

# AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS BULLETIN

The Socioeconomic and Professional Quarterly for AANS Members • Volume 12 No. 3 • Fall 2003

## Federal Medical Liability Reform

Neurosurgeons Plan to Preserve

Patients' Access to Care

### INSIDE THIS ISSUE

- Neurosurgeons to Preserve Health Care Access, 18
- AANS Launches NeurosurgeryToday.org, 26
- 72nd AANS Annual Meeting, May 1-6, 32
- AANS Member Needs Survey Results, 40



American  
Association of  
Neurological  
Surgeons

For advertising information, see the Bulletin's rate card at <http://www.aans.org/bulletin/bulletinratecard.pdf>, or contact Holly Baker, [hbaker@ascendmedia.com](mailto:hbaker@ascendmedia.com), 913.344.1392.



# CONTENTS

VOLUME 12 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.

James R. Bean, MD, *editor*

Robert E. Harbaugh, MD, *associate editor*

Manda J. Seaver, *staff editor*

## BULLETIN ADVISORY BOARD

Edward C. Benzel, MD  
Frederick A. Boop, MD  
Alan S. Boulous, MD  
William T. Couldwell, MD  
Fernando G. Diaz, MD  
Haynes Louis Harkey, MD  
David F. Jimenez, MD  
Ali F. Krisht, MD  
John A. Kusske, MD  
Joel D. MacDonald, MD  
Patrick W. McCormick, MD  
Cheryl A. Muszynski, MD  
Katie O. Orrico, MD  
A. John Popp, MD  
Gregory J. Przybylski, MD  
Michael Schulder, MD  
Brian R. Subach, MD  
Gary D. Vander Ark, MD

**CORRESPONDENCE** Send your correspondence regarding the *Bulletin* to [bulletin@AANS.org](mailto:bulletin@AANS.org). Your comments and suggestions may be included in a future issue edited for length, clarity and style. Correspondence is assumed to be for publication unless otherwise specified.

**ARTICLE IDEAS** Send an article or article idea to the *Bulletin*, [bulletin@AANS.org](mailto:bulletin@AANS.org). Writing guidelines are available at [www.aans.org/bulletin](http://www.aans.org/bulletin).

**PUBLICATION INFORMATION** The *AANS Bulletin*, ISSN 1072-0456, is published quarterly by the AANS, 5550 Meadowbrook Drive, Rolling Meadows, IL 60008, and distributed without charge to the neurosurgical community. Unless specifically stated otherwise, the opinions expressed and statements made in this publication are the authors' and do not imply endorsement by the AANS. AANS reserves the right to edit copy to comply with publication standards and available space. Searchable *Bulletin* archives are available at [www.aans.org/bulletin](http://www.aans.org/bulletin).

Copyright © 2003 by the American Association of Neurological Surgeons, all rights reserved. Contents may not be reproduced, stored in a retrieval system, or transmitted in any form by any means without prior written permission of the publisher.

## ADVERTISING SALES

Holly Baker, Ascend Media, (913) 344-1392. The *Bulletin's* rate card is available at [www.aans.org/bulletin](http://www.aans.org/bulletin).

## COVER STORY

**Federal Medical Liability Reform: Neurosurgeons Plan to Preserve Patients' Access to Care.** Katie O. Orrico, JD, 7

**Restore Reliability to Medical Justice: The Legal System Is Undermining Healthcare.** Nancy Udell, JD, 9

**Senate Vote Clarifies Course of Action.** Katie O. Orrico, JD, 11

**Laying Myths to Rest: Common Misperceptions of Federal Medical Liability Reform.** James R. Bean, MD, 12

**Will the U.S. Constitution Permit Reform?** Katie O. Orrico, JD, 13

**States Press Forward for Reform Legislation.** Katie O. Orrico, JD, 14

**A State in Crisis—Missouri: Neurosurgeon Offers PLI Survey as a Template for Others.** David F. Jimenez, MD, 16

**The Campaign Starts Here: NPHCA Charts Course for Federal Medical Liability Reform.** Stewart B. Dunsker, MD, 18

**NPHCA Contributors.** 20

## FEATURES

**NeurosurgeryToday.org** Kathleen T. Craig and Heather L. Monroe announce new Web site, 26

**72nd Annual Meeting Adventure** Manda J. Seaver describes "Advancing Patient Care Through Technology and Creativity," 32

**What AANS Members Need** Kathleen T. Craig summarizes new survey's results, 40

## DEPARTMENTS

**Calendar of Neurosurgical Events** Pediatric Section's annual meeting, Dec. 2-5, 52

**In Memoriam** Remembering David W. Cahill, MD, 50

**Letters** Reader says suspension's too soft for plaintiff witnesses, 42

**Newsline** *From the Hill*, *Neuro News* WFNS Selects AANS to host the XIV International Congress of Neurological Surgery in 2009, 4

**News.org** *Journal of Neurosurgery: Pediatrics* to launch in February, 42

## COLUMNS

**AANS Answers** Executive Director Thomas A. Marshall discusses the AANS Strategic Plan, 51

**Bookshelf** Cheryl A. Muszynski, MD, reviews *The Operating Room for the 21st Century*, 30

**Coding Corner** Gregory J. Przybylski, MD, shows how the PLI crisis affects reimbursement, 24

**Computer Ease** John Kestle, MD, researches software that tracks resident work hours, 49

**CSNS Report** Frederick Boop, MD, exhorts neurosurgeons to get involved in medical liability reform, 29

**Education** Heather L. Monroe describes the new Neurosurgical Reference Card, 23

**Governance** Susan M. Eget announces bylaws change, formation of 501(c)(6), 50

**NREF** Donors Jan. 1-June 30; Michele S. Gregory discusses the Celebrate a Life campaign, 47

**Personal Perspective** James R. Bean, MD, explains why federal medical liability reform is so crucial, 6

**Practice Management** Barbara P. Hurlbert, CMPE, shares ideas from 30 years' experience, 34

**President's Message** A. John Popp, MD, says there is no greater threat to neurosurgery than the medical liability crisis, 2

**Resident's Corner** Brian R. Subach, MD, offers a common-sense approach to minimizing liability risk, 28

**Timeline** Michael Schulder, MD, lends a historical perspective to the medical liability crisis, 48



# Magellan and Beyond

*Mapping a Course for Neurosurgery, AANS*

I fell asleep after a long day of surgery and found myself dreaming about the Straits of Magellan. This area of the world has held long-term interest for me both historically and cartographically, and over the years I have been able to acquire several maps that depict the straits from the 16th century to modern times.

History credits Portuguese explorer Ferdinand Magellan with becoming the first to circumnavigate the globe. This fact only hints at the arduous journey that he undertook, commissioned by the king of Spain to find a passage through the New World to the Spice Islands. In 1519 Magellan embarked on the voyage during which he would encounter the hazardous straits that now bear his name.

## **A Cultural Connection: WFNS and AANS**

My journey in September to Lisbon is, perhaps, what turned my subconscious thoughts to the tenacious navigator. In Lisbon, where it seems that homage to the famed explorers of the Renaissance can be seen everywhere, the American Association of Neurological Surgery (AANS) was awarded the honor of hosting XIV International Congress of Neurological Surgery, Aug. 23-28, 2009. The meeting will be held in Boston, an historic American city that is amply prepared, as is the AANS, to welcome our colleagues and friends from around the world to a spectacular event. I personally thank the delegates of the World Federation of Neurosurgical Societies for awarding the AANS this opportunity and I especially thank those within the AANS who worked so diligently to produce and present an exemplary proposal.

I also invite our international colleagues to join us for the 72nd AANS Annual Meeting, May 1-6, 2004, in Orlando, Fla. Taking its cue from the theme

“Advancing Patient Care Through Technology and Creativity,” this meeting will rigorously explore neurosurgical topics in four plenary sessions and more, while applying a creative lens to the continued advancement of patient care.

## **Through the Straits: NPHCA's Campaign**

Perhaps my nocturnal vision of the treacherous Straits of Magellan had more to do with a difficult “journey” for which neurosurgery has been preparing over the past few months: that is, neurosurgery’s campaign for federal medical liability reform, addressed in detail in the cover

*A. John Popp, MD, is the 2003-2004 AANS president. He is Henry and Sally Schaffer Chair of Surgery at Albany Medical College in New York.*



story. While it may seem that neurosurgery is out of its depth tackling a legislative issue of this complexity in the national arena, it must be reiterated that there is no greater threat to neurosurgery than the medical liability crisis, which is aided and abetted by the out-of-control and fundamentally unjust system by which liability claims are adjudicated, and that this fight is necessary to preserve our patients’ access to neurosurgical care.

The AANS fully supports Neurosurgeons to Preserve Health Care Access (NPHCA). As Stewart Dunsker, MD, who serves as that organization’s president, details in an article in this issue, the NPHCA will captain neurosurgery’s campaign for federal medical liability reform and represent neurosurgery in Doctors for

Medical Liability Reform, the coalition of high-risk specialties that lends ballast to the effort. If you have not yet responded to the call for each neurosurgeon to contribute at least \$1,000 annually for three years to NPHCA and help fund the campaign for federal medical liability reform, I invite you to use the envelope in this issue and make your contribution today.

## **Map Quest: AANS Strategic Plan**

My interest in maps is reflective of a neurosurgeon’s appreciation of a well-conceived strategy. So it was with vigor that last year as AANS president-elect I undertook, with the AANS Long Range Planning Committee, the development of a detailed strategic plan for the association. After a year of diligent work by the committee, the strategic plan was released in July and provided to all chairs of AANS committees. The AANS Strategic Plan is bound to the AANS annual budget, charting a clear course with measurable goals that will ensure the growth of the AANS as the premier membership association advancing our specialty.

## **Clear Sailing?**

Perhaps the most intriguing aspect of maps that depict the Straits of Magellan over a 500-year period is the changes portrayed, not so much in the attributes of the area itself, but in the cartographers’ knowledge and understanding of it. Our plans are tools, subject to change in response to our growing knowledge and understanding. Even with our meticulous mapping for the future of neurosurgery and the AANS, we cannot promise clear sailing. But persistent progress toward our destination is sure to reap rewards. ■

For advertising information, see the Bulletin's rate card at <http://www.aans.org/bulletin/bulletinratecard.pdf>, or contact Holly Baker, [hbaker@ascendmedia.com](mailto:hbaker@ascendmedia.com), 913.344.1392.

# NEWSLINE

News Members Trends Legislation

## FROM THE HILL

### REPORT SAYS CCI IS WORKING

Ninety-eight percent of services targeted by the National Correct Coding Initiative (CCI) edits were paid appropriately by Medicare in 2001, according to a recent report by the Office of the Inspector General (OIG). Medicare carriers are required to apply the CCI edits to the Part B services they process for payment when a provider bills for more than one service for the same beneficiary on the same date of service.

<http://oig.hhs.gov/oei/reports/oei-03-02-00770.pdf>

For frequent updates to legislative news, see the Legislative Activities area of [www.AANS.org](http://www.AANS.org)

- **CMS Will Accept Noncompliant Claims After HIPAA Deadline, Oct. 16** In September the Centers for Medicare and Medicaid Services (CMS) announced that after Oct. 16 it would continue to accept claims in formats not compliant with the transaction requirements of the Health Insurance Portability and Accountability Act (HIPAA). “Implementing this contingency plan moves us toward the dual goals of achieving HIPAA compliance while not disrupting providers’ cash flow and operations, so that beneficiaries can continue to get the healthcare services they need,” said CMS Administrator Tom Scully. The contingency plan permits CMS to continue to accept and process claims in the electronic formats now in use, giving providers additional time to complete the testing process. CMS will regularly reassess the readiness of its trading partners to determine how long the contingency plan will remain in effect.
- **GAO Study Evaluates the Impact of Rising PLI Premiums on Access to Care** On Aug. 29 the General Accounting Office (GAO) released a new study, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*. The GAO confirmed that in several “crisis” states increases in professional liability insurance premiums have contributed to reduced access to emergency and obstetrical services. The report also concluded, however, “that many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to healthcare.” The AANS and CNS provided the GAO with survey data demonstrating the impact that the crisis is having on patient access to neurosurgical care, but the GAO essentially rejected this information. The full report is available at [www.gao.gov/cgi-bin/getrpt?GAO-03-836](http://www.gao.gov/cgi-bin/getrpt?GAO-03-836). See the cover story in this issue of the *Bulletin* for in-depth information on the medical liability crisis and how it affects neurosurgery.
- **CMS Publishes Revisions to EMTALA Regulations** In September the Centers for Medicare and Medicaid Services (CMS) published its regulation revising current Emergency Medical Treatment and Labor Act (EMTALA) rules, making substantial changes that will benefit neurosurgeons. The CMS adopted nearly all of the AANS and CNS recommendations, particularly those related to the requirements for on-call physicians. The revised EMTALA rule clarifies that neurosurgeons will be permitted to be on call simultaneously at more than one hospital and that they may schedule elective surgery or other medical procedures during on-call times. The rule also states that neurosurgeons are not required to provide on-call services 24 hours per day, 7 days per week, 365 days per year, and that hospitals have flexibility to structure their call lists in a manner that reflects the limited number of neurosurgeons available to take call. The final rule was published in the Federal Register on Sept. 9 ([www.gpoaccess.gov/fr](http://www.gpoaccess.gov/fr)).
- **Neurosurgeons’ Medicare Fees May Fall by 4 Percent in 2004** On Aug. 15 the Centers for Medicare and Medicaid Services (CMS) published the proposed Medicare Physician Fee Schedule regulation for 2004. The proposed regulation includes a CMS estimate that there will likely be an across-the-board 4.2 percent reduction in payments to all physicians unless Congress intervenes to prevent the payment cut. The U.S. House of Representatives’ version of the Medicare reform legislation contains a provision requiring a minimum of 1.5 percent increase in 2004 and 2005, but without a corresponding allocation of money to fund the increases, Medicare fees in years 2006 and beyond would need to be reduced to pay for this stop-gap measure. The proposed regulation also recommends various changes to reflect the recent increases in professional liability insurance premiums, which would have a some positive benefit, resulting in a combined net-payment reduction of 4 percent for neurosurgeons in 2004. The proposed regulation can be found at [www.cms.hhs.gov/providerupdate/newregs.asp](http://www.cms.hhs.gov/providerupdate/newregs.asp); once there, scroll down to Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004.

## NEURO NEWS

### WFNS AWARDS AANS 2009

**CONFERENCE** During a September meeting in Lisbon, the delegates of the World Federation of Neurosurgical Societies selected the American Association of Neurological Surgeons (AANS) to host the XIV International Congress of Neurological Surgery. The meeting will be held in Boston in August 2009.

- **MGMA Report Demonstrates Increase in Demands on Practices** The Physician Compensation and Production Survey: 2003 Report Based on 2002 Data, published in August by the Medical Group Management Association (MGMA), showed an overall increase in physician compensation, but decreases in compensation for some specialists. For example, general surgeons experienced a year-to-year compensation decline of 0.8 percent. Compensation increases for a number of other specialties were barely in line with general inflation, and some specialties reported higher productivity while compensation remained static. “We expect to see even greater effects due to increases in professional liability insurance costs in 2003, and the full effect may not even occur until 2004 and beyond,” said William F. Jessee, MD, MGMA president and chief executive officer. “As costs go up and revenues decline, physicians find themselves working harder for no more money. As a result, they increasingly face difficult choices, such as avoiding high-risk procedures and patients, withdrawing from Medicare and other insurance programs, or leaving their practices entirely.”
- **AAA Declines to Enforce Pretreatment Arbitration Agreements** The American Arbitration Association (AAA) announced recently that it would not participate in arbitrations based on pretreatment agreements between patients and their doctors. An article on the use of such agreements, published in the Spring 2003 issue of the *Bulletin*, discussed the Florida Medical Association’s sample Healthcare Arbitration Agreement, a risk-management tool for Florida physicians. In commentary accompanying the article, AANS General Council Russell Pelton anticipated that the enforceability of such agreements would vary sharply from state to state. He recently stated, “The usefulness of pretreatment arbitration agreements has been put into even greater jeopardy by the AAA’s policy to refuse to participate in arbitrations based on pretreatment agreements.” The AAA policy, available at [www.adr.org](http://www.adr.org), reads in part, “As a result of a review of its caseload in the healthcare area, the American Arbitration Association has announced that it will no longer accept the administration of cases involving patients without a postdispute agreement to arbitrate.”
- **Farmers Insurance Group Leaves Liability Market** The exodus from the professional liability insurance (PLI) market continued in September with Farmers Insurance Group’s announcement that it had ceased issuing new policies and that, as of Jan. 1, it would stop renewals, subject to the approval of insurance regulators in each state. The Associated Press reported that in 2002, Farmers Insurance lost \$100 million on its PLI policies, and that its current policies, valued at \$94.5 million, are down from \$231 million in premiums the year before. The announcement was made in Missouri, where liability policies issued by Farmers Insurance are expected to expire within 15 months. Missouri is one of the states experiencing a severe PLI crisis (see cover story). Other states served by Farmers Insurance Group are Arizona, California, Colorado, Connecticut, Florida, Hawaii, Idaho, Montana, North Carolina, Nevada, Ohio, Oregon, Pennsylvania, Texas, Utah, Washington, and Wyoming.
- **Online CME Captures Physicians’ Attention** A growing number of physicians are going online for their continuing medical education (CME), according to a new report by Manhattan Research, [www.manhattan-research.com](http://www.manhattan-research.com). The report, titled eCME Research, says that the market for online CME has grown from 204,000 in 2000 to 363,000 in 2003. However, the report concluded that physicians were more interested in the concept of online CME than in the current offerings available to them. “Until the online experience can match that of offline offerings in terms of course design, interactivity, and effectiveness, the percentage of total CME will remain relatively stable for many practicing physicians today,” stated Ashley Wendus, senior analyst at Manhattan Research.

Send Neuro News briefs to the *Bulletin*, [bulletin@AANS.org](mailto:bulletin@AANS.org).

# Why Federal Medical Liability Reform?

*The Second Coming of the Medical Liability Crisis Must Be Its Last*

Scientific and technical progress has borne neurosurgery from an infancy of possibility in Harvey Cushing's operating theater to a maturity of high achievement in neurosurgical techniques that have helped thousands of patients across the country.

What irony, then, when poised at the threshold of new generations of research and of ever more refined surgical techniques, the engine of medical progress should grind to a crawl, even shift to reverse, due to exponentially escalating medical liability awards.

Today, the entire medical liability system is in a state of crisis. A major symptom is the rapid escalation of professional liability insurance (PLI) premiums: Since 2001, PLI premiums for high-risk specialists in states without legislative controls have grown to astonishing levels, some doubling overnight.

Some may recall that a situation exhibiting similar symptoms occurred in the 1970s. But never before has an exodus of neurosurgeons and other specialists from crisis states been so widespread. Never before have so many neurosurgeons sought retirement, career change or geographic refuge to escape the threat from random multimillion-dollar liability claims after years or decades of successful and respected practice. Never before have neurosurgeons abandoned their life's calling in mid-career in such numbers, dropping privileges to perform high-risk procedures or to treat high-risk illnesses because of the threat of bankruptcy from exorbitant liability claims linked to imperfect outcomes. Sadly, I am reminded of W.B. Yeats' words from "The Second Coming": "Things fall apart; the centre cannot hold; mere anarchy is loosed upon the world."

In general, a liability crisis gnawing through the nation's social fabric is described

nowhere so effectively as by Philip Howard in *The Collapse of the Common Good*. Payments for product liability claims reach billions of dollars and payments for professional liability claims, the hundreds of millions. In devising these awards, reason and proportion play no role and impose no restraint.

Today, the medical liability crisis is the most serious threat facing medicine, and particularly neurosurgeons and other high-risk specialists; all other political and professional issues pale in comparison. It is the only threat that drives physicians out of practice

*James R. Bean, MD, is editor of the Bulletin and chair of the AANS/CNS Washington Committee. He is in private practice in Lexington, Ky.*



altogether, depriving patients of timely care and communities of the safety and security of medical resources in time of need.

Opponents of reform claim that the astronomical PLI premiums are only a temporary product of economic recession, or of the insurance underwriting cycle, or of insurance company mismanagement, or of inadequate state insurance regulation, or of an epidemic of medical errors, or of poor medical and hospital quality control, or for various other diversionary reasons. Each of these arguments can be refuted when the facts are examined.

The one fact that looms insistently behind the blow and bluster is the inexorable rise in judgments and settlements that drives the PLI premiums through the roof. Claims without restraints and awards

without limits, the real causes of the crisis, are what require control; this is where legislative reform must focus.

Medical liability reform that preserves patients' access to neurosurgical care is both necessary and possible. Federal reform is necessary to bring consistency to a problem that neither recognizes nor respects geographic barriers. Medical liability qualifies for federal jurisdiction under the U.S. Constitution's interstate commerce clause. Sixty percent of the nation's \$1.4 trillion in healthcare expenditures flows through federal, not state sources. The president and his administration support reform, and the House of Representatives passed an effective reform bill (H.R. 5 in 2003). Only the Senate stands between the bill and the president's signature.

Public opinion drives legislative reform. The public is 75 percent in favor of medical liability reform, according to recent polls. But sympathy alone is no lifeline to healthcare access; it must be transformed into public demand for Senate action. Public opinion must be mobilized by an effective public information campaign that refutes disinformation and brings home to every voter the healthcare void opened by the medical liability crisis.

Neurosurgeons, among the hardest hit of specialists, must adopt a new and unaccustomed role: that of political activist. Personal practice survival demands it and public welfare requires it. We are not engaging in a campaign for this year alone. Since defeat means only spiraling claims, higher costs, and growing defections from specialty practice, defeat is not an option. Neurosurgery's campaign for reform ends only with enactment of effective federal legislation. ■



# Federal Medical Liability Reform

## Neurosurgeons Plan to Preserve Patients' Access to Care

KATIE O. ORRICO, JD

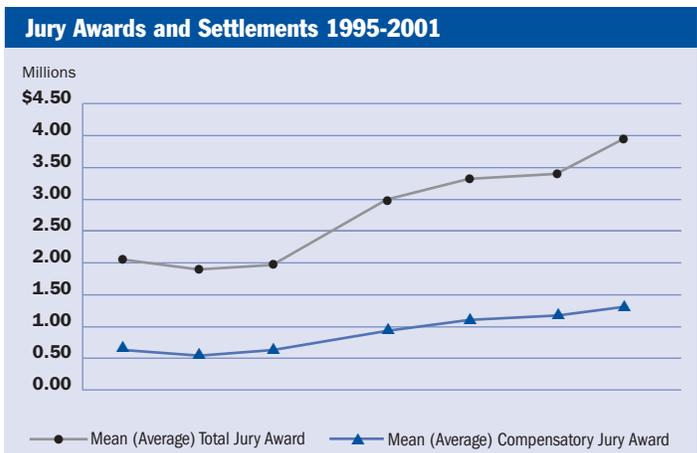
It comes as no surprise to neurosurgeons that the United States is in the throes of a medical liability crisis. The situation has become so critical that articles regularly appearing in the media report on the many physicians who are forced to limit services, move to other states where the medical liability system is more stable, or retire from practice altogether. Neurosurgeons are among the hardest hit by this crisis, with many struggling on a daily basis to keep their heads above water so they can remain in practice to serve their patients.

