

AANS Bulletin

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The American Association of Neurological Surgeons

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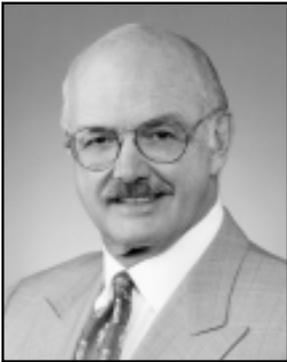
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Outreach Programs Among AANS' Top Priorities



Russell L. Travis, MD

One of the most important roles played by The American Association of Neurological Surgeons (AANS) is that of spokes-organization for organized neurosurgery. In that capacity we seek to collaborate with, learn from and educate our

colleagues in neurosurgery and related practice. In that regard, the AANS has embarked upon a more aggressive path to achieve these objectives over the past several years. We have launched several outreach programs – both in the U.S. and overseas – that I believe will have a positive impact on neurosurgical practice as a whole.

Primary Care Outreach

Changes in the political environment in the US have altered the way every neurosurgeon must market and build his or her practice. The AANS recognizes the importance of building strong referral relationships and is building a campaign to develop a consistent and vital communications flow between neurosurgery and the primary care physicians. I feel this “primary care outreach” program is one of the AANS most important projects considering the current managed care environment most of us operate our practices in.

For the past three years, the AANS and CNS have co-sponsored an exhibit at the Scientific Assembly of the American Academy of Family Physicians. The purpose of our booth is purely to educate and reinforce to family physicians the different aspects of neurosurgery and how their patients can benefit from neurosurgical treatment and consultation. This project has been extremely well received by the family physicians and we plan on expanding these efforts over the next several years. The AANS and CNS will sponsor a similar booth at the American College of Physicians –

American Society of Internal Medicine Annual Session in April, 1999, and the American College of Emergency Medicine Annual Meeting in September, 1999.

A new project developed by the **NEUROSURGERY://ON-CALL**® staff entitled “Chat with a Neurosurgeon” debuted at the AAFP meeting in September. The program involves a monthly open “chat” on our Web site and is especially designed for family physicians. More than 200 family physicians signed up to be involved in the project.

In addition, the Publications Committee has also recently released two new books designed especially for family physicians – The Guide to the Primary Care of Neurological Disorders by A. John Popp and The Treatment of Carotid Disease: A Practitioner’s Manual by Joshua Bederson. Both of these publications are designed to facilitate the diagnosis, management and referral of the neurological patient while in a primary care setting.

Another outreach tool the AANS and CNS are producing is the Getting SMART About Neurosurgery project. This is a marketing tool that is especially designed to help individual neurosurgeons forge relationships with primary care practitioners in their local communities. The first SMART project focused on lumbar spinal stenosis and was an overwhelming success. Round two focuses on cerebrovascular disease and will be released at the end of January, 1999. The neurosurgery “ambassador” package includes public education slides, a public education brochure, teaching slides designed at the primary care level, a referral booklet for primary care physicians and stroke team/stroke center development guidelines.

The AANS is also making an extensive effort to place speakers on the program of the AAFP Scientific Assembly. I have personally invited Lanny R. Copeland, MD, current President of the AAFP, to attend the scientific and board sessions of our next Annual Meeting in New Orleans. We are in the process of developing an afternoon scientific session at the New Orleans meeting specifically geared toward primary care physicians.

All of these projects help highlight the importance of a strong relationship between neurosurgery and the primary care physician, especially in a managed care market. Almost all non-trauma patients come to neurosurgeons through primary care referrals and it is essential we build a strong pathway for the flow of information and understanding about new procedures,

outcomes and patient care. I urge you all to initiate “outreach” programs within your own local area – whether it’s lecturing on new treatments in stroke care to primary care physicians, presenting new research at a local medical meeting or simply being available for a consult, these are the programs that will make a difference in the long term.

Other Medical Specialties

In our daily practices, the relationships with primary care physicians are crucial. However in the political arena, neurosurgery often finds it beneficial to align itself with other specialty groups. Almost all of the socioeconomic issues that are addressed by our Joint Washington Committee, lead by our Washington Office Director Katie Orrico, involve either outreach or collaboration with other medical specialties.

Recent projects include our leadership role in developing a specialty coalition to successfully reduce the proposed reductions in Medicare reimbursement to specialty services. Even though neurosurgery represents less than one percent of the healthcare dollars in the US, our organization spearheaded this effort and played a crucial role in bringing together other specialty groups with a common interest. We continue to work with these other specialty organizations to defend the rights of the medical specialties and are much stronger as one strong group instead of 20 individual organizations.

We also continue to work closely with the American Medical Association and American College of Surgeons on CPT coding, E/M documentation, Medicare fee schedules, graduate medical education reform and other issues facing neurosurgeons.

Our work with other organizations expands beyond public policy as we form joint projects with organizations to write practice guidelines, increase disease awareness and advocate for prevention.

International Outreach

Over the past few years medicine as a whole has taken on a more global approach. Not only can research and operative techniques be shared at the press of a button, but the flow of information and standards of care are becoming more internationally-oriented. Extensive outcomes studies and global research projects are underway and medicine promises to take on a more international flavor in the years to come as national borders become near invisible in the eyes of physicians and researchers.

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Congress Advances Managed Care Legislation; Edward R. Laws, Jr, MD, Featured at Congressional Length of Stay Press Conference

by Lori Shoaf
Senior Washington Associate



As we go to press, Congress is advancing patient protection legislation. The outcome may be determined before you receive this publication, but the Washington Office will notify neurosurgeons (via broadcast fax) of any late breaking news.

On July 24, 1998, the House of Representatives voted on two bills. In a close margin of five votes, the Democratic Patient Bill of Rights was defeated, while the Republican alternative (H.R. 4250—the Patient Protection Act) passed by six votes. The Senate has delayed action on managed care reform until September. The Democratic Patient Bill of Rights is not likely to pass, but the Senate Republican plan has a reasonable chance. If that bill is passed, the House and Senate will hold a Conference Committee to reconcile the vast differences between their respective bills. If legislation is agreed to by the Conference Committee and passed by both the House and Senate, it is unclear whether President Clinton will veto the bill. It is certain that the legislation will not include all of the patient protections sought by the Administration. President Clinton will have to decide whether to sign the bill on the premise that “something is better than nothing.”

The House and Senate Republican Patient Protection Acts includes the following provisions:

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Current Health Legislation

	HOUSE	SENATE
Access to Out-of-Network Specialists/Point of Service Option	A point of service option at the time of enrollment if the employer only offers one closed-panel HMO. Does not apply to ERISA and new Healthmart plans, and is not required if the health plan can prove that the option causes premiums to increase more than 1 percent.	A point of service at the time of enrollment if the employer only offers one closed-panel HMO. Only applies to ERISA plans and exempts businesses with 2-50 employees.
Gag Clauses	The legislation bans health plans from limiting communication between physicians and their patients regarding treatment decisions.	Same provision.
Appeals Process	The legislation requires that treatment denials be made within 30 days (10 days for urgent care and 72 hours for emergency care). Following a denial, the patient can appeal to an internal review board, but the internal reviewer is not required to be an independent physician trained in the specific medical specialty in question. Upon denial of an internal review, the patient may appeal to an external panel. The patient must pay \$25-\$100 to start the external review process, and it may last as long as 180 days.	The legislation requires that treatment denials be made within 30 days (72 hours for emergency care). Following a denial, the patient can appeal to an internal review board, but the internal reviewer is not required to be an independent physician trained in the specific medical specialty in question. Upon denial of an internal review, the patient may appeal to an external panel, but the service must be more than \$1,000.
Information Disclosure	The legislation requires plans to notify enrollees of covered and non-covered benefits, co-payment amounts and appeal rights. However, other information such as medical necessity criteria, utilization review procedures and accreditation information is required only if the patient requests that information.	The legislation requires plans to notify enrollees of covered benefits, co-payment amounts and appeal rights. It also requires that information on pre-authorization and specialist referral rules be disclosed. However, other information such as utilization review procedures and accreditation information is required only if the patient requests that information.
Coverage of Emergency Services	Covers only emergency medical screening under prudent layperson standard. Subsequent emergency medical services governed by “prudent emergency medical professional” standard.	Same provision.
Medical Malpractice Reform	The legislation creates a \$250,000 cap on non-economic damages, two-year statute of limitations, periodic payments of damages, and joint liability.	No provision.
New Health Insurance Options	The legislation includes provisions to allow Association Health Plans, Healthmarts, Community Health Centers and wider use of Medical Savings Accounts (MSAs).	The legislation includes provisions to increase the use of Medical Savings Accounts (MSAs).

Neither bill includes the following provisions advocated by the AANS and CNS:

- Prohibition on financial incentives to reduce referrals to specialists for medically necessary services.
- In-network access to all specialty care. Both the House and Senate ensure in-network access for pediatricians, OB/GYN and emergency care.

Dr. Laws Speaks Out on "Hospital Length of Stay" Legislation

On June 19, 1998, AANS Immediate Past President Edward R. Laws, Jr, MD, attended a press conference convened by Senators Dianne Feinstein (D-CA) and Alfonse D'Amato (R-NY) on S. 2315, the Hospital Length of Stay Act of 1998. The press conference was well attended and was covered by all of the major television networks. Speaking as the sole representative of organized medicine, Dr. Laws stressed the importance of this bill, which requires health plans to cover hospital stays for whatever duration is determined to be medically necessary by the attending physician, in consultation with the patient. Concern over arbitrary limits on hospital length of stay (for deliveries and mastectomies) prompted the introduction of this measure. Representatives Tom Coburn, MD, (R-OK) and Rosa DeLauro (D-CT) introduced a companion bill (H.R. 4093) in the House of Representatives. The bill prohibits health plans from requiring prior authorization for length of stay or imposing penalties for stays beyond a health plan's arbitrary limits.

Practice Expense Update

On June 5, 1998, the Health Care Financing Administration (HCFA) published the resource-based practice expense notice of proposed rulemaking (NPRM). Following a 90-day comment period, HCFA will finalize the new practice expense RVUs, which will be phased-in over a four-year period beginning on January 1, 1999.

Last year, HCFA proposed practice expense RVUs that would have reduced total neurosurgical income by 25-30 percent. This situation brought

organized medicine together to seek federal legislation aimed at preventing the implementation of this plan.

Neurosurgery was at the forefront of this successful legislative campaign, which resulted in the passage of language in the Balanced Budget Act (BBA) of 1997 that delayed the implementation of the new payment system and mandated HCFA to take an entirely new approach to devising their methodology.

Under the new proposal, HCFA predicts that overall neurosurgical incomes will be reduced by 10 percent. The cuts do not include any offsetting increases to the malpractice component of the RBRVS (past proposals have indicated that neurosurgeons' fees will increase by 5 percent when the malpractice RVUs are adjusted). By the year 2002, the total overall impact may result in a 5-7 percent decrease.

Although the AANS and CNS have made considerable progress, we still have concerns about the accuracy of the data and methodology. We are carefully evaluating the proposal and will address these issues in our comments to HCFA.

Physician Collective Bargaining—AANS and CNS Members Lead Legislative Effort

On July 20, 1998, Representative Tom Campbell (R-CA) introduced H.R. 4277, the Quality Healthcare Coalition Act of 1998. The bill provides that any group of healthcare professionals negotiating with a health insurer "shall, in connection with such negotiations, be entitled to the same treatment under the antitrust laws as that which is accorded to members of a bargaining unit unrecognized under the National Labor Relations Act." In other words, independent physicians will be able to collectively negotiate contract terms, including fees, without fearing "price fixing" penalties. The bill was introduced to help correct the imbalance of bargaining power between independent physicians and insurance companies.

The AANS and CNS strongly support the adoption of this measure and will work to move the bill in Congress. AANS and CNS members, George H. Koenig, MD, and Donald J. Prolo, MD, should be credited with getting the bill introduced. Several years ago, they met with Representative Campbell and urged him to address

this issue through federal legislation. Through the AANS, CNS and California Medical Association, they brought the issue to the AMA, where the House of Delegates unanimously supported the measure. In addition, Dr. Koenig has worked closely with AMA leadership to get the AMA to endorse the specifics of the Campbell bill.

While the bill will not go anywhere this year, on July 29, 1998, Henry Hyde (R-IL), Chairman of the House Judiciary Committee, held hearings on the legislation. The bill received considerable support by many members of the committee. Not surprisingly, the federal antitrust agencies oppose the measure, as does the health insurance industry.

Key Person Program

In our highly competitive special interest democracy, democracy only represents those who get involved. As more and more organizations vie for the attention of Congress, it is crucial that organized neurosurgery have a robust and active network of "grassroots advocates" to aid the Washington staff in their advocacy efforts. It is important for Members of Congress to realize that the messages delivered by the Washington staff genuinely represent the concerns of trusted neurosurgeon-constituents back home. Your efforts provide credibility for our message on Capitol Hill. The success of neurosurgery on various issues in Washington is directly linked to our grassroots members who contact their representatives in Washington, and our experience with the practice expense issue has demonstrated that we increase our success rate when all of our members get involved in the process.

The Washington Office recently acquired a new computer program that will enable us to communicate more efficiently and effectively on matters of federal legislation. Next year, members of the Key Person Program will receive information regarding effective communications with their Members of Congress, periodic newsletters exclusively for Key Persons and updates on issues of importance to neurosurgeons.

Get Involved

A new Congress in January presents an opportunity to improve our Key Person Program. The Washington Office will be

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Payment Delays Cause Concern Among Physicians

by Lori Shoaf
Senior Washington Associate

The growing problem of insurance companies delaying payments to physicians and hospitals is receiving attention from many state legislatures. Due to the declining reimbursement from all payers, physicians can no longer absorb the costs associated with payment delays. Many states are moving aggressively to ensure that payments are made within a reasonable timeframe. At the national level, Medicare requires clean claims to be paid within 30 days of receipt or interest (currently accrued at 6.25 percent per annum) must be paid. Medicaid has similar provisions for state plans.

Why are Payments Increasingly Delayed?

Many insurance companies blame payment delays on old computer systems or glitches resulting from new, recently installed systems. Insurance industry mergers, as well

as the growth of patients in managed care plans have compounded the problem. Increased scrutiny, including more stringent reviews of services rendered, requires claims processors to slow down turnaround times. Many physicians believe payment delays are stalling tactics designed to increase profits by allowing insurance companies to accrue interest on unpaid claims.

Highlights from the States

New York

Last year, New York passed a law mandating the payment of clean claims within 45 days of receipt. Failure to pay the claim after 45 days results in annual interest payments of 12 percent (calculated on a per diem basis). The New York action followed reports in the *New York Times* that Oxford Health Plan had failed to make payments totaling over \$200 million for at least three months. A subsequent investigation by the New York State Attorney General resulted in Oxford agreeing to pay the delinquent claims and a fine of \$3 million. New York has established a toll-free hotline (1-800-358-9260) so physicians and other providers can report payment delays.

Texas

In 1991, Texas passed a prompt payment law, which was strengthened last year. The statute calls for acknowledging receipt of a claim and requesting further

information within 15 days. Texas insurance commissioner, Elton Bomer, issued a bulletin in January warning insurers that they will be disciplined if they fail to comply with the 1997 law. This action was prompted after spot checks, in response to complaints from providers, disclosed many continued problems. The commissioner stated that "significant violations" were found and indicated that punitive actions could range from fines to loss of licensure.

