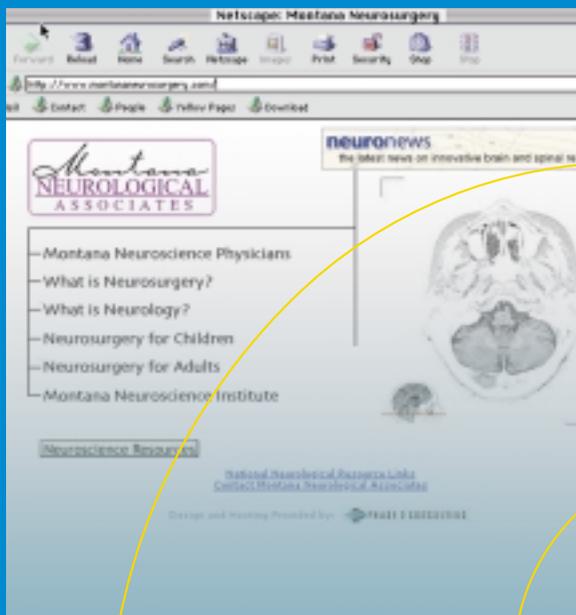


AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS BULLETIN

The Socioeconomic and Professional Quarterly for AANS Members • Volume 9 No. 4 • Winter 2000



MARKETING AND NEUROSURGERY WHAT WORKS AND WHAT'S APPROPRIATE



Getting Smart About Lumbar Spinal Stenosis

A Program of
Professional and Public Education

The American Association of Neurological Surgeons
and
The Congress of Neurological Surgeons



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- Dr. Dunsker Discusses AANS-CNS Merger
- Father/Son Reflect On Managed Care
- Gearing UP For Toronto



American
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Surgeons



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AANS BULLETIN

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Cover: Practice brochure image courtesy of Neuro Source, Inc.

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Unifying Our Profession

Merging AANS and CNS Would Strengthen Neurosurgery

Neurosurgery faces great challenges due to managed care and reimbursement cutbacks. Yet I am confident it is up the challenge, thanks in part to the AANS. Our organization is constantly evaluating what we do and how best to serve neurosurgery. We aim to be ahead of the curve, to anticipate and then surmount the obstacles that would harm neurosurgeons in the practice of their profession.

Our *Bulletin* is full of stories highlighting innovative and timely member benefits. The benefits will keep coming. In November the AANS held a planning meeting on being an efficient and cost-effective organization.

All this serves as a preface to what I really want to talk about. Just like the past, the future of neurosurgery will be linked to the AANS. Of course, we also need to consider the CNS, another vehicle for advancing our profession. The question is whether we need two separate vehicles to drive our profession forward.

No one thinks more highly than I do of the dedication and the abilities of the CNS leaders. You may have heard from them that it is desirable to keep two organizations because of tradition and because of culture.

But many of us see solutions to problems in different ways. Therefore I hope they will not be upset if I present a different opinion. The question of how to unify the activities of the AANS and CNS is very important to all of us, and I will speak frankly.

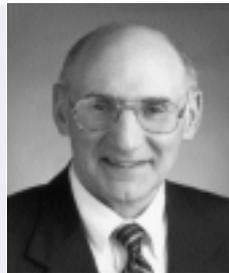
I am in favor of working together. I have advocated that and have worked for that. But I am for more than working together. I am for moving together. Regardless whether you call it a "joint venture," or a partnership, or a merger (a dreaded word to some)—regardless what you call it I am for

joining together, so long as we represent the interests of all neurosurgeons and so long as we do not destroy and waste AANS assets.

The cry is there is no economy of scale, but for starters the two organizations could save more than \$100,000 by combining board meetings.

The cry is that we must maintain the culture and traditions of the past. This is not an issue of culture, efficiency or tradition. It is an issue of working for members. It is an issue of advocacy for neurosurgeons. It is an issue of support of members' needs. It is an issue of what that takes to address them.

Stewart B. Dunsker, MD, is the 2000-2001 AANS President.



Two Comparable Groups

Are the AANS and the CNS really comparable and interchangeable? They are comparable. They are different, but they are not the same organizations. Let me emphasize that this is not an issue of superiority, but it is a very important issue of differences between our associations.

You have heard before and you will hear again how the CNS has a wonderfully low dues structure and supports many joint programs.

What do AANS dues pay for? What do members need and want?

Our members need and want an organization *to call*. How do I know that? Because neurosurgeons call the AANS more than 400 times a day.

Who wants his office to answer 400 calls per day for American neurosurgery? When a CNS member wants information on neurosurgery, he or she often calls the AANS. That requires infrastructure, and we must pay for it. Yet we are told the AANS money is not spent wisely, and the money, we are told, has not served us well.

We need an organization ready to stand up when the call arises. Several years ago the pedicle screw issue arose. The AANS President and Executive Director leapt into the fray. That was a member need. Our AANS president (Dr. Sidney Tolchin) stood up and mobilized the AANS. Our attorney, Mr. Russell Pelton, effectively led all the medical organizations in fighting the plaintiffs. That fight took several years and many AANS dollars, but it led to dismissal of the suits against all medical organizations.

That preserved our ability to use the pedicle screw and it preserved our patients' access to it. That successful stance for pedicle screws required the help of staff to coordinate those activities. That required an infrastructure with costs, an infrastructure we hear we do not need and we hear has not served us well.

When the rules changed for awarding CME credits for meetings, the AANS sent administrative staff away for more than a day to learn the intricacies. The next year other neurosurgery organizations needed to set up their CME accreditation process. They came to our expert and paid for a few hours of work. Who paid for the few days of work to gain that expertise? The AANS did. That is the infrastructure we hear we do not need and we hear has not served us well.

The very active AANS Professional Conduct Committee, which is a national model for associations, helps prevent inappropriate testimony by experts in court and helps protect all of us. That costs more than \$50,000

per year. Once we went to the U.S. Supreme Court to uphold neurosurgery. That is an infrastructure and a cost we hear has not served us well.

To use an analogy of Dr. Roberto Heros, the AANS Treasurer, the AANS is like a hotel that has rented services such as rooms to other neurosurgery organizations whenever they needed them. When the organizations go away, the AANS still has the hotel services to maintain so they are available the next time an organization wants to rent one of our service rooms.

But the AANS is not just an infrastructure; it is an organization working for neurosurgery. It is ready to meet challenges unnamed. We have a professional organization that is prepared to address the issues that we all face.

We in the AANS are for unifying those activities with a common board of directors, a common building and a common organization. Why unify? To make the house of neurosurgery stronger!

We are a profession of neurosurgeons and we must address all the concerns of neurosurgery—concerns that affect patients, concerns that embrace research, politics, economics and healthcare delivery.

The cry is that in the past the AANS has been too expensive. We cannot escape our history, but we are not living in it. The AANS' Board of Directors has hired an efficient Executive Director (Dave Fellers, CAE) to manage the operations.

CNS Model Won't Work

What has the CNS proposed for a unification model?

CNS proposes we build a third corporation in addition to the office staffs of the CNS and the AANS. Supposedly, we should be able to do this cheaper than the current scenario. Moreover, the new corporation should be beholden and responsible to two different board of directors.

Why will that not work? No one can serve two masters.

This is more than a conflict between physicians; this is a conflict between organi-

zations. Trying to have a third corporation beholden to two competing organizations is a divisive design destined to fail.

The AANS can downsize and can provide fewer services. But we cannot dismantle just part of an organization any more than you can remove some of the rooms from a hotel. We cannot fire one-third of a secretary, one-third of a typist and one-third of an accountant to save an employee's salary.

The office space, the computer and the telephone do not disappear proportionately. The CNS proposal to gradually put items and responsibilities into a new corporation will be a gentle growth for the CNS but will saddle the AANS with double costs.

One Organization Needed

Is the AANS perfect? No! But, in my judgment, it will not be made better by a series of amputations in order to form an additional infrastructure. What we need is:

- a merging of interests,
- a merging of assets,
- a merging of work.

We need to stop hearing about preserving a *culture*. We need to hear about preserving *neurosurgery*.

We can still have two meetings and two journals. After all, those are the real cultures of the two organizations, and we can still have room at the table for younger neurosurgeons.

The relations between the CNS and the AANS have consumed the activities of both boards of directors and both sets of leaders. That is a waste of precious time and precious money.

Advocate Instead of Bickering

We need to spend more time advocating for our neurosurgeons, not more time advocating for our associations.

We need to spend more time advocating for our patients, not advocating for a leader because of age.

We need to spend more time exploring new ways to educate our members, not exploring smaller buildings to house a new infrastructure.

Do you want to see neurosurgery work together and stop bickering?

Do you want to keep dues as low as possible?

Do you want to see us concentrate on education and advocacy and not on squabbling?

It is time to stop worrying about losing identity and start worrying about our patients and our neurosurgeons.

What we want and what we need is one organization that blends the best of both the AANS and CNS. Let me emphasize this is not a "takeover." Those who describe a merger as a "takeover" are trying to hide the true events behind a pejorative smoke screen. We are talking about a true merger of interests and a true a merger of work, so that the AANS and the CNS can concentrate on neurosurgical problems and not on relations between two organizations.

Let us have two journals and let us have two meetings, but let us have one fighter for neurosurgery. Let us have one board of directors to work together. Let us have one champion, an AANS/CNS for all of neurosurgery. With one organization and with one board we can build neurosurgery for today and for tomorrow! ■

Stewart B. Dunsker, MD, is a practicing neurosurgeon at The Mayfield Clinic, Professor of Clinical Neurosurgery, Vice Chairman of the Department of Neurosurgery and Director of the Division of Spine Surgery at the University of Cincinnati.

This editorial is adapted from a talk given by Dr. Dunsker to the Council of State Neurosurgical Societies September 23 in San Antonio.

WE WANT TO HEAR FROM YOU

The AANS Bulletin welcomes letters from our readers. Write to A. John Popp, MD, FACS, Editor, 5550 Meadowbrook Dr., Rolling Meadows, IL 60008 or e-mail us at ejc@aans.org.

NEWSLINE

NewsMembersTrendsLegislation

FROM THE HILL

CCI EDITS WITHDRAWN

Recent neurosurgical bundling edits have been overturned after AANS and CNS Coding and Reimbursement Committee members Samuel Hassenbusch, MD, and Greg Przybylski, MD, met with officials of the Health Care Financing Administration. Inaccurate coding edits that blocked coding for stereotactic computer-assisted guidance (61795) with appropriate intra, extracranial and spinal codes will be retroactively rescinded. Since July, Correct Coding Initiative (CCI) software edits that are sent to all Medicare carriers were denying claims for the usage of CPT code 61795 in the areas where it is appropriately used for such navigation. (See story on page 24.)

NOTE: At press time, because of the delays associated with the presidential and congressional election, Congress had not yet completed action on numerous bills critical to neurosurgery. These include: 1) a Patients' Bill of Rights, which incorporates provisions guaranteeing patients direct access to the specialist of their choice; 2) the Balanced Budget Reform Act, which contains provisions related to Medicare practice expenses, payment for on-call physicians and a comprehensive study of the EMTALA law; and 3) final action on the NIH appropriations bill. In the next issue of the *Bulletin* we will include a comprehensive year-in-review article highlighting the final action on these issues.

- **HCFA Publishes Medicare Fee Schedule.** The Health Care Financing Administration (HCFA) published the final Medicare Fee Schedule rule for 2001 on November 1. The new payment rates are effective on January 1, 2000. In the regulation, HCFA made additional changes to the practice and malpractice expense portions of the fee schedule. The impact of these changes will produce an additional estimated 1 percent reduction in neurosurgical fees. Thus, when the new practice expense RVUs are fully implemented in 2002, the total reduction (from 1998-2002) for neurosurgery will be 13 percent (compared to the 25 to 45 percent reduction initially proposed in 1997). The good news, however, is these reductions have been offset by increases in the Medicare conversion factor. For 2001, the conversion factor will rise from \$36.61 to \$38.26. The following table outlines the specific impact that the practice expense changes have had on key neurosurgical procedures:

Procedure	1998	1999	2000	2001	2002	% Change
Endarterectomy	\$1,263	\$1,220	\$1,236	\$1,228	\$1,170	-7%
Brain Tumor Removal	2,129	2,040	2,195	2,058	1,934	-9%
Carotid Aneurysm	3,071	3,059	3,359	3,448	3,384	+10%
Lumbar Discectomy	991	946	950	957	912	-8%
Lumbar Spinal Decompress	1,246	1,177	1,143	1,143	1,082	-13%
Office Consultation	97	103	117	118	121	+25%

- **AANS and CNS Push for HCFA Reform.** The medical community stepped up its scrutiny of the HCFA this year. The AANS and CNS joined a coalition effort to get key congressional committees to hold oversight hearings to investigate problems associated with HCFA. As a result, the House's Budget, Commerce, and Ways and Means committees held hearings, which led to the introduction of several bills at the end of the 106th Congress. The AANS and CNS are now working with the American Medical Association and other medical specialty societies to develop a comprehensive plan for HCFA reform. Organized neurosurgery hopes to persuade the federal government to implement reforms aimed at reducing regulatory burdens and bringing a more rational approach to enforcing fraud and abuse laws.
- **HCFA Moves Ahead With New E&M Guidelines.** The HCFA continues to develop yet another new Evaluation and Management Documentation Guidelines system. Although details remain incomplete, HCFA has decided to base its latest proposal on the 1995 single-system approach. Under the revised system HCFA plans to develop specialty-specific "examples" (possibly as many as 600 total for all specialties) and reduce E&M services from five to three levels. On behalf of the AANS and CNS, Troy M. Tippet, MD, continues to interface with HCFA on this project. He recently testified before the Practicing Physicians Advisory Council to express the concern that HCFA is developing the guidelines without meaningful consultation with physicians and that this new system will shift reimbursement from specialists to primary physicians. The new system will not likely be implemented until fall of 2002. In the meantime, neurosurgeons should continue to document based on either the 1995 or 1997 guidelines.

NEURO NEWS

THE "BLACK BOX" CRASHES

Medicare administrators announced in September the elimination of the "black-box" edits when reviewing claims, a move applauded by the American Medical Association and other medical societies. The use of the proprietary Commercial Off-the-Shelf Software forced physicians to guess about the correct way to code and resubmit a claim after a claim was denied. Medical societies pointed to a 1998 report by the Office of Inspector General that questioned the ability of commercial software to accurately detect inappropriate over-billing.

- **Privacy Rules to be Costly.** New rules from the Department of Health and Human Services (HHS) regulating the privacy and security of healthcare information will cost providers about \$25 billion nationwide, according to a report from Fitch Inc. HHS is expected to publish soon the rules of the Health Insurance Portability and Accountability Act. Healthcare providers, health plans and clearinghouses that transmit health information in connection with Medicare or Medicaid will have two years to comply with the law once the rules are effective. Conservative government estimates put the price tag at \$4 billion over the next five years. The Blue Cross and Blue Shield Association estimates a cost of \$43 billion.
- **French Neurosurgeon Wins Pediatric Award.** Christian Sainte-Rose, MD, was the 1999 recipient of the annual Robert H. Pudenz Award for Excellence in CSF (Cerebrospinal Fluid) Physiology. The award is sponsored by Medtronic PS Medical, based in Minneapolis. Dr. Sainte-Rose is professor of pediatric surgery at the Hospital Necker-Enfants Malades in Paris. He accepted the award October 2 at the 28th Annual Meeting of the International Society of Pediatric Neurosurgery in Istanbul. The award is named in honor of the neurosurgeon who developed the treatment of hydrocephalus using diversion-type devices.
- **HCFA Sets Coverage in Clinical Trials.** Medicare's coverage of routine care costs in clinical trials includes conventional care, services required as a result of the trial and treatment for complications that arise from the trial, announced the Health Care Financing Administration (HCFA). Excluded from coverage is the actual cost of the investigational item or service itself as well as data collection efforts. The coverage rules by HCFA allay most of the concerns of the AANS/CNS Joint Officers, including their concern that category B device trials not be impacted by the decision. HCFA declared that its rules do not take precedent over exemptions granted locally. Still troubling to the AANS and CNS is the fact that all federally approved or supported drug trials are covered effective immediately but device trials are not. Such trials will have to wait until HCFA initiates separate rulemaking for category A devices. The Medicare coverage for clinical trials, ordered by President Clinton in June, is intended to increase enrollment in studies and speed cures.
- **Burden of Physician Compliance Guidelines Remains.** The final physician compliance guidelines issued in September by the Office of Inspector General (OIG) include some important concessions to the concerns of the AANS and other medical societies but remain burdensome. The OIG decided that practices will not have to meet all seven of the compliance elements. The guidelines acknowledge that "full implementation of all components may not be feasible. . . . However, as a first step, practices can adopt those components which, based on a practice's specific history with billing problems and other compliance issues, are most likely to provide an identifiable benefit." The AANS and CNS have expressed extensive concerns about the proposed guidelines' complexity and the burden they impose. A full copy of the guidelines can be found at: www.dhhs.gov/progorg/oig/new.html. Comments sent to the HCFA can be read at **NEUROSURGERY://ON-CALL* (N://OC)**.
- **Pain Management Standards Ok'd.** New standards on pain management, a collaborative effort between the Joint Commission on the Accreditation of Healthcare Organizations and the University of Wisconsin-Madison Medical School, will take effect on January 1, 2001, according to *Reuters Health*. The Joint Commission Standards on Pain Management are expected to apply to all accredited U.S. hospitals, according to Jeffrey Apfelbaum, MD, professor of anesthesiology and critical care at the University of Chicago in Illinois. The standards call for pain to be considered the "fifth vital sign."

