

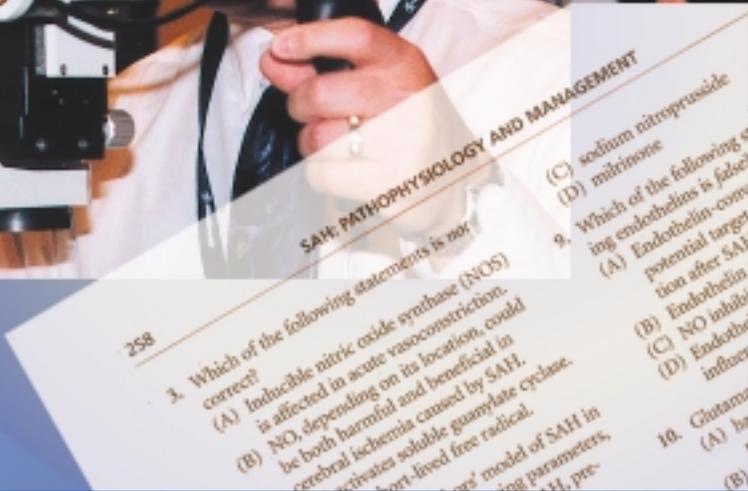
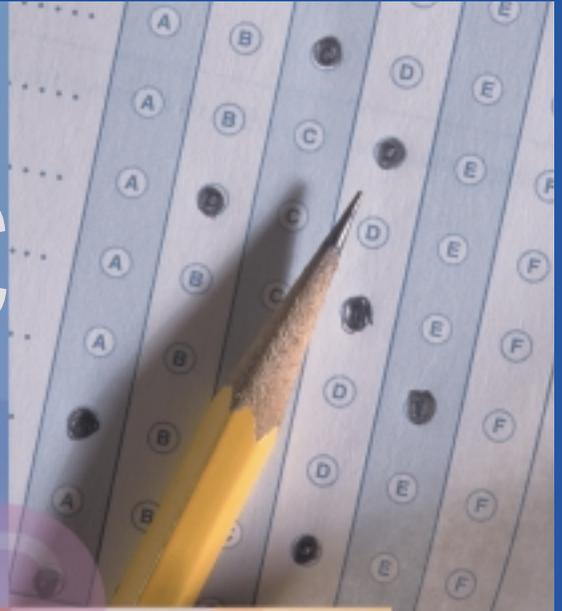
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

BULLETIN

The Socioeconomic and Professional Quarterly for AANS Members • Volume 10 No. 2 • Summer 2001

TESTY TOPIC

NEUROSURGERY PREPARES
FOR **RE-CERTIFICATION**



INSIDE THIS ISSUE

- AANS President Sets Priorities
- Annual Meeting Recap
- Statistical Study Completed



American
Association of
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Surgeons



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VOLUME 10 NO. 2

AANS BULLETIN

The quarterly publication of the American Association of Neurological Surgeons

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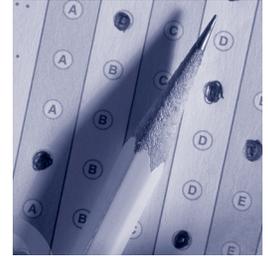
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Taking a Stand on Contemporary Issues

Neurosurgeons Need to Speak Out

A year is a very short time. A mere 365 days after I became president of the AANS in April, I will have to determine whether or not I made a difference for the organization and for you as members. In other words, I can neither waste time, nor can I sit back in complacency and wait for someone else to lead the debate regarding the medical, philosophical, and financial issues that we as neurosurgeons and citizens face everyday. For this reason I have titled the theme of my presidency "Speaking Out," and I expect everyone to join the dialogue.

Speaking Out

A number of contemporary issues are worth speaking out about:

- the future of stem cell research,
- genetic material patents,
- handgun-related violence,
- professional misconduct, and
- neurosurgical reimbursement, to name a few.

These issues are fraught with moral, ethical, religious, and emotional fireworks which make them explosive to discuss and impossible to agree upon, but we must reach a consensus about them and, what is more, we must speak out about them. Neurosurgeons can and should lead the

EDITOR'S NOTE

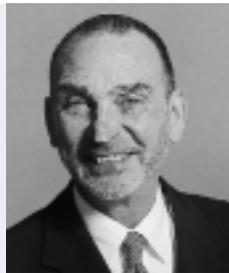
The results of the survey of *Bulletin* readers will be detailed in the fall issue, scheduled to be mailed in mid-September.

medical community by developing strong position statements, some of which may be controversial, and then stand ready to lead national debates.

Sparking Debate

I was recently reminded of just how charged these issues can be when I was

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



selecting the cover art for the 2002 AANS Annual Meeting program. My wish was to select a cover design that would reflect my desire to initiate an organizational debate regarding the use of handguns, but when I showed my art selection (which included two handguns) to some colleagues, a very emotional and heated discussion ensued. Some supported handgun legislation; some opposed it. Some were offended that a handgun was juxtaposed with a brain. Some thought that such issues had no place at an annual scientific meeting.

I realized that if the selection of a piece of art could cause such commotion, I should be prepared for an outright conflagration over stem cell research.

The use of stem cells, and their potential banned use, are issues that profoundly affect neurosurgeons every day. The future of our profession and our patients will be greatly influenced by scientific progress not only in this field, but also in the fields of genetic research and molecular biology.

The fact that stem cell research has been so closely linked with abortion sells the issue short and prevents the public from fully understanding the benefits derived from the use of fetal tissue. Though it will be an arduous task for us to develop a consensus on the issue, we should not shrink away from it—it is far too important.

The Path to Consensus

You already know that consensus is not reached overnight, and it is not done in the presence of only one opinion. It requires that all of us speak up individually in order for us to find our voice organizationally; it requires that you become actively involved in the process of shaping the future of neurosurgery and of the larger society. Join me in this effort to bring meaning to the words of Henry Longfellow, who wrote:

*Look not mournfully into the Past.
It comes not back again. Wisely
improve the Present. It is thine.
Go forth to meet the shadowy
Future, without fear, and with a
[manly] heart.*

In other words, there is no time like the present to speak out. ■

Stan Pelofsky, MD, is President of Neuroscience Specialists, Chief of Neurosurgery at St. Anthony's Hospital and Assistant Professor of Neurosurgery at Oklahoma Memorial Hospital in Oklahoma City, Oklahoma.

STORY ON DR. PELOFSKY

See the Meet the President story on page 13 that profiles the new President of the American Association of Neurological Surgeons.

NEWSLINE

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FROM THE HILL

AANS AND CNS BACK

PATIENTS' RIGHTS BILL

Senators Bill Frist (R-TN), Jim Jeffords (R-VT) and John Breaux (D-LA) introduced on May 15 the "Bipartisan Patients' Bill of Rights Act of 2001." President Bush supports the bill. The AANS and CNS have been working closely with the senators to draft the legislation. The bill mandates that patients can see the physician of their choice, patients have direct and timely access to specialists and health plans are held accountable for treatment denials, among other provisions. For more information, go to www.senate.gov/~frist/Press_Center/News_Releases/01-087/01-087.htm.

- **AANS and CNS Back HCFA Reform** The AANS and CNS have endorsed a HCFA reform bill. The two neurosurgical groups joined the AMA and more than 50 other national medical specialty organizations in March in endorsing the Medicare Education and Regulatory Fairness Act (MERFA), which would reform the auditing practices of the Health Care Financing Administration (HCFA). The bill would require HCFA to adequately educate physicians about Medicare's ever-changing billing rules and procedures, reform HCFA's audit process by giving physicians due process rights that currently do not exist, eliminate random pre-payment audits and require HCFA to conduct at least four Evaluation and Management documentation guidelines pilot tests before they are implemented. Physicians participating in these pilots would be given certain immunity from prosecution for mistakes and errors made during the pilots. To get a copy of the bill and current co-sponsors, visit <http://thomas.loc.gov/> and enter the bill numbers S. 452 for the Senate and H.R. 868 for the House.
- **Neurosurgery Supports Bills** The AANS and CNS recently endorsed the Paul Coverdell Medical Research Investment Act and the Treatment of Children's Deformities Act. The former is intended to increase private charitable giving to medical research by making certain changes to the tax code. These changes include altering the limitations on deductibility beyond the current 50 percent cap to 80 percent of adjusted gross income and extending the carry-forward for excess charitable gifts for medical research from five to 10 years. For a copy of the bill or a list of cosponsors, visit <http://thomas.loc.gov/> and enter bill number H.R. 744 or S. 393. The Treatment of Children's Deformities Act prohibits health plans from denying coverage of medically necessary reconstructive surgery for children. For a copy of the bill, go to <http://thomas.loc.gov> and enter bill number H.R. 792.
- **Audit Finds Fewer Improper Medicare Payments** The Department of Health and Human Services (HHS) published an audit report on March 6 that found improper Medicare payments in fiscal year 2000 to physicians, hospitals, and other providers totaled \$11.9 billion, or about 6.8 percent of the \$173.6 billion in processed fee-for-service payments reported by HCFA. The improper payments ranged from inadvertent mistakes to outright fraud and abuse. These numbers reflected HCFA's continued improvement in reducing improper payments. Previous audit reports showed \$13.5 billion or 8 percent in improper payments in fiscal year 1999 and \$23.2 billion or 14 percent in fiscal year 1996.
- **AANS and CNS Join Suit** The AANS and CNS joined the AMA, the American Association of Medical Colleges (AAMC) and other associations in March in submitting an amicus brief to the U.S. Second Circuit Court of Appeals in the case of *Mikes v. Straus*. In that case, the plaintiff alleged a violation of the False Claims Act (FCA) by claiming that the services for which defendants billed Medicare did not comply with the relevant standard of care. The lower court granted defendants summary judgment, saying in part that "submitting a claim to the Government for a service that was not provided in accordance with the relevant standards of care, . . . without more, does not render that claim false or fraudulent for FCA purposes." The plaintiffs have appealed the lower court decision. The AAMC's brief argued that the lower court holding was correct. The brief also argued that if the plaintiff's expansive interpretation of the False Claims Act is adopted by the court it would effectively transform the FCA into a federal malpractice statute.

NEWSLINE

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NEURO NEWS

MEDICARE TO COVER

NEW TREATMENT

HCFA recently announced that Medicare will now cover angioplasty of the carotid artery with stent insertion, a newer treatment option for the prevention of stroke. The treatment will be covered only under certain conditions. After a review of the scientific and clinical evidence, HCFA has determined that the Food and Drug Administration's willingness to approve certain IDE trials involving carotid stents as well as the evidence regarding carotid stenting concurrent with angioplasty are sufficient to provide limited access to this technology. The new coverage decision is posted on HCFA's Web site at <http://www.hcfa.gov/coverage/8b3-nn.htm>.

- **Neurosurgeons Work on Electrical Pacemaker.** A group of neurosurgeons in California are working on perfecting a neurological pacemaker that may help treat Parkinson's disease and other disorders. The deep-brain simulator uses electrical impulses to treat the tremors of Parkinson's. The device, made by Medtronic Inc. of Minneapolis, recently received approval from the Food and Drug Administration. "A lot of [Parkinson's] patients are hanging on to the Holy Grail of getting a transplant to cure them, while they're ignoring some incredibly effective therapy that's already here," Gary Heit, MD, PhD, a neurosurgeon at Stanford University, told the San Francisco Chronicle. The Medtronic device, known as the Solettra, may also be useful in treating epilepsy, obsessive-compulsive disorder, depression and addiction. Typically, the brain pacemaker is placed in the patient's chest with a wire surgically threaded through a small hole in the skull. For the moderately to severely affected Parkinson's patient, the device can decrease the disease's symptoms up to 85 percent and allow the patient to reduce his medication 50 to 60 percent.
- **Denver Neurosurgeon Aids Uninsured.** The success of Gary VanderArk, MD, in providing medical care for the uninsured in three Denver-area counties was recognized in a March story in the Rocky Mountain News. Dr. VanderArk began Doctors Care in 1988 to ensure that the working poor get access to medical care. He approached doctors, hospitals and foundations to donate their time and resources. In 2000 alone, more than 1,000 adults were referred to one of the program's 350-plus physicians and three hospitals for tests, care and prescriptions. More than 2,000 children were treated in the Doctor's Care for Kids Clinic. Dr. VanderArk's next goal is to help the uninsured statewide to get care. To that end, he helped found the Colorado Coalition for the Medically Underserved. A neurosurgeon in Denver for 30 years, Dr. VanderArk received the AANS 2001 Humanitarian Award at the annual meeting in Toronto.
- **New Implant for Spine Surgery Ready.** An artificial replacement for neck discs is expected to be sold in Europe sometime this year. Spinal Dynamics of Mercer Island, Wash., says its Bryan Cervical Disc System duplicates the anatomic function of the natural disc. The Bryan disc also helps protect the spine from the changes in mechanical stress imposed by fusion procedures that can contribute to degeneration of the discs above and below the level of surgery. Spinal Dynamics expects to begin clinical testing of the device in the United States this year in preparation for seeking U.S. marketing approval. The disc received European certification in September 2000. Medtronic Inc. of Minneapolis acquired the international distribution rights for the Bryan disc for an undisclosed amount. More than 200,000 patients worldwide undergo cervical spine surgery each year for the treatment of damaged discs.
- **Privacy Rules to Take Effect.** President Bush decided on April 12 to allow implementation of the new federally mandated medical privacy rules (*Bulletin*, Spring 2001, pp. 16-17). The rules require doctors, hospitals and other healthcare providers to get permission before disclosing personal patient information. The rules, which take effect in April 2003, create federal fines and imprisonment for those who improperly disclose medical information. In February, Health and Human Services Secretary Tommy Thompson delayed the Clinton administration-approved rules and sought additional input. More than 24,000 written comments poured in. Hospitals, insurance companies and drug manufacturers attacked the rules as too expensive and complicated. The Bush administration stood firm, saying the rules would be only slightly modified. The most significant change would give parents the right to information about their children's health, including records on abortion. The administration also agreed to clarify that doctors can share medical information with specialists treating the same patient.

A Certifiable Challenge

by Jay Copp

Organized neurosurgery prepares for recertification. Here is an overview of what surgeons can expect.

It wasn't long ago that a neurosurgeon could display his or her certificate from the American Board of Neurological Surgery (ABNS) and know the validation of competency was good for a lifetime. That changed for younger neurosurgeons in 1999 when the ABNS endorsed recertification and began issuing 10-year time-limited certificates. Now the concept of recertification is likely to give way to an entirely new process.

Neurosurgery and other medical specialties are considering adopting maintenance of certification. Instead of testing a physician every seven to 10 years, as the specialty Boards do now, physicians without lifetime certificates would have to demonstrate competence on an ongoing basis. A physician would not only take a test but also undertake periodic self-assessment and have his or her practice performance evaluated.

The American Board of Medical Specialties (ABMS) is the driving force behind maintenance of certification. It launched a study of physician competence three years ago in order to meet the demands of the public and legislators.

Maintenance of certification would significantly change how the ABNS and the 23 other specialty Boards, which constitute the ABMS, monitor the professionalism of specialists. For neurosurgeons and other specialties, maintenance of certification would significantly influence CME, annual meetings, journals, and other professional activities. CME, for example, may have to be reconfigured and tailor-made to ensure a neurosurgeon is meeting the requirements of maintenance of certification.