New Jersey

Anger from the provider community in New Jersey resulted in an agreement between the state government and New Jersey's ten largest HMOs last year. The agreement allowed the state to promulgate regulations whereby insurers are required to reimburse physicians and hospitals within 60 days of receipt of a clean claim. Late payments result in interest payments of 10 percent per annum.

Other States

Following is a chart indicating the prompt payment laws or regulations in each state. Neurosurgeons are encouraged to contact their state health insurance regulator if they are experiencing difficulties in getting claims paid. For more information on this issue, contact Lori Shoaf at (202) 628-2072 or via e-mail at LoriShoaf@aol.com.

"PROMPT PAY" STATUTES AND REGULATIONS

State	Status of Law	State Contact Person
Alabama	Clean claims must be paid within 45 days.	Evelyn Terri (334) 206-5366 Alabama Department of Public Health
Alaska	Claims must be paid within 30 days.	Katie Campbell (907) 465-2515 Alaska Division of Insurance
Arizona	Clean claims must be paid within 30 days or interest payments required.	Patty Moore (602) 912-8444 Arizona Department of Insurance
Arkansas	Clean claims must be paid within 30 days.	John Shields (501) 371-2766 Arkansas Department of Insurance
California	Claims must be paid within 45 working days. Interest accrues at 10 percent per annum.	Steven Goby (213) 736-2510 California Department of Corporation
Colorado	Clean claims must be paid within 60 days.	Michael Gillis (303) 894-7499 Colorado Division of Insurance
Connecticut	Claims must be paid within 45 working days. Interest accrues at 15 percent per annum.	Cliff Slicer (860) 297-3900 Connecticut Department of Insurance
District of Columbia	None. Department of Insurance will investigate abusive patterns.	Carol King (202) 727-8000 (ext. 3031) District of Columbia Department of Insurance
Delaware	None. Department of Insurance will investigate abusive patterns.	Mary Ann Schillis (302) 739-4251 Delaware Department of Insurance
Florida	Clean claims must be paid within 45 days.	Barbara Cartwright (904) 922-3100 Florida Department of Insurance
Georgia	Claims must be paid within 15 days. Interest accrues at 18 percent per annum.	Yvonne Martin (404) 656-2056 Georgia Office of the Insurance Commissioner
Hawaii	None. Department of Insurance will investigate abusive patterns.	Heidi Sands (808) 536-7702 Hawaii Medical Association
Idaho	None. Department of Insurance will investigate abusive patterns.	Joan Skrosch (208) 334-4300 Idaho Department of Insurance
Illinois	None. Department of Insurance will investigate abusive patterns.	Dave Grant (217) 782-6369 Illinois Department of Insurance

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“PROMPT PAY” STATUTES AND REGULATIONS (continued)

State	Status of Law	State Contact Person
Indiana	None. Department of Insurance will investigate abusive patterns.	Cynthia Tompkin (317) 232-2385 Indiana Department of Insurance
Iowa	None. Division of Insurance will investigate abusive patterns.	Kim Sacher (515) 281-5523 Iowa Division of Insurance
Kansas	None. Department of Insurance will investigate solvency of abusive entities.	Jay Rogers (913) 296-3071 Kansas Insurance Department
Kentucky	Claims must be paid within 30 working days. Interest accrues at 12 percent per annum.	Melissa Toles (502) 564-6027 Kentucky Department of Insurance
Louisiana	Clean claims must be paid within 30 days.	Barry White (504) 342-5900 Louisiana Department of Insurance
Maine	Clean claims must be paid within 30 days. Interest accrues at 1.5 percent per month.	Rick Diamond (207) 624-8475 Maine Bureau of Insurance
Maryland	Clean claims must be paid within 30 days. Interest accrues at 1.5 percent per month.	Joyce Yensen (410) 539-0872 Medical and Chirurgical Faculty of MD, Legal Division
Massachusetts	None. Division of Insurance will investigate abusive patterns.	Walter Marcinkus (617) 521-7777 Massachusetts Division of Insurance
Michigan	None. Department of Insurance will investigate abusive patterns.	Joan Miles (517) 335-2053 Michigan Department of Insurance
Minnesota	Claims must be paid within 30 days, however, this only applies to “nonparticipating providers,” i.e.: those without managed care contracts.	Irene Goldman (612) 282-6327 Minnesota Department of Health
Mississippi	Clean claims must be paid within 45 days. Interest accrues at 1.5 percent per month.	Anne Kelly (601) 359-3569 Mississippi Department of Insurance
Missouri	Provider must be paid in a timely manner in accordance with the provider’s contract. Note: A stronger bill that requires interest payments has been introduced this session.	Thomas Holloway (573) 636-5151 Missouri State Medical Association
Montana	Claims must be paid within 30 days. Interest accrues at 18 percent per annum. An administrative fine of up to \$1,000 can be imposed for each violation.	Clyde Dailey (406) 444-2040 Montana Department of Insurance
Nebraska	None. Department of Insurance will investigate abusive patterns.	Manuel Montelongo (402) 471-4821 Nebraska Department of Insurance
Nevada	Clean claims must be paid within 30 days.	Mary Robinson (702) 687-4270 Nevada Insurance Division
New Hampshire	None. Department of Insurance will investigate abusive patterns.	Robert Warren (603) 271-2261 New Hampshire Department of Insurance
New Jersey	Clean claims must be paid within 60 days. Interest accrues at 10 percent per annum.	Ed Kalleher (609) 633-0660 New Jersey Department of Health
New Mexico	None. Department of Insurance will investigate abusive patterns.	Diana Bonal (505) 827-4561 New Mexico Department of Insurance
New York	Claims must be paid within 45 days. Interest accrues at 12 percent per annum or fines of \$500 per day.	Matt Gilbone (518) 465-8085 New York Medical Society
North Carolina	None. Department of Insurance will investigate abusive patterns.	Deanne Nelson (919) 733-7343 North Carolina Department of Insurance
North Dakota	Claims must be paid within 15 days.	Marion Price (701) 328-2440 North Dakota Department of Insurance
Ohio	None. Department of Insurance will investigate abusive patterns.	Molly Poreo (614) 644-2658 Ohio Department of Insurance
Oklahoma	Clean claims must be paid within 30 days.	Nora House (405) 271-6868 Oklahoma Department of Health
Oregon	None. Department of Insurance will investigate abusive patterns.	Fred Lindgren (503) 947-7984 Oregon Department of Insurance
Pennsylvania	Clean claims must be paid within 45 days.	Harold Smith (717) 787-6835 Pennsylvania Department of Insurance
Rhode Island	None. Department of Insurance will investigate abusive patterns.	Rollin Bartlett (401) 277-2223 Rhode Island Department of Insurance
South Carolina	None. Department of Insurance will investigate abusive patterns.	Rob Ehrlich (803) 737-6160 South Carolina Department of Insurance
South Dakota	None. Department of Insurance will investigate abusive patterns.	Randy Moses (605) 773-3563 South Dakota Department of Insurance
Tennessee	Claims must be paid within 60 days. Interest accrues at 25 percent per annum.	Martha Holland (615) 741-2199 Tennessee Department of Insurance
Texas	Claims must be paid within 45 days (HMOs only).	Paula Herwick (512) 322-4266 Texas Department of Insurance
Utah	None. Department of Insurance will investigate abusive patterns.	Karen McKinley (801) 538-3800 Utah Department of Insurance
Vermont	Clean claims must be paid within 45 days.	Brendan Hogan (802) 828-3301 Vermont Department of Insurance
Virginia	Clean claims must be paid within 60 days. Interest accrues at 8 percent per annum.	Arlen Bolstad (804) 786-3591 Virginia Legislative Services
Washington	None.	Michael Huske (360) 753-7300 Washington Insurance Commissioner
West Virginia	None. Division of Insurance will investigate abusive patterns.	Robert Cadle (304) 558-100 West Virginia Division of Insurance
Wisconsin	Claims must be paid within 30 days. Interest accrues at 1 percent per month on unpaid balance.	David Cauffman (608) 266-3585 Wisconsin Department of Insurance
Wyoming	Claims must be paid within 45 days. Penalties and fines may accrue.	Lloyd Wilder (307) 777-7401 Wyoming Department of Insurance

Update on the Resource-Based Practice Expense Project

by Robert E. Florin, MD
Chairman, Physician
Reimbursement Committee

The project launched by the Health Care Financing Administration (HCFA) to convert the practice expense portion of the Medicare Fee Schedule (MFS) from a charge-based system to a resource-based methodology, has entered its second iteration.

First System Fails

The initial system proposed by HCFA in 1997 was a contrived collection of the estimated time and cost of non-physician labor, supplies and equipment consumed in the course of providing specific services and procedures. This methodology was supposed to take effect in January 1998, but collapsed when it became clear there would not be a large enough sample of respondents.

HCFA then focused on collecting data from panels of physicians, allied health professionals and administrators, in an effort to price the direct expenses of each procedure code at the CPT level. This data was used to match similar services provided by different specialties, and to determine the redistribution of practice expense payments to primary care providers. The calculated impact of this method on practice expense payments for neurosurgery would have caused a 25-30 percent decrease.

A coalition of specialties, including neurosurgery, similarly impacted by this proposed change was organized, and with substantial funding from the component specialty societies, began a campaign that eventually led to the Balanced Budget Act (BBA) of 1997. In the BBA, Congress required HCFA to use data on actual expenses rather than estimates; to use generally accepted accounting methods of allocating the expenses; and to consult with physician organizations in the development of a new methodology. To

make sure that HCFA obeyed, the BBA required the general accounting office to oversee the process.

Second Effort Better

The second method for assigning practice expenses to the procedure codes was published in June 1998, and has adhered to the requirements of the BBA. It uses data on actual costs by specialty, and attempts to allocate those dollars to the procedure codes by using a composite allocation methodology that, although complex, is about as good as we could expect for the first round of this complicated project. There are a substantial number of soft spots in the data HCFA has used, but they have already agreed to an ongoing process of refinement, which will enable the specialties to contribute their input for improving the quality of data over the next several years.

The impact of this version is notably better than the first model — with a 10 percent reduction in expense payments for all neurosurgical services by the end of the transition period in 2002. However, a number of our high volume procedures, such as lumbar laminectomy codes, will suffer greater reductions due to the extra cut in their practice expense relative value units, combined with the change to a single conversion factor that were imposed for the 1998 fee schedule. When these are added to the cuts in the above method, the drop in payments will be about 25 percent for these codes.

Data Problems

Our comments and complaints about the proposed rule have recently been filed with HCFA. The problems with data quality and possible data manipulation have been detailed, and efforts to moderate the negative impact will continue.

For example, the data we have received from practices that have returned the survey of neurosurgery practice expenses have been extremely useful. They have demonstrated that our actual expenses exceed the amount HCFA used in calculating our total pool of practice expenses by more than \$60,000 per neurosurgeon, per year. They also helped our argument that neurosurgeons are using their clinical staff outside of the office with increasing frequency, which demonstrates that the costs of such labor should be reimbursed rather than designated as a Part A Medicare expense paid by the hospital.

Survey will Continue

We plan to continue our survey because this is a data-driven game, and the players with good data generally prevail. At present, we have more than 100 neurosurgeons from nearly 30 practices in the database. Our goal is to have at least 250 neurosurgeons. This sampling should accurately reflect the spectrum of practice size, location and organization.

In this context, we will be able to use the data when we approach HCFA. In addition, this data will provide useful cost management information to our members as part of our Cost Containment Initiative.

For more information on Washington affairs, contact:

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Congress Advances (continued from page 4)

sending a short survey to the membership following the November elections. Please take a few moments to complete and return the survey.

You are our most important assets on Capitol Hill! If you have a special relationship with a member of Congress, or if you are willing to develop such a relationship, please watch for further information on how you can become involved in this effort.



The Long and Twisted Road to FDA Reclassification: The Pedicle Screw Finally Receives Approval—Litigation Drags On

No medical device or surgical procedure is free of risk. But the pedicle screw's path to approval by the U.S. Food and Drug Administration (FDA) was surely one that required stamina, determination and patience for everyone involved. Its tortured regulatory history is held up as proof by both its supporters and detractors that the FDA needs to change the way it regulates medical devices.

Capping a three-year process, the FDA formally reclassified pedicle screw spinal systems to Class II from Class III for certain indications. The final rule, published in the July 27, 1998 issue of the *Federal Register*, states that sufficient information exists to demonstrate the safety and effectiveness of pedicle screw spinal systems, intended to provide immobilization and stabilization of spinal systems in skeletally mature patients as an adjunct to fusion in the treatment of the following acute and chronic instabilities or deformities of the thoracic, lumbar and sacral spine: degenerative spondylolisthesis with objective evidence of neurologic impairment, fracture, dislocation, scoliosis, kyphosis, spinal tumor and failed previous fusion (pseudoarthrosis).

The reclassification, however, does not include spinal systems intended for use in the cervical spine or in pediatric populations.

Historical Perspective

The FDA's mission is to ensure the safety and efficacy of products it approves to be marketed in the United States, including all devices used in spinal surgery. The AANS fully supports this mission and has worked for many years in conjunction with the FDA, major spine societies, and medical device manufacturers to clarify standards for pedicle screws and other spinal-surgery devices.

The bone screw itself is a long-established, safe, and reliable medical device for use in many parts of the body, including the spine. The FDA approved the use of bone screws for general

surgery – such as arm and leg operations – in 1985.

Pedicle screw fixation systems were developed in the 1960s by Canadian, American, and French surgeons who understood that, when operating from the back of the spine, the strongest fixation site on the vertebral bodies are through the pedicles. These surgeons found that pedicle screw fixation permitted greater correction of deformity and more rigid fixation than wires or hooks. Also important, the screw fixation spared adjacent health vertebrae that might otherwise become fused and further limit the patient's flexibility.

Historically, the FDA has acknowledged that good medical practice requires physicians to use both devices and drugs in new ways ("off-label" uses) that the federal regulators did not initially envision. The FDA has respected the medical professional's autonomy and expertise in determining the best treatment options for patients.

Despite the FDA's viewpoint, the road to reclassification of the pedicle screw has been long and complex. It began on August 11, 1993, when the FDA sent letters to six manufacturers stating that they could not *advertise or promote* the use of bone screws as pedicle screws. The FDA *did not* ask the companies to stop manufacturing the screws, nor did it prohibit the use of them; it only stopped the *promotion* of them. According to a FDA representative, the use of bone screws in the pedicle represented a good method of enhancing spine fusions. But it didn't have a sufficient number of patient reports in its files to authorize the *advertisement* of the screws for use in the spine.

So, the FDA approached a group of spine-related specialty societies and asked them for assistance in developing a research study that would correct this deficiency.

Such a study would help determine whether there was sufficient clinical data regarding the use of bone screws in the pedicles of the spine to warrant reclassification of the device to Class II – the regulatory

classification currently applied to all other bone screws, and most other spinal fixation devices. Such classification would eventually allow these devices to be labeled and marketed for use in the pedicles. Also, it would allow timely regulatory clearances for a surgical method that had become, over the past several years, the standard of care in treating some patients with spinal disorders.