The leadership of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) has clearly recognized that medical liability is neurosurgery's most pressing problem and have moved to develop an aggressive public education and advocacy campaign aimed at passing federal medical liability reform legislation. The campaign will be conducted by neurosurgery's new nonprofit advocacy organization, Neurosurgeons to Preserve Health Care Access (NPHCA). The purpose of this article is to give neurosurgeons a detailed overview of the many facets of this issue and to make the case for reform.

### The Out-of-Control Medical Litigation System

The root cause of this problem is quite simple: the unrestrained escalation of jury awards and settlements, in even a small number of medical liability cases, is driving up physicians' professional liability insurance (PLI) premiums and is forcing some insurance companies out of business altogether. This problem is making it difficult, and sometimes impossible, for neurosurgeons to obtain affordable liability insurance so they can remain in practice. There is a wide body of evidence to substantiate these conclusions.

Jury Awards and Settlements 1994-2000		
Jury Awards for Neurological Injuries		
Injury	Median Award	Mean Award
Brain Injuries	\$4,280,000	\$9,985,126
Paralysis	2,750,000	6,843,017
Spinal Nerve Injuries	850,000	1,412,554
Settlements for Neurological Injuries		
Injury	Median Award	Mean Award
Brain Injuries	\$1,300,000	\$2,025,871
Paralysis	1,100,000	2,042,183
Spinal Nerve Injuries	500,000	959,261



**Medical liability awards are on the rise.** Medical liability awards have been increasing steadily; according to *Jury Verdict Research* data, from 1994 to 2000 the median jury award rose by 176 percent. The number of mega-verdicts is also on the rise, with the proportion of awards that exceed \$1 million increasing dramatically over this same time period. In 1996, 34 percent of all jury awards exceeded \$1 million. Four years later, the number of \$1 million awards increased to 52 percent, and the average jury award in 2000 was nearly \$3.5 million. Awards for neurological injuries top the list of jury verdicts and settlements (see Jury Awards and Settlements 1994-2000 table).

Not only are total jury awards rising, but the noneconomic damage portion now accounts for a steadily increasing proportion of these awards. According to *Jury Verdict Research*, from 1995 to 1997 the proportion of noneconomic damages compared with the total award was relatively constant. However, beginning in 1998 and continuing through 2001, noneconomic damages accounted for a significantly higher amount of total jury awards (see Jury Awards 1995-2001 graph).

**PLI premiums are skyrocketing.** The steep rise of medical liability awards is clearly responsible for the skyrocketing PLI premiums. Numerous studies demonstrate this linear relationship. In a June 2003 report, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, the U.S. General Accounting Office confirmed what neurosurgeons already know: Increased losses on claims are the primary contributor to higher PLI premium rates. According to the Insurance Information Institute, which analyzed data from A.M. Best (an independent insurance rating agency

Continued on page 8

Continued from page 7

that analyzes insurance companies' overall financial strength and creditworthiness), the cumulative underwriting loss for the PLI sector from 1990 to 2001 was nearly \$10 billion, and insurers now are paying out approximately \$1.40 for every premium dollar collected.

This situation obviously is not sustainable, and this trend is therefore forcing insurance companies, which must set their rates based on anticipated future losses, to steeply increase doctors' PLI premiums to ensure adequate reserves for payment of future judgments. As a result, over the past several years, physicians across the country have faced double-digit, and sometimes triple-digit, rate increases. Neurosurgeons have been disproportionately affected by these premium increases, and the trends are not encouraging. As the *Bulletin* has previously reported, according to a recent national survey of neurosurgeons conducted by the Council of State Neurosurgical Societies, between 2000 and 2002 the national average premium increase was 63 percent, from \$44,493 to \$72,682. The complete results are available at [www.neurosurgery.org/CSNS/CSNSsurveyreport092502.pdf](http://www.neurosurgery.org/CSNS/CSNSsurveyreport092502.pdf). A subsequent study by the AANS and the American Medical Association confirmed the CSNS findings, and from 2001 to 2003, premiums rose from an average of \$55,500 to \$84,100. In some states, neurosurgeons are now paying PLI premiums in excess of \$400,000 per year.

**Medical liability insurance is unavailable.** Not only are PLI premiums rising at astronomical rates, but many doctors also are finding it increasingly difficult to obtain insurance coverage at any price. Citing the increases in liability losses, recently many companies have stopped selling medical liability insurance or have gone out of business, leaving thousands of doctors scrambling to find replacement coverage. Of the companies that have remained in the market, many are no longer renewing insurance coverage for existing policyholders, or they are not issuing new insurance policies to new customers. This is particularly true in states that have no effective medical liability reform laws in place.

Throughout 2003, reports of neurosurgeons being denied coverage have increased in frequency. The situation appears to be particularly acute in Florida, Kentucky, Mississippi, Missouri, Pennsylvania and Washington, and individual neurosurgeons in these states have plenty of tales to tell that illustrate how they and their patients have personally been affected by the crisis. Across the nation, even those neurosurgeons who have just one claim against them (regardless of the outcome of the case) are finding it impossible to obtain affordable insurance coverage. Nationwide, the AANS/AMA survey found that in the last two years nearly 33 percent of surveyed neurosurgeons have switched insurance companies, and of these, 41 percent did so because their insurance company failed or withdrew from the market.

### Patient Access to Medical Care Is in Jeopardy

There are many casualties of the current medical liability crisis—but those affected the most are patients. Because the medical litigation

system is broken, across the nation patients are finding it increasingly difficult to get access to the care they need, when they need it. According to the AANS/AMA study, over 70 percent of survey respondents made at least one of the following practice changes—referred, instead of treated, complex cases; closed practice; moved to a different state; stopped providing certain services; stopped providing patient care; or retired—and a growing body of evidence demonstrates just how serious this crisis has become.

**Neurosurgeons are no longer performing some procedures.** According to the CSNS survey, 43 percent of neurosurgeons reported that they are no longer performing high-risk surgery such as treating brain aneurysms, removing brain and spinal tumors, or complex spinal surgery. In addition, many neurosurgeons are no longer operating on children.

**Neurosurgeons and trauma centers are closing their doors.** According to the American Board of Neurological Surgeons, in 2001 alone, 327 board-certified neurosurgeons retired, representing an alarming 10 percent of the neurosurgical workforce in the United States. The CSNS survey found that 29 percent of respondents were considering retirement. In addition, many neurosurgeons are no longer serving on call to hospital emergency departments. An August 2003 GAO report entitled *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, confirmed that rising PLI premiums have contributed to reduced access to emergency surgery services in the five states it reviewed (Florida, Mississippi, Nevada, Pennsylvania and West Virginia) because certain high-risk specialists, like neurosurgeons, are no longer serving on call to hospital emergency departments.

**Neurosurgeons are moving to states with a more favorable medical liability climate.** The list of states experiencing the exodus of doctors continues to grow. Nationwide, neurosurgery's survey data show that nearly 19 percent of practicing neurosurgeons either plan to move or are considering moving their practices to another state where the medical liability costs are relatively stable. Some states have been particularly hard hit. Mississippi, for instance, has lost 35 percent of its neurosurgeons in the past two years, and this year, 21 out of 79 neurosurgeons surveyed in Missouri stated that they were considering leaving the state. The flight of neurosurgeons from Florida, Pennsylvania, Washington and West Virginia mirrors this experience.

### A National Problem Requires a Federal Solution

Those who oppose federal legislation to address this crisis cite various reasons to support their contention that this is not a national problem that merits a federal solution. In particular, they note that the regulation of insurance and healthcare are generally state issues, and therefore principles of Federalism preclude federal legislation to address this problem (see "Will the Constitution Permit Reform?" page 13). They are, however, wrong. The undisputed truth is that this

Continued on page 10

# Restore Reliability to Medical Justice

## The Legal System Is Undermining Healthcare

NANCY UDELL, JD

Healthcare in America is suffering a nervous breakdown, and neurosurgeons and other high-risk specialists are at the center of the crisis. Doctors are striking, specialists are abandoning their practices, healthcare premiums are rising at unsustainable rates, and over 43 million Americans are uninsured.

But the underlying problem is our legal system. Justice today is a free-for-all. The crippling rise in professional liability insurance premiums is caused by an uncontrolled rise in jury verdicts, which have more than doubled in the last 10 years. But the total costs of our unreliable system are far greater. Some economists estimate that over \$100 billion is now wasted annually on unnecessary tests and procedures, ordered by doctors to build a record just in case there is a lawsuit.

Distrust of justice has adversely affected healthcare quality as well. Legal fear has replaced the honesty and candor that are vital both to humane care and to improved care. A culture of secrecy and blame keeps intelligence about mistakes and near misses underground.

Law is undermining healthcare because it is no longer reliable. Medical justice today is random. Many victims of error get nothing, while others win lottery-like awards when the doctor did nothing wrong. The resulting fear and distrust makes it impossible to make common-sense judgments.

The American Association of Neurological Surgeons (AANS) has taken an important step toward improving the quality of medical justice by raising the bar on the quality of expert testimony by AANS members. The testimony of expert witnesses underpins the reliability of judicial procedures, and the AANS is right to urge impartial, balanced testimony, rather than advocacy. If the testimony is substandard or worse—fraudulent—justice cannot be reliable.

But broader reform is needed—broader even than the proposed limits on noneconomic damages that have been so futilely debated in Congress. Merely putting caps on pain and suffering will not restore reliability or trust; in exchange for providing a lifetime of care, a neurosurgeon who did nothing wrong could still suffer a ruinous verdict.

Seventy prominent leaders of healthcare recently came together to demand an entirely new system of medical justice. The goal

of this new system is not to protect any one group but to be reliable—“reliable to protect patients against bad practices, reliable to protect caregivers who act reasonably and reliable to interpret standards of care so that all participants know where they stand and where they must improve.”

A reliable system of medical justice could take many forms, but because the critical issue in virtually all cases is whether the doctor complied with appropriate standards of care, the key element must be expert judges ruling on standards of care—with the benefit of impartial expert testimony they can rely on.

Judges must do that, rather than juries, because juries can only make judgments in individual cases—even with the benefit of reliable expert testimony. Juries can't make consistent rulings of what is reasonable care and what is not. In fact, juries have no authority to make rulings at all. Their role in civil cases is to decide disputed facts, like whether someone is telling the truth. It is not to declare standards of care that affect society as a whole.

Judges in special medical courts should have sufficient medical training to be able to define and interpret standards of care. They should be able to consider knowledgeably the testimony of expert witnesses and be influenced by their expertise more than their presentation skills.

Specialized courts are common in such areas as taxes, workers compensation, labor issues and vaccine liability, and a bill to fund pilot projects for special medical courts in individual states will be considered by the U.S. Senate shortly.

Creating a special medical court, an ambitious undertaking, will be opposed by the trial lawyers at every step because it is precisely the unreliability of the current system that gives them their leverage. But creating such a court will actually help to strengthen one of the oldest and most basic principles of the American system of justice: that like cases be decided alike.

The victim of unreliable justice is society as a whole, not just the medical profession. That's why reform must focus on achieving a reliable foundation of law for all. ■



**“The victim of unreliable justice is society as a whole, not just the medical profession. That’s why reform must focus on achieving a reliable foundation of law for all.”**

Nancy Udell, JD, is director of policy and general counsel for Common Good ([www.cgood.org](http://www.cgood.org)), a nonpartisan legal reform initiative that is actively involved in exploring the creation of a special medical court.

Continued from page 8

problem now touches nearly every American, and a federal solution is therefore a national imperative.

**Nearly all states are facing a medical liability crisis.** The AMA has identified 19 states in which all physicians are experiencing a medical liability crisis. These include: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia and Wyoming. For neurosurgery, the situation is even more widespread than the AMA reports: The CSNS survey has identified 25 states that are in a severe medical liability crisis, with an additional 12 states in potential crisis. In addition to states identified by the AMA, the crisis states for neurosurgery include Alabama, District of Columbia, New Hampshire, South Carolina, Rhode Island, Tennessee, Utah and Virginia.

**Every American pays the costs of the current medical litigation system.** According to the U.S. Department of Health and Human Services in its report *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System*, the current medical litigation system imposes enormous costs on the healthcare system. These costs are passed on to all Americans in the form of increased health insurance premiums, higher out-of-pocket medical expenses and higher taxes. Furthermore, each year, the federal government pays for the increased costs associated with the current medical litigation system through various healthcare programs, including Medicare, Medicaid, and other healthcare programs for veterans and members of the armed forces. The U.S. Congressional Joint Economic Committee estimates that federal medical liability reform legislation would generate significant fiscal savings for the federal government, and further that the combined annual budget savings attributed to decreased direct costs (that is, PLI premiums) and indirect costs (such as defensive medicine) would total approximately \$12.1 billion to \$19.5 billion.

**States face significant barriers to implementation of reforms.** Many states face barriers—some legal and some political—to enacting effective medical liability reform laws. In the past, some states, including Florida, Ohio and Pennsylvania, have enacted medical liability reform laws, only to have their highest courts strike them down as unconstitutional. New laws passed by Florida, Mississippi, and Nevada face certain court challenge, and it will be years before it is determined whether these laws pass state constitutional muster. Finally, in some other states, the issue has become a political one, effectively killing any chances for passage. As a consequence, despite the increasing medical liability crisis in many of these states, they are effectively powerless to act to resolve the problem (see “States Press Forward for Reform Legislation,” page 14).

### Solution Should Be Patterned After California’s MICRA

Fortunately, Congress does not need to start from scratch and identify and implement a solution that is untested. Faced with a similar

**CSNS Professional Liability Survey Results 2002**

State/City	2000	2002	Percentage Increase
Los Angeles, CA	\$48,000	\$52,000	8%
West Palm, FL	58,000	210,000	262%
Cleveland, OH	75,675	167,941	122%
Oaklawn, IL	110,000	282,720	157%
Philadelphia, PA	90,000	190,000	111%
New York, NY	154,890	251,126	62%

crisis in the early 1970s, the state of California, with bipartisan support, enacted the Medical Injury Compensation Reform Act, or MICRA. The key elements of MICRA include:

- providing full compensation for all economic damages, including medical bills, lost wages, future earnings, custodial care and rehabilitation;
- placing a fair and reasonable limit of \$250,000 on noneconomic damages, such as pain and suffering;
- establishing a reasonable statute of limitations for filing a lawsuit;
- allowing for periodic payments of damages rather than lump sum awards;
- preventing the double recovery of damages by allowing evidence of collateral source payments; and
- ensuring that the bulk of any award goes to the plaintiffs, not to the attorneys.

For nearly three decades, MICRA has ensured that legitimately injured patients get unfettered access to the courts and receive full compensation for their injuries, while at the same time providing stability to the liability insurance market to ensure that doctors can remain available to care for their patients. Over time, the rate of increase of premiums for California doctors has been significantly lower than in other states. From 1976 to 2000, premiums for physicians in California have risen only 167 percent compared with an increase of 505 percent for the entire United States.

Data from the CSNS survey likewise demonstrates that the rate of premium increase for an individual neurosurgeon in Los Angeles, Calif., is significantly lower compared to other neurosurgeons who practice medicine in crisis states where there are no reforms in place (see CSNS Professional Liability Survey Results 2002 table). The average rate of increase for the neurosurgeons in these states without reform was 143 percent as compared to just 8 percent in Los Angeles.

U.S. government experts also agree that MICRA does in fact hold down the costs of medical liability insurance, and over the years there have been a number of studies that have identified MICRA’s \$250,000 cap on noneconomic damages as a critical element in stabilizing premium costs.

Continued on page 17

# Senate Vote Clarifies Course of Action

**KATIE O. ORRICO, JD**

Voting mostly along party lines, on July 9 the U.S. Senate refused to take up S. 11, the Patients First Act. Modeled after California's legislation, the Medical Injury Compensation Reform Act or MICRA, the bill would, among other things, cap noneconomic damages at \$250,000 and establish expert witness standards in medical liability lawsuits.

The vote was 49 to 48, 11 votes shy of the 60 needed. All Republicans but two voted "yea," 45 Democrats and one Independent voted "nay," and three Democrats did not vote. The U.S. House of Representatives passed its reform bill on March 13, and the Bush administration fully supports the House-passed version of the bill, H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003. Therefore neurosurgery's advocacy efforts now must focus on changing the votes of 11 senators. Senate leaders have vowed to bring medical liability legislation up for additional votes throughout the remainder of the 108th Congress, so neurosurgeons need to keep the pressure on those senators who blocked consideration of this critical legislation. The complete tally of the Senate vote is listed below.

The fact that the first attempt at passage in the Senate failed is not necessarily bad news. First, the 49 "yea" votes for the bill is the highest

number of senators ever to vote in favor of such comprehensive reform legislation. Second, the vote provided a clear picture of current standings that will allow precise targeting of public education and advocacy efforts.

Further, the Republican leadership in the Senate has recently indicated its intention to pursue an incremental vote strategy. At press time, the expectation is that the Senate will vote on a medical liability reform bill that applies only to obstetric services sometime in October. The second bill, to be considered first thing next year, would apply MICRA-like protections to providers of emergency services, including neurosurgeons. The third and fourth bills likely will apply tort reforms to rural physicians and volunteer physicians. Finally, assuming the failure of all of these efforts, sometime before the 2004 elections the Senate will vote one last time on a comprehensive reform bill. It is possible, however, that Democrats will find it extremely difficult to vote against moms and babies, and should the first incremental bill pass the Senate, it could serve as the legislation that would be reconciled with the House-passed HEALTH Act.

Neurosurgeons are encouraged to contact their senators and stress the need to pass medical reform legislation. Sample letters that can be edited and sent via e-mail are available at <http://capwiz.com/noc/issues/alert/?alertid=2801021>.

AL	Richard Shelby (R) . . . . .	.Nay	LA	John Breaux (D) . . . . .	.Nay	OH	Mike DeWine (R) . . . . .	.Yea
	Jeff Sessions (R) . . . . .	.Yea		Mary Landrieu (D) . . . . .	.Nay		George Voinovich (R) . . . . .	.Yea
AK	Ted Stevens (R) . . . . .	.Yea	ME	Olympia Snowe (R) . . . . .	.Yea	OK	Don Nickles (R) . . . . .	.Yea
	Lisa Murkowski (R) . . . . .	.Yea		Susan Collins (R) . . . . .	.Yea		James Inhofe (R) . . . . .	.Yea
AZ	John McCain (R) . . . . .	.Yea	MD	Paul Sarbanes (D) . . . . .	.Nay	OR	Ron Wyden (R) . . . . .	.Nay
	Jon Kyl (R) . . . . .	.Yea		Barbara Mikulski (D) . . . . .	.Nay		Gordon Smith (R) . . . . .	.Yea
AR	Blanche Lincoln (D) . . . . .	.Nay	MA	Edward Kennedy (D) . . . . .	.Nay	PA	Arlen Specter (R) . . . . .	.Yea
	Mark Pryor (D) . . . . .	.Nay		John Kerry (D) . . . . .	.Not Voting		Rick Santorum (R) . . . . .	.Yea
CA	Dianne Feinstein (D) . . . . .	.Nay	MI	Carl Levin (D) . . . . .	.Nay	RI	Jack Reed (D) . . . . .	.Nay
	Barbara Boxer (D) . . . . .	.Nay		Debbie Stabenow (D) . . . . .	.Nay		Lincoln Chafee (R) . . . . .	.Yea
CO	Ben Nighthorse Campbell, (R) . . . . .	.Yea	MN	Mark Dayton (D) . . . . .	.Nay	SC	Ernest Hollings (D) . . . . .	.Nay
	Wayne Allard (R) . . . . .	.Yea		Norm Coleman (R) . . . . .	.Yea		Lindsey Graham (R) . . . . .	.Nay
CT	Christopher Dodd (D) . . . . .	.Nay	MS	Thad Cochran (R) . . . . .	.Yea	SD	Thomas Daschle (D) . . . . .	.Nay
	Joseph Lieberman (D) . . . . .	.Nay		Trent Lott (R) . . . . .	.Yea		Tim Johnson (D) . . . . .	.Nay
DE	Joseph Biden (D) . . . . .	.Nay	MO	Christopher Bond (R) . . . . .	.Yea	TN	Bill Frist (R) . . . . .	.Yea
	Thomas Carper (D) . . . . .	.Nay		Jim Talent (R) . . . . .	.Yea		Lamar Alexander (R) . . . . .	.Yea
FL	Bob Graham (D) . . . . .	.Not Voting	MT	Max Baucus (D) . . . . .	.Nay	TX	Kay Bailey Hutchinson (R) . . . . .	.Yea
	Bill Nelson (D) . . . . .	.Nay		Conrad Burns (R) . . . . .	.Yea		John Cornyn (R) . . . . .	.Yea
GA	Zell Miller (D) . . . . .	.Not Voting	NE	Chuck Hagel (R) . . . . .	.Yea	UT	Orrin Hatch (R) . . . . .	.Yea
	Saxby Chambliss (R) . . . . .	.Yea		Ben Nelson (D) . . . . .	.Nay		Robert Bennett (R) . . . . .	.Yea
HI	Daniel Inouye (D) . . . . .	.Nay	NV	Harry Reid (D) . . . . .	.Nay	VT	Patrick Leahy (D) . . . . .	.Nay
	Daniel Akaka (D) . . . . .	.Nay		John Insign (R) . . . . .	.Yea		James Jeffords (I) . . . . .	.Nay
ID	Larry Craig (R) . . . . .	.Yea	NH	Judd Gregg (R) . . . . .	.Yea	VA	John Warner (R) . . . . .	.Yea
	Michael Crapo (R) . . . . .	.Yea		Jon Sununu (R) . . . . .	.Yea		George Allen (R) . . . . .	.Yea
IL	Richard Durbin (D) . . . . .	.Nay	NJ	Frank Lautenberg (D) . . . . .	.Nay	WA	Patty Murray (D) . . . . .	.Nay
	Peter Fitzgerald (R) . . . . .	.Yea		Jon Corzine (D) . . . . .	.Nay		Maria Cantwell (D) . . . . .	.Nay
IN	Richard Lugar (R) . . . . .	.Yea	NM	Pete Domenici (R) . . . . .	.Yea	WV	Robert Byrd (D) . . . . .	.Nay
	Evan Bayh (D) . . . . .	.Nay		Jeff Bingaman (D) . . . . .	.Nay		John D. Rockefeller (D) . . . . .	.Nay
IA	Charles Grassley (R) . . . . .	.Yea	NY	Charles Schumer (D) . . . . .	.Nay	WI	Herbert Kohl (D) . . . . .	.Nay
	Tom Harkin (D) . . . . .	.Nay		Hillary Rodham Clinton (D) . . . . .	.Nay		Russ Feingold (D) . . . . .	.Nay
KS	Sam Brownback (R) . . . . .	.Yea	NC	John Edwards (D) . . . . .	.Nay	WY	Craig Thomas (R) . . . . .	.Yea
	Pat Roberts (R) . . . . .	.Yea		Elizabeth Dole (R) . . . . .	.Yea		Michael Enzi (R) . . . . .	.Yea
KY	Mitch McConnell (R) . . . . .	.Yea	ND	Kent Conrad (D) . . . . .	.Nay			
	Jim Bunning (R) . . . . .	.Yea		Byron Dorgan (D) . . . . .	.Nay			

# Laying Myths to Rest

## Common Misperceptions of Federal Medical Liability Reform

JAMES R. BEAN, MD

**T**he public debate over medical liability reform is riddled with misleading information and assertions about the cause of and solution for the liability crisis. These arguments appear to be intended to divert attention from the actual cause of rising professional liability insurance premiums, and to prevent legislative action that would reduce medical liability payouts. Two strategies seem to determine the character of the myths. One strategy is to shift blame to insurers, who are easy targets for public distrust. Another is to blame poor professional oversight, justifying litigation as a source of professional discipline. Some of the common myths follow.

