding possible edits for the use of CPT 61795, stereotactic computer-assisted volumetric (navigational) procedures, intracranial, extracranial, or spinal. Specifically, Dr. Rosen requested a list of spinal procedures for which it would be appropriate to use CPT 61795. The Coding and Reimbursement Committee does not believe that such a list is advisable, due to the rapidly developing use of the technology. The committee sent a letter to Dr. Rosen stating that a list of codes was not appropriate and stating that with multiple codes used in spinal procedures and evolving technology, many combinations of codes might occur in which CPT Code 61795 is used.

On May 1, 2002, CMS issued a Program Memorandum to its Medicare Carriers requiring them to correct an error in the payment for bilateral billing of CPT 63030. AANS and CNS had brought to the atten-

tion of CMS the fact that the Medicare Fee Schedule file on the CMS Web site indicated that billing of CPT 63030 with the -50 when the procedure was performed bilaterally would be denied. Believing the item to be an error, AANS/CNS Washington office staff contacted CMS in mid-January. CMS subsequently resolved the issue and, after July 1, 2002, Medicare carriers will be required to cover CPT 63030-50. In addition, physicians may resubmit claims for CPT 63030-50 denied by Medicare between Jan. 1, 2002, and July 1, 2002.

PEAC Accepts Cranial and Spinal Values

AANS and CNS presented proposed practice expense values for 33 cranial codes to the AMA Practice Expense Advisory Committee at its meeting in Chicago March 21 through March 23, 2002. In addition AANS and CNS joined the North American Spine Society in presenting proposed practice expense values for 23 spine codes. The practice expense values for all the codes were accepted as presented.

Medicare Coverage Decisions

The committee tracks Medicare Coverage Decisions and assists in responding to proposals when appropriate. Two methods exist by which Medicare coverage decisions are made. Local Medicare contractors may develop local coverage policies (90 percent of Medicare's coverage policies are determined by local carriers) or CMS may develop national coverage policies.

Recently the committee has been involved in both levels with regard to Medicare coverage decisions for Deep Brain Stimulation (DBS). At the local level, the committee worked with other societies to the effect that the California Medicare carrier (NHIC) agreed not to implement proposed bundling payment

recommendations for DBS.

At the national level, comments and testimony through the committee regarding scientific evidence of DBS for several new indications influenced the Medicare Coverage Advisory Committee Medical and Surgical Procedures Panel to consider a national coverage policy for DBS in treatment of Parkinson's disease.

Proposed 2003 Medicare Fee Schedule

On June 28, 2002, the CMS published its proposed rule for the 2003 Medicare Physician Fee Schedule. The proposal contains several changes that impact the income of neurosurgeons. First, CMS made changes in its formula for calculating the Medicare economic index, which is one of the key factors used to determine the annual fee schedule payment update. These changes would result in a cut in the payment update by four and four-tenths percent. In addition, CMS made some global changes in its calculation of practice expense RVUs, fees that result in an addition reduction of slightly less than one percent. Thus, neurosurgery's total reduction is estimated at about five percent. Absent from the proposal were any adjustments to the malpractice RVUs to reflect skyrocketing professional liability insurance premiums.

At press time, the AANS/CNS Coding and Reimbursement Committee is working with the AANS/CNS Washington Committee to finalize formal comments for submission by Aug. 27, 2002. The comments address concerns about the Medicare economic index and sustainable growth rate and strongly emphasize the need to use more current professional liability cost data in figuring the malpractice portion of the fee schedule. ■

Samuel Hassenbusch, MD, is chair of the AANS/CNS Coding and Reimbursement Committee.

NEWS.ORG

AANS/CNS Sections Committees Associations Societies

AANS Census

Go to www.aans.org and click the "MyAANS.org" button to complete the AANS census online via a secure Internet connection.

AANS News

ASAE Honors AANS Professional Conduct Program

The American Association of Neurological Surgeons has been elected to the 2002 Associations Advance America Honor Roll for its Professional Conduct Program. The national awards competition is sponsored by the American Society of Association Executives, headquartered in Washington, D.C.

The main purpose of the AANS Professional Conduct Program is to provide an equitable and impartial system for upholding the AANS' Code of Ethics and resolving complaints of unprofessional member conduct, including complaints of unprofessional conduct by members who testify inappropriately in professional liability cases. The AANS Expert Witness Guidelines, which are enforced through its Professional Conduct Program, have recently been cited by the Federal Court of Appeals as "the kind of professional self-regulation that furthers the cause of justice."

"Membership in a professional organization such as AANS requires conduct that meets a high professional standard," said Russell M. Pelton, JD, legal counsel for the AANS. "When members believe that other members are acting outside this standard, they want their association to have a program in place to respond—our program accomplishes that."

Now in its 12th year, the Associations Advance America program recognizes associations that propel America forward—with innovative projects in education, skills training, standards setting, business and social innovation, knowledge creation, citizenship, and community service.