The study, called the "Historical Cohort Study of Pedicle Screw Fixation in Thoracic, Lumbar and Sacral Fusions" was organized by a Scientific Committee composed of spinal surgeons representing each of the six principal medical societies concerned with the spine: The American Association of Neurological Surgeons, the American Academy of Orthopedic Surgeons, the Scoliosis Research Society, the Congress of Neurological Surgeons, North American Spine Society, and the Scoliosis Research Society. The Spinal Implant Manufacturers Group, consisting of some 14 companies, agreed to underwrite the cost of the study.

The AANS was supportive of the study and encouraged neurosurgeons to participate. Applications to participate in the study were distributed to the membership via the *Bulletin*. "The FDA has offered surgeons who use pedicle screws an opportunity to assume responsibility for determining safety and efficacy for a defined and limited study population," *Bulletin* readers were told. "If it is possible to acquire enough patients to analyze the information, the FDA may have no alternative but to stop the production and dissemination of pedicle screws. When the formal call goes out to surgeons who have used pedicle screws for spinal stabilization, you are urged to respond. Our combined participation is essential to the success of this study, and to the use of this cooperative approach for the resolution of similar problems in the future." The participating surgeons were assured by the FDA of the confidentiality of their reports, in order to encourage fair reporting of both good and bad results.

The study got underway in late 1993 and was completed in 1994. It reported on results from 314 surgeons who treated 3,498 patients. Approximately 87 percent of the surgeons participating in the study were orthopedic surgeons and 12 percent were neurological surgeons.

The Scientific Committee's principal conclusion based on the study's data was that pedicle screw fixation is as safe and effective as other means of achieving spinal fusion, both instrumented and non-instrumented, and that in some respects the results achieved with pedicle screws were clearly superior.

One of the Cohort Study's most compelling findings was that patients whose treatment for degenerative spondylolisthesis included pedicle screws achieved successful fusion at a rate of 90 percent. That is a superior result compared to the 70 percent of patients in the control group, who achieved fusion but did not receive implants. With regard to spinal fractures, pedicle screws were shown to offer comparable safety and efficacy compared to surgical treatments using other internal fixation devices.

Based on these findings, and after an in-depth review and meta-analysis of the literature, the FDA Advisory Panel on Orthopedic and Rehabilitative Devices subsequently recommended that the pedicle screw be reclassified from its existing Class III designation to Class II. However, no action was forthcoming.

Spine surgeons were left with a widening gap between the state of medical science regarding the use of pedicle screws and the FDA's approval of the promotion of those devices.

Litigation Filed

Casting a dark shadow over the reclassification process was a new threat arising in the courts. In December 1993, the ABC Network television show "20/20" broadcasted a segment that was highly critical of pedicle screws.

Following the "20/20" broadcast, thousands of lawsuits were filed across the country, almost all of which closely followed a format designed by the plaintiff's lawyers in New Orleans, Louisiana, and Philadelphia, Pennsylvania. The plaintiffs alleged that the devices were inherently defective and that the use of what they described as "unapproved" devices was experimental and,

therefore, malpractice. Not only were individual spine surgeons named as defendants, seven pedicle screw manufacturers and numerous distributors and hospitals were named, as well.

As a result of those filings, the Federal Courts formally designated the case as "multi-district litigation," and assigned them all to Judge Louis Bechtel in Philadelphia for discovery and pre-trial handling. Judge Bechtel designated the lead plaintiff's counsel as the Plaintiffs Legal Committee (PLC), with the responsibility for managing the prosecution of the cases, but denied the PLC's motion to have the cases combined and certified as a Class II.

According to the PLC, the industry had subverted the FDA's rules by using the physicians to help sell the pedicle screw and, in the process, patients were used as guinea pigs for an untested treatment.

As part of the discovery process for the litigation, plaintiffs' attorneys attempted to obtain the names of the physicians and patients who had participated in the Cohort Study. Confidentiality is a key component of most research protocols, and patients and physicians participating in the

Cohort Study were given that assurance of confidentiality as an inducement for their involvement and their reporting of all case results, both good and bad. The AANS had encouraged neurosurgeons to be part of the study believing their participation would be confidential.

Concerned about the potential chilling effect that the release of such information might have on future research, the AANS joined two other specialty societies – the American Academy of Orthopedic Surgeons and the North American Spine Society – in filing a successful "Motion to Intervene" to protect the confidentiality of this information.

The motion was granted, but within a matter of weeks, the AANS, CNS and the other associations were named as defendants. The PLC alleged that the associations had acted as "promotional centers" for the pedicle screw, engaged in "reckless, outrageous and wanton" promotion of hazardous spinal fixation devices, and "conspired with manufacturers for the illegal sale of dangerous medical devices." The groups all strongly denied the charges.

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WHAT DO THE FDA CLASSIFICATIONS MEAN

Class I – General Controls. Means the device is used in a simple, low-risk way, for which safety and effectiveness are relatively easy to determine. FDA pre-market approval and/or performance standards are not necessary. Crutches, canes and wheelchairs are Class I devices.

Class II – Performance Standards. Means that the FDA has enough information about a device, such as a bone screw and plate, to establish a performance standard, but not enough information to establish general controls to assure safety and effectiveness. Examples of Class II devices include intramedullary nails, bone screws and plates when used for long bone fractures, and cemented hip replacements.

When the pedicle screw was reclassified to this level it became clinically approved for use in fusions in the treatment of instabilities and deformities in the spine, including fractures dislocations, spondylolisthesis, scoliosis, kyphosis and spinal tumors. The FDA's reclassification simply provided regulatory clearance to sell and advertise these screws as the standard of care in treating selected patients with these kinds of disorders.

Class III – Pre-market Approval. Means that existing information is insufficient for establishing general controls and performance standards that could assure the safety and effectiveness of a device. Class III devices are generally considered investigational but also include new applications of an existing device that pose a potential risk. In short, more research is needed to determine when, where, and how the device should be used.

Initially, the bone screw was placed in this category, which allowed for its use, by a physician in any bone in the body to help the patient. However, it was not approved for use in any specific bone and a manufacture was barred from advertising the screw for use in the pedicle.

Pedicle Screw

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Impact on Education and Patient Care

As educational and professional organizations, the medical societies were put in the unfortunate position of not being able to provide forums in which surgeons could openly discuss research and clinical issues relating to pedicle screw, or demonstrate newly-developed techniques for pedicle screw implantation for fear of being sued.

The greater concern, however, was that the controversy surrounding pedicle screw was discouraging surgeons from recommending these devices when they were appropriate and that patients were not receiving appropriate treatment. In fact, according to an article published in the *Journal of Spinal Disorders*, (Vol. 8, No. 5), the process had a truly chilling effect upon a practice in Chicago during 1995. "It places a state-of-the art medical procedure under attack," wrote the authors, "thereby affecting patient care in two ways. First, patient confusion has been fostered in terms of what the role of the FDA is in their care. This has resulted in some patients refusing an instrumented procedure and opting for a sub-optimal procedure. There also has been an overall increased anxiety in patients. Second, all 11 lawsuits (filed in Illinois at the time) have identical allegations relying on the FDA issues."

The authors further noted that "two major Chicago-area hospitals have discontinued the use of these devices until reviewed by their Institutional Review Board. This review process is estimated to take approximately three months. Until this process has been completed, the community is unable to receive this state-of-the-art level of care."

Media Coverage

Early on, the national media began covering the lawsuit and the FDA Cohort Study. To assure that media reports present a balanced view of the related issues, the AANS prepared background information on pedicle screw for reporters and appointed Stewart Dunsker, MD, current AANS Vice President and founding member of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves, as the official spokesperson on the pedicle screw issue. He

also led the neurosurgical team supporting the FDA's retrospective study on the use of the pedicle screw.

The Association's key communication points were:

- The pedicle screw has proven to be a successful option for spine stabilization for specific types of conditions and has been a valuable tool for spine stabilization. When properly used, pedicle screws provide the same safety and efficacy as comparable internal fixation devices used to stabilize spine fractures. More than 300,000 patients have been treated with pedicle screw implants. Only 2,100 have participated in the related litigation, and the number of actual failures of the device, at most, is substantially less than 1 percent.
- When properly performed by qualified surgeons on appropriately selected patients, implantation of the pedicle screw is the best treatment for some spinal conditions. The Association was deeply concerned that the litigation and surrounding publicity has discouraged surgeons from recommending this procedure, and could prevent a growing number of patients from receiving the appropriate and proven treatment they need.

In a letter to the editor responding to an editorial about the litigation published in the *Wall Street Journal*, the AANS and CNS described the "guerilla litigation" and noted, "As surgeons specializing in spine care, we fear that the current controversy surrounding pedicle screws has begun to discourage surgeons from recommending these devices when they are appropriate and that a growing number of patients are not receiving this treatment as they should . . . The pedicle screw has become the standard of care for treatment of specific types of spinal conditions, promoting healing and liberating back-surgery patients from wearing uncomfortable body casts, often for months at a time. In some cases, it is the only fixation device that can be implanted to help the patient."

Reclassification Back on the Front Burner

In the midst of this turmoil, the FDA, once again, raised the prospect of reclassifying the pedicle screw. On October 5, 1995, it issued a formal call for public comments

regarding this action. The FDA believed that there was sufficient data available to take this step and that establishment of special controls would provide reasonable assurance of the safety and effectiveness of these implants.

The AANS, on behalf of its membership, responded to the FDA's call for comments and, in a letter to D. Bruce Burling, Director of the FDA's Center for Devices and Radiological Health, and 1995-96 AANS President Sidney Tolchin, MD, stated that the Association supported:

1. The proposal of the FDA and the findings of the Orthopedic and Rehabilitation Devices Panel to reclassify certain pedicle screw systems to Class II;
2. The proposal of the FDA to expand the uses of the device identified by the Panel to include pedicle screw spinal systems intended to provide immobilization and stabilization of spinal segments as an adjunct to fusion in the treatment of acute and chronic instabilities and deformities, including spondylolisthesis, fractures and dislocation, scoliosis, kyphosis and spinal tumors.
3. The proposal of the FDA to establish one regulation for the pre-amendments and post-amendments device.

In its response, the Association also urged the FDA to encourage further outcome studies to determine full efficacy of the devices and patient selection criteria.

The agency established a 180-day period for public comments, after which it would publish a final regulation to reclassify the devices. Unfortunately, that did not happen.

By May 1997, frustrated by the FDA's reluctance or unwillingness to finalize the proposed reclassification of pedicle screw systems, the AANS, acting through then-President Edward R. Laws, Jr., MD, filed a Citizen's Petition with the FDA requesting that the reclassification be made final. Under the FDA's regulations, the agency was required to respond to Dr. Laws' Petition within 180 days. When it failed to do so, the AANS followed up with repeated demands that the FDA follow its own regulations and finalize the reclassification.

Though the medical associations were taking an aggressive stance in fighting the litigation, at least one of the device

manufacturers decided to settle out of court. On October 17, 1997, over the objections of Sofamor-Danek and a number of other plaintiffs, Judge Bechtel approved a settlement by AcroMed in the amount of \$100 million. The objecting plaintiffs complained that they would be forced to unfairly accept small compensation for their injuries under the AcroMed settlement. Those plaintiffs, as well as Sofamor-Danek, appealed Judge Bechtel's approval of the AcroMed settlement to the Third Circuit Court. Final approval was put off until the spring of 1998.

Finally, Reclassification

On July 27, 1998, the FDA finally took action. When all the data was viewed in conjunction with the medical literature and the MDR and FDA's MedWatch surveillance data, no new issues relating to the safety or effectiveness of pedicle screw spinal systems were raised. Therefore, the agency had concluded that the data provided valid scientific evidence that certain special controls, in conjunction with the general controls applicable to all devices, would

provide a reasonable assurance of the safety and effectiveness of pedicle screw spinal systems for L5–S1 use, and for use at other levels for the treatment of degenerative spondylolisthesis with objective evidence of neurologic impairment.

The ruling supported the use of pedicle screw spinal systems when intended to provide immobilization and stabilization of spinal segments in skeletally mature patients as an adjunct to fusion for the treatment of the following acute and chronic instabilities or deformities of the thoracic, lumbar and sacral spine: degenerative spondylolisthesis with objective evidence of neurologic impairment, fractures, dislocations, scoliosis, kyphosis, spinal tumors, and failed previous fusion (pseudarthrosis).

The classification and reclassification does not carry over to pedicle screw spinal systems intended for use in the cervical spine, which are considered post-amendments Class III devices for which premarket approval is required. In addition, all valid scientific evidence reviewed by the panel and FDA were obtained from skeletally mature populations. To date, the safety and effectiveness of pedicle screw spinal systems in pediatric populations are post-amendments Class III devices for which premarket approval is required.

Under the reclassification, pedicle screw spinal systems must comply with the following special controls:

- 1) Compliance with material standards;
- 2) Compliance with mechanical testing standards;
- 3) Compliance with biocompatibility standards; and
- 4) Labeling which contains the following two statements in addition to other appropriate labeling information:

“Warning: The safety and effectiveness of pedicle screw spinal systems have been established only for spinal conditions with significant mechanical instability or deformity requiring fusion with instrumentation. These conditions are significant mechanical instability or deformity of the thoracic, lumbar, and sacral spine secondary to degenerative spondylolisthesis with objective evidence of neurologic impairment, fracture, dislocation, scoliosis, kyphosis, spinal tumor, and failed previous fusion (pseudarthrosis). The safety and effectiveness of these devices for any other

conditions are unknown.”

Precaution: The implantation of pedicle screw spinal systems should be performed only by experienced spinal surgeons with specific training in the use of this pedicle screw spinal system because this is a technically demanding procedure presenting a risk of serious injury to the patient.”

According to AANS President Russell L. Travis, MD, “The reclassification was a direct result of the Association's insistence that the reclassification be made final. I want to thank Dr. Laws, in particular, for keeping this issue front and center with the FDA. Without his persistence we might still be waiting for the FDA to act.”

AANS Dismissed from Litigation

On the heels of reclassification, things also began to move along with the Multi-District Litigation in Philadelphia. Presiding Judge Louis Bechtel granted the Defendant Associations' Motions to dismiss many of the elements of the Plaintiffs' initial claims. Early in 1998, he had begun remanding the cases back to the District Courts in which they had been originally filed, for ultimate resolution or trial. Then, working in conjunction with the other medical association defendants, the AANS filed Motions for Summary Judgment in many of those cases, which resulted in five decisions being entered—dismissing all claims against the association defendants.

In August, after the entry of those five decisions, and as a result of related negotiations, the Plaintiffs' attorneys agreed to dismiss the AANS and the other associations from all the remaining pedicle screw suits. The litigation will continue against the device manufacturers and implanting surgeons who are charged with individual malpractice.

In addition, the PLC is appealing some of Judge Bechtel's earlier rulings dismissing various aspects of the litigation. Those appeals, however, should not directly affect the AANS.

New Action

Despite the reclassification of the pedicle screw, and the release of the Medical Association defendants from the three-year litigation, the Plaintiff's Legal Committee

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HIGHLIGHTS OF PEDICLE SCREW RECLASSIFICATION

- Pedicle screw has been reclassified by the FDA from a Class III to a Class II device.
- Pedicle screw is now clinically APPROVED for use as an adjunct to fusion in the treatment of:
 - Acute and chronic instabilities or deformities of the thoracic, lumbar, and sacral spine
 - Fractures
 - Dislocation
 - Degenerative spondylolisthesis with objective evidence of neurologic impairment
 - Scoliosis
 - Kyphosis
 - Spinal tumors
 - Failed previous fusion (pseudarthrosis)
- Pedicle screw is NOT APPROVED for use:
 - In the cervical spine
 - In pediatric populations



Bush Invited to Deliver Cushing Oration

The forty-first president of the United States, George Herbert Walker Bush, has been invited to serve as the 1999 Cushing Orator. The Oration will be delivered at the AANS Annual Meeting in New Orleans, Louisiana, on Tuesday, April 27, from 11:30 AM–12:15 PM.