**Insurers made bad investment decisions in the last decade, and now are trying to make up for losses in the stock market by raising premium rates.** The strategy of this statement is to align lawyers, doctors and public opinion against insurance companies. However, insurer investments are 80 percent in bonds, unaffected by stock market fluctuations, and only 8 percent to 15 percent in the equity market, or stocks. The remainder is invested in mortgages, real estate, and short-term treasury notes or cash. Insurer return on investments has been stable at 5.0 percent to 5.5 percent since 1997, according to A.M. Best. Stock market decline had only minimal effect on investment return. However, decline in interest rates, led by reductions in the Federal Reserve discount rate since 2000, have reduced bond yields, and reduced funds available to subsidize premium income. Brown Brothers Harriman & Co. found that decline in equity income was balanced by capital gains in bonds, resulting in no net loss, and concluded that “investments did not precipitate the current crisis.”

The reduction in investment yield, however, has unmasked the effect of steeply rising awards since 1995, reducing the buffer between payouts and premiums, and requiring premium increases to bolster reserves and ensure solvency.

**The current crisis is only an insurance business cycle, and will stabilize without resorting to legislation.** If the crisis were simply a business cycle, all lines of insurance and all states would be equally affected. However, insurers are not pulling out of other lines of insurance, such as property and casualty. St. Paul’s is an example. In December 2001, St. Paul’s pulled out of all medical liability coverage after sustaining growing losses that could not be covered by premium increases, leaving 42,000 physicians nationwide without coverage.

**The insurance cycle would be prevented if state insurance regulation adequately controlled insurance company premium rates and insurer investments.** State insurance departments heavily regulate insurance and place strict limits on the types and risk of investments, as well as require annual reports on the status of investments. If investment regulation were the problem, all insurance lines offered by these companies would be equally affected. In regard to premium rate control, medical liability insurance payouts in 2001 were 150

percent of premium revenue, and in 2002, 165 percent. Excessive control of rate increases when losses mount beyond premium revenue can only result in one of two unsatisfactory outcomes: insurer insolvency and bankruptcy or insurer withdrawal from the state.

**Tort reforms unfairly penalize patients and are ineffective in holding down premiums.** Tort reforms do not take away the right to sue, or to collect awards for medical negligence. Nor do the proposed federal reforms inspired by California’s Medical Injury Compensation Reform Act, known as MICRA, reduce awards for true economic damages. The problem is noneconomic or “pain and suffering” damages, which are not objectively quantifiable. They are the unpredictable component of payouts that cause chaos in predicting insurance risk, leading to the large losses that are driving insurers out of particular states, out of liability insurance coverage, or into receivership. In some instances, noneconomic damages account for 66 percent to 75 percent of total awards. (For more on MICRA, see the cover story.)

**If the 5 percent of physicians who are responsible for 54 percent of payouts were disciplined by state licensure boards, the medical liability crisis would disappear.** This assertion fails to account for the randomness of liability claims and the types of specialties that account for the high awards. According to the Harvard Medical Practice Study of New York, negligence was associated with only 16 percent of liability claims filed in 1984, while only 13 percent of the negligent injuries found through chart review resulted in a claim. Another study found that 46 percent of claims paid had no negligence, while only 56 percent of cases of claims with negligence resulted in any settlement or award. That is, claims and negligence do not correlate.

Furthermore, The Doctors Company data lists neurosurgeons as sustaining the highest claim frequency, with a claim every 18 months, on average. This means that high-risk specialties are sued more often, not because of negligence, but because of the risk of the medical condition and the severity of the adverse outcome. The assertion that disciplining physicians with multiple lawsuits or even large payouts fails to recognize or acknowledge that medical liability claims do not effectively identify or deter negligence, and that actions to discipline physicians have no effect on reducing claim frequency or the size of the damages claimed or awarded. ■

**James R. Bean, MD**, is editor of the *Bulletin*, chair of the AANS/CNS Washington Committee, and serves as secretary/treasurer of Neurosurgeons to Preserve Health Care Access (NPHCA). He is in private practice in Lexington, Ky.

*This article is adapted from Medical Liability Reform—Now!, by the American Medical Association.*

# Will the U.S. Constitution Permit Reform?

## Why Congress Has the Power to Pass Federal Medical Liability Reform

KATIE O. ORRICO, JD

Opponents of federal medical liability reform legislation argue that the regulation of the business of insurance is a state function and traditional tort actions, such as medical negligence suits, are not federal causes of action, but rather are governed by state law. Therefore, principles of federalism hold that a federal medical liability reform law would violate the U.S. Constitution.

Article VI of the Constitution states:

“This Constitution, and the Laws of the United States which shall be made in Pursuance thereof... shall be the supreme Law of the Land...”

Thus, the U.S. Congress may pass any law, provided it is pursuant to an enumerated constitutional power. There are two sections of the Constitution that give Congress the power to enact federal medical liability reform legislation.

First, under Article I, section 8, clause 3, Congress has the power “to regulate Commerce with foreign Nations, and among the several states.” The U.S. Supreme Court has held that the business of insurance constitutes interstate commerce for purposes of the Commerce Clause (*United States v. South-Eastern Underwriters Association*). In addition, in *New York v. United States*, the court held that the only significant federalism restraint on the exercise of the commerce power is that the state regulatory processes may not be “commandeered” for federal purposes; there is no federalism restraint on federal regulation of businesses and individuals in areas traditional regulated by states.

The fact that Congress has traditionally deferred in large measure to the state regulation of the insurance industry does not mean that Congress must continue to do so. Congress does not invade areas reserved to the states by the 10th Amendment “simply because it exercises its authority... in a manner that displaces the States’ exercise of their... powers” (*Hodel v. Virginia Surface Mining & Reclamation Association, Inc.*).

Secondly, under Article I, section 8, clause 1, Congress has the power to spend for the “general Welfare of the United States.” The Supreme Court has held that Congress may require the states to implement tort reform as a condition of their acceptance of federal funds. In *South Dakota v. Dole*, the court held that Congress “may attach conditions on the receipt of federal funds, and has repeatedly employed the power ‘to further broad policy objectives by conditioning receipt of federal moneys with compliance by the recipient with federal statutory and administrative directives.’”

Clearly, under either of these two standards, federal medical liability reform legislation passes constitutional muster. As the Congressional Joint Economic Committee recently reported, reform legislation that includes, among other things, a cap on noneconomic damages would:



- yield significant savings in overall healthcare spending;
- halt the exodus of doctors from high-litigation states and specialties;
- improve access to healthcare;
- produce \$12.1 billion to \$19.5 billion in annual savings for the federal government; and
- increase the number of Americans with health insurance by up to 3.9 million people.

Other reasons to justify federal intervention based on the Commerce Clause include:

- patients frequently cross state lines to obtain healthcare and their health insurers (who ultimately pay for increased costs associated with medical litigation system) pay for this care;
- medical liability insurers no longer limit their services to a single state;
- national medical liability insurers are leaving the market (St. Paul’s, for example), leaving doctors in all states scrambling for coverage; and
- doctors practice medicine in more than one state;

Nearly all states are experiencing a medical liability crisis (the American Medical Association has identified 19 states in “crisis” and 25 states “showing problem signs”), and as many states face both state constitutional and political barriers to enacting reform legislation, a federal solution to this national problem is imperative. ■

Katie O. Orrico, JD, is director of the AANS/CNS Washington Office.

# States Press Forward for Reform Legislation

## Florida and Texas Now Among the Reformers

KATIE O. ORRICO, JD

While efforts to pass federal medical liability reform legislation continue, a growing number of states have likewise been considering reform legislation aimed at solving the current crisis. Within the past year or so, Arkansas, Georgia, Idaho, Mississippi, Nevada, Ohio, Pennsylvania, and West Virginia all have enacted some type of reform legislation, and many more have considered reforms, but failed to enact them.

Florida and Texas are the most recent states to pass reform laws. Both states have passed comprehensive reform bills in the past, but their state supreme courts had ruled that key provisions of the laws (particularly the caps on noneconomic damages) were unconstitutional. Following the recent enactment of these new laws, which contain damage caps, each state must pass an amendment to its state constitution to permit the implementation of these new laws. On Sept. 13, Texas voters overwhelmingly approved Proposition 12, granting the Texas legislature the authority to cap noneconomic damages in healthcare liability cases. Florida physicians are continuing to develop their constitutional amendment strategy.

### Florida Enacts Liability Reform

After convening three special sessions of the state legislature to consider medical liability reform legislation, on Aug. 14 the Florida House and Senate finally struck a deal and passed medical liability reform legislation. Gov. Jeb Bush subsequently signed the bill, which took effect on Sept. 15. The Florida Medical Association did not support the bill, in part because the noneconomic damage cap was inadequate to hold down escalating liability insurance premiums. Detailed information can be found at [www.fmaonline.org/tort](http://www.fmaonline.org/tort), but key provisions follow.

#### Caps on Damages

**1. Caps in "Routine" Medical Malpractice Cases** In cases against physicians, the law establishes a \$500,000 cap on noneconomic damages per claimant, regardless of the number of defendant physicians. Any one physician, regardless of the number of claimants, is not responsible for more than \$500,000. The maximum amount of noneconomic damages all claimants can recover in the aggregate against all physicians is \$1 million.

**2. Situations in Which the Cap Can Be Pierced** In cases involving wrongful death and permanent vegetative state, all claimants may recover a total of \$1 million from all physicians without any special findings by the court. If a case does not involve wrongful death or permanent vegetative state, but the trial court finds that a manifest injustice would occur if the lower cap was imposed *and* the finder of fact finds that a catastrophic injury has occurred, then only the injured patient may recover from a physician an additional amount up to \$1 million in noneconomic damages. A catastrophic injury is defined as severe paralysis, amputations, severe brain injuries, severe

burns, blindness and loss of reproductive organs.

**3. Caps in Emergency Room Situations** A different cap applies for physicians and facilities providing emergency care. For physicians, noneconomic damages shall not exceed \$150,000 per claimant and the total noneconomic damages recoverable by all claimants from all physicians are \$300,000.

**Good Samaritan Immunity** Any physician or hospital that provides emergency services pursuant to obligations imposed by federal or state Emergency Medical Treatment and Labor Act (EMTALA) requirements shall not be held liable for any civil damages as a result of such medical care unless they act with reckless disregard for the consequences of their care.

**Expert Witness Reform** The law includes various litigation process reforms, including new expert witness standards. The expert must be in the same or similar specialty as the defendant and must have been in the active practice of medicine in the last three years, involved in teaching, or in a clinical research program. The trial judge continues to have some discretion as to who can testify as an expert. In addition, the expert who signs the pretrial affidavit must have the same qualifications as the expert who testifies at trial.

**Insurance Reforms** The law would freeze insurance rates in effect on July 1, 2003, until new rates are calculated that take into account the new law's impact. The new rates are to take effect no later than Jan. 1, 2004. Liability insurers are required to implement discounts or surcharges based on individual providers' loss experience. Insurers must notify policyholders of average rate increases of 25 percent or more. Groups of 10 or more physicians are permitted to form a commercial self-insurance fund and physicians continue to be permitted to self-insure ("go bare").

**Quality Improvement** The law also includes several provisions related to patient safety and physician discipline.

### Texas Enacts Liability Reform

In early June the Texas legislature passed comprehensive medical liability reform legislation. Gov. Rick Perry signed the bill, which, took effect on Sept. 1. In contrast to Florida physicians, however, the bill was enthusiastically supported by the Texas Medical Association, mainly because of the \$250,000 cap on noneconomic damages. Highlights of the bill follow.

#### Caps on Damages

**1. Noneconomic Damages in Typical Malpractice Cases** In suits against physicians and other healthcare providers (other than healthcare institutions), the law includes a \$250,000 cap on noneconomic damages per claimant, regardless of the number of defendant physicians against whom the claim is asserted.

**2. Charity Care Cases** The law includes a \$500,000 cap on *all* damages in suits against a nonprofit hospital or hospital system, its

employees, and volunteers (including physicians), if the patient signs an acknowledgement that the care rendered is not for remuneration and liability is limited. The cap also applies if the patient is incapacitated or a minor, and a representative is not reasonably available.

**3. Nonprofit Hospitals** Cap on liability for nonprofit hospitals that provide at least 8 percent charity care and at least 40 percent of the charity care in the county is set at the \$100,000/\$300,000 damage limits that are applicable to governmental entities.

**Good Samaritan Immunity** The law limits liability for emergency care, and the definition of “Good Samaritan” is clarified to protect persons providing emergency care. Furthermore, jury instructions are required in cases involving emergency care to assure that the jury takes into account the emergency situation (for example, no medical records available, limits on time for diagnosis and treatment, etc.) when assessing a negligence claim.

**Sovereign Immunity** Physicians will be considered public servants when working for state and local agencies (hospital districts, county hospitals), and their liability is limited to \$100,000, with the governmental entity responsible for any excess award. “A public servant includes a licensed physician who provides emergency or post-emergency stabilization services to patients in a hospital owned or operated by a unit of local government.”

**Expert Witness Reforms** In a suit involving a healthcare liability claim against a physician, a person may qualify as an expert witness only if the expert is practicing medicine at the time testimony is given or at the time the claim arose. The law further provides for some general requirements and considerations as to the substantive qualifications of expert witnesses, but the trial judge has a fair amount of discretion in determining whether an expert meets the necessary qualifications. Within 120 days of filing a suit, the plaintiff must provide the defendant with an expert report and if the plaintiff fails to do so, upon motion of the defendant, the court shall award court costs and attorney fees and dismiss the case with prejudice. This report is not admissible in court.

**Periodic Payments** If requested by the defendant, the law mandates the periodic payment of future medical, healthcare, and custodial care when the award equals or exceeds \$100,000. The court has the discretion to award periodic payment of other future damages. Periodic payments of future healthcare terminate upon the death of the recipient, although periodic payments of future damages do not. Attorney fees are calculated on the basis of present day value of periodic payments.

**Proportionate Liability** The law ensures that named defendants are only held responsible for the portion of fault attributable to them.

**Statute of Limitations** The statute of limitations for bringing a medical negligence suit is generally two years, however the new law now imposes an absolute deadline for bringing suit and any healthcare claim not brought within 10 years is barred.

### A Comparison of Liability Premiums in Wisconsin and Pennsylvania

	1998	2002	% Change
<b>Internists</b>			
Wisconsin	5,607	5,205	2.7%
Pennsylvania	4,048	9,660	138.6%
U.S. Median	5,731	7,544	33.4%
<b>General Surgeons</b>			
Wisconsin	16,063	17,433	8.5%
Pennsylvania	12,617	41,753	230.9%
U.S. Median	22,457	27,922	30.2%
<b>OB/GYNs</b>			
Wisconsin	25,532	25,133	-1.6%
Pennsylvania	17,872	68,370	282.6%
U.S. Median	33,736	42,028	21.7%

**Settlement Offers** Litigation costs are shifted when a plaintiff refuses a pretrial settlement offer if the plaintiff’s award judgment is less than 80 percent of the defendant’s settlement offer.

### Wisconsin and Pennsylvania: Very Different Experiences

Much has been said about the beneficial impact that California’s Medical Injury Compensation Reform Act, or MICRA, has had in holding down professional liability insurance premiums. But California is not the only state that can boast this success. Others, including Indiana, Louisiana, and Wisconsin, have comprehensive medical liability reform laws on the books, and these too have proven effective in stabilizing premiums. A comparison between two states—Wisconsin, which had reforms in place, and Pennsylvania, which has not enacted meaningful tort reform—illustrate the beneficial effects that these reforms do indeed have.

Over the past several years, physicians in Pennsylvania have experienced significant increases in liability insurance premiums, while rates in Wisconsin have remained stable. Data collected by the *Medical Liability Monitor* and analyzed by the AMA, is shown in the table “A Comparison of Liability Premiums in Wisconsin and Pennsylvania.” ■

**Katie O. Orrico, JD**, is director of the AANS/CNS Washington Office.

# A State in Crisis: Missouri

## Neurosurgeon Offers PLI Survey as a Template for Others

DAVID F. JIMENEZ, MD

By now, every U.S. neurosurgeon surely must be aware of the extent to which the medical liability crisis is affecting access to healthcare in our country. Skeptics might wonder just how serious the problem really is.

In Missouri it was serious enough that with tremendous support of the Missouri State Medical Association, legislators from both sides of the aisle overwhelmingly passed significant tort reform. So why is Missouri still in deep trouble? In July the governor vetoed the bill; thus the ongoing concern.

True verifiable data is a powerful weapon that can be used in championing a cause. So, with the help of neurosurgeon John Krettek of St. Louis, earlier this year I embarked on an effort to gather data on rising professional liability insurance (PLI) premiums—a well-known symptom of the medical liability crisis—in Missouri. The hope is that our effort, detailed in this article, will serve as a template neurosurgeons across the country can use for gathering verifiable data that can reveal the extent of the crisis locally.

**Methodology** In order to obtain all the names of current practicing neurosurgeons in the state, a list was compiled from three different sources: the 2002 AANS/CNS Membership Directory, the 2002-2003 Missouri State Medical Association Membership Directory, and the American Neurological Surgery Political Action Committee (ANS PAC) database. The latter, found to be the largest database, was used as the master list. It was then cross-referenced with other two directories, and any neurosurgeons who were not found on the ANS PAC list were added to it.

Any names that could not be cross-referenced with either the AANS/CNS or Missouri State Medical Association directories were then further researched. Doctors were grouped by location to simplify the research. Each hospital or practice was asked to confirm all practicing neurosurgeons in the group. Neurosurgeons still in residency were removed from the list. If, after extensive research, contact information could not be found for a neurosurgeon, the name was removed from the list.

The Missouri Professional Liability Insurance Survey 2003, which covered data from 2000 to 2003, was developed and mailed to the known 89 practicing neurosurgeons in Missouri. A total of 79 surveys were completed and returned by fax, for a response rate of 88.7 percent. The survey results were entered into a Microsoft Excel spreadsheet and then tabulated and analyzed.

**Findings** Respondents reported significant annual increases in PLI premiums during the three-year period studied. Premiums increased by 36 percent between 2001 and 2002 and by 67 percent between 2002 and 2003, for an overall increase of 116 percent between 2001 and 2003.

Neurosurgeons most affected by increases in PLI premiums experienced increases of 164 percent (2001-2002), 148 percent (2002-2003), and 295 percent (2001-2003). The lowest premium in 2003 was found to be \$33,687.00 and the highest \$180,000.

### Missouri Neurosurgical Professional Liability Insurance Survey 2003

#### Annual Premium Costs

2001	2002	2003
\$21,819–\$97,000	\$28,649–\$113,000	\$33,687–\$180,000

#### Percent Increase in Annual Premium Cost

Years	Lowest % Increase	Highest % Increase	Mean
2001-2002	2.8%	164%	36.6%
2002-2003	13.4%	148%	67.5%
2001-2003	23%	295%	116.1%

#### Changes in Response to Premium Increases

Retirement	40%
Relocation	26.6%

As a result of the increases in premiums, 40 percent of the respondents indicated that they were considering early retirement. Six neurosurgeons already had retired in the past three years. Considering that 46 percent of the respondents were age 50 or older, such retirement plans could lead to a significant decrease in practicing neurosurgeons in Missouri during the next five to 10 years. Further, 26.6 percent stated that they were considering relocating to another state; Kansas and Indiana were the states most commonly mentioned.

Two-thirds of the respondents indicated that they plan to reduce the type of service they provide in their communities. The following areas were identified for reduction of services: Pediatric Neurosurgery, 33 percent; Trauma/Emergency Room Coverage, 33 percent; Cerebrovascular Surgery, 43 percent; and Cranial Work, 23 percent.

Fifty-three percent reported that they will decline accepting Medicaid patients, and 23 percent say they will stop accepting Medicare patients. This is not surprising considering that, when calculating the cost of liability insurance per case, neurosurgeons were paying up to \$582.00 per case in 2001, \$647.00 per case in 2002, and are paying \$1,240.00 per case in 2003. Given the low reimbursement rates for Medicaid and Medicare, it is evident that it would be impossible to sustain successful viable practices taking care of those patients.

#### Findings in Major Missouri Cities

The survey data was further broken down to show what is really happening in the main areas where Missouri neurosurgeons practice: Joplin, St. Joseph, Cape Girardeau, Kansas City, and St. Louis (where 53 percent practice).

In Joplin, five neurosurgeons have been covering the metropolitan area and now three are leaving the state. Two could not obtain insurance in Missouri and are moving to Kansas, and the third is moving to a “tort friendly” state where his insurance will

be \$30,000 each year instead of \$110,000 each year.

In St. Joseph the lone neurosurgeon left the state altogether. In Cape Girardeau two of the four neurosurgeons reported that their insurance was not renewed, and that they will be moving out of the state, as well.

Far worse, neurosurgeons living in eastern Kansas City (Missouri) have left the area: One chose to retire while the others moved to practice in Topeka, Kan. As for western Kansas City (Kansas), there were approximately 25 neurosurgeons practicing at the beginning of 2003. Those who are insured under the Kansas Healthcare Stabilization Fund and who are practicing in Missouri are considering limiting their practices to Kansas; if they decide to do so, the number left practicing in eastern Kansas City may drop to 15.

In the greater St. Louis area, 25 neurosurgeons are in private practice. Three retired when they saw their annual premiums triple to the \$100,000 range. Four neurosurgeons in one large-group practice were notified several weeks ago that they will not have their liability insurance renewed by their current carrier; two of them will retire, and the fate of the remaining two is unknown at the present time.

In another large practice, the liability policies of two neurosurgeons are not being renewed by their carrier, one due to three prior settlements and the other due solely to pending claims. One surgeon has been told that his premium will increase this year to \$311,000 and further, that he will not be allowed to perform any intracranial surgery! The other members in that group saw an increase in insurance premiums from \$60,000 this year to \$120,000 next year.

The data demonstrate that adequate delivery of neurosurgical care in Missouri is in serious jeopardy and that, in less than three years, Missouri has become a state in crisis. The uncontrolled increases in PLI premiums are a great threat to the practicing neurosurgeon. Given the Missouri neurosurgeons' plans to relocate, retire, and reduce services, there is indeed a real threat of significant reduction in the numbers of practicing neurosurgeons and therefore in patients' access to care in this state.

We are no longer dealing with simple anecdotes. We now know the extent of our problem, and more importantly, we can share this knowledge with others. This information has been appropriately relayed to legislators in Missouri, as well as those in the U.S. Congress. The governor and, more importantly, our patients, also are being informed of the true severity of this crisis. With verifiable data, there is hope that we will be able to turn the tide and achieve meaningful tort reform in Missouri or at the national level. ■

---

David F. Jimenez, MD, is professor in the Division of Neurosurgery at the University of Missouri-Columbia.