"The AANS Professional Conduct Program truly embodies the spirit of the Associations Advance America campaign. It is an honor and an inspiration to showcase this activity as an example of the many contributions associations are making to advance American society," said ASAE President Michael S. Olson, CAE.

Read about the AANS Professional Conduct Program in the cover story of the Spring 2002 *Bulletin*.

"My AANS" Features Online Census

Those accessing the abundance of information at www.aans.org lately may have noticed something new in the masthead. A button called "MyAANS.org" takes members to a secure area where they can complete the AANS census. "My AANS" eventually also will allow members to look up neurosurgical ICD-9 codes, pay dues online, access their own continuing medical education transcripts for use in tracking their CMEs, and act as an interactive resource for all speakers at AANS-planned meetings. After selecting the "MyAANS.org" button, members are asked to log in with their user name (e-mail address) and password. First-time users are asked to create a log-in by registering with their last name and member number. Help screens walk users through the process, so that everyone can feel comfortable navigating "My AANS." Once logged in, users can click on the "Census" tab and complete the census at one sitting or save it for completion at a later time.

"The census is a valuable membership tool because we not only receive the most updated information about our members, we find out how we can serve them better," said Chris Philips, AANS director of member services. "Our goal is to make it convenient for every member to complete the census, and we hope that providing online access to it via the secure 'My AANS' will go far in helping us accomplish this goal."

Section News

On-Call Stipends in Focus

The AANS/CNS Section on Neurotrauma and Critical Care highlighted controversy regarding stipends for on-call coverage in the new "In Focus" section of the latest issue of *Neurotrauma and Critical Care News*. The following commentary is available in its entirety at www.neurosurgery.org/trauma/newsletter/trauma0902.pdf.

As Donald Marion, MD, explained in his Chairman's Message: "Neurosurgeon availability is a prerequisite for any level I or level II trauma center. Unfortunately, designated trauma centers outnumber the number of practicing neurosurgeons in this country. In order to help neurosurgeons, and especially

Continued on page 40

Pediatric Neurosurgery Meeting in December

The annual meeting of the AANS/CNS Section on Pediatric Neurological Surgery is scheduled for Dec. 4-7, 2002, in Phoenix, Ariz. Additional information is available at www.neurosurgery.org/pediatric/meetings.

those in private practice, provide neurotrauma coverage, the Neurotrauma Section, together with our parent organizations, endorsed the AANS/CNS Position Statement on Improving Access to Emergency Neurosurgical Services, indicating that it is appropriate for hospitals to provide a reasonable stipend for being on the on-call panel at their hospital. As might be expected, many hospitals are resisting this suggestion, and in some locations neurosurgeons have found that they can no longer participate in trauma call, leading to the inability of their particular hospital to continue as a trauma center.”

John McVicker, MD, and Jack Wilberger, MD, provided their respective reviews of the stipend situation and their personal perspectives.

Dr. McVicker called for voluntary contracts between neurosurgeons and hospitals to help ensure neurosurgical availability: “Careful contracting with a hospital or system to provide services with specific safeguards and responsibilities for both parties may be the answer...Neurosurgeons engaged in a trauma program should be able to require the hospital to provide adequate equipment for neurosurgical procedures, maintain nursing and ancillary staffing at appropriate levels, and enter into defined transfer agreements when the on-call doctor unavoidably becomes unavailable. The contract can define fair compensation or the provision of other methods of compensation such as billing services, trauma data management, neurosurgical recruitment, etc. With or without a stipend, contracting for emergency department coverage is an appropriate and necessary step to protect yourself and your patients...”

Dr. Wilberger said that neurosurgeons “...have a moral and ethical obligation to make our talents and services available to deal with emergency neurosurgical problems...Trauma centers need neurosurgeons as part of the team to accomplish this worthy goal...A number of years ago, a true shortage of neurosurgeons in the Western parts of the United States gave rise to payment of stipends to neurosurgeons for trauma call...Has this practice relieved the manpower shortage? Has it made neurosurgeons more responsive to providing neurotrauma care? ... In a recent survey I conducted of 150 level I and level II trauma centers, 101 were providing reimbursement for trauma call...In those centers providing reim-

bursement, neurosurgical commitment was substantially less compared to those centers not providing reimbursement as measured by a neurosurgeon’s specific obligations to not only care for patients, but also to ensure that the trauma center continues to meet all of the oftentimes rigorous requirements for maintaining accreditation or verification. Thus, the Neurotrauma Section’s support of stipends for neurotrauma call has been, in my opinion, a step in the wrong direction.”