Marketing and Neurosurgery

Managed Care Era Ushers in Need for Marketing by Jay Copp

Neurosurgeons can no longer wait for patients to beat a path to their doors.

Many neurosurgeons refrain from marketing, considering that strategy incompatible with the practice of medicine. Yet marketing is not the same as advertising. A true marketing initiative involves education. And the tools for marketing are not shrill TV spots or highway billboards but patient satisfaction surveys, outreach to the media and community groups, AANS program materials, Web sites and, perhaps most importantly, improving customer satisfaction and building relationships with referring physicians.

Consider James Bean, MD, a private practice neurosurgeon in Kentucky, for example. He greets an office full of patients day after day. It's no accident his patient volume is steady. He and his staff assiduously court primary care doctors.

"We do local medical staff presentations from time to time. We communicate by letter to every referring physician about each patient contact," he says. "Whenever we find extra office time, we call referral sources, usually about patient contacts."

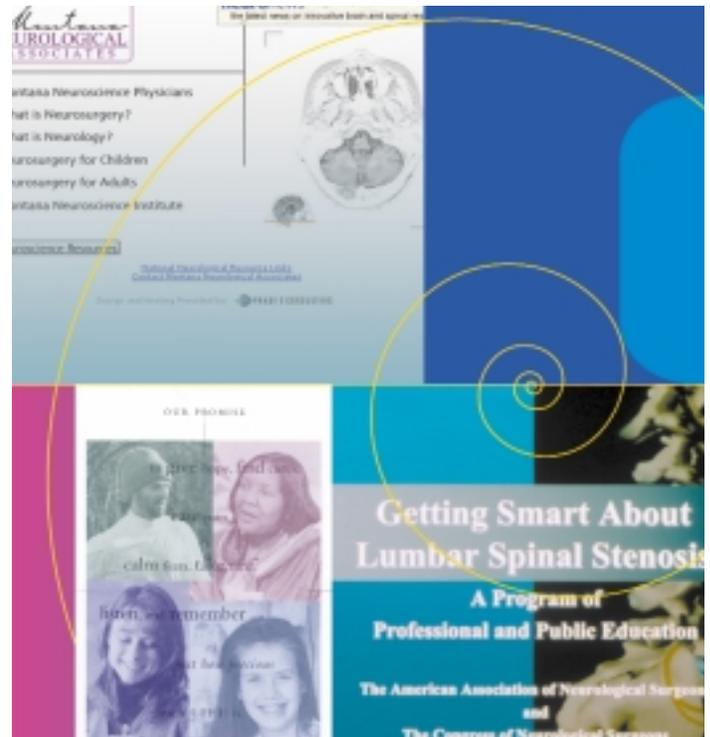
Dr. Bean doesn't buy ads in the Yellow Pages, advertise in newspapers or air a local radio spot. But he does indeed market his practice. "The most effective marketing strategy is direct conversation with primary care physicians who may make a referral and prompt written communications and responses to their referrals," he attests.

Marketing works for Dr. Bean, and it can work for all neurosurgeons. In a time of shrinking reimbursement, the need to market one's practice has become more acute. Neurosurgeons who wait for patients to beat a path to their door may eventually find the wolf at their door.

The New Consumer

Negative connotations blemish marketing. The "M" word conjures up images of a plaid-coated, hand-waving carnival barker hawking discounted cars or televisions. The assumption is that it's perfectly OK to pitch cars and washing machines but inappropriate to promote a health service.

Well, it is indecorous to aggressively advertise a health practice.



But that's not what marketing is. Marketing is a more sophisticated and more subtle strategy than blatant advertising. Even the most conservative neurosurgeon, one emotionally tied to the healthcare climate of prior generations, would feel comfortable with a genuine marketing plan.

"You should think of marketing as educating the public and referring physicians," says Rebecca Anwar, a senior consultant of the Philadelphia-based Sage Group, a healthcare consulting firm. "People get advertising and marketing mixed up. Most advertising would be very inappropriate for a neurosurgeon."

Anwar, who has a PhD from the London School of Economics, is the president of the National Association of Healthcare Consultants. She can attest from her work with the association that healthcare specialists are rapidly turning to marketing to maintain or increase patient volume. Orthopedic surgeons, radiologists, obstetricians, gynecologists and ophthalmologists in particular are embracing marketing.

Marketing is particularly important in the era of managed care. One of the primary goals of marketing is to increase patient satisfaction, and making patients happy is critical under managed care. If only five percent of a physician's patients express their dissatisfaction to a managed care entity, the physician could lose 100 percent of the patients from that plan if the contract is not renewed.

Power of the Internet

Besides shrinking reimbursement and managed care, what's driving the new emphasis on marketing?

In a word, the Internet.

The information highway has changed consumers. This the age of consumerism. The healthcare field is being transformed. Healthcare definitely is still not mall-like, a bastion of unfettered choice. But it definitely is more of an open marketplace.

Leland Kaiser, a notable futurist, says, "We have moved from physician-managed care to third-party managed care and are on our way to patient-managed care. Consumer empowerment via the Internet will forever change the way we deliver healthcare in this country."

"Neurosurgeons who wait for patients to beat a path to their door may eventually find the wolf at their door."

Care to hazard a guess what will happen to those who don't jump on the bandwidth?

Kaiser predicts that the "physician, clinic, hospital or third-party agency that does not understand this revolutionary transformation is doomed."

Consumers want physicians who are electronically accessible. More than one third of consumers are more likely to select a physician who offers electronic communication options such as appointment scheduling and test results than one who doesn't, according to a survey in 2000 by LaurusHealth.com. A growing

number of Internet sites grade doctors on such factors as education, accreditation and experience. Forty-eight percent of consumers would like the ability to send e-mails to their doctor, according to a survey in 2000 by Cyber Dialogue.

The power of the Internet can be deceiving, however. The point is not that consumers are wedded to technology but are enamored of choice. And that's why marketing is vital. The Internet has helped Baby Boomers, always quick to make their own demands, understand that choice is an option even when it comes to healthcare.

Former U.S. Surgeon General C. Everett Koop, MD, explains: "Baby Boomers have run our society since the 1960s. They are information junkies. They kick the tires, look under the hood, read

labels in supermarkets. Before this, the doctor was the authority, and the patient was passive. The Internet has changed all that."

No Shortcuts Allowed

A 36-year-old ophthalmologist in Silicon Valley does as many as a dozen vision-correction surgeries an hour. He provides patients limo pickup and dropoff. He buys 30-second TV spots, a 30-minute infomercial, radio and Internet ads. He even rented a billboard on a major highway.

Fortunately, there are a multitude of quieter, more dignified ways to reach out to consumers.

But the first step is to form a plan. Come up with an objective and methods to reach that goal.

Avoid flippantly saying, "I'd like to double my number of patients." That may not be realistic. Or it may be underestimating the potential patient base.

A neurosurgeon needs to analyze his or her patient base. Where are the patients coming from? Has there been a shift? Have some referring physicians stopped sending patients?

Marketing is not quick and easy. It takes planning and then careful execution.

"Marketing without a marketing plan would be like going on a trip without a map," says Anwar. "It's shooting from the hip.

"I'm a real stickler for market research. You don't just walk into a doctor's office and say you need surgery. And you don't embark on marketing without research."

Another preliminary step is getting staff informed and involved. Their relationships with patients and referring physicians can make or break the marketing plan. "Make networking important to them. That's basic common sense and courtesy, which is what marketing is all about," says Kristi Sykes, director of marketing for Knoxville, Tenn.-based Doctors Management, a health consulting firm.

Finally, before moving ahead with marketing, a neurosurgeon needs to make sure he or she can handle with aplomb any increase in patient traffic. Is another phone line needed? Another staff person? Providing poor service to a larger number of patients will eventually backfire.

Cautions Dr. Bean, "You should always have space available on the appointment list within a seven- to 10-day period after a referral is made. Nothing is more self-defeating than rapport building with physicians countered by no available office time. The good referrals will be sent elsewhere and the lousy ones, which have the leisure to wait, will fill the office six weeks later."

Marketing Strategies

Stan Pelofsky, MD, one of the owners of the Oklahoma City Spine Hospital, doesn't spend a dollar on marketing. Yet his operation is imbued with marketing savvy.

"Every person who works in our hospital has been handpicked," he says. "They understand the patients are facing a difficult situa-

Continued on next page

Need Marketing Assistance? AANS Gets Smart

Not sure you have the time or expertise to market your practice? Don't worry. The AANS offers a comprehensive array of programs and services to launch a successful marketing initiative.

The flagship program is **Getting SMART About Neurosurgery**, a collection of materials created by AANS and CNS that promote your practice to referral sources, patients, the media and civic groups. The Getting Smart package includes 200 patient information brochures, 100 physician referral booklets, ready-to-use slide presentations (for both patients and medical professionals), sample promotional letters and press releases. Neurosurgeons can choose from two topics: lumbar spinal stenosis and stroke.

The materials serve two purposes. They increase awareness of the scope and quality of neurosurgery and promote a neurosurgeon's practice. The patient brochures, for example, have a space for a label or stamp to insert your own name or practice logo.

Getting SMART makes marketing easy. Sample letters help you target senior citizen groups, hospital chiefs of staff and heads of primary practice resident programs with offers to be a speaker. The stroke materials also are available on CD-ROM or Zip disk as well as slides. The cost for either the stroke or lumbar spinal stenosis Getting SMART package is \$300.

A second popular marketing tool is the eight-page **Neurosurgery Today** insert that ran in *USA Today*. Reprints are ideal as an education and outreach tool for patients, referring physicians, managed care administrators and the media. The cost for 100 copies is \$50.

A Patient's Guide to Neurosurgery is a brand-new patient education brochure. It summarizes in lay language the many conditions treated by neurosurgeons. It can be mailed to referring physicians or handed out at health fairs, career days and lectures. A pack of 50 is \$50 for AANS members. (See story on page 27.)

Marketing advice is featured in several softcover books sold by the AANS, including **Starting A Medical Practice** and **Managing the Medical Practice**. AANS members can upgrade their listing for \$125 in the "Find a Neurosurgeon" section of **NEUROSURGERY://ON-CALL®**.

Finally, the AANS can help you get a deluxe home site on the information superhighway, where you are sure to be visited. **Medem**, an Internet partner of AANS, provides AANS members with free customized Web sites and can set up an e-mail service with patients, too. **SpineUniverse.com**, another Internet partner of AANS, offers the option of listing your practice in specialist referral data banks. Neurosurgeons who already have a Web page can link up to Medem and SpineUniverse or build a page on their own and link up.

The Internet partners function as referral sources for AANS members. Some visitors to these sites inevitably link up with the home pages of neurosurgeons. And you're in business. ■

Continued from page 5

tion and need support. We don't hire sourpusses. If they don't have a personality, they better find one.

"We have a hospital environment that is positive, upbeat and nurturing. That's the best marketing tool of all, far better than a newspaper ad."

The spine hospital also nurtures its relationship with referring physicians. Neurosurgeons send a letter within 24 hours of seeing a patient to the referring physician explaining the course of treatment. The bond of trust between the neurosurgeon and referring physician is solidified.

"Marketing is all about relationships with patients and referral sources," says Sykes. Seconds Anwar, "The golden source for a specialist are previously satisfied patients and referral sources."

"Internal marketing strategies should focus on building patient and referring physician satisfaction."

Think *Wizard of Oz* to appreciate the No. 1 principle of marketing. The Scarecrow, the Tin Man and the Lion already possessed inside of them what they believed they lacked. Dorothy only had to click her heels to go home. Specialists already possess the network they need to increase their patient volume. What they need to do is nurture that network.

Internal marketing strategies should focus on building patient and referring physician satisfaction. Are patients greeted

promptly and courteously? Are they cared for with kindness and gentleness rather than cold professionalism? Are the telephone calls of referring physicians returned quickly?

"You have to make your referral sources happy as a clam," says Anwar. "You may be the only game in town but maybe they don't like you. It could take a simple action like a phone call to set things right."

Neurosurgeons may want to consider surveying their patients to find ways to improve service. (See sidebar.) They also may want to distribute a practice brochure. It creates a positive image of the practice, provides information about services and office policies and saves time by addressing repetitive questions such as how to bill insurance or where hospital privileges are held. A practice brochure is a sort of super-delux calling card, a surefire method to instill respect for the practice.

A typical brochure is 4 by 9 inches, or small enough to fit comfortably inside a standard No. 10 business envelope, with six to eight panels. The cover should include a motto such as "our goal is your health," an encapsulation of the reason the practice exists. Neurosurgeon should use a reassuring photo of themselves talking to a happy, healthy patient. Especially for a first-time patient, a photo

helps immensely with familiarity, easing the discomfort of meeting with a new doctor.

Design the brochure with your audience in mind. A neurosurgeon in the rough-hewn backcountry of South Dakota or Idaho may want to consider a photo of himself hunting or fishing. The writing style should be warm and relaxed. A neurosurgeon in New York City needs a more sophisticated approach.

External Strategies

If Horace Greeley, the newspaperman who knew where fortunes were to be made, were alive today he might say, "Go Web, young man." Neurosurgeons need to market themselves through traditional means such as making speeches before civic groups and getting their name and expertise in the local newspaper. But they also need to hop on the information highway and take full advantage of an increasingly wired society. (See page 21.)

An estimated 72 million Americans have used the Web seeking healthcare information. And that number will be hopelessly outdated next month. Some neurosurgeons, as well as competitors, are already using the Internet to reach patients and referring physicians. Keeping up with the Joneses is essential. If nothing else, a Web site sends the message that a practice is innovative and progressive.

AANS members can get free customized practice Web sites and secure e-mail service with patients through AANS' partnership with Medem. (Call 888-566-AANS for information.)

The site should give an overview of a neurosurgeon's practice and a list of the physicians, nurses and other professional staff. It should highlight the surgeon's credentials, state the practice philosophy and offer patient education. A section for referring physicians can offer suggestions on when to refer a patient, post scientific papers and list hospitals where privileges are held.

The site is a way to make it easier for patients to schedule

Surveys a Key Tool in Assessing Patient Satisfaction

You are a competent, caring neurosurgeon. Your staff is polite and efficient. Your office is conveniently located near the community hospital. Yet your patient volume continues to drop.

The culprit could be a simple but overlooked problem such as a lack of patient privacy. Patients may not be able to give sensitive personal or medical information at the front desk without other patients overhearing.

A practice survey can help you identify hidden barriers to practice success. It's important to gauge patient satisfaction to ensure patients' needs are being met.

Minor annoyances for patients, already under stress and uncomfortable before they arrive, can keep them from returning and cause them to badmouth your practice to friends and their referring physician. Is the TV too loud? Is the waiting room too hot or cold? Is there ample, convenient parking? Maybe customer service is the problem. Can patients quickly get their questions answered over the telephone? Are staff friendly?

A survey with 20 to 30 questions, one that fits on both sides of a sheet of paper, will provide sufficient feedback. Surveys need to be done at six-month or 12-month intervals to compare results.

Surveys can be handed out to patients while they are in the office. Or you can hire a firm to coordinate either a mailed survey or a telephone survey.

Handing out surveys at the office is the least expensive option. But it's not scientifically valid because survey respondents self-select. Also, patients worried about confidentiality may not be can-



did. Still, if you want to spend little money and time on a survey, this may be the way to go.

A mail survey gives patients more time to reflect on their experiences. Getting a large enough response to be scientifically valid can be a problem, though some survey experts maintain that 50 patient responses per doctor will give you roughly the same data as 500 replies. Depending on the

size of your practice, the cost of mail surveys can be as low as \$1,500.

A telephone survey is expensive, as much as \$20,000. And some patients may resent being called at home (though a call being made on the behalf of a personal physician is hardly received with the same distaste as calls from telemarketers). But telephone surveys provide quick feedback and elicit a relatively high response rate.

Two publications sold by the AANS, *Starting a Medical Practice* and *Managing a Medical Practice*, contain background on surveys and sample surveys. Call (888) 566-10 for information.

The National Association of Healthcare Consultants can provide a list of firms that do surveys. Call (202) 452-8282.

Media, Public Outreach Bring In Patients

Neurosurgeons who are willing to work with the media and reach out to community groups will boost their patient volume.

Consider Stan Pelofsky, MD, for instance. He not only makes his rounds bedside but also in the community as a whole. The Oklahoma City neurosurgeon gives talks to Chambers of Commerce and meets with medical students at medical schools. To further increase his visibility, he distributes the *USA Today* insert done by AANS about neurosurgery.

"You can order copies from the AANS or print articles off the Web site and send them to the local TV news show with a note to say you're interested in talking about strokes. On a slow news day, you're in business," says Dr. Pelofsky, one of the owners of the Oklahoma City Spine Hospital.

Dr. Pelofsky's outreach is paying off. His hospital, owned and operated by physicians, is close to 100 percent occupied and will expand by six beds to 18.

Making yourself accessible to the media and community groups will steer patients to your door.

"You have to position yourself as the expert in your community," says Kristi Sykes, director of marketing for Knoxville, Tenn.-based Doctors Management, a health consulting firm. "Send out what we call 'technical-based alerts.' These can be case studies, updates on new technology, drug treatments."

Neurosurgeons need to show initiative. Build a relationship with the local media and reporters will come to you when a neurosurgery-related story breaks. Concentrate on the local newspapers and radio and TV stations, most of which carry a "health

beat" feature. Find out who the reporter is who covers health and position yourself as an information resource.

"Once you establish a positive relationship with the media, they will return to you when they need a spokesperson for a story," says Susan Nowicki, director of communications for the AANS.