**Additional Resources: Missouri Professional Liability Insurance Survey 2003, [www.AANS.org](http://www.AANS.org); Missouri State Medical Association, [www.msma.org](http://www.msma.org).**

### Reform: A Lifeline to Neurosurgeons and Patients

Federal liability reform legislation is possible. Policymakers generally don't act until a given situation is in crisis, and neurosurgery has made significant headway in demonstrating the widespread nature of the current medical liability problem and the growing public support for reform legislation. It is also highly likely that this issue will be at the forefront of the 2004 elections, and candidates for federal office will not want to be on the "wrong" side of this issue, lest they pay the price when the ballots are cast and counted.

There is no doubt that we have reached a very important juncture in the evolution of the U.S. healthcare system. At a time when lifesaving scientific advances are being made in nearly every area of healthcare, patients across the country are facing a situation in which access to healthcare is in serious jeopardy. Clearly the state of America's healthcare system now and in the future is therefore at risk, and left unchecked, the medical liability crisis has grave implications for patient access to neurosurgical care.

When patients can't find a neurosurgeon close to home, they must sometimes travel great distances, often going out of state, to get their medical care. When fewer neurosurgeons are available, hospital emergency departments and trauma centers must shut their doors, and patients with emergency medical conditions lose critical lifesaving time searching for an available emergency room. When neurosurgeons stop performing high-risk medical services, patients are often referred to academic medical centers, and these medical facilities already are overburdened and ill-equipped to handle the increase in patient volume.

When neurosurgeons retire at an early age, the looming shortage is accelerated and will place additional burdens on the healthcare system as the population ages and requires more medical care from an increasingly shrinking pool of practicing neurosurgeons. Once gone, these doctors are hard to replace, and those states currently facing a medical liability crisis are having a difficult time recruiting new neurosurgeons to their communities.

And finally, when the practice of medicine becomes so uninviting, fewer and fewer of our nation's best and brightest will want to become doctors, thus jeopardizing our country's status as one of the finest healthcare systems in the world.

Through Neurosurgeons to Preserve Health Care Access, the AANS and CNS are calling on all neurosurgeons to help preserve the profession and patients' access to neurosurgical care. This medical liability reform campaign represents a lifeline, but the commitment of every neurosurgeon is necessary to resolve this problem once and for all. ■

---

Katie O. Orrico, JD, is director of the AANS/CNS Washington Office.

# The Campaign Starts Here

## NPHCA Charts Course for Federal Medical Liability Reform

STEWART B. DUNSKER, MD

*“Come and volunteer with me. Come pull on the oar to strive, to seek, to work to win, and not to yield!”*

These words, inspired by the closing lines of Tennyson’s poem “Ulysses,” concluded my Presidential Address delivered at the 2001 Annual Meeting of the American Association of Neurological Surgeons (AANS). At that time the topic of concern was how, in so many instances, the “bureaucratic tail” wags the “health-care dog.” Rising professional liability insurance (PLI) premiums and medical liability reform necessary to resolve the situation were two among several issues that were discussed.

Within just two years, PLI premiums have soared nationally, with the most exorbitant premiums—nearly \$300,000 annually in Illinois, for example—concentrated in states where medical liability reforms have not been enacted. As a result, many neurosurgeons have found that they must: move to a state where they can obtain insurance; limit their practices—43 percent say they no longer perform intracranial procedures such as surgery for aneurysms; or close their doors.

Like a tidal wave the PLI crisis is sweeping neurosurgeons away, leaving our fellow Americans—who must have access to neurosurgical care—facing an expanding void.

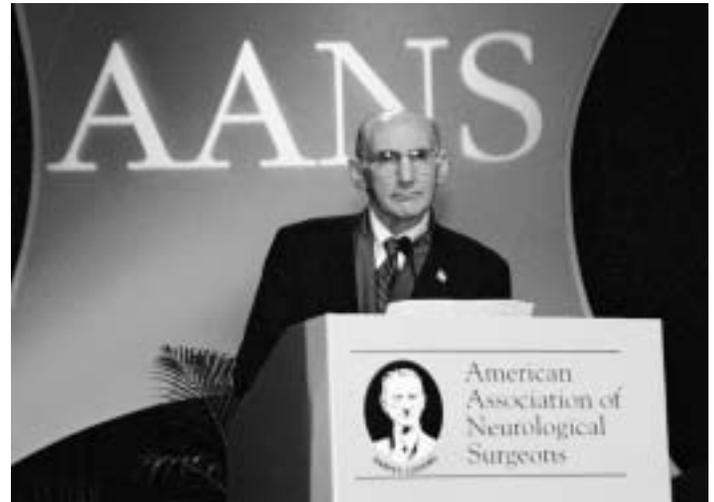
This is why gaining federal medical liability reform is neurosurgery’s most pressing concern today. It represents a lifeline to the preservation of neurosurgical care both for neurosurgeons and our patients. As such it necessarily occupies the apex of neurosurgery’s agenda. And so, like Ulysses, we find ourselves embarking on an arduous and perhaps extended journey, one that will take us into the relatively unfamiliar waters of legislative advocacy via an information campaign that enlists the help of the public.

### Neurosurgery’s Federal Liability Reform Campaign

Our goal, simply stated, is to enact legislation that will preserve access to neurosurgical care in every state. Neurosurgery supports federal legislation—such as California’s Medical Injury Compensation Reform Act, commonly known as MICRA—that contains reforms which have successfully minimized increases in PLI premiums. A critical reform is a cap on noneconomic damages, but other reforms, such as limits on contingency fees, requirements for expert witnesses, and reform to the system of medical justice, are important as well.

Such legislation has been introduced in the 108th Congress. A full accounting of progress so far this year is provided in “Battle Lines Drawn in the Senate” in this issue, but to briefly recap, the U.S. House of Representatives passed the HEALTH Act of 2003, H.R. 5, on March 13. However, in July the Senate failed to take up the Patients First Act, S. 11, falling short by 11 votes. The focus of our efforts at this writing is to change the votes of at least 11 senators.

How will we achieve this? As modern day hero Admiral Nimitz said, “It is an axiom that in preparing for any contest, it is wisest to exploit—not neglect—the element of strength.”



Stewart B. Dunsker, president of Neurosurgeons to Preserve Health Care Access, launched the NPHCA’s public information and advocacy campaign at the AANS Annual Meeting in April. Dr. Dunsker urged every neurosurgeon to give at least \$1,000 each year for three years or until federal medical liability reform is attained.

One area of strength is neurosurgeons’ ability to organize and lead. Earlier this year the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) formed Neurosurgeons to Preserve Health Care Access (NPHCA), an organization created specifically to conceive, execute and fund neurosurgery’s campaign for federal medical liability reform.

Another area of strength is our patients and their families; we must effectively communicate the issues from neurosurgery’s point of view and enlist their help in influencing their legislators to enact federal reforms. But we must reach even further to bring neurosurgery’s perspective to the general public through a targeted informational campaign. How else will the public learn that each neurosurgeon is sued once every 18 to 24 months in a complex judicial system that, according to a 2002 report by the U.S. Department of Health and Human Services, “does not accurately identify negligence, deter bad conduct, or provide justice” and which “forces injured patients to sue their doctors” and undergo what it calls a traumatic and random process? Sadly, without an information campaign, some may learn of the problem when a loved one needs neurosurgical care and there is no one to provide it.

A public information campaign of this magnitude can be undertaken only with appropriate funding. NPHCA launched a major fundraising initiative during the AANS Annual Meeting in April, and the initiative’s momentum continued through the summer with a mailing to all AANS and CNS members. At press time nearly \$650,000 has been raised from individuals and organized neurosurgery alike toward the goal of \$3 million (see the contributor listing on page 20).

## Doctors for Medical Liability Reform

But neurosurgery is not alone in its quest for federal medical liability reform. Other high-risk specialties that have borne the brunt of the PLI crisis alongside neurosurgery have joined NPHCA in a new powerhouse coalition called Doctors for Medical Liability Reform (DMLR). On behalf of neurosurgery, NPHCA has committed a minimum of \$1 million to the coalition, securing for neurosurgery the maximum of two votes in coalition governance. Other principal members and their contributions are the American Association of Orthopaedic Surgeons, \$1 million; American College of Emergency Physicians, \$1 million; Society of Thoracic Surgeons, \$1 million; American College of Surgeons, \$1 million; American College of Cardiology, \$500,000; and the North American Spine Society, \$100,000.

To date the DMLR has raised \$6 million toward the minimum goal of \$10 million to fund the campaign through the November 2004 elections. While the DMLR will continue to collaborate with various strategic partners and existing coalitions who share the same general goals, it will remain a separate entity to ensure that high-risk specialists are appropriately represented.

## Key Campaign Components

The four key advocacy components of the DMLR's campaign are:

- public education through advertising, television and print media;
- patient education through in-office education materials such as pamphlets and posters;
- grassroots political action programs and political contributions in targeted states; and
- legislative advocacy on Capitol Hill.

The coalition already has chosen a public relations firm that has extensive experience in fighting highly political battles in the national arena, and a campaign strategy has been charted. What remains is for all coalition members to meet their financial obligations.

Over the next few months, NPHCA will work aggressively to enlist the help of every neurosurgeon in the fundraising effort. Neurosurgeons not only will be asked to give, but also to identify non-neurosurgeons such as corporations, hospitals, and individuals whom we may be able to count among our partners in this important effort.

I have said this before, but perhaps it bears repeating: Neurosurgeons need to be part of the solution and give their ideas, time, effort and money. If neurosurgeons do nothing, the problem will continue to fester and worsen.

We may be in for a long voyage in rough waters, but the peril to us and to our patients if we do nothing is far greater. We must stay this course for federal medical liability reform. As Admiral Rickover said, "Good ideas are not adopted automatically. They must be driven into practice with courageous patience." ■

**Stewart B. Dunsker, MD**, is president of Neurosurgeons to Preserve Health Care Access (NPHCA). Dr. Dunsker is the 2003 AANS Cushing Medalist, and the 2000-2001 AANS president.

## About NPHCA

Neurosurgeons to Preserve Health Care Access (NPHCA) is a 501(c)(4) nonprofit advocacy organization created by the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS). NPHCA is dedicated to promoting sound public policies that preserve patient access to healthcare.

As its initial project, NPHCA will receive funds for and execute neurosurgery's public information and advocacy campaign aimed at passing federal medical liability reform legislation.

NPHCA board members are Stewart B. Dunsker, MD, president; Stan Pelofsky, MD, vice president; James R. Bean, MD, secretary/treasurer; A. John Popp, MD; Mark N. Hadley, MD; and Vincent Traynelis, MD.

## Contributing to NPHCA

The envelope in this issue of the *Bulletin* can be used to make contributions by check or credit card. Alternatively, personal or corporate checks payable to NPHCA can be sent to:

NPHCA, 5550 Meadowbrook Drive,  
Rolling Meadows, IL 60008

Except to the extent allocable to lobbying or certain other nondeductible purposes, contributions paid to NPHCA will be tax deductible as business expenses under Section 162 of the Internal Revenue Code. In January of each year the NPHCA will send all contributors a letter specifying that portion of the payments made to NPHCA which is not deductible for the preceding calendar year.

## Contacting NPHCA

Katie Orrico, director, Neurosurgeons to Preserve Health Care Access,  
Phone: (202) 628-2883, e-mail: korric@neurosurgery.org,  
Web site: www.neuros2preservecare.org

## Medical Liability Resources on the Web

### Supporters of Reform

- [www.neuros2preservecare.org](http://www.neuros2preservecare.org):  
Neurosurgeons to Preserve Health Care Access
- [www.hcla.org](http://www.hcla.org): Health Coalition on Liability and Access
- [www.ama-assn.org/go/liabilityreform](http://www.ama-assn.org/go/liabilityreform): American Medical Association
- [www.atra.org](http://www.atra.org): American Tort Reform Association
- [www.thedoctors.com](http://www.thedoctors.com): The Doctors Company
- [www.thepiaa.org](http://www.thepiaa.org): Physician Insurers Association of America

### Opponents of Reform

- [www.atla.org/medmal/main.aspx](http://www.atla.org/medmal/main.aspx) and [www.peopleoverprofits.org](http://www.peopleoverprofits.org):  
Association of Trial Lawyers of America
- [www.citizen.org/congress/civjus/medmal/index.cfm](http://www.citizen.org/congress/civjus/medmal/index.cfm):  
Public Citizen

# Special Thanks to those who have contributed to Neurosurgery's Medical Liability Reform Campaign

*Nearly \$650,000 Already Has Been Raised Toward the \$3 Million Goal*

Eustaquio O. Abay II, MD  
P. David Adelson, MD, FACS  
Todd Alexander, MD  
Abdul Amine, MD  
Bruce Ammerman, MD  
Brian T. Andrews, MD  
Ronald I. Apfelbaum, MD  
Paul Arnold, MD  
Gustavo J. Arriola, MD  
Anthony L. Asher, MD  
James I. Ausman, MD, PhD  
Nathan C. Avery, MD  
Robert J. Backer, MD  
Nevan G. Galdwin, MD  
David W. Barnett, MD  
Florence C. Barnett, MD  
Gene H. Barnett, MD  
Steven Barrer, MD  
Rebecca Barrett-Tuck, MD  
Jerry Bauer, MD  
James R. Bean, MD  
Vallo Benjamin, MD  
Edward Benzel, MD  
Deborah Benzil, MD  
Thomas A. Bergman, MD  
Charles H. Bill, MD, PhD  
William Bingaman, MD  
W. Ben Blackett, MD  
Gary Bloomgarden, MD  
Warren Boling, MD  
Charles Palmer Bondurant, MD  
Frederick Boop, MD  
Charles L. Branch, MD  
Rudy P. Briner, MD  
William C. Broaddus, MD, PhD  
James P. Burke, MD, PhD  
Paul J. Camarata, MD  
L. Philip Carter, MD  
C. Michael Cawley III, MD  
Howard Chandler Jr., MD  
Bennie W. Chiles, MD  
Patrick J. Cindrich, MD  
Samuel F. Ciricillo, MD  
John Cleary, MD  
Maurice Collada Jr., MD  
Chris Comey, MD  
Patrick Connolly, MD  
Gregory Corradino, MD  
Pamela J. Costello, MD, PhD  
Christopher Covington, MD  
Christine M. Cox, MD  
H. Mark Crabtree, MD  
Jeffrey Crecelius, MD  
J. Stuart Crutchfield, MD  
John Cummings, MD  
John D. Davis IV, MD  
Arthur L. Day, MD  
Philip C. Deaton, MD  
Gary C. Dennis, MD

Paul Dernbach, MD  
Karl N. Detwiler, MD  
Fernando G. Diaz, MD, PhD  
Antonio DiSclafani, MD  
Q. Michael Ditmore, MD  
Oliver Dold, MD  
Jose Dones, MD  
Michael Dorsen, MD  
M. Lawrence Drerup, MD  
Luis E. Duarte, MD  
Stewart B. Dunsker, MD  
Michael S. B. Edwards, MD  
Bruce Ehni, MD  
Richard G. Ellenbogen, MD  
Magdy El-Kalliny, MD  
Daniel P. Elskens, MD  
Shahin Etebar, MD  
Joel L. Falik, MD  
Jacques N. Farkas, MD  
Richard G. Fessler, MD, PhD  
Tony Feuerman, MD  
E. Malcolm Field, MD  
Sanford Fineman, MD  
Eric P. Flores, MD  
Thomas Francavilla, MD  
Stephen Freidberg, MD  
Anthony K. Frempong-Boadu, MD  
Victor T. Freund, MD  
Stanley W. Fronczak, MD, JD  
Mark A. Fulton, MD  
Walter E. Galicich, MD  
Daniel D. Galyon, MD  
Allan L. Gardner, MD  
Randy L. Gehring, MD  
Benjamin Gelber, MD  
Christopher C. Getch, MD  
Steven L. Giannotta, MD  
F. Gary Gieseke, MD  
Steven A. Gilman, MD  
Franz E. Glasauer, MD  
Rammy S. Gold, MD  
Marc S. Goldman, MD  
John G. Golfinos, MD  
Julius M. Goodman, MD  
Isaac Goodrich, MD  
Paul A. Grabb, MD  
Richard N. V. Gray, MD  
A. Lee Greiner, MD  
Peter J. Grillo, MD  
Robert L. Grubb, MD  
Mark N. Hadley, MD, FACS  
Regis William Haid Jr., MD  
Edward G. Hames III, MD, PhD  
Michael H. Handler, MD  
Hal Hankinson, MD  
Kimberly S. Harbaugh, MD  
Robert E. Harbaugh, MD, FACS  
David H. Harter, MD  
Robert Hash, MD

Michael D. Heafner, MD  
Robert F. Heary, MD  
Kenneth S. Heiferman, MD  
Leslie C. Hellbusch, MD  
Philip Henkin, MD  
Roberto C. Heros, MD  
William Hoffman, MD  
Peter Osbourne Holliday III, MD  
L.N. Hopkins, MD  
Thomas Hoyt, MD, FACS  
Matthew K. Hummell, MD  
George A. Hurt, MD  
John W. Hutchison, MD, FACS  
Warren Y. Ishida, MD  
Patrick Jacob, MD  
Theodore R. Jacobs, MD  
Jafar Jewad Jafar, MD  
Saied Jamshidi, MD  
Tariq Javed, MD  
N. Ross Jenkins, MD  
John Johnson, MD  
Joseph A. Justus, MD  
Ronald E. Jutzy, MD  
Kamal K. Kalia, MD  
Charles G. Kalko, MD  
David B. Kee, MD  
Donald B. Kelman, MD  
Kaveh Khajavi, MD, FACS  
George H. Khoury, MD  
Thomas A. Kingman, MD  
Jinho Kim, MD  
David G. Kline, MD  
Andrew J. Kokkino, MD  
Douglas S. Kondziolka, MD  
Kim Eng Koo, MD  
Jeffrey A. Kornblum, MD  
Robert R. Kraus Jr., MD  
Mark Kubala, MD  
Charles Kuntz IV, MD  
Richard S. Kyle, MD  
Barry J. Landau, MD  
Fredric Lax, MD  
Martin L. Lazar, MD  
Benjamin B. LeCompte III, MD  
Lyal G. Leibrock, MD  
Ricardo R. Leoni, MD  
James G. Lindley, MD  
Mark E. Linskey, MD  
Daniel V. Loesch, MD  
Marie L. Long, MD  
Michael Lusk, MD  
Joel D. MacDonald, MD  
Margaret MacGregor, MD  
Hish S. Majzoub, MD  
J. A. Marchosky, MD  
Paul J. Marcotte, MD  
Jerry Marlin, MD  
Thomas Marshall  
Robert J. Martin, MD

# anks

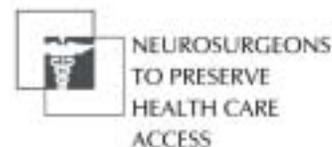
John McCloskey, MD  
Paul C. McCormick, MD  
Morris E. McCrary III, MD  
Michael P. McCue, MD  
J. McGregor, MD  
James E. McLennan, MD  
Muhammed Y. Memon, MD  
Yves Meyer, MD  
Daniel B. Michael, MD, PhD  
Thomas Mims, MD  
Abraham Mintz, MD  
Alon Mogilner, MD, PhD  
James A. Moody, MD  
Ross R. Moquin, MD  
Michael F. Moran, MD  
Jay K. Morgan, MD  
John C. Mullan, MD  
Bradley G. Mullen, MD  
Raj Murali, MD  
Karin M. Muraszko, MD  
Alan R. Murphy, MD  
Rhett Murray, MD  
Cheryl A. Muszynski, MD, FACS  
Richard C. Naftalis, MD  
Mahmaud G. Nagib, MD  
Raj Narayan, MD  
Paul B. Neson, MD  
Gerwin Neumann, MD  
M. Ellen Nichols, MD  
Russ P. Nockels, MD  
Keith A. Norvaill, DO  
Brian James O'Grady, MD  
Joan Frances O'Shea, MD  
David R. Oliver-Smith, MD  
Stephen L. Ondra, MD  
Stephen T. Onesti, MD  
Jeff Oppenheimer, MD  
Katie Orrico  
Carroll Prentis Osgood, MD  
Nelson M. Oyesiku, MD  
Stephen Papadopoulos, MD  
Savas Papazoglou, MD  
Andrew D. Parent, MD  
Jeffrey Erle Pearce, MD  
Marshall E. Pedersen, MD  
Stig E. Peitersen, MD  
Stan Pelofsky, MD  
Mick J. Perez-Cruet, MD  
Joel Pickett, MD  
Dave Piepgras, MD  
A. John Popp, MD  
Antonio R. Prats, MD  
Stefan Pribil, MD  
Donald J. Prolo, MD  
Morris W. Pulliam, MD  
John F. Raggio, MD  
Thorir S. Ragnarsson, MD  
Rodwan K. Rajjoub, MD  
Robert A. Ratcheson, MD

Daniel K. Resnick, MD  
Ali R. Rezai, MD  
Robert Richardson, MD  
M. Hytham Rifai, MD  
Thomas W. Rigsby, MD  
Kristen O. Riley, MD  
Andrew J. Ringer, MD  
Jon H. Robertson, MD  
Thomas G. Rodenhouse, MD  
Gerald E. Rodts Jr., MD  
Charles Rosen, MD, PhD  
Richard A. Roski, MD  
Jacob Rosenstein, MD  
David Rothbart, MD  
Brian Russell, MD  
James T. Rutka, MD, PhD, FRC  
Timothy C. Ryken, MD  
Sean Salehi, MD  
Thomas G. Saul, MD  
Raymond Sawaya, MD  
Karl M. Schmitt, MD  
Daria D. Schooler, MD  
Michael Schulder, MD  
Marc S. Schwartz, MD  
P. Robert Schwetschenau, MD  
Michael Shannon, MD  
Scott Shapiro, MD  
Peter M. Shedden, MD  
John S.C. Shiau, MD  
Lawrence M. Shuer, MD  
Adman Silk, MD  
Frederick A. Simeone, MD  
Bradbury A. Skidmore, MD  
Randall W. Smith, MD  
Roger D. Smith, MD  
Clifford T. Solomon, MD, FACS  
Teck-Mun Soo, MD  
Peter M. Sorini, MD  
Lahsman W. Soriya, MD  
Paul Spurgas, MD  
Scott C. Standard, MD  
Philip Starr, MD, PhD  
Harry Stephens Jr., MD  
Michael G. Sugarman, MD  
Philip W. Tally, MD  
Stephen B. Tatter, MD, PhD  
Kevin R. Teal, MD  
John M. Tew Jr., MD  
B. Gregory Thompson, MD  
Greg Errol Thompson, MD  
Larry D. Tice, MD  
Troy Tippet, MD  
William D. Tobler, MD  
Frederick D. Todd, MD  
John R. Tompkins, MD  
Kenneth Tonymon, MD  
Vincent Traynelis, MD  
Gregory R. Trost, MD  
Gerald F. Tuite Jr., MD

Alex Valadka, MD  
Marc Vanefsky, MD  
Gus G. Varnavas, MD  
Rand M. Voorhies, MD  
Kevin A. Walter, MD  
Beverly C. Walters, MD  
Ronald E. Warnick, MD  
Clarence B. Watridge, MD, FACS  
Jed P. Weber, MD  
William C. Welch, MD  
Dennis Wen, MD  
Charles A. Wetherington, MD  
Crystl D. Willison, MD  
Philip Willman, MD  
James T. Wilson, MD  
John A. Wilson, MD  
Joel W. Winer, MD  
Fremont Wirth, MD  
Timothy F. Witham, MD  
Christopher E. Wolffa, MD  
Richard Wohms, MD  
Daniel Won, MD  
James H. Wood, MD  
Cherylon A. Yarosh, MD  
Hwa-shain Yeh, MD  
Kong-Woo Peter Yoon, MD  
Michael S. Yoon, MD  
Jacob N. Young, MD  
Karol Zakalik, MD  
Mario Zuccarello, MD

- American Association of Neurological Surgeons
- Congress of Neurological Surgeons
- Council of State Neurosurgical Societies
- AANS/CNS Section on Disorders of the Spine and Peripheral Nerves
- AANS/CNS Section on Neurotrauma and Critical Care
- Neurosurgical Society of Alabama
- California Association of Neurological Surgeons
- Ohio State Neurosurgical Society
- Tennessee Neurosurgical Society
- Washington Association of Neurological Surgeons

This listing reflects contributions at press time. An updated listing is located at [neuros2preserve.org](http://neuros2preserve.org). Questions or concerns can be directed to Katie Orrico, NPHCA director, (202) 628-2883.