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Stereotactic Meeting Slated for May The Quadrennial Meeting of the American Society for Stereotactic and Functional Neurosurgery will be held May 18-21, 2003, at the Plaza Hotel in New York City. The event will feature workshops, keynote lectures and open papers on the topics of technology in stereotactic surgery, restorative surgery, stereotactic tumor surgery, stereotactic radiosurgery, movement disorder surgery, pain and the newly reemerging field of surgery for psychiatric disorders.

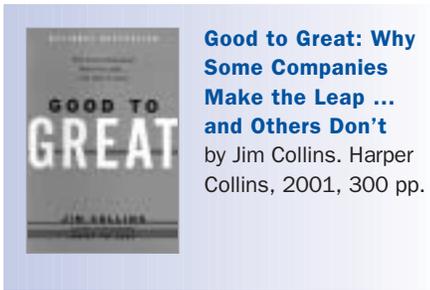
The meeting is being held under the auspices of Douglas Kondziolka, MD, ASSFN president. The scientific program, “Peering Into the Crystal Ball,” will emphasize what is in the pipeline and where stereotactic and functional neurosurgery will be in the not too distant future. Andres Lozano, MD, is serving as committee chair of the Scientific Program. Patrick Kelly, MD, the local meeting organizer, has produced an outstanding meeting environment and a roster of social activities to take advantage of springtime in New York.

Expected to attract 300 participants, ranging from neurosurgeons and scientists to surgical instrument manufacturers and other healthcare professionals, the meeting will provide a venue for experts and those new to the field to present their views and discuss controversies and coming therapies and technologies. Attendees will be able to gain awareness of the procedures and practices that are currently in use in stereotactic surgery and gain the knowledge they need to expand the field further.

Registration for the meeting can be completed online at www.med.nyu.edu/cme. Enrollment is limited. Abstracts can be submitted online until Nov. 15, 2002, at www.assfn.org.

In Practice, the Right People Are Key

Genius Takes a Backseat in a Successful Business



Good to Great: Why Some Companies Make the Leap ... and Others Don't
by Jim Collins. Harper Collins, 2001, 300 pp.

Good to Great is an interesting study of factors that transform a business to super success. Neurosurgeons, who all are in business, need to know what those factors are and how they can be put into practice.

Author Jim Collins and his research team have studied the history of companies in the United States. They identified 11 businesses that have gone from “solid performers” to “great companies” that have made the leap to great results sustained for at least 15 years. These 11 companies—Abbott Laboratories, Circuit City, Fannie Mae, Gillette, Kimberly-Clark, Kroger, Nucor, Philip Morris, Pitney Bowes, Walgreens, and Wells Fargo—have generated cumulative stock returns that beat the general stock market by an average of seven times in 15 years. Also studied were matched companies in the same industry that did not do as well.

Counterintuitive Conclusions Lead to Questions

This study is valuable because so many of the conclusions are surprising and counterintuitive. I was most surprised that:

■ **These companies were not led by charismatic leaders of great vision.** The leadership was instead characterized by humility and ability to always put the company first. Collins calls these kinds of leaders Level 5 Executives, whose ambi-

tion always is first and foremost for the institution, not themselves. A company led by genius leader with 1,000 helpers will always fall when the genius departs.

■ **Mission is not nearly as important as people.** To transform a company, the “who” questions comes before the “what” decisions—before vision, before strategy, before organizational structure, before tactics. The right people are a company’s most important assets; executive compensation has no relationship to success.

Every company must face the brutal facts of its current reality. Questions come before answers. Dialog, debate, and open discussion always win over coercion—but one must have faith.

Hedge-Hog or Fox?

Good-to-great companies are more like hedge-hogs (simple, dowdy creatures that know one big thing and stick to it) than foxes (crafty, cunning creatures that know many things but lack consistency).

Every great company must have a culture of discipline. This culture involves a duality. On the one hand, it requires people to adhere to a consistent system; yet on the other hand, it gives people freedoms and responsibility within the framework of that system.

Technology can be an accelerator of momentum but is not a creator of it. None of the good-to-great companies began their transformation with pioneering technology, yet they all became pioneers in the application of technology. How a company reacts to technological change is a good indicator of its inner drive for greatness.

The Buildup Before the Breakthrough

Good-to-great transformations never happen in one fell swoop. Enduring great

companies must go through a process of buildup to breakthrough. Like pushing a giant, heavy flywheel, it takes a lot of effort to get the thing moving, but when it’s moving it builds momentum. Good-to-great leaders spend no energy trying to “create alignment,” “motivate the troops,” or “manage change.” Under the right conditions, the problems of commitment, alignment, motivation and change take care of themselves.

The real question is not, Why greatness? but, What work compels one to try to create greatness? The book suggests that those who to ask the questions, Why should we try to make it great? or Isn’t success enough? are probably engaged in the wrong line of work. Additionally, there must be a deep understanding of what we are deeply passionate about and can be the best at, as well as what drives our company’s economic engine.

