

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

# BULLETIN

The Socioeconomic and Professional Quarterly for AANS Members • Volume 14 No. 2 • Summer 2005

# CME Evolution

**How the AANS  
Is Helping Members  
Meet All CME  
Requirements**

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## AANS MISSION

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

## AANS BULLETIN

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

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Articles or article ideas concerning socioeconomic topics related to neurosurgery can be submitted to the *Bulletin*, [bulletin@AANS.org](mailto:bulletin@AANS.org). Objective, nonpromotional articles that are in accordance with the writing guidelines, are original, and have not been published previously may be considered for publication.

The AANS reserves the right to edit articles for compliance with publication standards and available space and to publish them in the vehicle it deems most appropriate. Articles accepted for publication become the property of the AANS unless another written arrangement has been agreed upon between the author(s) and the AANS.

## PEER-REVIEWED RESEARCH

The *Bulletin* seeks submissions of rigorously researched, hypothesis-driven articles concerning socioeconomic topics related to neurosurgery. Selected articles will be reviewed by the Peer-Review Panel. Submit articles to the *Bulletin*, [bulletin@AANS.org](mailto:bulletin@AANS.org).

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## LETTERS

Send your comments on articles you've read in these pages or on a topic related to the practice of neurosurgery to [bulletin@AANS.org](mailto:bulletin@AANS.org). Correspondence may be published

in a future issue edited for length, clarity and style. Correspondence is assumed to be for publication unless otherwise specified.

## BULLETIN ONLINE

The current issue and searchable archives to 1995 are available at [www.aans.org/bulletin](http://www.aans.org/bulletin).

## PUBLICATION INFORMATION

The AANS *Bulletin*, ISSN 1072-0456, is published four times a year by the AANS, 5550 Meadowbrook Drive, Rolling Meadows, Ill., 60008, and distributed without charge to the neurosurgical community. Unless specifically stated otherwise, the opinions expressed and statements made in this publication are the authors' and do not imply endorsement by the AANS.

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# Meeting the Challenges of Neurosurgery

## Members' Benefits Are the Focus of the Coming Year

It is an honor and privilege to serve as president of the American Association of Neurological Surgeons. This is certainly an opportunity I had not anticipated, but I deeply appreciate the trust you have placed in me and I look forward to the challenges and opportunities of the coming year.

I have the good fortune to follow a long line of outstanding AANS leaders and I have inherited a strong, well-organized and effective organization. The educational opportunities the AANS has offered this past year are unexcelled, including an outstanding annual meeting; four superb journals—the *Journal of Neurosurgery*, the *Journal of Neurosurgery: Spine*, the *Journal of Neurosurgery Pediatrics*, and the online journal *Neurosurgical Focus*; continuing medical education and professional development courses; free journal subscriptions and annual meeting registration for residents in North America; and practical clinics, among others.

The Neurosurgery Research and Education Foundation has experienced tremendous growth. Guidelines for future relations between the AANS and its industrial partners have been developed and are consistent with those of the Accreditation Council for Continuing Medical Education, which accredits AANS educational programs. Information and testimony have been provided when requested to a myriad of government agencies and other organizations. CME tracking, directories and other brochures and educational materials have been produced for members' use.

With all of these expanded activities and member benefits, the financial health of the AANS nevertheless has improved. The organization's reserves have increased, allowing the AANS to avoid a dues increase for the fourth straight year

and to consider new initiatives that will benefit our members.

### CME: Top Priority for AANS

Continuing medical education is increasingly important to all of us in neurosurgery; as such, CME remains a top priority for the AANS. While CME is necessary for membership in the AANS, equally importantly it is necessary for state

*Fremont P. Wirth, MD, is the 2005–2006 AANS president. He is in private practice at the Neurological Institute of Savannah in Georgia.*



licensure, hospital privileges, and Maintenance of Certification by the American Board of Neurological Surgery. The ABNS requirements for Maintenance of Certification have of necessity been evolving over the last two years as the project moved from idea through planning to implementation: Beginning in January 2006, Maintenance of Certification will become a reality for neurosurgeons certified by the ABNS beginning in 1999.

The AANS is making every effort to parallel its CME requirements for AANS membership with the ABNS' requirements for Maintenance of Certification. Currently there are three methods of obtaining qualifying CME for the AANS' requirement of 60 neurosurgical credits earned in every three-year cycle. These include attendance at sponsored or jointly sponsored programs, such as annual meetings of the AANS and the Congress of Neurological Surgeons, section meetings and many neurosurgical society meetings. The second

method is through enduring materials such as books or online CME initiatives such as *Neurosurgical Focus*, for which up to 12 credits are available each year.

The third method is by attending ACCME-accredited programs which have been cosponsored-endorsed by the AANS, a simple process that is free through 2006. To receive cosponsored-endorsed status, programs first need to apply. The criteria for acceptance include that the program: is important to neurosurgeons; has ACCME accreditation; demonstrates meaningful neurosurgical input in the planning; and is not commercially sponsored. Thus, most state neurosurgical society meetings and many other educational offerings will qualify if the program's sponsoring organization applies for cosponsorship-endorsement.

CME is a very important issue, and the AANS is committed to making the entire CME experience as easy as possible for all of our members by tracking CME credits and ensuring that there are an abundance of quality programs that will meet the requirements of various national and state entities. For additional information, I refer you to an article in this issue by Christopher Loftus, MD, chair of the AANS Education and Maintenance of Certification Committee.

Additional information always is available on the AANS Web site, [www.AANS.org](http://www.AANS.org), or from AANS Member Services, (888) 566-AANS.

### Quality Care Is Safe Care

Quality of care and patient safety are intrinsically related issues which have received increasing attention recently from the media, government and even third party payers. The AANS has been addressing just these issues for many years, and our programs, already in place, attest to the

importance attributed to these concerns. Our efforts include, among others, CME requirements for membership, extensive educational offerings for AANS members and residents, support of prevention efforts through public service announcements and support of Think First, and the AANS Professional Conduct Committee, which is a model for all of medicine.

In an effort to further improve quality, the AANS is fostering the development of outcomes research. Guided by Robert Harbaugh, MD, the AANS is working on methods and programs to facilitate the gathering of this data in a user-friendly and cost-effective manner. Also under development are patient education materials such as compact discs that discuss operative consent for a variety of neurosurgical procedures. Patient safety and quality of care will continue as a priority for the AANS in the coming years.

### **New PAC Drives Legislative Agenda Forward**

By the time you receive this issue of the *Bulletin*, the new political action committee for neurosurgery—the American Association of Neurological Surgeons Political Action Committee, or AANS PAC—will be operational. Because it will be allied with our 501(c)(6) organization (the American Association of Neurological Surgeons), it will be a much more efficient vehicle for influencing liability reform and other issues of importance and for soliciting funds that support these crucial efforts. For example, the new structure will allow AANS PAC contributions to be solicited with the AANS dues statement, making it that much easier for members to support tort reform and neurosurgery’s entire legislative agenda. The PAC that has operated for neurosurgery to this point, ANSPAC, will dissolve; its leaders will be asked to continue their efforts on behalf of our members and our patients through AANS PAC, which will continue the important political activities of the old PAC.

After giving considerable attention to this matter, the Board of Directors primarily was motivated in its decision to form the

new PAC by the opportunity the new structure affords to strengthen and build upon neurosurgery’s legislative successes. Efforts in Georgia, Missouri and South Carolina have resulted in significant tort reform at the state level within the last year, thanks in large part to neurosurgery’s support of reform through Neurosurgeons to Preserve Health Care Access; the NPHCA is a coalition member of Doctors for Medical Liability reform, which produced the very successful Protect Patients Now campaign. All of these reforms, however, remain to be tested in the courts. Enacting national legislation continues to be of paramount importance. We have the momentum! Now is the time to “put the power on,” to borrow the metaphor suggested by Robert Ratcheson, MD, in his final President’s Message. I would like to encourage you to join me in support of tort reform by sending your financial contributions to both the NPHCA and the AANS PAC now!

### **New Leadership for AANS Bulletin, Archives**

Changing leadership is important in any dynamic, growing, effective organization, and the AANS is no exception. In addition to those elected to office at the 2005 AANS Annual Meeting, there were well over 100 committee-level appointments. The AANS is fortunate to have so many talented, dedicated individuals capable of contributing to our organization that the choice of project directors is difficult.

James Bean, MD, has done a magnificent job as editor of the *Bulletin* and has brought it to its current position as a vital link in the communication of current policies, problems and opinions to the AANS membership. We cannot thank him enough for the hours of work he has devoted to this publication and are pleased that he will continue to devote his energies to his role as AANS treasurer. William Couldwell, MD, who has been serving on the Bulletin Advisory Board, succeeds Dr. Bean as editor of the *Bulletin*, and I expect that the transition will be seamless. Dr.

Couldwell brings to this position tremendous talent and energy which will serve neurosurgery well in the coming years. I am pleased that he has accepted this responsibility.

Eugene Flamm, MD, has been appointed to the newly reinstated position of AANS historian. Chosen from a field of excellent candidates, he will guide the reorganization of the AANS archives into a useful resource for medical historians. This collection of materials has been of necessity neglected for reasons of financial prudence for the past several years and awaits reorganization into usable status. Furthermore, some of our sister societies have asked the AANS to serve as the repository of archival materials, thus adding to the value of this historical endeavor. Dr. Flamm also will provide his own perspective on the history of the organization, drawing from more than 30 years in neurosurgery and as a member of the AANS. Under his direction the archives will prove to be of increasing interest to us all.

The year ahead holds great promise for neurosurgery and for the AANS. Fittingly, the 2006 AANS Annual Meeting, themed Meeting the Challenges of Neurosurgery: Expanding Resources for a Growing Population, will cap the year’s activities; I invite you to mark your calendars now and plan to join me April 22–27 in San Francisco. I hope to see you there. ■

### **For Further Information**

AANS Annual Meeting, page 22

CME Evolution, page 26

From the Hill, page 9

Popp, AJ, and Orrico, KO. “2004 DMLR Campaign Posts Huge Successes,” *AANS Bulletin* Spring 2005. [www.AANS.org](http://www.AANS.org), Article ID 27710.

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# NEWSLINE

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## FROM THE HILL

### **CMS OFFERS SINGLE NATIONAL PROVIDER ID**

A new identifier for use in standard electronic healthcare transactions became available May 6 when the Centers for Medicare and Medicaid Services began offering a single provider identifier that will replace the different identifiers providers currently use for each health plan with which they do business. The necessary steps for obtaining a national provider identifier are outlined at [www.cms.hhs.gov/hipaa/hipaa2/npi\\_provider.asp](http://www.cms.hhs.gov/hipaa/hipaa2/npi_provider.asp).

Frequent updates to legislative news are available in the Legislative Activities area of [www.AANS.org](http://www.AANS.org).

- **New AANS PAC Poised for Political Action** In July 2005 the American Association of Neurological Surgeons, a 501(c)(6) organization, announced formation of the AANS PAC. “This new political action committee will be a much more efficient vehicle for influencing liability reform and other issues of importance and for soliciting funds that support these crucial efforts,” stated AANS President Fremont P. Wirth, MD. Officials said that the new organizational structure would streamline administration and allow funds previously allocated for general and administrative expenses to be directed toward lobbying efforts. The AANS plans to increase financial support of lobbying efforts by soliciting contributions to the AANS PAC with the billing for membership dues, among other fundraising efforts. The AANS PAC will replace the organization known as ANSPAC and will complement Neurosurgeons to Preserve Health Care Access. The NPHCA, which is supported by the AANS and the Congress of Neurological Surgeons, is one of 11 specialty societies comprising Doctors for Medical Liability Reform. Additional information will be posted at [www.AANS.org](http://www.AANS.org).
- **Senate Bill Supports Health Courts and Other Medical Litigation Alternatives** On June 29 the Fair and Reliable Medical Justice Act was introduced in the U.S. Senate by Sens. Mike Enzi, D-Mont., and Max Baucus, R-Wyo. The bill’s stated purposes are “to restore fairness and reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote early disclosure of healthcare errors and provide prompt, fair, and reasonable compensation to patients who are injured by healthcare errors; to promote patient safety through early disclosure of healthcare errors; and to support and assist states in developing such alternatives.” Text of bill S. 1337 is available at <http://thomas.loc.gov>.
- **Legislation to Prevent Medicare Cuts Introduced in U.S. House** Reps. Clay Shaw, R-Fla., and Ben Cardin, D-Md., introduced the Preserving Patient Access to Physicians Act of 2005 in the U.S. House of Representatives on May 12. The bill would require a minimum 2.7 percent increase in Medicare physician reimbursement for 2006. In addition, beginning in 2007, the bill would replace the current sustainable growth rate formula with a new system that bases annual payment updates on medical cost inflation. If Congress does not act this year, physicians are expected to receive a 5 percent cut in 2006 and cumulative reductions of approximately 30 percent from 2006 to 2013. Text of bill H. R. 2356 is available at <http://thomas.loc.gov>.
- **Specialty Hospital Moratorium Expires; CMS Outlines Next Steps** June 8 marked the official end of the 18-month moratorium on physician-investor referrals to most specialty hospitals. The next day the Centers for Medicare and Medicaid Services began a six-month review of its procedures for enrolling specialty hospitals in the Medicare program and for paying specialty hospitals for their services. During the review, which the CMS expects to complete by January 2006, the CMS will seek public comment from the EMTALA Technical Advisory Group, particularly regarding participation of specialty hospitals with emergency departments in local community service emergency services protocols, and through an Open Door Forum scheduled for September 2005. Additional information is available in the media center of [www.cms.gov](http://www.cms.gov). In addition, proposed legislation effectively would make the moratorium permanent. The Hospital Fair Competition Act of 2005, introduced in the U.S. Senate May 11 by Chuck Grassley, R-Iowa, and Max Baucus, R-Wyo., would end the “whole hospital” exception in the Stark law that allows self-referrals. Text of bill S. 1002 is available at <http://thomas.loc.gov>.

# NEWSLINE

NewsMembersTrendsLegislation

## NEURO NEWS

### **SURGICAL SITE INFECTION RATE FALLS 27 PERCENT IN ONE YEAR**

Forty-four hospitals participating in the 2002–2003 National Infection Prevention Collaborative reduced their surgical site infection rate by 27 percent, according to an article published in the July issue of the *American Journal of Surgery*. Appropriate timing of antibiotic administration and clipping rather than shaving the surgical site were among the methods employed.

- **AANS Issues Statement Supporting Healthcare Coverage for All Americans** On April 15 the AANS Board of Directors approved a position statement supporting health insurance coverage for every American. The statement recognizes that millions of Americans have no health insurance. A recent Robert Wood Johnson Foundation study analyzing data from the Centers for Disease Control and Prevention estimates that more than 20 million working adults do not have coverage. The U.S. Census Bureau's August 2004 estimate put the number of uninsured Americans much higher, at 45 million in 2003. By 2013, 56 million American workers under age 65 will be uninsured, according to a new study from the University of California, San Diego. The AANS position statement is available at [www.AANS.org](http://www.AANS.org), article ID 27362.
- **First NERVES Practice Survey Provides Benchmarking Data** The results of the annual neurosurgery practice survey, conducted in 2004 by the Neurosurgery Executives' Resource, Value and Education Society, were announced at the NERVES annual meeting in April. "The survey documents the state of neurosurgery at this point in time and provides a reliable data set with which individual practices can compare their data and get a good picture of how the practice is doing," said Mark Mason, who spearheaded the NERVES project. "In the future we'll have several years of data that can be compared to identify trends in the neurosurgical profession." A total of 54 practices representing 406 providers participated in the survey, which focused on revenue, expense and workload and also included questions on relevant issues such as ancillary services, emergency room coverage, and medical liability insurance. Survey results are available to all new and renewing members of NERVES. "NERVES plans to conduct its second annual practice survey in late 2005, and I urge neurosurgeons to support their practice administrators' membership in NERVES and to participate in the next NERVES practice survey," Mason said. Additional information is available at [www.nervesadmin.com](http://www.nervesadmin.com).
- **Studies Tackle ER Troubles** Several recently released studies focus on problems with the delivery of emergency care. In May the Centers for Disease Control and Prevention released 2003 National Hospital Ambulatory Care Survey results indicating that emergency room visits increased 26 percent between 1993 and 2003, an increase of more than 2 million visits per year. Visit rates increased most dramatically for adults over age 65. During the same period the number of hospital emergency departments decreased approximately 12.3 percent. The report is available at [www.cdc.gov](http://www.cdc.gov). A study published in the June 1 issue of the *Journal of the American Medical Association* found that nearly 50 million Americans do not have access to a level 1 or level 2 trauma center within one hour of sustaining an injury. Branas and colleagues concluded that the problem primarily is due to the dramatic geographic variation of trauma center distribution and proposed solutions that included need-based selection of trauma centers. A British study published in the May issue of the *Emergency Medicine Journal* focused on the transfer of patient care from emergency physicians to specialists. The study of referral patterns identified risk factors in patient transfer situations and developed and tested a standard protocol for transferring patient care. Reid and colleagues concluded that emergency doctors with specific training in making referrals can help achieve a safer patient experience. Specialists were the focus of a 2004 survey conducted by the Schumacher Group. The survey of 4,000 emergency department administrators indicated an increase from 65 percent in 2001 to 76 percent in 2004 of those who said that the lack of specialty coverage has caused patients to be diverted to other hospitals. The survey is available at [www.tsGED.com/ED\\_Survey.htm](http://www.tsGED.com/ED_Survey.htm). Emergency transfers also are the focus of this issue's Education department, page 12, which offers an in-depth look at neurosurgical emergency transfers. The AANS *Bulletin* reported results of the 2004 AANS/CNS Neurosurgical Emergency and Trauma Services Survey in the Winter 2004 issue, available at [www.aans.org/bulletin/IssueList.aspx](http://www.aans.org/bulletin/IssueList.aspx).