Maintenance of certification also would change the way a neurosurgeon approaches his or her career. For most specialties, recertification is centered on a test. Pass the test, hang the recertification certificate on the wall, and return your focus to your practice. Maintenance of certification brings a new dimension of continual attention to keeping skill sets and knowledge current. It means paying frequent and more focused attention to requirements for maintaining one's good standing within the profession.

Many of the details of how maintenance of certification will



work remain completely open. Like other specialties, the ABNS is free to turn away from the broad recommendations of the ABMS (though that is unlikely). The ABNS is also free to implement the principles of maintenance of certification in a manner that works for neurosurgeons. That is what the ABNS is working on now. The recertification process approved by ABNS in 1998, not scheduled to be implemented until 2006, is being reassessed in light of the principles of maintenance of certification.

"Maintenance of certification is here to stay," said Volker K.H. Sonntag, MD, Chair of the ABNS Committee on Maintenance of Certification. "The train has come in, and we've jumped aboard. But we need to get organized neurosurgery and practicing neurosurgeons to work together on this. We're not about to shove this down anyone's throat. We'll present this to neurosurgeons as we go along. We want input."

Task Force Formed

The roots of maintenance of certification go back to the decision by the American Board of Family Practice in 1969 to limit the validity of its certificates to seven years. The ABMS took notice and

urged other member Boards in 1973 to implement voluntary, periodic recertification. In 1993 the ABMS reaffirmed recertification and required all its Boards to establish plans for recertifying diplomates.

All 24 specialty Boards now limit (or plan to limit) the duration of the validity of their certificates. Some began recertification early on. Thoracic surgeons began receiving time-limited certificates in 1976, and urologists in 1985. Like neurosurgeons, other specialists took awhile to implement recertification. Anesthesiologists began receiving time-limited certificates in 2000. Otolaryngologists will not begin receiving time-limited certificates until 2002.

The traditional goals for recertification have been to improve the care of patients, to set standards for the practice of medicine, to encourage continued learning, and to reassure patients and the public that doctors remain competent throughout their careers. The public's concern about competency has escalated in recent years, especially after the Institute of Medicine released a report in

1999 that revealed that as many as 98,000 people die annually as a result of medical errors.

Recognizing the growing public demand for physician competency, the ABMS created a Task Force on Competence in 1998. David Nahrwold, MD, who heads the Task Force, said, "None of us tolerate incompetence in anything anymore, whether it's having your automobile repaired or any service you receive. We expect that, when we pay the bill, the job has been completely done. Needless to say, the medical profession is not immune to this."

"If our specialty does not do this, it is likely that a generic definition of physician competence will be applied to us."

Competency Defined

The Task Force has delineated six general areas of competency: medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice. The Task Force has also developed examples of the six areas. According to Ralph G. Dacey Jr., MD, ABNS Secretary, most of the examples can be applied fairly easily to all specialties, but the examples in the areas of professionalism and practice-based learning are problematic for neurosurgeons. In a March 2001 report from the ABNS to the AANS, he wrote, "It will be the responsibility of the neurosurgical specialty societies and the ABNS to define exactly what is competence for a neurosurgeon in these six areas. If our specialty does not do this, it is likely that a generic definition of physician competence will be applied to us."

The ABMS focus on physician competency has been mirrored and in some instances done in collaboration with similar efforts by other medical associations. Both the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges have committed to the six areas of core competencies, assuring that

the same principles of competency are nurtured at all levels of medical education and thereafter. Moreover, the ABMS is partnering with the Council of Medical Specialty Societies (CMSS) on competency issues. The ABMS/CMSS Joint Planning Committee is a distinct entity complementary to the Task Force on Competence.

The number of prominent medical groups exploring competency demonstrates the strength of the commitment of organized medicine to the issue. Assuring competency is a movement with powerful momentum.

Maintenance of Certification

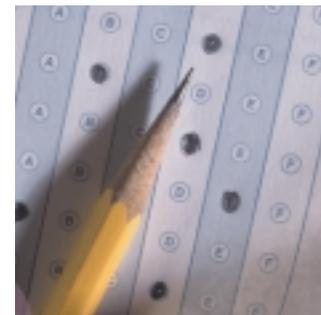
Besides defining physician competency, the Task Force on Competence supported and outlined maintenance of certification. A report from the Task Force stated, "It is now recognized that recertification is necessary but not sufficient to document that a physician is competent to practice a specialty." The Task Force recommends that to maintain certification a specialist provide:

- Evidence of professional standing
- Evidence of commitment to lifelong learning and involvement in a periodic self-assessment process
- Evidence of cognitive expertise
- Evidence of evaluation of performance in practice

Exactly how these requirements are fulfilled needs to be further developed by the ABMS and ultimately interpreted and implemented by the ABNS. Some preliminary details, which may or may not hold up, have emerged. Evidence of professional standing will mean maintaining a valid, unrestricted license, but it also may involve consideration of malpractice claims, peer review, and patient review such as patient satisfaction surveys.

Lifelong learning and self-assessment involve CME and self-assessment tools. "CME will have to support and be part of any program for maintenance of certification. You can't have maintenance of certification without CME," said Dr. Dacey. "CME will be done at a higher standard, in a more professional way."

Some specialties that began recertification years ago already are using self-assessment tools. The American Board of Internal Med-



Continued on next page

Continued from page 7

icine is developing one of the most sophisticated self-assessment procedures. Diplomates complete self-evaluation modules in clinical and communication skills, practice performance, medical knowledge, and patient/peer feedback. The modules can be completed in any sequence at one- to two-year intervals over the 10-year certification span of the ABIM. The modules generally have a pass-fail standard, may be repeated as often as needed, and can be done alone or in groups at home or in the office. The clinical and communications module, for example, consists of multimedia questions about standard physical examinations and communications techniques. Video clips and still images display physical findings, and they test skills such as visual inspection, auscultation, and percussion ability.

Cognitive expertise will be measured by a written examination, most likely proctored. The ABNS Recertification Committee already has been working on a cognitive exam. The Board expects to offer the test in 2006. It probably will consist of 250 general questions and possibly 200 questions related to a neurosurgeon's subspecialty. It may be taken as many times as needed to pass. Some neurosurgeons will fail at least on their first attempt. "The public won't accept it if everyone passes. That won't pass the muster," said Steven L. Giannotta, MD, Chairman of the ABNS.

Practice performance expertise may be measured by taking key cases covering the scope and range of a specialty, and identifying and assessing critical events in those cases. The American Board of Family Practice (ABFP) is one of the specialties that currently require demonstration of practice performance to earn recertification. The ABFP Office Records Review assesses how well a family physician does in caring for patients with hypertension, coronary artery disease, urinary tract infection, and other stipulated conditions. The physicians fill out data collection forms based on his or her review of patient charts, and the ABFP analyzes the physician's competence in treating illness.

Concerns Raised

Establishing a maintenance of certification program raises issues of oversight, cost, fairness, and legalities. The ABNS will have to resolve these issues while framing its own maintenance of certification program.

Some specialty Boards are concerned that maintenance of certification alone is not sufficient to assure the public that physicians are competent. They question whether the public would allow a specialty to monitor itself. It has been suggested that an independent oversight body may be needed. Pediatricians and internists have established the National Physician Quality Council. The council, consisting of physicians and non-physicians, would oversee the practice performance component of maintenance of certification. If the council comes to fruition, they may invite other Boards to participate. The ABNS is not interested in an oversight council and wants to oversee its own maintenance of certification.

"What internal medicine and pediatricians want sounds reasonable, but it's not for us," said Dr. Sonntag. "Who better to judge neurosurgeons than neurosurgeons? What could be more credible with the public than to ask patients how we're doing, to administer peer review, and to pass an exam?"

Cost is another factor in making maintenance of certification difficult for neurosurgeons. The ABNS may have to invest in additional staff and technology to administer the program. Dr. Sonntag, for one, holds that costs would be reasonable after the initial outlay to set up a program. "Once the process is established, it's more of a clerical matter than anything else," he said. "It might be more work for the ABNS office, but it's doable."

A thornier issue is imposing a set of requirements on younger diplomates, while neurosurgeons with lifetime certificates are exempt. (See story on page 40.) Unhappy younger neurosurgeons may argue that older neurosurgeons are the ones who have a greater need to renew their knowledge base. "I am concerned about the idea of taking a written exam on potentially irrelevant material," said John S. Yu, MD, of Los Angeles. "I am also concerned that the exam is limited to more recent graduates. That does not seem fair to me. Review of cases and peer comment seem more relevant."

Hugh Garton, MD, of Ann Arbor, Mich., another younger neurosurgeon, said, "Recertification should just document a process that should be going on anyway. As a subspecialist, my only concern is that the process take into account the specific practice patterns of the candidate."

Having only newly certified specialists subject to maintenance of certification also may cause a public relations problem. The public may not trust a system in which only some physicians among a specialty are rigorously monitored. It may, in fact, turn away from older specialists who are not subjected to the same requirements as younger ones.

However, the lifetime certificates are just that—lifetime. Altering that would be unfair and probably nearly impossible to uphold in court. Over the long haul the problem will disappear on its own. In the meantime, neurosurgeons with lifetime certificates may choose to undergo maintenance of certification voluntarily to prove their worth and marketability. Others may find they need to take part in maintenance of certification if they wish to get a license in another state. Some specialists who have crossed state lines have been denied a license because they had not been recertified.

Cost, fairness, and administrative concerns also were challenges when the specialty Boards established recertification. The Boards that began recertification years ago handled these issues and moved ahead. A challenge they are still grappling with in varying degrees is the harm that may come to specialists who fail to recertify. Physicians without certification are in danger of losing managed care contracts, as well as the prestige associated with higher professional standing.

The failure rate for recertification for general internists usually

hovers around 10 percent. The failure rate for family practice physicians was 8 percent in 1999. Other specialties have fared better. The failure rate for obstetricians-gynecologists is 4 percent, and the rate for orthopedic surgeons is minuscule.

ABNS leaders offer assurances that the exam for neurosurgeons will be fair and that neurosurgeons will have ample opportunity to meet all recertification requirements. "They will be given every chance in the world," said Mary Louise Sanderson, ABNS Administrator. Yet, she cautioned, "Every exam has to have a failing point; otherwise, it doesn't accomplish anything."

"Every exam has to have a failing point; otherwise, it doesn't accomplish anything."

Maintenance of certification isn't a matter of "either you're in or you're out," said Dr. Giannotta. "We'll partner with the educational societies like the AANS to put on remedial sessions to get doctors up to speed."

A final concern is a legal one. The ABMS wants to reassure the public that physicians are competent, but it needs to avoid appointing itself as the final arbiter of who is qualified to practice and who is not. "There are restraint of trade laws that

must be observed," said Dr. Giannotta. "We want to avoid a class action lawsuit. If recertification is linked directly to competence, the whole process could end up getting overturned in the courts."

Organized neurosurgery is taking steps to address these various concerns. The Council of State Neurosurgical Societies decided at its semiannual assembly in April in Toronto to ask the AANS Board of Directors and CNS Executive Committee to petition the ABNS to consider naming a liaison to the ABNS who received board certification after May 1999.

Conclusion

The Directors of the ABNS held a retreat in February to discuss maintenance of certification. Experts from the military, aviation, and other medical specialties described their extensive mechanisms to ensure competence. The Directors emerged from the retreat with the realization that neurosurgery lags far behind these fields in monitoring competence, and they resolved to move ahead with maintenance of certification.

The journey will be long, collaborative, and worthwhile.

"This is an opportunity to make a common sense and effective process that works for neurosurgeons and satisfies the demands of the public and various regulatory bodies," said Dr. Dacey. "The tendency might be to think that this is another burdensome set of requirements, but we have to respond to it. It won't go away." ■

Recertification Requirements Vary Widely

Like the ABNS, the 23 other member Boards of the American Board of Medical Specialties must decide how to implement maintenance of certification and how it will affect current recertification requirements.

How the other Boards currently handle recertification shows the range of options available to the ABNS as it proceeds with maintenance of certification.

The recertification requirements of the Boards vary widely in rigor. About half the Boards use proctored written exams; others use self-assessment exams. A few Boards offer an oral exam as an alternative, but few physicians choose this option. About half of the Boards require completion of continuing medical education courses or activities.

The American Board of Ophthalmology has one of the more detailed and stringent recertification processes. To recertify, diplomates must obtain 300 Category I CME credits, pass an exam, and successfully complete a practice assessment office record review. The purpose of the office record review is to determine if an ophthalmologist meets standards of patient care. The diplomates must choose five patients' records from three ophthalmic diagnoses and complete a computerized questionnaire on each patient's history, examination, diagnostic procedures, assessment, and management. The Board scores the form and provides feedback to the diplomates.

The 24 specialties' recertification policies share some similarities. All Boards assess mastery of recent advances in their specialty. No Board uses the same exam for recertification that it uses for certification. Also, for every specialty, recertification is voluntary for physicians who have lifetime certificates awarded before recertification requirements were developed. All but three of the Boards require recertification every 10 years. Family practice physicians and pediatricians must renew their certification after seven years, and colon/rectal surgeons after eight.

The American Board of Pediatrics offers an innovative recertification process. Pediatricians can take a one-day, written, open-book, proctored exam that consists of 300 multiple-choice questions. Or, they can opt for being tested via computer at home or at another location convenient to them. The computerized test involves three components: knowledge, diagnosis, and management. Components are taken one at a time, and three months are allowed to complete a component.

Recertification fees generally run around \$1,000, although some Boards charge considerably more. Allergists, for example, must pay \$2,000 to complete the recertification process.

—Jay Copp

2001 Annual Meeting

Outstanding Educational Program Highlights Toronto Gathering

BY JAY COPP

The 69th Annual Meeting of the AANS in Toronto offered in just six days in April innumerable opportunities to improve professional talents and patient care for years to come. Neurosurgeons honed their skills at clinics and seminars, advanced their scientific knowledge, enhanced their understanding of socioeconomic issues, honored their peers and renewed old friendships.

Here are some other numbers that show the scope and quality of the meeting:

- The meeting drew 2,466 medical attendees and 5,896 attendees altogether. The majority hailed from the United States and Canada but neurosurgeons from as far away as Germany, Brazil, Turkey and Australia also attended.
- The scientific program included 35 practical clinics, 21 scientific sessions, 126 oral abstract presentations and 500 poster presentations.
- Nearly 200 companies displayed more than 660 technical and institutional exhibits. The latest neurosurgical equipment was featured.

The meeting showcased neurosurgery to millions of people in the United States and Canada through outreach to the media. Fifty neurosurgeons took part in hometown radio interviews and three neurosurgeons participated in a live Web chat on WebMD. Additionally, dozens of reporters were on hand to file stories for their newspaper, radio station or Web site.



Stewart Dunsker, MD, AANS President, congratulates Julian T. Hoff, MD, recipient of the 2001 Cushing Medal.