Consider a Proactive Approach

- Write a column, op-ed or letter to the editor for your local newspaper.
- Suggest health segments for local radio and TV shows.
- Send a copy of the *Neurosurgery Today* insert from *USA Today* and offer yourself as a resource on stroke, back pain or other neurological condition.
- Sign up as a member of the AANS Spokesperson Network. (See story on page 18.)

In dealing with the media, communicate key points. Punctuate your points with phrases such as "the bottom line is ..." or "the most important thing to remember is ..." to ensure your message is getting across.

Precisely because the public associates neurosurgeons only with brain surgery, neurosurgeons need to be visible in the community, not just once or twice but often.

"Don't expect an immediate response," says Rebecca Anwar of the Sage Group in Philadelphia, a health consulting firm. "Marketing is a continuous process." ■

appointments. It should provide directions to the office and include information on billing policies and insurance matters. An interactive site can offer on-line appointment scheduling and the completion of registration forms in advance of an office visit.

Best of all, market your marketing tool. Announce the site in press releases to newspapers and flyers to patients and referring physicians. The Web is hip. Having a site in itself is a positive attribute.

One more external audience needs to be considered. Forming relationships with competitors can be productive. Orthopedic surgeons, chiropractors and radiologists frequently refer patients to neurosurgeons.

The Cost of Marketing

Some marketing strategies cost absolutely nothing, such as improving relationship with patients by being more friendly and accessible. More involved strategies such as surveys can cost tens of

thousands of dollars. Hiring a consultant and initiating a multiyear, full-blown marketing blitz can be quite expensive. Neurosurgeons intent on maximizing their marketing potential should allocate 3 to 8 percent of their gross income on marketing, says Anwar.

Another option is to appoint someone from the office staff with a marketing background to coordinate on a part-time basis the marketing initiative. Though the time investment for a neurosurgeon would still be substantial on the front end, this would free up time down the road.

Questions about the cost of marketing are really secondary to the cost of *not* marketing. Patients demand more today. Neurosurgeons ignore reaching out to them at their peril.

"People are becoming more sophisticated, more skeptical," says Anwar. "They need to be reassured. Marketing is an educational process and a reassuring process." ■

Jay Copp is staff editor of the AANS *Bulletin*.

Making Their Mark

Two Neurosurgeons Earn Recognition

Colleagues Hail Dr. Florin for Contributions

For years a small core of neurosurgeons have worked behind the scenes on reimbursement issues, representing the interests of neurosurgery. One of the most effective and knowledgeable experts on coding is Robert E. Florin, MD, whose tenure with the AANS RUC Advisory Committee ends next spring. Dr. Florin will remain an important resource for these issues, but his colleagues want to take the opportunity to salute him for his tireless efforts.

"Dr. Florin is probably one of the most knowledgeable physicians in the United States about the CPT system and RBRVS [Resource-Based Relative Value System]," says John A. Kusske, MD, AANS Vice President and former Chair of the AANS Managed Care Advisory Committee. "He has developed a detailed knowledge of the fundamental workings of the system and has developed original techniques to analyze the RBRVS. He is sought



after by all medical specialties for his knowledge."

Dr. Florin participated in the AMA's five-year review of Medicare's RBRVS, playing a crucial role in the recommendations submitted to the Health Care Financing Administration. For this service and other roles, he received the 1996

Distinguished Service Award from the AANS.

The AANS/CNS Joint Officers recently sent Dr. Florin a letter saluting him for his service to neurosurgery.

"Dr. Florin became a world-class expert in coding, reimbursement and in the workings of HCFA," says Stewart B. Dunsker, MD, AANS President. "He understood the process and the people. By sheer volume of work and by displaying dedication that is unrivaled, he mastered the entire scene and all the databases."

ABC Documentary Showcases Neurosurgeon

A network prime-time TV audience watched a neurosurgeon in action when he performed a hemispherectomy on a three-year-old girl at Johns Hopkins Children Center in Baltimore. The gripping drama was part of ABC's *Hopkins 24/7*, a six-part documentary series that aired in the late summer and fall. The show highlighted neurosurgery, allowing millions of Americans to see a delicate, life-altering procedure performed by a neurosurgeon.

This was not the first time Benjamin Carson, MD, chief of Pediatric Neurosurgery at Johns Hopkins, drew attention. In 1987, he was the primary neurosurgeon among a 70-member team that successfully separated seven-month-old German twins joined at the brain. The 22-hour operation to separate the Siamese twins was believed to be the first time hypothermia was coupled with circulatory bypass and deliberate cardiac arrest to spare brain tissue. In 1997, he led a team of doctors in South Africa in the first completely successful separation of vertical craniopagus twins from Zambia.

But it's not the headlines that motivate him. "The most satisfying part of the job is being able to walk out to those extraordinarily anxious parents who never believed that anything good was going to happen and to be able to tell them that their kid is doing great," he said in a live chat on ABCNews.com after the show.



Dr. Carson has performed 80 hemispherectomies. Johns Hopkins is a leading center of the procedure, performing one to two of the surgeries every month. The first hemispherectomy was performed by neurosurgeon Walter Dandy, MD, at Johns Hopkins in the 1920s.

Dr. Carson said he saw Alex in July along with other children he has operated on at a hemispherectomy reunion.

"Alex has done extraordinarily well—no more seizures and rapidly progressive development. The vast majority of the patients are just doing spectacularly," he said.

The TV program showed Alex's parents anxiously asking Dr. Carson basic questions the morning of the surgery. Dr. Carson said those questions had been answered for the parents before.

"Frequently, during periods of great anxiety, people will forget and we always say we have to tell them the same thing three times before it sinks in," he said. "I think it is very important for physicians to educate patients. I think the days of the doctor dictating should be gone, hopefully, because the most important thing that a person has is their life and their health and they should be fully informed so that they can be an active participant in their own health care."

Neurosurgery

Before and After Managed Care

A Father and Son Assess the State of Their Profession

A recent Newsweek story on "An Ailing Profession" profiled two physicians, a father and son, who deplored the era of managed care and fondly looked back to a simpler, more satisfying healthcare environment. The Bulletin asked doctors Fred A. and James A. Killeffer, father and son neurosurgeons who practice together in Knoxville, Tennessee, to assess the state of their profession.

Managed Care Is Nearly Unmanageable

FRED A. KILLEFFER, MD

In some ways, those were the good old days. After my residency, I began my neurosurgical career in 1969 as a salaried member of the UCLA/Wadsworth VA program in Los Angeles. I did a small amount of private practice to supplement my income. I had no bookkeeper or secretary. So I asked someone else's billing clerk to send out statements. When checks arrived, I put them in my personal checking account and I paid the billing clerk a few dollars a month. It was as simple as that.

Three years later I returned to East Tennessee and established a professional corporation with an established neurosurgeon in Knoxville. We had two employees, a bookkeeper/receptionist, and an office manager/transcriptionist, who also kept our hospital charts up-to-date. Two more neurosurgeons later joined us, and we opened a second office and hired two more employees.

In the 1970s and early '80s we handwrote our charges and collections in a spiral notebook, a page per day for each side of the ledger. At the end of the day you could quickly add up the volume of business and the amount of revenue. At the end of each month, the bookkeeper and secretary took a day to type out bills and mail them. They did not enjoy this day, but it was only once a month.

Most patients in that era had some insurance. When the insurance did not pay our full fee, we were allowed to "balance bill" and the patient paid on a monthly basis. Occasionally, social agencies paid a reasonable fee for indigent patients.

Sometimes the local medical society asked me to review charges

by other neurosurgeons that the patient or insurance companies protested as excessive. If it was significantly more than I charged, the medical society asked the other neurosurgeon to reduce the fee. This was the only form of "repricing" of which I was aware.

Pre-approval was never required. We could put patients into the hospital whenever and wherever we desired and do the tests and surgery we deemed necessary. Patients with back pain and/or radicular pain, for instance, were hospitalized for several days of physical therapy and a myelogram was done. We waited a day or two to operate and kept the patient in for another four or five days post-operative. The patients sometimes would even be given an overnight or weekend pass to go home while the hospital continued to bill and collect from the insurance companies.

The Past had Problems, Too

The downside of allowing physicians full authority was the opportunity for abuse. This was manifested by:

- Unnecessary hospitalization for the convenience of physician and patient. In my internship in the late '50s, children were actually put into the hospital so that their parents could go on vacation.
- Unnecessary surgery was sometimes done.
- Excessive charges were billed and often collected.
- Diagnostic procedures, often unnecessary, were done on demand simply to avoid a confrontation with the patient.

I saw these abuses very clearly and I am sure most of my colleagues saw them. Most of us did not engage in these abuses, but we did see them happening and usually did little about them.

In the early '80s I regularly attended the leadership conferences of the American Medical Association. I was then Chief of Staff at the University of Tennessee or president of the county medical society. Representatives of the Reagan administration told us that medical care costs were inflating at a rate more rapidly than other sectors of the economy and they would change this. Insurance companies had little incentive to keep costs down. They simply increased premiums to cover costs, which gave them more money to invest and thus improve their bottom line.

Thus the government's goal to decrease medical costs and increase access to medical care and the abuses by physicians, patients and insurance companies led to progressive changes. And eventually to the current flawed system.

The problems began when Medicare required universal adherence to their fee. Other third-party payers followed suit and became more careful about variations in fees. Employees demanded better medical benefits and employers balked at the rising premiums. To

avoid increasing premiums, insurance companies lowered reimbursement schedules. In turn, crafty physicians (individually and in small groups) reacted by “gaming” the system. The growth of managed care groups brought thousands into the system who, while they provided no medical care, had to be supported out of the overall healthcare budget. The rest is history—and our present state.

The Impact of Managed Care

How has all of this impacted my practice?

- My collection rate, which from 1988 to 1996 averaged between 78 and 88 percent, plummeted. It now hovers near 45 percent. This occurred without any significant change in my charges.

“Much of my time ... is consumed justifying management decisions to case managers and insurance adjusters.”

- Our two-man practice requires five and a half employees to keep up with the extra phone calls and paperwork required for precertification scheduling and for documentation, in addition to bookkeeping, patient scheduling and transcription.

- Much of my time, and even more of my nurses’ and bookkeeper’s, is consumed justifying management decisions to case managers and insurance adjusters. We must patiently refute their arguments, no matter how

ridiculous or trivial they may be. Just getting a human voice on the phone is often a frustrating undertaking.

- Hospitals have reacted to financial pressures by laying off personnel. It is increasingly difficult to schedule surgery and diagnostic studies. Hospital employees are overworked and frustrated.

Technological advances over the last 35 years have resulted in easier, more certain diagnosis and quicker, more technically satisfying operations. The medical and surgical aspects of the practice of neurosurgery are improved. However, the economic and management restraints have forced everyone to work harder, accomplishing less, earning less and obtaining less satisfaction.

Perhaps most distressing is the major part we physicians played in getting us here. Too many became obsessed with financial gratification and turned away from more noble goals. All of us are paying the price. Reversing the trend will be difficult. We must first dedicate ourselves to noble goals and then convince society of our dedication.



Doctors Fred A. (left) and James A. Killeffer say managed care leaves less time for the medical aspect of their practice.

Helping People Amid Piles of Paperwork

JAMES A. KILLEFFER, MD

My neurosurgical career has been entirely within the era of managed care. Thus the impact of managed care on the profession is somewhat difficult for me to appreciate. What I can understand is how managed care affects the reality of the practice of neurosurgery, in contrast to my expectations on entering the field. What I think is important to keep in perspective is that changes in the business management of healthcare should have very little effect on what being a neurosurgeon means.

I chose medicine and neurosurgery as a career for reasons that I am sure are common to many physicians and neurosurgeons. Medicine was a good way to cultivate my interest in science while providing a service to others. Growing up, I saw that my father and grandfather, a general practitioner, worked very hard. Yet they appeared to enjoy practicing medicine, held the respect of their patients and the community and found satisfaction with their role as hard-working but well-appreciated physicians. Although they shared their experiences about practicing medicine with me, busi-

ness and financial concerns were seldom mentioned. I entered medicine expecting to work harder than most people but also to enjoy the intellectual stimulation and sense of accomplishment that I thought came with being a good doctor.

Although I observed some neurosurgical procedures by spending time with my father prior to medical school, I first experienced it directly on a fourth-year medical school rotation. The logical sequence of neurosurgical diagnosis, the gratification of being able to treat problems effectively and the intellectual challenge of neurosurgical science appealed to me.

Residency training was not a disappointment. The primary challenges were to learn to effectively diagnose problems, learn neuroanatomy and surgical techniques, participate in research and learn the art of effective doctor-patient interaction. Although residency was very hard work, learning these skills and applying them was in line with what I had expected entering the field. Interestingly, in retrospect, I was exposed to very little about the socioeconomic aspects of neurosurgery during residency, and as I entered practice I looked forward to a challenging career practicing the science and art of neurosurgery.

Impact Painfully Clear

The reality of managed care and its impact on neurosurgery have become painfully evident to me in private practice. Diagnosing neurological problems, treating them correctly and helping patients and families understand and deal with difficult situations often seems only a minor part of my job. Demanding a great deal of time and effort are documentation beyond what is reasonably necessary, seemingly arbitrary roadblocks to necessary care and difficulty securing appropriate reimbursement.

Many neurosurgeons who I expected to be colleagues and competitors at providing superior care instead appear to often focus on vying to secure patient populations with the best reimbursement. They avoid challenging clinical situations because they reduce practice efficiency and increase liability.

I have found it necessary to devote considerable time and effort to learn to properly bill for my work, to avoid mistakes that could cost thousands of dollars or even be considered criminal. Courses and publications encourage neurosurgeons to reduce their workload by hiring physician extenders to take medical history, do physical exams, explain surgical procedures, make daily rounds, perform parts of operations and even completely perform some simple procedures. In short, I sometimes seem to be more of a businessman than a physician.

It makes sense to me that third-party payers, politicians and the public regard physicians as merely part of the supply chain of healthcare delivery rather than those most responsible for healthcare delivery. I can understand why many patients, whose health insurance is part of an employment benefit or government program, often demand superfluous tests, unnecessary procedures and

overly expensive medications rather than trusting the judgement of their physician. Physicians, feeling pressure to produce revenue and please their consumers, too often oblige.

Third-party payers, on the other hand, have as their primary goal limiting the flow of resources. They show minimal consideration for the welfare of patients or doctors. As a neurosurgeon in this environment, I am frequently disappointed that I cannot simply formulate a diagnosis, order confirmatory tests, treat problems as necessary and follow up appropriately. The logical intellectual process and human interaction that attracted me to neurosurgery are often hopelessly diluted by the Byzantine architecture of managed healthcare and lack of trust among doctors, patients and payers.

Away from Managed Care

One of my few experiences away from managed care is through a local clinic for people who can neither afford private insurance nor are eligible for government supported coverage. Patients pay a small percentage of the cost of their care; private contributions and donations of time and resources from physicians and hospitals account for the rest. Since the patients are of limited means and pay some percentage of the cost out of their own pockets, providers are directly responsible to them to provide good care as inexpensively as possible. The patients are generally cooperative, undemanding and appreciative. The primary care providers tend to refer patients only after a thorough primary work-up and delineation of a clear reason for neurosurgical referral. Documentation is limited to what is medically prudent.

Although the neurosurgical problems are often challenging, there are no third parties standing between the physician and the patient. I interview and examine patients, order only the most necessary tests and perform only the most necessary procedures. Although there is little financial gain, caring for patients in this environment is as close as my practice comes to approaching the expectations that I had entering neurosurgery.

Realistically, I expect that the majority of my neurosurgical career will remain within the superstructure of some form of managed care. I believe that through most of his career my father focused on what I consider the essence of neurosurgery—careful clinical diagnosis, judicious diagnostic testing and conscientious application of surgical therapy. My generation is encumbered with the burdens of dealing with third-party payers, healthcare management systems and dubious patients.

Even though we don't hear a lot about it, my guess is that my father's generation had their own set of frustrations encumbering their practices. I imagine that permutations of managed care will continue to create new burdens in the practice of neurosurgery as time goes by. The real challenges and rewards of being a neurosurgeon, however, will remain in diagnosing and treating people with neurosurgical disease. ■

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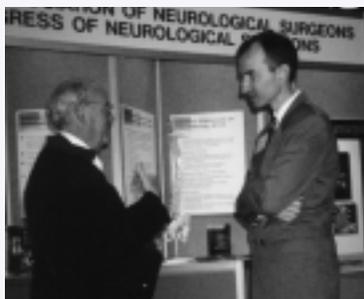
Destination Dallas: AANS Reaches Out to Family Physicians

The AANS/CNS reached out to 4,500 family physicians at the 2000 Scientific Assembly of the American Academy of Family Physicians in September in Dallas. Staff distributed literature explaining the role of neurosurgeons in treating the cervical spine, Parkinson's disease and other health concerns.

Three Texan neurosurgeons—AANS members Alex B. Valadka, MD, of Houston; and Richard Henry Jackson, MD, and Howard W. Morgan Jr., MD, of Dallas—mingled with family physicians to discuss referral matters and treatment options.

"The presence of the AANS and CNS helped inform family physicians that neurosurgeons do more than just brain surgery," said Heather Monroe, AANS communications manager. "We want them to associate neurosurgeons with low back pain, stroke, Parkinson's disease and other conditions."

Along with the neurosurgeons, Monroe and Jay Copp, AANS communications specialist, staffed the booth for the three days the Exhibition Hall was open. Meeting with family physicians gave them the opportunity to assess interest in various patient and physician education brochures.



Alex B. Valadka, MD (right), chats with a family physician at the 2000 Assembly of the American Academy of Family Physicians.

Based on the number of handouts and promotional items distributed, an estimated 800 family physicians visited the booth.