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

# Taking the Long View

*Think of MOC as a Personal Quest*

This issue of the *Bulletin* reviews continuing medical education and those ways in which the AANS is organized to assist its members in acquiring and recording CME credits. Since the requirements for the American Board of Neurological Surgery's Maintenance of Certification program are evolving, the educational means for meeting them and the database for recording them are evolving as well. Meeting the MOC requirements is a continuous concern of AANS members, who must be certified by the ABNS, and therefore helping them do so is a continuous concern of the AANS.

## From Recertification to Maintenance of Certification

In 1999 the ABNS issued its first 10-year, time-limited certificates. ABNS diplomates with certificates preceding 1999 are "grandfathered in," or exempted from the renewal requirement. But even they may become subject to a need for certificate renewal by institutional credentialing or state licensing rules that insist on current evidence of continuing education and examination.

The change in ABNS policy came 26 years after the American Board of Medical Specialties, the ABMS, first recommended recertification to its member boards, six years after the policy became a requirement, 29 years after family practice became the first specialty to adopt recertification, and after all but one (pathology) of the other 24 member boards had adopted recertification. It was late, but it was inevitable, as the pressure to conform to standards adopted by the ABMS and every other specialty could not be ignored.

During the past six years, since the first neurosurgery time-limited certificates were issued, the ABMS policy of recertification—periodic testing separated by 7–10 year intervals—has been supplanted by a plan of

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is the AANS treasurer.  
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practice in  
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continuous measures to verify training and performance qualifications for practice. This new concept marks a quantum change in the purpose of certification: to maintain and prove competency in practice, not just demonstrate adequate education, training, and testing ability on entering practice. Before this policy change, specialty boards certified training and knowledge testing, avoiding claims of assuring competence.

The transition in certification policy follows an evolution in political pressure and social policy. Quality and effectiveness of healthcare received a rebuke and a warning in two Institute of Medicine reports—*To Err Is Human* in 1999 and *Crossing the Quality Chasm* in 2001—that criticized the lack of measures to prevent medical injury and improve the outcome of care. The reports helped fuel a growing public demand for accountability in medical care. Part of the response in medicine is expanded specialty board requirements that demonstrate competence among diplomates. As the ABMS states on its Web site, the MOC program "will help to reduce medical errors and enhance the quality of care provided by physicians, and lead to better patient healthcare outcomes."

The ABMS provides a thorough review of board history and current policies in its 2004 Annual Report and Reference Handbook. It describes a series of stages over time of increasingly complex standardized certification processes, from single testing in a primary specialty to the current MOC pro-

gram. Part of the "social contract" which allows professions to self-regulate and avoid the burden of state control of training and performance standards is the willingness to oversee and discipline their members. As described by Paul Starr in his 1982 book *The Social Transformation of American Medicine*, professions have a technical specialized knowledge, require systematic training, and enforce professional performance standards and discipline. Evolving board certification policies are the means of meeting this public demand for professional oversight while preserving the authority to define and enforce professional standards.

## MOC: Every Neurosurgeon's Personal Quest

Certification by the ABNS is not simply an issue of pride of accomplishment and professional stature. It is required for AANS membership, and is commonly a prerequisite for specialty practice membership, hospital staff privileges, medicolegal expert qualification, and in some cases, health plan participation. Evidence of current certification is used by some states in medical license renewal in lieu of a repeat state licensing exam. It is a necessary piece of every neurosurgeon's professional *bona fides*, and periodic renewal soon will be every neurosurgeon's personal quest. The AANS is committed to providing members with as much assistance as possible to help them meet the MOC requirements.

With this column I conclude my term as editor of the AANS *Bulletin* and turn it over to Bill Couldwell, MD. I thank John Popp, MD, for his guidance as prior editor, I thank Manda Seaver for her exemplary and professional staff editorship, and I particularly thank the members of the Advisory Board and the new Peer Review Panel for their contributions to making the *Bulletin* a publication of unparalleled value. ■

# Patient Transfers Spark Town-Gown Tension

*The Second Article in a Two-Part Series*

In the Spring 2005 Bulletin, Education Editor Deborah L. Benzil, MD, related two cases of patient transfers, one necessary and one probably unnecessary, to her New York academic medical center, opening a dialogue concerning patient transfers and the tensions they often generate between community and academic neurosurgeons. In the same issue, William T. Couldwell, MD, offered his views on the positive and negative consequences of patient transfers to his Utah AMC. In this issue, Thomas C. Originano, MD, continues the discussion, sharing his experience at an Illinois AMC.

Academic medical centers in Cook County, Ill., including Loyola University Medical Center where I practice, have received a significantly increased number of transferred high acuity neurosurgical patients who represent a disproportionately poor payer mix. This situation has stressed the system of neurosurgical care delivery, threatening the viability of AMCs, where tomorrow's neurosurgeons are trained, and imposing formidable barriers for patients needing neurosurgical care.

Among the factors underlying the increase in transfers are unfunded mandates such as the Emergency Medical Treatment and Labor Act, residents restricted to an 80-hour workweek, the medical liability crisis, and the neurosurgical community's survival responses to these influences. Defining a problem is the first step in solving it, and in the interest of fostering discussion and proposing possible solutions, the issue of patient transfers to academic medical centers will be discussed not in the context of good or evil, but rather in terms of driving forces, consequences and the effects on patient outcomes.

My perspective is shaped by the neurosurgical environment in Illinois, a medical liability crisis state which in May passed

AMC's Collections Decline, Expenses Increase						
Year	% Invoiced Services Collected	Operating Expense	% Collections Allocated to Operating Expense	Malpractice Insurance Premiums (Group)	Number of Neurosurgeons	% Collections Allocated to Malpractice Insurance Premiums
2000	42%	\$583,817	12%	\$462,685	6.5	10%
2001	34%	\$745,000	16%	\$606,488	5.5	14%
2002	34%	\$775,000	13%	\$764,736	5.5	14%
2003	32%	\$1,034,710	18%	\$1,079,484	5.5	21%

Data Source: Department of Neurological Surgery, Loyola University Medical Center, Maywood, Ill.

modest tort reform that for doctors included a \$500,000 limit on noneconomic damages. Medical malpractice insurance premiums in uncapped states are increasing yearly by double digits, and academic medical centers are not immune to these increases. My faculty paid \$195,000 per person for malpractice premiums in 2003 with a 20 percent increase for 2004. The increase in premiums and the declining collection rate related to the shift toward a population with a low-reimbursement payer mix is shown in the table above, which also expresses malpractice premiums as a percentage of collections. Academic medical centers in the Chicago area pay a range of 21 percent to 35 percent of collections for malpractice premiums.

The demographics of the area of Illinois where I practice, Chicago and Cook County, fuel the increase of transferred patients. The area harbors five academic medical centers where approximately 40 faculty neurosurgeons and 33 residents practice. The greater metropolitan Chicago area (including northwest Indiana and southeast Wisconsin) has approximately 14 million people. Indigent residents of Cook County or those injured within its bounds are served by Stroger Hospital. However, the fastest growing populations are in the

counties surrounding Cook, where the driving force for this growth is the availability of factory jobs which typically do not provide benefits such as health insurance.

Compounding the issue of a rapidly growing uninsured or underinsured population is a concomitant decline of neurosurgical services in community hospitals for head injury, pediatrics, stroke and hydrocephalus. Within the collar counties, greater than 25 community hospitals no longer have cranial neurosurgery coverage. Conservative estimates for neurosurgical coverage in the greater Chicago area are 150 neurosurgeons or one neurosurgeon per 93,000 people. The impact of some neurosurgeons restricting their privileges to spinal cases redefines this ratio to one neurosurgeon per 100,000 people for spinal cases and one neurosurgeon per 350,000 people for cranial cases.

### The New Town and Gown

This voluntary limitation of privileges exclusively to spinal cases can decrease malpractice premiums, remove obligation for emergency room coverage at "high risk" hospitals, permit transfers of elective cranial cases to "safe haven" hospitals where surgery can be performed without the consequences related to trauma, and shift responsibilities

for urgent and emergent care to academic medical centers by evoking EMTALA. Community hospitals are complicit with this practice because it allows retention of low acuity, short stay, high margin cases, while transferring high acuity, high resource consuming, poorly reimbursing cases.

The concept of these transfers as “great resident cases” in the face of the resident workweek restriction to 80 hours is errant. Resident exposure has been cut by 20 percent to 25 percent and today many academic centers run operating rooms without resident involvement, especially after 6 p.m. Further, at my facility the restriction has resulted in a minimum expenditure of \$400,000 per year on the neurosurgical service alone for nurse practitioners to replace resident caregivers.

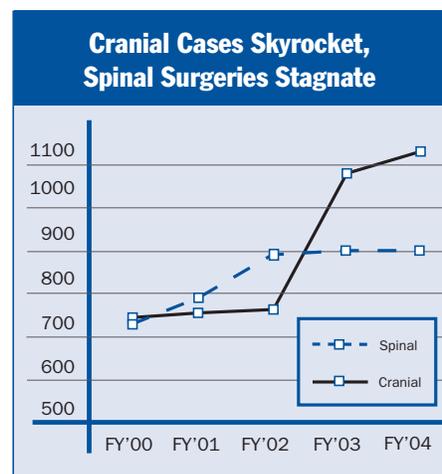
### The Consequences

The economic realities are harsh. Academic centers often function on small margins of 1 percent to 2 percent. Emergent and urgent transfers tend to have a higher acuity, poorer payer mix, longer length of stay (secondarily affecting hospital report cards) and a higher resource utilization. Failure to comply with EMTALA carries a \$50,000 per violation fine to the hospital and can lead to physician fines and Medicare sanctions.

The overall impact of this environment on academic neurosurgery has severe consequences. The ability to obtain and grow state-of-the-art technology and facilities is limited due to reduction in margin. Faculty retention and growth is threatened, especially in areas of poor reimbursement and growing need such as pediatrics, functional and trauma. Academic neurosurgery faculty salaries in Chicago are experiencing declines of between 10 percent and 30 percent. These economic pressures further impose on the ability to retain high earning academic spine surgeons and foster the maturation of junior to mid-level faculty. This ultimately could result in teaching centers that have a single senior professor and the rest junior assistant professors.

My institution has experienced an in-

crease in trauma admissions of 39 percent to 55 percent since 2003, primarily due to non-operative head trauma. This population has an extended length of stay, higher acuity and poorer payer mix. “Code Red: No Beds Available” now occurs 90 percent to 95 percent of the time Monday through Friday. As a consequence, patients with aneurysms or brain tumors cannot be accepted or their transfer is delayed. Emergent and urgent transfers take priority over elective schedules, forcing elective surgeries to be postponed due to lack of bed availability. Patients who develop intracranial pathology while at outside hospitals, even with board-certified neurosurgeons on staff, must be



Data Source: Department of Neurological Surgery, Loyola University Medical Center, Maywood, Ill.

transferred. Average transfer times, which are directly related to bed availability, now are approximately six hours and increasing.

Further, the above graph represents cranial and spinal volumes at my institution from 2000 to 2004. While poorly reimbursed cranial procedures have continued to increase, higher reimbursed spinal surgery has flattened in part due to retention of these cases in the community. Exacerbating this flattening has been a payer mix shift from commercial and worker compensation to low-reimbursing Medicare, Medicaid, health maintenance organizations, and self-payers.

All neurosurgeons do not bear the same weight of either the transfer crisis or

its consequences. Neurosurgeons must come to recognize the consequences of their survival tactics on academic training centers and patients. Academic neurosurgical centers, where tomorrow’s neurosurgeons are trained, are threatened. Patient access to care is jeopardized. Patient outcomes are being compromised.

The primary issue that must be resolved is patient access to care, which directly affects patient outcomes. It is doubtful that even with medical liability reform community practitioners would revert to previous lifestyles and practice patterns. Furthermore, it would be imprudent to resume procedures and patient management that one has not practiced for several years. Therefore, the solutions must be linked directly to the access to care issue:

1. Link access to care to caps on liability damages, rewarding neurosurgeons and institutions that care for patients regardless of payer mix, case mix or acuity.
2. Mandate transfer of all cranial cases to centers that manage all aspects of cranial surgery, linking margin to mission.
3. Make unrestricted provision of neurosurgical services a requirement of maintenance of certification.
4. Increase reimbursement to reflect the intensity of work associated with cranial surgery and the cost of high malpractice premiums associated with high risk surgery.
5. Change neurosurgical training to reflect social need (for example, institute a four-year course with emphasis on trauma, critical care and basic spine).
6. Discontinue holding neurosurgical meetings in states that do not have substantial medical liability reform, thereby linking reform to potent economic consequences.

Poor patient outcomes cannot and should not be the price paid for a stressed neurosurgical delivery system. The neurosurgery community must come together to forge solutions based on those things we hold in common, creating a new paradigm while holding to our old ideals. ■

**Thomas C. O'rigano, MD, PhD, FACS**, is professor and chair of the Department of Neurological Surgery at Loyola University Medical Center, Maywood, Ill.

# April Meeting Lays Course for 2005–2006

## *Liability Reform and Reimbursement Lead List of Concerns*

The Council of State Neurosurgical Societies met during the 2005 Annual Meeting of the American Association of Neurological Surgeons in New Orleans. During the CSNS meeting it was noted that the successful completion of the 2004 Leibrock Leadership Development Conference raised significant funds that will be used, with the consent of CSNS parent organizations the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, to support medical liability reform efforts. This initiative is a continuation of the efforts made by the AANS/CNS Washington Committee as well as the American Medical Association, which has recently noted that the liability crisis is still its number one concern: A medical liability crisis continues in 20 states, the average cost of a lawsuit is \$90,000 even if the doctor wins, and only 20 cents of every dollar awarded goes to the victim.

### Medical Liability Reform and DMLR: Your Support Is Needed

Doctors for Medical Liability Reform, a coalition of specialty societies which includes Neurosurgeons to Preserve Health Care Access, was discussed. Fifty-five Republicans have been elected to the U.S. Senate, and 53 of them are favorable to tort reform. Only Richard Shelby of Alabama and Lindsey Graham of South Carolina are Republican senators who have not been supportive, and it is felt that they never will be as they are trial attorneys. So far the Democratic side of the Senate has been cool toward tort reform.

Even though DMLR was successful with the 2004 Protect Patients Now campaign, much work still remains and the CSNS needs to continue to fund further tort reform efforts this year. For the effort to be successful, it is recommended that every neurosurgeon contributes a minimum of \$1,000 annually for the next three to five

Resolutions and additional CSNS information are available at [www.csnsonline.org](http://www.csnsonline.org).

years in order to fund a campaign effective in achieving permanent medical liability reform. As a point of reference, plaintiff attorneys in Florida contributed over \$50 million dollars this year, with individual contributions starting at \$1,000. There has been some success in tort reform in Georgia and South Carolina, where there now is a \$350,000 “stacked cap.”

### NERVES: A Remedy for Reduced Reimbursement

A critical issue in the next few months will be the participation of all neurosurgical groups in a sister organization known as NERVES (Neurosurgery Executives’ Resource Value and Education Society). NERVES is the organization composed of the business managers of various neurosurgical practices including private groups, employed groups, and academic groups. Its main purpose is to develop a comprehensive understanding of the needs of neurosurgeons and to integrate those needs into their individual practice settings. A major area of concern for NERVES is to optimize neurosurgical finances by improving reimbursement and minimizing costs which affect various neurosurgical practice groups. A 2004 survey conducted by NERVES identified the diversity of reimbursement schemes currently in existence in the United States. Gaining a full understanding of practice patterns and reimbursement structures will assist neurosurgeons in the negotiations required to receive appropriate payment for their efforts.

One important impending change in reimbursement for neurosurgeons’ work is pay for performance, an initiative recently

adopted by the Centers for Medicare and Medicaid Services. Pay for performance is intended to reimburse optimal practice performance at the currently nominal rate. Those neurosurgeons who perform “best” as determined by the CMS will receive full reimbursement, and others will be reimbursed at a lower level. The total available dollars for reimbursement will not increase, and it is likely that the actual total debit to CMS will be less since only the top 5 percent to 10 percent of neurosurgeons will be paid at the peak of pay-for-performance rates.