Many readers will be familiar with Jim Collins’ previous book, *Built to Last*. That book gave insight to the question, What does it take to start and build an enduring company from the ground up? Collins sees *Good to Great* as a prequel. While *Built to Last* emphasized discovering a company’s core values, *Good to Great* addresses a fundamental question raised, but not answered, in *Built to Last*: What’s the difference between a “good” BHAG (Big Hairy Audacious Goal) and a “bad” BHAG?

Good to Great promises a revealing look at the underlying principles of building a great company—and an interesting read for the neurosurgeon who desires to create a great practice. ■

Gary Vander Ark, MD, is a senior partner of Rocky Mountain Neurosurgical Alliance, Englewood, Colo., and past president of the Colorado Medical Society. He is the recipient of the 2001 AANS Humanitarian Award.

AANS Membership Increases

Board of Directors Approves 219 Applications

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William A. Brennan, MD
Brian V. Curtis, MD
Ian G. Fleetwood, MD
Clifford M. Gall, MD
Steven A. Gilman, MD
Frederick B. Gutman, MD
Walter J. Hader, MD
Richard L. Harrison, MD
Line Jacques, MD
Oliver Lee Kesterson, MD
Miriam Kim, MD
John Joseph Knightly, MD
Carl E. Lowder, MD
Michel Hanna Malek, MD
Paul J. Marcotte, MD
Paul G. Matz, MD
Vivek Mehta, MD, MSc
Cynthia Piccirilli, MD
Farhad Pirouzmand, MD
Michael Schlitt, MD
David John Sedor, MD
Christopher Smythies, MD
Mark M. Souweidane, MD
Scott C. Standard, MD
Mark K. Stevens, MD, PhD
Jeffrey A. Williams, MD

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Glenn B. Anderson, MD
Rein Anton, MD
Marc S. Arginteanu, MD
Anthony Michael Avellino, MD
Nathan Avery, MD
Florence C. Barnett, MD
Carter E. Beck, MD
Joe Benard, MD
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Mark Gerber, MD
Zohar Ghogawala, MD
Subrata Ghosh, MD
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Stephen M. Gutting, MD
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Stephen C. Houston, MD
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Deven Khosla, MD
Sagi M. Kuznits, MD
Jorge J. Lastra-Power, MD
Barbara E. Lazio, MD
Steven P. Leon, MD
Mark A. Liker, MD
Russell R. Lonser, MD
Demetrius K. Lopes, MD
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Alon Mogilner, MD, PhD
Serge K. Obukhov, MD, PhD
Susan C. Pannullo, MD

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Robert D. Robinson, MD
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Jeffrey W. Weinberg, MD
Benjamin T. White, MD
Timothy M. Wiebe, MD
Timothy F. Witham, MD
Joseph S. Yazdi, MD
Bo Yoo, MD
Julie E. York, MD

International (58)

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(Kuwait)
Kamil Melih Akay, MD
(Turkey)
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(Syria)
Bahram Aminmansour, MD
(Iran)
Carlos Barbosa-Cavalcanti, MD
(Brazil)
Rene Bernays, MD
(Switzerland)
Vyom Bhargava, MD
(India)
Markus F. Boerschel, MD
(Germany)
Jacques Born, MD, PhD
(Belgium)
Antonio Luiz Carone, MD
(Brazil)
Savas Ceylan, MD
(Turkey)
Yung-Hsiao Chiang, MD,
(Taiwan)
Olivier De Witte, MD
(Belgium)
Mohsen Dehbashi, MD (United Arab Emirates)
Wolfgang Deinsberger, MD
(Germany)
Ashit J. Desai, MD
(India)
Milind Prabhakar Rao Dunakhe,
MD (India)
Foad Elahi, MD (Iran)
Ashraf A. F. Elkerdany, MD
(Saudi Arabia)
Ersin Erdogan, MD
(Turkey)
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Hassan Kadri, MD (Syria)
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Nilton Luiz Latuf, MD
(Brazil)
Seungcheol Lee, MD
(South Korea)
Marc Levivier, MD, PhD
(Belgium)
Kriengsak Limpastan, MD
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PhD (Taiwan)
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Rudiger Lorenz, MD
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MD, PhD (Spain)
Bharat Mittal, MD
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(Netherlands)
Franklin B. D. Morgan II, MD
(Brazil)
Marwan Najjar, MD
(Saudi Arabia)
Yoko Nakasu, MD
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Peck-Leong Ong, MD
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Magdy A. Osman, MD
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Rade Mane Repac, MD
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Peter Schmiedek, MD
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Ashraf A. Shatla, MD
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Samuel Simis, MD
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Teeradej Srikijvilaikul, MD
(Thailand)
Masaaki Uno, MD
(Japan)
Peter Varady, MD
(Hungary)
Miguel Velasquez, MD
(Colombia)

Associate (27)