While other exhibitors lured family physicians to their booths with cappuccino, ice cream or smoothies, the AANS/CNS relied on a trinket with enduring popularity: its anatomically correct spine key chain. At a loss to locate a spine model for their office, several doctors said they use the key chain as a teaching tool. "This is much better than a picture out of a book," said one doctor.

The next AANS/CNS exhibit will be seen at the American College of Physicians – American Society of Internal Medicine meeting in the spring of 2001. ■

A Terrific Time in Toronto

69th Annual Meeting Promises to be Exceptional

BY JAY COPP

Oh Canada! The AANS 69th Annual Meeting April 21-26 in Toronto will offer highly useful practical clinics, inspiring special lectures and courses, 128 oral abstracts selected from a record-breaking number of submissions and, as always, the chance to catch up and network with colleagues and friends.

That's not all. Two more attractions are NBC's Tom Brokaw, the Cushing Orator, and Toronto itself, an acclaimed cosmopolitan city of diverse charms.

"The meeting promises to be absolutely superb," says Paul C. McCormick, MD, Annual Meeting Chair. "We are presenting a first-rate scientific program, an impressive array of technical exhibits and a number of social events that highlight the best of Toronto."

This may be the 69th annual meeting, but neurosurgeons, typically ahead of the curve, will be celebrating the 70th anniversary of the AANS. The association was founded on Oct. 10, 1931, as the Harvey Cushing Society by pioneers in neurosurgery. The present-day AANS continues to be pioneering, advancing the specialty of neurosurgery through innovative programs. The theme of the 69th

Annual Meeting is "Leading Neurosurgery Through Science, Education and Innovation."

The clinics and seminars will enable neurosurgeons to gather new knowledge and solidify areas of expertise.

"The scientific program offers a comprehensive and innovative variety of topics that address the contemporary issues in neurosurgery," says William A. Friedman, MD, Scientific Program Chairman. "The most advanced techniques and procedures from all areas of subspecialties will be featured in the scientific sessions and exhibits."

The three dozen practical clinics are in-depth, hands-on sessions taught by neurosurgical leaders. The five new clinics are "How to Evaluate a Job for Residents," "Skull Base Tumors," "Transoral Approaches to the Spine," "Coding the Basics" and "Evidence-Based Medicine."

The Breakfast Seminars offer plenty of food for thought as well as food for the body. The 71 seminars run the neurosurgical gamut.

Three special lectures will be given. Albert L. Rhoton Jr., MD, of the University of Florida will be the Schneider Lecturer on Monday, April 23. Canadian neurosurgeon Alan R. Hudson, MD, will be the

Snowed Over by Toronto

For those who think Canada is all about hockey and snow, Toronto by itself diminishes the stereotype. Peter Ustinov described it as "New York run by the Swiss." The world-class city offers a startling mix of cultural and culinary attractions. Canada's largest city (3.2 million people in the metro area) is the nation's center of culture, commerce and communications.

- After New York and London, Toronto is the third most important theater city in the English-speaking world.

- The rich restaurant scene reflects the cosmopolitan character of the city. Besides its Little Italy, Little India and half a dozen Chinatowns, the city is proud of its many Southeast Asia establishments.

- The Harbourfront features cafes, a bustling antiques market and some of the finest shopping in North America.

- The CN Tower is the city's unmistakable urban icon, a fluted concrete column that soars over the nearby SkyDome 1,815 feet into the air.

- The Royal Ontario Museum is the nation's largest museum with six million objects displayed in more than 40 galleries.



The CN Tower rises above the SkyDome.

- The city is known as "Hollywood North" by virtue of the many major films made here in recent years.

- The average daily high in April in Toronto is 53 degrees and the low is 38, so leave those parkas at home.



Visit the AANS Member Resource Center in Toronto to get your questions answered or to get information on programs and services.

Special Lecturer on Tuesday, April 24. Dennis Choi, MD, will be the Hunt Wilson Lecturer on Wednesday, April 25.

Tom Brokaw, the anchor of NBC *Nightly News* since 1982 and author of the bestseller *The Greatest Generation*, will give the Cushing Oration on April 24.

A record-breaking 1,116 abstracts were submitted for presentation. The Scientific Program Committee selected 128 to be presented at plenary, scientific and section sessions. Another 560 were selected for poster presentations.

The meeting concludes with three special courses on Thursday, April 26. Peter McL. Black, MD, PhD, of the Children's Hospital in Boston will moderate "Advances in Neurosurgical Imaging." L.N. Hopkins, MD, of Buffalo, N.Y., will moderate "Endovascular Surgery versus Microsurgery." Curtis A. Dickman, MD, of Phoenix, Ariz., will moderate "Minimally Invasive Spine Surgery."

New this year is an incentive program for handing in the Annual Meeting evaluation forms (See sidebar). Prizes include a five-night hotel stay at the 2002 Annual Meeting, complimentary registrations for the 2002 Annual Meeting, a pair of round-trip airline tickets to the 2002 Annual Meeting, AANS gift certificates for AANS products, one-year dues renewal and free admission to the wine and cheese reception.

Registration Details

The registration and housing reservation deadline for the Annual Meeting is March 16. Advance registration materials are being mailed in January. For information, call (888) 566-AANS or visit www.neurosurgery.org/meetings/2001. ■

AANS Solicits Feedback

The AANS is stepping up efforts to ensure its Annual Meeting and coding courses meet members' needs. Surveys will be sent to randomly selected participants to assess the impact of these programs on clinical or office practices.

The AANS' Education and Practice Management Department is reviewing the data sources that help it plan continuing medical education. These sources include literature research, current trends in neurosurgery, past program evaluations, federal regulatory issues, practice management and reimbursement needs, annual educational surveys, focus groups, committee recommendations, and clinical and technical developments. Data from needs assessment are translated into information, which is then presented as a product proposal. Needs assessments continue from the inception of the educational concept through implementation.

In medical terms, one can consider the educational needs assessment as part of the initial assessment, objectives as the diagnostic entity, the design of the program as the plan for patient care, delivery methodology as the implementation of the plan of care and the evaluation as the effectiveness of the treatment provided. Needs assessment appears as the first step. Yet as with patient care evaluation, it proceeds as a continuum.

Please complete the survey if you receive one. The AANS depends on your feedback in offering excellent continuing medical education.

Neurosurgery Tells Its Story

AANS Launches Media Outreach Program

BY HEATHER MONROE

What is it that attracts the media to the story of neurosurgery? The interesting fact that 70 percent of procedures AANS members perform are spine related. The fact that neurosurgeons have a role in treatment of disorders such as epilepsy, Parkinson's disease, low back pain, cervical spine, craniofacial abnormalities, sports-related head injuries, carpal tunnel syndrome, stroke and much more. Neurosurgeons indeed have a story to tell.

The AANS has positioned itself as the spokesorganization for neurosurgery and continues to pursue ongoing media coverage and recognition of the specialty from the public. As the spokesorganization for neurosurgery, the AANS is telling the story of neurosurgery and media nationwide have taken note. The AANS received extraordinary media coverage earlier this year during the AANS Annual Meeting in San Francisco. ABC's *Nightline* taped and broadcast interviews with members and neurosurgery has been featured on CNN, Reuters, ABC radio, WebMD, drkoop.com and more.

The media coverage encompassed scientific research breakthroughs including neural stem cells for cancer treatment and spinal cord injuries, the risks of stroke from cocaine use, Glasgow Outcome scale as a predictor of long-term brain injury, robot-assisted microsurgery, pituitary tumors and brain tumor metastases in breast cancer patients. In addition, over 15 million listeners nationwide tuned in to 45 AANS members' neurosurgery-focused radio interviews recorded during the AANS Annual Meeting.

AANS Forms Spokespersons Network to Assist Journalists

Reporters want to know what exactly is neurosurgery. How can a reporter get a neurosurgeon to comment on a story he or she is writing? Months ago, the AANS identified the need to develop a national spokespersons network to assist journalists across the country with these very questions. Within a few months, the AANS National Spokespersons Network was established and now comprises 46 AANS members from across the country who are prepared to assist reporters with stories on stroke, pain management, cerebrovascular surgery, pediatric neurosurgery, spine and much more.

Approximately 20 members of the AANS Network participated in media training held during the CNS meeting in San Antonio. Network members honed their skills on everything from how best to present themselves on camera to developing targeted talking points. Additional media training sessions will be offered in April 2001 during the AANS Annual Meeting in Toronto.

Other Media Initiatives

To keep the Spokespersons Network on its toes, AANS is actively involved in proactive media relations efforts concentrating on a number of initiatives including distributing camera-ready newspaper feature stories, pitches to national media and monthly mailings of press releases highlighting articles in the *Journal of Neurosurgery*.

Four camera-ready feature stories were distributed in early September to approximately 2,800 daily and weekly newspapers nationwide. They covered such topics as sports-related head injuries, low back pain, stroke prevention and Parkinson's disease. The AANS will monitor media pickup of these releases over the next year.

The first scientific press release related to the *Journal of Neurosurgery* was on "Catheter Manipulation Within the Brain." Distributed in August, the release was also posted on the AANS Web site. The press release has received ongoing media interest including an interview of study co-author AANS member Sean Grady, MD, on eYada.com's *The Doctor is In*. Other media calls came from *Medtech Insight*, *HealthScout*, *Clinical World Medical Device and Diagnostic News* and *Biophotonics International* magazine.

AANS has also responded to recent high profile stories in the news through distribution of press releases that position AANS as an informational resource for the media. For example, AANS distributed a press release to medical/health reporters nationwide, outlining stroke symptoms after the misdiagnosis of former president Gerald Ford.

Media Awards

To generate increased public and media exposure for the field of neurosurgery, the AANS Public Relations Committee is developing a new media awards program. The project will recognize journalists for their reporting of neurosurgery stories in print, radio and television. The awards, which will become an annual event, will be first presented at the 2001 AANS Annual Meeting in Toronto. The event will include a panel discussion with reporters that should lead to additional coverage of neurosurgery.

"What better way to actively promote the field of neurosurgery than directly to the journalists," said Ronald Warnick, MD, AANS Public Relations Committee Chair. "The media awards program gives AANS the opportunity to interact one-on-one with journalists, educating them about the broad scope of the specialty and the important ground-breaking work of a neurosurgeon."

AANS members, reporters and the general public are encouraged to visit the Media Center section of the AANS Web site for the most up-to-date news from the AANS. ■

Device Forum Launched

AANS/CNS Provide Input on New Products

The inaugural meeting of the AANS-CNS Neurosurgical Device Forum was held on July 30-31 in Gaithersburg, Md. The Forum was established to facilitate communication and input to the Food and Drug Administration (FDA) as well as with representatives from industry. One primary goal is to provide feedback on newly developing products and technologies relevant to neurosurgery. This activity is intended to provide the FDA with initial input for decision-making processes related to the review and approval of neurological devices or procedures, as well as for ongoing guidance document and standards development. A similar group in orthopedic surgery has significantly impacted the communication among various organizations to the benefit of all involved.

Representatives Selected

Neurosurgeons involved in research and development of devices in the rapidly changing fields relevant to neurosurgery were selected as members. Richard G. Fessler, MD, PhD, chairs the Forum with additional participation from Allan Friedman, MD; Phillip L. Gildenberg, MD; Alan R. Cohen, MD; Kevin T. Foley, MD; Isabella Germano, MD; and Ted Jacobs, MD.

Representatives at the CEO or chief of regulatory affairs level from seven of the major device manufacturers attended the initial meeting, including Sofamor Danek, Medtronic Neurologic, Codman, Target Therapeutical, Stryker, Sulzer-Spine Tech and Integrated Surgical Systems.

FDA Highlights

David Feigal, MD, Director of the Center for Devices and Radiological Health (CDRH), opened the Forum by expressing

his appreciation for neurosurgery's effort to provide review, insight and input into FDA's process. Several other high-ranking CDRH officials joined the meeting including Bernard Statland, MD, the new Director of the Office of Device Evaluation (ODE); Larry Kessler, ScD, Director of the Office of Surveillance and Biometrics; and Donna Lochner, CDRH Deputy Director. Representatives from all Division Branches (Plastic and Restorative, Orthopedic and General Surgery) that review neurological devices presented summaries of the devices they oversee and discussed current related branch activities.

Celia Whitten, MD, presented an overview of the FDA mission, the structure of ODE and the roles and responsibilities of the Division of General, Restorative and Neurological Devices that she directs. Janine Morris, a biomedical engineer and Reviewer for the General Surgery Device Branch, provided an explanation of the device process, classification system, use of guidance documents and consensus standards as well as a rundown of existing neurological device items. FDA staff also provided updates on several important issues currently affecting neurosurgery. Larry Kessler, MD, Director of the Center for Biologics Evaluation and Research, presented an overview of the new guidance document, "Reuse of Single Use Devices."

Recent activities in the oversight of Institutional Review Boards and the protection of human research subjects were also discussed. Particular concern was expressed regarding HHS's efforts to authorize the FDA to levy civil monetary penalties of up to \$250,000 per clinical investigator and up to \$1 million per research institute for violations of patient protection agreements. Such penalties

would not be covered by malpractice insurance, leaving surgeons with no ability to indemnify themselves. Members advised FDA that this would cause research to become a huge personal gamble. The end result would be a dramatic halt of biomedical research in the United States.

Future Areas of Need

At the request of FDA, an overview and report of personal experiences with vertebroplasty procedures was given to FDA staff. FDA has been conducting ongoing review of this procedure looking at how the bone cement is mixed and applied as well as its safety and efficacy. The Forum agreed that it would begin exploring the possible development of a Good Guidance Document for Vertebroplasty. A work group comprised of Forum members and members from groups such as the AANS/CNS, the American Society for Neuroradiology, the American Association of Orthopaedic Surgeons and the North American Spine is currently being formed. Once in place, this group will work with the FDA to define specific areas that need to be addressed regarding vertebroplasty after which guidance development would commence.

Also discussed at the meeting were the many neurological device standards and guidance documents that have become outdated or even obsolete. Forum members agreed that they should be reviewed. Stereotactic related items are particularly outdated and Dr. Gildenberg has agreed to initiate their review and revision.

Conclusion

Panel members finalized a Forum Mission Statement, which has now been approved by the Joint Officers of both AANS and CNS. Participants agreed that the initial meeting was extremely successful and well received by FDA staff. A follow-up meeting will be scheduled for spring 2001. ■

Richard G. Fessler, MD, PhD, is Chairman of the AANS/CNS Neurosurgical Device Forum. Cherie L. McNett is Senior Manager, Regulatory Affairs, AANS-CNS Washington Office.

Task Force Postmortem

Study Suggests Ways to Cut Practice Costs

The goal of the Cost Containment Task Force, formed in 1997, was to help neurosurgeons control practice costs and to contest federal reimbursement standards. The Task Force has derived some findings, and now is an apt time to review the results of the project.

Initially an AANS project, the Task Force eventually was folded into the functions of the Washington Committee. The purpose of the project was threefold:

1. Provide information and recommendations to be used by practices in containing costs and improving their bottom line.
2. Accumulate and provide pooled and comprehensive cost data to challenge the AMA Socioeconomic Monitoring Survey (AMA SMS) survey data provided to the Health Care Finance Administration (HCFA). The HCFA uses the data to determine the costs of operating neurosurgical practices. Many believe the figures are too low and do not reflect the actual practice expenses of neurosurgeons.
3. Create a data repository for modeling and cost analysis comparisons to challenge the AMA SMS survey data.

Three neurosurgical practices were selected as beta sites to test the cost comparison analysis. A rigorous data collection process initiated by Per-Se Technologies looked at: billing workflow and processes (including charge generation, system input and claims and statement processing), collections and payment posting, and coding activity. Compliance was reviewed by looking at procedure documentation, refund policy, write-off policies and insurance-only billing. Operational or billing results were inspected by looking at collection results, A/R metrics and payer mix activity.

Managed care contracting was reviewed in offices with significant contracts. An extensive review of financial management was carried out by looking at costs.

Initial Findings

The study encountered obstacles. The data gathering process was extremely time consuming for the practices. Billing information was not obtained electronically and summary level information was limited.

John A. Kusske is Vice President of the AANS Board of Directors and former Chair of the AANS Managed Care Advisory Committee.



Nevertheless, general observations can be made. First, practice costs exceeded industry standards in many categories. Additional billing staff, cross training and system knowledge in all three practices were needed. However, charge generation and system entry was appropriate and timely as was initial claims processing. Follow-up statement processing was untimely. There were high volumes of return mail and high volumes of patient calls, raising practice expense. Limited tracking of underpayments occurred with significant potential for lost revenue.

A sampling of operative reports showed that coding was generally appropriate. But documentation for consults was often lacking and E&M undercoding was prevalent. Professional courtesy issues created compliance problems as well as insurance-only billing and credit balances. No profitability or Medicare equivalent assessments had

been performed on capitation contracts.

The review of financial management showed that employee benefit costs exceeded industry standards. All practices paid 100 percent of employee health and disability premium costs and two of the three practices funded the entire employee pension with no employee contribution. Insurance premium costs exceeded industry standards for disability, workers compensation and malpractice premiums.

The reviewers also found that periodic fee schedule updates were required in the practices since indemnity insurance still accounted for between 10 to 20 percent of the payer mix. The surveyors also stressed that pension plan restructuring be considered in order to maximize physician contributions and minimize employee costs.

Of major interest were the costs per Relative Value Unit (RVU) in each practice. The average cost was \$21.08 per RVU. The numbers for each practice were \$19.43, \$25.08, and \$18.73, respectively. These numbers compare favorably with data gathered by the AANS Practice Expense survey in a larger sample of practices. The data was collected in the same categories as the AMA SMS information. These expense groups include malpractice, office expense, medical supplies, medical equipment, tax deductible expense, administrative payroll and non-physician, non-professional payroll.

