

## About the Cover...

The long-awaited debut of Neurosurgery's new site on the Internet has finally arrived. **NEUROSURGERY://ON-CALL™ (N://OC)** officially opened to the membership during the 1996 AANS Annual Meeting in Minneapolis. **N://OC**, which was designed by neurosurgeons, for neurosurgeons, offers access to a wide variety of information. Features include the CPT Coding Coach™, scientific reference database, detailed information on Professional Development Courses, information about pending legislation and government action affecting the practice of neurosurgery, special interest clinical topic resources, an on-line journal—and more!

The distinctive **N://OC** graphic images that appear on the cover of this issue of the *AANS Bulletin*, serve as navigational aides to guide you through the site. The brain image appears on the "splash page" of the site and is the first screen you encounter. Click on the brain and you are taken to the welcome page. From there users are taken to the table of contents, which features the "Thinker."



Inside the *Bulletin*, you will find a helpful guide that explains, step-by-step how to access the **N://OC** site through your own office or home computer. All AANS members will be provided with custom logins and passwords to **N://OC** allowing unlimited browsing privileges.

Cover illustration by Steve Connell Graphics.

## ARTICLES

<b>NEUROSURGERY://ON-CALL Goes On Line</b>	<b>7</b>
<b>Accessing NEUROSURGERY://ON-CALL</b>	<b>8</b>
<b>Use of Proprietary Guidelines and Pathways—or Caveat Emptor</b>	<b>11</b>
<b>AANS Executive Director Retires</b>	<b>12</b>
<b>Ways to Make Plans Pay You Faster</b>	<b>14</b>
<b>Spine Code Changes for 1996</b>	<b>17</b>
<b>Neurosurgical Residency Training Programs and the Work Force Debate</b>	<b>22</b>
<b>Member Comments on Ethics Review</b>	<b>29</b>

## DEPARTMENTS

<b>President's Message</b>	<b>2</b>
<b>Washington Update</b>	<b>3</b>
<b>Professional Development</b>	<b>20</b>
<b>Section News</b>	<b>32</b>
<b>Organizational Liaison</b>	<b>35</b>
<b>JCSNS</b>	<b>36</b>

<b>Membership</b>	<b>37</b>
<b>Research Foundation</b>	<b>38</b>
<b>THINK FIRST</b>	<b>42</b>
<b>Positions</b>	<b>46</b>
<b>Technological Advances</b>	<b>47</b>
<b>In Memoriam</b>	<b>47</b>
<b>Announcements</b>	<b>48</b>

## AANS Bulletin

A quarterly publication of  
The American Association  
of Neurological Surgeons

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The *AANS Bulletin* is published quarterly by The American Association of Neurological Surgeons, 22 South Washington Street, Park Ridge, Illinois 60068-4287, (847)692-9500, and is distributed without charge to the neurosurgical community. Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the authors' personal observations and do not imply endorsement by nor official policy of The American Association of Neurological Surgeons.

# Managed Care Gag Rules Raise Havoc with Patient Care—Surgeons Must Respond With Facts

The cover story of the January 22, 1996 issue of *Time* magazine laid out in chilling detail a worst-case scenario of how managed care has reshaped the practice of medicine. It described the experience of one cancer patient—Christy deMeurseres—as she fought to get the treatment she needed to survive. Unfortunately, the story had an unhappy ending; Mrs. deMeurseres died trying.

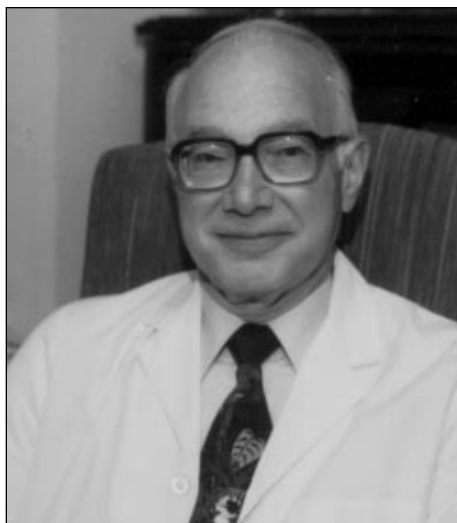
This patient's story is frightening, made even more disturbing by the apparent greed of the managed care company executives who denied her coverage for a bone marrow transplant—a procedure they considered expensive “experimental treatment”—then sold out their company shares for outrageous profits.

The article highlights a growing problem we all face: the intrusion of capitation, “gag rules” and other cost-controlling measures into the doctor-patient relationship. *Time* magazine's not very subtle implication is that patients can no longer trust their doctors to prescribe optimum care and, worse still, that the physicians' primary motivation for such action is financial.

### Gag Clauses

Gag clauses in physicians' managed care contracts have raised particular havoc with patient care. These provisions prevent physicians from being completely open with patients about the terms of their managed care coverage. Under a gag rule a doctor might be prohibited from discussing with patients treatments that are not covered by their managed care plan. Physicians can also be barred from referring patients to specialists outside the plan, even when they believe it may be in the patient's best interest. Other rules may prevent physicians from discussing their financial relationships with a managed care plan, especially if they have incentives to increase earnings by providing less care.

And, there is the greed factor. While many managed care plans have prospered mightily, they have not shared their good fortune with their subscribers. In the case of Christy deMeurseres' managed care plan, Health Net of Woodland Hills, California,



Sidney Tolchin, MD

its CEO Roger Greaves received a one-time \$18.1 million pay out (along with a guarantee of lifetime health care), when his company merged with the WellPoint Health Network. This amount was the equivalent to the average monthly premiums paid by 134,000 subscribers. It also could have paid for the entire treatment program of 180 patients like Mrs. deMeurseres.

The issue is a redistribution of wealth under the guise of corporate, management of health care. These resources are being taken from direct patient care, from hospital capital expenditures, from academic research, development and training, and from nurses and physicians to the benefit of corporate shareholders and administrative personnel of managed care groups. Until the public recognizes this, organized medicine is impotent to influence change, except to say, “NO!”

The public reaction to the *Time* story was one of outrage. The American Medical Association (AMA) has launched a major publicity effort calling for all managed care plans to immediately cancel gag clauses. It also has asked individual physicians to review their HMO contracts for any language that might prevent them from openly communicating with their patients and to defy such provisions.

As a result of the ensuing outcry, a new federal bill that would prohibit gag clauses in physicians' contracts with health plans has been proposed in the House of Representatives. The “Patient Right to Know Act” would bar plans from restricting physicians' communications with patients. The bill is being co-sponsored by Rep. Edward J. Markey (D- Mass.) and Rep. Greg Ganske, MD (R- Iowa).

Though such legislative relief is welcome, we—as physicians—must do more. Certainly we need to stand up for what is right and ethical in terms of patient care. But, more than that, we need to show both patients and managed care organizations that we are providing proved, effective treatment.

### Outcomes Data Will Help

Outcomes data is the answer. Lack of funding for outcomes studies is the problem. Our push should be for establishing these funds rather than railing against the sickening profits of such heinous managed care organizations.

Given adequate outcomes measures, these problems would never occur. I recently had the opportunity to talk with Representative Bill Thomas (R, CA) about the need for some mechanism to force organizations to contribute to well-organized, scientific-based outcomes studies when they deny health care on the basis of the experimental or investigational nature of a procedure. Any denial of care should be accompanied by grant offers to determine if that denial is appropriate. If such a procedure or treatment methodology cannot withstand evidence-based studies, it should *not* be paid for.

The AANS, in partnership with the CNS, has already taken a first step in the direction gathering outcomes information through the decision to develop an Outcomes Database for our new Internet web site, **NEUROSURGERY://ON-CALL™ (N://OC)**. The Database will serve as a research instrument that can be used for multiple, simultaneous research projects. The proposed system will be designed to

*(continued on page 4)*

## Health Insurance Reform on the Table Again

By Katie Orrico, Esq.

The U.S. Congress is once again considering national health insurance reform legislation. Unlike the comprehensive reform proposal advocated by President Clinton and the Democrats two years ago, the Republican bills generally focus only on limiting pre-existing condition exclusions and preserving portability. There are significant differences, however, between the House and Senate versions.

The House bill, which passed on March 28, 1996 by a margin of 267 to 151, includes the following provisions: (1) limitation on preexisting conditions; (2) group-to-group and group-to-individual portability; (3) guaranteed availability of coverage for group health plans; (4) guaranteed renewability of coverage for group health plans; (5) increased enforcement of, and penalties for, health care fraud and abuse; (6) tax deductible medical savings accounts (MSAs); and (7) medical malpractice reform.

The most controversial aspects of the House bill are the MSA and medical malpractice reform provisions. Under the bill, contributions to MSAs are deductible—up to \$2,000 for individuals and \$4,000 for families—if a high deductible health plan is purchased. The legislation also includes the following medical malpractice reforms. The key provisions are: (1) a \$250,000 cap on non-economic damages; (2) limitation of punitive damages to the greater of \$250,000 or three times the economic damages; (3) proportional liability for non-economic damages; (4) periodic payment for future economic and non-economic losses which exceed \$50,000; and (5) a 2-year statute of limitations that begins when the injury is discovered or should have been discovered.

The Senate bill, sponsored by Senators Nancy Kassebaum (R-KS) and Ted Kennedy (D-MA), is more narrow in scope than the House measure, containing only provisions related to preexisting conditions, portability and guaranteed availability and renewability. Senators Kassebaum and Kennedy are resisting any effort to amend the bill, and are pursuing a “no amendment” strategy, urging their colleagues not to offer any amendments so they can keep the bill



*Jack E. Wilberger, Jr., MD (at the podium) spoke on the issue of lifetime insurance caps on behalf of organized neurosurgery at Senator Jim Jeffords' (R-VT) press conference (left). Jim Brady (right), former Press Secretary to President Ronald Reagan, also spoke.*

“clean.” Because the legislation enjoys bipartisan support, they fear that if both Republicans and Democrats attempt to “load-up” the bill with such controversial issues as MSAs and malpractice reform, passage of any health reform this year will be in jeopardy.