Presidential Address

In his presidential address, Stewart B. Dunsker, MD, sharply criticized the regulatory burdens imposed on physicians by government and the insurance industry. "Each president of the AANS thinks they have seen the pinnacle of senseless destruction to patient care," said Dr. Dunsker wryly. The primary purpose of the AANS remains educational, yet the ever increasing regulatory repression has forced neurosurgeons to protect and preserve not only the nervous system but the healthcare system itself.

The current healthcare system is based on a false premise, said Dr. Dunsker. "Cost controls have never succeeded in providing long-term solutions to economic problems," he said. The cause of rising healthcare costs is not physician compensation but an aging population, increased demand for healthcare, especially for the sophisticated technology shown by the media, and increased labor costs. Yet the Healthcare Financing Administration, notorious for inappropriately evaluating reimbursement, has targeted physicians and hired former FBI agents who are mistaking "minor accounting errors" for fraud, said Dr. Dunsker.

Dr. Dunsker called on neurosurgeons to be more active in county medical societies, the American Medical Association and other such groups to leverage their influence. "Five thousand levers can move the government and insurance companies," he said. "We need to take part in the debate not in the halls of hospitals but in the halls of legislatures.

"It's easy to sit back and let other physicians do the work. The more we work . . . the more likely we are to change the future."

Canadian Healthcare

The future of medicine in Canada was the subject of a special lecture by Alan R. Hudson, MD, retired president and CEO of the University Health Network in Toronto. Dr. Hudson compared the health systems of Canada and the United States and implicitly offered some advice for his beleaguered U.S. colleagues.

Canada's universal healthcare system outperforms the U.S. system in infant mortality, longevity and other statistical categories even while spending considerably less, said Dr. Hudson. Canadians proudly cherish their system and derisively compare it with the "dreadful American system." Moreover, physicians in Canada get to decide what is medically necessary treatment and the bills they submit are paid in full. Also, regulatory paperwork both for physicians and patients is much less burdensome than in the United States.

Yet the Canadian system is inadequate in some important respects and is facing a financial crisis, said Dr. Hudson. The sys-

tem, ostensibly a one-tier system, actually has several tiers. Nearly one-third of healthcare spending in Canada is from private funds because some services such as the costs of drugs outside hospitals are not covered by the government. Accessibility is also an issue. Canadians in certain regions are much less likely to receive certain procedures such as cataract surgery. Another problem is the relative lack of high-end technology. The entire country does not have a single Gamma Knife.

Adding to these woes are rapidly rising costs in healthcare. "To put it succinctly, we can't afford it. Spending is going up," said Dr. Hudson. Further fueling the troubles are a nursing shortage and a brain drain among physicians, as healthcare professionals head to the more lucrative United States.

Dr. Hudson said the sage advice of New England poet Robert Frost can help Canada emerge from its predicament: "Originality and initiative are what I ask for from my country."

Cushing Orator

Tom Brokaw, the 2001 Cushing Orator, praised the U.S. men and women of the World War II era for saving the world from tyranny and fashioning an affluent modern world whose chief virtue is the abundance of political and individual freedom. Yet, said Brokaw, the anchor of *NBC Nightly News*, the United States today appears to have lost its way. Business, education, healthcare and the media are bogged down by narrow self-interest and mean-spiritedness.

Brokaw asked neurosurgeons to act patriotically. "I hope during the course of this meeting you advance your understanding of an exacting profession. That alone is a great contribution," he said. "I would hope you would ask from time to time, 'Is it enough? What else can I do not just as a physician but as a citizen?'"



Tom Brokaw was the 2001 Cushing Orator.

Neurosurgeons Honored

The exemplary "citizens" of neurosurgery were honored. Julian T. Hoff, MD, a long-time leader in research and education and an AANS Past President, received the 2001 Cushing Medal, the highest honor bestowed by the AANS. Gary VanderArk, MD, who organized a coalition in Colorado to help those without health insurance, received the 2001 Humanitarian Award. Co-recipients of the Distinguished Service Award were Frank P. Smith, MD, and Donald H. Stewart, MD, both longtime leaders in organized neurosurgery. Shekar N. Kurpad, MD, received the 2001 Van Wagenen Fellowship. Dr. Kurpad's research interest is using stem cell transplants to protect and restore cerebral circuitry after high-dose intra-arterial chemotherapy.

New Leaders

The Annual Meeting also saw the changing of the guard. Stan Pelofsky, MD, was elected the 2001-2002 President of the AANS. Roberto Heros, MD, was elected President-Elect; Volker Sonntag, MD, Vice President; Robert Allan Ratcheson, MD, Secretary; Arthur L. Day, MD, Treasurer; and Dr. Dunsker, Past President.

Joining the Board as Directors at Large were Steven L. Giannotta, MD, L.N. Hopkins, MD, and Richard Roski, MD. Joining as Ex-Officio members were Ross Bullock, MD (Neurotrauma Section), David F. Jimenez, MD (CSNS), T. Glenn Pait, MD (History Section), John G. Golfinos, MD (Young Neurosurgeons), and Thomas G. Luerssen, MD (Pediatric Section). ■

Lynn Martin Offers Advice on Advancement for Women Neurosurgeons

Women neurosurgeons who want to advance the status of women in neurosurgery must be more assertive and emulate the tough-minded negotiating strategies of men, said former U.S. Secretary of Labor Lynn Martin, who spoke at the WINS reception at the Annual Meeting.

"Women think they should mediate," said Martin. "Why not just say, 'These are the four things [we want.]'"

"I'm the biggest fan of lists," said Martin. "There is no argument, no fighting, no nothing. 'Here is the list.'" "

Martin, who gave the 8th Annual Ruth Kerr Jakoby Lecture, said that, unfortunately, neurosurgery is a particularly tough field for women to gain advancement in. "The tenure and research tracks to a great extent lay upon the exact times of child rearing," she said. "Women want to have ways to come in and out of the profession."

Not helping matters is the attitudes of some men. "It's still my

belief that there is an undercurrent of sexism in all the surgical disciplines. It's hard to hit because it's subtle—and that's a sign of progress," she said.

Women need to learn how to negotiate contracts and handle other business-related matters if they want to get ahead. "Like most women, I had no ability to negotiate contracts [after I left government]. Men do it better. Men do not emotionalize contracts and women still do," she said.

Martin said furthering women in medicine is not so much a gender issue as it is a human rights matter. She talked about how women in Afghanistan are not allowed to see a doctor, let alone become one. Equity in the workplace is "what America is about. If we do this right, we will all be better off."

—Jay Copp

Meet Your President

Stan Pelofsky, MD, Promises a Year of Action

BY JAY COPP

Stan Pelofsky, MD, the new president of AANS, is confident that he understands the issues neurosurgeons face on a daily basis and that he can effectively represent the rank and file. After all, he deals with those issues himself. "We're in the trenches," he said, referring to Neuroscience Specialists in Oklahoma City, Okla., a large multispecialty practice of which he is president. "We face the same problems our membership faces."

"One of the great strengths of the AANS is we're led by volunteers who are practicing physicians, unlike the AMA and the American College of Surgeons, who use paid executives," said Dr. Pelofsky. "Our leadership is totally connected to the everyday problems of the practicing neurosurgeon."

Dr. Pelofsky was elected President-Elect of AANS at the Annual Meeting in San Francisco in April 2000 and assumed the presidency at the Annual Meeting in Toronto in April. An active member of AANS since 1976, Dr. Pelofsky has served as Secretary of the AANS Board of Directors, Chair of the Council of State Neurosurgical Societies, and as a member of the Governance Committee, Task Force on Medical Education and the Washington Committee.

Dr. Pelofsky is a big supporter of new technology and research, especially stem cell research. "Stem cell research is the one area that appears to offer the most benefits in the future for our neurosurgical patients," he said. "I'm personally distraught that the federal government is poised to shut down funding."

"I would like the medical and scientific community to re-open

and lead the debate on stem cell research. It's our job to reframe the debate to stress the incredible potential that this research offers."

It's been a long climb for Dr. Pelofsky to his current stature in his practice and AANS. In his typically frank and down-to-earth style, he told the *Journal Record* of Oklahoma City that getting to this point in his career involved "just slowly marching up the ladder, hoping you don't miss a rung and fall flat on your back side."

A native of Brooklyn, N.Y., he completed his undergraduate degree at Long Island University and earned his medical degree from the University of Oklahoma in 1966. In 1967, he was commissioned by the U.S. Navy and served in DaNang, Vietnam, where he decided to become a neurosurgeon. He completed his residency training at University Hospital/Oklahoma Health Sciences Center.

He currently serves as Chief of Neurosurgery at St. Anthony's Hospital and as Assistant Professor of Neurosurgery at Oklahoma Memorial Hospital.

Dr. Pelofsky has written numerous chapters for books and articles for scientific journals on such topics as spinal cord stimulation for the relief of chronic back and leg pain, cranioplasty and the socioeconomics of spine disease.

Dr. Pelofsky has served as President of the Oklahoma State Neurological Surgery Society and as President of the Central Oklahoma Council of Hospital Medical Staffs. He also was the recipient of the Gubernatorial Appointment to the State of Oklahoma Advisory Council on Traumatic Spinal Cord and Traumatic Brain Injury. ■

A Pelofsky Primer

The *Bulletin* featured Dr. Pelofsky and his practice, Neuroscience Specialists, in the Winter 1999 issue. His comments below are from that article and from a recent interview with the *Bulletin*.

- **Practice philosophy:** Patient service and a "you bet" attitude are at the very heart of this very busy practice. We make an effort to see referred patients as quickly and efficiently as possible. We all diligently try to dictate our consultations and follow-up notes to our referring doctors the same day.
- **Advice for neurosurgeons starting their own practice:** Neurosurgery is not only a profession, it is also a business. A neurosurgeon must develop business acumen. The neurosurgeon entering practice should certainly become involved in their state neurosurgical societies as well as, most importantly, the Council of State Neurosurgical Societies—where more business knowledge is exchanged in the field of neurosurgery than anywhere else in the universe.

Membership in the AANS and participation in the courses AANS offers are a fabulous source of professional and business knowledge. Without this business knowledge, your reimbursement in the present marketplace will not be maximized.

- **Future of neurosurgical private practice:** Bigger is not only better but may be the only way. In this day and age, large groups cannot only accomplish economy of scale but also can develop contracting advantages. The solo practitioner and small practice groups will find it very difficult to compete against the large groups in the future.

My partners and I are quite proud of the spine hospital we recently built and now operate. It was a labor of love that has proved to be highly rewarding. For the first time in our careers we are now able to totally control the quality of care our patients receive.

Not Talking Can be Costly

Communication Can Prevent Liability Claims

BY JOHN A. McRAE, MD, AND JOAN BRISTOW, RN, MA

This is the second of a series of articles from The Doctors' Company (TDC) on potential liability exposures faced by neurosurgeons. For any risk management questions or comments, call TDC Risk Management at (800) 421-2368, ext. 243.

No one doubts that caring for the hospitalized patient requires a team effort, and each team member must have all the information necessary for effective participation. Communication among team members must be clear and complete.

Communication problems can occur in a variety of settings. For example, a patient may be jeopardized when the referring doctor provides too little information to a neurosurgical consultant or when nurse-to-nurse communication lacks critical data. The sort of communication problem that is most likely to precipitate a malpractice action occurs between nurses and physicians. As the following case illustrates, the fault generally lies with both parties.

Clear Instructions Are Essential

Several years ago, a 39-year-old man was brought to the emergency room of a large hospital, shortly after being struck in the head with a baseball bat. He was adequately evaluated and then discharged. Eleven days later, the patient returned to the ER complaining of increasing lethargy. He was hospitalized, and a CAT scan raised the question of an isodense subdural hematoma crescent. It was late in the evening by the time the scan was interpreted and the patient was alert, so his neurosurgeon decided to wait until morning to perform an MRI.

When the neurosurgeon left the hospital at 10 p.m., he wrote orders for the nurses to check the patient's vital signs hourly. The neurosurgeon gave no specific direction, however, to note the status of the patient's pupils or state of consciousness, or to call the neurosurgeon if any alteration occurred.

The neurosurgeon later said he felt it was unnecessary to leave such directions because the nurses should have understood their duty in this regard.

The nurses, however, were not alert to a progressive deterioration during the night. It was not until the patient was profoundly comatose at 4 a.m. that the neurosurgeon was called. A craniotomy performed at 6 a.m. identified a subdural hematoma. The patient died five days later.

At trial, several negligence issues arose, but the plaintiff's attorney mainly concentrated on failed communications—the failure of the neurosurgeon to give the nurses sufficiently clear instructions and the failure of the nurses to call the physician when the patient was obviously deteriorating. The jury returned

a verdict against the hospital and neurosurgeon and awarded the patient's family \$700,000 in damages.

Handling an Emergency Situation

Many lawsuits are brought against neurosurgeons when usual and customary complications occur. This shows that the informed consent process failed, either by omission or inadequacy. Neurosurgeons are the specialists on call for motor vehicle accidents and other emergent events. Frequently, the patient is not coherent or capable of providing informed consent. How should a neurosurgeon handle this type of emergency?

Although precedent allows the neurosurgeon to proceed with a surgical procedure and bypass the informed consent process by documenting the emergent condition of the patient, good loss prevention measures suggest another approach. While the patient is in preparation for surgery, the neurosurgeon can communicate with the patient's spouse, adult children, other family members or even friends and ask one of these people to participate in the informed consent process.

The neurosurgeon should share information about the risks specific to the patient and his or her injuries. The neurosurgeon should assess the level of understanding of the person who will sign the informed consent and should be straightforward. We often see lawsuits brought against a neurosurgeon when a patient dies during surgery or comes out of surgery with paralysis, even when either of these conditions would have occurred without medical intervention. It is the neurosurgeon's responsibility to convey these potential outcomes to whomever is reached for consent. A lawsuit may still be brought against the neurosurgeon, but defending the suit will be easier with this kind of communication and documentation of informed consent.

Evaluating the Situation

Whether it is preoperative or postoperative patient care, the neurosurgeon's responsibilities extend to giving clear and concise instructions to the allied health care professionals who attend the patient. It is important that the neurosurgeon give caregivers explicit written orders, followed by an oral repetition of the instructions. Neurosurgeons also should develop a rapport with their patients' bedside caregivers before emergencies occur. ■

John A. McRae, MD, a retired neurosurgeon in Southern California, serves on the TDC Board of Governors. **Joan Bristow, RN, MA**, is Vice President of TDC Risk Management. TDC offers malpractice insurance at a reduced rate as a benefit of AANS membership.

Statistical Study Results

Report Answers Common Questions About Neurosurgery

BY HEATHER MONROE

The media, AANS members, third-party payers, other medical associations, Congress, referring physicians and the general public have all inquired about statistics on neurosurgery. How many brain tumor procedures do AANS members perform every year? How many AANS members are in group versus academic or solo practice? What is the percentage of spine procedures performed in comparison to other neurosurgical procedures?

These questions now can all be answered with the AANS Neurosurgical Procedural Statistics report, which highlights procedures performed by AANS members throughout 1999. The report, the first-ever of its kind, was produced by the AANS Public Relations Committee and AANS Communications Department.

The results of the survey may come as a surprise to some AANS members. The top reported surgery performed in 1999 was spine (527,610), followed by cranial (191,991), CSF shunting (38,167), peripheral nerve (33,924), pain-functional (14,589) and extracranial cerebrovascular (8,362).