Looking to the Future

The project suggests that most practices need to take a hard look at their practice management. Expenses can be reduced in many ways to enhance the bottom line.

Unfortunately for the project, HCFA recently formulated new criteria for practice expense survey data and methodology. Only data that meets these criteria will be accepted. Therefore, collecting additional data via the Cost Containment project would be of little use. The Washington Committee has recommended that project findings be incorporated into practice management courses but that Phases II and III of the project not go forward. ■

Untangling the Web

Expand Your Practice through the Internet

You've had a physician Web page created for you through NEUROSURGERY://ON-CALL® (N://OC) or Medem; you've even developed a Web site for your practice. Patients are sending you e-mails and some want to come for treatment. What's next the step in expanding your practice through the Internet? Are you prepared for 30 or more e-mails per day? What's your policy for answering these inquiries? How do you avoid practicing medicine in another state without a license?

These are some of the issues you will face if you expand your practice through the Internet.

Be Specific

Your first step in using the Internet should be to put on your site clinical information on your subspecialty area or a specific disorder you treat. It's not realistic to promote your entire range of expertise. This information may be in the form of a clinical topic review, cases or even a grand rounds presentation. The subspecialty pages or site should be linked to other medical sites on the Web, including N://OC® and general medical index sites. An e-mail to the administrator is often all that is needed to have your site linked. More importantly, ask patient information and support sites to link to your material.

Prepare to Answer E-Mail

A well-linked Web site may generate more than 1,000 e-mails monthly. Try to answer them within 48 hours during the week. Also be sure to adhere to the new federal rules on the privacy and security of health-care information. (See page 5.)

You obviously will not be able to answer all these e-mails on your own. At our program, two nurses in collaborative

practice, one on the adult service and one on the pediatric service, answer the majority of questions.

Many of the e-mails will pertain to a medical condition. These can be answered directly or the patient can be pointed to the Health Resources section of N://OC® or other sites. Patients seeking a neurosurgeon can be referred to a local neurosurgeon or to "Find a Neurosurgeon" at N://OC®.

Some patients seek medical advice. Be

Dr. Oro' is Professor of Neurosurgery at the University of Missouri. He serves as director-at-large to the AANS Board of Directors.



careful not to provide a medical opinion online. It is still uncertain whether you are practicing medicine in your own state or in the state in which the inquirer resides. Some of these patients can be referred to clinical services in their own state or given general information about the condition.

Patients, of course, can send you records and radiographs. Once reviewed, a nurse can tell them whether a trip to your practice for an opinion would be worthwhile.

Some Internet patients will want to come to you for surgery. Additional tests that may be needed prior to surgery can often be arranged in or near the patient's own community. For studies that are specific to your institution, the test can be arranged a day or two in advance to reduce the number of visits the patient will make.

In our practice, patients make a minimum of three trips: the initial evaluation in the clinic, the surgical admission and at

least one postoperative follow-up.

A Different Kind of Bond

On first appearance it may seem that the follow-up of patients referred through the Internet will be less than normal. Actually, it may be the opposite. Your nurse will likely be in contact with the patient through e-mail and or by phone on a weekly or perhaps a daily basis. Patients referred through the Internet feel a different bond with you and your team. Once you have responded to them by e-mail, they know that this channel is open and will use it. You must be prepared to respond to this need and welcome it since it helps ensure good post-operative care.

Many patients contacting you through the Internet will never come to you for treatment. However, your response to their inquiries brings a new level of community service by our profession. Many of those who do visit for evaluation and possible treatment will become the greatest advocates for your practice. It is not uncommon for the results of a consultation with you to appear in an Internet chat room by that afternoon. Treat the patient well: bad news travels even faster than good. With planning, expanding your practice on the Net can be rewarding for both the patient and the physician. ■

Send your comments and suggestions to John Oro', MD, at oroj@health.missouri.edu.

WEB OUTREACH GOES ON

The AANS/CNS is continuing the **Disorder of the Month** feature on their Web site (www.neurosurgery.org/index.html). The latest topic for the public education initiative is concussion. Joel D. MacDonald, MD, coordinates the feature.

Coding Committee Serves as an Advocate

Brings Sense of Fairness to Reimbursement

The Coding and Reimbursement Committee (CRC), the newest iteration of joint action by the AANS and CNS, was created in January 2000. The CRC is neurosurgery's oversight body for the AMA CPT Editorial Panel and the AMA Relative Value Update Committee (RUC), both of which influence the medical payment policies of the Department of Health and Human Services' (DHHS) Health Care Finance Administration.

CRC was created within a cauldron of high emotion and acrimonious debate. It would be hard to imagine a more conflict-ed and contradictory topic than coding and reimbursement in neurosurgery in the 21st century. In a tug-of-war using CPT rules and fee schedule manipulation, Medicare and private managed care payers seek to reduce payments, while physicians seek to hold or raise them. Reimbursement for surgery, declining steadily for the past decade, remains in a tailspin that has yet to reach bottom.

For the past four years the Washington Committee has reported to the leaders and members of the AANS and CNS at their annual meetings about the fall in Medicare fees under resource-based practice expenses rules and conversion factor adjustments under the Balanced Budget Act of 1997. Major cuts in payment for the practice expense component of the Medicare Fee Schedule, which will not be completed until 2002, have driven this recent decline. All efforts taken by organized neurosurgery to stop the hemorrhage have slowed the decline in reimbursement but have not been able to reverse the trend.

Medicare is not the only source of payment problems. Commercial health insurance payments have fallen similarly, although for different reasons and by dif-



ferent mechanisms. However, they are linked by Medicare's Resource-Based Relative Value System (RBRVS). Because the RBRVS is used by a majority of payers, the cuts imposed by HCFA on surgical reimbursement reduce commercial health insurance payments. The phased reduction in all payment sources has resulted in financial strain, frustration and anger in neurosurgery practices, both academic and private, across the country.

Beyond public and private fee discounting, federal payment policy is enforced by fraud investigations of medical practices. Investigators from the Justice Department and the Office of Inspector General of the DHHS have pried into large academic institutions and small private practices, discovering errors or excesses in coding and billing, prosecuting simple misunderstanding or disagreement as felonious fraud. The profession has been transformed from an object of public respect and authority to a target for public accusation and distrust.

Determining Reimbursement

The significance of the CPT Editorial Panel and the RUC should not be underestimated, just as the threat of further loss in

Medicare payment can hardly be overestimated. The CPT Panel considers and recommends any changes sought by individual physicians, medical organizations, device manufacturers or others in the 7000 CPT codes, whether by addition, deletion, or modification. Those codes are the building blocks of payment, determining by precise description what services are rendered and how many allowable separate parts compose the reimbursable service. They translate the language of medical care into the jargon of accounting and payment. They are the tools of control or manipulation of payment policy and payment amount and thus are the source of struggle between physician organizations and HCFA for control of policy and flow of funds.

The AMA RUC is the counterpart, or other end of the seesaw, of federal payment policy for physician services. While CPT codes itemize the services eligible for payment, the RUC assigns relative values to new or revised CPT codes that represent the consensus of organized medicine as the best estimate of the relative value of each service considered. HCFA receives these recommendations from the RUC and most of the time accepts the relative values offered. Assigning a dollar amount requires applying the current Medicare conversion factor to the relative value units for the procedure, which yields a service price for each CPT code.

The CPT Editorial Panel meets quarterly to act on all requests to alter the CPT code and code modifier list. Those specialty societies recognized within the AMA Federation may designate an adviser to submit comments and give testimony supporting or opposing requests for coding changes that affect the specialty. The influence of the

specialty over CPT code revisions or additions flows through its specialty adviser. Coding changes can have powerful effects on payment, either positive or negative, and the effect is not always intuitive or immediately apparent. Many code submissions require negotiation and coordination among several specialties, since gain for one may mean loss for another. In overlapping specialties, competing strategies may threaten one another's gain.

The RUC meets three times annually to recommend relative values based on the RBRVS for new or revised codes received from the CPT Editorial Panel. The RUC serves as an interface between medical specialties and HCFA to assign values to codes. Twenty-two specialties, the AMA, the CPT Editorial Panel and the American Osteopathic Association have a voting member at the RUC, and each specialty society within the AMA has a specialty adviser at the RUC. Advisers and the committee member determine if the specialty has interest in a submitted code and may submit codes themselves for valuation. The advisers initiate and defend the valuation process based on the best available data. This includes a survey of members of the specialty society to determine work time and intensity, which are ultimately translated into a numerical value.

Coding Committee Formed

The RUC and CPT processes were handled by a small core group within neurosurgery for years. Byron C. Pevehouse, MD, responded to CPT requests for years. He parlayed vast personal knowledge and experience in CPT coding into a persuasive influence over its evolution. A decade ago, those responsibilities went to Richard Roski, MD, for the CPT Editorial Panel and to Robert Florin, MD, for the newly created RUC. Those tenures have come to an end. The opportunity existed to coordinate, expand, and support the combined CPT and RUC activities, which have such a profound influence on all neurosurgery payment for service.

Acting on the recommendation of the Washington Committee, the AANS and CNS in January 2000 approved the creation of a joint Coding and Reimbursement Committee, composed of CPT and RUC subcommittees. The goals of the committee are:

- expand the number of neurosurgeons involved in the RUC and CPT process, adding expertise, ensuring succession and reducing the individual time burden.
- coordinate information, decisions and action between and among CPT and RUC advisers, recognizing that each cannot think or act independently of the other without creating confusion or unexpected problems.
- enlist the assistance of neurosurgical subspecialties in considering CPT changes or code valuations.
- expand the oversight and support of the combined CPT activities to include both the AANS and CNS (formerly the AANS supported RUC activities alone).

Reporting Structures

The CRC is independent of the Washington Committee but acts closely with it. The CRC reports at Washington Committee meetings and joins the Washington report to the parent governing bodies. Creation of a Regulatory Affairs staff position within the Washington office, now ably filled by Cherie McNett, represented permanent staffing for the CRC. The CRC has a separate budget, including expenses for RUC and CPT meeting attendance and internal operations. But budgetary approval is gained from the parent bodies only after discussion and recommendation at the Washington Committee. This coordination with the Washington Committee has improved communication among all involved in political and regulatory affairs and broadened oversight of committee activities.

Robert Florin, MD, is the current RUC Subcommittee chair for the CRC and neurosurgery's RUC committee member. Upon completion of Dr. Florin's term in 2001, Gregory Przybylski, MD, will assume

those positions, backed by John Wilson, MD, as AANS RUC adviser and Frederic Boop, MD, as CNS RUC adviser. The CPT Subcommittee is chaired by Samuel Hassenbusch, MD, formerly a neurosurgery CPT adviser. Dr. Hassenbusch is one of only 10 elected CPT Editorial Panel members (four additional seats are reserved for payer and hospital representatives). CPT advisers and alternate advisers are John Piper, MD, Jeffrey Cozzens, MD, Michael Nosko, MD, and Patrick Jacob, MD.

Other committee members are: *CRC chair*: Jim Bean, MD; *CRC Vice-chair*: Lyal Leibrock, MD; *CPT Subcommittee*: Richard Fessler, MD; William Mitchell, MD; James Metcalf, MD; Isabelle Germano, MD; *RUC Subcommittee*: Monica Wehby, MD, and Gary Bloomgarden, MD

Section liaisons have been appointed to include the expertise and interest of subspecialties in coding and reimbursement recommendations. The liaisons are expected to provide advice on CPT and RUC issues that pertain to their subspecialty, gather feedback from leaders in the Sections, help ensure response to RUC time surveys and serve as a two-way communication link between the Section Executive Committee and the CPT and RUC advisers. The Section liaisons are: *Cerebrovascular*: Robert Harbaugh, MD; *Spine*: John Piper, MD; *Pain*: Samuel Hassenbusch, MD; *Stereotactic*: Kim Burchiel, MD; *Pediatric*: Paul Grabb, MD; *Trauma*: Donald Marion, MD; *Tumor*: Lawrence Chin, MD.

The CRC expects to be an important mechanism for building neurosurgery's future ability to interact with federal rule-making agencies. Along with federal legislative advocacy through the Washington office and interaction with federal administrative agencies such as the FDA, the CRC completes the organizational structure needed to at least try to bring sense to federal policy, fairness to payment and rationality to regulation. ■

James R. Bean, MD, a private practice neurosurgeon in Kentucky, chairs the Coding and Reimbursement Committee.

Use of Code 61795

How Reimbursement Process Failed

Current Procedural Terminology (CPT) is a dynamic process that undergoes frequent review to remain current with changing technology. On a quarterly basis, the CPT Editorial Panel of the American Medical Association meets to discuss new proposed CPT codes as well as revisions in existing codes. The panel accepted an important revision last year to 61795, which formerly described stereotactic, computer-assisted, intracranial volumetric procedures.

This stereotactic code was originally developed to describe the additional physician work in computer-assisted planning for removal of deep brain lesions. With rapid improvements in data processing speed and memory capacity, there was a substantial effort to improve this technology for greater utility as well as applicability. Both fixed and frameless computer-assisted systems have been developed to improve anatomical accuracy, reduce complications and facilitate successful treatment. Consequently, a proposal was submitted more than one year ago to revise the language of 61795, which described a similar application but with fairly narrow applicability to intracranial volumetric procedures.

Panel Accepts Revision

CPT advisers from neurosurgery and otolaryngology gave a multidisciplinary presentation to the CPT Editorial Panel to show the similarity of the work involved in code 61795 with its expanded applications to extracranial and spinal diseases. The panel revised the definition of 61795 to encompass stereotactic, computer-assisted, intracranial, extracranial and spinal navigation procedures. Since the modifications were not based on a change in physician



work, the Relative Value Update Committee did not require reevaluation of the code.

For CPT 2000, the code 61795 became applicable to computer-assisted navigational procedures in the head and spine. This code was an add-on code used to describe the additional physician work in compiling and manipulating the linkage between the imaging data and the patient's anatomy. As an add-on code, the work described by 61795 includes only intraoperative work. Therefore, one does not append the -51 modifier, as 61795 is used with a primary surgical code. However, existing codes that describe stereotactic procedures (such as 61793, stereotactic radiosurgery) already include the work of computer-assisted planning. As a result, 61795 should not be coded additionally as this work is bundled into the other stereotactic codes.

Denial of 61795

Although the payment for this revised code should not have changed, the actual payment policy for Medicare is subsequently determined by the Health Care Finance Administration (HCFA). Unexpectedly, a

change in the payment policy led to frequent denials of code 61795. One of the methods in which HCFA precludes unbundling is through computer edits. AdminiStar, a Medicare carrier, was previously under contract to maintain such edits through the Correct Coding Initiative (CCI). The specialty societies are usually not asked to advise HCFA about the appropriateness of these edits. In HCFA's evaluation of 61795, CCI edits were inadvertently created to allow use with the other stereotactic codes (in which it is actually considered bundled), but preclude use with non-stereotactic codes for which application was intended. Naturally, this led to substantial confusion as well as payment denials. Moreover, other insurance carriers also use the CCI process, further escalating the impact of this oversight.

After this problem was brought to the attention of the Coding and Reimbursement Committee, representatives contacted officials at HCFA to discuss the discrepancies. Upon review, it was determined that the edits were, in fact, inaccurate and that the payment policy will be retroactively changed. As a result, reimbursement for proper use of 61795 can be achieved in past claims in which payment was denied. Although future payment for appropriate use of 61795 should eventually become uncomplicated, the interval until the CCI edits are revised is uncertain.

The difficulties encountered with 61795 illustrate the complexity of the process through which physician work is described and reimbursed. There are multiple separate steps to creating coding and payment mechanisms. However, physician representatives are able to directly interface with only some of these processes. At the same time, active participation in the process allows effective interaction with payment policymakers when errors are encountered. ■

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

Light at the End of Tunnel

Grants Revised to Accommodate Neurosurgeons

The number of neurosurgeons involved in research has been stable or declining over the past two decades despite an increase in the number of practicing physicians and the funds available for biomedical research. Explanations for declining interest in research include an increasing proportion of students and residents with large academic debt, the increased time to prepare for a research career, a perception that research support is difficult to obtain, increased pressures to provide clinical care and inadequate time for clinicians to do research projects.

In the last decade, the number of residents in neurosurgery training has been stable with top quality candidates entering the subspecialty. The opportunity to obtain research training for our "best and brightest" during residency, however, has been threatened by several recent developments. First, nearly a quarter of training program directors believe that research does not belong in training programs, according to a survey conducted in 1998 by the Society of Neurological Surgeons.¹ Second, reluctance to pursue research training is related to reduced funding for non-clinical time in training (a problem related to HCFA funding for Graduate Medical Education). Third, surgeons are urged to increase patient volume in most academic centers simply to pay the bills.

A more subtle threat to research training during residency is the tendency to substitute clinical specialty training for research training. Folding fellowship training into the traditional training program was approved by the American Board of Neurological Surgery to encourage subspecialty growth without approving subspecialty Board certification. Thus the ABNS is willing to subordinate research training for

clinical training in the subspecialties of neurosurgery.

ABNS certification requirements provide a significant obstacle for research after training. All surgeons believe that it is essential to continue an active surgical practice to maintain skills and to pass the certification examinations. This problem, unique to surgeons, makes it difficult to commit to research after training.

Grant Programs Adjusted

In past years, the problem for neurosur-

Julian T. Hoff, MD, is Professor and Head of the Department of Neurosurgery at the University of Michigan (Ann Arbor).



geons who want to do research after residency was exemplified by the National Institutes of Health's K08 Award, designed for mentored research after training. The award required an 80 percent commitment of professional effort to research and no more than 20 percent dedicated to clinical activity for five years. This time allocation was a clear deterrent for surgeons who wanted to pursue a research career.