The AANS/CNS Washington Committee and the American Medical Association are working together to prevent significant drops in the reimbursement available to neurosurgeons. Participation in NERVES will assist all practice groups with gaining a better understanding of the changes in reimbursement planned by various third party payers and will assist the participants in learning how to respond to them appropriately. The CSNS greatly encourages all practicing neurosurgeons to support their practice managers and administrators in becoming members of NERVES. ■

**Fernando G. Diaz, MD, PhD**, is chair of the Council of State Neurosurgical Societies.

### For Further Information

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# OR Friend/Courtroom Foe

*Does a Product Rep in Your OR Have a Duty to Your Patient?*

For most neurosurgeons, it is a rare day in the operating room when a product representative is not present to facilitate a procedure, introduce a new product, or review options for expanding existing product use. These representatives are often well-educated, highly trained and polished communicators who work to maintain neurosurgeons' confidence. However, neurosurgeons must exercise great care in evaluating and acting on advice from these representatives regarding the use of their products. Consider the following summary of a true-life case.

## **Routine Surgical Case Goes Awry**

A neurosurgeon removed a patient's frontal meningioma. The case was routine and the tumor resection was complete. The bone flap was not replaced because of tumor invasion. The neurosurgeon decided not to use a cranial plating system or its titanium mesh cranioplasty alternative because he was concerned about scalp erosion. A product representative on the premises introduced an alternative cranioplasty product, describing it as a self-hardening hydroxyapatite material. The representative brought the product to the operating room and the neurosurgeon agreed to use it. After the material was prepared by the operating room staff with the guidance of the representative, it was applied to the cranial defect and the incision was closed. The patient had an uneventful postoperative course and made a good neurological recovery.

The patient later returned with wound puffiness and fullness. Imaging studies demonstrated breakdown of the cranioplasty material, and the incision was reopened. The wound was debrided and a new cranioplasty was created. The patient subsequently underwent three additional surgeries for closure of a cerebrospinal fluid leak, additional revision of the cranio-

plasty, and a final revision of the wound by plastic surgery. At no time did the patient suffer neurological injury, nor were there any infections or serious complications from these wound revision surgeries. The final cosmetic result was excellent.

The patient sued the manufacturer, alleging that the cranioplasty product was defective. The neurosurgeon was not named in the suit, and in fact, the patient had a great deal of respect for the neurosurgeon, liked him, and did not wish to sue him. However, in pretrial maneuvers, the company compelled the plaintiff's attorney to include the neurosurgeon as a codefendant in the legal proceedings. As the case proceeded, a primary issue became the reasonableness of the neurosurgeon's reliance on information and input from a product representative in the operating room.

## **Neurosurgeon's Defense: A Product Rep in the OR Has a Duty to the Patient**

In the jury trial that ensued, defense experts for the neurosurgeon asserted that a product representative's advice in lieu of the product insert was reasonable given the circumstances, particularly since this representative had been intensively trained on this particular product prior to the events of this case. They further asserted that the manufacturer's product representative in an operating room has a duty to the patient, including the duty to fairly represent the product's positive attributes, negative attributes, and potential complications, and that this is especially true if the product is represented as a solution for a surgical problem that occurs during an operative case, when the physician clearly has not had an opportunity to study product materials. They also contended that a product representative has a duty to the patient to warn and, if necessary, strenuously object if a surgeon

uses the product in a manner that may harm a patient.

## **Company's Defense: Reliance on Product Rep's Advice is Unreasonable**

Attorneys and defense experts representing the company countered, asserting that it was unreasonable to rely on a product representative for advice; rather the surgeon should educate himself or herself, and should, if necessary, scrub out of surgery to read reference material and package inserts and telephone company engineers. They asserted that the product representative in the operating room does not have a duty to warn a physician if the product is being used in an improper fashion, even if there is a high likelihood that using the product in an inappropriate way would result in harm to a patient, and that a product representative cannot practice medicine and cannot be held responsible for any medical decision made by a physician.

## **Verdict: Neurosurgeon's More Responsible**

The trial lasted more than one week; the jury returned a plaintiff's verdict for \$1.75 million, with 75 percent apportioned to the neurosurgeon and 25 percent apportioned to the product representative's company.

Because the number of innovative new products is expanding at a rapid pace, many of us frequently interact with product representatives. This case is worthy of our consideration because it illustrates that if there is an untoward consequence associated with a product, a congenial professional relationship with a product representative may not extend from the operating room to the courtroom. ■

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**Patrick W. McCormick, MD, MBA, FACS,** is a neurosurgeon in private practice in Toledo, Ohio.

# The Junctional Level Coding Dilemma

## *How to Code for Work Across Spinal Regions*

Choosing the appropriate code to describe spinal surgery performed across spinal regions such as the thoracolumbar junction has been a frequent dilemma for coders. The Current Procedural Terminology specifies a hierarchy of codes that identify work on the spine in cervical, thoracic, lumbar and sacral regions, but there are no specific CPT codes to identify work at the junction of these regions; the exception is 63087–63091 for anterior thoracolumbar corpectomy to allow for the unique additional work of diaphragmatic dissection.

Frequent questions concerning the difficulty of coding work performed at junctional levels prompted the CPT Editorial Panel to request instructional guidelines from the specialty societies earlier this year. These guidelines are currently under review by the CPT advisers from neurosurgery and orthopedics. This Coding Corner will examine the current proper choice of codes to describe junctional level spinal surgery.

**Discectomy** Anterior cervical and thoracic discectomy codes each have unique additional-level codes. Since exposure of the C7–T1 disc space utilizes an anterior cervical approach, the primary code 63075 for anterior cervical discectomy most appropriately describes decompression at the C7–T1 disc space. If additional discectomies are performed in the cervical spine, the additional level cervical code 63076 would be used.

If additional discectomies are performed in both the cervical spine and thoracic spine, two primary codes, 63075 and 63077, currently would be required, with 63075 appended with the –51 multiple procedural services modifier. However, since the typical patient would be undergoing an extended anterior cervical approach, it would seem more appropriate to continue to use the additional level cervical code 63076 for work in the upper thoracic spine,

but this is not currently possible because the CPT descriptor for 63076 is only linked to the anterior cervical discectomy code 63075. CPT advisers are considering submission of a proposal to change the CPT descriptor of 63076 to allow for additional levels of upper thoracic discectomy.

**Corpectomy** For an anterior corpectomy, the use of corpectomy codes 63081–63091 is straightforward. The thoracolumbar area also has specific codes (63087–63091), and additional-level codes are designated for each region. For a corpectomy performed in two spinal regions, two primary codes are chosen, one of which is appended with the –51 modifier.

**Laminectomy** Although primary level posterior laminectomy codes have individual codes 63045–63047 for specific spinal regions, they share a single additional-level code, 63048. If performing a cervicothoracic laminectomy, the primary cervical code 63045 should be used followed by 63048 for each additional level, regardless of whether the procedure is performed in the cervical or thoracic spine. Similarly, a thoracolumbar laminectomy should be coded with a primary lumbar code 63047 followed by 63048 for each additional level, regardless of whether the procedure is performed in the thoracic or lumbar spine.

**Arthrodesis** Posterior arthrodesis codes (22600–22612) would be used in a similar manner, as these also share the same additional-level code 22614. However, a single posterior arthrodesis at the cervicothoracic junction should be described with 22600, whereas a single posterior thoracolumbar arthrodesis should be described with 22612.

Coding for anterior arthrodesis would follow the same pattern. Since a C7–T1 arthrodesis would be performed through an anterior cervical approach, this procedure typically would be described using 22554. Additional level anterior arthrode-

sis is described with 22585, regardless of the spinal region where it is performed. Likewise, a T12–L1 arthrodesis would be described using 22558. Although there are no anterior codes for thoracolumbar junctional arthrodesis, this procedure would typically be performed with a decompression, in which case the corpectomy codes would identify the additional work of diaphragmatic take-down.

**Decompression** Additional difficulties are encountered in posterior decompressions for nondegenerative conditions such as spinal neoplasms (63300–63308). Although CPT includes single codes for each spinal region, some diseases affect more than one spinal region. It is recommended that a single primary code is chosen based on where the majority of the work is performed. It would seem unreasonable to use only one primary code for a four-level C3–C7 laminectomy for excision of intraspinal pathology, but two primary codes for a two-level laminectomy involving C7–T1. In this latter circumstance, a single primary cervical code should be used. In the circumstance of laminectomies performed in more than one spinal region (more than two segments in both regions), two primary codes should be used, appending one with the –51 multiple procedural services modifier. The anterior decompression codes for nondegenerative conditions follow the same rules as the degenerative anterior decompression codes.

Explanatory language now under development by the neurosurgery and orthopedics CPT advisers should help physicians and coders manage the sometimes confusing area of coding at junctional levels. ■

**Gregory J. Przybylski, MD**, is professor and director of neurosurgery at JFK Medical Center in Edison, N.J. He is a member of the CMS Practicing Physicians Advisory Council and the AANS/CNS Coding and Reimbursement Committee, and he plans and instructs coding courses for the AANS and the North American Spine Society.

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# Liability Is Rooted in Elective Spine Cases

Four Years of TDC Data Analyzed

RICHARD N.W. WOHNS, MD

Some neurosurgeons have given up cranial surgery privileges, and therefore emergency room coverage, primarily because of liability exposure. According to the 2002 CSNS Neurosurgery Medical Liability Survey, 56 percent of neurosurgeons have limited the services they provide and no longer treat brain tumors or aneurysms, operate on children, or perform complex spinal procedures. The survey also showed that 35 percent of neurosurgeons have altered emergency call coverage by eliminating certain emergency services, reducing hours or days on call, or stopping emergency call altogether. The key question is why: What factor or factors drive this profound change in practice design and economics?

## 2000–2004 TDC Data Show Trends in What Leads to Loss Payments

The 2004 AANS/CNS Neurosurgical Emergency and Trauma Services Survey indicated that a common reason neurosurgeons offer for relinquishing cranial surgery privileges and emergency room coverage is that the professional liability crisis has forced them to limit their risk of lawsuits. The relevant statistics that motivate neurosurgeons include the likelihood of being sued every two years, a 70 percent chance of a plaintiff victory in a case involving a claim of cognitive impairment, an increasing number of extremely large settlements and judgments, and finally a real risk of these settlements and judgments exceeding their policy limits. This situation has influenced some neurosurgeons to limit their practice to avoid the liability of intracranial and complex spine surgery. However, based on liability data from The Doctors Company,

2000–2004 Allocated Loss Adjustment Expense (ALAE) Paid for Elective Cases				
No Indemnity (Loss) Payments				
Case	Case Count	ALAE Paid	Average	Median
Carpal Tunnel	1	\$10,844	\$10,844	\$10,844
Cervical	31	\$650,720	\$20,991	\$10,380
Lumbar	45	\$1,176,131	\$26,136	\$9,104
Thoracic	9	\$84,330	\$9,370	\$10,716
Cranial	34	\$470,010	\$13,824	\$9,285
Evaluation and Management Only	4	\$18,375	\$4,594	\$2,780
Unknown	6	\$63,823	\$10,637	\$9,300
<b>Total</b>	<b>130</b>	<b>\$2,474,233</b>	<b>\$19,033</b>	<b>\$9,905</b>

2000–2004 Allocated Loss Adjustment Expense (ALAE) Paid for Emergency Cases				
No Indemnity (Loss) Payments				
Case	Case Count	ALAE Paid	Average	Median
Carpal Tunnel	0	0	0	0
Cervical	1	\$430	\$430	\$430
Lumbar	2	\$32,247	\$16,124	\$16,124
Thoracic	0	0	0	0
Cranial	0	0	0	0
Evaluation and Management Only	5	\$221,082	\$44,216	\$29,428
Unknown	0	0	0	0
<b>Total</b>	<b>8</b>	<b>\$253,759</b>	<b>\$31,720</b>	<b>\$16,124</b>

Data Source: The Doctors Company

it appears that routine elective spine practice may be the origin of most lawsuits.

The statistics of lawsuit frequency according to type of case that would justify this conclusion—that is, number of intracranial cases compared with spinal cases, or emergency cases compared with elective cases—have not yet been published in the neurosurgical literature or in the indemnity insurance statistics. The purpose of this paper is to provide 2000–2004 data from The Doctors Company that show trends in the professional liability risk profile for the types of encounters leading to loss payments.

## The Three Components of “Total Loss”

Insurers list three components of the total loss costs in medical professional liability:

1. indemnity;
2. unallocated loss adjustment expense; and
3. allocated loss adjustment expense.

■ **Indemnity** is the actual or estimated (reserve) amount to be paid in damages to the plaintiff. The total amount incurred represents the amount either paid or held in reserve to pay current open claims.

### 2000–2004 Indemnity (Loss) Payments for Elective Cases

Case	Case Count	Indemnity Paid	Average	Median
Carpal Tunnel	0	0	0	0
Cervical	9	\$6,431,000	\$714,556	\$850,000
Lumbar	18	\$9,028,000	\$501,556	\$357,500
Thoracic	1	\$30,000	\$30,000	\$30,000
Cranial	5	\$1,750,000	\$350,000	\$175,000
Evaluation and Management Only	0	0	0	0
Unknown	0	0	0	0
<b>Total</b>	<b>33</b>	<b>\$17,239,000</b>	<b>\$522,394</b>	<b>\$400,000</b>

### 2000–2004 Indemnity (Loss) Payments for Emergency Cases

Case	Case Count	Indemnity Paid	Average	Median
Lumbar	1	\$500,000	\$500,000	\$500,000
<b>Total</b>	<b>1</b>	<b>\$500,000</b>	<b>\$500,000</b>	<b>\$500,000</b>

Data Source: The Doctors Company

■ **Unallocated Loss Adjustment Expense (ULAE)** is the cost to the insurance company of managing its claims department to adjust and resolve claims, including such expenses as overhead and staff. These costs are not allocated to any individual claim, but are a general expense to the insurance company as part of their operations. For the most part ULAE is combined in financial reporting as part of “underwriting” expenses.

■ **Allocated Loss Adjustment Expense (ALAE)** is the specific cost of adjusting a specific claim or loss. Therefore it is allocated to a specific claim or loss. It is expressed as both actual (paid) and reserve (estimated) amounts. The components of ALAE include defense attorney expenses and fees, costs of records duplications, expert witnesses, trial preparations, etcetera.

### Data Suggest Primary Lawsuit Source Is Elective Spine Cases

The 2000–2004 data in the tables were obtained from The Doctors Company, which provides coverage to approximately 200 neurosurgeons nationwide. These data are assumed to be representative of the trends among neurosurgeons insured by other companies, although carrier and regional differences may exist. Conclusions drawn from this sample are not statistically significant. However, perceptions regarding liability exposure that affect decisions to renounce intracranial privileges may be altered by this trend analysis.

A review of the professional liability risk profile data from The Doctors Company suggests the following trends and additional analysis.

1. Lawsuits are predominantly related to elective spine cases.

2. Emergency and trauma cases do not lead to a significant number of lawsuits.

3. Collection of data from other carriers that provide neurosurgical liability coverage should be accomplished.

4. An aggregate analysis should be performed in order to obtain a statistically valid professional liability risk profile leading to loss payments.

In conclusion, while some neurosurgeons have given up their craniotomy privileges and therefore their emergency room coverage primarily because of liability exposure, 2000–2004 data from The Doctors Company demonstrate that routine elective spine practice is the origin of most lawsuits and that emergency and trauma cases do not lead to a significant number of lawsuits. Additional data from other insurance carriers should be obtained in order to compile a statistically significant neurosurgical liability risk profile. ■

**Richard N.W. Wohns, MD, MBA**, is chair of the AANS Professional Liability Committee and chair of the Northwest Quadrant of the Council of State Neurosurgical Societies. He is president and founder of South Sound Neurosurgery, PLLC, in the Puget Sound region, Wash.

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# AANS Members Vote to Expel Member

## *Six New Professional Conduct Cases Decided by Board of Directors*

**A**t the joint annual business meeting of the AANS and the American Association of Neurosurgeons on April 18 in New Orleans, the membership upheld an appealed decision of the Board of Directors expelling a member for unprofessional conduct. Also during the annual meeting the Board of Directors decided six new cases including another expulsion (not being appealed), a two-year membership suspension (being appealed to the general membership in April of 2006), one censure, and three dismissals of charges. A brief summary of the three sanctions appears below:

### **L. David Rutberg, MD: Expelled From AANS Membership**

The charges against L. David Rutberg, MD, were based on his submission of an expert opinion letter to a plaintiff's attorney certifying that another neurosurgeon had deviated from the applicable standards of care in the placement of pedicle screws in a patient, in failing to diagnose and treat a postoperative wound infection in a timely manner, in failing to properly monitor and assess the patient's condition and then in failing to consult with or refer the patient to appropriate specialists in a timely manner. Based on Dr. Rutberg's letter, a medical malpractice lawsuit was filed. However, after the initiation of preliminary discovery, and after consultation with other experts, the plaintiff's counsel determined that the suit was without merit and voluntarily dismissed the case.