For more than 30 years, the AANS has sponsored the Annual Cushing Oration, named for Harvey Cushing, MD, universally recognized as the Father of Modern Neurosurgery. Former Cushing Orators include H. Ross Perot, General Colin Powell, Wernher von Braun, and former president Jimmy Carter.

Mr. Bush, a decorated World War II naval pilot, graduated Phi Beta Kappa from Yale University in 1948 with a bachelor's degree in economics. Following his graduation, he moved to Texas where he began making his way in the oil business.

He emerged into the political arena in 1963 and, after losing his first campaign for the U.S. Senate in 1964, was elected to the U.S. House of Representatives from Texas' 7th District in 1966. One of the few freshman members of Congress ever elected to serve on the Ways and Means Committee, Mr. Bush was reelected to the House two years later without opposition.

Following a second unsuccessful try for the Senate in 1970, Mr. Bush accepted a number of important leadership positions, including U.S. Ambassador to the United Nations (1971); Chairman of the Republican National Committee (1973); and Chief of the U.S. Liaison Office in China (1974). Mr. Bush also served as Director of Central Intelligence (1976), and, in that capacity, strengthened the intelligence community and helped restore morale at the CIA.

In 1980, Mr. Bush lost his bid for the Republican presidential nomination to Ronald Reagan, but later accepted a spot on the national ticket and served as vice president of the United States from 1981-1989. Bringing foreign policy experience to his role, Mr. Bush coordinated his



President George Bush

administrative efforts to combat international terrorism and declare the international war on drugs. He also piloted a task force on regulatory relief aimed at increasing American competitiveness.

A leader in the political arena, Mr. Bush became the Republican Party's nominee for president and the American people's choice in 1988, winning 40 of the 50 states. In addition, he became the first sitting vice president to ascend to the presidency since Martin van Buren in 1837, and only the second president to serve a full term without Republican Party control in either chamber of Congress.

During his term in Office, Mr. Bush's leadership proved invaluable to the resolution of some of the most troubling crises of the century: Freedom prevailed in

the Cold War; the Berlin Wall fell; Germany reunified; historic arms treaties took place with Russia; and a 30-nation coalition was created to oppose Iraq's invasion of Kuwait—paving the way for Israel and her Arab neighbors to begin their quest for peace in the Middle East. Reflecting on the war in a recent television interview, Bush said, "We formed a historic coalition that made possible worldwide support for a moral end. More important, we gave peace a chance."

His administration pushed new ideas for educational reform, home ownership and environmental protection. Under his leadership, Mr. Bush successfully fought for and signed into law, among other things, the Americans with Disabilities Act and the Clean Air Act — landmark civil rights and environmental legislation. Speaking about these laws, Mr. Bush said, "These were major steps forward that required tremendous compromise with the Congress to get things done."

Since leaving office in 1992, Mr. Bush has served as Chairman of the Eisenhower Exchange Fellowship, as Honorary Chairman of the Points of Light Foundation, and as a member of the Board of Visitors at the MD Anderson Cancer Center in Houston, Texas. In addition, he and his wife, Barbara, have helped support more than 150 charitable organizations in their community and around the country.

The AANS invites you to help welcome George Bush to the 1999 Annual Meeting in New Orleans.

**Registration materials for the
1999 AANS Annual Meeting
will be mailed in February.**

Reflections From the New Editor of the *Bulletin*



A. John Popp, MD

The New Look of the *Bulletin*

As the recently appointed editor of the AANS *Bulletin*, I call to your attention to the changes made to the *Bulletin* over the past year. The new cover design heralds the evolution of permanent features within. The inside

layout includes an in-depth cover article, the president's message, the managed care update, this Op/Ed column and more. Other improvements are on the way as associate editor Jim Bean and I work with the staff at the AANS National Office to help the *Bulletin* evolve to effectively meet the changing needs of the AANS membership. We welcome your input on the changes to the *Bulletin* you will be seeing over the next few months and any ideas you might have about topics suitable for your membership publication.

Volunteerism – The Heart of an Organization

I have always felt that being a doctor, and especially a neurosurgeon, is more than a job. Neurosurgery is our craft, our life's work, and our passion. As a member of the neurosurgical community, I have been privileged to work with others who demonstrate daily great talent and professionalism. However, as a volunteer of the AANS, my life has been immeasurably enriched by the opportunity to contribute further to my profession, my colleagues, and my patients.

When I was asked to take on the responsibility of editor of the *Bulletin* last April, I accepted enthusiastically. Like most busy neurosurgeons, the idea of added responsibilities was not something I relished, however, I recognize the impor-

tance of volunteerism to the success of any organization, and remembered, with great respect, the vitality and involvement of other AANS volunteers. The efforts of the AANS volunteers in the pedicle screw litigation (see feature article on page 10); the Outcomes Committee; the Washington Committee; and numerous other AANS and CNS committees and task forces that showcase our member's talents and leadership skills leave me both motivated and challenged.

We often cannot define why a person volunteers, perhaps it is to promote ideals, return something to society, or simply to help others. We, as physicians, can serve a larger constituency than the patients we care for. As volunteers we can become involved in organizational activities that call on our expertise as professionals, business and community leaders. It is vital that we, as neurosurgeons, realize the importance of volunteering our time and efforts to support our medical community and our specialty.

The next time you walk through an Annual Meeting, stop and think of the thousands of volunteer hours that went into arranging the Scientific Program, the practical courses, the seminars, and the social events. The next time you read about what is happening in Washington, stop and think about the 12 neurosurgeons who spend a weekend in Washington every quarter volunteering for neurosurgery to make our collective voice heard by the policy makers. The next time you read the *Journal of Neurosurgery* consider all the hours of volunteer peer review that went into each article.

One only needs to consider the efforts of AANS presidents, Sid Tolchin, Chuck Rich, Ed Laws, and Russell Travis, during my term on the AANS Board. Each devoted countless hours before, during and after their presidency in the service of American Neurosurgery. Multiply these commitments of a few, by others who provide volunteer services regularly to their specialty, and one begins to understand the importance of these efforts.

From my personal perspective, participation by neurosurgeons in volunteer activities is essential for the well being of our specialty. We all can make our contribution for the greater good of neurosurgery in some way beyond that which we accomplish in our daily practice of neurosurgery, whether in our local or state societies, the Council of State

Neurological Society, or the AANS/CNS. Moreover, we should encourage our residents and young colleagues that volunteerism is an important part of the neurosurgeon's credo.

As a small specialty representing less than one percent of physicians in practice, Neurosurgery yields much greater clout than one would anticipate by our size. Much of this clout has come by the efforts of neurosurgeons through the years both in the clinical arena and in conclaves where medical policies are formulated. This trend, elemental to the survival of Neurosurgery, cannot be sustained effectively by a few committed volunteers but requires the efforts of many.

The AANS National Office

I was always intrigued by the men and women at the AANS Annual Meeting sprinting down the convention center halls in business suits complimented by a sturdy pair of Nike tennis shoes and staff badges bobbing around their necks. What could possibly necessitate such haste and determination?

Then I became acquainted with the vital role the staff at the AANS National Office plays in the success of the organization. While the efforts of our volunteers are essential to the success of Neurosurgery, the group of individuals who work full-time for the AANS are a key element in the Neurosurgical family.

I have observed that the staff at the National Office in Park Ridge is superb and know their job well. They meet deadlines and carry out the directives of the Board with a sureness of purpose and great professionalism. The National Office, for those who have not been there, also serves as a resource for the AANS membership. The magnitude of that role is exemplified by the fact that the AANS switchboard fields approximately 2,000 phone calls per week.

This special group of people is invaluable in keeping the organization on track and the work flowing. After having the experience of working with key individuals in the National Office over the past few years, I now clear a pathway, out of deference, whenever I see navy suits, bobby socks and gym shoes heading toward me during an Annual Meeting.

MANAGED CARE update

PSO vs. HMO: A Heads Up for Neurosurgeons



By John A. Kusske, MD

Be careful what you ask for, you just might get it. Congress, in the passage of the Balanced Budget Act of 1997 (BBA), gave providers exactly what they wanted — a federal “license” to enroll Medicare eligibles and assume risk for their total care, pocketing the entire Medicare premium.

Now, many hospitals and medical groups are considering whether they should become licensed provider-sponsored organizations (PSOs) in the next three years and compete with local health plans, the usual source of most of their customers. The BBA created a new Part C program of Title XVIII of the Social Security Act called the Medicare + Choice (M + C) program (often referred to as the PSO legislation).

Backlashing against managed care, providers lobbied long and hard to regain some of the clout they had in the past. The intent of the legislation was to offer Medicare beneficiaries a plethora of managed health plan options to complement the original Medicare option and, by doing so, move more Medicare beneficiaries into managed care.

PSOs are a direct contracting opportunity for providers targeting the senior population. The Health Care Financing Administration (HCFA) has completed interim final regulations for the M + C program and began accepting PSO applications August 1, 1998, with the first PSOs authorized to enter the Medicare-risk market on January 1, 1999. How can providers pass this up?

The PSO Quandary

The dilemma for providers posed by PSOs, however, is more complicated than whether or not the PSO will be profitable. According to Russell C. Coile, writing in the *Healthcare Strategist*, the question is: If

providers build managed care plans for the Medicare-risk market, will they be different than the commercial HMOs that doctors and hospitals have so often criticized? Or, as he said, “Is becoming an insurance company part of your strategic plan?” The PSO establishes a direct contractual link with purchasers, in this case HCFA, and eliminates the HMO or insurance company. PSOs enable providers to go directly to their market and sign up seniors just as if the PSO were a certified Medicare HMO.

It must be understood, up front, that PSOs will be heavily regulated. Any organization attempting to form a PSO must be ready to endure regulation. The major provisions of a PSO are: Eligibility, licensure, solvency, operational and quality standards, payment, enrollment, certification, and compliance. Many integrated systems have been developing the above competencies in order to manage global capitation. However, as reported in *Integrated Healthcare Report*, it is a giant step from managing global capitation to running a PSO, which, in reality, is the same as operating an HMO.

HCFA will focus on compliance in the following areas of the M + C programs: Fiscal solvency; information systems; network adequacy; access to care; appeals and grievances; governance; management; and accountability.

Benefits of PSOs

The advantages, according to Coile, for providers to form PSOs include: 1) receive 100 percent of the federal Medicare premium; 2) make all decisions about patient care with no third party authorization; 3) control the range of services, settings and alternatives; 4) measure their own performance; 5) manage their own administrative expenses; 6) determine the “medical loss ratio”; 7) be patient friendly; 8) manage and monitor their own clinical outcomes; 9) create their own risk pools and incentive arrangements; and 10) keep the savings that result from achieving clinical or administrative efficiencies.

Coile further points out that most hospitals and health systems have been pursuing strategies to become integrated delivery systems (IDS) for several years. More than 70 percent of all hospitals are now part of geographically dispersed networks. They’re building physician organizations and they have established infrastructures for managing risk. Coile

raises the question: If providers are not going to assume risk and try to control the premium, why are they investing in IDS development?

PSOs should be a dream come true. However, many hospitals, health systems and large medical groups are reluctant to form PSOs, waiting to see how other PSOs evolve. Providers have a limited history of assuming risk and some provider-sponsored HMO organizations have experienced major losses.

Financial losses are only one of the potential hazards for providers directly engaging in Medicare-risk arrangements. Others, according to Coile, include: 1) retaliation against providers from competing Medicare-risk health plans; 2) consumer backlash that providers are operating care-denying plans; 3) community concern that hospitals may risk their financial reserves in PSO ventures; 4) regulatory compliance with state insurance/HMO regulations; 5) legal and malpractice risk of becoming a care-authorizing entity; 6) information systems’ capital investments may be substantially higher for a PSO; 7) provider backlash if provider-sponsored organization denies treatment requests; and 8) physician relations could deteriorate if PSOs are inaccurate with medical claim payments.

PSOs and Patient-Friendly Services

When Congress created PSOs, it offered the provider community an opportunity to level the playing field with insurers and HMOs. It also gave provider-sponsored organizations an opportunity to reinvent managed care. After years of complaining by doctors and hospitals about HMO practices, the PSO model may offer a more patient-friendly process. However, PSOs might disappoint some consumers by not differentiating themselves from competitive health plans.

PSOs must demonstrate that they value health care consumers and manage risk, not avoid it. Moreover, they must promote health care and demonstrate a new level of community responsibility by addressing unmet health needs. A tall order, indeed.

Luddites, Lemmings and Outcomes Studies

by Robert E. Harbaugh, MD,
FACS

In the early part of the 19th century, English craftsmen feared that their jobs would be lost to machines that were being used to manufacture textiles. Some of the workers who advocated destruction of the hated machines organized themselves into bands and swore their loyalty to King Ludd, probably a mythical figure. These followers of King Ludd came to be known as the Luddites. Although they proposed the destruction of property, Luddites rejected violence against people and enjoyed considerable support in their communities. Starting in Nottingham in 1811, the followers of King Ludd, usually masked and working at night, began rioting and dismantling establishments that were using new technology. The Luddite movement rapidly spread to Yorkshire, Lancashire, Derbyshire and Leicestershire. In 1812, a band of Luddites threatened the property of an employer named Horsfall who, in turn, had them shot. Horsfall was later killed in reprisal and the government of Robert Banks Jenkinson, second Earl of Liverpool, decided that enough was enough.

Severe repressive measures were instituted against the Luddites, thereby resulting in a mass trial at York in 1813. Many of the Luddites were hanged or deported, and the organization withered. The depression that followed the Napoleonic Wars resulted in a rebirth of the movement, but legal repression and a reviving economy eventually led to the dissolution of the Luddite bands.

Twentieth Century Luddites

Today, the term Luddite is applied to those who reject technological progress. Indeed, anyone who questions the value of the latest technological innovation runs the risk of being labeled a Luddite — and a Luddite is definitely something you don't want to be. The term carries with it the connotation of hopeless resistance against the inevitable. It conjures up the picture of a pitiful, benighted creature facing a future for which it is poorly prepared. None of us

want to get behind the curve and find out that we no longer have a future. Because of our desperate fear of being labeled Luddites, we run the risks of acting like lemmings.

The Lemming Factor

Lemmings are small rodents belonging to the family Cricetidae. They are found primarily in the northern temperate and polar regions of Eurasia and North America and are divided into four genera: *Dicrostonyx*, the arctic lemmings; *Myopus*, the red backed lemmings; *Synaptomys*, the bog lemmings; and *Lemmus*, the true lemmings.

Lemmings are fetching little creatures five or six inches long with short legs, small ears, a stump of a tail and long, soft fur. They are herbivores who feed on roots, grass and other shoots. They also are prolific—breeding from spring to fall with a gestation period of 20 days, and up to nine lemmings per litter.

What sets the lemming apart from other rodents are their regular fluctuations in population density and their periodic migrations. For reasons that are poorly understood, the true lemming suffers from population explosions every three to four years.

When a population explosion occurs, lemmings begin to move from areas of highest population density. The migration begins furtively at night, but as the number of migrating lemmings increases they become bolder and move throughout the day. The migration will often follow roads made by people or other animals.