Despite this “no amendment” strategy, organized neurosurgery is actively supporting an amendment to be offered by Senator Jim Jeffords (R-VT) when the Senate votes on the Kassebaum/Kennedy bill. The Jeffords measure will raise the lifetime limits of employer sponsored health insurance to \$10 million. This provision would go a long way towards protecting individuals with head and spinal cord injuries, whose lifetime medical costs can exceed \$5 million.

### Press Conference

Recently, to help promote the issue, The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) participated in a press conference held by Senator Jeffords. Speaking on behalf of the AANS and CNS, Jack E. Wilberger, Jr., MD, Chairman of the AANS and CNS Joint Section on Neurotrauma and Critical Care, pointed out that “patients with spinal cord injuries are typically young adults, who are

increasingly living to normal life expectancies. . . As a result, they very often incur medical expenses that exceed the lifetime limits set by their insurance policies. As neurosurgeons, we are involved in the ongoing care of head and spinal cord injuries and see first hand the hardships these patients can endure when their insurance benefits are depleted.”

Because of the significant differences between the House and Senate, it is unclear whether any health insurance reform will pass the Congress this year. The issue is on a fast track, but since this is an election year, there are very few legislative days remaining to work out the differences.

### Practice Expenses

The Health Care Financing Administration (HCFA), pursuant to a Congressional mandate, is in the process of developing resource-based practice expense relative values for nearly 7,000 CPT codes. This new system, which will be implemented on January 1, 1998, will change the current charge-based method for calculating the practice expense component of the Medicare Fee Schedule. The impact on neurosurgeons may be quite significant, and representatives from the AANS and CNS are therefore working closely with HCFA to assure that accurate data reflecting neurosurgeons actual practice costs are collected.

The research project has two phases. During the first phase HCFA will collect data on indirect and direct practice costs. They will collect this data utilizing two mechanisms—a mailed survey and small group consensus panels, or Clinical Practice Expert Panels (CPEPs). The survey instrument will be mailed to approximately 5,000 randomly selected physician practices beginning in late April (See Box). We expect that very few neurosurgical practices will be selected.

Regarding the consensus panels, HCFA convened the first CPEP meetings in February, and several neurosurgeons participated on the neurosurgical panel. The panel developed cost data on a small sample of neurosurgical procedure codes (reference services). The data from these reference

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## ► Reform on the Table

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services will then be extrapolated to all neurosurgical CPT codes. HCFA plans to convene one or two more CPEP meetings, to further refine the data.

In the second phase of the project, HCFA will contract with several health researchers to develop methodologies for analyzing and applying this data. Each of these different methodologies may produce drastically different results; thus this phase of the project may have the most impact on the final outcome. One of HCFA's stated goals for physician payment reform is to establish payment equity by redistributing payments from procedure-oriented specialties to primary care physicians. It is therefore anticipated that HCFA will select the methodology that furthers this philosophy.

The AANS and CNS have some serious concerns about this project, including the small sample size, the complexity of the survey instrument, the accuracy of data collected and the rapidly approaching deadline for implementation. These concerns are shared by a large number of medical specialty societies, who, along with the AANS and CNS, have

formed a coalition to urge the Congress to delay implementing this new payment system for at least two years. In the meantime, the AANS and CNS are participating in several private initiatives to collect and analyze neurosurgical practice costs so we can develop alternative data to present to HCFA if and when it becomes necessary.

### Addenda

Because several local Medicare carriers have ceased or restricted payment for pallidotomy, representatives from the AANS and CNS recently met with HCFA urging the establishment of a national Medicare policy for payment of pallidotomy for individuals with Parkinson's Disease. A HCFA advisory committee met in March and recommended that Medicare should continue paying for pallidotomy for patients with Parkinson's Disease. For the time being, the precise payment policies will be determined by the local Medicare carriers, but HCFA will further discuss the necessity for a national policy.

HCFA's five year review of the Medicare Fee Schedule (physician work component values only) is near completion. We anticipate that nearly all of the AANS and CNS recommended changes will be accepted by HCFA. The new values

will be published in the *Federal Register* in late spring.

The AANS and CNS recently submitted testimony to the House and Senate Appropriations Committees regarding funding for the National Institutes of Health for fiscal year 1997. In our statement, we urged the Congress to focus on four areas of research: (1) stroke and the treatment of cerebrovascular diseases; (2) molecular biology as it applies to tumors and other nervous system disorders; (3) image-guided stereotactic surgery for treatment of brain tumors, strokes, spinal disorders and degenerative diseases of the nervous system; and (4) outcomes research into the effectiveness of new therapies for neurologic disorders.

### ATTENTION ALL NEUROSURGEONS

If you receive a survey in the mail from the Health Care Financing Administration and/or its contractor, Abt Associates, requesting data on your practice costs, please notify:

Katie Orrico  
Washington Committee for Neurosurgery  
(202) 628-2072

## ► Gag Rules

(continued from page 1)

provide a basic data collection platform to accumulate common outcomes and demographic data. This platform will form the basis upon which specific research studies may be built.

The system will allow authorized users to enter medical data into the database, edit and update that data, provide a mechanism to prompt the user to provide additional data on a periodic basis, search and browse the data and provide an analysis to study participants in a graphical format.

### Personal Thoughts

What does all of this mean to us as neurosurgeons? Has the current controversy affected how we care for patients? Perhaps

the following will sound familiar to you.

I recently sent home a patient following a multi-level cervical laminectomy the day after her surgery. I am not a capitated physician. I was not coerced by a health maintenance organization or carrier to release her early. It was my decision that she would be better served by early discharge since she was at increased risk for infection and hospital-acquired complications. Why then did I still feel guilty? It is this latter insinuation into the **feelings** that I have for my patients and those they have for me that is becoming intolerable.

As a career Naval Officer, I did not enter medicine to make big bucks. The income I have earned in the practice of neurosurgery will allow me to retire, hopefully, without becoming a burden on society. The reason the public is in the

pickle it is right now is that society has not taken upon itself the responsibility of determining the worth of a neurosurgeon, or any other physician for that matter.

The swiftness of change brought on by managed care is breathtaking. The sad truth is we are no longer the sole arbiters of patient care.

Some of our members have suggested that we take an aggressive public stance on this issue. However, we will not have a lot of credibility about patient caring and advocacy unless we first take a good look at ourselves as human beings and caretakers of the public good.



Sidney Tolchin, MD  
President





# NEUROSURGERY://ON-CALL™ Goes On Line

**N**EUROSURGERY://ON-CALL™, the AANS/CNS Internet site, was officially opened to the membership during the 1996 AANS Annual Meeting in Minneapolis. The meeting highlighted electronic communications and emerging technology, and the “Grand Opening” of the site was promoted throughout the meeting.

A special booth in the technical exhibit hall specifically demonstrated uses of **N://OC**. A total of 18 workstations were located throughout the exhibit hall, registration area and spouse hospitality suite. The stations allowed individuals to send e-mail and “surf the Net” becoming familiar with the many features of the **N://OC** site and others.

Technical staff were available during the meeting to assist members using the software.

Hands-on courses on the Internet were held daily. The course covered various topics such as installation and configuration of Internet access software, ways to explore the Internet and gain access to **N://OC**, and the usefulness of the Internet to neurosurgeons and their practices.

Additionally, a Breakfast Seminar, “Impact of Computers on Neurosurgery”, was conducted by **N://OC** Editor, Richard Toselli, MD; Cavett Robert, MD; and Oliver D.W. Grin, MD. The seminar provided information on the use of computer technology in neurosurgery from advanced imaging and stereotactic surgical guidance to use in patient care and office management.

## Site Features

### NEUROSURGERY://ON-CALL™

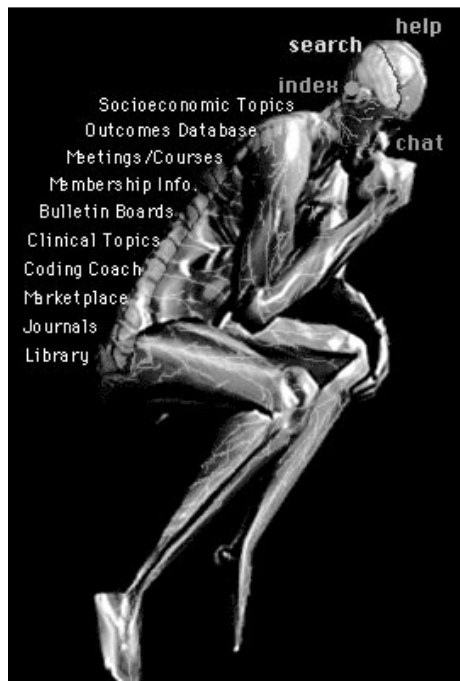
provides a wide variety of information to the neurosurgical community. The site currently contains the following features and additional sections will be added throughout the year.

**CPT Coding Coach™** — This database, which is exclusive to **N://OC**, is an automated CPT coding assistant designed to help you and your staff in learning how to accurately code procedures. The Coding Coach guides each user through a session of the CPT coding process based on an expert logic tree. Using the CPT Coding

Coach™ users view a series of interview forms and a number of alternative selections. The computer selects the correct CPT codes and sorts the codes into one of several orders for submission.

### Neurosurgical Reference Database—

This library contains a comprehensive database of abstracts from the *Journal of Neurosurgery* and *Neurosurgery* along with nearly 250 other neuro-related journals. The database also allows the user to search the AANS and CNS Annual Meeting and Section Meeting abstracts and neurosurgical images providing *the most comprehensive neurosurgical reference search available anywhere.*



*The “Thinker” helps users navigate the Web site.*

There are currently three years of meeting abstracts on-line and the five most recent years of the National Library of Medicine’s peer-reviewed journal abstracts and updates are provided monthly. The selected search engine is currently the top commercial leader used by both IBM and Yahoo. It provides full text, sounds-like, and categorical queries, as well as query result relevance ranking along with many other features.