The NINDS recognizes the problem and seeks more neurosurgeons who are in training or recently completed training to pursue research as part of their academic life, to enhance research relevant to our specialty, to increase the translational aspects of research and to stimulate a return to academic pursuits within all training programs.

Director Gerald Fischbach, MD, appointed a subcommittee of the NINDS

Advisory Council a year ago to develop a plan to accommodate research by neurosurgeons and neurologists during their training years and soon afterward. (Robert Martuza, MD, and myself were the neurosurgery representatives on that committee). Grant programs already in existence were adjusted to resolve the problems noted above. Those programs designed for medical students were made more user friendly, including 1) suspension of loan interest payments during research training, 2) funds for travel, cost of living, supplies, etc. and 3) training for one or two years during medical school or immediately afterward.

Residents in training and surgeons who recently have finished training are included in the revision process. The new KO8a Award features competitive salaries eliminating the need for departmental subsidies, more funding for supplies, suspension of loan interest during the research years and reduced time required for research training for neurosurgeons (50 percent each for research and clinical activity). Better access to awards (such as the RO1) is also part of the plan. For those who are successful in research during training and progress from a KO8a Award to the RO1 award, payment of loan principle *as well as interest suspension* will be made available during the period of the award. These revised programs likely will be made available in 2001.

It should be noted that the NINDS budget has grown 15 percent annually over the past two years, with an anticipated increase of 15 percent during the coming fiscal year. It is hoped that Congress will continue to support biomedical research fulfilling its promise to *double* research funding over six years, commencing in fiscal year 1998. We are halfway there. There is a bright light at the end of the research tunnel. There couldn't be a better time for neurosurgeons to apply for grants from NIH. ■

Julian T. Hoff, MD, is Chair of the AANS Neurosurgery Research and Education Foundation and AANS liaison to the National Institutes of Health.

¹Gupta SK and Hoff JT: The role of research training in neurosurgery. *AANS Bulletin*, pp. 32-33, Fall 1999.

The 'I' of a Campaign Tiger

Campaign Aims to Increase Membership Support

The Neurosurgery Research and Education Foundation (NREF) will step up its efforts to advance neurosurgery. But before we peer into the future, a brief history lesson is in order.

The NREF was established in 1980 as the Research Foundation by the leadership of AANS in response to the alarming rate at which federal and private funding for medical research was being cut.

The first Research Fellowship Award, a two-year grant, was given in 1983 to provide funding for research training for neurosurgeons preparing for an academic career as clinician investigators. In 1985, the Foundation began funding a Young Clinician Investigator Award, a one-year grant, given to young faculty members for pilot studies so they could develop preliminary data to support more permanent funding from other sources.

In the early stages of the Foundation, AANS membership accepted the fund-raising challenges of supporting these grants and made a substantial commitment to the future of neuroscientific research through the establishment of an endowment fund. In 1985, the annual campaign to support the Foundation began. Since that time, AANS membership has been solicited yearly by mail for donations.

Each year, the Scientific Advisory Committee of NREF reviews grant applications and makes funding recommendations to the NREF Executive Council based on scientific merit and the value of each proposal. Although both groups would welcome the opportunity to fund all proposals that are recommended, resources are limited.

Improving the Annual Campaign

The 2000/2001 NREF annual campaign is currently in the process of revision. A key

element of the campaign is our name change. In the fall of 1999, the foundation's name was changed to the Neurosurgery Research and Education Foundation. This change was made to broaden the mission of the Foundation to incorporate the education of neurosurgeons in research, while at the same time position the NREF as a funder of basic and clinical research for neurosurgery. Hopefully the name change will help us reach all neurosurgeons.

Our goal is to increase AANS membership support above the current level of 4 percent participation. In addition to a yearly mailing and an option to donate on dues statements, leadership will participate in a peer-to-peer solicitation program. People give to people and that is why almost 80 percent of all charitable donations come from individual donors. NREF's peer-to-peer campaign will be modeled on a typical major gifts program that emphasizes the "Five I's of Fundraising."

The first "I" is easy in a membership organization and that is to *identify* the potential donor. The second "I" is to *inform* the donor about your organization. This is done through the *Bulletin*, the AANS Annual Meeting, *N:OC*® and other means.

The third "I" refers to the *interest* or motivation of donors. The Foundation has begun to address this by changing our focus to include both basic and clinical research.

Plus, for the 2001 Annual Meeting, the inaugural Hunt-Wilson Lecture has been made possible by a generous donation to NREF from Timir Banerjee, MD. Dr. Banerjee endowed this lectureship out of his desire to honor his mentors in perpetuity.

Involving the donor in your organization is the fourth "I." Most NREF donors are the leaders in neurosurgery and AANS.

The final "I" is *investment* in your donors. The investment in your donors is the difference between fundraising, which is typically a one-time event or activity, and development, which is a process. Encourage the donors to learn more about NREF and the studies we have funded. If we are able to follow the five "I's" of fundraising we should be able to receive the best member gift of all—a renewed gift.

Commitment to Research

AANS was founded on a commitment to research and training in the scientific method. NREF was founded to support research endeavors and to expand the field of neurosurgery. With the support of all AANS members, NREF can fund promising young investigators who will be at the forefront of science, representing the future of neurosurgery.

For information on contributing to NREF, contact Barbara S. Schwarz, Director of Development, at (847) 378-0540. ■

THIRD ANNUAL SILENT AUCTION

The Young Neurosurgeons Committee's Third Annual Silent Auction will be held April 23-25 during the 2001 AANS Annual Meeting in Toronto. The auction benefits the Neurosurgery Research and Education Foundation, the research division of the AANS. Please stop by the AANS Member Resource Center during the meeting to bid on the items up for auction. To donate an item for auction or volunteer to staff the auction booth, contact auction chair Larry Chin, MD, at (410) 328-3113 or lchin@smail.umaryland.edu.

Two New Publications

Educate Patients, Reduce Malpractice Risk

Two new publications from AANS will help neurosurgeons educate their patients, increase referrals and reduce the risk of malpractice claims.

A Patient's Guide to Neurosurgery, scheduled to be available this month, is a patient brochure that summarizes in lay language the many conditions treated by neurosurgeons. The *AANS Guide to Informed Consent* explains how to develop an informed consent program and includes software to set up the program. It will be available sometime this winter.

A Patient's Guide to Neurosurgery

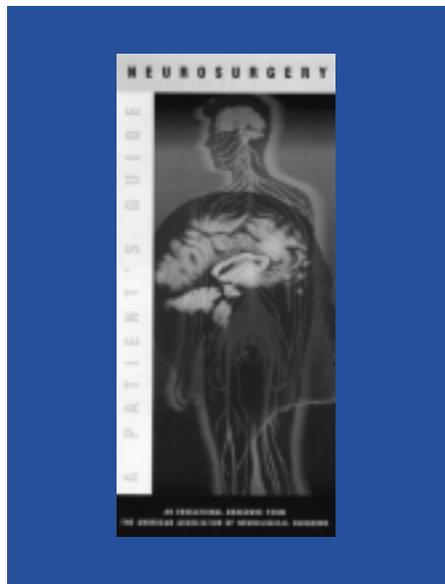
A Patient's Guide to Neurosurgery is in response to requests by AANS members for materials to build their practice. Other brochures on specific conditions such as low back pain also will be forthcoming.

The new brochure emphasizes that neurosurgeons do more than brain surgery. It also explains the extensive education and training completed by neurosurgeons.

Designed to be distributed to patients, the brochure can be mailed or handed out at health fairs, career days and lectures before community groups. It also can be sent by physicians or other health care professionals who refer patients to neurosurgeons. There is ample room on the brochure to add a label with personal practice information.

The brochure addresses:

- The Brain and Beyond: An overview of the scope of what neurosurgeons do.
- The Making of a Neurosurgeon and Becoming Board Certified: The requirements to become a board-certified neurosurgeon.



- When Can a Neurosurgeon Help: An outline of some of the specific disorders of the brain, spine and nerves treated by neurosurgeons including aneurysms, carpal tunnel syndrome, epilepsy, low back pain, Parkinson's disease and more.
- Neurosurgery—Yesterday and Today: A brief history of neurosurgery and the evolution of the AANS.
- Investing in the Future of Neurosurgery: A description of the Neurosurgery Research and Education Foundation.
- Breaking New Ground: Advances in the field of neurosurgery.

The price for a pack of 50 brochures is \$50 for AANS members and \$60 for non-members.

AANS Guide to Informed Consent

The *AANS Guide to Informed Consent* should reduce the risk of malpractice claims by assisting neurosurgeons in communicating and documenting the risks, benefits and alternatives to medical procedures.

The binder includes two sections. Part I is a guide to developing an informed consent program. Included is information on what informed consent is, how to develop an informed consent program, how to avoid common causes of malpractice claims, what to include in patient materials about the treatment, what to include in the consent document and how to archive documents.

Part II consists of sample neurosurgical documents. The documents cover diagnosis, nature/purpose of treatment, risks/complications/side effects of treatment and the risks/complications/side effects of not undergoing treatment, anticipated results and a consent form.

The samples are available on a disk, saved in word processing software that requires no installation or downloading. The cost is \$250 for members and \$300 for non-members.

To order these publications, call the AANS at (888) 566-AANS. ■

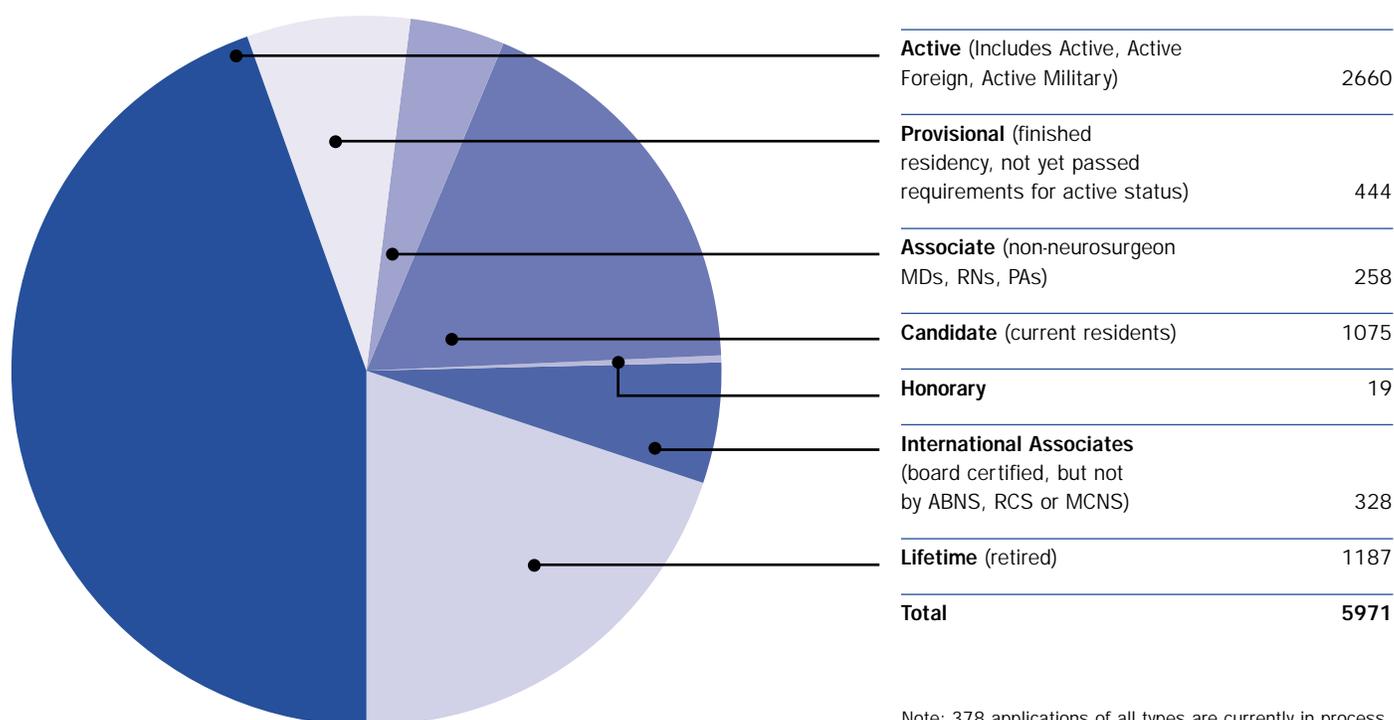


HAVE YOU CHANGED YOUR ADDRESS?

Let us know by writing us at: American Association of Neurological Surgeons, 5550 Meadowbrook Drive, Rolling Meadows, IL 60008. Or e-mail kjs@aans.org.

A Statistical Snapshot of AANS Members

A Breakdown of Membership by Type



Help Us Locate 'Missing' Members

Mail has been returned to us from the Post Office for the following members. If you can help us locate these individuals, please call (888) 566-AANS.

Apio Claudio Antunes, MD, PhD
 Jack L. Barlass, MD
 Albert D. Bartal, MD
 David Danoff, MD
 William Darmody, MD
 Laverne S. Erickson, MD
 Joel Eduardo Garcia Pacheco, MD

Adolphe Y. Gerol, MD
 Salim Y. Ghostine, MD
 John Hankinson, MD
 Scott Lee Henson, MD
 Norman C. Hill, MD
 William S. Huestis, MD
 Tetsuo Kanno, MD
 Chul-Jin Kim, MD
 Nills G. Lundberg, MD
 Richard Malmros, MD
 Marius Maxwell, MD, PhD

Helge Nornes, MD
 J. E. O'Connell, FRCS
 John C. Oakley, MD
 Rolando R. Padilla, MD
 Sadda V. Reddy, MD
 Jose Salazar, MD
 Paul Lloyd Scharf, MD
 Keisuke Ueki, MD
 Lester J. Wallman, MD
 Arthur W. Williams, MD
 Darin B. Zahuranec, MD

CSNS Takes Action

Resolutions OK'd on Helmets, Trauma Care, Education

The Council of State Neurological Societies (CSNS) passed resolutions on helmet use, trauma care funding and medical school education at its semiannual assembly September 23 in San Antonio, Texas.

The Assembly passed a resolution supporting trauma system planning and development act funding, critical to the field of neurotrauma. The resolution was referred to the Washington Committee to take aggressive action to secure funding.

The Assembly passed a resolution confirming the council's official policy on the value of using helmets during recreational activities such as riding a motorcycle, bicycle and moped. The resolution was referred for policy statements and publications from the two national neurosurgical organizations.

The third resolution was on the need to expose medical students to neurosurgical issues. The resolution was referred for report to the Communications and Education Committee of CSNS. The Committee will try to pull together the efforts of the two national organizations and the Senior Society to encourage medical schools to allow neurosurgery ingress into medical student education. The Committee will make a report in Toronto.

Risk Management Education

The Neurotrauma Committee reported on the development of risk management education in the core curriculum of public schools in various states. The Committee reviewed an attempt to pass such a law in California.

A packet on how to duplicate the strategy in California will be provided to all of the delegates, alternates and appointees of the CSNS. A second tactic is to convince various

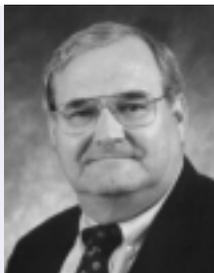
State Departments of Education of the importance of injury risk management in a public school curriculum.

The Neurotrauma Committee also reported on reimbursement for trauma coverage. The survey that was done needs to be further reviewed to assess its statistical validity.

AANS/CNS Integration Survey

The last resolution discussed was from the San Francisco semiannual assembly. The

Lyal G. Leibrock, MD, FACS, is the Chairman of the CSNS.



CSNS approved a resolution on an organizational membership survey regarding the integration of the AANS and CNS. The one-page survey was developed to determine what the membership perceives as the best form of national organization. It should have been in the mail prior to the publication of this issue of the *Bulletin*. The survey will be reviewed at CSNS' Executive Committee Meeting on March 10 in Chicago.

National Leadership Conference Set for July in Washington, D.C.

In other CSNS news, the AANS and CNS approved the first-ever National Leadership Development Conference. The conference will be held July 20-24 at the Washington Court Hotel in Washington, D.C. The event is intended to involve and invest individuals from every state to be politically active (to carry the water for

neurosurgery) among health policy staffers, senators, congressmen and state representatives. The leadership conference will teach them that as well as how to lobby elected officials. The conference includes a practice management coding course and a visit to the Hill.

The conference is a critical endeavor for neurosurgery. It is important for each state to be involved. The CSNS sent e-mails urging people who are interested in receiving this training to attend the meeting to learn from experts in the lobbying field. The goal is to establish a network of individuals the Washington Committee can use when various political issues arise. Neurosurgery may not win all the time, but at least we would have the opportunity to be heard. The Chairman and the entire CSNS encourage all neurosurgeons who are interested in this endeavor to attend the conference to receive valuable training.

Committee Reports

CSNS also heard many interesting committee reports. The Coding and Reimbursement Committee provides logistical workforce support for coding and reimbursement issues. The Workforce Committee will be addressing pediatric neurosurgical workforce issues in certain areas of the country. The use of physicians' assistants and nurse practitioners in neurosurgical practice will be assessed not only by the Workforce Committee but also by the Medical Practices Committee.