The AANS Professional Conduct Committee concluded that if Dr. Rutberg had reviewed all of the clinical material in an unbiased manner, he would also have reached the conclusion that the complaint was without merit in the first instance and the lawsuit would not have been filed. The committee concluded, and the Board of Directors agreed, that Dr. Rutberg's Letter of

Merit constituted unprofessional conduct and that this, coupled with his previous suspension of membership for unprofessional conduct, warranted Dr. Rutberg's expulsion from the AANS. After the Board of Directors approved the committee's recommendation to expel Dr. Rutberg, he filed a Notice of Appeal to the General Membership. Dr. Rutberg's letter explaining his position was distributed to all voting AANS members prior to the joint annual business meeting, as was a letter by then-AANS President Robert Ratcheson explaining the rationale for the board's decision. At the meeting, the members upheld the Board of Directors' decision and Dr. Rutberg was expelled.

### **Robert Rand, MD: Expelled from AANS Membership**

The Board of Directors approved the AANS Professional Conduct Committee recommendation that Robert Rand, MD, be expelled for unprofessional conduct consisting of certain expert testimony statements made in a professional liability lawsuit. Dr. Rand had been suspended previously for unprofessional conduct due to his testimony in an earlier matter. The current case involved a cervical intramedullary tumor that had been missed by other physicians and the patient had been quadriplegic for 12 hours prior to neurosurgical referral. Dr. Rand testified that if the patient had received immediate surgery, the patient would have been able to walk and would have regained most other activities of daily living.

The committee was not critical of Dr. Rand's testimony that immediate surgery should have been offered to the patient (the tumor was removed 48 hours later), but concluded that Dr. Rand's testimony about the patient's expected recovery with surgery amounted to egregious advocacy and was flagrantly unprofessional. The Professional Conduct Committee concluded and the

board agreed that this testimony, considered along with the prior unprofessional conduct suspension, warranted Dr. Rand's expulsion from the AANS.

### **Edward C. Tarlov, MD: Censured by AANS Board of Directors**

The Board of Directors approved the AANS Professional Conduct Committee recommendation that Edward C. Tarlov, MD, be censured for unprofessional conduct based upon an expert opinion letter supporting a professional liability lawsuit.

The case involved a middle-aged woman who underwent a repeat lumbar disc excision that was complicated by a tenuously sutured dural tear. She had a difficult postoperative course that was felt to be consistent with low cerebral spinal fluid pressure. She was readmitted urgently the day after discharge with dysphasia and a computed tomographic scan of the head demonstrated a hemorrhagic venous infarction. Dr. Tarlov provided the plaintiff's attorney with an expert opinion letter stating that the patient "was confused and at times used words inappropriately" and concluded that "it was clear that she was developing a neurological deficit with speech disturbance" which the treating neurosurgeon failed to recognize as a developing stroke. Review of the medical records covering the initial hospitalization indicated evidence of normal speech with no observation of a developing dysphasia in either the treating neurosurgeon's progress notes or in the nursing notes. Dr. Tarlov's opinion was based upon subsequent deposition statements of the patient's husband that were in direct contradiction to the hospital records and the recollection of the treating neurological surgeon.

The committee concluded, and the Board of Directors agreed, that in assuming the correctness of the husband's state-

ments and rejecting the statements of the treating neurosurgeon, as well as the hospital records, Dr. Tarlov failed to be an unbiased educator (deciding between the conflicting “facts” was a jury responsibility) and became an advocate for the plaintiff.

### About the AANS Professional Conduct Program

The AANS Professional Conduct Committee evaluates complaints by one or more AANS members about another member or members and makes recommendations to the Board of Directors. The committee has recently been averaging about 12 cases per year, most of which involve expert witness testimony in medical malpractice lawsuits. Four cases are scheduled for hearings in Boston during the 2005 Annual Meeting of the Congress of Neurological Surgeons. Over the last decade the AANS has dis-

missed between 30 percent and 40 percent of the complaints alleging unprofessional expert testimony.

Established in 1982, the AANS Professional Conduct Committee has served as a model for other professional associations to structure and adopt similar professional conduct programs. In June of 2001, the AANS Professional Conduct Committee’s work was examined by the 7th Circuit Court of Appeals in a landmark case for professional associations, *Austin v. AANS*. This opinion strongly supported the AANS Professional Conduct Program, indicating the need for a professional association to have an internal mechanism for self-regulation. The program also received an honor roll designation from the American Society of Association Executives in 2002. ■

**W. Ben Blackett, MD, JD**, is the chair of the AANS Professional Conduct Committee.

### For Further Information

- Notices of Suspension: L. David Rutberg, MD, AANS *Bulletin* Winter 2002, [www.AANS.org](http://www.AANS.org), Article ID 21455; and Robert Rand, MD, AANS *Bulletin* Spring 2003, Article ID 9886.
- Pelton, RM. “Professing Professional Conduct: AANS Raises the Bar for Expert Testimony,” AANS *Bulletin* Spring 2002. [www.AANS.org](http://www.AANS.org), Article ID 9916.
- AANS Expert Witness Guidelines, [www.aans.org/about/membership/ExpWitness03Dec04.pdf](http://www.aans.org/about/membership/ExpWitness03Dec04.pdf).
- AANS Code of Ethics, [www.aans.org/about/aanscodeofethics\\_12\\_04.pdf](http://www.aans.org/about/aanscodeofethics_12_04.pdf).

# Enthusiastic Response to 20

*More than 6,000 Participate in Education and Innovation in Neurosurgery*

MANDA J. SEAVER

**T**he pageantry and relaxed hospitality associated with The Big Easy were abundantly evident throughout the 2005 AANS Annual Meeting, held April 16–21 in New Orleans, but education and innovation in neurosurgery were the main attractions for the thousands of attendees.

The 73rd Annual Meeting of the American Association of Neurological Surgeons was planned by a 16-member committee that focused on creating a participatory meeting event intended to serve as a primary source of neurosurgical continuing medical education, to advance neuroscience research, and to promote excellence in clinical practice. Led by Richard G. Fessler, MD, annual meeting chair, and James T. Rutka, scientific program chair, the committee included Mitchel S. Berger, MD; Catherine Culicchia; Frank Culicchia, MD; Anthony L. D'Ambrosio, MD; Carlos A. David, MD; Jonathan A. Friedman, MD; Isabelle M. Germano, MD; Joseph A. Hlavin, PA-C; David F. Jimenez, MD; Timothy B. Mapstone, MD; Gail L. Rosseau, MD; Andrea Strayer, CNRN; Eve C. Tsai, MD; and Benjamin T. White, MD.

A total of 6,084 attendees answered the AANS' invitation to participate in the year's premier neurosurgical event. AANS members attending represented more than one third of the AANS membership. In addition, 328 member residents took advantage of complimentary registration offered this year, resulting in a 21 percent increase over their attendance last year.

Neurosurgeons had the opportunity to earn 21 category 1 CME credits for attending the entire meeting, representing approximately one third of all credits required in the three-year cycle for AANS membership. Neurosurgeons additionally could earn 24 credits for



**2005 AANS ANNUAL MEETING: THE COMPLETE EXPERIENCE** (clockwise from top left)

1. The AANS Resource Center, stocked with useful products and services and staffed with knowledgeable personnel, hums with activity. The Resource Center was located in the Annual Meeting Exhibit Hall, where 2,731 people staffed 761 booths for 223 companies. 2. Catch! A costumed reveler invites the participation of partygoers during the Mardi Gras-style parade at the opening reception. The Sunday evening festivities sparked a week of scientific exploration. 3. Gunnar Soerensen, MD, of Germany scrutinizes one of 498 scientific posters encapsulating new research results. Ten top posters were displayed on large screens in high traffic areas. 4. Stan Pelofsky, MD, 2001–2002 AANS president, exhorts colleagues to support medical liability reform through donations to Neurosurgeons to Preserve Health Care Access.

# 05 AANS Annual Meeting

attending some of the 80 breakfast seminars and 41 Saturday and Sunday practical clinics. For neuroscience nurses, 30.8 continuing nursing education contact hours were available.

Committee members chose a variety of topics that would appeal to a range of neurosurgeons and related medical professionals. In three plenary sessions, 137 oral presentations related new research findings. Eight studies thought to have an appeal beyond neurosurgery to the greater scientific community and to the general public were selected through a peer-review process for media release:

- “Intraventricular Passive Immunization Against Beta-Amyloid as a Treatment for Alzheimer’s Disease in Transgenic Mice”
- “Age-Related Changes in Cerebral Blood Flow May Explain Worse Outcome in Female Head Trauma Patients”
- “Multicentric Phase III Study on Fluorescence-Guided Resection of Malignant Gliomas With 5-ALA: Preliminary Results on Interim Analysis of 270 Patients”
- “The Induction of Venous Collateral Circulation by Staged Separation of Craniopagus Twins”

Continued on page 24

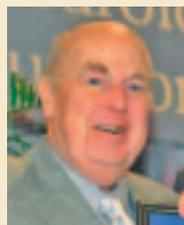
## AWARDS AND HONORS



### **Cushing Medal— Martin H. Weiss, MD**

Dr. Weiss received the Cushing Medal, the highest honor bestowed by the AANS. “I am in awe to be a member of this group,” he said. He was recognized as a

premier pituitary surgeon who has generously served the profession in leadership positions over 34 years. Observing that no one operates in a vacuum, Dr. Weiss thanked his family, his mentors, and his neurosurgical colleagues for allowing him to do the things he wanted to do.



### **Distinguished Service Award— John C. Van Gilder, MD**

Dr. Van Gilder was honored as a gifted neurosurgeon who has given many years of service to the AANS, to his patients, and to the

neurosurgical community, including service as chair of the Residency Review Committee for Neurosurgery. “Today’s young neurosurgeon is much better qualified,” he observed. “It has been an honor to work with young neurosurgeons.”



### **Honorary Member— Armando J. Basso, MD**

Dr. Basso of the University of Buenos Aires was recognized for his outstanding accomplishments in the field of neurosurgery. An International member of the

AANS since 1994, Dr. Basso said that the honor was unexpected and that “I particularly appreciate it coming from one of the premier neurosurgical organizations in the world.” Honorary members must be internationally renowned and have made outstanding educational, research, or clinical contributions to the field of neurosurgery.



### **Humanitarian Award— Tetsuo Tatsumi, MD**

Dr. Tatsumi was honored for his many years of dedication to the international medical community, and particularly for his humanitarian work

delivering neurosurgical services to people in Honduras and Guatemala. He acknowledged the AANS “for inspiring me and guiding me through my neurosurgical career,” and the Foundation for International Education in Neurological Surgery, known as FIENS, for “inspiring young neurosurgeons who want to learn under very difficult circumstances.”



### **Van Wagenen Fellow— Devin K. Binder, MD**

Dr. Binder will work directly with Dr. Johannes Schramm at the University of Bonn’s epilepsy research and treatment center to learn surgical techniques and approaches to epilepsy treatment. The Van Wagenen Fellowship is offered annually for post-residency study in a foreign country for a period of 12 months. Dr. Binder’s fellowship is July 1, 2005–June 30, 2006.



### **Louise Eisenhardt Resident Travel Scholarship— Martina Stippler, MD**

During the second plenary session, Women in Neurosurgery honored Dr. Stippler for her paper “Continuous

Magnesium Infusion for Cerebral Vasospasm Prophylaxis in Aneurysmal Subarachnoid Hemorrhage,” which she then presented. The study of 76 adult patients found a lower incidence of cerebral vasospasm in patients receiving magnesium.

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- “Is There a ‘July Effect’ in Pediatric Neurosurgery at Teaching Hospitals?”
- “Changing Patterns of Traumatic Brain Injury Epidemiology and Mortality Risk”
- “Deep Brain Stimulation for Pain: A Meta-Analysis”
- “Prospective Blinded Outcome Assessments in Spinal Surgery”

Articles published on these topics and others presented at the annual meeting already have reached an estimated audience of 417 million people. An additional 40 million radio listeners are estimated to have heard about neurosurgical topics and the annual meeting directly from the 50 neurosurgeons who took part in Hometown Radio Interviews. The interviews paired each participating neurosurgeon with a seasoned broadcaster to craft an educational message about any aspect of neurosurgery for airplay in the neurosurgeon’s community. The medical liability crisis and deep brain stimulation for tremor and epileptic seizures are among the 60-second stories, available in MP3 format, which can be heard at [www.soundtargeting.com/html/stories.html](http://www.soundtargeting.com/html/stories.html).

To assist them with effectively communicating important research and activities to the public through the media, meeting attendees were able to participate in a media training breakfast seminar as well as a media awards program that featured an interactive question and answer segment. After award presentation to journalists Vicki Mabrey of CBS 60 Minutes Wednesday for a program on normal pressure hydrocephalus, Melissa Fletcher Stoeltje of the San Antonio Express-News for a story on a paralyzed woman’s will to walk again, and Debi Chard of WCSC-TV in Charleston, S.C., for a feature on S.C. neurosurgeon volunteers in Iraq, reporters and neurosurgeons discussed what makes a good story and why media is



2004–2005 AANS President Robert A. Ratcheson, MD, left, transfers the gavel to newly elected President Fremont P. Wirth, MD, whom Dr. Ratcheson recognized as an “outstanding gentleman and an outstanding individual.” Dr. Wirth accepted the gavel, saying, “It is a pleasure to assume this position, and I hope I can count on your support.”

necessary. Reporters stressed that the patient is a necessary component for personalizing the story and that reporters function as translators who explain complex ideas in layman’s terms. A Belgian neurosurgeon in attendance, Jacques Brotchi, said, “I favor the links between neurosurgeons and the media because [without them]

## SPECIAL SCIENTIFIC SESSION:

# Neurosurgery With the Masters: In My Experience

Each of these master neurosurgeons shared his more than 30 years of experience with his colleagues. This well-attended program concluded the 2005 AANS Annual Meeting.



**James T. Rutka, MD,**  
moderator



**David G. Kline, MD,**  
peripheral nerves



**Edward R. Laws Jr., MD,**  
pituitary



**Arnold H. Menezes, MD,**  
spine



**Albert L. Rhoton Jr., MD,**  
microsurgical anatomy

the population does not know what we are doing.”

Nine AANS/CNS section presentations offered an intensive look at advances in neurosurgery’s subspecialties. The sessions presented research, information and awards related to spine and peripheral nerves, pain, tumors, cerebrovascular, neurotrauma and critical care, pediatric, stereotactic and functional neurosurgery, and the history of neurosurgery.

Three poster viewing sessions in the exhibit hall featured 498 posters, selected from several hundred submitted abstracts, that encapsulated significant scientific research. Ten of the top posters gained additional exposure by display on large screens in high traffic areas during the meeting. Category 2 continuing medical education credit was available both for those presenting and for those viewing posters.

Awards and honors bestowed at the annual meeting emphasized the highest ideals of neurosurgery. Named lectures honored both the namesakes and the lecturers who, at the apex of their professions, were asked to share their wealth of experience with

their colleagues. This year Julian T. Hoff, MD, delivered the Richard C. Schneider Lecture on the topic “Maintaining Professionalism.” Darell Bigner, MD, discussed “Molecular Neurosurgery: Targeted Therapy of Brain Tumors” for the Ronald L. Bittner Lecture. Charles Warlow, PhD, made a compelling case for rigorous randomized trials in neurosurgery in his Van Wagenen Lecture. “The Search for a Cure for Paralysis Due to Spinal Cord Injury” was

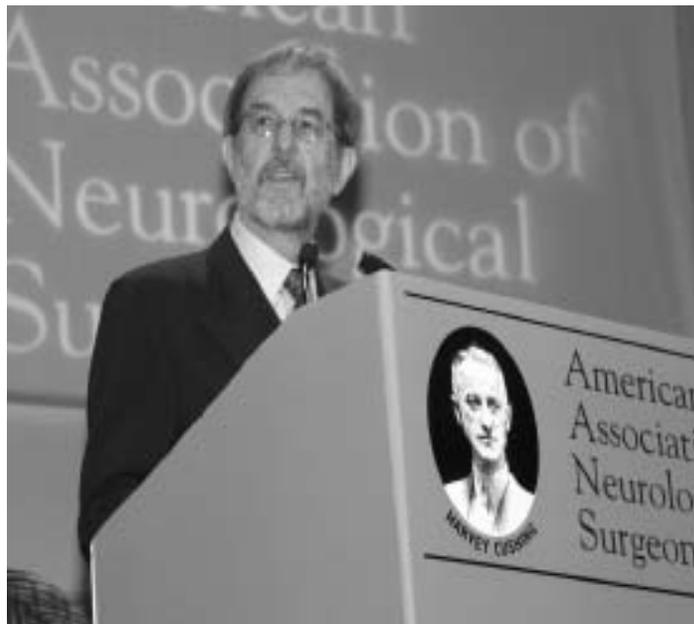


Julian T. Hoff, MD, delivers the Richard C. Schneider Lecture.

the topic of Robert G. Grossman, MD, for the Rhoton Family Lecture, while Henry J. Peter Ralston III, MD, discussed “Pain and the Primate Thalamus” in the Hunt-Wilson Lecture. Cushing medalist Martin H. Weiss, MD, offered a sampling of a lifetime’s experience in “Pituitary Surgery: A Surgical Odyssey,” the Theodore Kurze Lecture.