**Clinical Topics** — This section of the site quickly and easily enables you to retrieve and share sub-specialty specific information. Sub-specialty sections include Cerebrovascular Surgery, Pain, Tumor, Stereotactic and Functional Surgery, Pediatrics, Neurotrauma and Critical Care, and Spine and Peripheral Nerves. Also found in this area is a listing of fellowships by specialty.

**Chat Room** — Live chat rooms give AANS/CNS members a place to meet “on-line.” Like the clinical topic area, chat rooms are sub-specialty specific. In addition, there is a “general auditorium” area where lectures and other moderated sessions are held.

**Marketplace** — A comprehensive selection of AANS and CNS products are available for purchase on-line, including neurosurgical books, videotapes, self assessment exams, patient education brochures and more. This area will also contain a product information section which affords neurosurgical vendors an opportunity to post information describing their products and services.

**Meetings and Courses** — Detailed information on AANS, CNS, Joint Section and regional AANS Professional Development Courses is contained in this area. Members will eventually be able to register on-line for meetings sponsored by the AANS and CNS. Also available on-line is a calendar of all neurosurgical meetings of which the Associations are aware.

**Socioeconomic** — This section provides information about pending legislation and government action affecting the practice of neurosurgery.

**Journals / On-line Journal** — The on-line journal, *Neurosurgical Focus™*, provides original science in a peer-reviewed, fast-track format. This electronic-only format gives neurosurgeons an additional outlet for publishing their research material, with the further goal of distributing scientific information in a relatively short time frame. Subscription and contribution information, editorial

*(continued on page 10)*

# Accessing **NEUROSURGERY://ON-CALL**™

The Internet is a network of computers all connected to form a global community of information resources. The Internet provides you with four basic tools: electronic mail (e-mail), remote login to access another computer (Telnet), file transfer (FTP) for transferring files between computers, and World Wide Web access.

By now you have received a custom login and password giving you full access to **NEUROSURGERY://ON-CALL**™ (**N://OC**). Once you have received your login name and password and have installed your browser software, you will be ready to begin "surfing the Internet" and the **N://OC** home page.

## Connecting to the Internet

Any personal computer can connect to the Internet, but the type of Internet services you want will depend on how much computing power you have. Graphical Internet browsers, such as Netscape (the most popular World Wide Web browser), require at least four megabytes of random access memory to run at usable speeds on either Windows or Macintosh computers.

The National Office along with the Beta Test Group and Oversight Committee have tested several browsers and agree that Netscape is the recommended browser. **N://OC** is designed to HTML 3 standards, uses Netscape extensions and works best with this web browser. You should be aware that some major providers (including America OnLine) are designed to the older HTML 2 standard and can not display all of the features included in the **N://OC** site. If you currently use another WWW browser but would like a copy of the Netscape Navigator software, simply click the *Netscape* button located on the second screen of **N://OC** and you may download the latest copy of the software.

If you or your hospital is affiliated with a university, chances are you already have an Internet connection. If you are not sure if your affiliated university has Internet access, check with your administrative or information services department prior to using the phone lines in your office to connect. Undoubtedly, if there is an available institutional connection, it will

access the Internet more quickly than a dial-up connection to an Internet Service Provider (ISP) from your office.

Connecting to the Internet via a home or office stand-alone computer requires a modem. A modem transmits digital information from a computer through ordinary phone lines to a network provider or Internet access provider. All modems work basically the same but will require software to enable them to access the Internet via an ISP.

Speed is the most important aspect in selecting a modem. Modem speed is measured in BAUD. BAUD refers to the signaling rate that the modem can achieve over a standard phone line. The higher the BAUD, the faster the data can be moved, as measured in bits per second (BPS). The more bits your modem can send and receive, the faster the information will travel over the phone lines and the quicker you will see the screens displayed.

A 28,800 BAUD modem may make use of data compression to achieve data rates in excess of 57,600 BPS. You should be aware that some ISPs will not allow you to use this feature. It is wise to ask this question when choosing an ISP. At this time, you can buy a 28.8 BAUD modem for approximately \$150 to \$300. This is currently the fastest speed for Internet access using standard phone lines. Connection speeds will vary among different Internet providers.

Ideally, your Internet Service Provider (ISP) should give you modem dial-in access to a phone number that is only a local phone call away. Each ISP has different procedures for connecting to their network, and different limitations on Internet Services, but they all should give you graphical browser access to the Internet via a SLIP or PPP - type connection. Rates vary from ISP to ISP. Make sure your ISP has reliable connections and technical support that are available beyond normal business hours and on the week ends.

Netscape software which allows members to access the Internet and **N://OC** was distributed to members at the AANS

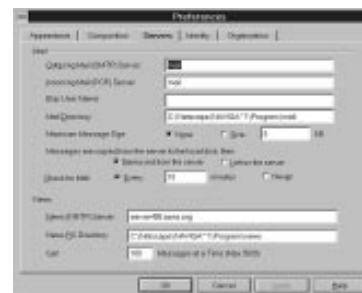
Annual Meeting and can also be purchased at any local computer store and from many ISPs. Login names and passwords were also distributed to membership. If you cannot locate your login name and password, simply call 847/692-9500 (9:00 AM to 5:00 PM CST) and a staff person will be happy to assist you.

In order to access the **NEUROSURGERY://ON-CALL**™ site, you must configure your Netscape browser and know how to open a "URL". The "Universal Resource Locator" name (URL) is the equivalent of an address on the Internet. The following instructions (for both Windows and Macintosh) will show you how to configure your browser for use with **NEUROSURGERY://ON-CALL**™ and to set this address as your "home" or starting address.

## Windows

After you have installed your Netscape software, you must configure the software to access **NEUROSURGERY://ON-CALL**™.

1. To configure the Netscape browser to use the section bulletin boards:



Click on **Options**

Click on **Mail and News Preferences**

Click on **Servers**

In the space marked **News (NNTP) Server** enter the value  
server4OO.aans.org

Fill out the remaining spaces as directed by your ISP provider or as it was configured in the automatic setup procedure.

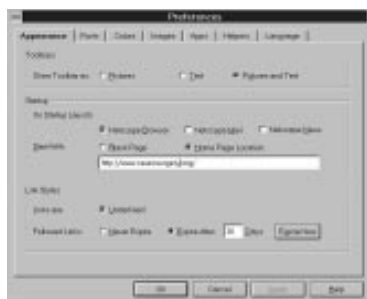
Click on **OK**

*(continued on next page)*

## ► Accessing N://OC

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2. To make **NEUROSURGERY://ON-CALL™** your home location:



Click on **Options**

Click on **General Preferences**

Click on **Appearance**

Next to the section marked **Start With:** click on **Home Page Location** and enter **www.neurosurgery.org** in the space provided.

Click on **OK**

## Macintosh

After you have installed your Netscape software, you must configure the software to access **NEUROSURGERY://ON-CALL™**.

1. To configure the Netscape browser to use the section bulletin boards:



Click on **Options**

Click on **Mail and News Preferences**

Click on **Servers**

In the space marked **News (NNTP) Server** enter the value **server400.aans.org**

Fill out the remaining spaces as directed by your ISP provider or as it was configured in the automatic setup procedure.

Click on **OK**

2. To make **NEUROSURGERY://ON-CALL™** your home location:



Click on **Options**

Click on **General Preferences**

Click on **Appearance**

Next to the section marked **Start With:** click on **Home Page Location** and enter **www.neurosurgery.org** in the space provided.

Click on **OK**

## Both Windows and Macintosh Formats

3. To access the **N://OC** site, you may now click on the **Home** button or enter the URL into the **Open Location** dialog box found under **File**.
4. Once you access the **N://OC** site you will see the "splash page" with a rotating brain and the words "Click Above To Continue".



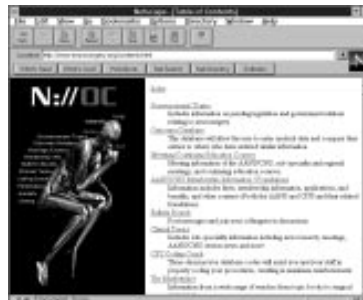
You may click on this screen at any time to continue to the Welcome page. **You do not have to wait for the brain image to stop spinning. Alternatively, you can set the homepage for any page which you feel you visit most frequently.**

5. The Welcome Page looks like this:



You may click on the operating room doors at any time to move further into the site or you may click on any of the link items on this page for further information about that item.

6. The Table of Contents page looks like this.



The "Thinker" on the left is a navigation tool. You may click on any of the topics listed on or near the "Thinker." You may also click on link items on the right of the page. If you move beyond this page, you will be required to enter your login and your password.

7. Clicking on a non-public link on this page will cause the system to ask you for your login and password. Simply type your login into the proper space and then **TAB** to the password space and enter the password here. Click on **OK** to complete your login and to gain access to the "members only" areas of the site.

**If you lose your login or password please call 847-692-9500 and ask to speak to a Help Desk person.**

(continued on next page)

## ► Accessing N://OC

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### Explore the Site

Finally, the best way to learn about **NEUROSURGERY://ON-CALL™** is to explore it. Click on images and links that lead to other areas and explore. Use the “Navibar” at the

top and bottom of the pages to assist you in moving about the site. The doors will take you back to the Welcome Page. The Thinker will take you to the Table of Contents. Use the links of the brain as a shortcut to the indicated areas. The far right of the Navibar is either an up arrow or a down arrow. The up arrow takes you to the top of the current page. The down arrow takes you to the bottom of the current page.

Remember that **NEUROSURGERY://ON-CALL™** was designed with you, the neurosurgeon, in mind. The goal of **NEUROSURGERY://ON-CALL™** is to provide you with the finest neurosurgical information resource on the World Wide Web. Please enjoy this tool as you explore and make frequent use of this service.



## ► N://OC On Line

(continued from page 7)

board biographies and highlights of upcoming articles in the *Journal of Neurosurgery* and *Neurosurgery* are also included in this area.

**Browsing** — Wondering where to find neurosurgical information on the Internet? An area named “Other Sites of Interest” which is located in the Clinical Topic section, allows you to quickly find over 100 other medical related Internet sites. This option will simplify and expand your access

to important neurosurgical information. The list of sites continues to grow and will be updated on a regular basis.