Lemmings are not suicidal. They hesitate to enter water and will look for means to avoid swimming. Nevertheless, in the case of the Norway lemming, many of the migrants follow the pack over cliffs and into the sea. No one knows why the lemmings continue on to death by drowning. My bet is that some influential lemmings have told them that the wave of the future lies just over the cliff, and they don't want to get left behind. If we could understand lemming speech we might hear them muttering “minimally invasive,” “neuroendovascular surgery,” “endoscopic,” and “image guided” as they took the plunge for their terminal sea bath.

Neurosurgeons need to avoid being lemmings as much as we need to avoid being Luddites. It is likely that some innovative approaches in neurosurgical care offer solutions to clinical problems that improve patient care and/or reduce cost. We would be Luddites if we avoid a new method of treatment because we already

know how to treat the problem. It is equally likely that some of the neurosurgical innovations will prove to be very expensive without improving patient care.

We are lemmings if we follow the latest fad simply because we are afraid to get left behind. Therefore, neurosurgeons need to critically evaluate new technologies emerging in the medical arena. Outcomes studies in neurosurgery will make this evaluation process easier.

Importance of Outcomes Studies

Outcomes research is a relatively new field, or intellectual endeavor, which seeks to rigorously evaluate the effectiveness of medical care from a patient- and community-oriented standpoint. Methodologies that exist within the field of outcomes research allow us to evaluate new technology and its impacts on the effectiveness of our medical care.

For example, a case control study to ascertain whether any benefit accrues to patients from the use of image-guided techniques for the neurosurgical treatment of gliomas would be of great value. If, as the advocates of such technology maintain, image-guided surgery makes procedures safer, faster and more cost effective, then it should be possible to perform a case control study to document this. A prospective, randomized study would not be necessary.

Rather, a control group with patients matched for age, location, size and grade of tumor, and adjunctive therapy could be compared to the image-guided treatment group in terms of postoperative neurological status, functional health status, resource utilization and duration of survival. Group size necessary to assure adequate statistical power can be determined prospectively. The results of such studies largely impact the medical community.

The application of outcomes research could have a profound effect on the practice of neurosurgery. The claims of technological advances need to be evaluated with the same rigor as other hypotheses. In this way, neurosurgeons can avoid the fate of the Luddite, who thinks it is highly unlikely that a new technology will improve care, only to find out later, that he was mistaken. We also can avoid the fate of the lemming who, mesmerized by proponents of the latest technological marvel, fail to see the precipice.

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Shielding Your Practice and Savings From Lawsuits

by David B. Mandell, JD, MBA, and Christopher Jarvis, MBA

Asset protection is one way to shield your practice and savings from lawsuits. It is a small, but rapidly expanding, legal specialty that focuses on protecting a client's wealth from all types of threats, including lawsuits, creditor claims, and taxes. The attorney practicing asset protection must be familiar with many legal areas such as corporate law, estate planning, income tax planning, creditor rights, partnership law, and the law of foreign countries and trusts to safeguard a client's assets effectively.

For a physician, the goal of asset protection planning is to gain the greatest degree of financial security, in terms of his or her practice and personal financial affairs. This is achieved through a plan that uses existing state and federal exemptions, employs particular joint ownership forms, and creates protective legal structures, such as corporations, limited partnerships, and trusts. This is undertaken with one objective in mind — to shield the physician's medical practice and personal wealth from all types of claims. Asset protection planning has an attractive side benefit: It can result in significant estate and income tax savings, as well.

Because the threat of medical malpractice and business-related lawsuits is so high, the primary focus of asset protection for a physician is to legally secure his or her wealth from such threats. This means owning one's practice and other personal wealth in legal forms that make it extremely difficult, if not impossible, for others to "get at" them. Such a legally defensible position has a corollary benefit. Once potential claimants see that a physician's wealth and practice are protected, they are much more likely to drop the claim or settle for "pennies on the dollar." Either way, the physician saves the time, expense, and stress involved in defending claims and costs that would be incurred even if the case was ultimately won at trial or was covered under an insurance policy. In my experience, the costs of setting up an asset protection plan can be recouped

by discouraging or settling only one lawsuit. The following is one example.

Dr. Nathan, Neurosurgeon

Dr. Nathan operates a hospital-based practice with his partners, Doctors Stephano and Janko. Dr. Nathan is married, and the couple's principal assets are their home equity and a mutual fund portfolio. Both their home equity and the funds are worth approximately \$300,000 each, for a total of \$600,000 of marital wealth.

Dr. Stephano and the partnership were sued for \$800,000 for sexual harassment. (The same principles would apply for any non-malpractice claim or for malpractice claims in excess of coverage limits.) What could Dr. Nathan expect if he had not engaged in asset protection planning?

The partners' malpractice insurance policy probably would not cover them for the alleged sexual harassment. Most medical malpractice policies specifically exclude coverage for behavior in violation of state law, which sexual harassment is, by definition. Because the practice is operated as a general partnership, all partners share equal financial responsibility for the suit and any resulting judgment. Dr. Nathan's, personal savings are completely vulnerable to this lawsuit threat, as are Doctors Stephano's and Janko's. Without prior asset protection planning, Dr. Nathan could lose hundreds of thousands of dollars if the suit is successful. His only option to recoup these dollars would be to sue his own partner, Dr. Stephano, for reimbursement—an unappealing option, at best.

Preventative Measures

The unfortunate part of this hypothetical scenario is that Dr. Nathan could have easily protected himself from lawsuit threats like this one by implementing simple, inexpensive asset protection strategies. To insulate himself from claims against his partners, he could have established a professional corporation or association (in those states that

allow it) to be the partner in the partnership. This would have shielded his wealth from all claims other than those arising from his behavior. In this situation, his practice and personal equity would have been protected by such a legal entity.

Second, he could have protected his home equity by establishing a variety of home ownership options, as discussed in the April edition of *NeuroPractice*.

Third, to protect his mutual funds, Dr. Nathan could have established a joint ownership for tenancy. If his state recognizes tenancy by the entirety ownership, and affords high protection to it, all \$300,000 of the funds would have been shielded using this ownership form. Even if Dr. Nathan lived in a state where tenancy by the entirety does not exist, most states would grant protection for half of the funds (\$150,000) had he owned them in joint tenancy with his wife.

A second option to safeguard the funds, which is available in all 50 states, would have been to own the funds through a family limited partnership (FLP). Through an FLP, the funds would be almost untouchable because they would be protected from any lawsuit against Dr. Nathan professionally or personally, as well as any suit filed against his wife or the couple. Moreover, through the FLP, Dr. Nathan and his wife would retain 100 percent of control over the funds at all times. If Dr. Nathan and his wife had children, they could lower their income taxes through the FLP. This is accomplished by "sharing" income with the children on paper, thereby making use of their lower tax brackets. (This is a more advanced technique that requires expert guidance.)

Finally, Dr. Nathan could have protected his mutual funds by using an irrevocable trust, also called an "asset protection trust." The trustee of the trust (usually a trust company or responsible advisor) is the legal

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Tribute to Charles G. Drake, MD

Charles G. Drake, MD, the 1977-78 AANS President, died on September 15, 1998, of metastatic cancer. Dr. Drake, a 41-year AANS member, was a Professor Emeritus of Neurosurgery at the University of Western Ontario (London).

Dr. Drake earned his medical degree from the University of Western Ontario (London) before completing his residency in general surgery at Victoria Hospital (London) and his residency in neurological surgery at Toronto General Hospital.

An active contributor to organized neurosurgery, Dr. Drake served as Chair of the Editorial Board of the *Journal of Neurosurgery* (1975-76), as President of the American Surgical Association (1987-87), as President of the American College of Surgeons (1984-85), as President of the World Federation of Neurosurgical Societies (1977-81), as Director of the American Academy of Neurological Surgeons (1968-70), and as a member of approximately 40 scientific organizations.

Dr. Drake is the recipient of numerous awards, including the AANS Harvey Cushing Medal (1988); the Canadian Medical Association's FNG Starr Award (1986); and the London Foundation's Ivey Award for Excellence (1986).

A world-renown expert in cerebrovascular surgery, Dr. Drake published more than 200 articles for peer reviewed journals. He lectured and completed visiting professorships at medical schools and clinics all over the world.

On behalf of his contributions to organized neurosurgery and his community, Dr. Drake was recently recognized as a Companion in the Order of Canada—the country's highest and most prestigious civilian honor.

AMA and Sunbeam Reach Settlement

The American Medical Association (AMA) and Sunbeam Corporation recently reached a settlement in the trademark licensing suit. The \$20 million suit was filed by Sunbeam in 1997, when the AMA Board of Directors determined a contract between the two organizations to be contrary to long-standing AMA practices.

Under terms of the settlement, the

AMA has agreed to reimburse Sunbeam \$2 million for out-of-pocket expenses, including attorney fees, as mandated by the original contract. The AMA also will compensate Sunbeam \$7.9 million for damages related to the Board's 1997 decision not to proceed with the licensing agreement.

"Reaching this settlement was a team effort," said Randolph D. Smoak, Jr., MD, Chair of the AMA's Board of Trustees. "It resolves all existing differences between our organizations and closes this chapter in the life of the AMA, once and for all."

Attack of the Millennium Bug

According to the Senate's Special Committee on the Year 2000 Technology Problem (Y2K), the medical industry is not making significant strides to combat the millennium bug. The bug, which affects computers, devices, and software systems that use only two digits to represent the date, will cause systems on or after January 1, 2000 to mistake the year for 1900. This error could be devastating to the medical industry.

To demonstrate the magnitude of this problem, the Gartner Group, a market research firm, polled approximately 17,000 companies in 75 countries worldwide to get an idea of how firms must act to solve

their Y2K problem. They found that most companies spend 10 percent of their IT budget in their first year of tackling the millennium bug, 30 percent the next, and 40 percent the third year.

All told, the health care industry is working far below the average to combat this problem, thereby thrusting the industry into a critical position as we approach the year 2000.

TICLID Warning

According to the Food and Drug Administration, Roche Laboratories recently announced changes to the way ticlopidine (TICLID) is labeled. These changes will more prominently describe an adverse reaction to TICLID, thrombotic thrombocytopenic purpura (TTP), and give information about its diagnosis and treatment.

TICLID is used to reduce the risk of thrombotic stroke in patients who have experienced stroke precursors, or who have had a stroke and are intolerant or allergic to aspirin, or have failed aspirin therapy. The revised labeling moves the previously bolded TTP warning into the boxed warning. This change has been made to provide additional information regarding the diagnosis and management of TTP.

Shielding Your Practice (continued from page 21)

owner of the funds and would control them. Yet the trustee would be required to follow the terms of the trust as specified initially by Dr. Nathan and his wife. These terms might have included the creation of a college fund for their children, support fund for their parents, or even a plan for charitable gifts. In this type of a trust, Dr. Nathan and his wife would have to "irrevocably" give up control of the funds, and the funds would be unavailable to any of their creditors, including those involved in lawsuits. Despite such benefits, using this tactic must be seriously considered because ownership and control of the funds are given away forever.

Using these maneuvers, Dr. Nathan could have limited his lawsuit exposure to all types of lawsuit risks, including this potentially devastating sexual harassment

claim. It would be imperative, however, that Dr. Nathan implement these strategies before trouble (like this lawsuit) arises. Courts look down on transfers made when there is already a "probable creditor" lurking. Nonetheless, the costs involved in these strategies would have been minimal when compared to the potential loss.

Attorney and CME author David B. Mandell and financial consultant Christopher Jarvis speak frequently to medical groups and advise physicians throughout the country on asset protection, retirement and estate planning issues. Mandell and Jarvis are affiliated with TriArc Advisors LLC (1-888-317-9895). AANS Bulletin readers can receive audiotape on asset protection by calling TriArc at (800) 554-7233.

Section on Cerebrovascular Surgery

The American Association of Neurological Surgeons and Congress of Neurological Surgeons have joined forces, once again, to develop a marketing communications campaign specifically for neurosurgeons. The program, "Getting SMART About Neurosurgery: Stroke," will be launched at the CV Section Meeting, January 31 to February 3, 1999, in Nashville, Tennessee. The meeting, jointly sponsored by the AANS and CNS and in conjunction with the American Society of Interventional and Therapeutic Neuroradiology (ASITN), will immediately precede The American Heart Association's 24th International Joint Conference on Stroke and Surgery.

The stroke program is an easy-to-use public education and practice tool developed for neurosurgeons by neurosurgeons. It consists of two slide presentations; stroke center development guidelines; a referral brochure; a patient brochure; and a media kit, and is designed to deliver the following messages:

- Stroke is a medical emergency that demands the immediate attention of a neurosurgeon;
- Stroke, the leading cause of the loss of independence in young adults, affects both young and old;
- Stroke evaluation requires neurosurgical input; and
- Neurosurgeons, as stroke prevention and treatment specialists, are exploring the newest treatments for preventing and stopping stroke.

For questions regarding the next Getting SMART program, contact Barbara Peck, Communications Manager, at the AANS National Office at (847) 692-9500 (ext.517).

Section on Pain

The Section on Pain recently produced a CD-ROM titled, "Interventional Therapies in Neurosurgical Pain Management," that highlights more than 20 presentations delivered at the 1998 AANS Annual Meeting's Satellite Symposium. The CD is a user-friendly learning tool that explores neurosurgical treatment options for pain.

The Pain Section will host a Satellite

Symposium April 22-23, 1999, in New Orleans, Louisiana. Please watch for more details.

Section on Pediatric Neurological Surgery

The Pediatric Section has recently established a one-month traveling fellowship for residents interested in broadening their exposure to pediatric neurosurgery. Two fellowships per year will be awarded, and members of the Pediatric Section will evaluate potential candidates. The maximum fellowship stipend is \$2,500.

If you are interested in applying for this fellowship, contact R. Michael Scott, MD, The Children's Hospital, Department of Neurosurgery, 300 Longwood Avenue, Bader 319, Boston, Massachusetts 02115. The deadline for applications is October 31, 1998.

The 27th Annual Meeting of the AANS/CNS Section on Pediatric Neurological Surgery will be held December 1-4, 1998, in Indianapolis, Indiana. This year's Raimondi Lecturer, Robert Zimmerman, a noted pediatric neuroradiologist at the Children's Hospital of Philadelphia, will discuss "Advances in Magnetic Resonance Imaging of the Pediatric Nervous System."

Section on Disorders of the Spine and Peripheral Nerves

The Section on Disorders of the Spine and Peripheral Nerves will host its 1999 Annual Meeting February 10-13, at the Disney Yacht and Beach Club Resort in Lake Buena Vista, Florida.

Section on Neurotrauma and Critical Care

In May 1998, the National Athletic Trainers' Association (NATA) convened an inter-association task force to develop guidelines for the proper removal of helmets, shoulder pads and face masks from football players with suspected spine injuries. Serving on the task force and representing the views of our Section was Julian E. Bailes, Jr., MD.

According to the task force, removing helmets from athletes with potential cervical spine injuries may worsen existing injuries or cause new ones. Removal of athletic helmets should, therefore, be avoided unless individual circumstances dictate otherwise.