### Cushing Orator Takes H&P of Three “Patients”

How their medical conditions influenced the achievements of three prominent historical figures was the focus of biographer Edmund Morris in his 2005 Cushing Oration. Ludwig van Beethoven, Theodore Roosevelt and Ronald Reagan, all subjects of Morris biographies, were scrutinized under his literary microscope. Morris introduced his subjects with a succinct characteri-



Edmund Morris delivers the Cushing Oration.

zation: “Reagan knew about as much about Beethoven as Beethoven knew about Reagan” while “Roosevelt’s idea of sublime music was ‘Hail to the Chief.’”

Beethoven’s progressive deafness is well-known, but few are aware that he suffered repeated illnesses throughout his adult life and that his greatest music was written after he had completely lost his hearing. “All his art came out of his physiological condition,” Morris summarized. Roosevelt, a sickly boy whose response to his infirmity was fanatical exercise, reportedly said, “I’m going to live life to the hilt until I am 60 and then I’m going to die.” Morris termed Roosevelt’s energy drive “by any standards phenomenal” and noted that “When you compare the list of accomplishments to the list of ailments, ‘giant’ applies.” In contrast, Reagan, who lived what Morris called a charmed life for almost 70 years, used his “physical positivity” to stave off the effects of the assassination attempt against him. Morris, designated the official Reagan biographer during the Reagan presidency, noted that he never saw signs of neurological deterioration in Reagan, who it is now known suffered from Alzheimer’s disease, while he was in office.

In an early morning interview before his lecture, the Pulitzer Prize-winning biographer discussed some similarities in how he and a doctor might deal with their respective “patients,” first observing the surface, then palpating to locate sensitivities that need to be explored. With the curling Mississippi River framed in the picture window behind him, the Kenya-born and educated author also revealed a surprising boyhood inspiration for his fascination with American figures: Twain’s tale of a quintessential American adventurer, “Tom Sawyer.”

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# CME Evolution

How the AANS Is Helping  
Members Meet  
All Their CME Requirements

“Since education is a lifelong process, we are all conscious of persistently shoring up to atone for educational deficiencies which could not possibly have been anticipated,” observed Harvey Cushing in a 1925 address dedicating Yale University’s Sterling Hall of Medicine. Dr. Cushing perhaps could not have foreseen the extensive formalization of lifelong education that is being implemented today, initially through various continuing medical education requirements and now via maintenance of certification programs, but he certainly was well acquainted with the forces driving health policy, among them public opinion, public need and advancing technology. He quite possibly would be gratified to know that the American Association of Neurological Surgeons, the professional medical association founded in his honor, is assertively acting to develop neurosurgical opportunities for CME and to assist neurosurgeons in complying with the CME requirements of multiple organizations.

## By Christopher M. Loftus, MD

Continuing medical education, long an integral component of a neurosurgeon’s professional career, took on new significance when the American Board of Medical Specialties announced its maintenance of certification mandate. The purpose of MOC, which affects all 24 member boards, is basically to assure the public that medical practitioners adhere to a standardized system of lifelong learning. As an ABMS member, the American Board of Neurological Surgery announced its own MOC program in 2002.

Compliance with MOC requirements, a vigorous CME component among them, is a hot button issue for all practicing neurosurgeons and for AANS members as well. As a member benefit, two years ago the AANS established the Education and Maintenance of Certification Committee, which specifically is charged with interfacing with the ABNS regarding tracking of CME information and potentially transmitting this information to the ABNS for credit recognition. It was and remains my privilege to chair this committee and to work through the CME evolutionary process on behalf of the membership.

I have prepared this article to inform you, our members, of where we stand; what we have already done to make compliance with MOC as easy, streamlined, and productive for you as we can; and what we have planned for the next 12 months. I also will answer a number of frequently asked questions about AANS member benefits and how they complement the ABNS MOC program.

AANS members have traditionally obtained CME credits because of their commitment to staying current, continuing lifelong education, and acquiring new knowledge. To my mind the joy of learning is the primary purpose of CME. However, over the years CME requirements necessarily have evolved. AANS members currently are required to satisfy two separate sets of CME requirements. First, acquisition of category 1 CME credit has always been required

as a condition of ongoing membership in the AANS. For this membership requirement we specify 60 credits of category 1 neurosurgical CME for every three-year cycle. Second, ABNS diplomates certified in 1999 and after (and who may or may not be AANS members) will be required to obtain 150 CME credits for every three-year ABNS cycle. This is only one of the requirements of the ABNS MOC process. I will not discuss further the ABNS requirements regarding MOC since that information really needs to be disseminated to diplomates by the ABNS itself. For the purposes of this article, I will primarily discuss the CME requirement for AANS membership.

It is important for Active and Active Provisional AANS members to understand that the AANS CME requirements for membership (toward the AANS Continuing Education Award in Neurosurgery), and the ABNS CME requirements for its MOC program are different both in terms of the number of hours required and the type of CME that is acceptable. As I said, the AANS requires 60 credits per three-year cycle of category 1 neurosurgical CME. The ABNS has informed us that they will accept other types of CME credit in different categories. One thing is certain: *All category 1 CME credits counted toward AANS membership will also count toward ABNS MOC.* What our members need to know now is that the AANS, as a member benefit, will log and track all CME credits for members at [www.MyAANS.org](http://www.MyAANS.org), even those credits that don’t meet the AANS membership requirement.

The AANS does and will continue to accept paper transmission of CME documents to be logged in a member’s file that ultimately will be transmitted to the ABNS as part of the MOC cycle. The process of doing this implies that members will send in some CME credit verification certificates that do not currently fulfill the AANS membership requirement. Let there be no confusion about this. We are happy to track, log, and transmit this information to the ABNS.

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However, for the purposes of AANS membership, the AANS has established criteria regarding acceptable CME credits. These criteria are flexible and inclusive. I will discuss this process in somewhat greater detail later. In addition, you will note that the number of credits required for AANS membership is significantly lower in the three-year cycle than the number of credits required for ABNS MOC requirements.

The next question on the member's mind is, no doubt, "What qualifies for what?" As I said, I am going to limit my comments to credits that are acceptable for the AANS Continuing Education Award in Neurosurgery. When the EMCC was formed, its members specifically looked for ways to maximize the number of available offerings to members and to make this as clear as we could to the membership. We canvassed members of all the AANS/CNS specialty sections to ask which meetings they thought were appropriate for credit and what would be of value to members in the specific subspecialty disciplines. As we did this we kept in mind the four basic principles, mandated by the AANS Board of Directors, delineating quality CME for members. These principles were outlined in then-President Robert Ratcheson's message in the Winter 2004 issue of the AANS *Bulletin*, and I will repeat them here:

1. The program is of importance for neurosurgeons.
2. The program is not sponsored by a commercial entity.
3. The program must have meaningful neurosurgical input in the planning stage.

4. The sponsoring organization must be an accredited provider of CME.

The AANS designates programs that meet these criteria as either jointly sponsored or cosponsored-endorsed activities. Jointly sponsored activities are those that the AANS sponsors with other groups that are not accredited to provide CME credits on their own. After submission and acceptance, these programs qualify to receive CME credits through the AANS. Cosponsored-endorsed activities are those that provide their own CME credits from sources such as state neurosurgical societies or other accredited providers of CME. These programs must meet the above criteria in order to be cosponsored-endorsed by the AANS. Detailed information about these programs and processes is available at [www.AANS.org](http://www.AANS.org). I'll discuss these two designations again in the frequently asked questions section.

In addition, the EMCC has worked hard to provide alternative methods and a broad repertoire of offerings, besides meeting attendance, for members to obtain category 1 CME credits that fulfill their AANS membership requirement. You will note on the AANS Web page that the online journal *Neurosurgical Focus* now has a CME component that allows AANS members to accrue category 1 CME credit, without charge, by reading the journal online and taking a true-false test. We plan to have this benefit available for the *Journal of Neurosurgery* as well within the next six months. Later this year we expect to have no-charge patient safety programs online which qualify for category 1 CME credit for AANS mem-

## AANS EDUCATION AND MAINTENANCE OF CERTIFICATION COMMITTEE (EMCC)

### CHAIR

Christopher M. Loftus, MD

Mitchel Berger, MD

Julius Goodman, MD

Robert Harbaugh, MD

David Jimenez, MD

Paul McCormick, MD

Jon Robertson, MD

James Rutka, MD

Joni L. Shulman, AANS

Clarence Watridge, MD

## ACRONYMS AND ABBREVIATIONS

<b>AANS</b>	<b>American Association of Neurological Surgeons</b> <a href="http://www.AANS.org">www.AANS.org</a>
<b>ABMS</b>	<b>American Board of Medical Specialties</b> <a href="http://www.abms.org">www.abms.org</a>
<b>ABNS</b>	<b>American Board of Neurological Surgery</b> <a href="http://www.abns.org">www.abns.org</a>
<b>ACCME</b>	<b>Accreditation Council for Continuing Medical Education</b> <a href="http://www.accme.org">www.accme.org</a>
<b>AMA/PRA</b>	<b>American Medical Association Physician's Recognition Award</b> <a href="http://www.ama-assn.org">www.ama-assn.org</a>
<b>CNS</b>	<b>Congress of Neurological Surgeons</b> <a href="http://www.neurosurgeon.org">www.neurosurgeon.org</a>
<b>CME</b>	<b>Continuing Medical Education</b>
<b>EMCC</b>	<b>Education and Maintenance of Certification Committee</b>
<b>MOC</b>	<b>Maintenance of Certification</b>
<b>SANS</b>	<b>Self-Assessment in Neurological Surgery</b>

bership and which likewise may help members fulfill the requirements of their state medical societies regarding patient safety and professionalism competencies.

Further, members who purchase the *Vertebroplasty and Kyphoplasty* book, released at the AANS Annual Meeting in New Orleans as the latest AANS Publications Committee offering, have an option to obtain CME credits by completing an online self-assessment test based on the text material. Also available in the AANS catalog is the *Minimally Invasive Spinal Techniques DVD*, which offers optional CME. The AANS Publications Committee will continue its efforts to produce enduring materials that offer CME. In addition, the AANS has partnered with Oakstone Medical Publishing, producers of CD ROM-based CME products, to make Oakstone products that qualify for category 1 neurosurgical CME available to AANS members at favorable rates.

I think you will agree that the AANS members serving on the EMCC have worked hard to provide you with a rich banquet of CME offerings that qualify for AANS membership credit, including the major annual meetings, the section meetings, meetings of specialty societies that fit in the cosponsored-endorsed category, online CME test-taking products, and enduring materials products. The EMCC likewise has endeavored to ensure that topics such as patient safety, professionalism, and ethics are being considered for devel-

opment as vehicles for CME credit. We plan to continue broadening the repertoire wherever possible to do so.

Let me go on to answer some frequently asked questions regarding CME for the AANS membership requirement.

### Frequently Asked Questions

#### *How do I get credit?*

Attendance at any of the AANS sponsored or jointly sponsored meetings is automatically logged for all medical attendees. This information will appear on the member's CME page at [www.MyAANS.org](http://www.MyAANS.org), where it will be available for certificate generation. For meetings in the cosponsored-endorsed category, we ask

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## CME ON THE AANS WEB SITE

### CME Tracking

[www.aans.org/education/cme.asp](http://www.aans.org/education/cme.asp)

### CME Accepted by the AANS

[www.aans.org/education/educational/cme\\_list.pdf](http://www.aans.org/education/educational/cme_list.pdf)

### Cosponsored-Endorsed Activities

[www.aans.org/education/co\\_sponsor.asp](http://www.aans.org/education/co_sponsor.asp)

### Jointly Sponsored Activities

[www.aans.org/education/jointly.asp](http://www.aans.org/education/jointly.asp)

### Home Study CME

[www.aans.org/education/home\\_study\\_cme\\_act.asp](http://www.aans.org/education/home_study_cme_act.asp)

## AANS CME POLICY: JAN. 1, 2005–DEC. 31, 2007

Active and Active Provisional members are required to document receipt of the Continuing Education Award in Neurosurgery to maintain membership in the AANS. This award is earned by documenting at least 60 neurosurgical credits within the CME cycle. The current three-year cycle is Jan. 1, 2005, through Dec. 31, 2007.

On Jan. 1, 2005, the AANS Executive Committee implemented new rules and regulations to assist members in obtaining and tracking appropriate CME credits to meet the anticipated requirements of ABNS Maintenance of Certification as well as those mandated by other outside organizations.

Members will only earn the award by attending designated neurosurgical category 1 AMA/PRA activities. As of Jan. 1, 2005, these include:

- AANS-sponsored meetings
- AANS online CME (*Neurosurgical Focus*)
- AANS jointly sponsored meetings
- AANS cosponsored-endorsed meetings
- AANS/CNS section meetings
- CNS annual meetings and SANS

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the member to send in a certificate, which will be manually entered by AANS staff into the member's record for accrual toward the AANS Continuing Education Award in Neurosurgery. AANS staff is prepared and pleased to do this as a member benefit. Certificates from meetings that do not qualify for the AANS award also should be sent in so that this information can be logged and tracked for state requirements as needed, as well as transmitted to the ABNS and counted toward the MOC requirement.

While this record-keeping service is a membership benefit for AANS members, neurosurgeons who are ABNS diplomates but who are not members of the AANS will be charged a fee. This is only appropriate, and it would be inappropriate for AANS members to shoulder the cost of providing this service to neurosurgeons who do not choose to be members of the association. Since you are reading this article in the AANS *Bulletin*, you are most likely a member of the AANS and don't have to worry about this any further.

#### *How is the AANS helping me meet my ABNS MOC obligation?*

The AANS and the EMCC cannot make decisions on behalf of the ABNS. Only the ABNS Board of Directors can do this. Therefore, you, as a member, should understand that there most likely will always be a mismatch, albeit small, between what CME credits the AANS will accept toward AANS membership requirements and what the ABNS will accept for its MOC requirements. The ABNS basically will accept credits from more providers to fulfill its requirement of 150 credits per three-year cycle, while the AANS will accept a smaller repertoire of offerings, consistent with the four principles outlined above, but requires only 60 credits for its three-year cycle. ABNS diplomates, who must meet the ABNS requirements for MOC, should have no difficulty satisfying their CME requirement for AANS membership simultaneously since the AANS requires far fewer credits.

The EMCC is taking special pains to make sure that the AANS logging and tracking system for CME is accurate, simple, allows members to print out certificates for whatever purposes they may need and also offers a broad range of opportunities so that members have the option to get CME online rather than being forced to attend multiple meetings. The EMCC also is specifically addressing the issues of professionalism, ethics and patient safety competencies because we think that more and more state boards are going to require related CME credits as a condition of licensure.

#### *My meeting doesn't appear on the list. What do I do?*

From the EMCC's inception, we did everything we could think of to be sure that all qualified meetings were included on the master list of jointly sponsored or cosponsored-endorsed meetings that count toward the CME requirement for AANS membership. We asked neurosurgeons and neurosurgical leaders in various specialties what they thought would be appropriate. We recognize that the process is evolutionary. We continue to include new meetings; for

## IMPORTANT DATES FOR ABNS MAINTENANCE OF CERTIFICATION (MOC)

### 2005

Diplomates with 10-year time limited certificates dated 1999, 2002, and 2005 will receive ABNS MOC applications. After applications have been returned to the ABNS, diplomates will receive user names, passwords and instructions.

### March 31, 2007

The first cognitive examination will be given for diplomates certified in 1999.

### Dec. 31, 2008

End of the first 3-year cycle for diplomates certified in 1999, 2002, and 2005.

### Summer 2009

New certificates will be issued to diplomates certified in 1999 who have successfully completed their initial MOC plan.

### Jan. 1, 2010

Diplomates certified in 1999 begin their second 10-year cycle for MOC.

## THE FOUR COMPONENTS OF NEUROLOGICAL SURGERY MAINTENANCE OF CERTIFICATION (MOC)

### 2005 Start Date

#### 1. Professional Standing (every three years)

- Full, unrestricted license to practice medicine in all jurisdictions in which the diplomate practices.
- Hospital admitting privileges to practice neurosurgery.
- Recommendations from the chief of staff of primary hospital.

#### 2. Lifelong Learning and Self-Assessment (LLSA) (every three years)

- 150 hours of CME.
- SANS examination.