### Future Offerings

The **N://OC** Editorial Board will be reviewing several possible additions to the web site including a “case of the week” section.

An Outcomes Database is currently under evaluation. The proposed project is designed to provide a basic data collection platform to accumulate common outcomes and demographic data. This platform will

provide the basis on which specific research studies may be built.

The system will allow authorized users to enter medical data into the system, edit and update that data, provide a mechanism to prompt the user to provide additional data on a periodic basis, search and browse the data and provide an analysis to study participants in a graphical format. The general database program will be available to universities or other researchers for a small customization fee. The database is projected to be available for the CNS meeting in October of this year.

## N://OC Editorial Board Elected

The following members have been elected to serve on the **N://OC** Editorial Board: Gene Barnett, MD; Richard Bucholz, NM; Sam Ciricillo, MD; Mark Dias, MD; Robert Harbaugh, NM; John Popp, NM; Cavett Robert, MD; William Rosenberg, MD; Bradford Walters, MD.

The Editorial Board is responsible for all aspects of the Web site’s administration, project development, and long-range planning. The Board will monitor activities of Internet technology which benefit neurosurgery and keep the AANS and CNS leadership updated on these activities. They are responsible for monitoring the activities and progress of the site. They will also review and recommend new projects for possible inclusion in the site and will work closely with Content Editors to ensure the National Office staff receives new information on a regular basis.

Feel free to contact the Editorial Board with your suggestions by writing them c/o AANS National Office, 22 South Washington Street, Park Ridge, IL 60068-4287 or by e-mail at [info@neurosurgery.org](mailto:info@neurosurgery.org).

# Use of Proprietary Guidelines and Pathways—or Caveat Emptor

By Robert E. Florin, MD  
Chairman, AANS Guidelines and  
Outcomes Committee

A number of individual members, as well as several neurosurgical groups, have voiced their concerns regarding use of privately developed guidelines and care pathways that conflict with common practice in their communities. One of the most common of these products is the Healthcare Management Guidelines for Inpatient and Surgical Care developed by Milliman and Robertson (M&R).

These guidelines came to our attention in March 1994 when Blue Cross-Blue Shield of Rhode Island proposed use of the M&R Guidelines as a basis for reimbursement. The physicians in Rhode Island criticized the M&R Guidelines and the very short length of stays (LOS) assigned to many services. It appeared that these guidelines were statements designed to influence case managers and were based principally on actuarial data with little linkage to the medical literature.

The Rhode Island physicians recruited help from several specialty societies as well as the American Medical Association (AMA) Practice Parameters Forum and ultimately their U.S. Senator before they were able to counter the widespread application of the M&R guidelines in their state.

At about the same time, the Blues in New Jersey, HealthNet and Prudential began using these "Optimal Recovery Guidelines" developed by M&R, which were described as benchmarks toward which health plans should strive. They were based on several assumptions that included absence of any complications in the patient and the availability of integrated non-hospital systems of continuing care such as home health care, rehabilitation and other nursing services in the post-hospital period. M&R did acknowledge that the guidelines should be modified to the local market and used accordingly.

## Problems with Development

Investigation into how input was gathered for development of the neurosurgical

M&R Surgical Guideline	CPT-4 Procedures	LOS from M&R Guideline	LOS from National Disch. Database
S-300 Carotid Endarterectomy	35301, 34001	1 day	4 days
S-310 Cerv. Lam.	63020, 63076	1 day	5.5 days
S-400 All Cranioplasties	62120, 62140 62141, 62142 62143	1 day	3.5 days
S-810 Lumbar Discectomy	63030, 63042	1 day	4.5 days
S-820 Lumbar Fusion	22558, 22612 22625, 22630	2 days	7 days
S-1050 Ventricle-Peritoneal Shunt	62223	1 day	8 days

pathways in the M&R Inpatient Optimal Recovery Guidelines (ORG) revealed that they were based on a telephone survey of several neurosurgeons in the San Diego area who provided their opinions about procedures that are done in the specialties of Neurosurgery and Orthopedics. Information that was developed on average length of stay for the procedures we examined was obtained from a very large national database of patient information—National Hospital Discharge Survey (NCHS).

Our in-depth examination showed that the M&R LOS data were extraordinarily short and not likely to be applicable to the average hospital patient. Careful reading of the introduction to the M&R Manual revealed that they acknowledged that their LOS data was developed by actuaries and represented the shortest 10th percentile of all patients discharged in the Western PAS study as applied to patients without any sort of complications. Consequently, their LOS represents an unrealistically short LOS for almost all current hospitalizations.

The optimization to which they aspire requires a variety of support services and structures that very few hospitals could provide in 1994, the year in which the data was gathered. For example, the table shown above provides a comparison of the M&R LOS to the median LOS from a large national database of patients discharged (NCHS), and highlights the unreasonably short LOS expected to be met in the M&R material.

## Accepted without Validation

The real problem with the M&R material is that their "optimal recovery guidelines" are being adopted by hospitals, insurance companies and review agencies without confirming whether the data is reasonable to local circumstances and the patient population. Furthermore, they have not met the AMA Attributes of Guidelines as published and adopted by the AMA Parameters Partnership and Forum.

While the actuarial data shows that it is possible to meet such marks for 10% of the patient population under ideal circumstances, it is certainly not clear that they can or should be met for the great majority of patients. Despite this, physicians are being pressured to handle all their patients as if they fell into that shortest 10th percentile, regardless of whether it is appropriate for the individual patient.

The insurance companies and review agencies are using the M&R Guidelines without the careful inspection and adaptation to realistic local circumstances that are required to make them more true to fact. Unfortunately, many hospitals and review firms are desperately seeking some pre-formed package of guidelines and the M&R package just happens to meet their needs. As an example, the following companies have been using these guidelines: CIGNA, Prudential, Take Care, Interscope, Kaiser, Aetna, and many of the Blues.

*(continued on page 28)*

## AANS Executive Director Retires

Carl H. Hauber, JD, CAE, will retire May 1, 1996, after 19 years as Executive Director of The American Association of Neurological Surgeons (AANS). Mr. Hauber opened the AANS National office in 1977 with one part-time secretary and an annual budget of less than \$500,000. In succeeding years, he oversaw and guided the development of a wide array of programs and activities as well as a twenty-fold increase in annual budget, reflecting nearly two decades of devotion to building a central service

facility for the neurosurgical specialty as a whole.

Complementing the progress achieved by neurosurgery in the period 1977-1996, the AANS has also been at the "cutting edge" in the association management field under Mr. Hauber's staff leadership. During his tenure as Executive Director, the AANS received a number of awards for organizational excellence, including the American Society of Association Executives (ASAE) Award of Excellence for Educational

Programming in both 1983 and 1994, the ASAE Award of Excellence for Finance and Administration in 1994, the American Medical Association's National Congress on Adolescent Health Award in 1989 and the Professional Convention Management Association's Award for Excellence in Meeting Management in 1994.

Mr. Hauber came to the AANS with an established reputation as a "thinker" and "doer" in association management. A quarter century ago, he developed and espoused the concept of a "Fourth Generation of Association Management" which accurately predicted the present philosophy of indirect management and facilitation by staff to complement strong volunteer leadership. The concept was not understood by some at the time when most dynamic associations were essentially lead by very visible Staff who were often referred to as "hired guns." His frequent lectures on this subject in the association community are still recalled as initiating the staff-volunteer relationships that are so critical for dealing with demands placed upon associations today.

Prior to joining the AANS, Mr. Hauber was Executive Director of the American Dental Hygienists' Association (1971-1977) and of the American Oil Chemists' Society (1962-1971). He entered the association management field while attending law school in 1958, managing the national affairs of the then new Underwater Society of America. He received his *Juris Doctor* degree from the University of Illinois in 1961.

Throughout the years Mr. Hauber maintained a "second career" as an active member of the U.S. Air Force Reserve. He retired in 1986 with the rank of Colonel, having compiled a total of 30 years active and inactive duty for training. His final assignment was as Deputy Chief of Staff/Air Transport (IMA), Military Airlift Command, Scott Air Force Base, Illinois. His decorations include the Legion of Merit, Meritorious Service Medal and Air Force Commendation Medal with Oak Leaf Cluster.

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## Carl H. Hauber, JD, CAE—Highlights of Tenure at The American Association of Neurological Surgeons

- ◆ Established the AANS National Office and Staff.
- ◆ Established a system within the AANS to offer services to other neurosurgical organizations on a cost-recovery basis. As a result, staff services have been provided to the Congress of Neurological Surgeons, the American Association of Neuroscience Nurses, regional societies and Joint and AANS Sections, having an important synergistic impact on the AANS National Office.
- ◆ Convinced the Board of Directors to establish a permanent headquarters, coordinated the search for and ultimate purchase in 1983 of the AANS National Office Building in Park Ridge, Illinois, resulting in savings in rental costs over the first decade that exceeded the cost of the building. In later years, encouraged the purchase of the AANS Annex Building, thereby ensuring that the National Office Building will remain adequate to serve the Association past the turn of the century.
- ◆ Developed the proposal which resulted in Board of Directors approval for establishing the AANS Professional Development Program and instituted this continuing medical education program that presently serves as many members per year as attend the AANS Annual Meeting. In the five years following its establishment, the Program has added nearly a half-million dollars in net revenue to the Association while providing educational programs at prices consistently below those from other sources.
- ◆ Gained Board of Directors approval to establish the AANS Publications Program;
- organized and staffed this program which has earned over \$400,000 in net revenue for the Association and has made the AANS the largest U.S. publisher of neurosurgically-related books in the five years following its inception.
- ◆ Convinced AANS leadership that establishment of a poster paper program in connection with the AANS Annual Meeting would substantially increase and improve the communication of significant original scientific information to the neurosurgical community, resulting in the combined acceptance (for oral and poster presentation) of more than 600 papers per year, as opposed to fewer than 100 before this program was established.
- ◆ Convinced the Board of Directors that the marketing of the Annual Meeting Exhibit Program should be placed in the hands of the Staff and not an outside sales organization, resulting in expansion of the Exhibit Program into the largest scientific exhibit servicing the neurosurgical community worldwide, and substantially reducing the related costs.
- ◆ Prepared the proposal that convinced the Board of Directors to discontinue the *AANS Newsletter* in favor of the *AANS Bulletin*, which has become the keystone of the AANS Member Communications Program and has been published at costs comparable to publishing the same amount of information in the *Newsletter* format because the inclusion of substantial advertising nearly offset the additional production costs of the new format.
- ◆ Instituted the Comprehensive Neurosurgical Practice Survey, the single most comprehensive source of demographic data on the neurosurgical specialty in the United States.
- ◆ Established the AANS in-house printing facility which has continued to temper the rising costs of the Association's written communications to neurosurgeons.
- ◆ Working with IBM and an independent programmer, developed the first association application for the System 32 mini-computer, which became a popular prototype for future mini-computer applications among small associations in the 1970s and early 1980s.
- ◆ Convinced the Board of Directors to establish a historical archive to preserve documents and memorabilia of historical significance to neurosurgery and initiated the *Leaders in Neuroscience* video-taped oral history series, preserving significant personal commentary of many surgeons who contributed notably to the development of the specialty. The neurosurgical memorabilia collection resulting from donations to this program is presently valued at over \$700,000.
- ◆ Co-published a definitive article in *Neurosurgery* entitled *The Evolution of Organized Neurosurgery in the United States* (citation).
- ◆ Created the policy base and the rules for the maintenance of an Expert Witness Testimony File, a concept that has been the subject of study throughout the medical association community and has served as a prototype for other organizations seeking to establish similar programs.