"These statistics are critical to the AANS in furthering public outreach efforts," said Ronald Warnick, MD, Chair of the AANS Public Relations Committee. "The statistics within this report support our message to the public that neurosurgery is not just brain surgery. It is also low back pain, Parkinson's disease, neck pain, epilepsy, stroke, carpal tunnel syndrome and others."

Another highlight of the report is the finding of a slight upswing in the number of surgeries performed. Forty percent of all respondents reported that they performed more surgeries in 1999 than the previous year, 24 percent reported a decrease in surgical procedures and 37 percent reported that the number of surgical procedures remained the same.

The four-page survey was distributed in June 2000 to a random sampling of more than 1,500 active AANS members in solo, group and academic practices. The survey asked members to identify procedures based on CPT codes. More than 400 AANS members responded to the survey.

The results were extrapolated to the entire AANS membership. The results were then compared to external benchmarks in the Health Care Financing Administration database and the Dartmouth Musculoskeletal Atlas. The survey results were consistent with those external benchmarks.

The results reflect the number of procedures performed by AANS members. It does *not* represent the total number of operations or cases performed by all neurosurgeons.

AANS Public Relations Committee Members dedicating their

time to this project included Bruce Kaufman, MD, Robert Harbaugh, MD, and Dr. Warnick.

The AANS began publicizing the results of the report in the spring. The statistics also will be used in AANS promotional materials and AANS press releases. In addition, members of the 50-person AANS National Spokespersons Network received a copy of the report. The report is posted at www.aans.org.

Mat Press Releases A Success

Four camera-ready mat releases or newspaper articles were written and produced by the AANS Public Relations Committee and AANS Communications Department last fall. As of May 2001, these articles were printed in more than 150 daily and weekly newspapers, reaching a combined circulation audience of more than 2 million people nationwide.

The articles were designed to further educate the public about the broad scope of neurosurgery. The four topics were sports-related head injuries, low back pain, stroke and Parkinson's disease.

AANS members helping on this initiative were Howard Weiner, MD, Ghassan Bejjani, MD, Peter Le Roux, MD, and Dr. Warnick.

The articles will continue to run in newspapers across the country. To view the mat releases, visit www.neurosurgery.org/aans/media/matpress.html.

Journal of Neurosurgery Articles Publicized

The AANS Public Relations Committee and Communications Department have initiated a project to further educate the public about neurosurgery while highlighting new and innovative neurosurgical procedures.

On a regular basis, the Public Relations Committee identifies articles in the *Journal of Neurosurgery* and *Journal of Neurosurgery: Spine* that are of public interest. A press release is drafted based on a chosen study and at least one author of the study (typically an AANS member) is interviewed. The release is then distributed to reporters nationwide.

Each press release has been successful in garnering media interest. A press release on "Catheter Manipulation Within the Brain" received exceptional media coverage including an interview by Sean Grady, MD, on the show, "The Doctor is In," for eYada.com and calls from *Medtech Insight*, *HealthScout*, *Clinica World Medical Device* and *Diagnostic News* and *Biophotonics International* magazine.

A press release on "Neurosurgeons Find Strong Association Between Cigarette Smoking and Aneurysm Rupture" received interest from the *New York Times* and *Neurology Reviews*. ■

Healing Across Borders

Louisiana Neurosurgeon Aids Southeast Asia

BY JAY COPP

A Louisiana neurosurgeon, Thomas Flynn, MD, has traveled to subtropical Southeast Asia on humanitarian missions more than two dozen times since 1985. The climate and landscape he encounters are similar to his home state but the neurosurgical environment is a world apart.

The back country of Thailand has one neurosurgeon for five million widely scattered villagers. Ho Chi Minh City in Vietnam has three or maybe four x-ray machines in the entire city. Laos has no CTI or MRI machines whatsoever. The amount of aneurysm clips, self-retaining retractors and other medical equipment taken for granted in the United States are in comparably short supply, too.

Dr. Flynn's mission has been to transport desperately needed medical supplies to Southeast Asia. While there, he teaches, makes rounds and works in clinics and hospitals. He also arranges for Southeast Asian doctors and medical students to come to Baton Rouge on fellowships. The goal has been to empower the neurosurgical community in Southeast Asia by teaching them the latest skills and technologies.

The 15 medical personnel that have come to the United States on fellowships either work at Dr. Flynn's Neuro-Medical Center or at Our Lady of the Lake Hospital.

Many neurosurgeons provide free care, volunteer in deprived communities or otherwise give back to society. Dr. Flynn does it on a grander scale than most. The AANS saluted Dr. Flynn for his philanthropy when he was awarded the association's 1999 Humanitarian Award.

He recently rescued 60 wheelchairs fated for a garbage dumpster and had them shipped to Thailand. One nation's trash is another's treasure. Dr. Flynn has a sharp eye for discarded or obsolete equipment and supplies that work just fine in less prosperous nations such as Laos and Vietnam.

The equipment he sends to Southeast Asia is not always free. And the shipping costs are steep. Dr. Flynn estimates he has spent more than \$1 million out of his own pocket supplying overseas hospitals and clinics with surgical microscopes, stereotactic CRW frames, double J catheters and myriad other items.

His generosity of time and money has won him friends in high palaces. He once spent a day with Queen Sirikit of Thailand at the palace in Bangkok. King Bhumipol and her both have conferred honors on Dr. Flynn. He first came to the attention of the queen when he donated supplies to a hospital she sponsors.

U.S. medicine is a welcomed import in Thailand, says Dr. Flynn.

"They are very keen to emulate American medicine. They use American textbooks. The doctors understand English very well, if



Thomas B. Flynn, MD (right), put his neurosurgical skills to good use while in Thailand.

not speak it," he says.

Vietnam is another story. The medical community has received him warmly, but authorities remain suspicious of Americans. In the 1980s, soldiers stopped the bus he was on and jabbed him with their rifle butts. Fortunately, Dr. Flynn was traveling with the then-vice minister of health, a former Viet Cong general, who convinced the soldiers to calm down.

Dr. Flynn first visited Southeast Asia at the suggestion of a longtime U.S. missionary, whose daughter worked in his Baton Rouge practice. Dr. Flynn's mission is more than medical. He is accompanied on his trips by a Christian missionary, who doubles as his translator.

"I feel very strongly about my faith," he says. "I don't stand on the corner and wave a Bible. But we make people aware that what we're doing is an act of Christian charity. We don't have mass rallies but, hopefully, the seeds are planted."

Neurosurgeon Frank Culicchia, MD, of New Orleans sometimes accompanies Dr. Flynn on his trips.

Last year Dr. Flynn began the Southeast Asian Medical Aid and Teaching Foundation to formalize his charitable outreach. One of his goals is to regularly send neurosurgeons to Southeast Asia to teach. With enough assistance, eventually the neurosurgical community in Southeast Asia would no longer need charitable physicians such as Dr. Flynn.

Those interested in assisting Dr. Flynn's efforts can reach him at (225) 769-2200 or at hallsboy@prodigy.net. ■

The Harm of Economic Credentialing

Hospitals Tempted to Use Financial Data to Select Staff

Economic credentialing may be defined as the use of economic criteria, unrelated to quality assurance, to determine a neurosurgeon's qualification for the grant or renewal of medical staff membership or privileges. This type of credentialing is inappropriate. The need to prevent economic considerations from affecting medical determinations regarding quality care is critical. The introduction of economic factors into medical staff credentialing is particularly threatening. Patients will be denied hospital services if qualified physicians are denied medical staff membership because of the economic mix of their practices and patients.

Physician Profiling

In its day-to-day management, a hospital administration utilizes information systems to gather data necessary for billing, payroll, personnel and planning. Given the constant flux in healthcare financing in both the private and public sector, hospital billing and collection data systems are becoming particularly complex and have spawned a variety of data to assist hospital accountants. The data collection has led to the creation of physician profiles.

Physician profiling, i.e., accumulating data separate from medical staff quality assurance systems on the physician's admission and treatment decisions, already has created the potential for economic pressures to affect the care provided the hospitalized. How physician-specific economic information is utilized in the hospital is key for quality assurance. Appropriately utilized, some profile information has or could play a positive role in assessing care quality. Conversely, the inappropriate use of profiles for economic reasons in the credentialing system can have devastating, long-term effects on quality and access to care.

A review of the literature and of the data systems available to hospitals was summarized last year in CMA ON-CALL (the California Medical Association's online library) Document 1212. It shows that some data may serve a purpose related to patient care and other data commonly collected by hospitals clearly does not. According to the CMA Document 1212, criteria that could be used by hospitals can be grouped into three categories: 1) criteria that are valid for quality assurance purposes, 2) those that may have validity for quality assurance, 3) those that have no quality assurance validity. Examples of criteria that have validity for quality assurance purposes include length of stay, number of ICU days, excessive and redundant testing, fraud and abuse, health status, office proximity and disruptions of hospital operations, as they pertain to patient care and excessive number of denial letters.

Examples of economic data that may have quality ramifications depending upon the clinical context include comparison of resources used (variation studies), number of tests ordered, comparative profiles of physician outcomes and resources utilization within the same DRG category, number of hospital admissions vis-à-vis outpatient services utilization and number of consultants/referrals.

Selected examples of criteria that do not apply to quality include personal referral patterns, resource utilization in dollars, physician profit by reimbursement, physician profit by cost, revenue per physician, commercial payor profiles, market need for particular type of physician, comparative use of inpatient services and operating room underutilization.

Although the use of the above fiscal information may appear to be sound busi-

ness practice, straight application of sheer business motives in the delivery of healthcare, most particularly in a hospital, is not acceptable in public policy or law. Selection of medical staff members based on the relative profit by cost or reimbursement level, or other criteria wholly unrelated to the quality of care provided, creates innumerable hazards. The ultimate problem is the unavoidable negative affect of economic credentialing on patient care. Physicians whose patient base generates less profit for the hospital may be refused medical staff membership. People who have the misfortune to contract an inefficient disease will go without hospital care. The use of, or sanctioning of, economic credentialing may convert the medical staff to a listing of those practitioners who generate profit rather than high quality medicine.

The Exclusive Contract

Exclusive contracts have existed for a long time throughout the nation. Traditionally, these contracts were entered into to assure access and quality of care. More recently, financial considerations have grown in importance as reasons for exclusive contracting. The exclusive contract has the potential for abuse by circumventing the quality improvement mechanisms of the medical staff. The contract may put the physician or physician group in a position of being controlled by the hospital's financial plan. Neurosurgeons need to recall that the negotiation position of a single doctor or small group of doctors versus the hospital corporate entity is rarely one of equal bargaining power, particularly where there is a surplus in the specialty and no other local facility in which to practice. ■

John A. Kusske, MD, is former Chair of the AANS Managed Care Advisory Committee.

Practice Expense Revisions

Coding Committee Strives for Equity

Although many assume that reimbursement for a procedure code represents payment for physician work, this is only one variable in the complicated formula determining the allowable payment. Given the frequent adaptation by third-party payers of the Resource-Based Relative Value System (RBRVS) of the Health Care Finance Administration (HCFA), changes in the calculation of total relative value units will have broad effects on non-Medicare reimbursement as well.

In response to a Congressional mandate, HCFA is in the process of “refining” the practice-expense calculations so that these are also “resource-based” values. Given the potential for significant changes in this component of the total relative value, it is timely to discuss the evolution of this process and the current efforts of the Coding and Reimbursement Committee (CRC) to maintain an equitable transition.

With the creation of RBRVS by Professors Hsiao and Braun, HCFA adopted a formula for calculating the total relative value (RVU) of a procedure code based on three components and a correction factor. First, the physician work component (RVw) reflects the time, effort and complexity of the physician activities before, during and after a surgical procedure is performed within the designated global period.

The second component involves an estimation of the expense to the practice (RVpe) in performing the required services. Finally, the third component reflects the malpractice cost (RVm). These components are further adjusted by geographical correction factors.

Although the relative proportion of these three components varies among procedures, a typical breakdown of total RVU is 50 percent RVw, 45 percent RVpe, and 5 percent RVm. Consequently, changes in the

practice expense calculation can have a significant impact upon the total RVU.

Advisor Group Created

The original allocation of resource-based practice expense was derived from a HCFA-contracted study by Abt Associates. The study used two groups of experts to develop a database of cost estimates. The Clinical Practice Expert Panels (CPEPs) were comprised of physicians and administrators nominated by specialty societies to estimate direct costs.

In contrast, the Clinical Practice Expert Panel Technical Expert Group consisted of representatives from organized medicine who were charged with monitoring data collection to ensure reliability. The transition to a resource-based calculation began in 1999.

Because of concerns about the validity of the CPEP process, the Relative-value Update Committee (RUC) of the American Medical Association created an advisor group called the Practice Expense Advisory Committee (PEAC). A basic set of ground rules were developed to examine direct expense inputs (clinical labor, office supplies and equipment) on an individual code basis. Although standard postoperative surgical supply packages were developed by the PEAC, the CRC presented separate supply packages for neurosurgical procedure codes that were accepted by the PEAC as well.

A significant achievement was agreement to clinical labor times for evaluation and management (E&M) services. This facilitated development of staff time for the E&M components of surgical procedure codes with global periods. The committee accepted the recommendation to use the RUC database of postoperative visit frequency and service level to calculate post-service clinical staff time.

Another significant achievement was the development of a “standard package” for preservice clinical staff time for 90-day global procedures by a PEAC workgroup. Currently, the preservice clinical staff time for neurosurgical procedure codes can vary from none for emergency procedures to more than two hours for spinal procedures.

Although a “standard package” for preservice clinical staff time of one hour was developed, opportunity to provide data showing different times and staff blends was given. The CRC recommended longer preservice time and a different clinical staff blend to the PEAC in March based upon preliminary survey data. However, the PEAC showed significant discomfort with adopting times that deviated from the standard package. Consequently, the prior Preservice Workgroup was reconvened to develop criteria for deviating from the standard package.

Effect on Reimbursement

Although implementation of the standard preservice clinical staff time for all 90-day global codes has been postponed for one year, this process soon may have a significant impact on reimbursement for all procedure codes. The CRC will continue to accumulate survey data to determine if the standard preservice time and clinical staff blend is truly representative of neurosurgery. With input to and guidance from the Preservice Workgroup of the PEAC, the CRC will make every effort to ensure an equitable distribution of practice expense dollars among procedure codes. ■

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

N://OC® Update

Many Improvements Increase Web Site's Value

BY JOEL D. MACDONALD, MD

NEUROSURGERY://ON-CALL® was founded in part to subserve the mission of the AANS. Specifically, N://OC was intended to promote the specialty of neurological surgery and improve neurosurgical patient care. It has evolved into a powerful communication tool and educational resource for both practicing clinicians and the general public. Over the last quarter, N://OC has enjoyed ongoing stability in site utilization. During the month of March alone, 52,442 page impressions were logged to the AANS component of N://OC. Page impressions represent the number of actual pages viewed. Over 19,000 user sessions occurred and a total of 11,431 unique visitors were recorded. These statistics suggest that N://OC is an important vehicle for information.

Several New Projects

Several projects have recently been completed or are currently under way to enhance the utility of both N://OC and the AANS Web site within N://OC.