#### 3. Cognitive Knowledge (every 10 years)

- MOC Cognitive Examination taken during the eighth, ninth, or 10th year of the MOC process.

#### 4. Performance in Practice

- Key Cases selected from a list of procedures which cover the subspecialties (every three years).
- CAT (every three years) 15-question survey given to 20 patients who respond via phone or Internet.
- Surgical Case Log consisting of six months of practice data submitted every 10 years within four years of the end of the 10-year cycle.

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example, we recently have endorsed state neurosurgical meetings in Pennsylvania, Missouri and Texas.

*So how does my meeting become a jointly sponsored or cosponsored-endorsed activity?*

The organizers of any meeting of any neurosurgical CME offering should contact the AANS Education Department. There are two separate processes for attaining joint sponsorship and cosponsorship-endorsement. Information and an application for each process are available from the AANS Education Department and online at [www.aans.org/education/co\\_sponsor.asp](http://www.aans.org/education/co_sponsor.asp) and [www.aans.org/education/jointly.asp](http://www.aans.org/education/jointly.asp). A frequently updated list of jointly-sponsored and cosponsored-endorsed activities is available at [www.aans.org/education/educational/cme\\_list.pdf](http://www.aans.org/education/educational/cme_list.pdf). We ask that the application process be done so that we have documentation of the neurosurgical content and planning of the CME activity per ACCME requirements, and to make sure that the course is not commercially sponsored. The process is efficient, and jointly sponsored or cosponsored-endorsed status can be granted fairly easily. Regarding meetings at a local level, such as hospital grand rounds or departmental conferences, the AANS does not feel that we have enough oversight to place such meetings in the cosponsored-endorsed category. We still encourage members to send in these certificates for logging into their records at [www.MyAANS.org](http://www.MyAANS.org) for potential recognition by the ABNS as part of their MOC process.

I offer a final take-home message about the CME process at the AANS and the function of the EMCC: The EMCC has worked hard, and will continue to do so, to develop a process whereby members can easily and seamlessly acquire the necessary credits to maintain their AANS membership as well as satisfy the requirements of the ABNS MOC program. We are developing as many options as we can, as quickly as possible, so that members may obtain CME credits from national meetings, in meetings of their subspecialty, in meetings at the state level, and online or with enduring materials and CD ROM activities. We will continue to develop this broad repertoire of options. We invite you to go online and take a look at [www.MyAANS.org](http://www.MyAANS.org) and your CME record. If you have a state meeting or a special offering and you'd like to seek cosponsored-endorsed status, by all means, contact us and we will make it as easy for you as we possibly can. CME tracking and CME offerings are member benefits, and we are taking our responsibility of providing these benefits very seriously. Let us know how we can help and we will do everything we can to do so. ■

**Christopher M. Loftus, MD, FACS**, is chair of the AANS Education and Maintenance of Certification Committee. He is chair of neurosurgery at Temple University in Philadelphia, Pa.

## CME Options and Your Budget

PATRICK W. McCORMICK, MD, AND MANDA J. SEAVER

From a business perspective, satisfying continuing medical education requirements translates into several line items in a neurosurgeon's annual budget. Increased CME requirements, a shrinking bottom line, and an abundance of new CME opportunities suggest that now may be a good time to reevaluate CME needs and budgetary allocations.

CME decisions obviously cannot be based on cost alone. The benefit of a specific CME offering to a particular neurosurgeon can vary greatly depending upon factors such as interest, learning style and application of CME topic to one's practice. However, analyzing variations in cost among the types of CME offerings currently available can be useful in getting the most value for the expenditure.

While not intended as an exhaustive analysis of neurosurgical CME, a review of 2004 AANS CME offerings, plus the annual meeting of the Congress of Neurological Surgeons and AANS/CNS section meetings, revealed an average cost of approximately \$46 per credit. This figure is based on the lowest available registration fee, such as the early registration member rate. Using this average figure, an AANS member might expect to spend a minimum of \$2,300 per year for CME toward the MOC requirement of 150 credits every three years, or \$920 per year toward the AANS requirement of 60 credits every three years.

When differentiating among types of CME, costs varied widely. Courses were most costly at about \$87 per credit, reflecting their specific focus and related expenses, such as cadaver material, while meetings averaged \$30 per credit. As might be expected, home study was most wallet-friendly, averaging \$11 per credit.

Most surveys indicate that doctors still prefer "live" CME. AANS members seem to echo this sentiment, as in 2004 they rated discounts on live CME—specifically courses and annual meeting registration—as the top member benefit. In estimating cost of live CME, however, costs related to travel and lost income attributed to time away from practice must be included.

One could conservatively budget \$700 for each trip, \$150 per day for travel expenses, and \$1,600 per day for lost income away from practice. Assuming three trips and eight travel days annually, costs quickly mount to \$16,100. When excluding home study options, the average cost of CME fees rises to \$53 per credit.

It becomes obvious that highly valued live CME is relatively expensive and that a large portion of this cost can be attributed to time away from practice. This situation can be mitigated by maximizing the amount of credits earned while traveling, such as by attending breakfast seminars during an annual meeting, and minimizing time away from practice, for example by attending weekend courses and utilizing home study, which also is less expensive per credit. ■

**Patrick W. McCormick, MD, MBA, FACS**, is a neurosurgeon in private practice in Toledo, Ohio. **Manda J. Seaver** is staff editor of the *Bulletin*.

# Neurosurgical Focus Offers Online CME

## Two Neurosurgeons Review NSF's Online CME Services

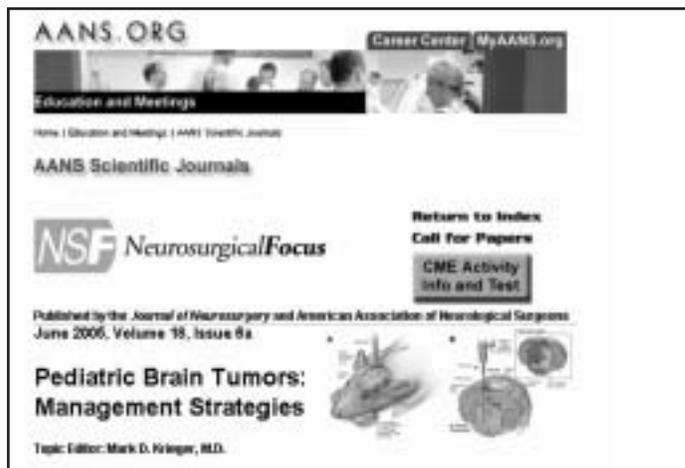
Beginning with the August 2004 issue of *Neurosurgical Focus*, the online, rapid-publication journal of the American Association of Neurological Surgeons, AANS members were afforded the opportunity to earn continuing medical education credits online at no cost. For each issue of *Neurosurgical Focus*, members can earn one category 1 CME credit by taking a 10-question exam. Once the exam is passed, one credit automatically posts to the participant's CME transcript at password-protected [www.MyAANS.org](http://www.MyAANS.org). AANS members can complete the exam or view their CME transcripts, by subspecialty if preferred, at [www.MyAANS.org](http://www.MyAANS.org), and they can earn up to 12 credits per year through this free service. The CME opportunity now is offered from the current issue back to the April 2004 issue. To mark the one-year anniversary of this member benefit, the *Bulletin* asked two AANS members to test the service and review its functionality.

### A User-Friendly and Worthwhile Service

ALAN S. BOULOS, MD

With the continued need for neurosurgeons to earn and document CME credits, the AANS has provided its members with a streamlined method for earning and documenting neurosurgical CME credit online. *Neurosurgical Focus*, the online journal of the AANS *Journal of Neurosurgery*, is providing CME credit that is automatically documented for members at [www.MyAANS.org](http://www.MyAANS.org).

*Neurosurgical Focus*, located at [www.AANS.org](http://www.AANS.org), is awarding one CME credit per issue to AANS members who take a 10-question true-false examination and answer at least seven questions correctly. Each issue of *Neurosurgical Focus*, published monthly, explores a certain neurosurgical subject or therapeutic technique such as radiosurgical, endovascular, endoscopic, or minimal access surgical options. The articles are published in a format similar to that of the *Journal of Neurosurgery*. The advantage of the online journal is the short time between submission and peer-reviewed acceptance of the article for publication. In fact, many articles have been published within two months of submission. This short turnaround provides readers with the latest information regarding rapidly evolving technology. Each issue invites submissions on a particular topic; however, the journal also accepts articles on previously published topics, widening the options for submission considerably.



The online neurosurgical journal *Neurosurgical Focus* also is a convenient resource for continuing medical education credit. The NSF Web page can be accessed directly at [www.aans.org/education/journal/neurosurgical](http://www.aans.org/education/journal/neurosurgical), where links to the last six issues are available. Previous issues, with CME credit available to April 2004, are accessible via the Archives link in the NSF tool bar. Test-takers read the journal and then select the link CME Activity Info and Test, where instructions for taking the 10-question CME quiz and a link to the test on [www.MyAANS.org](http://www.MyAANS.org) are located. One category 1 CME credit is recorded automatically on the CME transcripts for successful participants.

Recent issues of *Neurosurgical Focus* also provide links to related articles published in the *Journal of Neurosurgery*.

The process for receiving CME credit through *Neurosurgical Focus* is straightforward. After reviewing the articles, select the CME link and login to [www.MyAANS.org](http://www.MyAANS.org) with your username and password. A 10-question true-false exam, which includes a question or two from each of the articles, is provided. You must answer a minimum of seven questions correctly to receive the credit. You can take the examination twice, and incorrect responses and the corresponding articles are listed. This system allows for review of important aspects of the articles so that the examination can be repeated. Once the examination is passed, you are asked to answer four questions regarding the educational value of the journal, and then one CME credit is then added to your account at [www.MyAANS.org](http://www.MyAANS.org).

I have earned CME credits for the past several issues on trigeminal neuralgia, glomus tumors, endovascular treatment of aneurysms, and carotid stenting. The design of the *Neurosurgical Focus* CME interface is simple and useful. The questions are reasonable and representative of each article. The questions are submitted by the authors and therefore often reflect important points within the article. Overall, this new *Neurosurgical Focus* offering is user-friendly and worthwhile. The format of the online journal is improving and could be a great avenue for rapid communications of new scientific evidence. ■

Alan S. Boulos, MD, is assistant professor and Herman and Sunny Stall Chair in Endovascular Neurosurgery at Albany Medical College in New York.

## A Convenient Supplemental CME Source

MONICA WEHBY, MD

As the requirement for neurosurgical CME credits becomes imperative for maintenance of certification, options other than the expense and time of attending a national meeting must be explored. One such opportunity is earning one category 1 CME credit per issue by reading the online AANS journal *Neurosurgical Focus*.

*Neurosurgical Focus* is easily found at [www.AANS.org](http://www.AANS.org), and CME credit is available for issues dating back to April 2004. Simply select a topic that interests you, read the journal, and take a 10-question quiz. You have two chances to pass with a minimum score of seven correct answers. The program will instantly inform you of incorrect answer and will refer you to the article in the issue where the correct answer is found. I found the questions to be reasonable and actually bits of information that I had retained from reading the articles, as opposed to obscure minutia. The CME credit is posted automatically on your individual transcript housed at [www.MyAANS.org](http://www.MyAANS.org).

The upside of this opportunity is the convenience of obtaining credits at a time of your choosing, such as during lunch or if some-

one no-shows in clinic, and the test-taking process can be interrupted as often as necessary without penalty. You can even stop midway through the exam and return to the same question later, providing you have not yet scored it.

The downside is that, despite the comment in the directions that “articles that should be read to pass the exam are clearly identified,” I found that, after a determined but fruitless search, this is not the case. There are approximately 10 articles in each issue, and all must be read prior to taking the exam. This endeavor took me about two-and-a-half hours (your own results may vary), although I did learn something in the process. If all articles are required reading before taking the test, making this at least a two CME credit exercise would be more appropriate.

The current time commitment seems excessive for one CME credit, but the convenience makes it a supplemental CME source worth considering. ■

Monica Wehby, MD, is a neurosurgeon with Microneurosurgical Consultants P.C. in Portland, Ore.

New users of [www.MyAANS.org](http://www.MyAANS.org) will need to register using member number and e-mail address. Assistance is available from AANS Member Services at (888) 566-AANS (2267) or [memberservices@AANS.org](mailto:memberservices@AANS.org).

## AANS Offers CME Record-Keeping Relief

MANDA J. SEAVER

A \$20,000 fine and suspension of his state medical license for at least one year was the penalty sustained by a top Medicare official for falsifying the number of continuing medical education credits he had earned. The Maryland Board of Physicians imposed the sanctions May 25 on internist Sean R. Tunis, chief medical officer and director of the Office of Clinical Standards and Quality for the Centers for Medicare and Medicaid Services.

Dr. Tunis, quoted in a June 4 Washington Post story, said he had “been diligent in maintaining his knowledge of clinical medicine” and cited “careless record-keeping” as the source of the problem.

Considering that failure to demonstrate compliance with CME requirements could render a physician unable to practice, accurate accounting of earned CME credits takes on particular significance.

In 2003 the American Association of Neurological Surgeons launched an integrated, online system for CME tracking at password-protected [www.MyAANS.org](http://www.MyAANS.org). Neurosurgeon Eric Potts reviewed the system’s functionality in the Summer 2003 issue of the *Bulletin*; the article is available at [www.AANS.org](http://www.AANS.org), article ID 9910. In brief, for Active and Active Provisional members of the AANS, membership requirements are summarized, links to current CME policy and information are provided, and progress toward the AANS Continuing Education Award in Neurosurgery is depicted on-screen.

### Progress Toward State of California CME Requirements

33/100



In 2004 a similar screen was added for state CME requirements. To activate the state

screen, members (or their chosen delegates) login to [www.MyAANS.org](http://www.MyAANS.org) and select the states in which they hold a license to practice medicine. The screen shows the specific state relicensure requirements, based on information in the American Medical Association’s State Medical Requirements and Statistics publication, and the individual’s progress toward meeting them. Members also have the option of entering their state licensure number for inclusion on their printed transcripts. For AANS members and nonmember tracking service subscribers who participate in the American Board of Neurological Surgery’s Maintenance of Certification program, a similar screen will show progress toward those requirements.

While users can monitor their CME credits online at any time, the AANS additionally mails annual CME transcripts to Active and Active Provisional members. In the final year of the AANS three-year CME cycle, multiple letters are sent to those with CME deficiency in time for them to take action and meet the AANS membership requirements. Although specifics are not yet finalized, a mechanism will be implemented for notifying MOC participants of CME deficiency. ■

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

# The 80-Hour Workweek Revisited

## At Two-Year Mark, Neurosurgery Has Survived

*"They're going to restrict resident hours..."; "Congress will pass a law..."; "Can you believe 80 hours a week...?"*

First there were rumors, then threats, and finally the bone-chilling reality: On July 1, 2003, the Accreditation Council for Graduate Medical Education implemented work hour restrictions for all medical residents. Not surprisingly, neurosurgery has survived the intervening two years, and a look at how the specialty has complied with the ACGME's changes, how residents and attendings have coped, and how neurosurgery might rethink the resident training paradigm now seems to be in order. To this end, I offer my views based on my experiences with the residency program at the University of Maryland as well as observations from visiting different programs around the country.

### Programs Adjust to Work Hour Restrictions; Resident Fatigue Is Relieved

The 80-hour workweek can be traced to a New York case in which resident fatigue was deemed to have contributed to a patient's death. In 1989 the New York legislature passed resident work hour restrictions, commonly known as the 405 Regulations, although they were not fully enforced until recently. Similar regulations were voluntarily mandated by the ACGME, the governing body of all residencies and sponsor of neurosurgery's residency review committee, essentially under the threat of national legislation or workplace rules instituted by the Occupational Safety and Health Administration. Adding fuel to this movement were tragedies involving post-call residents in motor vehicle accidents.

Numerous accounts indicate that compliance with the guidelines has been excel-

lent. While the 80-hour workweek does represent an unfunded mandate, most programs have responded appropriately by increasing the use of physician extenders and home call, funding an increase in length of residency, and assigning extra residents to take call; I am not aware of any programs in which attendings have taken over in-house call. In programs with several residents, the night-float rotation (a dedicated resident taking night call only) has been popular. While the educational merits of this practice may be debated, in my opinion, it isn't a bad way for the more junior residents to learn management of patients in the intensive care unit.

Anecdotal evidence suggests that in some programs residents are covering fewer cases, but my overall impression is that the resident operative experience has been unchanged—a point confirmed by an article in the May 2005 *Journal of the American College of Surgeons*. This article does point out, however, that there has been a drop in coverage of outpatient clinics.

While the fears of compromised resident education may have been alleviated, questions remain about a change in the prevailing attitude within training programs. An inevitable "shift mentality" takes over when one is required to turn over work and responsibility to another person. Some lapses are inevitable, but there seems to be more tolerance of less-than-perfect patient care at all levels (including the attending level), perhaps in recognition of the Sisyphean nature of modern American medicine. It will be a worthy challenge for neurosurgery to maintain or even to improve its standards of quality.