### ► Executive Director

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While serving as Chief Staff Executive for AANS, Mr. Hauber also discharged volunteer leadership obligations to his association management colleagues. He

served as Vice Chairman of the Board of Directors of the ASAE in 1984-1985 and was a member of the ASAE Board 1981-1985. He received ASAE's highest award, the Key Award, in 1978 and received its counterpart, the Samuel B. Shapiro Award, from the Chicago Society of Association Executives in 1984. An avid skindiver, Mr.

Hauber received the coveted NOGI Award for Distinguished Service from the Academy of Underwater Arts and Sciences.

In retirement Mr. Hauber will continue to serve as a volunteer leader in association management and will continue to make the case for effective staff-volunteer relations.

# Ways to Make Plans Pay You Faster

By Karen Zupko

**N**eurosurgeons experiencing rising accounts receivable can benefit by taking a more activist approach in directing their staff to set-up collection efforts with insurance companies and managed care plans. Here are a series of ideas to help you re-engineer the accounts receivable process in your office.

## Re-Think the Account Receivable Report Format

Instead of reviewing the listing of aged accounts receivable, alphabetically by patient, ask your staff to print the listing by payer type. In other words, run a separate listing for: Medicare, indemnity, worker's comp, and each HMO and/or PPO.

With many medical software programs you can actually have a report which shows the largest balance first, making the problem analysis and follow-up work easier, quicker and profitable. Unfortunately, many staff are unaware of this report option but can learn about it by calling your vendor's "help-line". By having reports prepared in this way it's easy to see which plan owes the most and to determine who the chronic non-paying offenders are.

## Resubmit Lost Claims by Registered Mail

As your staff will tell you, many managed care plans seem to have a perpetual problem losing mail and claims. When sending claims to habitual plan offenders, we recommend using the U.S. Postal Service registered mail service. Doing so provides you with a record of who received the claims and when.

This is an excellent technique to use when there are many claims worth tens of thousands of dollars for surgery. Along with the documentation send a sheet that shows the payment terms of the contract—usually 30-45 days—highlighted in yellow. This is technique particularly important since many managed care plans cannot or will not accept electronic claims.



*Karen Zupko is President of Karen Zupko & Associates, a practice management consulting firm based in Chicago. She is a frequent speaker at AANS Professional Development Courses on practice management topics.*

## Collect In Person

One neurosurgery practice had the provider representative from a leading HMO visit the office to review a stack of unpaid claims. With her intervention, a check arrived in just under 10 days.

Another top-notch administrator used all of the standard approaches with a local third-party-administrator with no result. Fed up, she finally visited their business office with all of the documentation and picked up a check within a week. The personal touch was, evidently, very motivating.

Both examples show that the old saw is true: "It's the squeaky wheel that gets the grease."

## Contact Employee Benefit Managers

Most companies have someone in charge of negotiating for the company health benefits who can help you resolve payment and medical issues with the plan. In our experience these individuals have always been dismayed to learn about a physician's not getting paid—after all that's why they pay the premium.

Contact this person with the patient's permission—often it works best to make the call together—and ask for their help in processing the claim for payment.

## Step up Internal Claim Quality Control Efforts

Not all delayed or unpaid claims are the plan's fault, as one neurosurgeon in the Midwest found out. He discovered two things, first that his office made an exceptional number of basic errors in filling out claim forms, including incorrect social security numbers, missing dates of birth, contract numbers transposed, and failing to attach required referral forms.

His staff held the attitude that once the claim was filed it ceased to be their problem. His probing paid off and now all claims are double-checked before being mailed. Plus, his staff respects the fact that he now inspects their work.

Secondly, this surgeon discovered that the disorganized billing staff did not respond to requests for more information from carriers. This error was costly and explained nearly half of the \$74,000 in the over 90 days category on the aging reports. Following up on insurance company requests is now a specific individual's job and she has a 24 hour turn-around time frame.

Be sure you have enough trained, conscientious people on your staff to handle the business office responsibilities. And, try the advice of business experts: "Manage by walking around." Neurosurgeons who convey the impression to their staff that they are too busy to care about the business side of the practice will probably get a staff effort that is similar and find themselves "cash poor".

Stepping up your review and taking action on overdue claim submissions can improve your cash flow and reduce the dollars in accounts receivable significantly. To learn about other techniques for improving your accounts receivable process, attend the AANS-sponsored course on Accounts Receivable Management—or send your staff. For information call the AANS Professional Development Department (847) 692-9500.





# Spine Code Changes for 1996

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



**T**he group of CPT codes that deal with major surgical procedures in the spine (22100-22889) (graft codes) were revised during 1994-1995 by a work group from the American Association of Neurological Surgeons (AANS) and the American Academy of Orthopaedic Surgeons (AAOS). The codes for preparation and harvesting of bone grafts for spinal procedures (20930-20938) were also revised to more clearly distinguish the actual service involved.

The object was to provide for the changes in surgical technology and procedures that have evolved over the past ten years while improving the accuracy and specificity of the descriptors of the services covered by each code. Use of older CPT codes/descriptors was resulting in a failure to accurately portray the real scope of services frequently delivered to a patient in a single surgical session for management of a complex spinal problem. Misuse and misinterpretation of some of the codes also led to cumulative charges and bills that became an embarrassment to those who were called upon to defend such behavior.

An agreement was reached with the CPT committee of the AAOS to refine these codes in a manner that would allow for each delivered service to be reported and billed, but which would more fairly apportion the value of each such service within the total

package provided. This "Chinese menu" style of unbundling these codes encourages a building block technique in coding for a collection of services provided during the course of a single operative session.

After the CPT codes were reviewed and approved by the CPT Editorial Panel of the American Medical Association (AMA), they were forwarded to the AMA RVS Update Committee (RUC) for review and revaluation of the physician work component. Fifty-five codes were in this package, and required a survey by the orthopedists and neurosurgeons who provided these services. This was completed last Spring and presented to the RUC. The survey results led to relatively small changes in the physician relative values for work (RVWs) for the majority of the codes.

## Instrumentation Codes Reduced

However, the spinal instrumentation codes were a part of this review and revaluation, and were reduced in their RVWs by 50%. The reasons for this decrease were based on the initial valuation of these codes in the CPT 1994 as a group of procedures to be used in addition to another code such as an arthrodesis, and was valued for physician work to cover only those services up to and including the day of surgery (000 Global) with the aftercare apportioned to the primary code (arthrodesis). The RUC agreed that these codes should be reclassified as add-on services with a ZZZ Global period, which meant that only the intra-operative service for the instrumentation would be apportioned as physician work.

The result of this change was a reduction in the adjusted RVW of 50%. This was the final agreement that was sent to the Health Care Financing Administration (HCFA) and approved after review at that level.

*“Use of older CPT codes/descriptors was resulting in a failure to accurately portray the real scope of services frequently delivered to a patient in a single surgical session for management of a complex spinal problem.”*

## One Last Chapter

There is one more chapter to this story about the instrumentation codes. When HCFA reviewed these codes, there was agreement that they had been re-valued appropriately by reducing the RVUs by 50%. However, HCFA did not apply that same 50% cut to the practice expense RVUs and the malpractice expense RVUs for each of the revised instrumentation codes.

HCFA did a reallocation of the practice expense and malpractice expense RVUs for work, practice expense and malpractice expense to adjust the RVUs in each category. When this was done, the total RVUs for most of the spinal instrumentation codes had been reduced by 60%, which is the current level published by HCFA. Our comments and complaints about this extra reduction have not been accepted as a basis for restoring the extra costs, since HCFA feels that these services were overvalued initially and now are more reasonably valued.