The Communications and Education Committee now is under a mandate to run the leadership conference and to promote neurosurgical education by developing access to the curriculum of various medical schools. The Young Neurosurgeons Committee is developing a survey to assess the views of residents and young physicians on recertification. This is a busy and active group that will continue to do its best to work in the social and economic arenas of neurosurgery for the entire organized neurosurgical community. ■

NEWS.ORG

AANS/CNS Sections Committees Associations Societies

SpineUniverse Site Up

The AANS section of the SpineUniverse.com Web site is now up and running. It includes information for both patients and referring physicians. AANS members can register their practices free-of-charge in the "Find a Specialist" section, which allows visitors to the site to search by specialty, geographic location and other criteria. SpineUniverse.com will also provide a link to a neurosurgeon's Web site. SpineUniverse is at: www.spineuniverse.com. For information, contact Susan Nowicki, APR, AANS Director of Communications, at san@aans.org.

Section News

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Section on Cerebrovascular Surgery The fourth annual meeting of the AANS/CNS Section on Cerebrovascular Surgery and the American Society of Interventional and Therapeutic Neuroradiology (ASITN) will be held on Feb. 9-12 at the Hilton Waikoloa Village in Hawaii. The conference also is sponsored by the Japanese Society of Surgery for Cerebral Stroke and the Japanese Society of Intravascular Neurosurgery.

Participants can obtain up to 27.5 hours in category 1 credit toward the AMA Physician's Recognition Award and view the latest technical exhibits and 100 posters. More than 400 scientific presentations and 20 state-of-the-art luncheon seminars with over 75 speakers will be part of the program.

Thirty-six oral paper presentations will be made, and two "How I Do It" sessions featuring "Management of Unruptured Aneurysms" and "Management of Arteriovenous Malformations" will be offered. Two special courses will be presented on Friday, Feb. 9. Special Course 1 is "Critical Care of Neurosurgical and Endovascular Patients." Special Course 2 is "Extracranial Carotid Reconstruction: Endarterectomy, Angioplasty and Stenting."

For information, visit www.neurosurgery.org/cv.

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Section on Neurotrauma and Critical Care The Committee on Outcomes and the AANS/CNS Section on Neurotrauma and Critical Care announced an online tool to track outcomes of patients with subdural hematomas.

The tool allows neurosurgeons to enter basic clinical and outcome data on their patients with subdural hematoma at presentation and three months later. Entered data can be compared with others using the tool, providing a nationwide benchmarking of an individual's practice.

The tool is available at: <http://research.outcome-sciences.com>. A username and password can be obtained through n:oc@www.neurosurgery.org/practicemgmt.

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Section on Pediatric Neurological Surgery Anthony J. Raimondi, MD, lost his long battle with lymphoma on June 16. There are few in pediatric neurosurgery who were not touched by his energy and devotion to our field. David McLone, MD, delivered the following eulogy for Dr. Raimondi July 28 at Children's Memorial Hospital in Chicago:

"Most of you know of Dr. Raimondi's contribution to Children's Memorial Hospital and Northwestern University. Some may not know that he was unique in that he was Professor of Surgery, Professor of Radiology and Professor of Anatomy. He also was given a chair in neurosurgery while chairman at Northwestern.

I arrived from the University of Michigan in 1965. I already knew that I wanted to be a neurosurgeon. I did not realize that I was soon to meet a man who would determine what kind of neurosurgeon I wanted to be.

My first impression of Dr. Raimondi was a man too young to be a chairman—and great hair. I think I most remember the great hair. Tailored Pucci suits, monogrammed shirts and a white coat always left open so that it flowed with his rapid gait. A gait that exuded confidence bordering on cockiness. Usually some resident or secretary was at his side struggling to keep up. On one of these jaunts I accompanied him to the parking lot where I saw my first Alpha Romeo, an Italian sport car, naturally. Years later I would acquire my own Alpha Romeo.

This was to be the hardest that I would work in my life and at the same time the most exciting part of my medical education. This man made rounds an event. We worked every other night all night and then sat in a dark room each afternoon for two hours to go over the day's angiograms. We were convinced that he had eyes in the back of his head. If your head nodded he called on you. He taught us anatomy, to think, plan and execute. During his time at Cook County Hospital he established a residency training program, the first accredited in 10 years. He was awarded a National Institutes of Health grant to study hydrocephalus in genetic mutant mice and established a research laboratory.

But it always came back to children. He knew that they were special and their neurosurgical needs were not understood or met. He would identify pediatric neurosurgery as a specialty, introduce angiography as

a diagnostic tool in children, define the vascular changes characteristic of hydrocephalus in the infant, and popularize a safe and effective means to treat it.

His arrival at Children's Memorial propelled this institution into international prominence. Dr. Raimondi established a pediatric neurosurgical service that we, the staff and children, continue to benefit from today.

Words like flamboyant, charismatic, and others have been used to describe this man.

I prefer teacher."

This article was reprinted with permission from Short Cuts, December 2000.

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AANS/CNS Section on Disorders of the Spine and Peripheral Nerves The Section has established two new research grants—the Larson Award and the Sonntag Award. The awards provide peer review for clinical research projects to improve proposals and thereby enhance competitiveness for NIH funding. The awards also establish the AANS/CNS Spine Section as a known source for quality clinical research.

The awards, which range from \$15,000 to \$30,000, are for primary investigators of planned clinical studies requiring national level funding for grant proposals and external consultations. The funds also are to help develop proposals, planning meetings and the collection of pilot data. Work that can be completed without such support, such as literature review and preliminary protocol design, should be done before applying for the awards.

The format of the proposal should follow that of the NIH grant package. Specifically, applications should not exceed five single-spaced pages. The applicants should address their specific aims, pertinent literature review and previous studies review. A plan for use of the funds and a detailed budget are required. The budget should not include salary support for the primary investigator or co-investigators.

Send six copies of the proposals to be received no later than December 15, 2001, to Michael G. Fehlings, MD, PhD, Toronto Hospital, 399 Bathurst St., Suite 2-417, Toronto, Ontario M5T 2S8 Canada.

Information is available at (416) 603-5627,

mfehlings@torhosp.toronto.on.ca or at www.neurosurgery.org/spine.

Submissions are sought for two other awards. The Cloward Fellowship Award, sponsored by Danek/Medtronic Sofamore, Danek, is awarded annually to one or two U.S. or Canadian trained neurosurgical residents to provide supplemental funds for advanced education and research in disorders of the spine or peripheral nerves in the form of fellowship training. The amount of the award is \$30,000. The deadline is September 15, 2001.

The Mayfield Award is presented annually by the Section on Disorders of the Spine and Peripheral Nerves to the neurosurgical resident who authors an outstanding research manuscript detailing a laboratory or clinical investigation in the area of spinal or peripheral nerve disorders. Two awards are available, one for clinical research and one for basic science research. Each award is valued at \$500. The application deadline is Sept. 15, 2001.

For information and submission forms, contact Keith R. Kuhlengel, MD, 1671 Crooked Oak Dr., P.O. Box 10247, Lancaster, PA 17605-4207, (717) 569-5331, kkuhleng@redrose.net, or visit www.neurosurgery.org/spine.

Why attend the 17th Annual Meeting of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves? First, you can earn up to 20.5 credit hours in category I toward the AMA Physicians Recognition Award. Second, attend scientific sessions presented by leading experts in spine and peripheral nerve neurosurgery. And, third, enjoy the many attractions of the Pointe South Mountain Resort in Phoenix, located along the unspoiled foothills of the Phoenix South Mountains. The meeting will be held February 14-17. Other highlights include pre-meeting special courses on "New Concepts and Technologies: The Impact on Your Practice" and "Management of Nerve Injury," more than 36 oral presentations, more than 100 scientific posters and more than 70 exhibits displaying the latest innovations. In addition, there will be a post-meeting resident course on the "Fundamental Principles of Spine Surgery" and a post-meeting course on "CPT Coding for Spine Surgeons."

For information, call the AANS at (847) 378-0500 or visit www.neurosurgery.org/spine.

Menezes Honored

The Section on Disorders of the Spine and Peripheral Nerves honored Arnold Menezes, MD, for his valuable contributions to the field of spinal surgery at its 2000 Annual Meeting in Palm Springs, Calif. Dr. Menezes has been active within the Section for more than a decade. He is presently Professor and Vice Chairman of the Division of Neurosurgery at the University of Iowa in Iowa City, where he has practiced for more than 25 years.

Pharmacia-Upjohn Resident Research Award Deadline

The application deadline is March 1 for the Pharmacia-Upjohn Resident Research Awards in Cerebrovascular Disease. Available to residents in training programs in North America, the award provides up to \$15,000 in support of research related to cerebrovascular disease. Funding is available July 1. For applications, contact Robert J. Dempsey, MD, Dept. of Neurological Surgery, University of Wisconsin, 600 Highland Ave., Madison, WI 53792, (608) 263-1410, massey@neurosurg.wisc.edu.

AANS/CNS Voice Concern Over Lumbar Spinal Stenosis Study

The AANS and CNS are concerned that a draft study on lumbar spinal stenosis is faulty and will promote nonsurgical intervention. The Washington Committee found fault with the draft of a study by the Agency for Healthcare Research and Quality on "Treatment of Degenerative Lumbar Spinal Stenosis: An Evidence-Based Summary and Analysis of the Literature."

The AANS and CNS issued a letter to the agency expressing concern about the draft report. Signed by Stewart B. Dunsker, MD, AANS President; Issam A. Awad, MD, CNS President; and Curtis A. Dickman, MD, Chairman of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves, the letter read in part:

"In general, the report is a thoughtful and comprehensive evidence-based analysis of the published medical literature on the topic of degenerative lumbar stenosis. ... Based on the review of the literature, the report concludes that there is very limited objective scientific evidence available, that is, a paucity of Class I and Class II evidence exists on this important health concern, which means that very few evidence-based conclusions can be drawn. This said, however, the AANS and CNS wish to raise two important points for your consideration.

"1. Management of patients with degenerative lumbar spinal stenosis with disabling symptoms requires clinical judgment and experience, and is based on the severity of neurological signs and symptoms. Large clinical experiences support the value of surgical and nonsurgical treatment for selected patients with lumbar spinal stenosis. **The AANS and CNS therefore strongly believe that the paucity of Class I and Class II data should not be used as a basis to deny patients access to surgical and nonsurgical treatment options for this disease and that the report should include a statement to this effect.** Despite an absence of formal clinical trials, patients still need to be treated for this disease and the collected observational experience of neurosurgeons definitely suggests that many patients are indeed helped by surgery. **It would be inappropriate, therefore, for this report to serve as the basis of denying these patients**

the opportunity for treatment while additional information is collected about the natural history, diagnosis and management of the problem.

"2. Neurosurgeons have extensive clinical experience with the treatment of lumbar spinal stenosis, which provides valuable information. **There is a lot we do know about this disease despite the lack of randomized, blinded study data.** For example, the anatomy, pathophysiology, and mechanics of the disorder have been clearly characterized. The neurological signs and symptoms and the extent of patient disability caused by lumbar stenosis are well understood. Lateral recess stenosis causes nerve root impingement, central canal stenosis causes neurogenic claudication, nerve root, and cauda equina dysfunction. We do know how to definitively image this disease entity with MRI and CT/myelography. Based on this information, neurosurgeons treating patients with lumbar spinal stenosis are therefore able to discern appropriate treatment mechanisms for their patients.

"There are numerous examples of successful medical treatments that have been implemented based on physicians' treatment experience rather than as a result of randomized clinical studies. ... **The final report should therefore recognize that while prospective, randomized, blinded clinical studies may be the so-called "gold standard" by which many evaluate the efficacy of medical treatments, such studies are not always required to determine the most appropriate ways in which physicians treat their patients.** Such is the case for spinal stenosis, particularly in situations where conservative management options have failed. If this report leads to the withholding of surgical treatment because this mode of treating this disease is not subject to a double-blinded study, we are very concerned that many of our citizens with progressive disability will be denied helpful intervention.

"Clearly, this report demonstrates a need for further studies that address the clinical management of lumbar spinal stenosis, and we hope that this report will encourage the funding of high quality clinical research to answer the questions that it explores. **To that end, we encourage you to include a strong recommendation in the report that specifically solicits the financial resources that are needed to conduct this research.**" ■

AANS News

Residents Given Free Membership As part of its outreach to young neurosurgeons, the AANS has decided to offer automatic membership to all domestic neurosurgical residents, free of charge. Domestic residents (those from the United States, Canada and Mexico) also receive reduced fees for meeting registrations, practice management courses and neurosurgical publications, in addition to obtaining member benefits such as the *Bulletin*.

The AANS has added 527 new and established residents since the new policy began July 1. About 120 new residents are expected to be added in each of the next two years.

The advanced registration fee for domestic residents for the 2001 Annual Meeting is \$130, \$110 less than it would be if they attended as a non-member. Residents also receive a 50 percent discount for coding courses.

The AANS has undertaken a number of initiatives to reach out to young neurosurgeons and female neurosurgeons. The AANS invited the Chairman of the Young Neurosurgeons Committee, B. Gregory Thompson Jr., MD, to participate in Board deliberations and appointed Gail L. Rosseau, MD, and Diane L. Abson-Kraemer, MD, to Co-Chair the AANS Membership Committee.

The Association also named a National Office executive staff member to serve as a liaison to each of the AANS/CNS Sections, as well as to the YNC, WINS and CSNS.

CME Courses Offered Online Using distance learning technology, AANS is partnering with Economedix, LLC, to present 21 dynamic programs that earn CME and/or CEU credits.

The courses will be offered online, via teleconferencing or "on demand" at the convenience of physicians and staff, directly into a physician's practice. The seminars address all elements of practice operations including coding and reimbursement, human resources, patient flow and marketing, compliance and Medicare, and financial management.

Each course can be viewed by an unlimited number of practice employees and physicians for

only \$99. Those who sign up for all 21 seminars can get a free personal computer and Internet service for six months.

Distance learning programs are convenient and cost-effective ways to provide education and training for neurosurgeons and their practice staff.

Upcoming courses cover changes for 2001 in Medicare, CPT, ICD-9 and RBRVS.

For information, see the insert in this *Bulletin*, call or e-mail Jane Ries of the AANS at (847) 378-0558 or jmr@aans.org or visit <http://yourmed.practice.com>.



AANS Compiles Expert Witness Transcript Library The AANS maintains an electronic library of expert witness testimony to assist members and their attorneys in malpractice litigation.

The library includes the deposition and trial transcripts both of neurosurgeons who have testified as defense experts and neurosurgeons who have testified as plaintiff's experts. The policy of the AANS is to encourage its members to testify on both sides of malpractice litigation when appropriate, and the library is not intended to aid either plaintiffs or defendants generally.

Copies of transcripts in the library are available to attorneys of AANS members. The database is searchable by witness name, not by type of case or expertise.

For information, contact Claudette Matthews at (847) 378-0504.



Head Injury Book Available A book and CD-ROM on severe traumatic brain injury now are available from the AANS. *Management and Prognosis of Severe Traumatic Brain Injury* includes updated guidelines for the management of severe head injury and the addition of a new section on early indicators of prognosis in severe traumatic brain injury. Created by the Brain Trauma Foundation and the AANS, the book addresses key issues relating to the management and prognosis of severe TBI adult patients, providing accurate and authoritative information to assist physicians in clinical decision making

The price is \$100 for members and \$125 for non-members. To order, call the AANS at (888) 566-AANS and mention order #790. ■

AANS Backs Patient's Bill of Rights

The AANS, in conjunction with the Patient Access Coalition, joined the American Medical Association (AMA) in a promotional effort to urge passage of a patient's bill of rights. The House passed a strong measure dubbed the Noorwood/Dingell bill. Senate Democrats, with the help of a handful of Senate Republicans, were attempting to force a vote on the bill in the Senate. The provisions desired by the AMA include the rights to an independent and fair external appeal of health plan decisions, holding health plans accountable when their decisions harm patients, having physicians decide what treatment is medically necessary, choosing one's own health practitioners, timely access to needed specialty care and the guarantee that these rights apply to all Americans.

Neurosurgery News

Decade of Spine and WorldSpine 2 Meeting Plans Move Forward

BY EDWARD BENZEL, MD

The Decade of the Spine project, described in the Summer 2000 *Bulletin*, has evolved into essentially two separate but intertwined projects: (1) The Decade of the Spine initiative and (2) the preparation of a World Spine 2 meeting.

The planning of the Decade of the Spine initiative is moving forward under the auspices of the Council of Spine Societies (COSS). This initiative will begin in January 2001 and end in December 2010.

There appeared to be little international enthusiasm for an international Decade of the Spine Initiative at the recent World Spine I meeting held in August in Berlin, probably because many countries and foreign spine associations are heavily involved with the Bone and Joint Decade project. This most certainly has not precluded our efforts in the United States regarding our own Decade of the Spine and the concept of an international/multidisciplinary meeting.

At the World Spine I meeting, Doctors Volker Sonntag, Rick Fessler, Steve Papadopolous, Ed Benzel, Hansen Yuan (an orthopaedic surgeon from Syracuse, N.Y.), and Eric Muehlbauer, Executive Director of the North American Spine Society (NASS), discussed the Decade of the Spine and the Council of Spine Society's involvement with the initiative. They also discussed the concept of a World Spine 2 meeting. It was agreed at a meeting of International Spine Society chairmen that World Spine 2 should take place, probably in 2003. The United States was thought to be the most appropriate location.

At a gathering of the aforementioned Americans following this meeting, it was tentatively concluded that Chicago was the most appropriate site and that plans would be made via Dr. Fessler as meeting chairman/coordinator. An orthopaedic surgeon to be named later would function as his counterpart. The AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves (Joint Section) and NASS will

tentatively jointly sponsor this meeting. This will require financial backing from both organizations and eliminate the need for support by COSS.