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Linda Batts, RN
Susan Bell, MS, RN, CNRN
Connie Cerne, PA-C
Colleen Christiansen, RPA-C
John J. Connors III, MD
Mario S. Cuevas, PA-C
Christine R. Dunbar, PA-C
Gregory R. Faltyn, PA-C
Mary Grandon, PA-C
Yolanda M. Johnson, RPA-C
Howard I. Kagan, PA-C
Dawn R. Kuerley-Schaffer, RN
James Mark Leipzig, MD
Walter C. Low, PhD
Randall Mathis, PA-C
Katherine L. McIntosh, PA-C
Luz P. Newell, BSN, CNOR
Dorabeth Parsons, PhD, PA-C
Jacque P. Pasternacki, PA-C
Stefanie Sanderson, PA-C
Jeffrey Wayne Sherman, MD
Andrew F. Venditti, PA-C
Sharon Whitney, PA-C
Natalie White, PA-C
Michael L. Whitworth, MD
Rosa Williams, PA-C

A New Way to Help Colleagues Connect

BY KATHLEEN T. CRAIG

Introducing the New AANS Membership Directory on CD-ROM

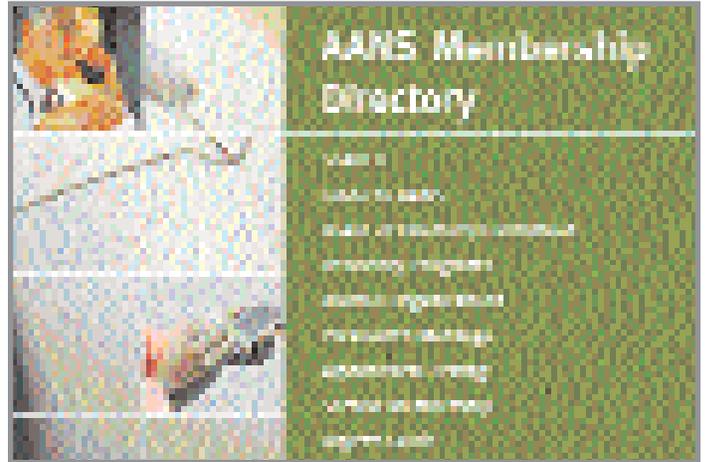
AANS is making it easier for neurosurgeons to locate and communicate with one another through a new membership directory available in September. The AANS Membership Directory CD-ROM, sponsored by an educational grant from Aesculap, capitalizes on the enhancements that CD-ROM technology affords. Easy to store, space saving and portable, this new directory was designed to be an indispensable tool for members. And, the CD operates on both PC and Macintosh platforms.

“The practice of neurosurgery is being transformed by technology,” said Robert E. Harbaugh, MD. “It is imperative that AANS evolve with the times and offer members services they can customize to their individual needs.”

Dr. Harbaugh, along with Harold J. Pikus, MD, both of whom are members of the AANS Digital Technology Committee, spearheaded development of the new directory in an effort to ensure that the end-user member’s needs would be well met. They championed incorporating the ability to export user-specified lists for use on one’s personal computer or personal digital assistant (PDA) into the new CD-ROM version of the directory.



A multitude of search options are available, including “wildcard” searches.



From the AANS Membership Directory’s Main Menu, users have ready access to an alphabetical listing of members, a handy search mechanism, and regularly referenced association information.

Now, members will be able to conduct a search using a multitude of options and specific criteria, and then export the resulting contacts into their personal computer’s address books. From there, it’s a simple step to synchronize their address books to a handheld computer, such as a PDA.

Want to create a list for patient referrals? Search by geographic location or area code. Can’t quite remember how to spell the name of your colleague? Search by the first few letters (wildcard search) and browse the results. Looking for an expert in a particular field? Search by subspecialty or even by subspecialty and location. Not only can members export these lists, they can also print them.

“Digital technology allows for not only expanded membership listings, but also enhanced options,” said Dr. Harbaugh. “With a few mouse clicks, obtaining information on a member’s subspecialty, section membership, residency history, and more is a simple matter.”

In addition, e-mail links are active. So once a colleague has been located, e-mailing him or her directly from the Membership Directory is a simple matter.

Even Technophobes Can Operate the Easy-to-Use CD

Operating the directory from the CD is the simplest means of accessing its rich content. The CD’s auto-start feature makes operation easy. However, instructions on how to install the CD contents onto one’s hard drive are included. Also, help screens assist



Selecting this option enables members to check the AANS Web site for the most up-to-date and accurate listing. Membership data on the Web site is refreshed weekly.

users in finding the most direct route to the information they are looking for.

More Than a Directory

The AANS Membership Directory offers more than a means of searching and contacting AANS members. Favorite features of previous directories remain available. In fact, these favorites are enhanced.