**Examples of the new/revised codes, including comparisons between the 1995 and 1996 total RVUs, are located on the following two pages.**

## ► Spine CPT Codes

(continued from previous page)

SPINE CPT CODES										
CPT	DESCRIPTOR	96 RVW	96 RVP	96 RVM	96 RVU Total	96 GLOBAL	1996 RVUs-1995 RVUs			
							RVW	PE	Malp	Total
22100	Remove part of neck vertebra	9.05	7.64	1.09	17.78	90	0.86	1.27	0.26	2.39
22101	Remove part, thorax vertebra	9.00	8.01	1.38	18.39	90	0.81	1.44	0.19	2.44
22102	Remove part, lumbar vertebra	9.00	4.50	0.67	14.17	90	0.22	0.12	0.05	0.39
22103	Remove extra spine segment	2.34	2.23	0.37	4.94	ZZZ				
22105	Remove part of neck vertebra	0.00	0.00	0.00	0.00	90				
22106	Remove part, thorax vertebra	0.00	0.00	0.00	0.00	90				
22107	Remove part, lumbar vertebra	0.00	0.00	0.00	0.00	90				
22110	Remove part of neck vertebra	11.59	9.72	1.64	22.95	90				
22112	Remove part, thorax vertebra	11.59	9.90	1.63	23.12	90				
22114	Remove part, lumbar vertebra	11.59	7.25	1.17	20.01	90	0.00	-0.11	0.02	-0.09
22116	Remove extra spine segment	2.32	2.21	0.36	4.89	ZZZ				
22140	Reconstruct neck spine	0.00	0.00	0.00	0.00	90				
22141	Reconstruct thorax spine	0.00	0.00	0.00	0.00	90				
22142	Reconstruct lumbar spine	0.00	0.00	0.00	0.00	90				
22145	Reconstruct vertebra(e)	0.00	0.00	0.00	0.00	ZZZ				
22148	Harvesting bone graft	0.00	0.00	0.00	0.00	ZZZ				
22150	Reconstruct neck spine	0.00	0.00	0.00	0.00	90				
22151	Reconstruct thorax spine	0.00	0.00	0.00	0.00	90				
22152	Reconstruct lumbar spine	0.00	0.00	0.00	0.00	90				
22210	Revision of neck spine	22.51	13.83	2.43	38.77	90				
22212	Revision of thorax spine	18.14	17.29	2.83	38.26	90				
22214	Revision of lumbar spine	18.14	15.00	2.70	35.84	90	0.00	-0.11	0.02	-0.09
22216	Revise, extra spine segment	6.04	5.70	0.90	12.64	ZZZ				
22220	Revision of neck spine	20.15	16.64	2.63	39.42	90				
22222	Revision of thorax spine	20.15	13.61	1.58	35.34	90				
22224	Revision of lumbar spine	20.15	14.68	2.66	37.49	90				
22226	Revise, extra spine segment	6.04	5.07	0.89	12.00	ZZZ				
22230	Additional revision of spine	0.00	0.00	0.00	0.00	ZZZ				
22305	Treat spine process fracture	1.86	2.38	0.37	4.61	90	1.86	2.38	0.37	4.61
22310	Treat spine fracture	1.86	2.52	0.69	5.07	90	1.86	2.52	0.69	5.07
22315	Treat spine fracture	8.36	5.51	0.86	14.73	90				
22325	Repair of spine fracture	17.19	8.32	1.34	26.85	90				
22326	Repair neck spine fracture	18.43	15.93	2.74	37.10	90				
22327	Repair thorax spine fracture	17.56	15.95	2.35	35.86	90				
22328	Repair each add spine fx	4.61	4.40	0.72	9.73	ZZZ				

(continued on next page)

## ► Spine CPT Codes

(continued from previous page)

SPINE CPT CODES										
CPT	DESCRIPTOR	96 RVW	96 RVP	96 RVM	96 RVU Total	96 GLOBAL	1996 RVUs-1995 RVUs			
							RVW	PE	Malp	Total
22505	Manipulation of spine	1.77	1.31	0.17	3.25					
22548	Neck spine fusion	24.08	22.74	3.82	50.64	10				
22554	Neck spine fusion	17.24	19.81	3.52	40.57	90	-1.17	0.00	0.00	-1.17
22556	Thorax spine fusion	22.27	21.68	3.58	47.53	90	-0.90	0.00	0.00	-0.90
22558	Lumbar spine fusion	21.22	20.17	3.38	44.77	90	-0.90	0.00	0.00	-0.90
22585	Additional spinal fusion	5.53	5.40	0.93	11.86	90				
22590	Spine & skull spinal fusion	19.50	21.57	3.44	44.51	ZZZ	0.54	0.00	0.00	0.54
22595	Neck spinal fusion	18.19	22.46	3.87	44.52	90	-1.05	0.00	0.00	-1.05
22600	Neck spine fusion	14.74	19.36	3.32	37.42	90	-3.31	0.00	0.00	-3.31
22610	Thorax spine fusion	14.62	17.87	2.75	35.24	90	-0.49	0.00	0.00	-0.49
22612	Lumbar spine fusion	20.19	20.60	3.33	44.12	90	-2.06	1.38	0.24	-0.44
22614	Spine fusion, extra segment	6.44	5.65	0.92	13.01	90				
22625	Lumbar spine fusion	0.00	0.00	0.00	0.00	ZZZ				
22630	Lumbar spine fusion	20.03	18.44	3.15	41.62	90	-0.90	0.00	0.00	-0.90
22632	Spine fusion, extra segment	5.23	4.99	0.82	11.04	90				
22650	Additional spinal fusion	0.00	0.00	0.00	0.00	ZZZ				
22800	Fusion of spine	16.92	21.66	3.58	42.16	ZZZ				
22802	Fusion of spine	29.74	28.32	4.61	62.67	90	-1.57	0.00	0.00	-1.57
22804	Fusion of spine	35.00	28.32	4.61	67.93	90				
22808	Fusion of spine	25.00	18.41	3.15	46.56	90				
22810	Fusion of spine	29.00	18.41	3.15	50.56	90				
22812	Fusion of spine	31.00	25.93	4.24	61.17	90	3.80	0.00	0.00	3.80
22820	Harvesting of bone	0.00	0.00	0.00	0.00	90	-2.79	-3.64	-0.74	-7.17
22830	Exploration of spinal fusion	10.22	13.07	2.18	25.47	ZZZ				
22840	Insert spine fixation device	6.27	5.98	0.98	13.23	90	-6.27	-11.63	-2.65	-20.55
22842	Insert spine fixation device	7.19	6.86	1.12	15.17	XXX	-7.23	-12.76	-2.90	-22.89
22843	Insert spine fixation device	8.97	8.55	1.40	18.92	ZZZ				
22844	Insert spine fixation device	10.96	10.45	1.71	23.12	ZZZ				
22845	Insert spine fixation device	5.98	5.70	0.93	12.61	ZZZ	-6.50	-10.27	-2.34	-19.11
22846	Insert spine fixation device	8.28	7.90	1.29	17.47	ZZZ				
22847	Insert spine fixation device	9.20	8.77	1.44	19.41	ZZZ				
22848	Insert pelvic fixation device	6.00	5.72	0.94	12.66	ZZZ				
22849	Reinsert spinal fixation	12.86	11.76	1.97	26.59	ZZZ				
22850	Remove spine fixation device	8.98	9.17	1.50	19.65	90				
22851	Apply spine prosth device	6.71	6.40	1.05	14.16	90				
22852	Remove spine fixation device	8.40	9.80	1.57	19.77	ZZZ				
22855	Remove spine fixation device	9.10	7.46	1.25	17.81	90				

## Course Schedule "At-A-Glance" May–December 1996

## Professional Development

W I T H

The American Association of Neurological Surgeons



### '96 Reimbursement Update for Neurosurgeons

June 28-30, Orlando, FL  
August 23-25, San Francisco, CA  
November 8-10, Chicago, IL

**Course Chairman: Richard A. Roski, MD**

This is not just another reimbursement course! Designed specifically for neurosurgeons and their office staff, this course offers practical tips and suggestions for modifying office systems that should increase reimbursements. It also reviews challenging coding cases and matches your skill against the experts. This course also features two pre-courses: Understanding Anatomy and Terminology, and Accounts Receivables.

### How to Prosper in Managed Care for Neurosurgeons

June 1-2, Philadelphia, PA  
October 26-27, Location: TBA  
November 2-3, Chicago, IL

**Course Chairman: John A. Kusske, MD**

Learn the inside scoop on managed care and what it really means to your medical practice. This comprehensive course will provide you with the opportunity to learn about practical aspects of dealing with contracts, re-engineering practice business systems to ensure correct payment, understanding capitation, and negotiating contracts. Because of the overwhelming demand for this very popular course, early registration is recommended.

### Surgery of the Cervical Spine: Hands-On

June 21-23, Memphis, TN

**Course Chairmen: Regis W. Haid, MD and  
Richard L. Saunders, MD**

Explore new and innovative techniques in "Surgery of the Cervical Spine." You will review current concepts, and based on intensive interactive discussions, laboratory sessions will focus on hands-on cadaver surgical instruction. You will see and perform a variety of decompression and stabilization techniques utilizing screws, wires, and plates. Four different types of anterior plates will be shown.

### Spine Surgery—Hands On: A Comprehensive Approach for Neuro- surgeons, Neuroscience Nurses & Physician Assistants

May 18-24, Albuquerque, NM

**Course Chairman: Edward C. Benzel, MD**

Neurosurgical advances occur rapidly! The need to increase your knowledge and sharpen your skills is a constant challenge. To help you meet this challenge, the AANS presents two unique hands-on courses. One is designed for neurosurgeons interested in the treatment of cervical, thoracic and lumbar spine disorders, and the surgical approaches to all regions of the spine. The other focuses on topics of interest to neuroscience nurses and physician assistants, and includes the opportunity for hands-on cadaver experience.

### Stereotactic Neurosurgery

November 15-16, San Francisco, CA

**Course Chairman: Philip L. Gildenberg, MD, PhD**

The field of stereotactic neurosurgery has advanced rapidly since surgical targeting techniques have become entwined with CT and MR scanning procedures. This course addresses procedures which can be readily added to the general practice of neurosurgery as well as the use of more sophisticated techniques that require specialized resources. There will be ample time for hands-on experience utilizing various types of apparatus available from several manufacturers.

### Neurosurgical Critical Care for Neurosurgeons, Neuroscience Nurses & Physician Assistants

June 20-22, Chicago, IL

**Course Chairman: Michael J. Rosner, MD**

Neurosurgical Critical Care for 1996 is tailored specifically for neurosurgeons and their clinical associates. A team of experts will present the most comprehensive and informative course available on managing patients with critical multi-system problems. Faculty will stress scientific management of critically ill patients by applying quantitative relationships associated with neurosurgical diseases. Current concepts in neurosurgical critical care, such as cerebral perfusion pressure management, modern fluid management and cerebral pathophysiology, will be addressed.