Before removing the helmet of an injured athlete, the following alternatives should be considered:

- Most injuries can be visualized with the helmet in place;
- Neurological tests can be performed with the helmet in place. For example, the eyes may be examined for reactivity, the nose and ears checked for fluid and the level of consciousness may be determined;
- The athlete can be immobilized on a spine board with the helmet in place;
- The helmet and shoulder pads elevate the supine athlete. Removal of the helmet and shoulder pads, if required, should be coordinated to avoid cervical hyperextension; and
- Removal of the facemask allows full airway access to be achieved. Plastic clips securing the facemask can be cut using special tools, permitting rapid removal.

Section on Tumors

The Membership Services Committee of the Section on Tumors has partnered with **NEUROSURGERY://ON-CALL**[®] to develop internet-based resources related to brain tumor research and therapy. The services are expected to be available by fall 1998, and will include:

- Expanded lists of neuro-oncology fellowships, funding sources, and meetings of interest;
- A listing of brain tumor publications and book reviews, as well purchase forms to order textbooks online;
- An online membership directory that will allow searches by name, institution or geographical location;
- A national survey on negative brain tumor trials that will be coordinated by Tom Chen, MD, from UCLA;
- A section where members can submit brain tumor questions to the National Cancer Database;
- A listing of support services for brain tumor patients and their families;
- A joint project with the Society for Neuro-Oncology to provide concise summaries of literature relevant to neuro-oncology on a quarterly basis; and
- Links to other Web sites and discussion groups that focus on brain tumor diagnosis and treatment.

The Public Pages of NEUROSURGERY:// ON-CALL®—A Resource for You and Your Patients

By A. John Popp, MD

On the Internet, medical Web sites number in the 10's of thousands and provide everything from patient brochures to abstracts from scientific journals and other clinical information. These sites have proven to be valuable learning tools for both physicians and patients.

Neurosurgeons have the added benefit of **NEUROSURGERY://ON-CALL®**, the official AANS/CNS Web site. Launched in April 1996, **N://OC®** is one of the largest neurosurgery-related sites on the Internet and provides easy access to everything from organizational information to online abstract submission, and from Section information to online ordering of publications. With more than 20,000 users per month, **N://OC®** continues to grow in content and Web-based services, as well as usage. One of the most frequently visited sections of our Web site is the Public Pages.

History of the Public Pages

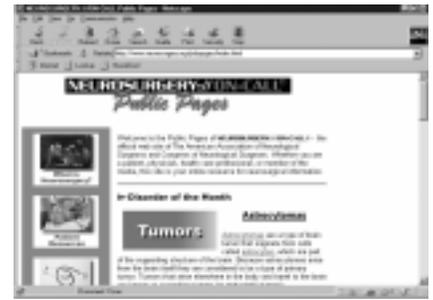
The Public Pages were conceptualized as an important part to **N://OC®** as a whole. With more and more people turning to the Web as a source of medical information, both the AANS and CNS felt that taking a strong role in providing the general public with appropriate medical information was critical.

Much research was done to see what type of content and services other associations were offering online. The **N://OC®** Editorial Board believed that the Public Pages should be content-rich, visually appealing, and easy to navigate. Subsequently, in December 1996, the **N://OC®** Editorial Board approved a proposal that outlined the content and development goals for the new section. The Public Pages section went online in April 1997, linked as a second main section of **N://OC®** from the "splash page."

Usage of the Public Pages

An important goal of the Public Pages was to provide a convenient source of information to patients, referring physicians and the media. In addition, this section of **N://OC®** was viewed as a resource for AANS and CNS members in obtaining patient education material for their practice.

Efforts to draw users to the Public Pages have included registering the section with all of the major Web search engines, promoting links back to the Public Pages from related sites, and educating our



N://OC® Public Pages

members as to the value of the content within this section. Since its official launch, the Public Pages section has enjoyed a steady increase in site traffic. This part of **N://OC®** attracts more than 200 users per day, and over 6,000 users per month. The most frequently visited area of the Public Pages, is "Find A Neurosurgeon," a service which allows users to search for a neurosurgeon by area code, name, or city and state. The other popular areas include "Patient Resources," "Ask A Neurosurgeon," and the topic brochures.

What are the Public Pages

Each month, a specific neurological disorder or procedure topic is featured on the main page. This area provides a brief description of the topic; links to additional information, such as patient education brochures; Frequently Asked Questions (FAQs); and a list of other Web sites of interest. Through the "Ask A Neurosurgeon" feature, users are encouraged to ask questions on the featured topic—questions which are then answered by a neurosurgeon and posted on the site. In addition to this featured topic, the Public Pages are divided into five sections:

What is Neurosurgery?

Designed to introduce the public to the specialized field of neurosurgery, this section describes neurosurgical care, including both operative and nonoperative intervention, and provides a glossary of neurosurgical terms. It also provides background information on The American Association of Neurological Surgeons and Congress of Neurological Surgeons. Also included is a link to the CyberMuseum of Neurosurgery, an exciting display of historical material available from the AANS Archives.

Public Pages—Volunteers Make it Successful!

The **N://OC®** Public Pages relies on its advisory group to help develop content and generate ideas to improve the site. Their dedication and commitment is critical to the success of this area of **N://OC®**.

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N://OC® Editor

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Pain Section

Jeffrey Alan Brown, MD
Pain Section

William C. Hanigan, MD, PhD
History Section

Mark S. Dias, MD
Pediatric Section

Patient Resources

Here, patients can find information on neurological diseases, including signs, symptoms, treatment options, and diagrams. From Astrocytomas to Lumbar Stenosis, this section provides full-color online brochures, answers Frequently Asked Questions, and lists other resources for information. "Ask a Neurosurgeon," a popular feature in this section provides a question and answer forum for users. Questions users e-mail to us are answered by a neurosurgeon and posted here, making Patient Resources a personal and interactive section.

Physician Resources

This section is a great resource for referring physicians. It features the AANS and CNS "Getting SMART" program brochure, *Lumbar Spinal Stenosis and the Aging Patient*, and access to a full search of the N://OC® Library. This section also includes guideline referrals and offers a monthly online chat service.

The chat service provides neurosurgeons with a forum to discuss selected topics and answer questions in a moderated chat format. Topics for discussion, which will take place one Tuesday a month at 7 PM EST, will include: "Sports-related Concussions and Mild Head Injuries," moderated by Alex Valadka, MD, and David McKalip, MD, on October 20, 1998; "Identifying Victims of Shaken Baby Syndrome," moderated by Bruce Kaufman, MD, on November 17, 1998; "Options in Treating Chronic Cervical Neck Pain," moderated by Richard Toselli, MD, on December 15, 1998; "TIA: A Warning Sign of Stroke," moderated by Warren Selman, MD, on January 26, 1999; and "Carpal Tunnel Syndrome and Treatment Options," moderated by David Jimenz, MD, on February 23, 1999.

The online chat, which was promoted at this year's American Academy of Family Physicians meeting, was enthusiastically accepted by more than 200 family physicians who signed up for the service.

In The News

This portion of the Public Pages gives users access to the latest information and news releases concerning topics in the field of neurosurgery. Users also can access

Can Your Patients Find You Online?

NEUROSURGERY://ON-CALL® (<http://www.neurosurgery.org>) is pleased to offer "Find A Neurosurgeon," a service that will help you reach the people who want to know about you and your practice.

This online resource, in the Public Pages section of the Web site, is a directory of AANS and CNS members searchable by name, city and state, and area code.

In "Find a Neurosurgeon," a basic directory listing is free and includes your name, address and phone number. However, you may choose to upgrade your member listing to provide users with more details about yourself and your practice. Two expanded profiles are available:

Option 1

If you don't have a personal Web site, this option is for you. This profile includes

- Photo
- Contact information
- Education and training experience
- Subspecialty interest
- A 500 word description about your practice, research interests, etc.

Cost: \$500—one time fee

Option 2

You may want to consider this option if you already have a personal Web site.

This profile includes:

- Photo
- Contact information
- Subspecialty interest
- A hypertext link to your web site.

Cost: \$125—one time fee

As more and more people turn to the Internet for health related information, N://OC® is poised to help them find neurosurgical information, specifically *you!* For more information or to request an application, please contact Allison Casey by phone at (847) 692-9500, or e-mail her at avc@aans.org.

Annual Meeting media kits, and read the Position Statements of the AANS and the Annual Report.

Find a Neurosurgeon

The most frequently visited area of the Public Pages, this feature allows users to find a neurosurgeon in their community. By typing in the name of the city and state, area code or last name, they will instantly be given a list of neurosurgeons names, addresses and phone numbers. Members of the AANS and CNS can, for a small fee, upgrade their listing to provide more details about themselves and their practice. (See side bar on page to right for more details.)

As more and more people turn to the Web for medical information, a general concern has been raised as to how people can be assured of the quality and credibility

of health-related sites. With the backing of the AANS and CNS, N://OC® Public Pages have developed a content-rich Web site and are proud to be considered a premier, quality site for neurosurgical information. Over the next year, we have plans to double the usage of the Public Pages, a goal that will be accomplished by adding more content for patients and referring physicians. We encourage you to use this section of our Web site as a resource for your practice by mentioning N://OC® (<http://www.neurosurgery.org>) and how to reach it to your patients and referring physicians.

New Awardees

by Julian T. Hoff, MD

Applicants for the 1998 grants continued to be of the highest caliber. The Scientific Advisory Committee has done an admirable job of reviewing the proposals of these young neurosurgeons and has managed the difficult job of identifying the most outstanding applicants worthy of the financial support of the Research Foundation. A total of 39 applications were received, of which the following five individuals were awarded. We anticipate good results from their work.

Tord D. Alden, MD

1998 Research Fellow
University of Virginia

Sponsor: Gregory A. Helm, MD
Chairman: John A. Jane, MD, PhD

Research Title: *Bone Morphogenetic Protein-2 Gene Therapy in Neurosurgery*

Abstract: The overall aim of this proposal is to develop novel gene therapy strategies for improving the treatment of diseases that require spinal fusion. Numerous animal studies have demonstrated the efficacy of viral vectors for delivering therapeutic genes to many different tissues. However, the limitations of this approach include the utilization of viruses that have low transfection rates and the lack of tissue specific transgene expression. Traumatic fractures, lumbar stenosis, multiple cervical discectomy, tumors, degenerative processes, and congenital diseases are just a few examples where spinal fusion is utilized in neurosurgery. Recombinant human bone morphogenetic protein-2, an osteoinductive protein, has been shown in animal models to improve the fusion mass. The goal of this proposal will be to develop an efficient gene delivery system to express the BMP-2 gene using an adenoviral construct. The BMP-2 gene will then be placed under the control of the tissue specific osteocalcin promoter, which should target gene expression to osteoblasts.

Judith L. Gorelick, MD

1998 New York City Post-Graduate
Neurosurgery Course Research Fellow
University of Michigan

Sponsor: Daniel S. Wechsler, MD
Chairman: Julian T. Hoff, MD

Research Title: *The Role of the MXI1 Growth Suppressor Gene in the Pathogenesis of Glioblastoma Multiforme*

Abstract: Malignant tumors of the brain and central nervous system are responsible for over 12,000 deaths per year in the United States, and of these tumors, glioblastomas multiforme is the most malignant and the most difficult to treat despite the use of aggressive multimodality therapy. Since it is currently well accepted that malignancy likely results from successive genetic alterations which lead to disordered control of cell growth, a better understanding of these mechanisms might suggest new approaches to therapy. MXI1 is a putative tumor suppressor gene, which maps to a region of chromosome 10 that is frequently involved in a significant proportion of human glioblastomas. To date, studies of the MXI1 gene have demonstrated frequent loss of heterozygosity (LOH) at the MXI1 locus and a reduction in growth rates of glioblastoma cell lines where MXI1 has been reintroduced in vitro. Through these studies, we hope to gain a deeper appreciation of the complexity of the mechanisms that modulate the function of MXI1, and to more fully understand the pathways to neoplasia.

James M. Schuster, MD

1998 Research Fellow

University of Washington/Seattle
Sponsor: Richard S. Morrison, MD
Chairman: H. Richard Winn, MD

Research Title: *The Effects of Loss of p53 Function on Apoptotic Pathways in the Malignant Progression of Astrocytes*

Abstract: Mutations of the p53 gene are among the most common genetic aberrations in human tumors including CNS tumors. The loss of p53 mediated apoptosis (programmed cell death) can significantly enhance the survival of tumor cells and is associated with a more aggressive tumor phenotype. This investigation will determine if the loss of wild-type p53 function in serial passages of astrocytes derived from p53 (+/-) mice results in changes in the expression of relevant cell death effectors, as well as the rate of spontaneous and stress induced apoptosis. We also will determine if increased expression of proapoptotic proteins introduced using an adenovirus vector will reduce in vitro growth and malignant transformation in p53 (-/-) astrocytes.

Frederick F. Lang, MD

1998 Rhone-Poulenc Rorer Young
Clinician Investigator
MD Anderson Cancer Center
Sponsor and Chairman: Raymond Sawaya,
MD

Research Title: *Adenovirus-Mediated p53 Gene Transfer Combined with Ionizing Radiation and Antineoplastic Agents Against p53-Wild-Type Human Gliomas*

Abstract: Transfer of the p53 gene using an adenovirus vector may be an effective alternative for treating gliomas, but current experience suggests that this type of gene therapy may have significant limitations as a single treatment modality because of the resistance of clones containing wild-type p53 alleles. Studies from our laboratory indicate that adenovirus-mediated p53 gene transfer into human glioma cell lines that contain wild-type p53 sensitizes the cells to ionizing radiation and to certain antineoplastic agents. The purpose of this proposal is to elucidate the biological mechanisms underlying the sensitizing action of combining adenovirus-mediated p53 gene transfer with radiation or chemotherapy, and to explore the therapeutic potential in vivo of combining p53 gene transfer with these modalities.

Carl Laurysen, MD

1998 Shirley L. Bagan Young Clinician
Investigator

Washington University/St. Louis
Sponsor: Jack R. Engsborg, MD
Chairman: Ralph G. Dacey, Jr, MD

Research Title: *A Computer Analysis Outcome Study of Cervical Spondylotic Myelopathy*

Abstract: The natural history of cervical spondylotic myelopathy is poorly understood, with up to 75 percent of patients showing progressive deterioration. The first aim of this study will use objective, quantitative computer generated measures, and a physical performance test, prior to, and following surgery to assess the effect of surgery on patients with cervical spondylotic myelopathy. The second aim is to determine if post-surgical functional outcomes can be predicted from pre-surgical, clinical, and diagnostic imaging measures. All patients will undergo pre-operative physical performance testing, diagnostic imaging, and computerized assessment of gait, spasticity, and strength. Post-operatively, three, six, and 12-month repeat testing will be performed to determine changes in functional outcome.

Increased Corporate Support Paves the Way for 1998 Campaign

by Julian T. Hoff, MD
Chairman, Executive Council
AANS Research Foundation
John O'Connell, Fund
Development Officer

The Research Foundation of the AANS enjoyed a very good year in 1997, as our overall campaign raised close to \$380,000 for neuroscience research. As a result of this successful campaign, we were able to approve five grant applications in 1998 (see story on page 25). This year's campaign can exceed last year's impressive results, but only with the expanded help of AANS members.

The highlight of our most recent campaign has been the exponential increase in corporate support through our Corporate Associates Program. Setting the pace is a very generous gift of \$80,000 from Rhone-Poulenc Rorer, which allowed them to attach the Rhone-Poulenc name to one of our 1998 Young Clinician Investigator Awards. Right behind is another generous gift of \$50,000 from the Synthes Groups. (Additional corporate gifts are outlined in a box on page 27.) We are up to 17 Corporate Associates as of this writing, with more companies signing on every month. We applaud these progressive companies, and encourage our members to support them, as well.