- **Residency Programs:** A complete listing in a printable format, this section also includes the option of e-mailing the program director or department director from the file, without going back to search for contact information.
- **AANS/CNS Section Membership:** The officers and complete membership listings of each section are included.
- **Related Organizations:** This section features favorites such as the Council of State Neurosurgical Societies, Women in Neurosurgery, and Think First, and includes a listing of organizations related to neurosurgery, such as international neurosurgical associations. In cases where Web site addresses are known, the links are active and will take members directly to an organization's Web site.
- **Guide to AANS:** This section contains general information about AANS, membership benefits, national office service directory



Help screens make navigation simple—even for technophobes. A mouse click on any area in question provides detailed information and handy tools that help users make the most of all the AANS Membership Directory has to offer.

(with active e-mail links) and the AANS Bylaws and Code of Ethics.

- **Board of Directors and Committee Listings:** This section features the AANS Board of Directors and complete committee listings; officers and committee chairs can be contacted by e-mail directly from the file.
- **AANS Products & Services:** Detailed information about AANS educational meetings, neurosurgical publications, practice management resources, research opportunities through the Neurosurgery Research and Education Foundation and benefits exclusive to AANS members are included here.
- **Buyer's Guide:** A new addition to the directory, this section offers a complete listing of exhibitors at the AANS Annual Meeting—alphabetically and by product category.
- **Printable Alphabetical Listing:** AANS knows some members like the familiarity of a printed directory. This listing is formatted for convenient printing and also is searchable.

Give Us Your Feedback

AANS remains committed to helping neurosurgeons stay connected. Members are encouraged to contact AANS with feedback regarding the new directory or ideas for other new member benefits: info@ans.org or (847) 378-0500.

Kathleen T. Craig is the AANS director of marketing.

Innovator Transformed Neurosurgery

Theodore Kurze, MD, Pioneered the Binocular-Operating Microscope

Theodore Kurze, MD, FACS, internationally renowned neurosurgeon, died at his home in Newport Beach, Calif., on May 10, 2002.

Dr. Kurze's research and practice transformed how neurosurgery is practiced worldwide. He pioneered the use of the microscope in neurosurgery in 1957, when he removed a tumor from the acoustic-vestibular nerve of a five-year-old child. Dr. Kurze's introduction of the operating microscope revolutionized the practice and art of neurological surgery by enabling more intricate procedures, thereby reducing damage to adjoining brain matter, nerves, and blood supply. He developed many neurosurgical procedures made possible by his application of the microscope, including use of the microscope to remove tumors from the cranial nerves themselves, while preserving the nerve and its functions.

"Ted had the sense to walk the microscope across the hall from the laboratory to the operating room—it was a simple, fabulous, constructive idea," said Peter J. Jannetta, MD, in the *Los Angeles Times*.

Dr. Kurze was a key figure in establishing the role of Los Angeles County-USC Medical Center as a leader in the development of neurosurgical concepts and instrumentation. From 1959 to 1987, he was on the medical faculty of the University of Southern California, and chairman and

professor of neurological surgery from 1963 to 1979. Concurrently he was chief physician and then director of neurological surgery at the Los Angeles County Medical Center (1961-1979).

He had introduced the binocular-operating microscope to the neurosurgical operating room while in private practice in Los Angeles. After joining the Los Angeles County-USC Medical Center as chairman and chief physician in neurological surgery, he established the first cranial based binocular micro-neurosurgical facility.

In addition to much specialized neurosurgical equipment pertaining to the use of the microscope in the operating room, he participated in the development of the Kurze urinometer, the Kurze scissors, and what came to be known as, the Kurze light, a miniature light source that was mounted on the surgeon's forehead, thereby eliminating the shadow of the traditional overhead surgical lamp. He also pioneered the use of diagnostic ultrasound and other imaging technologies in neurosurgery.

Born in Brooklyn, New York, on May 18, 1922, Dr. Kurze grew up in Floral Heights, Long Island. After graduation from Washington College in Chestertown, Maryland in 1943, he received his MD degree from Long Island Medical College, now SUNY Downstate Medical School, in 1947. Dr. Kurze completed a rotating

IN MEMORY of Dr. Kurze, John J. Guarnaschelli, MD, and his wife, Martha L. Guarnaschelli, established the Kurze Lecture with an endowment of \$100,000. The first Kurze Lecture will take place at the 2003 AANS Annual Meeting.

internship at Saint Monica's Hospital in Phoenix, Ariz., and began a neurological surgery residency at the Veteran's Administration Wadsworth Hospital in Los Angeles. From 1949 to 1951 Dr. Kurze was a captain in the U.S. Army Medical Corps in General Surgery, stationed in Germany and later at Ft. Bragg, N.C. On returning to Los Angeles in 1954, he completed a residency in general surgery and then his residency in neurological surgery at Los Angeles County General Hospital. He gained certification by the Board of Neurological Surgery and entered private practice. Before joining the medical faculty at USC in 1959, he was an instructor in neurological surgery at the University of California at Los Angeles.