■ **The AANS Online Marketplace.** This online store is a popular destination within the Web site. The products are primarily neurosurgical textbooks and AANS publications. The Marketplace has undergone a significant reorganization with a new scheme for categorizing publications. Each product now includes a more detailed and broader description of its contents. An improved key word search system has also been employed to facilitate more rapid and accurate retrieval of relevant products.

■ **Membership Application.** N://OC staff is working with the membership departments of both the AANS and the CNS to develop an online membership application. This will allow prospective members of both organizations to complete all the necessary components of the application process online. It is hoped that this system will facilitate more rapid review of prospective members and ultimately an improved efficiency in enrolling new members.

■ **Guidelines Database.** The AANS Department of Education and Practice Management recently completed a database repository of clinical guidelines at www.neurosurgery.org/guidelines/repository.asp. Working in conjunction with the Outcomes Committee, this database will be gradually expanded to include standardized recommendations on the breadth of neurosurgical clinical problems.

■ **New Member Benefits Page.** This new page can be accessed at www.neurosurgery.org/aans/membership/benefits.html. The comprehensive page details the many benefits offered with AANS membership in terms of clinical education, practice management resources, professional services and service benefits. Each line item is hyperlinked to a detailed document regarding the specific bene-



fit. This page is a useful relay point to investigate everything from continuing medical education opportunities to professional liability insurance and membership related discount programs.

■ **Neurosurgical Focus.** *Neurosurgical Focus* is undergoing a facelift. This high quality online electronic journal is one of only eight similar electronic journals listed in Index Medicus. In the past, journal articles have been provided in PDF format to maintain the high quality look and feel of the *Journal of Neurosurgery*. Unfortunately, this format precluded extensive key word categorization of the individual articles; therefore, there has been no convenient method for conducting a search of the content of articles. The updated version, slated for release over the summer of 2001, will include a method for searching the entire holdings of *Neurosurgical Focus* and links to publication-quality PDF downloads. This will significantly strengthen the journal's utility as a research tool.

■ **Capitol Hill Link.** Finally, a new icon for "News from Capitol Hill" now provides a rapid link to late breaking news from the Washington Committee. The new icon, which displays our nation's Capitol Building, is accessible on many pages throughout N://OC and the AANS Web site. The Capitol Hill page will be updated frequently, providing an easy way to keep abreast of ongoing initiatives of organized neurosurgery.

N://OC continues to thrive in the turbulent waters of the Internet economy. It is an important online focal point for educational resources and communication. It continues to represent a valuable member service. Please stop by N://OC today and see what is new.

Joel D. MacDonald, MD, is Editor of NEUROSURGERY://ON-CALL®.

How to Stay Compliant

A Primer on Risk Management, Part II

This is the second of a two-part series on regulatory bodies.

Neurosurgeons must comply with more than 132,000 pages of Medicare and Medicaid regulations. What can you do to protect yourself so as to minimize the risk of federal prosecution? There are three things that are absolute requirements: education, documentation and compliance.

The Necessity of Education

Neurosurgeons need to know the innumerable regulations promulgated by the government and others. Fortunately, there are many educational resources to assist you. The AANS and CNS offer courses and seminars on reimbursement and practice management. The American Medical Association offers a wealth of programs and educational materials, as do state and local medical societies and most hospitals. In addition, the medical industrial complex has created a whole new opportunity for private consultants, who, for a fee, can assist you on nearly every aspect of your practice.

The bottom line is that you must continue to educate yourselves on these practice management issues. Indeed, it is virtually a requirement of the federal government that you do so, as ignorance of the law is no defense.

Documentation

As residents, you are probably all too familiar with the Payment at Teaching Hospitals or PATH audits. Four early investigations of teaching hospitals under this audit program resulted in settlements in excess of \$65 million. The largest problem was the lack of documentation to demonstrate that the service actually did take place and that the reimbursement was therefore appropriate.

You must have documented proof of the services you provide. Vague notes or references in patient charts are not sufficient. Two areas require specific attention: Medical Record Documentation and the HCFA 1500 Form.

The federal government requires that a medical record documents (a) the site of the service, (b) the appropriateness of the services provided, (c) the accuracy of the billing and (d) the identity of the caregiver.

Medical records should be complete and legible. Documentation of each patient encounter should include the reason for

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the encounter, any relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression, or diagnosis, plan of care, and date and legible identity of the caregiver. CPT and ICD-9-CM codes used for claims submission should be supported by documentation and the medical record. Finally, appropriate health risk factors must be identified.

The HCFA 1500 is the billing form that must be used to be reimbursed by Medicare. In completing the form, make sure the reason for the visit or service is linked with the diagnosis code. Use modifiers appropriately. Provide Medicare with *all* information about a beneficiary's other insurance coverage.

Compliance

The Office of Inspector General's compliance program (Office of Inspector General's

Compliance Program Guidance for Individual and Small Group Physician Practices, September 2000) is complicated and burdensome. Why should you attempt to understand it? The six criminal statutes highlighted in Appendix B of the report and the four civil and administrative statutes highlighted in Appendix C of the report!

The components of voluntary compliance are: conducting internal monitoring through periodic audits, developing written procedures for compliance, designating a compliance officer in your practice, conducting training practice standards, responding appropriately to detected violations, developing open lines of communication among employees about compliance and enforcing disciplinary standards through well-publicized guidelines. The OIG acknowledges that full implementation of all the above components may not be feasible for all physician practices. Note, however, that there is a general feeling that the lesser of two evils is to *not* have any compliance program as opposed to *having one, but not following it*. Make sure that you set up a realistic plan and adhere to it!

Conclusion

Gone are the days when the practice of medicine was a personal relationship between doctor and patient. The exam room is now overcrowded and in addition to the doctor, patient and nurse, you will find your Congressman, HCFA, government auditors, insurance company bean counters, accountants, billing clerks, compliance officers and the dreaded lawyers. To counteract this, organized neurosurgery is helping to develop a comprehensive reform proposal similar in nature to the IRS reform legislation of several years ago.

As complicated as all of these may seem, it isn't brain surgery. If you continue to educate yourselves on these issues and participate in the regulatory and political processes, you will be able to effectively deal with the governmental regulatory bodies and stay out of jail and prosper as successful practicing neurosurgeons. ■

Basic Digital Imaging

How to Get Great Intraoperative Images

Most surgeons have attempted photography of an interesting case at one time or another. Typically, 35mm slides are shot through a camera coupled with the operating microscope. Occasionally, just one print from each roll of film may be worth showing. Most often, picking up the dark, blurred, and often featureless results from the photography department brings a sense of frustration.



The afocal setup assembly is mounted on the microscope eyepiece, and the remote control is placed near the microscope control arm.

The digital revolution of the past five years has provided a multitude of consumer digital cameras with capabilities once the province only of professional photographers. The neurosurgeon with a working knowledge of computers, employing one of these modest cameras, can obtain spectacular intraoperative images far beyond the typically frustrating results obtained with film. This article will attempt to provide a basic guide to intraoperative digital imaging using today's commercial digital cameras and the operating micro-

scope. It is hoped that it will convey the simplicity of operation of today's affordable equipment and the excellent results that can be achieved using it.

Anatomy of the Digital Camera

The heart of the digital camera is the CCD or charged-coupled device. This solid-state semiconductor consists of a thin matrix of silicon which has been sparsed into a grid of picture elements or pixels. These pixels act as light sensors. As photons of light strike a pixel, an electric charge is created. This charge is proportional in magnitude to the intensity of the sensed light. The resulting electrical charges are then transferred in sequence to an analog-to-digital converter which outputs an electronic rendition of the image which can then be stored or displayed with a computer.

Important Camera Features

There are a number of excellent cameras available on the market and the list grows longer each day with the addition of more sophisticated and higher resolution capabilities. Important features to consider when selecting a camera for intraoperative imaging include the CCD format or resolution, optical zoom capabilities, threaded lens, storage and transfer method and an LCD.

CCD resolution is critical for sharp, crisp output of the image to a monitor or when printing to slide or film. The more pixels present on a CCD chip, the higher the resolution. This is achieved by subdividing a chip into smaller and smaller pix-

els. The multi-megapixel cameras with greater than 2 million pixels (non-interpolated) are preferable.

Optical zoom refers to the ability of the lens to change focal lengths, thereby enlarging the subject image. Care must be taken in discerning optical zoom and digital zoom. Digital zoom refers to a camera's ability to further enlarge the image by interpolating and adding new pixels to the image. The result is significantly inferior and has little usefulness for intraoperative imaging. The minimal optical zoom capability should be at least 3X.

Another important feature regarding the lens is the ability to take macro images, which are extreme "close-up" shots, usually within one foot or less. This feature is needed for through the microscope shots as well as for framing individual pictures of CTs or MRI films.

Lastly, the presence of threads on the camera's lens allows significant flexibility in using alternative lens converters, filters, and coupling the camera to the microscope. A variety of accessories are available which screw onto these threads.

The method of image storage and ease of download refers to how the camera stores and downloads its pictures to the computer or printer. Various methods are employed by different camera manufacturers. These include fixed storage within the camera, 3.5 inch floppy discs, removable memory cards and, in some newer cameras, recordable CDs or miniature hard drives such as the IBM Microdrive. For ease of use and maximum flexibility as well as economic concerns, removable type media is preferred. Downloading to a computer can be accomplished via parallel, SCSI, or serial cable and in newer cameras via USB cable. USB is preferable due to the faster communication with the computer, but it requires a USB equipped PC or MAC. Most cameras that offer USB also offer serial and/or parallel connection options.

Most digital cameras offer a preview screen apart from the optical viewfinder. Preview screens are small LCD color dis-

plays built right into the camera. The small LCDs are essential in framing and composing intraoperative images. It allows you to preview what the camera will see before the picture is taken, as well as allow for fine adjustments during coupling of the camera to the microscope. In addition, they allow review of taken images to ensure the expected result. The optical viewfinder although useful for most general photography, has no value during intraoperative imaging.

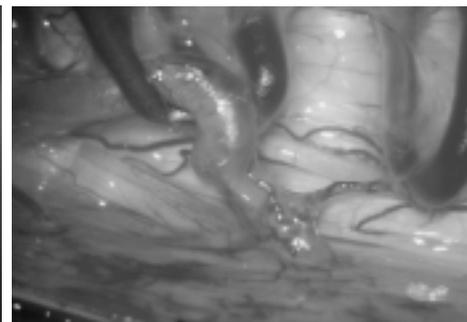
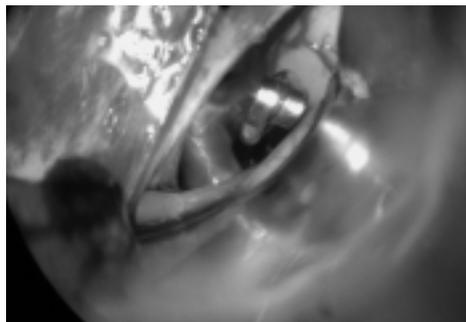
Camera Recommendations

The ideal camera for intraoperative imaging should contain a high resolution megapixel CCD, optical zoom and macro capabilities, removable type storage media, threaded lens, color LCD, and remote capabilities. There are a number of excellent consumer digital cameras on the market for less than \$1,000 which meet these capabilities. These include the Olympus 3000Z and 3030Z, Epson photo PC 3000Z, Cannon Powershot G1, and the Nikon family of cameras.

The Nikon family includes the 800, 950 and 990 models. The newer 880, although an excellent camera, requires an adapter in place of standard lens threads. The author prefers the Nikon 990 camera. This 3.34 megapixel camera can take images with a maximal size of 2038 x 1536. It has both full automatic and full manual settings. Its lens is a nine-element 3X optical zoom lens that contains 28mm threads and boasts the closest macro capability on the market. The camera uses CompactFlash cards and has a 1.8-inch LCD. It has USB and serial capabilities as well as a TV video output. Lastly, it can be controlled remotely with an optional wire remote control.

Affixing the Camera

Unlike 35mm SLR cameras, commercial digital cameras are equipped with lenses that are not removable. In order to photograph through the microscope, one must employ a configuration termed afocal coupling. Afocal coupling is a method of photography frequently used by amateur



astronomers for imaging the planets; the camera's lens is lined up with the eyepiece of the telescope or, as in our case, the microscope.

Photographing afocally can be done by simply holding the camera up to the eyepiece. Take care to hold the camera as close as possible to the eyepiece and center the image on the LCD view screen. Use the zoom capability of the camera to zoom in on the image to enlarge the field of view and minimize vignetting (when the image from the eyepiece does not fill the camera's field of view, resulting in a circular image that does not reach the corners of the picture frame). See the photos above.

Although this method generally works, it is a less than ideal setup. A more stable configuration involves threading an appropriate adapter to the camera lens allowing it to be mounted on the microscope eyepiece throughout the case. The specific thread size must be known for the type of camera used, and the adapters can be purchased from photography or astronomy vendors.

For the Nikon 990, the thread size is 28mm, and the adapters required are a 28-to-T thread step up ring, and an eyepiece projection adapter. The step up ring is connected to the camera lens followed by the eyepiece projection adapter. The entire assembly is then secured to an unused eyepiece on the microscope via three thumb-screws on the eyepiece projection adapter. A remote control cable can be hooked up to the camera and secured near the microscope's control arm, where the surgeon or assistant can reach it during the case. The set up is depicted in the photo on page 22.

The left photo is an example of a poorly aligned image resulting from handheld exposure. Notice the circular field of view. On the right is a properly framed image of a Type 1 Spinal AVM.

File Types and Storage

There are several standard formats for storing images on a computer. Many cameras can be set by the user to different levels of quality and resolution. The degree of resolution needed depends on the final output desired. Some rules of thumb are listed in the Resolution Table. The greater the degree of resolution, the larger the file that must be stored on the computer. In order to store images more compactly, various file compression formats are in use. The two most common are the tiff (tagged image file format) and jpeg (joint photographic experts group). When taking images, it is recommended that the highest resolution be used. This will allow flexibility if at a later date one wishes to output the images for print, 35mm slide, or reproduction for publication. TIFF format is also preferable to JPEG.

Summary

Intraoperative imaging through the microscope need not be restricted to 35mm film. The digital revolution has placed in the hands of consumers a variety of equipment with capabilities of a professional level. As this article has briefly outlined, using a relatively simple setup and modest equipment, spectacular images can be recorded with a minimum of effort. ■

Carlos A. David, MD, is a neurosurgeon at Lahey Clinic Medical Center, Burlington, Massachusetts.

CSNS Recommends Action

Meeting Requirements and Recertification Considered

The semiannual assembly of the Council of State Neurosurgical Societies (CSNS) took place in April in Toronto. The CSNS discussed and acted upon a number of issues referred by grassroots neurosurgeons. Delegates heard a summary of a recent survey on neurosurgical professional associations and acted upon four resolutions advanced by several state societies and their members.

Survey Results

The CSNS reported the results of its organizational survey on a merger between the AANS and CNS. Sixty-two percent of respondents favored a merger of the two parent organizations, 26 percent favored some type of joint venture between the two groups and 12 percent wanted to leave things as they are. The response rate to the survey was 31 percent. A more detailed report will be published in an upcoming issue of the *Bulletin*.