Our Supporting Level Corporate Associates, who give at least \$25,000 each year, participate in the Corporate Advisory Council, which reviews issues that may impact the scope and direction of the Research Foundation. In the past year, titles to 10 meritorious but unfunded research project applications were shared with this body, paving the way for potentially increased funding for several studies. The closer working relationship we are building with our corporate supporters now enhances opportunities for significant advances in neuroscience, and could foster the creation of new grant categories in

outcomes studies and clinical applications.

Not to be outdone, we clinicians must step forward and do our part to support this important initiative. The challenge is there to show our own support for our Research Foundation. Grants from the Research Foundation not only encompass some of the most promising neuroscience studies conducted in the United States today, but help pave the way for sustained funding from institutional sources such as the NIH. See what some of our past winners, your colleagues, say about the Research Foundation:

"I applaud the AANS for the establishment of the Research Foundation, and I implore them to continue to fund this important resource. It is imperative that we, as an academic organization, continue to encourage academic productivity from our junior members through efforts such as the Research Foundation."

William T. Couldwell, MD, 1993 Young Clinician Investigator

"Research funding is becoming progressively more difficult to obtain. Young investigators are subject to the 'Catch-22' phenomenon of not being able to obtain funding because they have no track record. However, they do not have a track record because they have not been able to obtain research funding. The award permits a young investigator to establish an independent laboratory, and begin to accumulate data and experience that can lead to later funding."

Kenneth A. Follett, MD, 1991 Young Clinician Investigator

"The goal of aiding young neurosurgeons to attain valuable research experience is an extremely important one, and the Foundation should be encouraged in its current efforts."

John Aranyapur, MD, 1988 Research Fellow

Soon, I will be asking each of you, as members of the AANS, to support the future of our profession. It is through the type of basic research being funded by your Research Foundation that we can improve our specialty and the lives of our patients.

Donors who support the Research Foundation will be recognized in the spring issue of the *Bulletin*, on our Web site **NEUROSURGERY://ON CALL**[®], and will have their name on display on the Donor Wall at the 1999 AANS Annual Meeting in New Orleans, Louisiana. Gifts from groups of \$1,000 or

more also will be acknowledged as "Neurosurgical Group Supporters."

All members should consider joining the Cushing Scholars Circle, with a minimum donation of \$1,000 for a Cum Laude designation (see chart on page 27). Established last year, gifts of \$1,000 or more will receive an invitation to the Cushing Orator Luncheon, the most prestigious event at our Annual Meeting. Gifts of less than \$1,000 also will be noted by category.

Giving to the Research Foundation is easy. Most give by check, but there are other ways: You can make a pledge, and pay via invoiced installments. Or, you can give by credit card. The most advantageous method is a gift of appreciated stock or other securities. If you itemize, you may be able to deduct the full market value of the gift, and avoid all taxation on the capital

(continued on page 27)

Robert Ojemann, MD, Steps Down as Chairman; Julian Hoff, MD, Appointed Successor

The Research Foundation owes a huge debt of gratitude to Robert G. Ojemann, MD, of Massachusetts General Hospital/Harvard University and Past President of the AANS, for seven years of dedicated service as the Chairman of the Research Foundation. During his tenure, a more active member campaign, as well as a corporate solicitation campaign were started, increasing annual revenues from \$85,000 in 1990, to nearly \$380,000 in 1997. Assets of the Research Foundation have grown substantially under his leadership, from \$2.4 million in 1991, to over \$5 million today. Please join us in applauding Dr. Ojemann for his leadership and vision these past seven years.

The Research Foundation also is grateful to Julian T. Hoff, MD, University of Michigan and Past President of the AANS, for assuming the mantle of Chairman of the Research Foundation. Dr. Hoff has pledged to carry on the important work begun by his predecessors, Dr. Ojemann and Robert King, MD, and looks forward to leading this Foundation to the forefront of neuroscience research funding.

RESEARCH FOUNDATION CORPORATE ASSOCIATES PROGRAM

The Executive Council of the AANS Research Foundation gratefully acknowledges the financial support given by the following companies. These companies have set the highest example of leadership by their commitment to neuroscientific research. Please join the Executive Council in applauding their efforts.

SUPERIOR ASSOCIATE

(Gifts of \$75,000 to \$100,000)

Rhône-Poulenc Rorer Pharmaceuticals

SUPPORTING ASSOCIATES

(GIFTS OF \$25,000 TO \$50,000)

Codman/Johnson &
Johnson Professional, Inc.
Elekta

Sofamor Danek Group, Inc.
Synthes Spine/Synthes Maxillofacial

CONTRIBUTING ASSOCIATE

(Gifts of \$10,000 to \$25,000)

Depuy Motech/AcroMed
Sulzer SpineTech, Inc.

ASSOCIATES

(GIFTS OF \$5,000 TO \$10,000)

Aesculap
Bayer Corporation
Carl Zeiss, Inc.
Leica, Inc.
Medtronic
Midas Rex Institute
Pharmacia & Upjohn, Inc.
PMT® Corporation
Radionics
Surgical Dynamics

Research Foundation (continued from page 26)

gain. Call John O'Connell, our Fund Development Officer, at (847) 692-9500, or e-mail him at jro@aans.org to learn of the ways you can maximize your gift.

Gifts can be made in tribute or memory of a loved one or a mentor. There is no greater honor in ensuring the future of our specialty than through remembering someone who helped you achieve your current measure of success. Memorial and tribute gifts will be listed on our recognition sites, and surviving family members will be notified of your generosity.

Also, remember to name a gift to your Research Foundation through a specific mention in your will or estate trust. Gifts after death keep on giving and are a key source of our charitable support. Life income plans also can be structured, giving you and your family a significant source of retirement income, while ultimately benefiting this Foundation.

Pedicle Screw (continued from page 13)

recently filed a "Motion for Order Requiring Disclosure of Additional Confidential Information and For Court Appointment of an Expert Witness with Respect to the Historic Cohort Study of Pedicle Screw Fixation." The PLC is seeking, once again, to obtain the disclosure of the names of the physician-participants in the Cohort Study and to appoint an expert to audit the findings of the study.

Under the PLC's proposal, the court-appointed auditor would perform a site visit at each of the of the 315 participating study sites, which are the medical offices of the participant-researchers. The auditor would not only review the adequacy of the responses provided, but would also be required to check all of the physicians' other files to cross-verify that patients were properly included in the study. In the process, all of the names of the physician-researchers would be, of necessity, released. In addition, the identities of countless patients would be disclosed along with their complete medical records.

As the Bulletin went to press, the AANS, the American Academy of Orthopedic Surgeons, North American Spine Society, and the Scoliosis Research Society, had filed a Memorandum, asking Judge Bechtel to reject the motion, citing the associations' original concerns about patient and physician confidentiality as well as the tremendous burden that would be placed

on the medical practices of the named orthopedic surgeons and neurosurgeons. Judge Bechtel's decision is pending.

In the meantime, a legal precedent has been set, according to AANS General Counsel Russell Pelton, who served as Liaison Counsel for all of the medical associations. "Medical societies must be free to provide forums for the discussion of evolving medical treatment. The pedicle screw litigation threatened that process. It had a profound impact on patient care and the future of medical research. We believe that the process we followed in seeking protection against this mass tort litigation established some legal precedent that will protect other associations from similar legal problems in the future."

In a further attempt to prevent the implementation of the down classification, on August 28, 1998, the PLC sued the FDA seeking to enjoin the reclassification of pedicle screws. The PLC's suit alleges that the FDA based its actions on false statements from manufacturers and fatal defects in the Cohort Study, and that the agency violated Federal Law in the way it handled the down classification. The case has been assigned to Judge Bechtel and no action has yet taken place.

Members are encouraged to visit the official AANS/CNS Web site (<http://www.neurosurgery.org>), for the latest updates on this continuing story.

ANNUAL GIVING LEVELS

The Harvey Cushing Scholars Circle (Gifts from Individuals)

Summa Cum Laude	\$5,000 and up
Magna Cum Laude	\$2,500 to \$4,999
Cum Laude	\$1,000 to \$2,499

Other Giving Levels

Honor Roll	\$500 to \$999
Sponsor	\$250 to \$499
Supporter	\$100 to \$249

Neurosurgical Group Supporters (Gifts from Groups and Organizations)

A gift of \$1,000 or more that is received from an organization or group of doctors will be recognized within the Neurosurgical Group category. Individuals will also be listed at their giving level.

MOVING?

When moving remember to send your change of address to:
AANS Member Services
22 South Washington Street
Park Ridge, Illinois 60068-4287

Continuing Medical Education

with the AANS

The AANS Professional Development Program (PDP) offers a variety of continuing medical education (CME) courses that are designed to give you the best and most up-to-date educational opportunities for both clinical training and practice management. The full calendar of courses for 1999 is now under development and will be sent to all members in late fall. In the meantime, the following courses have been confirmed:



SOCIOECONOMIC COURSES

Reimbursement Foundations: Neurosurgical Billing and Coding for Efficiency

February 25-27 • Memphis, Tennessee • The Peabody Memphis
March 25-27 • Baltimore, Maryland • Hyatt Regency Hotel
June 10-12 • San Francisco, California • Hotel Nikko
August 26-28 • Chicago, Illinois • Fairmont Hotel

Learn the "best practices" to use in neurosurgery offices for efficient coding and prompt billing and payment. Course covers reimbursement cycle basics and related business systems, CPT and ICD-9-CM coding principles for neurosurgery, 1998 Medicare changes, E & M documentation, subspecialty case coding, and the use of modifiers. You'll get practical, hands-on coding experience that's neurosurgery specific. Register early – enrollment is limited to 100 participants per session, and this popular course fills quickly!

Advanced Coding and Reimbursement Concepts in Neurosurgery

February 19-21 • San Juan, Puerto Rico • Condado Plaza Hotel
May 14-16 • Palm Beach Gardens, Florida • PGA National Resort & Spa
August 5-7 • Boston, Massachusetts • Fairmont Copley Hotel
November 19-21 • Phoenix, Arizona • Ritz Carlton Phoenix

This course begins with an assessment of your individual coding IQ, then continues with such topics as RVU financial analysis, subspecialty case coding, reducing audit risks through better coding and documentation, and troubleshooting denials and delays. The basics *will not* be covered! In order to ensure an underlying knowledge base of the participants, it is suggested that you first attend a "Foundations" course. Because of the intense, interactive nature of this course, enrollment is limited to 80 participants per session in order to provide the best experience for all. Register early – this popular course fills quickly!

CLINICAL SKILLS COURSES

Topics in Neurosurgical Critical Care

February 4-7 • San Juan, Puerto Rico

This course provides an excellent continuing analysis of neurosurgical critical care. Approximately 65 percent of the time will be devoted to problem solving involving the integration of different modalities of therapy. This course covers fever complications and infection; advantages and disadvantages of nutritional support; advanced techniques of neurosurgical intracranial monitoring in daily critical care; and the pharmacology and selection of appropriate sedatives, paralytics, and antibiotics in the intensive care unit to more effectively meet your treatment goals. Also learn to better integrate treatment modalities using simultaneous manipulation of fluids, Na⁺, vasopressors, volume expanders, and complex hemodynamic data in the treatment of cerebral edema and ischemia.

HANDS-ON CLINICAL SKILLS COURSES

Spine Surgery – Hands-On: A Comprehensive Approach for Neurosurgeons and Neuroscience Nurses

May 15-21 • Albuquerque, New Mexico

This is the consummate course for practicing neurosurgeons who desire an in-depth review of anatomy, surgical exposure, decompression, and stabilization of the entire spinal axis. Designed to provide a comprehensive hands-on learning experience that conceptually covers the entire spine and emphasizes fundamentals, particularly biomechanics. Takes a team approach to spinal surgery, integrating nurses and physician assistants into the course curriculum. A fast-paced, intensive learning experience, this course utilizes cadaver material and surgical instrumentation.

ORAL BOARD REVIEW COURSES

May 23-25 • Baltimore, Maryland
November 14-16 • Houston, Texas

These entirely interactive courses provide the board-eligible neurosurgeon with an in-depth review of clinical neurosurgery in a format patterned after the oral board examination. This course provides a broad overview of neurosurgical practice. Work with expert faculty who will critique and help you organize your responses to oral-board type questions in intense one-on-one sessions. Help build your confidence while identifying areas requiring more study. Both sessions are offered just prior to the American Board of Neurological Surgery oral exams for those desiring a pre-exam review.

The American Association of Neurological Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.



The American Association of Neurological Surgeons designates these educational activities for the designated hours in category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

For more information or to register, please call the Professional Development Department at 847-692-9500, or e-mail us at info@aans.org or visit our Web site at www.neurosurgery.org

The AANS—Your Premiere Source for Neurosurgical CME

IT'S EASY TO REGISTER FOR AN AANS PDP COURSE

The AANS offers four easy ways to register for a Professional Development Program (PDP) course:

If using a credit card (Visa, MasterCard, or American Express):

- Phone your registration to the Professional Development Department at (847) 692-9500
- Fax your registration to the Professional Development Department at (847) 692-2589
- Register online via our Web site, **NEUROSURGERY://ON-CALL®**. Once at the site (<http://www.neurosurgery.org>), go to the "Meetings/CME" page and to the "1999 Schedule of Courses." All online registrations are secured and your credit card number will be available to no one but our registrars. The site also features the most up-to-date information about the courses!

If paying by check or credit card:

- Mail your registration to the box number shown on the enrollment form.

Register Early! Many courses sell out months in advance. Registrations are taken on a first-come, first served basis and payment must be included in order for enrollment to be completed. We *strongly urge* you to refrain from making travel reservations until you receive confirmation from the AANS that your registration has been accepted.

WATCH FOR INFORMATION ON THE FOLLOWING COURSES ALSO PLANNED FOR 1999:

Hands-On Clinical Courses

- Brachial Plexus
- Spine Review: For Young Neurosurgeons

Clinical Skills Courses

- Advanced Brain Anatomy for Nurses
- Surgical Management of Movement Disorders
- Re-Introduction to Critical Care
- Image-Guided Neurosurgery

Young Neurosurgeons Course a Success

"Spine Review – Hands-On: For Young Neurosurgeons," the first Professional Development Program (PDP) course created especially for the younger practitioner, was held August 15-21, 1998, in Albuquerque, New Mexico, and drew rave reviews. With an initial registration limit of 36 participants, 39 neurosurgeons eventually enrolled.

Modeled after the comprehensive spine course for experienced neurosurgeons, the young neurosurgeons project was developed by PDP Committee Chairman Edward Benzel, MD, who also serves as chairman of the comprehensive course. It was designed for young neurosurgeons who are four years or less past their training. The curriculum emphasizes the fundamentals and foundations of spine surgery and includes an emphasis on basic sciences, particularly biomechanics.

Intensive Experience

Participants spent four-and-one-half days totally immersed in intense clinical lab sessions, side-by-side with some of the nation's leading spine surgeons. They participated in stimulating case discussions evaluating diagnostic and treatment options, reviewing their own cases with faculty and colleagues, as well as developing appropriate rationales for clinical decision

making. At the conclusion of each day, they participated in an interactive learning game called the "Spine Bowl," which is modeled on the popular television show "Jeopardy." One afternoon, Dr. Benzel even led the group on a mountain hike.