For advertising information, see the Bulletin's rate card at <http://www.aans.org/bulletin/bulletinratecard.pdf>, or contact Holly Baker, [hbaker@ascendmedia.com](mailto:hbaker@ascendmedia.com), 913.344.1392.

# Neurosurgical Reference Card

*New Tool Aims to Educate and Attract Medical Students*

Thousands of medical students each year are faced with the weighty task of choosing the area of medicine in which they will specialize. With so many options—neurosurgery, orthopedic surgery, plastic surgery, family practice, emergency medicine and other areas—it is essential that the next generation of physicians is educated about neurosurgery, not only to capture the interest of the brightest among them, but also to provide them with useful and easily accessible information about the nervous system and its disorders.

In an effort to address both of these needs, the American Association of Neurological Surgeons (AANS) created the Neurosurgical Reference Card, a pocket-sized resource that illustrates the Glasgow Coma Scale, peripheral nerve distribution, Karnofsky Scale, dermatomal sensory distribution, and more.

“Regardless of their ultimate choice of specialty, we wanted the Neurosurgical Reference Card to be an essential resource that medical students would use on a regular basis,” said Mick Perez-Cruet, MD, a member of the AANS Public Relations Committee, which spearheaded development of the card. “Medical students may not be aware of the variety of conditions treated by neurosurgeons, and may not learn more until late in their training.”

Today more than 10,000 second-year medical students from across the country are better informed about neurosurgery, having in hand a Neurosurgical Reference Card sent to them this summer compliments of the AANS. A letter from AANS President A. John Popp, MD, introduced each card and acquainted the students with the AANS and its mission to advance the specialty of neurological surgery in order to provide the highest quality of neurosurgical care to the public.

Only a small number of those who received the cards are likely to become neurosurgeons. Doctors can be certified in a total of 36 general medical specialties and in an additional 88 subspecialty fields, according to the American Medical Association.

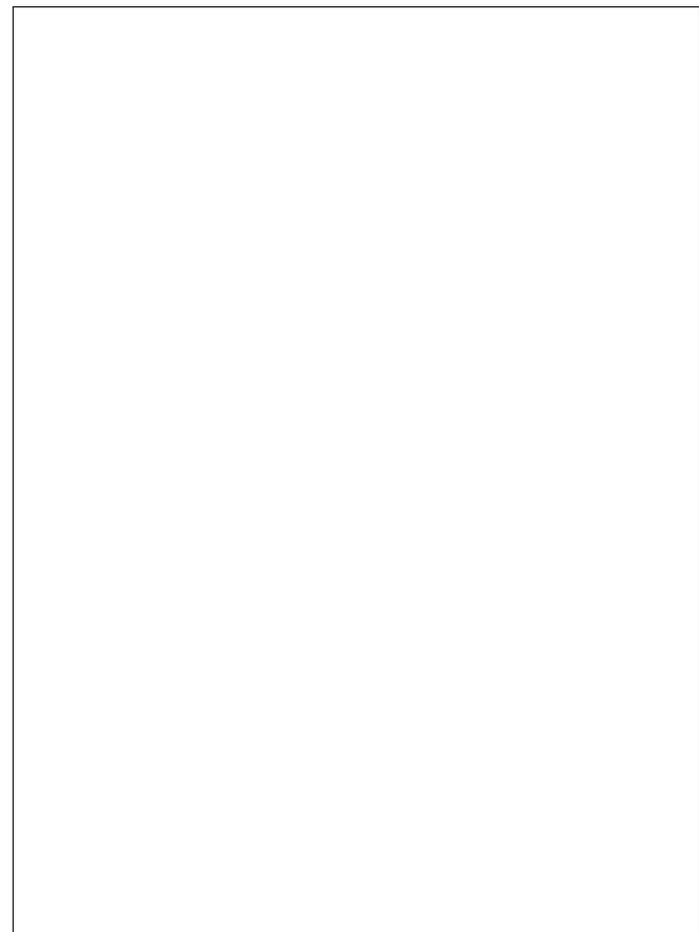
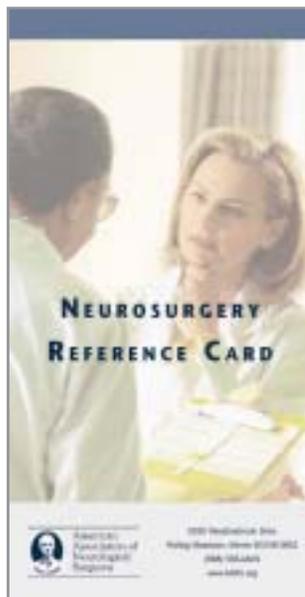
“With so many general and subspecialty choices, we would like to continue the tradition of attracting highly qualified stu-

dents into neurosurgery,” said Alex Valadka, MD, chair of the AANS Public Relations Committee. “Approximately 130 residents per year are accepted into 90 or so training programs.”

For those who choose other medical specialties or even for physicians who are currently practicing, the AANS Neurosurgical Reference Card constitutes a convenient, functional resource. Neurosurgical residents, fellows, nurses, physician assistants and office staff are also likely to appreciate the card’s credible information and functional design. ■

**Heather L. Monroe** is AANS director of communications.

More information about the AANS Neurosurgical Reference Card is available at (888) 566-AANS (2267), ext. 539 or the AANS Online Marketplace at [www.AANS.org](http://www.AANS.org). The cards are \$30 for AANS members and \$45 for nonmembers.



# Method or Madness?

## *How the PLI Crisis Affects Neurosurgeons' Reimbursement*

President Bush's January 2003 announcement of support for professional liability reform focused considerable attention on the impact of skyrocketing professional liability insurance (PLI) premiums upon high-risk specialists like neurosurgeons. Comparatively little focus, however, has been placed upon addressing the growing PLI costs in the Medicare Physician Fee Schedule.

This Coding Corner will review the methodology used by the Centers for Medicare and Medicaid Services (CMS) to determine physician costs including PLI and evaluate their proposed method for addressing these exponentially growing costs in the fee schedule.

Through the Omnibus Budget Reconciliation Act of 1989, the resource-based relative value system (RBRVS) was developed as the method for determining physician payment through Part B Medicare. A system of relative value units (RVU) was created to measure physician work, practice expense, and professional liability costs. The Relative Value Update Committee (RUC) of the American Medical Association (AMA) was formed to develop recommendations to the CMS regarding the physician work component of the total RVU. With the congressional mandate to develop a resource-based method for measuring practice expense, the Practice Expense Advisory Committee (PEAC) of the RUC has gradually refined the practice expense component to better reflect the resource costs of providing a physician service down to the Current Procedural Terminology (CPT) code level. However, the RUC has not previously addressed the PLI component of the total RVU directly.

### **CMS Methodology**

In the proposed rule published in the Federal Register on Aug. 15, the CMS discussed its

**“It is imperative that physicians utilize appropriate avenues to inform their patients and the U.S. Congress about the constraints that are being placed upon the practitioner, which are resulting in reduced access to care and a reduction in the workforce.”**

methodology for allocating funds in the Part B Medicare to the PLI component of the fee schedule as well as for distributing funds regionally to account for varying expenses in different states and localities. Although the PLI component represented 5.6 percent of total RVU in 1992, it has gradually been reduced to only 3.18 percent in 2003. Acknowledging the rapidly escalating costs of PLI, the CMS has proposed to change the “weighting” of the PLI component to 3.87 percent. While this may seem like an inadequate proportion of a neurosurgeon's payment to cover PLI costs, this percentage reflects the total proportion of the physician payment allocation to PLI costs for all physicians, regardless of specialty.

Once the pool of funds has been allocated to the PLI component of RVU, the funds are distributed to each individual CPT code based upon a weighted frequency of the actual specialties providing the service. Each specialty has a calculated risk factor based upon the average national premium for that specialty divided by the average national premium for the lowest-risk specialty. For example, thoracic surgeons are assigned a risk factor of 8.14 compared with dermatologists who are assigned a risk factor of 1.12. The weighted-average risk factor is calculated based upon the specialties providing the service and then multiplied by the total work RVU provided for that service.

A scaling factor is developed from the

total risk-adjusted PLI RVU and the money assigned to each individual CPT code. For procedures performed nearly exclusively by neurosurgeons, the proportion of the physician payment attributable to PLI is approximately ten percent. Finally, a budget neutrality adjustment must then be made if this component of the fee schedule increases.

### **PLI Workgroup Raises Concerns**

Several concerns were raised at the PLI Workgroup meeting of the RUC in September, and these concerns will be included in a comment letter addressed to the CMS regarding the proposed rule. In the past, the CMS has used an average of PLI data over a three-year period to update the weighting of the PLI component. For example, the current weighting has been in place since 2001, and is based on PLI premium data collected between 1996 and 1998. Naturally, the significant time interval between data collection and inclusion in the fee schedule creates a substantial underestimation of the true current costs of PLI premiums.

The CMS proposes to use a five-year average based upon 1999-2002 PLI premium data and estimates of 2003 data to develop weighting for the 2004 fee schedule. Given the exponential growth of premiums in the last few years, this method would again significantly underestimate the actual resource-costs of PLI currently. The RUC recommended developing esti-

mates of 2004 PLI premiums based on the exponential growth of 2001-2003 premiums and using only estimated 2004 premiums in their calculations.

Secondly, the CMS currently obtains PLI premium data on the 20 highest-volume medical specialties from insurance carriers on a voluntary basis. Only three of the 20 specialties are considered high-risk specialties (orthopedic surgery, general surgery, and emergency medicine); neurosurgery and obstetrics are not among the highest-volume specialties. Moreover, the premium data obtained only examines mature \$1 million/\$3 million claims-made premiums. Although patient compensation funds such as the Pennsylvania Catastrophic Fund are considered, the cost of

gress of Neurological Surgeons (CNS), the RUC recommended that the CMS use the risk factor of only the specialty performing more than 50 percent of the service. If less than 50 percent are performed by a single specialty, then a weighted-average of the highest volume specialists performing more than fifty percent of the service should be done.

Moreover, the volume calculations should omit CPT codes submitted by surgical assistants, which likely accounts for the observed coding of surgical procedures by internists and neurologists. Although this method will continue to exacerbate the relative overpayment for the lower risk specialists performing the procedure, it allows for the least reduction for the highest-risk

ment to the conversion factor. However, the PLI Workgroup noted that the recommended option would simply redistribute the cost of PLI among the other components, resulting in little change in the total RVU and therefore little change in payment.

Although physicians do not wish to see a reduction in the conversion factor (the multiplier of the total RVU that determines Medicare payment), a scaling of the other two components fails to address the impact of escalating PLI costs. Consequently, the RUC recommended that the work and practice expense RVU remain stable. Although budget neutrality constraints would require the CMS to reduce the conversion factor to account for the anticipated growth in PLI costs, the RUC further recommended that the CMS support congressional legislation to increase the funding of Medicare Part B and prevent a reduction in the 2004 conversion factor.

Obviously, the issues regarding the Medicare Physician Fee Schedule are quite complicated as well as politically influenced. Consequently, the AMA and specialty societies including the AANS and CNS are drafting comment letters to address the proposed rule from the CMS. As the spread between reduced payments and increasing costs widens to unsustainable proportions, it is imperative that physicians utilize appropriate avenues to inform their patients and the U.S. Congress about the constraints that are being placed upon the practitioner, which are resulting in reduced access to care and a reduction in the workforce. ■

## **“Although the PLI component represented 5.6 percent of total RVU in 1992, it has gradually been reduced to only 3.18 percent in 2003.”**

“tail” coverage is not included. The RUC recommended that premium data should be collected from all specialties and that the tail coverage should be included as well.

In addition, the method for assigning PLI RVU to a particular procedure requires a weighted-average of the surgical risk factors of all the specialties providing a particular service. According to the Medicare database, many of the CPT codes used by neurosurgeons are also used by orthopedic surgeons and neurologists. The weighted-average method results in an under-accounting of the true cost borne by the highest risk specialty. In support of a comment letter previously submitted by a group of medical specialty societies that included the American Association of Neurological Surgeons (AANS) and the Con-

specialist without developing a differential payment policy among physicians in different fields.

### **CMS Recommendation of Most Concern**

Finally, the recommendation made by the CMS in the proposed rule that generated the most concern involved the method to be used in adjusting for the expected growth of the PLI RVU component. The CMS proposed to adjust the work and practice expense components of the RVU so that a change in the conversion factor to maintain budget neutrality would not be required. Alternatively, the CMS suggested that the work RVU component could be left stable (as had been previously recommended by the RUC) and the changes would be made to the practice expense RVU and an adjust-

**Gregory J. Przybylski, MD**, is professor and director of neurosurgery at JFK Medical Center in Edison, N.J. He represents the AANS on the AMA Relative Value Update Committee (RUC), and he is chair of the RUC's PLI Workgroup. He also is on the faculty for AANS coding and reimbursement courses.

# NeurosurgeryToday.org

*New Web Site for the Public Debuts This Fall*

BY KATHLEEN T. CRAIG AND HEATHER L. MONROE

A family member suffers a stroke. A child is diagnosed with hydrocephalus. A colleague considers surgery for treatment of carpal tunnel syndrome. Where can they go to find valuable information addressing these disorders and a host of others? Beginning this fall, they will be able to access [www.NeurosurgeryToday.org](http://www.NeurosurgeryToday.org), the new public Web site of the American Association of Neurological Surgeons (AANS).

Neurosurgeons report that more and more people are using the Internet as a primary tool for obtaining information about their condition, or that of a friend or family member. The AANS developed the new, user-friendly site to provide the public with credible neurosurgical information crafted by AANS experts. The site's design also promises to increase convenience for those who are researching disorders of the nervous system and potential neurosurgical treatments.

"We have organized the information on the site using state-of-the-art navigational tools," noted Robert Harbaugh, MD, chair of the NeurosurgeryToday.org Committee. "This information can better prepare a patient for a neurosurgical consult, but it does not replace medical advice from a board-certified neurosurgeon."

New navigational bars on the site include:

- **What Is Neurosurgery?**—Features a detailed overview of the neurosurgical specialty including the subspecialties of tumor, pain, trauma, cerebrovascular, spine and peripheral nerves, pediatric neurosurgery and stereotactic and functional areas.

- **About Us**—Offers background information about the AANS and the history of neurosurgery dating back to Harvey Cushing, MD.

- **Find a Board-Certified Neurosurgeon**—This useful tool locates neurosurgeons in one's locality searching by area code or city. As a benefit of membership in the AANS, members in the Active, Active Provisional, and International categories will be included in this database. For those who are certified by the American Board of Neurological Surgery, the certification date will appear; otherwise the field will list "board-eligible" or "internationally certified."

- **Legislative Activities**—Links to breaking information, legislative updates and announcements from the AANS/CNS Washington Committee.

- **Media Center**—Area of the site for reporters, the general public, and AANS members to access news and archived AANS press releases highlighting neurosurgical scientific studies, legislative information, AANS officers and award winners, and more.

- **Research**—Directs visitors to information about Neuro-Knowledge™, a partnership that offers Web-based clinical research opportunities, and the Neurosurgery Research and Education



Foundation (NREF), which funds studies in the areas of spine, tumors, epilepsy, stroke, pain, the central nervous system, and more.

- **Professional Information**—Provides a direct link to [www.AANS.org](http://www.AANS.org), the Web site for members of the American Association of Neurological Surgeons.

The new site also features: a comprehensive search function to locate specific information; an extended list of scientific press releases from AANS annual meetings; articles and fact sheets on disorders of the nervous system; articles from a *USA Today* supplement emphasizing that neurosurgery is more than brain surgery; a neurosurgical statistics report; camera-ready newspaper articles; public service announcements on bike helmet safety; and more.

## **AANS.org: Professional Pages Gain Enhancements**

The AANS capitalized on the opportunity to enhance the professional pages of the Web site with a contemporary design that complements [www.NeurosurgeryToday.org](http://www.NeurosurgeryToday.org), among other improvements.

"It had been several years since the AANS assessed Web site content and navigation to ensure that it met the needs of all AANS audiences—from members to allied professionals, the media and our corporate partners," said Dr. Harbaugh. "The creation of the new AANS public site enabled us to reevaluate our professional pages as well. Visitors will find many enhancements on the new site that will keep them coming back."

The AANS kept several priorities in mind when reorganizing [www.AANS.org](http://www.AANS.org):

- News and features that members have accessed most frequently will appear on the main pages.

- Visitors to the site will be able to locate desired content within three mouse clicks.



- A comprehensive search feature and a site map will aid visitors in locating information and resources.

- Existing content will be enhanced with additional features.

The 2002 Member Needs Survey reported that legislative issues reigned as the most member important priority. In response, the AANS added the Legislative Activities area, which highlights not only the efforts and accomplishments of the AANS/CNS Washington Committee, but all AANS resources directed toward advocacy efforts. The Medical Liability Reform area consolidates news and resources to help neurosurgeons manage their practices during this time of crisis.

Continuing medical education (CME) is another area that AANS members rated as highly important. In the Education and Meetings area of [www.AANS.org](http://www.AANS.org), in-depth information about courses and meetings that provide neurosurgical CME is available. There also are direct links to a calendar of neurosurgical events that shows events by month, with the added functionality of listing them by topic (spine, for example). A breakout listing of programs that offer neurosurgical CME credit is available, as is a direct link to CME tracking on the members-only, personalized pages of [www.MyAANS.org](http://www.MyAANS.org). (For more information about CME tracking, see “Tracking CME Online” in the *AANS Bulletin*, Summer 2003.)

In addition, international neurosurgeons and allied professionals now have a gateway to information and activities of interest to those practicing outside of the United States or North America. Together with education and research opportunities, the area offers links to international organizations.

### New Online Career Center

AANS members now have a neurosurgical online job board, easily accessible through [www.AANS.org](http://www.AANS.org). Available to members as a

complimentary membership benefit, the AANS Online Career Center lists open positions in all areas of neurosurgery.

Members can search positions by geographic location, subspecialty, and other criteria. A resume and curriculum vitae can be posted, anonymously if preferred. Administered through *HealthCareers*, the center includes all of the “bells and whistles” of national job boards like *Monster.com*—but the Online Career Center is specific to neurosurgery.

In addition, the center offers a special conference feature. Those looking for neurosurgical positions are matched with prospective employers, and a meeting between them is facilitated when both are registered for major neurosurgical conferences such as AANS annual meetings.

### Other New Features

A new library allows visitors to locate archived meeting abstracts, *Bulletin* articles, press releases and guidelines. Look for this area to be completed by December 2003.

The online AANS Membership Directory has moved to the personalized pages of [www.MyAANS.org](http://www.MyAANS.org) and will offer enhanced search criteria and the ability to create and download personalized lists; it is available only to members as benefit of AANS membership. Enhancements will be available by December 2003.

Links to subspecialty sections are available from the main menu at [www.AANS.org](http://www.AANS.org).

The AANS will continue to evaluate the effectiveness of these Web sites, and visitors are encouraged to communicate suggestions and recommendations: [info@AANS.org](mailto:info@AANS.org) or (888) 566-AANS (2267). ■

**Kathleen T. Craig** is AANS director of marketing.

**Heather L. Monroe** is AANS director of communications.

### Quick View of AANS Online Resources

#### For the Public

**[www.NeurosurgeryToday.org](http://www.NeurosurgeryToday.org).** Neurosurgery’s “front door,” inviting the public to become better informed about disorders of the nervous system and how neurosurgeons can help.

#### For AANS Members and Healthcare Professionals

**[www.AANS.org](http://www.AANS.org).** “Professional pages” with in-depth information on the AANS and how the association is working for its members.

#### For AANS Members Only

**[www.MyAANS.org](http://www.MyAANS.org).** Members-only site provides a virtual tool-kit with CME resources and tracking of credits, the Online Career Center, the Online Membership Directory, and more.

# Training Alone Does Not Protect You

## *A Common-Sense Approach to Minimizing Risk*

**T**he crisis of rapidly escalating professional liability insurance (PLI) rates faced by those of us in neurosurgical practice does not directly affect residents and fellows since their PLI premiums are covered by their cooperating institutions. Yet, because of the high-risk nature of the neurosurgical profession—unfortunately, all neurosurgeons now can expect to be named in a lawsuit during their careers—it is no less important for neurosurgical residents and fellows to learn to identify risks for medicolegal action and the means of avoiding such risks.

There are several areas in which residents may find themselves vulnerable to legal action. The following discussion of these areas is not intended to provide legal advice, but rather to share some common-sense ideas, based on my recent experiences as a resident and as an attending physician, for practicing both good medicine and risk management.

### **Shared Care and Other Concerns**

The first area concerns the onus for shared care. The foundations of postgraduate medical education are based on this key principle. If there is an adverse outcome, the legal question likely will pertain to whether the delegation of responsibility was reasonable given the individual's level of training, experience and capabilities, as well as whether the attending physician's supervision was adequate.

The concept of shared care pertains to the temporal relationships of resident and staff coverage (change of shifts, cross-coverage, and transfers to other services), as well as to the various responsibilities of team members, extending from the initial physician through his or her colleagues to fellows and residents at various levels of training.

The best advice, particularly for those working in structured university settings, is that the most responsible physician (the attending) must be identified to all parties (particularly to the patient); orders must be written; clinical notes must be accurate and up-to-date; physicians should review nursing notes whenever possible (since any inaccuracies can be corrected in physician notes); the concerns of others should be heeded and when in doubt, one should "ask prior to acting"; and when transferring a patient's care to others, the reasons for such a transfer should be clearly stated, not only to the receiving team, but especially to the patient and the patient's relatives.

When undertaking a surgical procedure, the resident not only must be familiar with the procedure, but must insist on assistance if the procedure is unfamiliar. One should stay within his or her safe boundaries and call for help sooner rather than later.

The value of the clinical record cannot be overestimated. Detailed documentation is of an undeniable benefit in defending physicians, should the need arise. Moreover, one must acknowledge that the principal reason for a medical record is to facilitate clinical care. When documenting one's thoughts, the comments should be limited to clinically relevant material. The results of investigative or laboratory procedures, must be appropriately recorded and communicated to patients within a reasonable time frame. The records must be completed contemporaneously, and under no circumstances should one attempt to alter a record after the fact.

To err may be human, but the clinical record is the first order of defense for eliminating many errors. For example, mistakes in the administration of medication are less likely to occur if one habitually verifies the

identity of all patients and their allergies prior to ordering medications.