Three Resolutions Passed

In terms of action items, the CSNS passed three substitute resolutions, rejected a resolution and referred another to the Washington Committee. Accepting the recommendation of its Reference Committee, the CSNS rejected a resolution asking the AANS/CNS to change its annual meeting requirements. The rejected resolution encouraged the AANS to revise its bylaws requiring members to attend an annual meeting at least once every three years. The resolution also asked the AANS to allow attendance at AANS/CNS Joint Section meetings to count in fulfillment of the bylaws requirement.

The CSNS passed a substitute resolution concerning recertification. The approved resolution asks the AANS Board

of Directors and CNS Executive Committee to petition the American Board of Neurological Surgery (ABNS) to consider appointing a liaison to the ABNS who received board certification after May 1999 and will be required to be recertified. The original resolution called for the CSNS to survey neurosurgeons eligible for Board recertification to determine a fair and convenient testing methodology and process.

The CSNS passed a substitute resolution encouraging U.S. neurosurgeons to ask their county medical societies to survey members on their career plans over the next three years and to analyze future human resource requirements in each community. The original resolution called for such a survey and also asked for county medical associations to form Coalitions for Healthcare Workforce Survival to make recommendations to counteract critical shortages of healthcare workers and services.

The third substitute resolution passed by the CSNS encourages physicians to determine yearly overhead costs for each service (CPT) and to use the overhead costs to negotiate equitable reimbursement fee schedules from third party payers. The assembly accepted the Reference Committee's substitute resolution with intent to refer to the CSNS Health System Cost Control Committee for submission of articles to disseminate this information.

The CSNS voted to refer a resolution on the Campbell Bill (which allows coalitions of independent physicians to bargain collectively with insurers) to the Washington Committee. The resolution requests the CNS and AANS to contribute to a fund that allows the Law and Economics Consulting Group to analyze the cost of passage of the Campbell Bill to consumers and employers and to present its findings to the Senate.

Other Activities

The CSNS delegates discussed a number of other timely issues impacting neurosurgeons, including:

- The Medical Practices Committee discussed surveying membership about various aspects of the rules and regulations of the Health Care Financing Administration and its handling of Medicare. The committee will work on the survey with the intent of distributing it to a statistically valid subset of neurosurgeons annually and getting initial results before the Congress meeting in San Diego this fall.
- The Health System Cost Control Committee discussed the resolution concerning practice expense costs and noted how rising practice expenses have led many physicians to leave their practices. In Santa Clara County in California, for example, 62 percent of physicians over the age of 50 reportedly are planning to leave their practice, which will result in loss of access to medical care.
- The Medico Legal Committee discussed the rising number of lawsuits and the increased cost of malpractice insurance. National tort reform is needed. Part of the problem is malpractice testimony by physicians who are not members of neurosurgical groups and thus cannot be disciplined by organized neurosurgery. Some redress can be accomplished through state boards of medicine or in the military through the chain of command.
- The Neurotrauma Committee discussed a position statement from the AANS/CNS Section on Neurotrauma and Critical Care for approving ancillary and emergency neurosurgical services. The committee decided that a position statement is necessary and that the position statement in question

Taking Charge of Change

Authors Give Step-by-Step Advice for Physicians

Leading Physicians Through Change: How to Achieve and Sustain Results

by Jack Silversin and Mary Jan Kornacki, an ACOE Publication, 185 pages. ISBN: 0924674814; \$38.

Change is the only constant in healthcare today. If neurosurgeons want to influence change with their colleagues, they ought to read *Leading Physicians Through Change: How to Achieve and Sustain Results*.

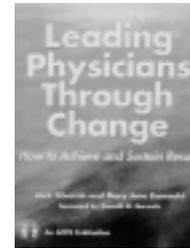
This book presents a step-by-step manual for leading the process of change. "Change Foundation," part I of the book, deals with an organization's capacity to develop and implement change. "Change Levers," part II, takes you through the process of change. "Moving to Action," part III, is devoted to taking steps to apply the change model and features a case study.

These authors understand physicians' reluctance to change; their book is based on 20 years of consulting with groups of doctors. The authors place a consistent

emphasis on communication.

The first three chapters explore the current state of most physician organizations. Crucial to change is a shared vision, uniform expectations and agreement on what kind of compact is needed for success. An important lever for change is to have agreement about what role each individual will play. Then, involving all the physicians in a group, guidelines must be drawn for productivity. To get physicians to accept the need for change involves creating a tension that will energize the process. Resistance is inevitable and must be addressed. Physician leaders can help change occur by creating a consistent context for the change that includes financial incentives, non-monetary rewards, resources, training, staffing, measurement and feedback.

This is a practical book and you will easily identify with the examples used. Each chapter begins with an assessment that can help the reader get in touch with the current state of his or her physician group in regard to the topic covered in the chapter.



Every chapter includes sidebars contributed by healthcare leaders, who offer their insights and experience with an issue discussed in the chapter. At the end of every chapter are tools for taking action that can help the reader put the material to practical use.

The sign posts on the path to organizational success today read "adapt," "improve," "reduce variation," "teamwork" and "transform." The words seem not to be part of neurosurgeons' present vocabulary but this is a language that we must all learn. As medicine moves ever forward, knowledge of how to change will be as important to physicians' success and the vitality of their organizations as clinical knowledge and commitment to excellence. ■

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

CSNS Report

Continued from page 24

was sufficiently general but needs to be worded more strongly. The recommendations were forwarded to the section's Executive Meeting. (Note: A position statement was later drafted. See page 35.) The committee also decided that a liaison to Think First was not needed.

- The Reimbursement Committee discussed the current status of coding development for this year. A series of six new surgical endoscopy codes was

developed as well as a revision for editorial change of an existing code. New codes that will be presented at the CPT Editorial Panel in August include ventricular catheter placement with an endoscope; dissection for adhesions or fenestration of cysts; removal of cysts, foreign bodies, brain tumors or pituitary tumors; and third ventriculotomy.

- The Workforce Committee is undertaking a survey of practicing neurosurgeons

to determine their intent to retire and at what age. This survey will be analyzed to determine the impact of workforce requirements especially in relation to spine, trauma and pediatric services.

- The Young Physicians Committee is working on a project to gain access to medical student and primary core curriculum in order to provide information on the total scope of the practice of neurosurgery. ■

Functional Knowledge

What You Should Know About Stereotactic Surgery

Since its birth over 50 years ago, the field of stereotactic surgery has evolved into two separate but intimately related fields. Although functional neurosurgery is still practiced by those few neurosurgeons with special training, stereotactic image guided neurosurgery is commonly used and should be familiar to all neurosurgeons.

Stereotactic Primer

Image guided stereotactic surgery involves the use of three-dimensional guidance systems to efficiently approach pathological structures within the brain to facilitate craniotomy or to treat masses with focused radiation, as with stereotactic radiosurgery or brachytherapy.

Functional neurosurgery involves the use of three-dimensional guidance systems and related neurophysiological techniques to do procedures that change the function of the nervous system, that is, to make lesions or to stimulate anatomical targets to treat movement disorders, pain, epilepsy or certain psychiatric illnesses. Functional neurosurgery remains a true subspecialty, practiced only by those neurosurgeons with specialized training in the neuroanatomical and neurophysiological background. It involves problems more often in the realm of neurologists than neurosurgeons.

Image guided stereotactic surgery, however, has evolved into a discipline that every neurosurgeon should know. The use of guidance techniques can make craniotomy more efficient, minimizing the size of the exposure and the invasiveness, allowing an approach through the least eloquent path, defining resection boundaries that may not be apparent to the surgeon's eye, and minimizing manip-

ulation of brain tissue outside the pathologic process. All this may add up to improved outcome, faster recuperation, fewer adverse neurological sequelae and, consequently, less cost in the long run.

Stereotactic radiotherapy with the Gamma Knife or linear accelerator will not be practiced by all neurosurgeons. A few neurosurgeons would practice conformal stereotactic radiotherapy that involves focussed fractionated radiation techniques that permit maximal radiation

Philip L. Gildenberg, MD, PhD, is Past-Chairman, Joint Section on Stereotactic and Functional Neurosurgery.



to a tumor while minimizing radiation to the rest of the brain. Yet, all neurosurgeons should know the indications, limitations, and potential complications of these techniques.

Knowledge is Power

As stereotactic radiosurgery becomes available to most potential patients, its use as a primary modality or adjunct treatment cannot be ignored. For instance, there is increasing statistical evidence that the outcome may be better in certain patients with acoustic neurinoma treated with stereotactic radiosurgery rather than conventional surgery. It is no longer necessary to leave a patient with a severe neurological deficit in an attempt to resect a tumor or a residual portion of tumor intimately involving cranial nerves

or brain stem when it could be treated as well with stereotactic radiosurgery or conformal stereotactic radiotherapy.

The neurosurgeon only can apply the best clinical judgment during surgery if he or she knows whether that last bit of tumor could be treated better by stereotactic radiation or whether the risk of injury to a cranial nerve or venous sinus is justified.

Information about stereotactic and functional neurosurgery has become important for all neurosurgeons, especially those now using image guided techniques for craniotomy.

A Specialty on the Rise

The number of neurosurgeons practicing image guided stereotactic techniques is growing rapidly. The number of neurosurgeons who recognize the importance of knowing about stereotactic radiation techniques is increasing. This has resulted in a renewed interest in membership in the Joint Section for Stereotactic and Functional Neurosurgery, as well as membership in the American Society for Stereotactic and Functional Neurosurgery and the World Society for Stereotactic and Functional Neurosurgery. We invite all neurosurgeons to become members, since we believe that all neurosurgeons should have an interest in the ever-expanding field of stereotactic surgery.

Further information about membership and application forms can be obtained through the AANS Membership Services Department at (847) 378-0508. ■

EDITOR'S NOTE: The World Society for Stereotactic and Functional Neurosurgery Annual Meeting is September 11-14, 2001, in North Sydney, Australia. For information, go to www.wssfn.org.

Enhance Your Practice

AANS Membership for Nurses Pays Off

Time is a neurosurgeon's most valuable and scarcest commodity and the lack of it your biggest challenge. Your neurosurgical practice is only as efficient and effective as the support team you have assembled. The professional support staff you hire can enhance, expand and safeguard your practice.

The neurosurgical nursing staff must achieve and maintain a high level of expertise to complement their experience in the fast-changing technological medical market. Today's patient consumers are medically literate about their healthcare. They are no longer misinformed consumers but well-researched Internet shoppers. Patients can access state-of-the-art diagnostic and treatment information and research literature. They can check on your credentials and summaries of malpractice cases in the

state registries. They have choices even within the managed care industry.

Benefits of Membership

On behalf of the AANS Adjunct Subcommittee on Allied Health Science Professionals, I encourage neurosurgeons to sponsor their professional nurses who have also chosen neurosurgery as their specialty to seek Associate Membership in the AANS. Nurses who have credentialed their expertise by certification and experience can further their proficiency and enhance your practice by participation in the AANS.

Membership benefits provide far more than reduced meeting registration fees and frequent mailings of neurosurgical materials. Membership and annual meeting attendance offer participation in collaborative practice education to heighten practice

horizons. Keeping current in our discipline can no longer depend upon journals and books that are months in the editorial process. The Internet and interactive meetings are now fundamental to our education. Joint Section newsletters and seminars keep AANS members on the leading edge of information including the initiation and results of clinical trials and alternative treatments available for your patients.

Focused current information relevant to your subspecialty is imperative. Patients are increasingly more knowledgeable about their disease. Staff must be prepared to respond. Unique networking opportunities at the annual meeting allow them to discuss issues with other nurses, neurosurgeons and physician assistants. They can identify resources ranging from outcome measures to clinical problem solving.

The ability to access the major neurosurgical equipment companies and their senior representatives is invaluable and cannot be underestimated. Staff will have more time to examine the new technology and discuss equipment problems. They can also collect information from the durable medical equipment companies to improve your patient care.

The patient education materials, resources, and organization information must not be undervalued. The ability to offer input in person to companies on your needs is the essence of a collaborative practice. Simultaneous sessions can be a challenge but not if your colleagues share information. Keeping up is not enough to be an expert: we must keep ahead.

I invite you to sponsor and encourage your nursing colleagues to apply for Associate Membership. Please contact me or the Membership Office for further information. I can be reached by phone at (305) 585-5475, via fax at (305) 585-2644 or by e-mail at msutherl@med.miami.edu. The number for the Membership Services Department is (847) 378-0543. ■

Mimi Watson Sutherland, RN, BSN, MS, CNRN, is Co-Chair of the AANS Adjunct Subcommittee on Allied Health Science Professionals.

In Memoriam: Joseph Ransohoff, MD, 85

Joseph Ransohoff, MD, who organized one of the world's first intensive care neurosurgery units, died January 30, 2001, in Tampa. He was 85.

Dr. Ransohoff was Director of Neurosurgical Services at Bellevue Hospital Center and Professor and Chairman of the Department of Neurosurgery at the New York University School of Medicine from 1961 to 1992. He trained more than 60 neurosurgeons, many of whom went on to lead departments at medical schools across the country, according to the *New York Times*. At Bellevue, he broke new ground when he developed an intensive care neurosurgery unit. He was known for taking advanced technologies such as lasers and CAT scans and adapting them to brain surgery.

A third-generation surgeon, Dr. Ransohoff was born in Cincinnati and received his undergraduate degree from Harvard University and his medical degree from the University of Chicago. After his training, he served as a neurological surgeon with the U.S. Army during World War II. After the war, he went on to a prominent practice in New York and later served as a medical consultant for the 1960s hit TV series *Ben Casey*.

He moved to Tampa in 1992 after ostensibly retiring. He served as Professor of Neurosurgery and Neurology at the University of South Florida School of Medicine and Director of Neurological Surgery at the Moffitt Cancer Center and Research Hospital.

He is survived by his wife, Lori Cohen Ransohoff, MD, their two children, Jake, 11, and Jade, 5, and a daughter and son from an earlier marriage, Joan Wynn and Joseph.

Combine the AANS and CNS

I just read the very interesting President's Message by Dr. Stewart Dunsker relating to the merger of the AANS and CNS (*Bulletin*, Winter 2000). As one who in years past had the opportunity and privilege of serving both organizations as Chairman of the old Joint Council of State Neurosurgical Societies, I feel obliged to comment. It has been interesting to watch the usual progression, beginning with membership on the Executive Committee of the CNS and ending as a member of the Board of Directors of the AANS. The irony of split loyalties has not been lost. I have been impressed by the dedication displayed first to the CNS and then to the AANS with a requisite change in viewpoint associated with change in organizational responsibilities.

Having practiced for years in a community environment and having witnessed the blood battle that occurs when two or more hospitals try to merge, I see a strong parallel with what is occurring between the AANS and CNS. The interests of the orga-

nizations usually become subservient to the interests of the leadership. Hospital mergers, which would have been clearly beneficial to the community and to the medical staffs, have been thwarted because one administration would have to fall or, at least, give up certain positions of leadership. I cannot but help believe this is the major source of friction between the AANS and CNS.