### Minimally Invasive Neurosurgery - Neuroendoscopy: Hands-On

October 25-26, Cleveland, OH

**Course Chairman: Alan R. Cohen, MD**

This state-of-the-art, hands-on course is one you will not want to miss! It provides an in-depth overview of current indications for neuroendoscopy, as well as surgical pitfalls to be avoided. Expertise will be gained through setting up the equipment and performing a series of orientation and dissection exercises. Space in this course is limited, so register today!

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

The American Association of Neurological Surgeons designates these continuing medical education activities for the designated hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

**To register for an AANS course, call the PDP Department at (847) 692-9500.**

## PROFESSIONAL DEVELOPMENT

### Advanced Thoracic and Lumbar Spine Management : Hands-On

October 18-20 , Chicago, IL

Course Chairman:

Charles B. Stilleman, MD

Associate Chairmen:

Edward C. Benzel, MD and Eric J. Woodard, MD

You will be engaged in a series of cases that cover a variety of thoracic and lumbar spine management techniques. Emphasis will be placed on anatomical, biomechanical and clinical considerations. Operative indications and surgical algorithms will be discussed. Expert faculty will facilitate the discussions and lead you through extensive, hands-on instruction utilizing cadavers and sawbones.

### Attention: Neurosurgeons and Office Staff!

The AANS Professional Development Department is still taking registrations for '96 Reimbursement courses in:

San Francisco, CA, August 23-25  
and  
Chicago, IL, November 8-10

Due to the overwhelming demand and sold out courses, the AANS Professional Development Department has added another "**'96 Reimbursement Update for Neurosurgeons**" course to its schedule. It will be held June 28-30 in Orlando, FL and will feature the most comprehensive updated information on:

- ◆ Reimbursement Guidelines
- ◆ Coding Regulations
- ◆ Medicare Rules
- ◆ New Spine Codes

Don't delay! For more information or to register, call (847) 692-9500.

### Surgery of the Cervical Spine: Hands-On

June 21-23, Memphis, TN

Course Chairmen:

Regis W. Haid, MD and Richard L. Saunders, MD

An in-depth review of current concepts in cervical spine surgery.

#### Topics include:

- |                      |                             |
|----------------------|-----------------------------|
| ◆ Bone Healing       | ◆ Anterior Corpectomy       |
| ◆ Anterior Plating   | ◆ Anterior Odontoid Screw   |
| ◆ Orthoses           | ◆ Cable Overview            |
| ◆ Subaxial Fixation  | ◆ CLC2 Overview             |
| ◆ Spinal Stereotaxis | ◆ Occipital Cervical Fusion |

**Enrollment is limited!** Register today for a first-rate experience in hands-on spine education!

### Neurosurgical Critical Care for Neurosurgeons, Neuroscience Nurses & Physician Assistants

June 20-22, Chicago, IL

Course Chairman:

Michael J. Rosner, MD

If you want to significantly increase your ability to manage critically ill patients, you must make time for this course! This educational experience will help you better understand critical care and how it impacts your patients. After this course, you will be able to:

- ◆ Use simple quantitative relationships
- ◆ Apply relationships in ventilator and respiratory patient management
- ◆ Apply and integrate quantitative relationships
- ◆ Better manage patients with central nervous system and spinal cord dysfunction
- ◆ Precisely manipulate cardiac output, blood pressure and cardiovascular status

See the AANS Professional Development 1996 course schedule for more information, or call (847) 692-9500.

## THANK YOU !

As our Professional Development Program enters its seventh year, we want to express our thanks for your continuing support. From a first-year offering of just five courses, the annual schedule has expanded to include more than 20 socioeconomic and clinical skill courses. We look forward to many more years of educational success.

— The Professional Development  
Committee

# Neurosurgical Residency Training Programs and the Work Force Debate

By A. John Popp, MD  
Henry and Sally Schaffer Chair  
of Surgery  
Head, Division of Neurosurgery,  
Albany Medical College, Albany, NY

The “economics of medicine” once almost exclusively the purview of physicians—has increasingly become a societal concern. Many forces underlie this shift in focus, including the rising costs of medical care in the United States; the growth in managed care (which has become the insurance of choice for many); the increasingly strident call for national health care reform; and the shifting demographics of the population served by medicine (such as the drastic increase in the elderly population).

Central to discussions relating to medical socioeconomic policy-making is the issue of “right-sizing” the physician work force in accordance with the health care needs of society.

Analyses of work force requirements in the face of the burgeoning popularity of managed health care appears to have demonstrated a need for fewer physicians, particularly specialists. Indeed, in 1992, the Council on Graduate Medical Education

In a report published in 1993, Wennberg et al.<sup>2</sup> asserted that the present number of clinically active neurosurgeons was 2.5 times the number needed, provided the entire U.S. population was enrolled in a health maintenance organization (HMO). Of even greater concern was their report that, even if neurosurgery training programs stopped producing residents immediately, it would take more than 25 years for the supply of neurosurgeons to be reduced to a number compatible with that needed in a managed health care system based on the classic HMO.

Determining the appropriate number of neurosurgeons needed to provide optimal care, however, is both difficult and controversial, and manpower adjustments based on inherently imprecise projections of patient need are fraught with peril. Equally serious problems are created when there is either an undersupply or an excess of neurosurgeons available, although the latter takes longer and is more difficult to remedy than a shortage.

A shortage of neurosurgeons results in suboptimal delivery of needed services, with the result that some patients may not be able to obtain neurosurgical care or may experience a significant delay in treatment. Alternatively, an

Another unintended result would be an alteration in market forces, resulting in reduced compensation for services and underutilization of competent, highly trained physicians. Thus, from the perspective of both the specialty and the patients it serves, the need to “right-size” the neurosurgical work force is a pressing one, and one that is inextricably linked to the dynamic of quality versus cost.

## Historical Perspective

Neurosurgery has a long history of interest in work force size, beginning with Cushing who opined that it took a population of one million people to generate enough cases for one neurosurgeon. The American Association of Neurological Surgeons (AANS) began to formalize this interest during the 1960's and, in 1970, neurosurgery, as a specialty, was unique in obtaining a National Institutes of Health (NIH) grant to study manpower.

More recently, the AANS conducted three comprehensive practice surveys — in 1987, 1992 and 1995—the results of which provide important data on the demographics and practice habits. These surveys, taken collectively, also offer an important “over time” perspective.

On a parallel front, the Manpower Committee of the Joint Council of State Neurosurgical Societies (JCSNS) has also been collecting pertinent work force information, having published its first report in 1993 under the direction of Stanley Pelofsky, MD, current chairman of the JCSNS.<sup>1</sup> The Committee's initiatives have since been carried forward by two surveys conducted in 1995. The first, directed by Tim Harrington, MD, sought to determine the current status of manpower and the effects of managed care on neurosurgical practice in selected geographic areas of the United States. The second study—the Residency Manpower Survey (RMS)—under the direction of the author, focused on the collection of data and opinions relating to neurosurgical residency programs and manpower.

*“The need to “right size” the neurosurgical workforce is a pressing one, and one that is inextricably linked to the dynamic of quality versus cost.”*

(COGME) recommended that 50% of all physicians be primary care practitioners by the year 2000 and that the number of first-year residency positions be drastically reduced from 140% to 110% of the number of physicians completing their education in U.S. medical schools annually.

Neurosurgery, whose work force represents less than 1% of all practicing physicians, has frequently been cited as a specialty with an excess of care providers in relation to the needs of the patients served.

oversupply of neurosurgeons creates different problems that can have a profoundly negative impact on both the specialty itself and the quality of care delivered.

For instance, a surplus of neurosurgeons may translate to a reduced number of operations being performed by each and, thus, diminished experience for certain procedures. Some<sup>2</sup> assert it also would mean a lower threshold for the performance of surgery, resulting in an increased number of operations performed and increased costs.

(continued on page 27)









## ► Work Force Debate

(continued from page 22)

### RMS Aims and Methodology

The specific aims of the RMS were to: 1) determine the feasibility of collecting “meaningful” data on residency manpower and training from a large percentage of neurosurgery program directors, 2) collect data from training programs on factors influencing neurosurgical manpower such as geography, population density, use of physician extenders and changes that residency training programs might make in the future, 3) seek the opinion of residency training program directors about the effects of current economic trends on residency training activities, and 4) obtain information from university-based neurosurgical units without training programs about intent to establish such a program.

The survey was sent to the directors of all residency training programs in the United States and Canada currently listed by the American Board of Neurological Surgery (ABNS). In addition, directors of neurosurgery departments at university-based medical schools without residency training programs were sent the survey for completion.

### Good Response Rate

The response rate (N = 90) was gratifying: 76% of U.S. programs, 33% of Canadian programs and 38% of LCME-approved (Liaison Committee on Medical Education) medical schools without training programs responded, yielding an overall response rate of 65%. The largest percentage (33%) of the programs responding were located in geographic areas with populations >2.5 million; 20% of the programs were in areas with populations of 1 to 2.5 million. Of 88 programs that responded, 40 (45%) had referral areas that extended beyond their immediate metropolitan area.

The data collected were sufficient to allow some interesting and, in some instances, surprising conclusions to be drawn. Predictably, a substantial number of respondents registered concern about the present and future supply of neurosurgeons.

In fact, it was the impression of 55% of the survey respondents that too many neurosurgeons are currently being trained. The factors most frequently cited as contributing to this perception were, in descending order, concerns about managed care, present job availability, and changes in work load and/or income. Additionally, 53% of the respondents believed that there were too many neurosurgeons practicing within their geographic area.

### Conflicting Responses

Despite these concerns, however, some of the program directors surveyed indicated a desire to increase their number of residency positions, or in the instance of LCME-approved medical schools without neurosurgery residency training programs, a desire to apply for a new program. Equally puzzling, given this expressed desire, was the fact that most respondents (73%) believed that the quality of their program would be jeopardized if a new training program were established within 50 miles of the existing one.