With regard to errors of diagnosis, in a liability suit the court must differentiate between negligence and an error in judgment. To that end a resident will be judged against his or her peers in a number of aspects. One is well advised to know the facts prior to making any comment on a patient's care.

When consulting with patients over the telephone, it is best to err on the side of bringing people to the emergency room or outpatient office. Although doing so may seem painful to the already overburdened resident on call, one must remember that even the simple advice of giving Tylenol creates a duty to that patient.

### **Professional Conduct Speaks Volumes**

In summary, it is relatively rare that a resident is actually named in a liability suit; however, it is entirely possible that a resident's actions may place the attending physician in a precarious position. One's professional conduct is often a key factor in the avoidance of legal action. There must be continuous and precise dialogue with members of the surgical team, especially with the attending physician. Always defer to the attending physician, who makes the ultimate decision in most matters. Maintain confidentiality, particularly in public areas, and respect the patient's privacy as much as possible, even in semi-private rooms.

Above all, establish and maintain a professional relationship, centered on courteous and honest communication, with patients and their families. ■

**Brian R. Subach, MD**, currently a neurosurgeon at The Virginia Spine Institute, Reston, Va., until recently served as an attending physician at Emory University School of Medicine. He is secretary of the AANS Young Neurosurgeons Committee.

# Get Involved in Medical Liability Reform

*If the Crisis Strikes Home, You Have Waited Too Long*

In September the Executive Committee of the Council of State Neurosurgical Societies (CSNS) met and reviewed seven resolutions that will be discussed and voted upon at the Oct. 18 meeting.

That same week I received a phone call from an old friend who has been in practice for two decades in a Southern metropolis. "Do you know of any good jobs around?" he queried. He explained that despite a careful and conservative practice, which had carried him through two decades of busy clinical practice without a single medical liability suit, his liability insurance carrier had recently sent him a letter announcing that it no longer could afford to offer him malpractice coverage...at any price. As a consequence, he was forced to close his doors and look for another state in which to practice. He was unable to get liability insurance in the state in which he had given good care for 20 years.

In a Midwestern suburb another neurosurgeon, a solid fixture in his community, had to file bankruptcy after 25 years of hard work for his local community. A single adverse judgment in a medical liability suit exceeded his insurance limits. The courts garnered his personal assets, forcing him to file for bankruptcy protection. Now he finds that when he applies for a credit card, he can't get one. He can't buy a car because no one will approve his loan application.

In a Northeastern city, a group of two established neurosurgeons was told last year that their professional liability insurance carrier would probably not be able to cover them in the upcoming year. These neurosurgeons were unable to get liability insurance through any other carrier in the state. After a month of putting operations on hold, not knowing whether to close their doors or forge ahead, they received notice that they would be covered for another year

but that their premiums would be \$180,000 per person. Now, a year later, they have received a similar letter from their liability insurance carrier, and once again they don't know whether they will be able to keep their doors open for another year.



*Frederick Boop, MD,  
is chair of the  
Council of State  
Neurosurgical  
Societies.*

As we get caught up in our busy lives we hear stories like these, but don't stop to think that such catastrophes actually do happen and that they really could happen to us.

Clearly, the medical liability crisis has progressed in severity from what it was just one year ago. At that time there was widespread concern about the rapidly increasing professional liability insurance rates, and the ultimate concern was that as neurosurgeons began to move, retire, or limit or close their practices, eventually there would be an adverse effect on patient access to neurosurgical care.

The 2002 CSNS study of neurosurgeons' professional liability insurance rates, reported in the *Bulletin's* Winter 2002 issue, confirmed both the rapid rate of increases and their adverse effect on how or whether neurosurgeons could continue to practice.

And now we hear ever more frequently of neurosurgeons who must close their doors. It is apparent that the crisis will not resolve itself.

The leadership of organized neurosurgery is attacking the medical liability crisis through a public information campaign

to enact federal medical liability reform. Neurosurgery and several other "at risk" specialties have joined together in this effort. Isn't it time you got involved?

## Give Just Two Things

Your profession is calling upon you to give just two things—your time and your money. The leadership of the AANS and CNS has asked every neurosurgeon to contribute \$1,000 per year for three years to Neurosurgeons to Preserve Health Care Access (NPHCA). The CSNS Executive Committee members each have given \$1,000 to NPHCA, showing support for this important initiative in both word and deed. We ask you to do the same. If you wait until this crisis strikes home, you have waited too long.

The CSNS, in conjunction with the Washington Committee, also is planning the National Leadership Development Conference (NLDC), which will take place in Washington, D.C., next summer from July 16 to 19. We particularly are in need of neurosurgeons from states in which key legislators are running for reelection.

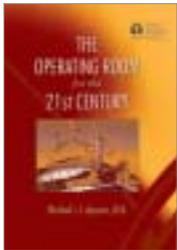
The NLDC will offer one day of lectures on the issues before Congress that will have the greatest impact on practicing neurosurgeons. You will learn how discuss these issues with your legislators, and then you will have the opportunity to put your skills to the test the next day on Capitol Hill. Your efforts will pave the way for future communication between your legislators and our Washington Committee personnel as well as Washington Office staff.

Please plan to attend. As a constituent, you have the greatest impact on your legislators' votes. ■

Checks payable to NPHCA can be sent to Neurosurgeons to Preserve Health Care Access, 5550 Meadowbrook Drive, Rolling Meadows, IL 60008-3852.

# OR for the 21st Century

*Neurosurgeon's New Book Delivers Provocative Insights*



**The Operating Room for the 21st Century** by Michael L.J. Apuzzo, MD, the American Association of Neurological Surgeons (AANS) and Thieme, 2003, 250 pp.

Most of us would expect that a book dedicated “to all innovators and visionaries—past, present, and future” would provide provocative and challenging insights on its chosen topic. In large part, *The Operating Room for the 21st Century*, edited by Michael L.J. Apuzzo, MD, delivers on that expectation.

## A Look at the Past and the Future

The first of three sections offers an interesting and entertaining trip through history, describing the evolution of the operating room from the introduction of anesthetics to modern-day concerns about the environmental impact on personnel working in the operating room.

The authors share lessons they learned from having been involved in the design of an “ideal” operating suite more than a decade ago, describe what a state-of-the-art current suite might be, and speculate on what the future holds. Some of the trends they mention are: progressive minimalism, based on molecular nanotechnology; molecular and quantum computing; intraoperative and advanced visualization (scanning probe microscopy, for example); robotics and bionics; and great advances in information access, accrual, analysis, and exchange.

## Technologies That Hold Great Promise

In the second section, many of the leaders who in recent years have collaborated in the

introduction of new methods for imaging, robotics, monitoring, communication, visualization, and data presentation offer their perspectives on the 21st century operating room. Others discuss the role of telemedicine and telesurgery, novel concepts in lighting, magnification, and image integration, and the future of noninvasive surgery.

An engineer provides his perspective on the future of robotics in the practice of neurosurgery: “We believe that controllable nanorobots can and will be built. If such devices can be injected...into the brain, would it be possible for them to detect the presence of a tumor and destroy it?” The answer seems to be that yes, such a scenario is likely to be realizable within 10 to 20 years.

Use of computer power and robotics is stressed as well. The authors of chapter nine put it very well: “The overwhelming amount of information now available to the neurosurgeon must be seamlessly integrated and coupled with intraoperative machinery capable of exchanging information in a fashion that assists neurosurgeons and their staff in delivering their skills faster, safer, and more accurately than that attainable by human cognition alone.” The authors go on to propose building a DOTELL (DO what the surgeon asks and TELL the surgeon what he or she needs to know). They describe the DOTELL as “a single, obedient assistant capable of integrating and processing all data input as well as coordinating the output to all necessary instrumentation.”

## The New OR

The third section includes several chapters that discuss functional operating room design geared to accommodate these new technologies and to meet goals such as improved efficiency for the institution and its medical staff, as well as improved out-

comes for patients. The first chapter in the section describes how integrated interventional facilities that combine imaging, passive image-guided localization, monitoring, modular design, redesign of the operative work space, monitored transport, and integration with intensive care facilities can go a long way to meet such goals.

Other chapters point out that the dramatic changes that might ensue also will require surgeons to change, in both attitude and skills. Surgeons will be partners with scientists and will possess a better understanding of the molecular and biological events that cause tumors and other conditions requiring treatment, and will use this information for patients’ benefit.

## General Themes Emerge

Despite the broad scope of the book and the extensive speculation its topic has engendered, several subthemes run through much of the content. One subtheme relates to the economics of advanced technologies. Great progress is feasible, but many contributors to the book believe that any such progress will depend more on financial and political decisions than on technical bottlenecks. The most overriding subtheme is that neurosurgeons must embrace new technology for its positive impact on their practice.

Time invested in reading *The Operating Room for the 21st Century* is very well spent. Consider a statement from the authors of chapter 11: “Not only keeping up with the technology but also helping to push it forward and expand its possibilities are challenges to all of us who choose to practice in a field as dynamic, and as likely to benefit from improved technology, as ours. Should we choose to meet this challenge, and selectively and judiciously incorporate these sophisticated, powerful technologies into our operating rooms, there is a potential for great benefit to our patients.” ■

Cheryl A. Muszynski, MD, is a neurosurgeon at Children’s Hospital of Wisconsin and associate professor of neurosurgery at the Medical College of Wisconsin.

For advertising information, see the Bulletin's rate card at <http://www.aans.org/bulletin/bulletinratecard.pdf>, or contact Holly Baker, [hbaker@ascendmedia.com](mailto:hbaker@ascendmedia.com), 913.344.1392.

# 2004 AANS Annual Meeting Adventure

*Advancing Patient Care Through Technology and Creativity*

BY MANDA J. SEEVER

**A**dventure is in order for the 72nd Annual Meeting of the American Association of Neurological Surgeons (AANS). Taking its cue from the theme “Advancing Patient Care Through Technology and Creativity,” the meeting is set in delightful Orlando, Fla., of which it is said that 62 days would be required to see all 95 of its theme parks and attractions.

For six days, May 1-6, the Orange County Convention Center on International Drive in Orlando is the site of neurosurgery’s premier annual event. Under the direction of Annual Meeting Chair William T. Couldwell, MD, this exploration of technology and creativity officially opens Sunday, May 2, with an evening reception held at Universal Orlando’s Islands of Adventure. The islands of Jurassic Park and The Lost Continent will be open exclusively to AANS Annual Meeting attendees.

The scientific program, planned under the leadership of Richard G. Fessler, MD, promises an exemplary exposition of neurosurgical topics. Highlights include:

- a fourth plenary session on Thursday, May 6, that will focus exclusively on socioeconomic issues;
- a new format for the Thursday morning breakfast seminars that will offer opportunities to present challenging cases and elicit feedback from peers;
- eight section sessions on Tuesday and Wednesday afternoons;
- a Tuesday afternoon session that will be dedicated exclusively to peripheral nerve topics;
- nursing contact hours, which will be available for two breakfast seminars each day, Monday through Wednesday, as well as one full-day practical clinic;
- a full-day practical clinic that focuses on practice management; and
- a full-day Beyond Residency course.

On Tuesday, May 4, the Cushing Oration features a different sort of adventurer. Ken Burns, who is perhaps best known for his breakthrough documentary “The Civil War” and, more recently, “Baseball,” has pioneered new ways of bringing the past to life in the field of documentary film. In an interview with San Francisco Focus, he observed, “Without a past, we deprive ourselves of the defining impressions of our being...The airing out of history is a kind of medicine...That’s what I’m interested in: the healing power of history.”

Immediately preceding the AANS Annual Meeting, on Friday, April 30, the spotlight will turn to exploration of neurosurgery in the U.S. and Latin America. The AANS will welcome neurosurgeons from Latin America to the Latin American-American Symposium of Neurosurgery, co-chaired by Jorge Mendez, MD, of Chile, and Roberto Heros, MD, of the AANS. Topics of discussion include: Latin America’s Healthcare and Training Systems; Surgical Originals

(CVD); Surgical Techniques; Surgical Originals (Tumors); and Endoscopy. A reception will follow the day-long event.

Registration and housing for the Annual Meeting will be available in January 2004. The advance registration deadline is April 2. The most up-to-date meeting information is available at [www.AANS.org](http://www.AANS.org). ■

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

## KEN BURNS 2004 Cushing Orator

**C**reativity and technology unite in the work of filmmaker Ken Burns, who has been making documentary films for more than 20 years. “All my work is about waking the dead,” he has said.

Burns first attracted the nation’s attention as director, producer, co-writer, chief cinematographer, music director and executive producer of the landmark television series “The Civil War,” which premiered in 1990. The film generated praise from audiences and critics. The

*Washington Post* said, “This is not just good television, nor even just great television. This is heroic television,” and “Our Iliad has found its Homer,” was George Will’s uncharacteristically laudatory comment. The series has been honored with more than 40 major film and television awards, including two Emmy Awards, two Grammy Awards, Producer of the Year Award from the Producer’s Guild, People’s Choice Award, Peabody Award, and others.

Most notable among his work is the PBS series “Baseball.” Four-and-a-half years in the making and more than 18 hours in length, this film covered the history of baseball from 1840s to the present. It became the most watched series in PBS history, attracting more than 45 million viewers. “Baseball” earned Burns an Emmy, the Clarion Award, and The Television Critics Awards for Outstanding Achievement in Sports and Special Programming.

His recently completed works include a series of biographies on the lives of Elizabeth Cady Stanton, Susan B. Anthony, and Mark Twain. His major series on the history of jazz is currently airing on PBS.



For advertising information, see the Bulletin's rate card at <http://www.aans.org/bulletin/bulletinratecard.pdf>, or contact Holly Baker, [hbaker@ascendmedia.com](mailto:hbaker@ascendmedia.com), 913.344.1392.

# What's Wrong With Your Bottom Line?

*A Practice Administrator Shares Ideas From 30 Years' Experience*

**A**fter managing medical practices for more than 30 years, I have found that most doctors' offices lose some of their accounts receivable and business income on a consistent basis. Why does this happen?

Increasing income for your practice doesn't necessarily require adding new services or products. This article delves into some of the potential areas in a neurosurgical practice where some "additional" income can be harvested.

The primary area under review is the billing and collections of the accounts receivable.

**1. Check insurance eligibility of all new patients.** Print out this eligibility for the medical record or attach it to the electronic medical record. Not doing so could be a costly area of lost income. Preexisting condition, often due to changes in jobs with a lapse in insurance or COBRA coverage, is the primary pitfall for denial of payment. When new patients come to their appointments without their insurance cards, our practice reschedules their appointments to protect the practice from denied payment due to incorrect or incomplete information. Remember: Most patients can't afford to pay cash for neurosurgery.

**2. Collect all copayments, coinsurance, and deductibles at the time of service.** Don't collect these at the front desk; talk to the patient in a private area of the office. If the patient is unprepared to pay, reschedule the appointment. It is very hard to collect this money after services are rendered. The better strategy is to inform the patient at the time the appointment is scheduled of which fees will be collected.



**3. Send every denial on a claim back to the insurer for a review.** This process takes time but can result in a payment over and above the original payment.

**4. Be diligent in collecting patients' balances.** We use two billing reminders, the Friendly Reminder and the Final Notice; both of these notices look like checks. Using these billing reminders has increased our collections to 60 percent of all notices sent.

**5. Turn delinquent accounts over to a reputable collection agency as soon possible.** Our practice sends one patient statement. If there is no response in 30 days, we send the Friendly Reminder. If there is no response in 30 days, we send the Final Notice. If there is no response in 10 days, we then turn the account over to a collection agency. The collection fee is added to the patient's balance. Patients are notified of this policy by a statement at the bottom of the patient information sheet that tells them they will

be responsible for collection costs if the account is turned over to a collection agency for nonpayment. Patients complete the information sheet on their first visit and every time they experience a demographic change.

**6. Have new patients sign a patient responsibility policy.** Our practice's Patient Responsibility Policy states our collection policy and has a schedule of payments for a range of balances. This upfront disclosure helps patients know at the first visit about the practice's policy regarding collection of fees.

**7. Do not accept a letter of protection from an attorney, if at all possible.** An LOP might be presented when a patient's primary payer is auto insurance and there is no secondary payer (such as health insurance). The usual personal injury payment is \$10,000 total. This money can be taken for medical bills as well as lost wages. The patient usually has to retain an attorney to secure payment on medical bills. Payment

can take years. If payment is received at all, the attorney will often offer a reduction in payment to settle the account. Allowing LOPs to remain on your accounts receivable for years is just plain “bad business.”

**8. Ask patients whose primary insurance is auto to bring an exhaust letter or personal injury payment worksheet to the initial visit.** This letter or worksheet will be attached to the healthcare insurance claims to reduce coordination of benefits paperwork. This will speed up the payment of these claims.

**9. Work the Insurance Pending and Accounts Receivable lists every month from beginning to end.** Working these two reports will dramatically increase revenue. Hire a part-time employee if necessary to complete this task. This employee will more than pay for himself.

**10. Thoroughly investigate all refunds to insurers.** Don't refund any money unless the refund request is in writing and you are sure that the reasoning is correct. If you feel that the request is incorrect, write to the insurer explaining why. Your practice doesn't need to be the center of a fight between payers.

**11. Make no exceptions to your office collection policy.** For example, “professional courtesy” is a write-off forbidden by most managed care contracts. Your managed care contracts spell out what the practice can and cannot do to deliver medical care and collect payment for that care.

**12. Institute solid internal controls to prevent fraud.** Fraud alone can cause a practice a significant loss of income that can never be recovered. To reduce the likelihood of fraud, a process that contains checks and balances should be implemented. For example, one employee should open the mail, another employee should enter the charges and receipts, and a third employee should balance the receivables every day. The practice manager should receive and examine the documentation and balancing reports every day.

**13. Use practice management software to compare payments with managed care fee schedule allowances by Current Procedural Terminology code.** As payments are posted from explanation of benefits forms (EOBs), the correct allowable will show on the payment screen. For our practice, which has many managed care contracts, this feature allows us to confirm correct allowables quickly and efficiently. If the EOB is incorrect, the managed care plan must be contacted for an explanation. Incorrect allowables on EOBs can occur as much as 30 percent of the time. Are the insurance companies keeping your money by paying you less than you are owed?

**14. Examine your managed care contracts every year.** If your contracts are written on a percentage of the current Medicare fee schedule, you have lost as much as 18 percent over the past two years due to decreases in the relative value units of neurosurgery codes. If possible, in your managed care contract negotiations try to “carve out” the 10 to 15 procedures that your neurosurgeons perform most often and set them at a higher rate than the rest of the contract. This item alone can add more income to your practice without increasing the number of procedures performed.

#### **More Ideas ...**

In addition to billing and collections, the following are some other areas that can increase your bottom line.

■ Every year it is worth your time to examine the major items in your overhead. Have your insurance agent research your health insurance, general liability insurance, professional liability insurance, and workers compensation insurance. Look at the available options on a spreadsheet with details of each quote. Take bids on office supplies, banks, lawyers, accountants, technology connectivity and medical supplies. A word of caution: Don't take the lowest quote at face value without considering the quality of the service as well.

■ Cut down on staff overtime. This can

be one of the most costly areas in any neurosurgical practice. Analyze how you can prevent overtime. For instance, the office doesn't have to staff every position all day long. Staggering lunch hours to cover the phone and front office adds to the practice's customer service image by providing a live voice option when other practices are closed for two hours.

■ Make staff education and communication a high priority. This is one of the most important investments any practice can make. Don't train employees for a few days and then walk away, leaving them to fend for themselves after that. It takes six months for any employee to be completely trained. Many new employees leave during the initial probation period due to utter frustration because of inadequate training. New employees can't learn their job by osmosis. It's a hands-on learning process with management supervision.

■ Try to diversify the number of the managed care contracts in which your neurosurgical practice participates. Any practice with more than 20 percent of its income dependent upon one insurance plan sets itself up for financial hardship if the contract is terminated for any reason.

Our neurosurgical practice follows all the above suggestions consistently. We have crafted a practice with benchmarking in the exceptional range for areas such as billing and collections.

Practice management is a constant challenge. Education and networking have given me the tools to strive to make my practice the best it can be. Now for the first time there is an organization for neurosurgical practice managers that provides the tools to accomplish tasks like increasing your practice's bottom line. The organization is NERVES (Neurosurgery Executives Resource Value & Education Society). More information about this organization is available at [www.nervesadmin.com](http://www.nervesadmin.com). ■

---

**Barbara P. Hurlbert, CMPE**, [bhurlbert@lyerlyneuro.com](mailto:bhurlbert@lyerlyneuro.com), is practice administrator for Lyerly Neurosurgical Associates in Jacksonville, Fla., and secretary of NERVES.

# What AANS Members Need

*Survey's Findings Are Incorporated Into New AANS Strategic Plan*

BY KATHLEEN T. CRAIG

The American Association of Neurological Surgeons (AANS) made progress in the crucial and ongoing assessment of member needs by conducting a comprehensive opinion survey of AANS members in the fall of 2002.

The 2002 AANS Member Needs Survey evaluated members' opinions of current AANS benefits and services and the AANS Executive Office operations, as well as future needs. Overall, the survey found that most respondents were quite satisfied with the benefits they were receiving as AANS members and that membership dues were commensurate with the services they were receiving. The survey also identified several areas that could be reviewed and re-focused to match members' priorities.

Survey results were distributed to AANS leadership, including all AANS committee chairs, to ensure integration of the results in all aspects of AANS operation and planning. The survey results also underlie the very premise of the recently released AANS Strategic Plan, which is simply that members' needs are what drives the AANS as the professional association for neurosurgeons.

## Core Findings

Members responded consistently across several categories including: age; years in practice; type of practice (e.g. private); practice setting (e.g. large group); and practice region.

However, responses showed that practice setting did affect the percentage of time members spent in subspecialty areas. For example, neurosurgeons working in large, multispecialty practices said they spent more time working in the cerebrovascular, endovascular and movement disorders areas compared to those working in other practice settings.

## Current Benefits

The survey asked members to rate the importance of AANS products, services and benefits. It also asked members how satisfied they were with those services.

Legislative issues, particularly obtaining medical liability reform, reigned as the most important membership benefits. Other legislative priorities included:

- maximizing Medicare and other physician reimbursement;
- implementing Medicare reform and coding changes in Current Procedural Terminology;
- representing neurosurgery with regard to the Emergency Medical Treatment and Labor Act (EMTALA) regulations and improving trauma systems; and
- reducing regulatory oversight of neurosurgeons.

## Top-Rated Benefits of AANS

Description	Mean Importance	Mean Satisfaction	Difference
Obtaining professional liability reform	4.73	2.47	2.26
Maximizing Medicare and other physician reimbursement	4.56	2.62	1.94
Implementing Medicare reform	4.51	2.72	1.79
Implementing beneficial CPT coding changes and policies	4.5	3.32	1.18
Representing neurosurgery in EMTALA regulations and improving trauma systems	4.2	3.22	0.98
<i>Journal of Neurosurgery</i> -print	4.18	3.92	0.26
Reducing regulatory oversight of neurosurgeons	4.11	2.64	1.47
<i>Journal of Neurosurgery: Spine</i> -print	4.1	3.92	0.18
Complimentary CME transcript	4.08	4	0.08
Managing Coding and Reimbursement Challenges in Neurosurgery (courses)	4.05	3.85	0.2
CME tracking	4.01	3.9	0.11

Members rated legislative advocacy efforts as very important, but rated their satisfaction with progress on those issues relatively lower. For news on how the AANS and the Washington Committee are working on behalf of members on all of these legislative issues, visit [www.aans.org/legislative](http://www.aans.org/legislative).