I feel Dr. Dunsker represented the AANS well. I am sure Dr. Issam Awad can do equally well with the CNS. More important than the needs of the leadership of both organizations are the needs of the neurosurgeons they represent. It is hard to attend two national meetings and there is obviously a great deal of overlap between the two. In addition, the cost is becoming prohibitive.

I believe the AANS and CNS must find a way to look beyond proprietary interests and do what is right for all of us. I register my vote for merging the AANS and CNS. I concur with Dr. Dunsker that it would strengthen neurosurgery.

Paul D. Croissant, MD, Pontiac, Michigan

Two Meetings Work Well

I read with interest the commentary by Dr. Stewart B. Dunsker regarding the problems which have been raised between the AANS and CNS. In my previous letter to the CNS publication I stated that the whole scenario that has been created is totally childish and does not belong in neurosurgery. I do agree with Dr. Dunsker that an effort should be made for neurosurgery and not the egos of the two associations.

There is absolutely nothing wrong with having two journals and two meetings. In fact, it is quite practical to have two meetings because it will give the neurosurgeons the convenience of going to one or the other.

There is absolutely nothing wrong with having a combined meeting of both board of directors while they are still maintaining their independence.

Things are fine as they are. We need just a little bit more cooperation and controlling of our egos.

David A. Yazdan, MD, FACS, Brick, New Jersey

MEDICOLEGAL UPDATE

Status of Unprofessional Conduct Complaints During the past two years (1999 and 2000) the AANS received 15 complaints from members alleging unprofessional conduct on the part of other members. Of those, four cases were dropped when the complainants elected not to proceed and present evidence supporting their allegations. In four other cases, the complainants have not yet submitted evidence supporting their allegations but the files are still considered active. In the remaining seven cases, after considering the evidence submitted by both the complainants and the respondents, the Professional Conduct Committee concluded that six warranted hearings and one did not because the allegations did not establish a prima facie case of unprofessional conduct. Hearings were conducted for the six cases in which the Committee concluded that a prima facie case of unprofessional conduct had been established. Three resulted in recommended letters of censure, two resulted in recommended six-month suspensions of membership and one recommended expulsion. The recommendations of the Committee were all approved by the AANS Board.

AANS Wins; Dr. Austin Files Appeal Another matter on the medicolegal front is the suit brought by Donald C. Austin, MD, against the

AANS resulting from the suspension of his membership in April of 1997. He filed suit in federal court in Chicago claiming he was deprived of due process in the proceedings, resulting in his loss of substantial income as an expert witness. The court granted the AANS' Motion for Summary Judgment on October 20, 2000, and Dr. Austin has filed an appeal in the United States Court of Appeals for the Seventh Circuit. That appeal is still pending.

AANS Sued in Georgia A complaint was filed in the United States District Court for the Southern District of Georgia by Gary J. Lustgarten, MD, seeking to temporarily and permanently enjoin the AANS' Professional Conduct Committee from conducting a hearing on charges brought against Dr. Lustgarten by Mark A. Gold, MD. The suit claims in four counts that Dr. Gold and the AANS' Officers and Directors were guilty of a civil conspiracy to chill and thwart Dr. Lustgarten and others from testifying as expert witnesses in medical malpractice cases. The suit also seeks compensatory and punitive damages. The AANS' General Counsel, Russell M. Pelton, commented that he believes the suit is meritless and is confident that the AANS will prevail, as it did in the similar suit filed by Donald C. Austin, MD.

Section News

Nominations Sought for Humanitarian Award

The Humanitarian Award was established in 1987 to honor an AANS member whose activities outside the art and science of medicine bring great benefit to medicine.

The nomination for the award is open to all living members from any category of AANS membership. Voting members are invited to submit nominations for the award. Nominations should be submitted by Oct. 1, 2001. The award will be presented at the 2002 Annual Meeting in Chicago. For more information, contact Volker K.H. Sonntag, MD, AANS Vice President and Chair of the Humanitarian Award Committee, at (602) 406-3458 or at volker.sonntag@bneuro.net.

For a nomination form, contact Diana Hughes of the AANS at (847) 378-0507 or at ddh@aans.org.

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Section on Cerebrovascular Surgery Members attending the 2001 Meeting of the AANS/CNS Section on Cerebrovascular Surgery/American Society of Interventional and Therapeutic Neuroradiology in Hawaii were able to access "Meeting Manager" software for a Palm Pilot, thanks to the diligent efforts of Hal Pikus, MD. The "Meeting Manager" software included a searchable database of the accepted abstracts for the SCVS/ASITN meeting. It allowed participants to preview abstracts of interest and create a personalized schedule. Both the Macintosh and PC platforms were supported.

■ The Basic Science Subcommittee of the SCVS Technology Review Panel was formed recently under the able direction of Robert Dempsey, MD, and Sander Connolly, MD. The subcommittee was given a mandate to report to members of the Joint Section on the development of new technologies that have implications for cerebrovascular research. The subcommittee's initial report presages the importance of gene chip analysis as the harbinger of a new genetic-therapy revolution. The committee emphasizes that "in the next decade, medical practice will transform from traditional pharmacotherapy to more targeted and precise gene-based therapy."

CV Section members who would like to participate on this subcommittee, particularly young members with an interest in basic science research, are encouraged to contact either Dr. Dempsey or Dr. Connolly.

■ Target Therapeutics has funded a new fellowship program (with joint oversight by the CV Section and the ASITN) to support new training slots in neuroendovascular surgery. This program will be funded separately from the existing "Sean Mullan Target Fellowship," currently funded through the CV Section to individual applicants. For information, contact Ken Cammarata, American Society of Interventional and Therapeutic Neuroradiology, 2210 Midwest Rd., Suite 207, Oak Brook, IL 60523-8205, Kcammarata@asnr.org.

This article was excerpted from Cerebrovascular News.

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Section on Neurotrauma and Critical Care The Trauma Section is working hard on many fronts to promote optimal care of neurotrauma patients. Numerous guidelines projects, modifications of EMTALA laws and efforts to promote emergency room on-call stipends for neurosurgeons are but a few areas in which the Trauma Section is heavily involved.

The Section also surveyed the American Association for the Surgery of Trauma (AAST) to learn how the AAST membership views the trauma care provided by neurosurgeons. Although nearly 60 percent of respondents reported that neurosurgeons were in charge of the care of adults who had required a craniotomy for isolated head injury at their hospital, only 31.5 percent indicated that neurosurgeons were in charge of the care of nonoperated adults with isolated head injury ($P < 0.001$).

Likewise, although over 60 percent of respondents thought neurosurgeons should be in charge of the care of adults with isolated head injury who had required a craniotomy, only 42 percent thought neurosurgeons should be in charge of the care of nonoperated adults with isolated head injury ($P < 0.001$).

These questions were repeated for pediatric patients with isolated head injury and for both adults and children with combined head injury and systemic injury. Overall, the frequency with which neurosurgeons acted as "leaders of the team" depended on whether a craniotomy had been performed. Furthermore, the responses consistently indicated that neurosurgeons should be in charge of the care of head-injured patients more frequently than they actually were in charge.

The survey also asked about the frequency of specific problems with neurosurgeons taking trauma call. Almost 45 percent of respondents thought neurosurgeons were too reluctant to place intracranial pressure (ICP) monitors in trauma patients, 35 percent thought neurosurgeons were too slow in getting trauma patients to the operating room, 43 percent thought neurosurgeons did not answer pages promptly and 18 percent reported neurosurgeons on trauma call did not answer pages at all. The likelihood of respondents indicating that non-neurosurgeons should be allowed to insert ICP monitors and even perform trauma craniotomies was significantly related to whether the

respondent reported inadequate neurosurgical performance of these activities.

This report provides a rare opportunity for neurosurgeons to view themselves as others see them. The results indicate that management of head-injured patients is commonly directed by non-neurosurgeons, especially when these patients have not undergone a trauma craniotomy. If the trauma surgeons at particular hospitals experience continuing dissatisfaction with how neurosurgeons provide neurotrauma care, it is possible that the trauma surgeons may begin inserting ICP monitors and performing other interventions that historically have been the domain of the neurosurgeon.

The results of the survey were published in *Neurosurgery* (*Neurosurgery* 48:17-25, 2001) and also may be read on www.neurosurgery-online.com.

A longer version of this article originally appeared in Neurotrauma and Critical Care News.

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Section on Pediatric Neurological Surgery Pediatric neurosurgery is in its last year as a "provisional section" of the American Academy of Pediatrics (AAP). Pediatric neurosurgery expects to be granted full status later this year. Plans for collaborative presentations that fulfill the educational and scientific contributions to the Academy are in place for the fall 2001 meeting of the AAP. The neurosurgical section will participate with the orthopedic section to provide a program on the management of spasticity for the AAP membership. The neurosurgical section also will participate with the AAP's critical care section to provide a program on head injury.

■ The Section was asked to provide three topics to the online journal *Neurosurgical Focus* in the coming year. The topics will be Chiari 1 Malformations, Myelomeningocele and Child Abuse. Jerry Oaks, MD, is assembling the Chiari 1 Malformation text. *Neurosurgical Focus* can be found on **NEUROSURGERY://ON-CALL®**.

■ Traveling fellowships for the year 2001 were awarded to Ketan Bulsara, MD, a PGY5 at Duke who will spend four weeks with Arnold Menezes, MD, in Iowa City studying pediatric spine procedures, and to Ian Hegger, MD, who will spend two weeks with Michael Scott, MD, at Boston Children's Hospital.

There were three applicants for the International Traveling Fellowship. Fajardo Rivera, MD, of Hon-

duras was selected to receive the fellowship to spend four weeks in Denver with Kenneth Winston, MD.

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Section on Stereotactic and Functional Neurosurgery Membership in the American Society for Stereotactic and Functional Neurosurgery (ASSFN) and the AANS/CNS Section for Stereotactic and Functional Neurosurgery continues to grow with the resurgence of surgery for movement disorders and the widespread application of image-guided technology to all branches of neurosurgery. In 2000, there were more than 300 members, and new member certificates have been sent to 16 applicants this year so far.

The ASSFN has a new Web site (www.assfn.org), thanks to Andres Lozano, MD, who led this effort. He was assisted by Joel MacDonald, MD, who has tremendous experience in this area. The site will serve as the perfect forum for communication among members and other interested individuals. It will have links to other appropriate sites and to **NEUROSURGERY://ON-CALL**. The World Society of Stereotactic and Functional Neurosurgery also has a sister Web site at www.wssfn.org.

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Section on Tumors The spring 2001 issue of *Tumor News* included a story about RSR13, a small molecule that may facilitate the tumor killing effect of radiation therapy through its capacity to increase tumor oxygenation. *Tumor News* interviewed Jean-Francois Liard, MD, PhD, about agent RSR13. The molecule, which will soon begin Phase III testing, reduces the hemoglobin oxygen binding affinity by binding to the central water cavity of the hemoglobin tetramer. It enhances the diffusion of oxygen from the blood to hypoxic tissues. Direct measurements of oxygen in human tumors have confirmed significant tumor hypoxia in many types of cancer, including malignant gliomas. Hypoxia is believed to be a major cause of radiation treatment failure.

The Phase III trial, to be conducted as Study RSR13 RT-011 and scheduled to begin this summer, will be a randomized, open-label, comparative study of cranial radiation therapy, with or without RSR13 and supplemental oxygen, in patients with newly diagnosed glioblastoma multiforme. When the protocol is finalized, interested investigators will be identified. An investigators meeting will be organized in the next few months.

Research Awards for Residents

The Executive Committee of the AANS/CNS Section on Neurotrauma and Critical Care, together with the Synthes and Codman companies, is seeking applications from residents for the 2001-2002 annual awards. The Synthes Award for Resident Research on Spinal Cord and Spinal Column Injury and the Synthes Award for Resident Research on Brain and Craniofacial Injury will be awarded at the annual AANS and CNS meetings. Codman Fellowship in Neurotrauma supports young neurosurgeons in obtaining additional clinical and research training in the field of neurotrauma.

For information, contact Michael G. Fehlings, MD, Chair, Fellowship/Awards Committee of the AANS/CNS Section on Neurotrauma and Critical Care, at michael.fehlings@uhn.on.ca.

Continued from page 31

Dr. Liard said a Phase II study in glioblastoma multiforme showed RSR13 plus RT increased median survival 27 percent compared to NABTT historical controls. Preliminary Phase II results in NSCLC show an 87 percent response rate in patients treated with RSR13 plus RT following induction with pacli-

taxel and carboplatin. A pivotal Phase III trial in treatment of brain metastases was initiated in March 2000. Data from 12 completed Phase I and II trials and over 400 patients show a favorable safety profile over traditional cytotoxic drugs. Dr. Liard concluded that he is confident that RSR13 has the potential to be an important addition to radiation therapy in a variety of indications. ■

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

The Section has embarked on some exciting projects that will come to fruition in the year ahead.

New Research Endowment Committee. Reflecting the Section's growing commitment to supporting spine-related research education, the Executive Council voted in April to establish a Research Endowment Committee. This effort is designed to significantly expand the amount of funding currently expended on spine research. The Section has an extant grant awards program that provides funding for clinical projects related to the spine and peripheral nerves and offers peer review for clinical research projects to help improve the quality of the proposal and, therefore, enhance competitiveness for National Institutes of Health funding. The new fund will expand on that effort. The Section will provide the initial seed money from reserves to establish the endowment.

In related news, the Council announced the recipients of the Section's 2001 Research Awards. They are:

- **Sanford Larson Award:** R. Hon Hurlbert, MD, PhD, of the University of Calgary in Calgary, Alberta, Canada, for "Management of type II odontoid fractures: A prospective randomized comparison of primary anterior screw fixation versus halo vest immobilization."
- **Volker Sonntag Award:** Y.R. Rampersaud, MD, FRCS, of the University of Toronto for "Intra-operative computerized tomography and spinal navigation: Applications in the cervical spine."

Applications for the 2002 grants must be submitted no later than December 1, 2001. Complete information on application requirements can be found at: www.neurosurgery.org/spine/awards.html.

Annual Meeting. The Section's 2001 Annual Meeting was a resounding success on all levels. The meeting saw a record registration of 945. Commercial and organizational exhibits reached an all-time high of 70 booths.

Membership. Membership in the Section continues to grow, with the approval of 47 new members in April. Total Section membership stands at 1,429 physicians.

Peripheral Nerve Disorders Section. There has been discussion about the need for a separate section on peripheral nerve disorders. Less than two decades ago, carpal tunnel release was the most common neurosurgical procedure performed. However, this and other peripheral nerve surgery has become a much smaller part of the neurosurgeon's scope of practice.

At the Executive Council meeting there was agreement that the peripheral nerve specialists have not received adequate program time to present at the Section annual meeting nor at the meetings of the two parent organizations. Moreover, there is not a good understanding of the current status of peripheral nerve surgery. To identify the extent and scope of the situation, as well as other surrounding issues, the Executive Council agreed to have the Section sponsor a survey, under the direction of Allen Maniker, MD, Assistant Professor, Department of Neurosurgery, New Jersey Medical School. The survey will attempt to discover what types of peripheral nerve procedures neurosurgeons feel comfortable performing, to whom they refer cases and if they feel their training was adequate.