Dr. Kurze authored numerous articles, book chapters, monographs, reviews, invited papers, and proceedings. Throughout his career he held many visiting professorships worldwide and received numerous national and international honors and awards.

He acted as a consultant in the production of many television productions, beginning with "Ben Casey, MD," and received an award from the Academy of Television Arts & Sciences as the subject of NBC's introductory program for its "Lifeline" series.

Dr. Kurze is survived by his wife Joan Kurze; four adult children by a previous marriage, Janet Kurze, Peter Kurze, Carol Nicholson, NIH, and Heather Kurze; and eight grandchildren. ■

RECENTLY DECEASED AANS MEMBERS

Munir H. Abbasy, MD

Sherry L. Apple, MD

Elliott E. Blinderman, MD

Shelly N. Chou, MD

Robert D. Dickins Jr, MD

Warren Ho, MD

Lawrence J. Mervis, MD

Guy L. Odom, MD

Theodore Rasmussen, MD

Roy C. Selby, MD

Manuel M. Velasco-Suarez, MD

Spine Course Initiates Clinical Ed Program

AANS-MERI Master Series Promises Excellence, Innovation, Affordability

This summer the American Association of Neurological Surgeons held its first regional clinical education program in three years. The sold-out “Innovations in Spinal Fixation: An Advanced Course” was held July 27-28, 2002, at the Medical Education and Research Institute (MERI) in Memphis, Tenn., with 26 neurosurgeons from across the country in attendance.

Course Directors Christopher I. Shaffrey, MD, Regis W. Haid, Jr., MD, and J. Patrick Johnson, MD, in conjunction with the AANS Education and Practice Management Department, developed an educational event that presented the viewpoints and techniques of world-renowned neurosurgeons and orthopedic surgeons who constituted the program faculty. As course planning commenced, three areas were identified as critical for implementing a successful clinical training program: faculty recruitment and program content; commercial support; and location.

The involvement of Dr. Shaffrey and Dr. Haid was critical to the success of the program, especially in recruitment of both neurosurgeons and orthopedists for the course’s faculty. “We were extremely gratified to see the international leaders in orthopedic deformity surgery teaching at an AANS hands-on cadaveric course,” said Dr. Haid. “Only by cooperation between our disciplines can we continue to advance the field of spine care.” He noted, “The AANS has continued to assume a leadership role in promoting joint educational ventures with our colleagues.”

The program combined didactic with hands-on teaching methodologies. Each of the three sessions—Thoracic Instrumentation, Lumbar/Sacral/Pelvic Instrumentation and Occipitocervical Instrumentation—



Neurosurgeons in action during “Innovations in Spinal Fixation.”

began with lectures on program content and ended with time in the lab to implement what had been learned. Eight stations, consisting of three or four attendees and one or two faculty members, allowed for a high faculty-to-participant ratio, ensuring individualized instruction.

Dr. Shaffrey pointed to the faculty and to the structure of the course, which allowed the faculty to discuss and demonstrate techniques on cadavers and then supervise participants performing the techniques, as key factors in creating an effective learning environment. “The course was a success because it was set up as a one-on-one mentoring experience rather than a traditional meeting,” he said. “Time and flexibility were built into the course, enabling participants to address the surgical techniques needed to overcome specific problems in their practices. I feel every participant learned several ‘pearls’ that can be used immediately to improve their patient care.”

Additionally, as AANS analyzed re-entering the clinical education market, keeping registration fees low for the membership was identified as being of the

utmost importance to achieving success. In the interest of course affordability, AANS partnered with Medtronic Sofamor Danek and DePuy Acromed, which provided equal educational grants in support of the program and exhibited on-site. Without this support, a clinical education program would be cost-prohibitive for both course organizers and attendees.

The final piece of the clinical education puzzle fell into place with the identification of the MERI location. A state-of-the-art facility, MERI offers a unique instructional opportunity, using fresh, unembalmed anatomical material and the latest medical technology to provide a realistic operating room environment. With a large meeting room and auditorium in addition to the teaching laboratories, MERI was an ideal location, supporting the course flawlessly.

Next Course Planned for Late January

Moving forward in the development of future clinical course offerings, AANS has extended its relationship with MERI to implement a “master series” of courses. The courses will take advantage of MERI’s state-of-the-art equipment, instrumentation and research, coupled with the most knowledgeable experts in the field, courtesy of AANS. The AANS-MERI partnership takes important strides toward fulfilling AANS’ mission of advancing the specialty of neurological surgery to provide the highest quality of neurosurgical care to the public.

The first course offering under this new arrangement, “Advanced Endoscopic Surgical Procedures,” is scheduled for Jan. 31-Feb. 1, 2003, at MERI. Details of this course and others, as well as registration information are available at www.aans.org. ■

Jane M. Ries, MHA, is the AANS director of education and practice management.