Member services such as the *Journal of Neurosurgery*, continuing medical education transcripts and tracking of credits, and the AANS Membership Directory, were highly rated in both importance and satisfaction. AANS annual meeting activities and practice management courses such as Managing Coding and Reimbursement Challenges in Neurosurgery also rated very highly in both categories. In general, respondents said they were very satisfied with most of the services that were most important to them.

## Usefulness of the AANS Bulletin

Survey respondents said that the AANS *Bulletin* was an important benefit and that they were very satisfied with it. Several specific sections that recur in every issue were rated highly, such as the Coding Corner column and the President's Message, as well as several departments including the Calendar of Neurosurgical Events,

Newline (From the Hill and Neuro News), and News.org (news items from AANS and other organizations). *Bulletin* features and cover stories also were rated highly.

A comprehensive online *Bulletin* readership survey is scheduled for this winter, and members are encouraged to participate in it to ensure that this member publication continues to meet their needs.

### Future Membership in AANS

On a scale in which a “5” rating indicates “most likely to renew membership in AANS,” 97 percent of respondents said that they would renew their membership in the next year. The mean response was 4.64. Nearly as many respondents indicated that they would renew their membership in the next two years.

When asked to rate their agreement with the statement “AANS dues are appropriate for services provided,” 90 percent of those surveyed responded affirmatively. The mean response was 3.61.

### Self-Education Preferences

Survey respondents indicated that physically attending a course is still their preferred method of education. Of the self-education options available from AANS, such as DVDs or videos, respondents preferred print publications to DVDs/videos or CDs, though less significantly than has been reported in past surveys. Respondents expressed moderate interest in participating in online educational courses, but this option was the least preferred.

### Interaction With the AANS Executive Office

Members reported high satisfaction with their interaction with staff at the AANS Executive Office in Rolling Meadows, Ill. The majority of respondents indicated that they contacted the office between one and five times per year. Just over 43 percent had not contacted the Executive Office at all in the preceding year.

A variety of types of interactions were evaluated. Members were most satisfied with online registration for AANS courses and meetings (with a mean of 4.2 on a five-point scale), and with the accuracy of staff response to member inquiries (with a mean of 4.02). Other evaluated interactions and their mean responses included accuracy of order fulfillment (3.97), timeliness of staff response to inquiries (3.96) and online abstract submission (3.92).

### Future Needs

AANS asked members to indicate the importance of potential activities, services or programs that could be offered by the AANS in the future. Again, legislative issues topped the list, with “obtaining medical liability reform” at the summit. Implementing

## Future Benefits & Services

Description	Mean	Standard Deviation
Obtaining professional liability reform	4.71	0.64
Implementing Medicare reform (i.e., fundamental structural changes to current Medicare program)	4.58	0.73
Implementing beneficial CPT coding changes and policies	4.54	0.76
Maximizing Medicare and other physician reimbursement	4.53	0.8
Spine	4.38	0.79
Other	4.34	0.76
Foster positive media coverage of the neurosurgical specialty	4.27	0.89
Representing neurosurgery in EMTALA regulations and improving trauma systems	4.23	0.85
Cranial	4.16	0.83
Tumor	4.15	0.81
Reducing regulatory oversight of neurosurgeons, e.g., eliminating E&M documentation guidelines	4.08	0.96
Cerebrovascular	4.02	0.89
Self-assessment (maintenance of competence)	4.01	1.02
Positioning neurosurgeons to the general public (media relations and public education campaigns)	3.98	0.97

Medicare reform (that is, fundamental structural changes to the current Medicare program), securing beneficial coding changes in Current Procedural Terminology, and maximizing Medicare and other physician reimbursement all rated similarly in terms of importance to members.

### Member Demographics

The majority of respondents were in private practice (52 percent) and in small neurosurgical groups of two to five members (30 percent). Thirty-five percent were between 46 and 55 years old; 28 percent were between 56 and 65, and 26 percent were between 35 and 45. Thirty-four percent of respondents were in practice for 10 to 19 years, with the next largest cluster, 28 percent, in practice 20 to 29 years. The majority of respondents, 60 percent, said that their primary subspecialty was spine, followed by 25 percent who said it was pediatric.

Complete survey demographics are available on the AANS Web site at [www.aans.org/membership/2002\\_demographics.pdf](http://www.aans.org/membership/2002_demographics.pdf). ■

**Kathleen T. Craig** is AANS director of marketing.

# NEWS.ORG

AANS/CNS Sections Committees Associations Societies

**Splendid Science** RUNN 2003 (Research Update in Neuroscience for Neurosurgeons) is scheduled Nov. 9-16 in Woods Hole, Mass. The course is sponsored by the Society of Neurological Surgeons, [www.societyns.org](http://www.societyns.org).

**New Pediatrics Journal to Launch in February** Beginning in February 2004, the *Journal of Neurosurgery: Pediatrics* will be published quarterly, with subsequent issues available in May, August and November. This new journal will replace *Pediatric Neurosurgery* as the official journal of the American Society of Pediatric Neurosurgeons, and it will serve as an official publication of the American Association of Neurological Surgeons (AANS). *The Journal of Neurosurgery: Pediatrics* is devoted to the publication of work primarily relating to pediatric neurosurgery, including studies in clinical neurophysiology, organic neurology, ophthalmology, radiology, pathology, and molecular biology. Articles on unusual cases and technical notes of special instruments or equipment that might be useful to others in the field of neuroscience also are accepted. Additional information is available at (434) 924-5503, [jneuro@virginia.edu](mailto:jneuro@virginia.edu) or [www.thejns-net.org](http://www.thejns-net.org).

**YNC Seeks Nominations for Public Service Citation** The AANS Young Neurosurgeons Committee requests nominations for the 2004 YNC Public Service Citation, which honors public service contributions outside of the field of neurosurgery, whether enacted in

the United States or abroad. Nominees should be actively engaged in neurosurgical training or within the first seven years of neurosurgical practice. The award will be presented at the Young Neurosurgeons Luncheon on May 3, during the 2004 AANS Annual Meeting in Orlando, Fla. Nominations may be directed to Chris Philips of the AANS at [cap@aans.org](mailto:cap@aans.org); the deadline for receipt of nominations is April 15.

**Pediatric Section Holds 32nd Annual Meeting Dec. 2-5** The AANS/CNS Section on Pediatric Neurological Surgery will host its 32nd Annual Meeting in Salt Lake City, Utah, at the Grand America Hotel. Meeting dates are Dec. 2-5, 2003. Advance registration deadline is Wednesday, Nov. 5. Online meeting registration, housing reservations and the preliminary program are available at [www.neurosurgery.org/pediatric/meetings](http://www.neurosurgery.org/pediatric/meetings).

**CV/ASITN Meeting Scheduled for Feb. 1-4** The Seventh Joint Annual Meeting of the AANS/CNS Cerebrovascular Section and the American Society of Interventional & Therapeutic Neuroradiology will be held Feb. 1-4, 2004, at the Sheraton San Diego Hotel & Marina San Diego, Calif. More information is available at [www.neurosurgery.org/cv/meetings](http://www.neurosurgery.org/cv/meetings).

## LETTERS

**EDITOR:** I read with distress the Notice of Suspension on page 31 of the Spring 2003 *Bulletin*. Dr Rand's membership in the AANS was suspended for a year for unprofessional testimony. At our business meeting in San Diego, another neurosurgeon was suspended for three months after the Professional Conduct Committee had suggested a six-month suspension.

I suggest that these sanctions are totally inadequate. Both of these neurosurgeons should not have been suspended but should have been permanently expelled from the AANS. Stewart Dunsker and Stan Pelofsky at the San Diego meeting described the crisis in medical liability that currently exists. Their solution is to attempt to get MICRA-style legislation passed at a federal level. This will help but will not resolve the problem.

The problem is not plaintiff lawyers. Plaintiff lawyers sue. That is what they do for a living. However, under our current system, they would not have any case were it not for the collusion of the expert medical witness.

Without that collusion, this entire wretched system would collapse and

a rational, equitable, responsive system to compensate injured patients would have to be developed. It will never be developed if the expert plaintiff witness is allowed to testify and receive only a wrist-slapping suspension.

I applaud Dr. Dunsker and Dr. Pelofsky in their efforts and I have sent my \$1,000 to Neurosurgeons to Preserve Health Care Access. However, I strongly feel that even if federal MICRA-style legislation is enacted, we are pushing the solution to this problem to our children's generation.

I wrote an editorial in *Surgical Neurology* (28:320, 1987) in which I discussed my rationale and suggestions for dealing with the professional testifier. These people do not deserve to be members of our collegial organization. Let us expel them and not slap their wrists.

Stephen R. Freidberg, MD  
Burlington, Mass.

For advertising information, see the Bulletin's rate card at <http://www.aans.org/bulletin/bulletinratecard.pdf>, or contact Holly Baker, [hbaker@ascendmedia.com](mailto:hbaker@ascendmedia.com), 913.344.1392.

# Advancing the Specialty

*Neurosurgery Research and Education Foundation  
Recognizes Supporters From Jan. 1 through June 30, 2003*

The Executive Council of the Neurosurgery Research and Education Foundation (NREF) of the American Association of Neurological Surgeons (AANS) gratefully acknowledges the individuals, groups and corporations who generously supported the NREF Jan. 1 through June 30, 2003. Included are gifts in loving memory of Cindy Gough Barbier, Loyal Davis, MD, James Greene, Robert Jackson Love, and Edith Ross.

These donors are recognized for understanding the importance of providing critical funding for many of the most promising neurosurgical studies being conducted today. These studies, which enhance science and improve patient care, have set a high standard for the neuroscientific community.

The investment of these NREF supporters in the future of the neurosciences will reap positive rewards—new advances in the areas of brain tumors, stroke, epilepsy, and disorders of the spine. Ultimately, these funded research projects will lead to medical breakthroughs and saved lives.

The AANS members, general public and corporations supporting NREF these past six months include:

## Cushing Scholars Circle Gifts of \$1,000 or More

### Gifts of \$100,000

Martha and John J. Guarnaschelli, MD

### Gifts of \$5,000 to \$15,000

John R. Clifford, MD

### Gifts of \$2,500 to \$4,999

Mark J. Krinock, MD

Russel H. Patterson Jr., MD

Guillermo G. Sepulveda, MD

### Gifts of \$1,000 to \$2,499

Christopher J. Abood, MD

James S. Anderson, MD

Ronald I. Apfelbaum, MD

Julian E. Bailes Jr., MD

Vallo Benjamin, MD

Charles H. Bill II, MD, PhD

Peter McL. Black, MD, PhD

Gary M. Bloomgarden, MD

Bikash Bose, MD

G. Rees Cosgrove, MD, FRCS

William T. Couldwell, MD, PhD

Arthur L. Day, MD

Fernando G. Diaz, MD, PhD

Patrick W. Elwood, MD

A. Willard Emch, MD

Thomas B. Flynn, MD

Paul D. Forrest, MD

M. Sean Grady, MD

Robert G. Grossman, MD

J. Frederick Harrington Jr., MD

Griffith R. Harsh IV, MD

Roberto C. Heros, MD

John A. Jane, MD, PhD

Jeffrey K. Kachmann, MD

Robert B. King, MD

Marc A. Letellier, MD

Robert L. Martuza, MD

Carole A. Miller, MD

George A. Ojemann, MD

John J. Oro, MD

Savvas Papazoglou, MD

Nettleton S. Payne, MD

Donald O. Quest, MD

Richard L. Rovit, MD

Brian Scanlan

John F. Schuhmacher, MD, FACS

Edward L. Seljeskog, MD

Warren R. Selman, MD

Christopher B. Shields, MD, FRCS(C)

J. Marc Simard, MD, PhD

Gary K. Steinberg, MD, PhD

Philip E. Stieg, PhD, MD

Elizabeth Sweet

Troy M. Tippet, MD

Edward Von der Schmidt III, MD

Seth M. Zeidman, MD

Steven Christopher Zielinski, MD

### Gifts of \$500 to \$999

Jaime A. Alvarez, MD

Jose F. Alvarez-Dib, MD

Frederick A. Boop, MD

Henry Brem, MD

Edwin R. Buster, MD

Pamela J. Costello, MD, PhD

Francisco Cuevas-Salazar, MD

Domenic P. Esposito, MD

Stephen R. Freidberg, MD

Michael L. Griffith, MD

Julian T. Hoff, MD

Keller Kaufman-Fox

Jay M. Levy, MD

Thomas A. Marshall

Thomas D. Meek, MD

Ganesalingam Narenthiran, MD

A. John Popp, MD

Elisabeth M. Post, MD

Kalmon D. Post, MD

Richard A. Roski, MD

Arthur O. Schilp, MD

Michael Schulder, MD

Peter M. Shedden, MD

Greg Errol Thompson, MD

David D. Udehn, MD

David Allan Yazdan, MD

### Gifts of \$250 to \$499

Nicholas M. Barbaro, MD

Thomas A. Bergman, MD

Sharyn D. Brekhus, MD

Jeffrey N. Bruce, MD

Isa S. Canavati, MD

David A. Cech, MD

Linda Cloward

Jeffrey D. Cone, MD, FACS

Christopher Covington, MD

Joel A. Feigenbaum, MD

Henry Feuer, MD

Michael J. Fox

Anthony K. Frempong-Boadu, MD

Grant E. Gauger, MD

Catherine Gilmore-Lawless

Vicente C. Gracias, MD

Charles Joseph Hodge Jr., MD

James A. Kenning, MD

Alexandra R. Kunz, MD

Richard S. Kyle, MD

Ranjit Kumar Laha, MD

Frederick F. Lang Jr., MD

David C. Leppla, MD

Michel F. Levesque, MD

Mark R. McLaughlin, MD

Dante Joseph Morassutti, MD

Donald J. Moyer Jr., MD

Raj K. Narayan, MD

Paul B. Nelson, MD

Katie Orrico, JD

Vivekanand Palavali, MD

Andrew D. Parent, MD

Bruce E. Pollock, MD

Archimedes Ramirez, MD

Allen S. Rothman, MD, FACS

James T. Rutka, MD, PhD, FRC

Keith L. Schaible, MD

Charles L. Schnee, MD

Randall W. Smith, MD

Robert F. Spetzler, MD

Timothy Strait, MD

Scott W. Strenger, MD, FACS

Alex B. Valadka, MD

Harry R. Van Loveren, MD

Charles J. Wright, MD

### Gifts of \$100 to \$249

Bizhan Aarabi, MD

Moustapha Abou-Samra, MD

Charles B. Agbi, MD

Todd D. Alexander, MD

Brent T. Alford, MD

Julio Aljure, MD

Nobuo Aoki, MD

Roy A. E. Bakay, MD

Beverly Barbier

Frank D. Barranco, MD

Craig A. Baumgartner, PA-C

James R. Bean, MD

David W. Beck, MD

Steven J. Beer, MD

Mitchel S. Berger, MD

Mark H. Bilsky, MD

David J. Boarini, MD

Jonathan A. Borden, MD

Robert C. Buza, MD

Lynn Callery

Rafael Camacho Morales, MD

K. Casey

Israel P. Chambi-Venero, MD

Bohdan W. Chopko, MD, PhD

Ivan Ciric, MD

Maurice Collada Jr., MD

Jose R. De La Cruz, MD

David F. Dean, MD

Grace Delgros

Richard A. Dirrenberger, MD, FACS

Michael V. DiTullio Jr., MD

Annie Dubuisson, MD

Jack Hibbard Dunn, MD

Stewart B. Dunsker, MD

Mark Eastham, MD

Susan Eget

Walter J. Faillace, MD, FACS

Jacques N. Farkas, MD

Basilio Fernandez, MD

Donald H. Frank, MD

## Celebrate a Life

*In Tribute to Those Who Mean So Much*

### MICHELE S. GREGORY

When surgical procedures were not enough and the prognosis was bleak, a patient's family wanted to do something to honor the life and memory of its loved one. Frank Culicchia, MD, from West Jefferson Medical Center in suburban New Orleans, suggested making donations to celebrate the life of that loved one by supporting research and education at the American Association of Neurological Surgeons (AANS) through the Neurosurgery Research and Education Foundation (NREF).

In similar spirit:

A grateful patient, who underwent successful brain tumor research five years ago, recently honored her neurosurgeon with a gift to the NREF in his name.

Friends of a well-respected and accomplished neurosurgeon honored him and his work with a donation to the NREF, maintaining that he set the standard for others to emulate.

These are a few examples of how people have honored the memories, lives or lifelong work of colleagues and loved ones. A named donation to the NREF, in the spirit of surgical advances and saving lives, is possible through the NREF's "Celebrate a Life" campaign. The campaign will be unveiled this fall, and materials that can be provided to patients and their families will be made available to AANS members.

NREF supports basic science and clinical-based research projects by annually awarding one- and two-year fellowships and Young Clinician Investigator awards to the most promising young neurosurgeons. Their studies are aimed at solving the neurosurgical crises of today, paving the way for life-changing advances in the neurosciences. The grant applications are reviewed and scrutinized by a committee of neurosurgeons who determine which projects merit funding, using a rating scale similar to the one used by the National Institute of Health. ■

**Michele S. Gregory** is AANS director of development, (847) 378-0540 or [msg@AANS.org](mailto:msg@AANS.org).

Mark A. Fulton, MD  
William F. Ganz, MD  
Robert E. Germann, MD, PC  
Gregory G. Gerras, MD  
Zohar Ghogawala, MD  
Dewitt B. Gifford, MD  
Todd M. Goldenberg, MD  
David L. Goldman, MD  
Jon F. Graham, MD  
Peter J. Grillo, MD  
Robert L. Grubb Jr., MD  
Mary K. Gumerlock, MD  
Robert R. Hansebout, MD  
Michael D. Heafner, MD  
M. Peter Heilbrun, MD  
Deborah C. Henry, MD  
Mary Louise Hlavin, MD  
Brian Holmes, MD  
Jonathan W. Hopkins, MD  
Bermans J. Iskandar, MD  
Masanori Itoh, MD  
Darrell Jackson  
Richard William Johnson, MD  
Joseph T. King Jr., MD  
Barry A. Kriegsfeld, MD  
Richard Charles Krueger Jr., MD, PhD  
Mark J. Kubala, MD  
Byung Duk Kwun, MD, PhD  
David J. Langer, MD  
Mark S. Le Doux, MD  
James J. Leech, MD  
Eugene W. Leibowitz, MD, FACS  
Victor Manuel Leon-Meza, MD  
Marc Levivier, MD, PhD  
Arthur Litofsky, MD  
Marie L. Long, MD  
Blas Ezequiel Lopez Felix, MD

Laverne Ray Lovell, MD  
William C. Madauss, MD, FACS  
Hish S. Majzoub, MD  
Stavros N. Maltezos, MD  
William H. McAllister IV, MD  
Duncan Q. McBride, MD  
Shannon and Susan McGuire  
Robert C. Meredith, MD, FACS  
Luis A. Mignucci, MD  
Thomas I. Miller, MD  
Hiroshi Nakagawa, MD  
Yoko Nakasu, MD  
Jeffrey G. Ojemann, MD  
Ayub Khan Ommaya, MD  
Max Endel Ots, MD  
Dwight Parkinson, MD  
Stan Pelofsky, MD  
Richard E. Pelosi, MD  
Mick J. Perez-Cruet, MD  
Barry J. Pollack, MD  
Donald J. Prolo, MD  
Melvin E. Prostkoff, MD  
Morris Wade Pulliam, MD  
Robert A. Ratcheson, MD  
Juan Carlos Reina Gama, MD  
Albert L. Rhoton Jr., MD  
Michael H. Robbins, MD  
Scott C. Robertson, MD  
Alfredo Roman Messina, MD  
Arthur P. Rosiello, MD  
Gail L. Rosseau, MD  
David Rothbart, MD  
Catherine A. Ruebenacker-Mazzola, MD  
James Karl Sabshin, MD  
Toshisuke Sakaki, MD  
Douglas F. Savage, MD  
Brad A. Selland, MD

Mitesh V. Shah, MD  
Howard J. Silberstein, MD  
William W. S. So, MD  
Paul E. Spurgas, MD  
John D. Steichen, MD  
Daniel R. Stough, MD  
Richard C. Strauss, MD  
Viviane S. Tabar, MD  
Kiyoshi Takagi, MD  
Mark A. Testaiuti, MD  
Carson J. Thompson, MD  
Phillip A. Tibbs, MD  
Humberto Tijerina, MD  
Russell L. Travis, MD  
Hani J. Tuffaha, MD  
Donn Martin Turner, MD  
Jamie S. Ullman, MD  
Dominic Venne, MD, MSc  
Octavio A. Villasana Delfin, MD  
Gregory E. Walker, MD  
Nancy Ware, RN  
Clarence B. Watridge, MD, FACS  
Stuart M. Weil, MD  
Sanford R. Weiss, MD  
William C. Welch, MD  
W. Brian Wheelock, MD, FRCS  
Francis J. Williams, MD  
Fremont P. Wirth, MD  
Ronald F. Yake, MD  
Kenneth S. Yonemura, MD  
Robert A. Yount, MD

### Gifts up to \$99

Eustaquio O. Abay II, MD  
Pablo J. Acebal, MD  
Elisa Agpaoa, RN  
Dr. & Mrs. P. Shannon Allison

George A. Alsina, MD  
Mark E. Anderson, MD  
Kathleen H Baker, BSN, CNRN  
Becky Beyer, CNRN  
Shaad Bashir Bidiwala, MD  
Richard P. Boyer, MD  
Mr. & Mrs. Bill Callery  
Linda Susan Casey, PA-C  
Lucie Cavaroc  
Mona & L. Sidney Charbonnet Jr.  
Tanvir F. Choudhri, MD  
Young Chung, MD  
Mr. & Mrs. Charles Compton Jr.  
Caitie & Edwin T. Connick  
Rae Cote  
Tedde Denys  
Robert E. Dicks III, MD  
Mr. & Mrs. Jack Dienes  
Robert L. Dodd, MD  
James C. Dozier, MD  
Alessandro Ducati, MD  
Eugene S. Flamm, MD  
Kathy & George Flowers  
Holly S. Gilmer-Hill, MD  
Roberta P. Glick, MD  
Vivek A. Gonugunta, FRCS  
Carroll J. Green, PA-C  
Rosalyn Gregory  
Art Hagar  
Lynn H. Haines, MD  
Peter Osborne Holliday III, MD  
Lynn Hollihan, RN  
Mr. & Mrs. James F. Holmes and family  
Maurizio Iacoangeli, MD  
George Ingorokva, MD  
Shota Ingorokva  
Anthony Joseph Inzana, PA-C  
Continued on page 48

# TIMELINE: Neurosurgery Through History

## Medical Liability and the Surgeon: Wisdom From a Century Ago

It may be of small comfort to us in 2003 that the issue of medical liability has been on our collective mind for some time now.

In 1910 W.W. Keen, then emeritus professor of surgery at Jefferson Medical College, published his monumental work *Surgery: Its Principles and Practice*. This eight-volume work is of special neurosurgical interest, as in the third volume it contains Harvey Cushing's first comprehensive publication on brain surgery, "Surgery of the Head."