The greatest benefit of the 80-hour workweek is that resident fatigue has largely been relieved, and, if one follows the logic underlying the work hour

restrictions, that patients therefore are safer. It also isn't "Pollyannaish" to say that residents deserve to have humane working conditions, and attendings need to get over the fact that we worked 120 hours a week (in the snow, uphill, both ways).

### If Fine-Tuned, Restrictions May Offer Opportunities

In fact, under the right circumstances, residents could be encouraged to use their "extra time" to increase their academic productivity. The right circumstances might involve an addendum to the current policy which, if residents could pass certain fatigue tests, would relax the restriction of 30 consecutive hours worked with 10 hours off between shifts (that word again) and allow them to finish clinic, or go to conference or to the lab if they choose.

Although most programs have coped well with the 80-hour workweek, the restrictions have strained some programs; those programs with one resident per year have arguably experienced the greatest difficulty. Further, the ability for neurosurgical residents to cover multiple types of hospitals—for instance a Veteran's Administration or children's hospital—and thus be exposed to a variety of educational experiences, has been compromised.

As we develop solutions for the work hour restrictions, we must avoid exacerbating the apparent current shortage of neurosurgeons. It is time to reevaluate our training practices. More neurosurgeons need to be trained—perhaps by adding new programs and more residents to existing programs, or shortening the length of some programs. But I'll leave that meaty topic for a future Residents' Forum. ■

**Lawrence S. Chin, MD**, is professor of neurosurgery at the University of Maryland Medical Center in Baltimore.

# 2005 Awardees

## *\$390,000 to Infuse Neuroscience Research*

**T**he Neurosurgery Research and Education Foundation is pleased to announce its 2005 grant recipients. This year, NREF awarded nine grants, four Research Fellowships and five Young Clinician Investigator Awards totaling \$390,000. Since its inception in 1981, NREF has continued its efforts to increase the number of grant awards from year to year.

**The NREF Research Fellowship** provides funding for neurosurgical residents who are preparing for academic careers as clinician investigators. Applicants must be physicians who have been accepted into, or who are in, approved residency training programs in neurological surgery in North America. The Research Fellowship is a two-year commitment totaling \$70,000 or a one-year grant totaling \$40,000. This year's winners include:

- Daniel P. Cahill, MD (2 years), Massachusetts General Hospital
- Ali Chahlavi, MD, MS (1 year), Cleveland Clinic Foundation
- Suresh N. Magge, MD (1 year), University of Pennsylvania
- NREF/DePuy Spine Research Fellowship, Joseph G. Ong, MD (1 year), University of Pittsburgh

**The NREF Young Clinician Investigator Award** supports junior faculty who are pursuing careers in research. Applicants must be neurosurgeons who are full-time faculty in North American teaching institutions and in the early years of their careers. The purpose of this award is to fund pilot studies, providing preliminary data to be used to strengthen applications for more permanent funding from other sources. The one-year award provides \$40,000. This year's winners include:

- Gavin W. Britz, MD, University of Washington
- William T. Curry Jr., MD, Massachusetts General Hospital
- Stephen Russell, MD, New York University
- NREF/Medtronic Neurological YCI Award, Emad Eskandar, MD, Massachusetts General Hospital
- NREF/Kyphon YCI Award, James W. Leiphart, MD, The George Washington University

The NREF expresses its deep appreciation to the AANS members, the general public and corporate supporters Kyphon, Inc., Medtronic Neurological, and DePuy Spine, a Johnson & Johnson Company, for their continued support and contributions which make these NREF fellowships possible. For more information on how you can support NREF grants and the future of neurosurgery, please contact the director of development at (847) 378-0500. Grant applications for 2006 are now available. For more information and a copy of the application, please visit at [www.aans.org/research](http://www.aans.org/research). ■

**Terri L. Bruce** is AANS development coordinator.

For advertising information, see the Bulletin's rate card at <http://www.aans.org/bulletin/>  
or contact Bill Scully, [bscully@cunnasso.com](mailto:bscully@cunnasso.com), (201) 767-4170.

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AANS/CNS Sections Committees Associations Societies

## AANS Humanitarian Awardees

**2005**  
Tetsuo Tatsumi, MD, FACS

**2004**  
Charles L. Branch Sr., MD

**2003** No award

**2002**  
Edgar M. Housepian, MD

**2001**  
Gary D. Vander Ark, MD

**2000**  
Merwyn Bagan, MD, MPH

**1999**  
Thomas B. Flynn, MD

**1998**  
Lee Finney, MD

**1997**  
Robert J. White, MD

**1996** No award

**1995**  
Melvin L. Cheatham, MD

**1994**  
E. Fletcher Eyster, MD

**1993**  
Manuel Velasco-Suarez, MD

**1992**  
William H. Mosberg Jr., MD

**1991**  
George B. Udvarhelyi, MD

**1990**  
A. Roy Tyrer Jr., MD

**1989**  
Hugo V. Rizzoli, MD

**1988**  
Gaston Acosta-Rua, MD

**1987**  
Courtland H. Davis Jr., MD

**AANS Seeks 2006 Humanitarian Award Nominations by Oct. 15** Voting members of the AANS are invited to submit nominations for the 2006 Humanitarian Award by Oct. 15. The award will be presented at the 2006 AANS Annual Meeting in San Francisco April 22-27. 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 society. Nominees can be living members from any category of AANS membership who give selflessly of time or talents to a charitable or public activity; who are deserving of recognition by the AANS; and whose actions enhance neurosurgery's image. Nominees may be recognized for activities of international, national, regional or local nature that benefit humanity collectively or individually without providing remuneration to the recipient. Nominations must be submitted using the form available at [www.AANS.org/shared\\_pdfs/nomination\\_%20form.pdf](http://www.AANS.org/shared_pdfs/nomination_%20form.pdf), or by contacting Susan E. Funk at [sef@AANS.org](mailto:sef@AANS.org) or (847) 378-0507.

**AANS Releases Minimally Invasive Spinal Techniques DVD** The new AANS *Minimally Invasive Spinal Techniques DVD*, a set of six digital video disks, features didactic presentations and footage of hands-on lab instruction using cadaver material and offers continuing medical education credits. Leading spinal surgeons, both neurosurgeons and orthopedic surgeons, present sessions on percutaneous spinal techniques, spinal fusion and instrumentation, fundamentals, current techniques, and more. After purchasing the DVD set, viewers can earn 12 category 1 CME credits by passing an online examination.

A complete list of presentations and faculty who appear on the DVDs as well as sample video clips are available from the AANS Online Marketplace at [www.AANS.org](http://www.AANS.org).

**New Vertebroplasty and Kyphoplasty Book Offers CME** New techniques used to treat painful osteoporotic compression fractures are detailed in the new AANS book *Vertebroplasty and Kyphoplasty*, which offers the opportunity to earn continuing medical education credits. The multidisciplinary book written by

Daniel K. Resnick, MD, and Steven Garfin, MD, also addresses when vertebroplasty is used in neoplastic diseases of the spine and covers patient selection, choice of procedure, complications, management, and expected outcomes. Readers of this state-of-the-art resource can earn 15 category 1 credits after passing an online exam. The book can be ordered from the AANS Online Marketplace at [www.AANS.org](http://www.AANS.org).

**WINS Past President Is First Woman to Chair a U.S. Academic Neurosurgery Department** (contributed by Isabelle M. Germano, MD, and Donald O. Quest, MD) The 1991 president of Women in Neurosurgery, Karin Muraszko, MD, was appointed chair of the neurosurgery department at the University of Michigan in November 2004. The appointment made Dr. Muraszko the first woman neurosurgery chair in North America, 155 years after Elisabeth Blackwell became the first woman to earn a medical degree in the United States. Dr. Muraszko also was the first woman accepted to Columbia University's neurosurgery program. Even today few women are applying for neurosurgical residency positions, although approximately 50 percent of U.S. medical school attendees are women. In 2000, only 100 of 3,175 actively practicing neurosurgeons certified by the American Board of Neurological Surgery were women. In addition to her involvement in WINS, Dr. Muraszko is active in many professional organizations including the AANS, for which a WINS liaison attends meetings of the Board of Directors and the Scientific Program Committee.

WINS was founded in 1989 by a handful of women who recognized the need to mentor young women who want to pursue careers in neurosurgery. WINS has created a brochure for medical students to provide information about neurosurgery as a career, and the organization holds an annual leadership and development course at AANS annual meetings for all those who want to learn how to maximize opportunities within their hospitals and community. An annual travel scholarship is provided to a woman resident who presents the best research abstract at the AANS annual meeting. Additional WINS information is available at [www.neurosurgerywins.org](http://www.neurosurgerywins.org).

Continued on page 38

**AANS and ACS Select Health Policy Scholarship Recipient**

The AANS and the American College of Surgeons chose Gary M. Bloomgarden, MD, of Yale University School of Medicine to participate in the Leadership Program in Health Policy and Management, a week-long event held in May at Brandeis University. Dr. Bloomgarden also will serve for one year as a pro tem member of the ACS Health Policy Steering Committee.

Continued from page 37

**AANS/CNS Section on Pain Plans Symposia** (contributed by Richard Osenbach, MD) The AANS/CNS Section on Pain is planning several exciting educational opportunities during the upcoming annual meetings of the AANS and of the Congress of Neurological Surgeons.

The Pain Section symposium scheduled for the 2005 CNS Meeting in Boston, entitled Evidence-Based Analysis of the Treatment of Spinal Pain Syndromes, will feature nationally recognized speakers who will review the available evidence for procedures such as spinal fusion, vertebroplasty and kyphoplasty, spinal cord stimulation, and intrathecal drug delivery. Given the increasing emphasis and demand by the federal government and private payers for evidence-based outcomes, this topic is particularly timely and should provide the framework for a very interesting and provocative discussion.

The 2006 AANS Annual Meeting in San Francisco will be highlighted by two related symposia. A full-day satellite symposium immediately preceding the meeting will focus on the medical and business aspects of designing and implementing a neurosurgical pain practice. The symposium will address various neurosurgical aspects of pain management, issues related to coding and reimbursement, and other administrative issues that impact the ability of our specialty to maintain a high level of visibility and involvement in this important area of medicine. During the AANS meeting, the Pain Section will be present an afternoon symposium entitled The Neurosurgeon's Role in Pain Management: Are Neurosurgeons Losing Pain Treatment? The purpose of the symposium is to present a global perspective on how neurosurgeons fit into the ever-evolving specialty of pain medicine. More information will be available in the near future.

**AANS/CNS Section on Tumors Highlights Accomplishments**

(Contributed by Isabelle Germano, MD) Under the leadership of Chair Raymond Sawaya, MD, the AANS/CNS Section on Tumors enjoyed a very productive six months. The section's 20th anniversary was observed last fall with a special issue of the Journal of Neuro-Oncology and a memorable celebration at the Sixth Biennial Tumor Symposium in

San Francisco. Membership in the section increased to more than 1,700, and over the past 12 months the section's financial assets increased by 7.5 percent. In addition, fellowship accreditation for neurosurgical oncology was officially approved by the Society of Neurological Surgeons.

Several significant Tumor Section activities and events occurred in conjunction with the 2005 Annual Meeting. The Immunotherapy Task Force's fourth annual meeting, chaired by Roberta Glick, MD, offered outstanding presentations on multiple aspects of this field. Two new officers were selected—Chair Ronald Warnick, MD, and Secretary-Treasurer Michael W. McDermott, MD—and seven tumor awards were presented, including one new award, the Integra Foundation Award, which recognizes research of benign peripheral or central nervous system tumors. The Tumor Section's scientific program, planned by Donald O'Rourke, MD, included a special symposium on contemporary and novel techniques of neuroimaging.

Detailed information about the Tumor Section, which serves as the official voice of the AANS and the Congress of Neurological Surgeons in all matters related to brain and spine tumors, can be found at [www.neurosurgery.org/tumor](http://www.neurosurgery.org/tumor).

**New Officers To Continue NERVES Momentum**

Officers selected by the Neurosurgery Executives' Resource, Value and Education Society during the NERVES April 15–16 meeting in New Orleans are Nick Green, president; Barbara Hurlbert, CMPE, president-elect; Debra Schultz, secretary; Johanna Hartigan, treasurer; and Mark Mason, past president.

Organized in 2002, NERVES focuses on providing administrators with the tools and resources needed to manage neurosurgical practices effectively. An inaugural project involved developing and launching an annual practice survey that would provide neurosurgical practice benchmarking data, including provider production, compensation, and operating costs. Highlights of the 2004 survey, which was based on 2003 data, were announced at the NERVES meeting in April, and the next NERVES survey of 2004 data is scheduled to be conducted later in 2005. Additional NERVES information is available at [www.nervesadmin.com](http://www.nervesadmin.com).

# Touchstones for AANS Progress

*Stable, Secure Organization Evidenced at 2005 Annual Meeting*

**W**ith the annual scientific meeting of the American Association of Neurological Surgeons just concluded in New Orleans, neurosurgeons, industry and the public have once again had the opportunity to participate in the premier educational and social event of the AANS calendar.

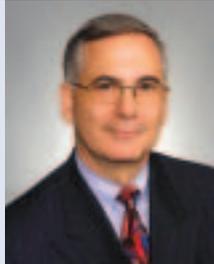
One measure of this association's growth can be taken by comparing the issues leadership and membership addressed during this year's meeting with those that were at the forefront of the 2000 AANS Annual Meeting in San Francisco.

Five years ago, the educational offerings were selected to give members insight into advancing technologies, the latest skills in innovative surgical techniques, and the tools to deal with increasing socioeconomic pressures and demands on the management of their practices. But in 2000, the critical leadership issues confronting the AANS focused on financial instability and uncertainty, a completely new—and unproven—management team, unprecedented turnover of the professional staff, and alarming polarities dividing the allied groups within the house of neurosurgery.

## Full Focus on Member Needs in Evidence

This year in New Orleans, the educational selections continued expanding their reputation for superior faculty and diverse topics with programs such as the latest innovations in minimally invasive surgery, developing medical liability action plans, and discussions of the most current practical aspects of movement disorder treatments, to name but a few. The leadership issues, however, were significantly different than they were five years ago; this year, they were indicative of a stable organization, secure in its leadership and management founda-

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



tions, and proactively addressing issues affecting the physicians and specialty it represents, rather than dealing with fractiousness and uncertainty.

Rather than implementing financial scenarios to immediately reduce the scope of its services, New Orleans agendas centered on proposals to expand AANS services to address the needs of its members, needs that were identified by the membership itself rather than assumed by staff and leaders. For the third consecutive year, committees were driven by a comprehensive strategic plan, eliminating duplicate and nonproductive effort and assuring focus in the areas the members themselves identified as meaningful.

The AANS consistently advocates for its members on issues ranging from tort reform to workforce issues, outcomes measurement to relationships with international colleagues, and partnership with industry to partnership with collegial organizations. Correspondingly, the 2005 AANS Annual Meeting was a portrait of an association in full flight with its responsibilities to the science, education, and leadership of neurosurgery.

## Members and Staff Lose a Genuine Colleague: Ken Nolan, IS Director, Will Be Missed

Sadly, the AANS staff undertook this year's task of mounting yet another successful annual meeting knowing they had lost a valuable professional colleague.

Two days before staff began arriving in New Orleans, AANS Information Systems Director Ken Nolan passed away unexpectedly. Ken was a part of the AANS management team since July 2000.

The monumental growth of technologically driven membership services was realized under Ken's direction. Online tracking of continuing medical education credit for members, establishing and implementing the dedicated AANS.org Web site, establishing the journal *Neurosurgical Focus* online, the ongoing yeoman's work of improving the AANS technological security systems and comprehensive membership database, implementing the online voting technologies, executing the technological upgrade of the AANS/CNS Washington office computer systems and redesigning the Web site for the American Board of Neurological Surgery were but a small sampling of the innovations the AANS membership benefited from under Ken's professional expertise.

The AANS membership lost a loyal employee who provided many innovative services. But the AANS staff lost a good-natured, dedicated colleague who was as ready with a laugh as he was with an idea. That the AANS professional staff could undertake the arduous task of putting on the premier educational event in neurosurgery with its attendant expectations of flawless execution, without the opportunity at the time to pay tribute to their colleague, spoke more of their performance at this year's meeting than any words could describe.

The membership is served exceptionally well by the AANS professional staff, and the organization's exceptional growth realized by the dynamic partnership between staff, leadership and membership was never more apparent than it was at the 2005 AANS Annual Meeting in New Orleans. ■

Continued from page 25



Opening reception guests are dazzled by the festive Mardi Gras atmosphere greeting them as they enter the party.

### Members Cast Their Ballots at Annual Business Meeting

One of the meetings within the meeting, the joint annual business meeting of the American Association of Neurological Surgeons, a 501(c)(6) entity, and the American Association of Neurosurgeons, a 501(c)(3) organization, was called to order at 5:30 p.m. on Monday, April 18.