Partner Support

The course was the first of what is hoped to be affordable, innovative learning programs aimed at neurosurgeons who are at the beginning of their careers. It was offered at a reduced registration fee over its sister course, "Spine Surgery Hands-On: A Comprehensive Approach for Neurosurgeons and Neuroscience Nurses," because it was underwritten, in part, by funds contributed through the "PDP Educational Partnerships with Industry." The goal of this program is to enhance PDP course offerings while making them more economically feasible.

The University of New Mexico also provided support for the course through the use of its clinical and teaching facilities.

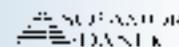
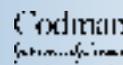
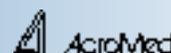
According to course participant Kamran Sahrakar, MD, "The course easily qualifies as the most valuable week spent since my training. I hope the response from other participants is as enthusiastic so that the course can be conducted in the future. To close our eyes to the changing role of the neurosurgeon in the treatment of spinal

disorders would be a serious error. Your course assists the young neurosurgeon in remaining competitive and knowledgeable in this subspecialty. Please accept my sincere thanks for all you (Dr. Benzel) have done to make it possible."

Based on the participants' enthusiastic response to the course, plans are to repeat it in August 1999, with exact dates and location yet to be determined.

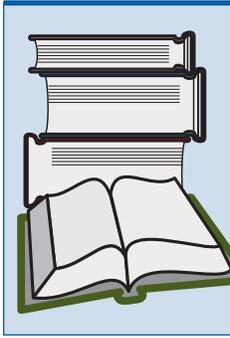
"The faculty and I were very pleased with how well the course went," said Dr. Benzel. "My goals were to leave participants, exhausted, fulfilled and exhilarated and I believe we accomplished my mission!"

The AANS wishes to acknowledge our **Professional Development Educational Partners** for their generous support of medical education.



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NOC ad

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Think First Ad



New Neurosurgical Topics Series Books Available

Neurosurgical Treatment of Movement Disorders (#132),

edited by Isabelle M. Germano, MD, provides an overview of and treatment strategies for patients with movement disorders. The volume opens with reviews of the classification and history of movement disorders. The second section includes comprehensive coverage of ablative and restorative surgical procedures for the treatment of Parkinson's Disease. Technical advances in surgery for patients with Parkinson's Disease also are presented. In the next section, hyperkinesia and the operative treatment of hemifacial spasm and spasmodic torticollis are covered. A chapter is included on ablative procedures for treating dystonia. This book is intended as a comprehensive and practical guide for neurosurgeons and neurologists who treat patients with these common and disabling conditions. A team approach to the treatment of movement disorders is stressed.

Calvarial and Dural Reconstruction (#133),

edited by Setti R. Rengachary, MD, and Edward C. Benzel, MD, provides straightforward descriptions of the management of a variety of calvarial and dural defects, both congenital and traumatic. The volume opens with a review of the colorful history of calvarial reconstruction. The next section includes comprehensive coverage of the cranioplasty materials used in calvarial procedures, including the newer materials now available. In the third section, illustrations and text describe reconstruction for complex procedures such as frontal sinus fracture, the floor of the anterior cranial fossa, and posttraumatic and postoperative skull defects. The various forms of synostosis and the indications, risks, and complications also are discussed. This book provides the practitioner with a plethora of information about calvarial reconstruction.

Intracranial Endoscopic Neurosurgery (#134),

edited by David F. Jimenez, MD, provides neurosurgeons with information on the clinical and surgical aspects of intracranial endoscopy. The volume opens with a review of the physics and instrumentation of neuroendoscopic systems. The second section includes comprehensive coverage of the anatomy used in neuroendoscopic procedures. In the third section, illustrations and text describe how endoscopic surgery can be used as an alternative to traditional surgery for such complex procedures as hematoma evacuation, abscess, and third ventriculocisternostomies. A chapter is included on the avoidance and management of complications frequently encountered. This book provides the practitioner with a solid foundation of the field of endoscopy as practiced by neurosurgeons.

President's Message (continued from page 2)

For the AANS, we feel it is pivotal that we make a strong presence in the international arena and now is the time to push forward with this effort. John Jane, MD, and his team at the *Journal of Neurosurgery* and the AANS marketing staff have made a concerted effort over the past several years to increase awareness, participation, and contributions by international neurosurgeons. We have taken AANS text books and other publications, the *Journal*, Annual Meeting information, Professional Development Program course brochures and other information to meetings in Germany, Japan, Denmark and Turkey. We will be returning to Japan this fall, and, for the first time, visiting our colleagues at their meeting in South America.

It isn't necessarily how many books we sell or *Journal* subscriptions we process that are the important factors at these types of meetings. It is the process of building long-term relationships with our international colleagues that is important. I traveled to Germany in June and had the opportunity to forge relationships with leaders in neurosurgery from all over Europe. We have extended an invitation to these neurosurgeons to attend the AANS 1999 Annual Meeting in New Orleans.

The scope and reach of the AANS has surged beyond the borders of American neurosurgery. This is a trend that can be seen in just about every industry in the United States. Neurosurgeons now must become involved and must make time to communicate with primary care physicians, work with other specialists and interact with international colleagues. It is the wave

of the future and key to how we must position ourselves for success.

One of the most frustrating lessons to be learned by any neurosurgeon, not just the young, but unfortunately many of the middle and older practicing neurosurgeons, is that we can no longer simply dedicate our time and efforts to doing what we totally enjoy – operating and caring for neurosurgical patients. Our world has been encroached upon by a changing political and industrialized medical world. To survive in neurosurgery, as we wish it to be, each of us must pull with our national organization in every outreach program available. The AANS/CNS can develop the programs, but unless the membership carries them forth, they are to no avail.

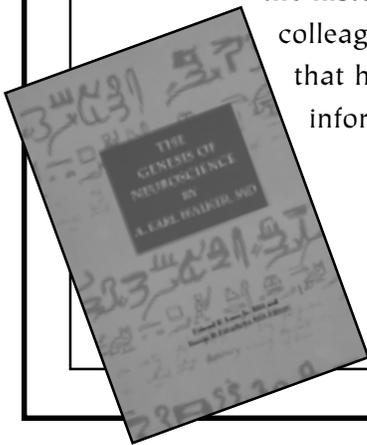
Russel S. Travis

Genesis of Neuroscience

by A. Earl Walker, MD

Editors Edward R. Laws, Jr., MD, and George B. Udvarhelyi, MD

This book relates the evolution of ideas in neuroscience up to the end of the 19th century as told by Dr. A. Earl Walker. During his lifetime, Dr. Walker began compiling material for a book combining his love and knowledge of neuroscience and the history of the neurosciences. After his death, his widow and two former colleagues gathered together the many notes, file cards, and photographs that he had left. The result is a narrative that medical students will find informative and that all neuroscientists will find enlightening.



\$65 U.S. Dollars

Call 847-692-9500 or Fax 847-692-6770 to order

A Publication of The American Association of Neurological Surgeons

Spectacular Scientific Program Planned for the 1999 AANS/CNS Section on Disorders of the Spine and Peripheral Nerves Annual Meeting

Meeting Highlights Include:

- New this year: The Scientific Program has been expanded to flow in the exhibit hall, where attendees will have an opportunity to participate in Surgical Techniques Workshops. The topics include:
 - Techniques in Cervical Spine Stabilization
 - Operative Image Guided Surgery in the Spine
 - Pedicle Fixation- Revisited
 - Indication and Techniques for Interbody Fusion
- Presentation of 34 oral scientific papers
- Presentation of over 100 scientific posters
- Scientific Sessions presented by leading experts in spine and peripheral nerve surgery to include:
 - Controversies in Spine and Peripheral Nerve Surgery
 - Interbody Fusion
- Over 60 Exhibits displaying the latest advances in spine and peripheral nerve surgery and technology
- Each physician is eligible to earn a maximum of 18 hours in category 1 toward the American Council for Continuing Medical Education

**February 10-13, 1999
Disney Yacht and Beach Club Resort,
Lake Buena Vista, Florida**

**For registration information contact:
The American Association
of Neurological Surgeons
Phone: 847.692.9500 Fax: 847.692.2589**

Positions

fall '98

Neurosurgeon Pacific Northwest

Active private group practice of neurosurgeons seeks a fifth partner. We are a progressive, well-positioned group in the most rapidly growing area of the Pacific Northwest, the Portland metropolitan area. We seek a BE/BC neurosurgeon with a desire to practice general neurosurgery. Subspecialty training in cerebrovascular neurosurgery or spinal instrumentation is desirable. Our primary admitting hospital, which is adjacent to our office, has superb neuroradiologic support, an excellent operating suite and working environment.

The Portland metropolitan area offers a great quality of life with abundant cultural and recreational opportunities. The practice is well positioned for continued growth.

Please send letter of interest and CV to:
Jay Miller, MD

Northwest Surgical Specialists, P.C.
505 NE 87th Ave. Suite 160
Vancouver, WA 98664-6440

or call: (306) 256-8584 • E-mail: jdmnss@aol.com

A major Health Care System in Northern New Jersey is actively recruiting another member. The current group consists of 3 neurosurgeons and the position will become available starting January 1999. The service is based in two tertiary care teaching hospitals and it receives transfers from other hospitals of the System. There is state of the art neurosurgical equipment, three MRI's, a new angiographic suite, a dedicated neurosurgical ICU and dedicated neurosurgical operating room. Approximately 600 major neurosurgical operations are performed here per year. Our practice is primarily elective spine surgery, including complex spine instrumentation. The volume of the practice is high and also includes microsurgery for tumors, aneurysms, AVM's, stereotaxic brain surgery. The portion of trauma is small. We are in the process of developing functional neurosurgery for the treatment of Parkinson's disease and spasticity. We are located in a pleasant suburban community with excellent schools and which is located 40 minutes from New York City.

We are interested in a young, dedicated, energetic person with good technical skills and personality that would allow him to become a member of a hard working, competent team who has completed his residency within the last 2 years. The person we are looking for should have a basic understanding and skills of spine instrumentation or endovascular training and preferably an interest or expertise in another area of neurosurgery.

Interested candidates please fax your CV to:
O. Hubschmann, MD, (973) 325-6545 or mail to:
O. Hubschmann, MD, 101 Old Short Hills Road, Suite 409,
West Orange, NJ 07052.

Partnership Practice

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Fax: 973-746-6634

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Positions

fall '98

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High Volume, Growth Potential Opportunity in Fort Smith, Arkansas. Spine, General Neurosurgery Solo Practice. Guaranteed base salary plus incentives. Board certified or eligible preferred. Spine Fellowship training beneficial but not required.

Please contact: J. Michael Standefer, MD
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Phone: 501-785-3400
Fax: 501-785-2295
E-mail: mstan@ipa.net

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A spectacular Scientific Program is planned for
**The Annual Meeting of the
Section on Cerebrovascular Surgery of**

**The American Association of Neurological Surgeons
and Congress of Neurological Surgeons and
The American Society of Interventional and Therapeutic Neuroradiology**



**OPRYLAND HOTEL
CONVENTION CENTER**

Opryland Hotel • Nashville, Tennessee
January 31–February 3, 1999

Who should attend: This meeting is directed towards cerebrovascular nurse clinicians, physician assistants, residents, active neurologist, neurosurgeons, and endovascular surgeons and is directly applicable to their practice.

Highlights of the meeting include:

- 20 Luncheon Seminars featuring educational topics in cerebrovascular surgery;
- Scientific Sessions presented by leading experts in cerebrovascular surgery;
- 40 exhibitors showing the latest advances in technology;
- Presentation of 35 oral scientific papers;
- Presentation of 100 scientific posters;
- Eligibility to earn a maximum of 20.5 hours in category 1 toward the Accreditation Council for Continuing Medical Education.

For Registration and Housing Information Contact:
AANS/CNS Section on Cerebrovascular Surgery Meeting Office
22 South Washington Street, Park Ridge, Illinois 60068-4287
847/692-9500 Fax 847/692-9595 cv@neurosurgery.org
<http://www.neurosurgery.org/meetings/sectmeet/summary.html>



ASITN



Please mark your calendars and plan to join us for what promises to be an exceptional meeting.

Calendar

fall '98

Twenty-eighth Congreso LatinoAmericano De Neuro-Cirugia

October 10-15, 1998
Santiago, Chile
Fax: 562-639-5534

The Japan Neurosurgical Society 57th Annual Meeting

October 14-16, 1998
Sapporo, Japan
81-11-716-1161 (ext.5984/5987)

Biology of Neurologic Disease Meeting

October 18, 1998
Montreal, Quebec, Canada
(616) 545-6724

American Neurological Association

October 18-21, 1998
Montreal, Quebec, Canada
(612) 545-6284

American College of Surgeons Annual Meeting

October 25-30, 1998
Orlando, Florida
(312) 202-5000

Second International Meeting of Pan Arab African Neuro-radiology Society

October 31-November 1, 1998
Tunis, Tunisia
216-1-563-142 or 216-1-572-230

North American Spine Society (NASS)

October 28-31, 1998
San Francisco, California
(847) 698-1630

American Academy of Neurological Surgery

November 3-8, 1998
Santa Barbara, California
(313) 936-5015

American Pain Society

November 3-9, 1998
San Diego, California
(847) 375-4715

American Heart Association Annual Meeting

November 8-11, 1998
Dallas, Texas
(214) 373-6300

Congress of the European Society for Pediatric Neurosurgery

November 12-15, 1998
Marseille, France
33-4-91-49-31-74

The British Cervical Spine Society Meeting and The Society for Back Pain Research

November 13-14, 1998
London, England
0171-837-3611, Ext. 3028

Society for Neuro-Oncology

November 13-15, 1998
San Francisco, California

The Japanese Society for Intravascular Neurosurgery - 14th Annual Meeting

November 19-20, 1998
Mito, Ibaraki, Japan
81-29-228-4713

AANS/CNS Pediatric Section Meeting

December 1-4, 1998
Indianapolis, Indiana
(847) 692-9500

Cervical Spine Research Society

December 3-5, 1998
Atlanta, Georgia

American Epilepsy Society

December 4-10, 1998
San Diego, California
(860) 586-7505

Neurosurgical Society of the Virginias Annual Meeting

January 14-16, 1999
Hot Springs, Virginia
(410) 646-0220

European Association of Neurosurgical Societies, Winter Meeting

February 13-16, 1999
Lublin-Warsaw, Poland
48-81-74-25-981

Fourth World Congress, International Stereotactic Radiosurgery Society

February 24-27, 1999
Sydney, Australia
61-2-9956-8333

American Society of Neuroimaging Annual Meeting

February 25-27, 1999
Scottsdale, Arizona
(612) 545-6291

Britspine 1999

March 3-5, 1999
Manchester, England
Fax: 44-161-787-4706

First South Asian Neurosurgical Congress

March 12-14, 1999
Kathmandu, Nepal
009-77-1-221988

Fifteenth Mexican Congress of Neurological Surgery

July 25-31, 1999
Cancun, Mexico
52-5-5430013

Eleventh European Congress of Neurosurgery

September 19-24, 1999
Copenhagen, Denmark
45-35452390

Fourth World Stroke Congress

November 25-29, 2000
Melbourne, Australia
61-3-9682-0288



The American Association of Neurological Surgeons

**April 24-29, 1999
New Orleans, LA
(847) 692-9500**