EVENTS

Calendar of Neurosurgical Events

AANS LEADERSHIP 2002-2003

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W. Brian Wheelock, MD
Edie E. Zusman, MD

AANS NATIONAL OFFICE

5550 Meadowbrook Drive
Rolling Meadows, IL 60008
Phone: (847) 378-0500
(888) 566-AANS
Fax: (847) 378-0600
E-mail: info@aans.org
Web site: www.aans.org

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Ronald W. Engelbreit, CPA,
deputy executive director
Susan M. Eget, *associate executive director*

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Lisa M. Sykes, CMP, *meeting services*
Laura K. Varner, *development*

AANS/CNS WASHINGTON OFFICE

725 15th Street, NW, Suite 800
Washington, DC 20005
Phone: (202) 628-2072
Fax: (202) 628-5264
Web site: www.neurosurgery.org/
socioeconomic/dcstaff.html

American College of Radiology Annual Meeting

Sept. 28-Oct. 2, 2002
Miami, Fla.
(800) 227-5463

Peripheral Markers of Blood Brain Barrier Failure

Oct. 4-6, 2002
Cleveland, Ohio
(216) 445-3449

American College of Surgeons Annual Meeting

Oct. 6-11, 2002
San Francisco, Calif.
(312) 202-5244
www.facs.org

Child Neurology Society Conference

Oct. 9-12, 2002
Washington, D.C.
(651) 486-9447
cns@tc.umn.edu

American Association of Electro- diagnostic Medicine Annual Meeting

Oct. 9-13, 2002
Toronto, Ontario, Canada
www.aaem.net/registration_brochure_online.htm

Neurosurgical Society of America Interim Meeting

Oct. 10-12, 2002
Indianapolis, Ind.
joseph.piepmeyer@yale.edu

American Society of Anesthesiologists Annual Meeting

Oct. 11-16, 2002
Orlando, Fla.
(847) 881-2570
www.asahq.org

American Neurological Association 127th Annual Meeting

Oct. 13-16, 2002
New York, N.Y.
www.aneuroa.org/annual.html

Korean Neurosurgical Society Annual Meeting

Oct. 16-19, 2002
Seoul, Korea
www.wfns.org/principal_conferences.html

Functional Brain Mapping Tutorial

Oct. 21-25, 2002
UCLA Medical Center
(310) 794-1221

emitchell@mednet.ucla.edu

European Federation of Neurological Societies Congress 2002

Oct. 26-30, 2002
Vienna, Austria
efns-head@magnet.at

Neuro-Endoscopy Surgery

Oct. 26, 2002
The Cleveland Clinic Foundation
Cleveland, Ohio
(216) 445-3449
tobinm@ccf.org

XXX Latin-American Congress of Neurosurgery

Oct. 26-31, 2002
Lima, Peru
www.30clan.galeon.com

International Society for Pediatric Neurosurgery Annual Meeting

Oct. 27-31, 2002
Kyoto, Japan
81 3 3433 1111
www.ispn.org

Research Updates in Neurobiology for Neurosurgeons/RUNN Course

Oct. 27-Nov. 3, 2002
Woods Hole, Mass.
www.societyns.org

For a frequently updated, comprehensive listing, go to www.neurosurgery.org/aans/calendar.

Education and Practice Management Course Schedule

● Beyond Residency: The Real World

Oct. 26, 2002 Chicago, Ill.
Oct. 4, 2003 Los Angeles, Calif.

● Managing Coding & Reimbursement Challenges in Neurosurgery

Nov. 15-16, 2002 Washington, D.C.
Jan. 31-Feb. 1, 2003 Tampa, Fla.
Feb. 21-22, 2003 San Antonio, Texas
March 14-15, 2003 Seattle, Wash.
May 16-17, 2003 Chicago, Ill.
Aug. 22-23, 2003 Charlotte, N.C.
Sept. 26-27, 2003 San Francisco, Calif.
Nov. 21-22, 2003 Baltimore, Md.

● Neurosurgical Review by Case Management: Oral Board Preparation

Nov. 10-12, 2002 Houston, Tex.
May 11-13, 2003 Cincinnati, Ohio
Nov. 9-11, 2003 Houston, Texas

● Advanced Endoscopic Surgical Procedures

Jan. 31-Feb. 1, 2003 Memphis, Tenn.

● Basic Principles of Anatomy and Terminology for Neurosurgery Office Staff

Jan. 30, 2003 Tampa, Fla.
Feb. 20, 2003 San Antonio, Texas

● Neurosurgical Practice Management

May 18, 2003 Chicago, Ill.
Sept. 28, 2003 San Francisco, Calif.

For more information or to register call (888) 566-AANS or visit www.neurosurgery.org/aans/meetings/epm/epmcourses.html.