Meeting highlights included a vote on a member's appeal to the general membership of his expulsion (the outcome is detailed in Governance, page 20). Secretary Jon H. Robertson, MD, detailed strong membership numbers, and Treasurer James R. Bean, MD, reported on the AANS' robust financial health, asserting that "the outlook is very optimistic for this fiscal year and for 2006."

Retiring board members were honored for their service, and voting members elected new officers. The 2005–2006 AANS Board of Directors includes officers Fremont P. Wirth, MD, president; Donald O. Quest, MD, president-elect; Robert L. Grubb Jr., MD, vice-president; Jon H. Robertson, MD, secretary; James R. Bean, MD, treasurer; and Robert A. Ratcheson, MD, past president; directors at large Robert E. Harbaugh, MD; Christopher M. Loftus, MD; James T. Rutka, MD; Warren R. Selman, MD; and Troy M. Tippett, MD; regional directors Jeffrey W. Cozzens, MD; Paul E. Spurgas, MD; Clarence B. Watridge, MD; and Edie E. Zusman, MD; Eugene S. Flamm, MD, historian; ex-officio members

Rick Abbott, MD; Lawrence S. Chin, MD; Fernando G. Diaz, MD; Robert F. Heary, MD; Andres M. Lozano, MD; Dennis E. McDonnell, MD; Richard K. Osenbach, MD; Robert H. Rosenwasser, MD; Alex B. Valadka, MD; and Ronald E. Warnick, MD; and liaisons Isabelle M. Germano, MD; Mark G. Hamilton, MD; and Nelson M. Oyesiku, MD.

Dr. Ratcheson was honored for his year of service at the AANS helm in the manner tradition requires: with presentation of his state flag (Ohio) and the presidential portrait, which both had been displayed at the AANS Headquarters Office during his presidency, and a replica of the sterling silver cigarette box that commemorated Harvey Cushing's two thousandth tumor operation.

Earlier in the day Dr. Ratcheson delivered the Presidential Address, "Fast Forwarding: The Evolution of Neurosurgery."

Offering his perspective on the state of neurosurgery today, he tackled several topics, among them medical liability reform, which he said "deserves everyone's support," the positive and negative consequences of resident duty hour restrictions, and complex issues related to neurosurgical emergency service.



Robert A. Ratcheson, MD, delivers his Presidential Address, "Fast Forwarding: The Evolution of Neurosurgery."

The related topics of neurosurgical training and the neurosurgical workforce also were discussed. Noting that there are 5 percent fewer neurosurgeons practicing now than in 1998, Dr. Ratcheson warned that eight-year or nine-year training programs "may lead outstanding students to bypass neurosurgery." He also observed, "We should reflect upon what we are missing when the great majority of women do not consider neurosurgery as a career."

In his introduction of this former Van Wagenen Fellow, Dr.

## 2005 YNC Silent Auction Raises \$23K for NREF

TERRI L. BRUCE

**T**he Seventh Annual Silent Auction, sponsored by the Young Neurosurgeons Committee and held during the AANS 73rd Annual Meeting, raised more than \$23,000 to benefit the Neurosurgery Research and Education Foundation

research grant program. NREF grant awardees are the neurosurgeons of tomorrow—residents and faculty members just emerging onto the neurosurgical scene.

Among the 95 items up for bid was a beautiful white gold and diamond Circle of Life pendant. After a remarkable 12 bids the pendant sold for \$750. Other exciting items were a 20GB iPod and two iPod Shuffles. After furious bidding, all three items sold for more than their listed value. Other state-of-the-art electronics, fine bottles of wine, trips and airline tickets, a vintage Mickey Mouse cookie jar, a remote control airplane, poker chips, paintings, jewelry, and gift certificates were offered.

Outstanding medical items, such as autographed books from many authors, courses, binoculars and more, were of great interest this year. One medical course sold for \$900 and a pair of binoculars sold for \$1,000.



NREF Chair Martin H. Weiss, MD, and AANS Development Director Michele S. Gregory invite support of the Neurosurgery Research and Education Foundation. The Silent Auction booth is shown above.

The NREF and the Young Neurosurgeons Committee thank everyone who participated in and contributed to the success of this year's auction. The auction could not have been as successful as it was without the generous support of the companies, individuals and organizations that donated and purchased items from this year's auction. The Eighth Annual Silent Auction will be held next April in San Francisco, and we invite your participation.

For more information about the Silent Auction or the NREF fellowship grant program, please visit [www.aans.org/research](http://www.aans.org/research).

**Terri L. Bruce** is AANS development coordinator.

Wirth characterized Dr. Ratcheson as “someone who will do the right thing for the right reason at the right time,” and he said he had profited from Dr. Ratcheson’s wisdom and commitment to excellence and quality.

### Impressive From Start to Finish

Among the abundance of educational and social programs associated with the 2005 AANS Annual Meeting, the innovative Sunday evening opening reception was a memorable event. Taking its cue from a city that knows how to entertain, the innovative event, held at Mardi Gras World near the banks of the Mississippi, mimicked a Mardi Gras celebration. Party adventurers were treated to their own Mardi Gras parade and were coaxed into exploring the various entertainment and refreshments offered in each successive room, all against a backdrop of brightly painted, festive floats. Children were treated to balloons and face painting, while all could browse the float creations under construction in the workshop.

The final day of the annual meeting was as impressive as the first. Five breakfast seminars featured “meet the experts” in the fields of pediatric, cerebrovascular, lumbar spine, tumor and cervicothoracic spine neurosurgery. A socioeconomic session included an update from the AANS/CNS Washington Committee, a special lecture on managing managed care organizations, and the presentation of four papers reporting research on socioeconomic topics. The day, and the annual meeting, concluded with a well-attended special scientific session, Neurosurgery With the Masters: In My Experience, that featured presentations on peripheral nerve, pituitary and spinal neurosurgery, and microsurgical anatomy.

The 2006 AANS Annual Meeting, themed Meeting the Challenges of Neurosurgery: Expanding Resources for a Growing Population, will be held April 22–27 in San Francisco, Calif. As details of next year’s meeting become available, the information will be posted at [www.aans.org/annual/2006](http://www.aans.org/annual/2006). ■

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



# Broken U.S. Healthcare System Exposed

*Will Federal Reserve-Like Overseer Lead to a Solution?*



**Critical Condition: How Health Care in America Became Big Business and Bad Medicine**, by Donald L. Barlett and James B. Steele, 2004, Doubleday, 288 pp., \$24.95.

The broken U.S. healthcare system is the subject of a new bestseller by Pulitzer Prize-winning authors Donald L. Barlett and James B. Steele, investigative reporters for the New York Times. In their book *Critical Condition: How Health Care in America Became Big Business and Bad Medicine*, the authors expose the vagaries of American healthcare and propose detailed solutions for many of the problems.

The authors begin by examining what U.S. politicians call the world's best healthcare system. The United States certainly spends more for healthcare than any country in the world: 75 percent more than Canada and twice as much as anywhere else. Yet, the World Health Organization ranks the United States 29th among the countries of the world—between Slovenia and Portugal—in years of healthy living. The authors characterize the U.S. healthcare system as a “stunningly fragmented collection of businesses, government agencies, healthcare facilities, educational institutions, and other special interests wasting tens of billions of dollars and turning the treatment of disease and sickness into a lottery where some losers pay with lives.”

How did the U.S. healthcare system get so bad? The authors' answer is that America sold out to Wall Street. The business practices that the Street has introduced—cutting corners, trimming costs by eliminating nurses, hiring less-qualified physicians, replacing skilled employees with unskilled, paying poverty-level wages to many workers, driving down the

salaries of professionals, and even curtailing the cleaning of hospital rooms, operating rooms, and doctors' offices to meet financial projections—also have been adopted with a vengeance by the so-called nonprofit side of medicine, so much so that the nonprofit and for-profit sides of medicine now are often indistinguishable.

The federal government also bought into the business model. Government policymakers thought that investor-owned managed care companies would solve the problem of high priced healthcare through competition. First hospitals were bought up by large corporations. Then doctors' practices also become part of big business.

Even so, costs have continued to rise. The authors point out that one of the reasons for increasing costs can be traced to Madison Avenue. Since 1997 the U.S. Food and Drug Administration has opened the door wide to advertising directly to consumers on television, and Americans are being blitzed with advertising. For example, the pharmaceutical industry presents the treatment for erectile dysfunction as its approach to public service, creating a demand for a treatment even when a medical need may not exist.

At the same time, administration of the healthcare system has become increasingly complicated. The authors do a pretty good job of illustrating how insurance companies game the system to avoid paying doctors for services they have performed. They also describe the new trend of outsourcing everything possible to overseas labor.

Then, in the best chapter of this book the authors say, “It need not be this way.” Americans do not have to be the most overtreated, undertreated, and mistreated patients on earth. The authors propose a new system that is universal and provides affordable, accessible care. They want a single-payer system but don't want the gov-

ernment to run it, suggesting instead a quasi-governmental organization like the Federal Reserve System, which oversees the nation's money and banking policies. The organization they propose, which they want to call the U.S. Council on Health Care, would be largely independent of politics.

The funding mechanism would consist of just two taxes—a gross-receipts levy on business and a flat tax, similar to the current Medicare tax, on all individual income. Everyone would be covered for the basics, and copayments would be based on income. Any catastrophic illness would be covered. Patients would have complete freedom of choice of doctors and hospitals. The system would emphasize prevention and would include basic formulary; the council also could negotiate the best possible prices for drugs. In addition, to reduce medical errors dramatically, the council could oversee creation and operation of a single information technology system that links all healthcare players.

What will be the driving force that convinces Americans that we need a new healthcare system? First it will be working Americans disenchanted with rising costs and shrinking care. Secondly, it will be corporations that can no longer compete with foreign companies because of the cost of healthcare benefits. The crisis that we face represents an exceptional opportunity to rethink our values, our priorities, our budget, and our options. ■

**Gary Vander Ark, MD**, is director of the Neurosurgery Residency Program at the University of Colorado. He is the 2001 recipient of the AANS Humanitarian Award.

## Pulse Point

In April 2005 the American Association of Neurological Surgeons issued a statement affirming its support of health insurance coverage for every American. The position statement is available at [www.AANS.org](http://www.AANS.org), article ID 27362.

# TIMELINE: Neurosurgery Through History

## A Specialty Flowing With Milk and Vegetables?

Whatever the exact type of practice, neurosurgeons work hard to ensure payment for professional services. After all, the Talmud states that “a physician who does not demand to be paid does not deserve to be paid.” There are coding courses, books, software, consultants, billing managers, and so on, all part of the third-party reimbursement system. We do our best to eke out the maximum we can under the rules while insurers do their best to pay us the minimum possible. If only we could return to a kinder, gentler time....

Doctors used to provide a fee schedule to prospective patients. For emergency care, payments were collected when possible from patients or families. The Newark Medical Association published such a schedule in

1853. It recommended \$1 for a consultation, \$2 for leeching, and between \$20 and \$100 for (yes) trephination. When a family could not afford the full amount, they paid what they could, provided something as barter, or the surgeon waived his fee (working *pro bono*, “for the good”).

Harvey Cushing benefited from the system of private practice in place at Johns Hopkins Hospital as he began his career in brain surgery. But he certainly was not immune to the vagaries of practice, noting in 1907 that “people are slow in paying their bills these days.” This required him to seek a handout from his obstetrician father.

R.M. Peardon (Pete) Donaghy was a pioneer in microneurosurgical technique at the University of Vermont. His online biography ([www.med.uvm.edu/neurosurgery/donaghy.html](http://www.med.uvm.edu/neurosurgery/donaghy.html)) notes how he survived medical school in part by free access to milk from the

**“People are slow in paying their bills these days.”**

—Harvey Cushing

UV dairy school. Years later, upon his appointment as chair of the new neurosurgery department, the dean suggested that vegetables from the school of agriculture could defray part of his salary.

Managing a practice has always been a part of medicine and of neurosurgery. Neurosurgeons’ income increased as a result of the modern insurance system and now is threatened by it. “Boutique” practices that charge well-heeled patients to pay as they go may satisfy certain medical groups, but it is doubtful that this solution would work for most neurosurgeons. Fresh milk and vegetables, anyone? ■

**Michael Schuldner, MD**, is associate professor in the Department of Neurological Surgery and director of image-guided neurosurgery at UMDNJ-New Jersey Medical School.



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# EVENTS

## Calendar of Neurosurgical Events

**Pennsylvania Neurosurgical Society Annual Meeting**

July 15-16, 2005  
Hershey, Pa.  
(717) 558-7750

**Modern Treatment of Tumors of the Nervous System**

July 23-29, 2005  
Merida, Mexico  
www.xviiiicmcn.org

**11th Annual Montana Neurosurgery Symposium<sup>+</sup>**

July 31-Aug. 4, 2005  
Pray, Mont.  
(406) 329-5733

**Hydrocephalus 2005**

Aug. 15-17, 2005  
Queenstown, New Zealand  
www.madeline.org

**Tennessee Neurosurgical Society<sup>+</sup>**

Aug. 20-21, 2005  
Franklin, Tenn.  
(901) 259-5324  
www.tennessee-neurosurgery.org

**Symposium on Keyhole Techniques in Neurosurgery**

Aug. 25-27, 2005  
Sydney, Australia  
www.neuroendoscopy.info

**7th Annual Interventional Neuroradiology Symposium**

Sept. 9-10, 2005  
Toronto, Canada  
(416) 978-2719  
www.cme.utoronto.ca

**33rd Annual Meeting of the International Society for Pediatric Neurosurgery**

Sept. 11-15, 2005  
Vancouver, Canada

(604) 681-5226  
www.ispn.org

**7th International Stereotactic Radiosurgery Society Congress**

Sept. 11-15, 2005  
Brussels, Belgium  
www.isrs2005.com

**Western Neurosurgical Society<sup>+</sup>**

Sept. 17-20, 2005  
Lake Tahoe, Calif.  
(909) 558-4417  
www.westnsurg.org

**American Association of Electrodiagnostic Medicine Annual Meeting**

Sept. 21-24, 2005  
Monterey, Calif.  
(507) 288-0100  
www.aanem.org/meetings/  
meetings.cfm

**2nd Annual Practical Critical Care**

Sept. 22-23, 2005  
Charlottesville, Va.  
(434) 243-5703  
www.cmevillage.com

**2005 Annual Meeting of the American Academy of Neurological Surgery<sup>+</sup>**

Sept. 22-24, 2005  
Half Moon Bay, Calif.  
(205) 934-2918

**Advances in Biology & Treatment of Malignant Brain Gliomas**

Sept. 23-24, 2005  
Rome, Italy  
www.neurosciences2005.org

**American Neurological Association Annual Meeting**

Sept. 25-28, 2005  
San Diego, Calif.

(952) 545-6284  
www.aneuroa.org

**2005 Annual Meeting of the Congress of Neurological Surgeons**

Oct. 8-13, 2005  
Boston, Mass.  
(847) 240-2500  
www.neurosurgeon.org

**American Society of Pediatric Neurosurgeons Review Course<sup>+</sup>**

Oct. 21-23, 2005  
Chicago, Ill.  
(630) 681-1040  
www.aspn.org

**Research Update in Neuroscience for Neurosurgeons**

Oct. 23-30, 2005  
Woods Hole, Mass.  
www.societytyns.org

**Association of Military Surgeons of the United States Annual Meeting**

Oct. 30-Nov. 4, 2005  
Nashville, Tenn.  
(800) 761-9320  
www.amsus.org

**World Congress of Neurology**

Nov. 5-11, 2005  
Sydney, Australia  
www.wcn2005.com

**Endoscopic Neurosurgery Workshop**

Nov. 6-9, 2005  
Ghent, Belgium  
www.neuroendoscopy.org

**23rd Annual Neurotrauma Society Symposium**

Nov. 10-11, 2005  
Washington, D.C.  
(305) 663-6777  
www.neurotrauma.org/2005

<sup>+</sup>These meetings are jointly sponsored by the American Association of Neurological Surgeons. The frequently updated Meetings Calendar and continuing medical education information are available at [www.aans.org/education](http://www.aans.org/education).

### 2005 AANS Courses

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

■ **Managing Coding & Reimbursement Challenges in Neurosurgery**

Aug. 26-27, 2005 . . . . . Chicago, Ill.  
Sept. 16-17, 2005 . . . . . Nashville, Tenn. (Advanced)  
Dec. 2-3, 2005 . . . . . Washington, D.C.

■ **Neurosurgery Review by Case Management: Oral Board Preparation**

Nov. 6-8, 2005 . . . . . Houston, Texas

■ **Neurosurgery Practice Management: Improving the Financial Health of Your Practice**

Sept. 18, 2005 . . . . . Nashville, Tenn.

■ **Anatomy & Terminology**

Aug. 25, 2005 . . . . . Chicago, Ill.

■ **Current Advances in Spinal Fixation**

Feb. 11-12, 2006 . . . . . Memphis, Tenn.

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