World Spine II. The Section is moving forward to support World Spine II, a scientific meeting organized as part of the Decade of the Spine initiative. This meeting, tentatively scheduled for 2004 in Chicago, will be jointly sponsored by the Section in cooperation with the North American Spine Society.

New officers. The following new officers took office at the Section's Executive Council meeting in April: Chairman, Paul C. McCormick, MD; Secretary and Chair-Elect, Nevan G. Baldwin, MD; Treasurer, Gerald Rodts, MD; and Past President, Curtis A. Dickman, MD.

AANS News

Neurosurgical Focus Makes Changes *Neurosurgical Focus*, the online, indexed, rapid-publication journal of the AANS, announced a new manuscript submission policy. To provide the most current neurosurgical information available, the journal encourages manuscripts on any previously published *Neurosurgical Focus* topics, (www.neurosurgery.org/focus/archives.html) as well as on new upcoming topics. Also, the manuscripts will now be reviewed by each of the Sections.

To receive an updated topic schedule via e-mail, contact *Neurosurgical Focus* at smr6a@virginia.edu. The topic schedule also can be found at www.neurosurgery.org/focus/callforpapers.html.

Neurosurgical Focus Topics & Editors

Changing Management Strategies for Post-traumatic Intracranial Mass Lesions, October 2001, submission deadline: August 15, 2001, topic editor, M. Ross Bullock, MD

Intracranial Arteriovenous Malformations, November 2001, Submission Deadline: September 15, 2001, topic editor, Philip E. Stieg, MD

Metastatic Spine Tumor, December 2001, submission deadline: October 15, 2001, topic editor, Ziya Gokaslan, MD

Treatment of cervical spine, January 2002, submission deadline: November 15, 2001, topic editor, Vincent Traynelis, MD

Low-grade gliomas, February 2002, submission deadline: December 15, 2001, topic editor, Joseph M. Piepmeyer, MD

Neurocysticercosis, March 2002, submission deadline: January 15, 2002, topic editor, Christopher M. DeGiorgio, MD

AANS Sponsors Equipment Leasing Take advantage of the Equipment Leasing program (administered through Henry Schein Financial Services) offering innovative equipment leasing programs with a pre-approved credit line of up to \$200,000. As an AANS member you can take advantage of the broadest range of competitive and flexible financing options with a customized payment schedule that fits your financing requirements. For information call (800) 443-2756.

New Brochures for Patients Produced In addition to *A Patient's Guide to Neurosurgery*, the first brochure in the AANS patient education brochure line, the AANS has produced two new patient brochures. Like the first brochure, *A Patient's Guide to Low Back Pain* and *A Patient's Guide to Neck Pain* are designed for distribution to patients in the office, to be mailed or handed out at health fairs, or given out at career days and lectures before community groups.

Both of the new brochures outline common disorders associated with the condition, address conservative treatment options, describe surgical options, explain what the patient can expect regarding recovery after surgery and outline the neurosurgeon's role in treatment. Each includes a glossary of terms to further educate the patient.

The brochures can be sent to healthcare professionals who refer patients to neurosurgeons. There is space on the back of each of the brochures to add a label with personal practice information.

The price for a pack of 50 brochures is \$50 for members, \$60 for nonmembers. These costs apply to all three brochures. More information on the brochures can be found at www.neurosurgery.org/marketpl.

To order *A Patient's Guide to Neurosurgery*, *A Patient's Guide to Low Back Pain* and *A Patient's Guide to Neck Pain*, call the AANS Membership Department at (888) 566-AANS.

New Travel Program Set The AANS' new travel program specializes in deluxe travel adventures, chartering small ships that can bring passengers to many wonderful destinations that large cruise ships cannot navigate. The travel program vendor is INTRAV, which books top-notch speakers and guides who enhance appreciation and understanding of the places visited. Destinations are often off the beaten path yet close to local attractions. Excursions are reserved for program passengers such as AANS members, typically with 30 to 50 passengers.

The first package AANS will offer is Cruising the Rivers & Waterways of Europe. Other cruises are the Historic Waterways of Bohemia and Saxony, Journey of the Czars, Waterways of the Scottish Glens and Impressionist Landscapes Along the Seine River.

To obtain a catalog, call INTRAV at (800) 456-0020 and mention your AANS membership.

AANS Offers Purchasing Program

The AANS has partnered with Henry Schein, Inc. to offer a variety of programs and service benefits to neurosurgeons. Members can receive significant savings on medical supplies and pharmaceuticals through the AANS-sponsored purchasing program PricePoint. The program features items dedicated to neurosurgery practices, with contract pricing specifically for AANS members. Henry Schein, Inc. boasts a 99.9 percent fulfillment rate with virtually no back orders, superior service and convenient ordering options. You'll have thousands of brand name items, private brand and generic products to choose from, all backed by the Henry Schein Lowest Price Guarantee. If you find a product for less, Henry Schein, Inc. will match it. To enroll in the PricePoint Purchasing Program, call (800) 772-4346.

Board OKs Two Policies

Positions Approved on AIDS Care, ER Pay

The AANS Board of Directors convened April 19-20 in Toronto during the 2001 Annual Meeting. The highlights are summarized here.

Finance Committee. AANS Treasurer Roberto Heros, MD, presented the 2002 operating budget. As submitted, the budget is balanced and gains significant ground over the 2000 deficit budget. The Board approved the budget as submitted.

Membership Committee. In anticipation of a change in the AANS Bylaws and upon recommendation of the Membership Committee, the Board approved the automatic promotion of Active (Provisional) members to Active membership upon notification of their successful ABNS certification. Previously, these members had to apply for a change in status. Accordingly, 114 individuals were transferred from Active (Provisional) to Active membership.

Other membership approvals included 116 new Active (Provisional), 15 Associate, 34 International and 50 Active members. This brought total AANS membership to 6,459, representing an 18.2 percent increase over the 2000 total of 5,283 members.

Committee and Liaison Retirements. Motions were presented to eliminate organizational liaisons and committees now deemed redundant or unnecessary. Eliminated were: the Investment Subcommittee of the Finance Committee; the Annual Meeting Registration Committee (its functions are assumed by the Marshal's Committee); the liaisons to the American Registry of Pathology; and the Healthcare Resources Advisory Committee. Also, the Electronic CME subcommittee of the Education and Professional Development Committee was changed to a subcommittee of the new Digital and Electronic Committee.

Policy Statements. The board approved two draft policy statements. (See sidebar.) ■

AANS/CNS SUPPORTS AMA POLICY ON TREATING PATIENTS WITH HIV AND AIDS

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.

When physicians are unable to provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services.

A physician who knows that he or she is seropositive should not engage in any activity that creates a significant risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients.

AANS/CNS POSITION ON IMPROVING ACCESS TO EMERGENCY NEUROSURGICAL SERVICES

The Emergency Medical Services (EMS) system is in the midst of a growing crisis because of a recognized shortage of on-call specialists. This problem extends to the provision of emergency neurosurgical care. Since neurosurgeons are a vital component of the EMS system, their active participation is essential. Reimbursing neurosurgeons for serving on-call to hospital emergency departments is therefore appropriate.

1. Within their capabilities, hospitals have a legal obligation under the Emergency Medical Treatment and Labor Act (EMTALA) to provide screening and stabilization services to patients who come to emergency departments. As part of this obligation, hospitals are required to maintain a list of physicians who are on-call to treat patients in the emergency room and to ensure that on-call physicians respond when called.

2. Neurosurgeons have a variety of financial and contractual problems with managed care plans. In many instances, these contracts have no on-call arrangement, or require on-call availability without reimbursement, or have reimbursement rates that are extremely low. Because of these and other economic pressures, neurosurgeons are finding it increasingly difficult to subsidize emergency medical care through internal "cost-shifting," thus limiting their ability to subsidize their own on-call activities.

3. Neurosurgeons are faced with increased risks and liability when providing emergency care. Because of the seriousness of cases in the emergency medical setting and because of the lack of a pre-existing physician/patient relationship, neurosurgeons have a greater potential to be part of a medical malpractice action. In addition, neurosurgeons who provide on-call services must also comply with the mandates of EMTALA, subjecting them to potential fines of \$50,000 for any violations of this complex law and regulations.

Position Statement: To facilitate the availability of neurosurgeons for on-call services to hospital emergency departments, hospitals may provide neurosurgeons with reasonable compensation for serving on the on-call panel. This compensation should supplement any reimbursement the neurosurgeon receives for services rendered while serving on-call.

EVENTS

Calendar of Neurosurgical Events

International Society for Pediatric Neurosurgery Annual Meeting

June 29-July 3, 2001
Aalborg, Denmark

Neurosurgical Leadership Development Conference

July 21-24, 2001
Washington, D.C.
(888) 566-AANS

Mexican Congress of Neurological Surgery

July 21-27, 2001
Puerto Vallarta, Mexico
52-48-245224

World Society for Stereotactic and Functional Neurosurgery Annual Meeting

September 11-14, 2001
North Sydney, Australia
61-2-9956-8333
www.wssfn.org

International Society of Neurological and Instrument Invention Meeting

September 12-15, 2001
Queensland, Australia
www.nsa.on.net/isntii.htm

Western Neurosurgical Society Annual Meeting*

September 15-18, 2001
Victoria, Canada
(619) 268-0562
rapaisano@aol.com

World Federation of Neurological Societies

September 16-20, 2001
Sydney, Australia
61-2-9241-1478

Congress of Neurological Surgeons

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

American Neurological Association

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

WINS Leadership and Strategic Planning Conference

September 30, 2001
San Diego, California
(914) 493-8392

American College of Surgeons Annual Meeting

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

RUNN 2001

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

Society for Neuroscience

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

Leadership Conference Set

The Council of State Neurosurgical Societies will sponsor its first **Neurosurgical Leadership Development Conference (NLDC) July 21-24, 2001, in Washington, D.C.** The purpose of the NLDC is to train individual neurosurgeons on how to be effective "grassroots" leaders so they can develop personal relationships with their members of Congress and become effective "lobbyists" for neurosurgery.

The program includes a full-day practice management education course addressing CPT coding, implementing compliance plans and cost containment strategies. Registrants will receive Category I CME credits. The program includes grassroots and political education training and a trip to Capitol Hill to meet with senators and representatives.

To register call the AANS at (888) 566-AANS. The cost is \$500.

American Heart Association

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

American Academy of Neurological Surgery Annual Meeting*

November 12-16, 2001
Palm Beach, Florida
(507) 284-2511

2001 AANS/CNS Section on Pediatric Neurological Surgery Annual Meeting

Nov. 28 - Dec. 1, 2001
New York, New York
(888) 566-AANS

Cervical Spine Research Society Meeting

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

American Epilepsy Society 55th Annual Meeting

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

California Association of Neurological Surgeons Annual Meeting

January 18-20, 2002
San Francisco, California
(916) 454-6850

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

February 2-6, 2002
Dallas, Texas

American Academy of Orthopaedic Surgeons Annual Meeting

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

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

February 27-March 3, 2002
Orlando, Florida

AANS 70th Annual Meeting

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

Third Arctic Stereotactic Conference

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

Society of Neurological Surgeons Annual Meeting

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

International Society for the Study of the Lumbar Spine Annual Meeting

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

Education and Practice Management Courses

• **Managing Coding and Reimbursement Challenges in Neurosurgery**
Aug. 24-25Chicago, Illinois
Sept. 21-22Baltimore, Maryland
Nov. 16-17Atlanta, Georgia

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

• **Neurosurgical Practice Management: Improving Your Competitive Advantage**
Aug. 26Chicago, Illinois

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

*Jointly sponsored by the American Association of Neurological Surgeons

Recertification Assures Public

Neurosurgeons Must Accept the Risk

Between 1969 and 1999, virtually every major specialty switched from lifetime certificates to time-limited certificates, conforming to policy of the American Board of Medical Specialties. The rationale for recertification was to reassure the public that the specialist was fully qualified to practice the specialty today, not 10 or 20 years ago. In May 1999, the American Board of Neurological Surgery (ABNS) tested the first cohort of neurosurgeons for time-limited certificates. To maintain Board certification, these and future Board diplomates will be required to pass another examination and meet other as yet incompletely-defined CME and practice outcome criteria.

Transition to Recertification

The transition to time-limited certificates completes a chapter in neurosurgical credentialing in which the specialty clung to rigorous traditional training and knowledge-testing standards. At the same time it opens a new chapter, in which the specialty accepts the responsibility to verify for public benefit, not only initial training and knowledge, but something more important from a public perspective: the continuing competence of the specialists certified by the Board. If certification is to satisfy the public interest, it must certify current competence, which is the public demand.

The transition to recertification, now termed maintenance of certification, has sparked a predictable reaction among those neurosurgeons subject to the new rules. Most worrisome among residents, new graduates and new diplomates is the fear that by failing an exam in the future, they could arbitrarily, and without appeal, lose the ability to practice their chosen profession in the midst of an otherwise entirely

successful career. They question the ability of the testing and evaluation format to truly measure their skill and knowledge. They worry about the time and stress necessary to study and prepare for the new examination. They wonder about the availability and effectiveness of continuing education opportunities to prepare for the renewal examination. And they question the fairness of recent graduates being subject to the new rules, while older diplomates, "grandfathered in" under the

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technicality of a time-unlimited certificate, and perhaps more in need of testing for competence in newer science and techniques, escape the strain, risk and discipline imposed by the new Board policy.

The ABNS has recognized both the need to convert to time-limited certificates, and more recently, the need to communicate with its current and future members about the demands and conflicts it faces, what options it is considering, what decisions it has made and why those actions are justified. Steven Giannotta, MD, Chairman of the ABNS, presented a detailed explanation of recertification to both the CSNS Young Physicians Committee and the AANS Young Neurosurgeons Section at the AANS Annual Meeting in April in Toronto. The cover story of this issue is devoted to the issue of neurosurgical recertification and

the ABNS' ideas and plans. The young neurosurgeons of the Council of State Neurosurgical Societies (CSNS), concerned about recertification, passed a resolution in Toronto requesting the ABNS "consider appointing a liaison to the ABNS who has received board certification subsequent to May 1999." This openness and opportunity for communication should go a long way to allay fears among members over whether the final decisions about testing include the perspective of those whom the policy affects, satisfying both their needs as well as the profession's public responsibility.

Benefits of Recertification

Recertification as a policy juxtaposes the interests of patients in contrast with those of neurosurgeons and paradoxically exposes both joint benefit as well as conflicting interests. Neurosurgeons benefit from the exclusive status conferred by the certificate and the access to licensing, contracting, reputation and practice it confers. That benefit comes with the risk, however, that failing the recertification requirements, their privileges and livelihood may be imperiled or lost.

The public benefits from the assurance that certified neurosurgeons pass minimal professional standards and patients can feel safe in their care. The assurance of competence, however, is not a guarantee of perfect result and cannot imply a warranty either of the performance of the neurosurgeons certified by the Board or against the unpredictability of disease.

So overwhelmingly has specialty recertification been adopted by specialty boards, that it is no longer optional or avoidable. Our professional responsibility to the public is to see that we make the transition in education and testing in a way that most effectively achieves the stated goal of publicly demonstrated maintenance of competence. Our professional obligation to our members is to make the process of recertification fair and relevant to practice. Although late, we are well on our way to achieving the goal. ■