The concept of the World Spine 2 meeting was introduced to the international spine community at the World Spine I President's Reception and was met with significant enthusiasm. Organized neurosurgery will play a substantial role in both the Decade of the Spine initiative and the World Spine 2 meeting. Logos for each project are forthcoming. Their introduction, as well as the introduction of the Decade of the Spine concept and the plans for the World Spine 2 meeting, will coincide with the beginning of the Decade in January 2001.

Edward Benzel, MD, is Director of Spinal Disorders at the Cleveland Clinic Foundation and Chairman of the AANS/CNS Spine Focus Task Force.

Stroke Study Raises Hopes On Neural Cell Transplantation

Transplanting neural cells grown in a laboratory into the brains of stroke patients appears to be safe and may help the patients regain mobility, according to a new study authored by a Pittsburgh neurosurgeon.

Douglas Kondziolka, MD, professor of neurological surgery and radiation oncology at the University of Pittsburgh Medical Center, said more testing is needed before researchers know whether the treatment is truly effective in helping to reverse the paralysis and other impairments of stroke but preliminary results are encouraging.

According to CNN.com, Dr. Kondziolka and his colleagues followed 12 patients who had major problems after a stroke. Six months after receiving transplants of two million or six million cells called LBS-Neurons, none of the patients developed transplant-related problems or complications.

"This study was designed to evaluate if it's feasible to put these cells into the brain and whether the process is safe," Dr. Kondziolka told CNN.com. "With these positive results, now we can move on to a larger study with more patients to find out whether these transplants really help patients recover their lost abilities."

The results of the study were published August 22 in *Neurology*, the journal of the American Academy of Neurology. ■

Riding High in Colorado

Practice Deals Effectively with Managed Care

Name: Rocky Mountain Neurosurgical Alliance

Location: Englewood, Colo.

Neurosurgeons: Nine

Employees: 23

Primary Hospitals: Five

Web site: www.rmna.net

With nine neurosurgeons, Rocky Mountain Neurosurgical Alliance (RMNA) is the largest neurosurgical group in Colorado, and one of the largest non-academic groups in the Rocky Mountain West. We have found that a larger practice has enabled us to develop a greater degree of individual focus and expertise. We have been able to build very active multidisciplinary brain tumor and movement disorders programs and cutting-edge complex spine, radiosurgery, vascular, and neurotrauma programs.

This paradigm allows us to participate in leadership positions in national, regional and state neurosurgery organizations, which we view as key to the future of our specialty. We are able to engage in community service and have a strong commitment to the medically underserved. A senior partner, Gary D. VanderArk, MD, takes the lead role through Doctor's Care and Colorado Coalition for the Medically Underserved.

Our goal is to provide the best general neurosurgical care for our own community, while providing superb, accessible and responsive tertiary neurosurgical services to other communities in the Rocky Mountain West. We endeavor to build good relationships with other neurosurgeons in our region by helping them keep general neurosurgical cases in their own hospital while serving as their preferred tertiary resource option for more difficult or unusual neurosurgical problems.

Key affiliations. RMNA has always had a close affiliation with the Colorado Neurologic Institute (www.thecni.org). Since its inception by Dr. VanderArk in 1988, this non-profit community-supported neurologic institute has become one of the largest, most complete neuroscience centers in the region.

We also enjoy a close affiliation with Craig Rehabilitation Hospital, a preeminent National Model Brain Trauma Rehabilitation hospital dedicated to the care of the brain and spinal cord injured patient. These affiliations allow for ample opportunity to develop research and clinical interests in a multidisciplinary environment.

John H. McVicker, MD, is a senior partner of the Rocky Mountain Neurosurgical Alliance.



Managed care strategies. Working in a rapidly growing community with a very high proportion of managed care, we have learned to work at maintaining an aggressive business posture, careful contracting practices, and most importantly, tightly monitored practice management data. The entire group reviews income, overhead, new contracts and receivables (including claims aging) monthly.

When individual contracts come up for renewal, we are able to come to the negotiating table with hard data on the managed care company's performance. We have found our best contracts to be those we negotiated ourselves. To this end, we have abandoned affiliations with independent

practice associations (IPAs) in favor of direct contracting with payors. We have found it useful to include our own provisions for hot buttons such as timely payment and strict adherence to nationally accepted coding standards such as the "Correct Coding Initiative." We work diligently to exclude "boilerplate" provisions that we find unacceptable.

In some instances, we have had to temporarily resign from participation in managed care plans to successfully effect the contract provisions we sought. In addition, we have carefully cultivated relationships with hospitals and hospital systems and entered into several contracts for providing neurotrauma services for trauma centers. Such contracting practices have allowed us to maintain a positive cash flow and the fiscal leeway to bring on additional partners for practice expansion into other localities.

Investment initiatives. The infrastructure required to maintain superb data management across multiple practice locations, such as high capacity servers and T1 Internet connections, has been our largest capital outlay. It has already paid significant dividends by increasing our business office capacity and efficiency. We have recently spun off our practice administration as a separate management services company that provides cost-efficient coding, billing and practice management services to several other surgical groups. This further improves our own cash flow and produces good will: we have been able to increase collections in other practices by as much as 30 percent over baseline.

By developing a culture of excellence in a multidisciplinary environment, a private practice can participate in much of the best of the academic world, such as research, teaching, presentations and organized neurosurgery. By adhering to an aggressive private business model, the practice can maintain flexibility, independence and security in a rapidly changing economic environment. Rocky Mountain Neurosurgical Alliance has worked to achieve the best of both worlds. ■

Changing of the Guard

New Slate of Officers Up for Election

The AANS' Board of Directors approved the slate of 2001 officers presented by the Nominating Committee at their meeting Nov. 18 in Chicago. AANS members will vote on the slate at the Annual Meeting in April in Toronto.

Roberto C. Heros, MD, is slated as president-elect of the AANS, Volker K.H. Sonntag, MD, as vice president and Arthur L. Day, MD, as treasurer. The slated directors-at-large are Steven L. Giannotta, MD, L.N. Hopkins, MD, and Richard A. Roski, MD. The slated Nominating Committee members are Howard M. Eisenberg, MD, Robert L. Grubb Jr., MD, and Christopher M. Loftus, MD.

Stan Pelofsky, MD, president-elect and chair of the Long Range Planning Committee, announced that two members, Albert Rhoton Jr., MD, and Robert Maciunas, MD, have made significant contributions to support two new endowed Annual Meeting lectureships.

The Awards Committee announced that Julian Hoff, MD, will receive the 2001 Cushing Medal at the Annual Meeting in Toronto. Frank Smith, MD, and Donald Stewart, MD, will be jointly presented with the Distinguished Service Award. Robert Martuza, MD, will receive the 2001 Farber Award.

The Professional Conduct Committee presented two cases for review and action by the Board of Directors. Upon recom-

mendation of the committee, the Board suspended one member, a Florida neurosurgeon, for six months for improper advocacy and for failing to present the broad spectrum of neurosurgical thought and practice in his testimony. In the other case, on the recommendation of the Professional Conduct Committee, the Board dismissed the charges against an Arizona neurosurgeon on the basis that the evidence did not establish a prima facie case of unprofessional conduct. In both cases, respondents had testified as plaintiffs' experts in medical malpractice cases against other neurosurgeons.

Regarding membership:

- Per sanctions specified in the Bylaws, the BOD approved dropping 105 members from the AANS membership in the U.S. Active and Associate and International Associate categories for non-payment of dues. A member can be dropped for failure to pay two years' worth of dues—current and immediate past year dues. Members can be reinstated if the amount in arrears is paid.

- As part of the overall effort to recruit International members, the BOD directed the Membership Committee to identify ways to streamline and simplify the membership application process.

- The Board approved 527 new candidate (resident) members, 12 Active members, 30 Active Provisional members, 15 International Associate members and three Associate members, bringing the total organizational membership to 5,884.

- The Board approved changing the AANS resignation procedure to offer Lifetime member status to eligible resigning members. Also, the Membership Committee will contact a member to urge him or her to continue their membership.

The Board also approved:

- a proposal to track CME credits for members only for CME activities sponsored or jointly sponsored by the AANS or sponsored by the CNS.

- a recommendation from the Coding and Reimbursement Committee that Jeffrey Cozzens, MD, be appointed as the AANS CPT Adviser in lieu of Richard Roski, MD. ■

AANS Wins Major Victory in Court Case

On October 20, 2000, Judge Elaine Bucklo of the United States District Court for the Northern District of Illinois granted the AANS summary judgment in the lawsuit brought by former member Donald C. Austin, MD. Dr. Austin had sued the AANS after the Professional Conduct Committee found that he had testified unprofessionally as a plaintiff's expert in a medical malpractice case that permanence of a recurrent laryngeal nerve injury was necessarily the result of surgical negligence in an anterior cervical fusion procedure.

The Professional Conduct Committee recommended, and the Board of Directors concurred, that Dr. Austin be suspended for six months, and Dr. Austin's appeal to the General Membership was denied by a vote of 194 to 5 at the AANS' Annual Meeting in Denver in 1997. Dr. Austin resigned from the AANS and then filed litigation claiming that not only was he deprived of due process in the AANS proceedings but that the entire proceedings were improperly skewed against plaintiffs' experts. Dr. Austin complained that the "unfair" disciplinary action by the AANS had caused his income as a plaintiffs' expert witness to drop substantially, that his reputation was sullied and that he was entitled to damages as a result.

In granting the AANS summary judgment, Judge Bucklo ruled that "Dr. Austin received as much due process as anyone might hope for." Russell Pelton, General Counsel for the AANS, who handled the matter throughout, stated that this was a major victory not only for the AANS but for all organized medicine as it reaffirms the right of an association to discipline its members for unprofessional conduct, including inappropriate testimony as a plaintiffs' expert witness. Dr. Austin has decided to appeal this decision to the United States Court of Appeals.

EVENTS

Calendar of Neurosurgical Events

California Association of Neurological Surgeons Annual Meeting

January 19-21, 2001
San Diego, California
(916) 454-6850

Richard Lende Winter Neurosurgery Conference*

Feb. 3-9, 2001
Snowbird, Utah
(801) 531-7806

2001 Annual Meeting of the AANS/CNS Section on Cerebrovascular Surgery**

February 9-12, 2001
Waikoloa (the Big Island), Hawaii
(888) 566-AANS

American Stroke Association's 26th International Stroke Conference

February 14-16, 2001
Ft. Lauderdale, Florida
(214) 706-5262

2001 AANS/CNS Section on Disorder of the Spine and Peripheral Nerves Annual Meeting*

February 14-17, 2001
Phoenix, Arizona
(888) 566-AANS

Mayo Clinic Winter Neuroscience Symposium

February 25 – March 2, 2001
Snowmass, Colorado

(800) 325-7787, ext. 5251
sstuckey@mayfieldclinic.com

American Academy of Orthopaedic Surgeons Annual Meeting

February 28 – March 4, 2001
San Francisco, California
(708) 384-4257

Neurosurgery in the Rockies

March 4-8, 2001
Vail, Colorado
(303) 315-4125
diana.doyle@uchsc.edu

Interurban Neurosurgical Society Annual Meeting*

March 9, 2001
Chicago, Illinois
(708) 216-8920

Southern Neurosurgical Society*

March 14-18, 2001
Austin, Texas
(540) 345-2229

2001 AANS/CNS Section on Pain Interventional Therapies in Neurosurgical Pain Management Workshop*

April 19-20, 2001
Toronto, Ontario; Canada
(888) 566-AANS

AANS 69th Annual Meeting

April 21-26, 2001
Toronto, Ontario; Canada
(888)566-AANS

American Pain Society Annual Meeting

April 19-22, 2001
Phoenix, Arizona
(847) 375-4715
info@ampainsoc.org

American Academy of Neurology Annual Meeting

May 5-12, 2001
Philadelphia, Pennsylvania
(651) 695-1940
www.aan.com

Neurosurgical Society of Alabama Annual Meeting

May 5-7, 2001
Orange Beach, Alabama
(205) 939-6914

Society of Neurological Surgeons Annual Meeting*

May 20-22, 2001
Cleveland
www.societyofns.org

Georgia Neurosurgical Society

May 26-27, 2001
Sea Islands, Georgia
tara@mag.org

Fifth International Stereotactic Radiosurgery Society Congress

June 4-7, 2001
Jerusalem, Israel
972-3-795-1444

American Medical Association Annual Meeting

June 17-21, 2001
Chicago, Illinois

International Society for the Study of the Lumbar Spine

June 19-23, 2001
Edinburgh, United Kingdom
(416) 480-4833

Neurosurgical Leadership Development Conference

July 20-24
Washington, D.C.
(216) 444-5381
Barnett@neus.ccf.org

World Society for Stereotactic and Functional Neurosurgery

September 11-14, 2001
North Sydney, Australia
61-2-9956-8333
www.nsa.on.net/wfns.htm

International Society of Neurological and Instrument Invention

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

Western Neurosurgical Society Annual Meeting*

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

World Congress of Neurosurgery

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

American Academy of Neurological Surgery*

November 14-17, 2001
Palm Beach, Florida
(507) 284-2511

2001 AANS/CNS Section on Pediatric Neurological Surgery Annual Meeting

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

Cervical Spine Research Society

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

American Epilepsy Society 55th Annual Meeting

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

**Jointly sponsored by the American Association of Neurological Surgeons
** Jointly sponsored by the American Association of Neurological Surgeons and the American Association of Interventional and Therapeutic Neuroradiology and in collaboration with the Japanese Society of Surgery for Cerebral Stroke and the Japanese Society of Intravascular Neurosurgery*

Education and Practice Management Courses

• Managing Coding and Reimbursement Challenges in Neurosurgery

Jan. 12-13 Orlando, Florida
Feb. 9-10 Seattle, Washington
March 16-17 Dallas, Texas
May 18-19 Scottsdale, Arizona
Aug. 24-25 Chicago, Illinois
Sept. 21-22 Baltimore, Maryland
Nov. 16-17 Atlanta, Georgia

• Neurosurgery Review by Case Management: Oral Board Preparation

May 27-29 Savannah, Georgia
Nov. 4-6 Houston, Texas

For more information or to register for these courses, call 888-566-AANS or visit www.neurosurgery.org/aans/meetings/epm/courses.html

Madison Avenue and Neurosurgery

Marketing Works Best When It Educates

I remember the first time I saw a billboard announcing a well-known malpractice lawyer's immediate and enduring availability. I experienced a rush of realization that I had just witnessed a confirmation of the prevailing opinion of the field of medicine about the practice of law—not repeatable in a publication of this quality. Yet here we are 20 years later with a *Bulletin* cover article on marketing. What has happened in the intervening years to change my opinion—and that of many in medicine—that marketing is not only ethical but essential?

Several factors have changed the need for communication about our specialty to our customers including but not limited to patients and referring physicians. First and foremost is patient expectation. Our patients are no longer passive consumers of healthcare. Their appetite for medical knowledge about their illness is voracious. They often treat their quest for medical care as a mission where decisions about whom will render their care is a matter of comparing outcomes, reputations and location.

Competition is another factor changing perceptions about the medical market place. Neurosurgery as a specialty vies with orthopedics for spine and peripheral nerve surgery, vascular surgery and interventional radiology for carotid surgery, otolaryngology for skull base and anesthesia for pain management. Neurosurgery is dwarfed by many of these competing specialties. How is a primary care physician to appreciate the distinctive knowledge neurosurgeons possess, such as the fact that our specialty trains for five years or more for spine surgery, not just a one-year fellowship as do others called “spine surgeons”? How do patients understand that neurosurgeons are more than brain sur-

geons? How do we influence the media? How do we educate medical students about the breadth of our specialty?

A Dignified Educational Tool

It is my personal perspective that marketing, applied as a dignified educational tool, is the obvious solution to a broad spectrum of misunderstandings and ignorance about our specialty. We don't want a

A. John Popp, MD, is Editor of the AANS Bulletin, Chair of the Washington Committee, and Henry and Sally Schaffer Chair of Surgery at Albany Medical College.



strident, over-the-top approach but a subtle, respectful strategy that informs and educates.

We have all participated in some forms of marketing. Providing good service to referring physicians and high quality care to patients always has been a strategy for maintaining and increasing market share. I give you two examples from my own practice: First, I telephone the referring physician from the operating room immediately after completing surgery. Many tell me they have never been called by a surgeon before and appreciate the information.

Second, several years ago my colleagues and I wrote a text about primary care and the neurosciences (*A Guide to the Primary Care of Neurological Disorders*, published by the AANS) that I present to referring primary care physicians and to others in my area. This has both served to educate refer-

ring physicians and showcase the talents of neurosurgeons in providing care. All of us likely have similar strategies that work in our local market.

Telling Neurosurgery's Story: A Marketing Tradition

Whether or not neurosurgeons like the idea of marketing, they benefit from it. The AANS has offered a diverse array of programs and services that target the public, the media, referring physicians, managed care organizations, medical specialties and legislators with marketing messages. The *Getting SMART* package is an easy-to-use public education and practice-building tool. The *Find a Neurosurgeon* component of **NEUROSURGERY:// ON-CALL®** places the names of neurosurgeons a key stroke away from Internet users. Reprints of the *Neurosurgery Today* insert that ran in *USA Today* function like an eight-page ad, albeit one that conveys messages with honest narrative rather than flashy images that appeal to emotions.

Marketing professionals know a well-grounded marketing campaign involves research, strategy and fine-tuned target audiences. The goal is not so much persuasion as it is education. The method is not to trumpet guarantees but to place in front of the desired audience the facts needed to make a choice.

I still react strongly when I see a billboard touting a malpractice lawyer. Some forms of marketing prey on people's fears, worries and troubles. But the abuse of marketing by some does not diminish the value, power and propriety of a low-key marketing initiative. With the aid of AANS and its marketing tools, neurosurgery can tell its story and reach the people who need to hear our message. ■