However, tucked away near the very end in a supplemental volume, after about 8,000 pages of learned text on surgery, lies a chapter entitled "The Legal Relations of the Surgeon" by Hampton L. Carson, Esq. He served as the attorney general of Pennsylvania and as the president of the Pennsylvania Bar Association;

in addition, he began what grew to be a most important collection of early Americana, and published articles on the history of law.

The chapter includes a section entitled "Malpractice." The term is defined as "doing that which a prudent man would have avoided under like or similar circumstance," and a specialist is described as one who "must have and employ the ordinary knowledge and skill in that specialty. An impracticable standard of excellence is not required."

Carson does list many "striking instances of malpractice," including such contemporary-sounding cases as "leaving sponges, gauze, or tubes in wounds or body" and "failure to use x-rays where such were indicated and possible" (note that X-rays had been dis-

**"There is no insurance of a perfect result."**

covered only in 1895).

However, in discussing the "law of negligence" in cases of malpractice, he refers to many decisions that emphasize that "mere failure to effect a cure [does not] raise a presumption of lack of skill or care. There is no

insurance of a perfect result." He summarizes that "An error in judgment, unless gross, is not tantamount to lack of skill...Negligence of the surgeon is not to be presumed from a mere lack of satisfactory results."

As neurosurgeons we know this all too well. Our challenge remains to make it clear to our patients and their families. ■

**Michael Schulder, MD**, is associate professor in the Department of Neurological Surgery and director of Image-Guided Neurosurgery at UMDNJ-New Jersey Medical School.

## NREF DONORS

Continued from page 47

Horst Iwe, MD  
 Steven M. James, MD  
 Woodrow Janese, MD, FACS  
 Yevgeniy Khavkin, MD  
 Mr. & Mrs. Michael Kincade  
 Mr. & Mrs. Charles M. Knisley  
 John P. Latchaw, MD  
 Robert E. Lieberman, MD  
 David W. Lowry, MD  
 Larry Lykins  
 Paul Mark  
 Roberto Martinez-Alvarez, MD, PhD  
 Mr. & Mrs. Jack McGuire  
 Salvatore Mingrino, MD  
 Michelle Mora  
 Gerri P. Morella-Zaleski, RN, CNOR  
 Reuben P. Morris Jr., MD  
 Sait Naderi, MD  
 John P. Olson, MD, PhD  
 Jacque P. Pasternacki, PA-C  
 Russell Pelton, JD  
 Dorothy Poppe  
 Joann Potter  
 Louis J. Provenza, MD  
 Michael R. Puumala, MD  
 Mahmoud Rashidi, MD  
 James E. Reed

Thomas W. Rigsby, MD  
 Mr. & Mrs. Richard Rosenfeld  
 Robert C. Rostomily, MD  
 Fortino Salazar, MD  
 Mr. & Mrs. Gerard Schlak  
 Lillian Schonberg  
 Barbara & Samuel Shearman  
 Robert Lewis Simons, MD  
 Joel M. Singer, MD, PhD  
 Florence Smith, RN  
 Mr. & Mrs. Arthur Smith  
 Carolyn Stalcup  
 Marcus Stoodley, MD, PhD  
 Sara G. Swigart  
 Philipp G. Tanner, MD, PhD  
 Irakli Toidze  
 Mr. & Mrs. John Trice  
 Jaime A. Trueba-Reyes, MD  
 Ugur Ture, MD  
 Marc A. Vanefsky, MD  
 Eugenio F. Vargas, MD  
 Stacey Waltenbaugh, RN  
 Teresa A. Weeks, RN, MSN, FNP  
 Dennis Yung K. Wen, MD  
 Mr. & Mrs. Bryan Westerman  
 David A. Wiles, MD  
 Chi Keung Wong, FRCS

Eric L. Zager, MD  
 Lucia Zamorano, MD

### Memorials

**In loving memory of William Sweet, MD**  
 Elizabeth Sweet

**In loving memory of Cindy Gough Barbier**  
 Dr. and Mrs. P. Allison, Beverly Barbier,  
 Mr. & Mrs. Bill Callery, Lucie Cavaroc,  
 Mona & L. Sidney Charbonnet, Mr. &  
 Mrs. Charles Compton Jr., Caitie &  
 Edwin Connick, Rae Cote, Grace  
 Delgros, Tedde Denys, Mr. & Mrs. Jack  
 Dienes, Kathy & George Flowers, Art  
 Hagar, Mr. & Mrs. Holmes and family,  
 Mr & Mrs. Michael Kincade, Mr. & Mrs.  
 Charles Knisley, Mr. & Mrs. Jack  
 McGuire, Susan & Shannon McGuire,  
 Mr & Mrs. Richard Rosenfeld, Mr. &  
 Mrs. Gerard Schlak, Lillian Schonberg,  
 Barbara & Samuel Shearman, Mr. &  
 Mrs. Arthur Smith, Carolyn J. Stalcup,  
 Sara Swigart, Mr. & Mrs. John Trice,  
 Mr. & Mrs. Bryan Westerman

**In loving memory of James Green**  
 Employees of Salsco, Inc.

### Tributes

**In honor of Dean H. Echols, MD, and  
 Homer D. Kirgis** John R. Clifford, MD

### Corporate Associates

**Gifts of \$50,000**  
 DePuy AcroMed, a Johnson & Johnson  
 Company

**Gifts of \$20,000 to \$49,999**  
 American Brain Tumor Association  
 Kyphon  
 Medtronic Neurological

**Gifts of \$5,000 to \$9,999**  
 Anspach  
 PMT Corporation  
 State University of New York-Syracuse

**Gifts up to \$4,999**  
 Penn, Schoen & Berland Assoc., Inc.

# Tracking Resident Work Hours

*Available Software Is Not Yet Ideal, but It's Helpful*

**A** new reality began July 1. We are all now responsible for tracking our residents' work hours and ensuring compliance with the new regulations mandated by the Accreditation Council for Graduate Medical Education (ACGME).

In order to do this in the Department of Neurosurgery at the University of Utah, a number of options involving commercial time-tracking software were considered.

## Among the Options

One option from Time America Inc. is an Internet-based data collection system called NETtime. The company manages the data and provides customized reports as requested. The cost includes set-up fees, a monthly fee of \$50 per clock, and hourly charges to write customized reports.

A second option is a product called TimeClock. It can be installed on a network, so that data entry may be accomplished at a number of stations and pooled for analysis.

A third option is to have residents track their hours on paper and then have the data entered into a tracking system. Either of the electronic methods allow a number of options for data entry. For example, the data can be entered via magnetic bar codes, key-punch pads or by desktop icons on a personal computer.

## Using TimeClock

At the University of Utah, we chose to purchase the TimeClock system. It is installed on the local university network so that data can be entered from networked personal computers at the adult and pediatric hospitals in our residency program. The cost of this system depends on the number of users (25 users, \$2,000).

This system is accessed through a small desktop icon. When residents arrive at work in the morning, they "clock in" by clicking

**"An ideal system would be completely passive and would allow more detailed tracking of activity inside the hospital."**

on the icon. They are then presented with a short menu, which asks them whether they are on call that day or not. When they leave the hospital they click on the icon again to "clock out." This system will handle shifts that last past midnight, and it will count the work hours after midnight toward the previous day's total hours.

A number of reports are available from the database. A report that details time-in and time-out each day for each resident is easily obtained. In addition, summary reports are available that show total hours per week or hours by job code. The latter report allows us to determine the hours worked while on call, off call and/or post call. The system also can be configured to report time off, so that we can check whether residents have been off for 10 hours between shifts and whether they have had one 24-hour period off each week.

## A Glitch in the System

The main hurdle has been compliance: It has been an uphill battle to get everyone to use the system regularly. A software glitch does not allow a user to clock in the morning if they have forgotten to clock out the night before. Therefore, residents get behind on their data entry until the system administrator can enter the missing data.

Another option that we are presently considering is to have residents record their data on weekly time sheets and then have the data entry done by the system administrator. The data recording and reporting features would be the same, but our informal input for the residents suggests that this might be easier for them than clocking in and out on the desktop each day.

In summary, keeping track of resident work hours represents a change in the usual daily routine that now appears to be part of our lives. The software available to assist us with compliance is not yet ideal, but it is a step in the right direction. An ideal system would be completely passive and would allow more detailed tracking of activity inside the hospital. This may be doable in the future using hand-held computer-based or pager-based wireless communication technology. In the meantime, the commercially available systems are helpful and reasonably priced. ■

**John Kestle, MD**, is associate professor in the Department of Neurosurgery at the University of Utah.

## FOR MORE INFORMATION

- NETtime (Time America Inc.) [www.timeamerica.com](http://www.timeamerica.com)
- TimeClock Plus (Data Management Incorporated) [www.timeclockplus.cc](http://www.timeclockplus.cc)
- "ACGME's New Requirements: An Overview" (*AANS Bulletin*, Summer 2003, [www.AANS.org](http://www.AANS.org).)

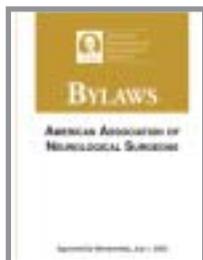
# Members Approve Addition of 501(c)(6)

## *Bylaws Change Expands Horizons for AANS*

In response to the increasing number of political and legislative issues affecting neurosurgeons, the Board of the American Association of Neurological Surgeons (AANS) recommended a bylaws change that allows a companion organization to form and operate under Section 501(c)(6) of the Internal Revenue Code. Members approved the bylaws change this summer by mail-in ballot.

This action broadens the association's functionality from that of an entity whose primary purpose is education and research, organized under Section 501(c)(3) of the Internal Revenue Code, to an entity that additionally has the freedom to coordinate political activities and sponsor major income generating programs, organized under Section 501(c)(6).

The association now functions seamlessly as two organizations in one. The 501(c)(6) serves as the umbrella organization, while



many activities and functions, education and research among them, remain under the 501(c)(3). Appropriately, and to capitalize on the positive name recognition of AANS, the new 501(c)(6) entity assumed the name "American Association of Neurological Surgeons." The 501(c)(3) entity adopted the name "American Association of Neurosurgeons." However, both entities share identical leadership and membership. While there are many subtle benefits to the change, it is nevertheless functionally transparent.

### The Vote

Materials that outlined the proposed revision to the AANS Bylaws were mailed to members before the 2003 AANS Annual

Meeting in April. Revisions to the proposal then were presented at the AANS Business Meeting, which took place during the Annual Meeting. Following the meeting, ballots were sent to all voting members. In order to be counted, ballots had to be returned by June 30. On July 1, it was announced that members had overwhelmingly approved the change in the AANS organizational structure.

Copies of the revised AANS Bylaws, including those for both the 501(c)(6) and the 501(c)(3) entities, are available on the 2003–04 AANS Membership Directory CD-ROM, sent to all AANS members in October. The bylaws are available on the AANS Web site, [www.AANS.org](http://www.AANS.org), and the bylaws booklet can be requested from the AANS by phone, (888) 566-AANS, or fax, (847) 378-0600. ■

**Susan M. Eget** is AANS associate executive director.

## IN MEMORIAM



**David W. Cahill, MD**, of Tampa, Fla., died July 2. He was piloting a twin-propeller Beechcraft Baron when it crashed on landing in Memphis, Tenn.

Dr. Cahill founded the Department of Neurological Surgery at the University of South Florida College of Medicine in Tampa. Nationally respected for his skill in complex spinal cord surgery, he joined the USF College of Medicine in 1983 and served for 20 years

as professor and more recently as chairman of neurosurgery.

"He was a superb neurosurgeon and a wonderful teacher, said Robert M. Daugherty, MD, dean of the USF College of Medicine, in the St. Petersburg Times. "We've lost one of our leaders, someone who exemplified quality in everything he did."

He was a diplomate of the National Board of Medical Examiners, American Board of Psychiatry & Neurology, and the American Board of Neurological Surgery, as well as a licensed surgeon in Florida, Maryland and Virginia.

A leader in his profession, Dr. Cahill was a member of the American Association of Neurological Surgeons (AANS), the Congress of Neurological Surgeons and several subspecialty sections. He was the AANS delegate to the Council of State Neurosurgical Societies (CSNS) from 1996 to 2002, and a member of the CSNS Executive Committee from 1997 to 2002. He also was a member of the Executive Committee of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves from 1994 to 1997.

A Virginia native, Dr. Cahill received his undergraduate and medical degrees from the University of Virginia. He served his surgical internship and residency in neurology at the Medical College of Virginia, and his surgical residency at the University of Maryland, where he was elected chief resident in 1982.

His extensive publications include work on repairing the spinal cord, as well as collaborations with other faculty members on brain repair and Parkinson's disease research. ■

# AANS Strategic Plan

*New Roadmap's a Nimble Mechanism for Sustaining Growth*

**M**ost strategic plans collect dust in a three-ring binder. That certainly has been my experience with the professional and trade associations where I have worked in the last 19 years.

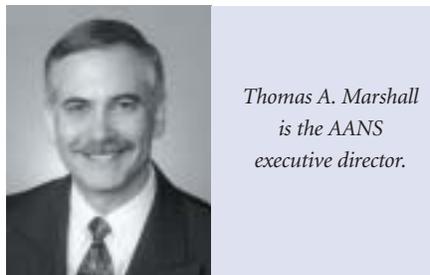
And if management staff of membership associations endlessly debates the many Gordian knots of operating an organization driven by volunteer leadership, the one dilemma we all seem to agree on is this: how do you demonstrate the intellectual need for a strategic planning mechanism when you know how easily—and how often—all that work and “future casting” can be relegated to a boardroom bookshelf?

## The Need for a Strategic Plan

Demonstrating the need for a bona fide strategic plan at the American Association of Neurological Surgeons (AANS) was the easy part of the process. As he mentions in his President's Column in this issue, last year A. John Popp, MD, added an additional goal to his duty as president-elect of chairing the Long Range Planning Committee (LRP). Coming out of the rebuilding phase—stabilizing the AANS infrastructure and finances—I discussed with Dr. Popp the need to “close the AANS governance loop” by having the newly instituted financial system integrate annually with a similar leader-driven, goal-setting process for planned organizational growth.

Dr. Popp immediately set about leading the LRP through the hard part of the process: conducting a detailed assessment of the AANS infrastructure, both internally and externally. After an all-day facilitated retreat in November, followed by weeks of task force conference calls and a final editorial evaluation this past April, the AANS now has an operative strategic plan that completes the three-year process

**“Above all, the AANS Strategic Plan provides a roadmap to guarantee that your association will adhere to a robust, forward-thinking mission of continual growth that identifies your needs now, anticipates your needs in the future, and stays on a fiscally responsible growth track to support those needs as the most multifaceted resource for neurosurgeons.”**



*Thomas A. Marshall  
is the AANS  
executive director.*

of stabilizing this association's finances and refining its mission.

Does this mean that the AANS Strategic Plan always will be able to accurately forecast and prevent with precision all the environmental forces that may adversely affect the specialty, and do so far enough in advance to always prevent them?

No. That is the most common myth of any strategic planning process or product.

## The Strategic Plan Benefits Every Member

What it will do is assure that when problems and setbacks do occur to you, to the specialty, or to your association, the AANS will be financially stable enough, nimble enough, and structurally sound enough to make critical changes in its short-term member services without losing sight of its goals and objectives for long-term growth.

What does this mean to you as an AANS member? First and foremost, you can be assured that your organization will

always be driven primarily by your specifically identified needs. The new AANS process of annual strategic planning contains mechanisms that assure your needs are regularly identified, and then are kept at the forefront of AANS leadership and management decision-making. It means greater accountability to your needs by AANS committees and governance. And it means that both leadership and management will direct the AANS with an open and comprehensible fiscal accountability that guarantees the prudent expansion of the services that specifically meet its members' expectations.

Above all, the AANS Strategic Plan provides a roadmap to guarantee that your association will adhere to a robust, forward-thinking mission of continual growth that identifies your needs now, anticipates your needs in the future, and stays on a fiscally responsible growth track to support those needs as the most multifaceted resource for neurosurgeons.

With the AANS Strategic Plan now operative and its ongoing assessment mechanisms operative, you can be assured that the proper balance of staff, leadership, and general membership participation in the direction of the AANS is finally in place.

This is one strategic plan that won't collect dust. ■



# EVENTS

Calendar of Neurosurgical Events

## AANS LEADERSHIP 2003-2004

### OFFICERS

A. John Popp, MD, *president*  
Robert A. Ratcheson, MD, *president-elect*  
Randall W. Smith, MD, *vice-president*  
Jon H. Robertson, MD, *secretary*  
Arthur L. Day, MD, *treasurer*  
Roberto C. Heros, MD, *past president*

### DIRECTORS AT LARGE

Steven L. Giannotta, MD  
L.N. Hopkins III, MD  
Paul C. McCormick, MD  
Richard A. Roski, MD  
James T. Rutka, MD

### REGIONAL DIRECTORS

Gene H. Barnett, MD  
Paul E. Spurgas, MD  
Frederick D. Todd II, MD  
Clarence B. Waltridge, MD

### EX-OFFICIO

James R. Bean, MD  
Frederick A. Boop, MD  
G. Rees Cosgrove, MD  
Regis William Haid Jr., MD  
Donald W. Marion, MD  
Mark R. McLaughlin, MD  
Andrew D. Parent, MD  
Oren Sagher, MD  
Raymond Sawaya, MD  
Michael Schulder, MD  
Warren R. Selman, MD

### LIAISONS

Deborah L. Benzil, MD  
Mark N. Hadley, MD  
W. Brian Wheelock, MD

### AANS EXECUTIVE OFFICE

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

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

### DEPARTMENTS

*Communications*, Heather L. Monroe  
*Development*, Michele S. Gregory  
*Education and Practice Management*,  
Jane M. Ries, MHA  
*Information Services*, Kenneth L. Nolan  
*Marketing*, Kathleen T. Craig  
*Meeting Services*, Lisa M. Sykes, CMP  
*Member Services*, Chris A. Philips

### 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](http://www.neurosurgery.org/socioeconomic/dcstaff.html)

### NERVES: The Business of Neurosurgery

Oct. 16-17, 2003  
Denver, Colo.  
[c.harris@arlingtonneuro.com](mailto:c.harris@arlingtonneuro.com)  
[www.asahq.org/annmtg](http://www.asahq.org/annmtg)

### 2003 Annual Meeting of the Congress of Neurological Surgeons

Oct. 18-23, 2003  
Denver, Colo.  
[www.neurosurgery.org/cns/meetings](http://www.neurosurgery.org/cns/meetings)

### American College of Surgeons Annual Meeting

Oct. 19-23, 2003  
Chicago, Ill.  
(312) 202-5244  
[www.facs.org](http://www.facs.org)

### American Neurological Association Annual Meeting

Oct. 19-22, 2003  
San Francisco, Calif.  
(612) 545-6284  
[www.aneuroa.org](http://www.aneuroa.org)

### North American Spine Society 18th Annual Meeting

Oct. 21-25, 2003  
Montreal, Quebec, Canada  
(708) 588-8080  
[www.spine.org/18AnnMtg.cfm](http://www.spine.org/18AnnMtg.cfm)

### 10th Congress of the Brazilian Academy of Neurosurgery

Nov. 5-8, 2003  
Recife, Brazil  
[www.abnc2003.com.br](http://www.abnc2003.com.br)

### The 21st Annual National Neurotrauma Sumposium

Nov. 6-7, 2003  
Biloxi, Miss.  
(305) 663-6777  
[www.neurotrauma.org](http://www.neurotrauma.org)

### Society for Neuroscience

Nov. 8-12, 2003  
New Orleans, La.  
(202) 462-6688  
[www.sfn.org](http://www.sfn.org)

### Research Updates in Neurobiology for Neurosurgeons/RUNN Course

Nov. 9-16, 2003  
Woods Hole, Mass.  
(303) 806-0777  
[www.societytyns.org/runn](http://www.societytyns.org/runn)

### American Board of Neurological Surgery Meeting

Nov. 11-14, 2003  
Houston, Texas  
(713) 441-6015  
[www.abns.org](http://www.abns.org)

### AO ASIF Spine Course for Residents and Fellows

Nov. 15-16, 2003  
Portland, Ore.  
(800) 769-1391  
[www.aon.org/courses/spine](http://www.aon.org/courses/spine)

### Annual Meeting of the Association of Military Surgeons of the U.S.

Nov. 16-21, 2003  
San Antonio, Texas  
[www.amsus.org](http://www.amsus.org)

### 11th Asian-Australasian Congress of Neurological Surgery

Nov. 22-26, 2003  
Singapore, China  
[www.aasns.com](http://www.aasns.com)

### 2003 AANS/CNS Section on Pediatric Neurological Surgery Annual Meeting<sup>+</sup>

Dec. 2-5, 2003  
Salt Lake City, Utah  
(888) 566-2267  
[www.neurosurgery.org/pediatric/meetings](http://www.neurosurgery.org/pediatric/meetings)

### American Epilepsy Society 57th Annual Meeting

Dec. 5-10, 2003  
Boston, Mass.  
(860) 586-7505  
[www.aesnet.org](http://www.aesnet.org)

### Advanced Techniques in Image-Guided Brain and Spine Surgery

Dec. 6-7, 2003  
New York, N.Y.  
(212) 241-6252  
[www.mssm.edu/neurosurgery/imageguided](http://www.mssm.edu/neurosurgery/imageguided)

### Craniofacial Surgery & Transfacial Approaches to Skull Base

Dec. 6-7, 2003  
St. Louis, Mo.  
(314) 535-4000  
[pawslab.slu.edu/cme/craniofacial](http://pawslab.slu.edu/cme/craniofacial)

<sup>+</sup>These meetings are jointly sponsored by the American Association of Neurological Surgeons. For frequently updated listings, go to the Meetings Calendar at [www.AANS.org](http://www.AANS.org).

### Upcoming AANS Courses

For information or to register call (888) 566-AANS or visit [www.AANS.org](http://www.AANS.org).

#### ● Advanced Coding & Reimbursement Challenges in Neurosurgery

March 19-20, 2004 . . . . .Atlanta, Ga.

● **Basic Principles of Anatomy and Terminology**  
Jan. 29, 2004 . . . . .New Orleans, La.  
Feb. 19, 2004 . . . . .Scottsdale, Ariz.

● **Managing Coding & Reimbursement Challenges in Neurosurgery**  
Oct. 31-Nov. 2, 2003 . . . . .Maui, Hawaii  
Nov. 21-22, 2003 . . . . .Baltimore, Md.  
Jan. 30-31, 2004 . . . . .New Orleans, La.

Feb. 20-21, 2004 . . . . .Phoenix, Ariz.  
May 21-22, 2004 . . . . .Boston, Mass.  
Aug. 27-28, 2004 . . . . .Chicago, Ill.  
Sept. 24-25, 2004 . . . . .Philadelphia, Pa.  
Nov. 12-13, 2004 . . . . .San Diego, Calif.

● **Neurosurgery Review by Case Management: Oral Board Preparation**  
Nov. 9-11, 2003 . . . . .Houston, Texas  
May 16-18, 2004 . . . . .New Orleans, La.

● **Neurosurgical Practice Management**  
May 23, 2004 . . . . .Boston, Mass.  
Aug. 29, 2004 . . . . .Chicago, Ill.

● **Beyond Residency: The Real World**  
May 1, 2004 . . . . .Orlando, Fla.