More than 80% of respondents believed that the number of neurosurgical training program positions should be regulated, but there was little consensus in opinion as to the method by which this should be accom-

vagaries of predicting health care needs. Moreover, if such a reduction were to be undertaken by the national organizations representing the specialty of neurosurgery, it would almost certainly be considered a violation of the Sherman Antitrust Act. Furthermore, a reduction in neurosurgical work force without commensurate reduction in other surgical specialties would place neurosurgery at risk of an increased loss of market share, as has recently occurred in the areas of spinal, vascular and peripheral nerve surgery.

### Clarification of Some Issues

Two sections of the survey that were intended to elucidate issues concerning work force distribution—one yielding geographic/demographic data and another exploring fellowship training opportunities—provided preliminary data but were insufficient to allow definitive conclusions to be drawn. An analysis of any mal-distribution of neurosurgical work force would require geographic and population data that extend far beyond the scope of this survey. Likewise, although programs were queried on fellowship training opportunities at their institutions, the data gathered was inadequate to do more than underscore the necessity of including neurosurgical fellows among

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*“Radical downsizing would not help in the short term if the oversupply of neurosurgeons is as serious as some believe.”*

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plished (e.g. government mandate, market forces, payers or “other”). Some, in hallway conversations, have argued that the ABNS or the Residency Review Committee (RRC) should simply reduce the number of training programs and residents, but this approach poses some problems.

Radical downsizing would not help in the short term if the oversupply of neurosurgeons is as serious as some believe, and it could result in a serious shortage of neurosurgeons in the future given the

the work force when conducting manpower analysis.

According to the survey results, the impact of international medical graduates (IMG's) on neurosurgical manpower was negligible. Currently IMG's represent approximately 20% of residents training in all graduate medical education programs per year, but less than 3% of the neurosurgical residents annually,

(continued on next page)

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## ► Work Force Debate

(continued from page 22)

over the past decade. Most respondents (84%) indicated that they would favor accepting IMGs for training if the trainees would agree to reside permanently in their country of origin upon completion of the program. This raises an interesting option for meeting the "service" component of the neurosurgical programs should the number of U.S. trained residents entering training programs annually be reduced.

### Program Funding

Funding of residency training programs was the last major topic included in the survey. According to survey results, 71% of the funding for neurosurgical training is derived from hospitals, with the remainder being provided by the department/division of neurosurgery or other sources.

Despite the fact that hospitals' funding will likely be seriously curtailed if proposed Medicare cuts become law, 62% of the respondents denied that such cuts would affect their decision to expand or reduce the number of individuals in their training program. It is surmised that regional initiatives at reducing training program dollars, as currently under consideration as part of New York State's 1996 budget, coupled with the federal mandates, will result in regional changes.

### Manpower Only One Aspect of Controversy

There is widespread consensus that "right-sizing" the physician work force has considerable merit, especially in this era of medical-economic crisis. However, work force analysis is an inexact, complex, and rapidly changing field of inquiry, and the consequences of manpower adjustments are serious. Both the supply and the demand sides of the equation must be further explored, along with such variables as

percentages of time engaged in patient care versus other professional pursuits, distribution of the neurosurgical work force, and impact of managed care.

The residency manpower issue is only one part of any work force model albeit an important part. It is our intent to further develop this residency survey—refining question structure and analysis, breadth of data collected and validating testing methods.

This done, the residency manpower data we obtain, in concert with the data derived from other work force supply/need analyses, will allow us to contribute substantially to the ongoing manpower dialogue. To do otherwise would be to jeopardize the quality of neurosurgical practice and to abdicate responsibility for the fate of our specialty to others. Thus, the neurosurgical community must strive, with the aid of meaningful, comprehensive data, to speak with one voice in addressing the issue of manpower planning.

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1. Pelofsky, S. Manpower Committee Report, Joint Council of State Neurosurgical Societies. April 1993
  2. Wennberg, J.E., Goodman, D.C., Nease, R.F. & Keller R.D. "Finding Equilibrium in U.S. Physician Supply." *Health Affairs*. Summer, 1993; 89-102

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## ► Caveat Emptor

(continued from page 11)

This acceptance stands to do great mischief to the system as it currently operates. As Dr. Frederick Spong, a Senior Consultant with M&R said during a lecture at the AMA Parameters Forum in June 1994, they plan to "manage by exception all cases not meeting the standard", whether or not it is adapted to local circumstances. This in turn cannot help but generate an enormous amount of telephone traffic that has the effect of harassing the physicians and their patients.

The goal of reducing the bed days by over 40% as an optimum target cannot be achieved under any but the most optimized circumstances, targeting the uncomplicated

younger-than-Medicare patient with no comorbidities. This, in effect, represents a cost shift to the outpatient setting, not without significant risk to such patients as a CABG or Total Hip Arthroplasty patient discharged on the fourth day (M&R LOS).

### What's Ahead

The AMA considered this problem at the June 1994 House of Delegates meeting and produced two Resolutions (710 and 715) that addressed the situation. The AMA advocated that all guidelines be developed in accord with its own principles for guidelines, and that all managed care plans, third party payers and utilization review organizations consult with relevant physician organizations before development and implementation of such guidelines.

There are some hospitals that have been able to develop such optimized patient care programs during the past two years. When the physicians, nursing staff as well as hospital administrators work together to improve the efficiency of the system, substantial improvements can and are made. In some instances, the targets actually exceed those advocated by the M&R Guidelines, when there are no complications, and when the patients are young and otherwise healthy.

However, this is not an overnight change but requires a carefully planned and executed program of stepwise and incremental change. It represents a consensus among the various involved providers in order to avoid inadvertent harm to the patient while traversing this slippery slope.

## Member Comments on Ethics Review

The Professional Conduct Committee has a tough job, one that requires dedication and sensitivity. Each year, the Committee conducts multiple reviews of actions by members who provide expert witness testimony in a variety of matters under litigation. The Committee, under the leadership of its Chairman, W. Ben Blackett, MD, JD, and consisting of Rick Batsdorf, MD, and Robert D. Harris, MD, have consistently acted in a very responsible and mature manner. Most case reviews do not lead to sanction (in fact, only one review led to censure this past year), however, each individual's case receives very careful consideration.

Not long ago, a member's actions with regard to witness testimony made on behalf of plaintiff were reviewed for possible violation of the AANS Code of Ethics. The member, who was not sanctioned, expressed satisfaction about the due process followed in that review and subsequently

submitted the following comments regarding the experience.

"I believe the AANS Guidelines and Code of Ethics produce more thoughtful and accurate testimony. I wholeheartedly support them.

"I thank the committee for their work and scrupulous attention to detail, which this report reflects. I am sorry the committee was burdened with this. I know this review was not easy. After reading the report, I believe that, had I been more precise and diligent in my presentation, this issue would not have needed to come before the committee.

"Although I cannot say I enjoyed the process of being called before the committee, I found the committee members to be fair, thorough, and completely knowledgeable about the facts of the case. I believe the final report reflects this.

"When I agree to review a potential medical malpractice case, whether for the plaintiff or the defense, I take that responsibility very seriously. I have always attempted to conduct my review and testimony within the guidelines for testimony published by the AANS. I agree that our current system is less than ideal for the resolution of questions of quality and malpractice. Unfortunately, it is the system which we have and must live and work within. Over the years, I have developed some reputation for quality review of cases. I believe that overall this has been of benefit to neurosurgery, not only in testifying for the defense, but also in providing a resource for attorneys for the review of cases which minimize or abort bases of alleged malpractice.

"While it is rare for me to testify on behalf of a plaintiff against a neurosurgeon, this was one of the exceptions. Had I to do it over again, I would still be willing to stand as an expert for the plaintiff."

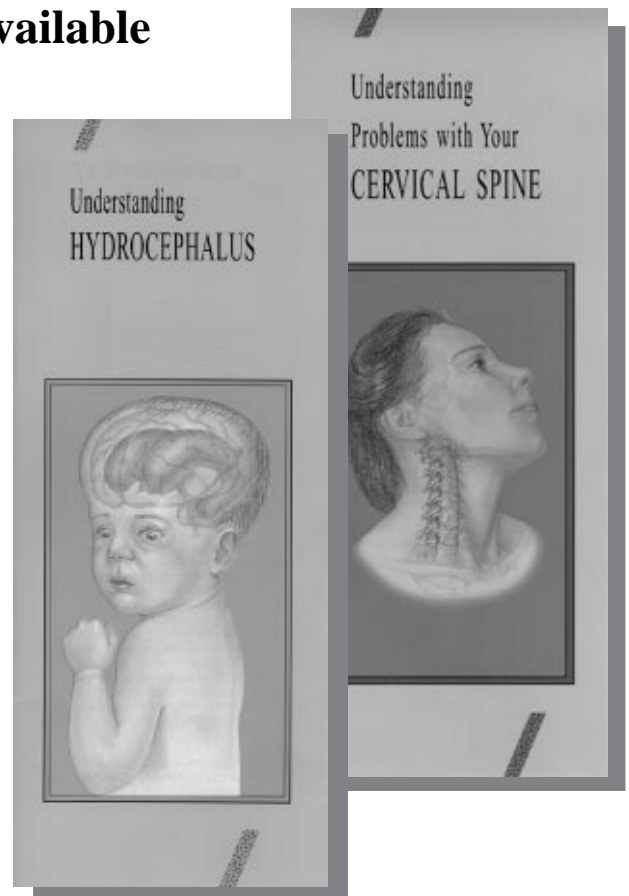
## New Patient Education Brochures Available

The Publications Committee has introduced two new patient education brochures—"Understanding Hydrocephalus" and "Understanding Problems With Your Cervical Spine" which are now available for member use.

The 20-page brochure on hydrocephalus contains a detailed description of the condition, outlines how it is diagnosed, and describes the treatment options. Particular attention is given to shunts. The 28-page cervical spine brochure explains the spinal anatomy, as well as diagnosis, treatment and recovery process for the most common disorders.

Both brochures explain the role of the neurosurgeon in treating the various disorders and provide basic glossaries of related medical terms. Each publication features detailed drawings by a nationally-known medical illustrator. Sample brochures and an order form will be sent to all AANS members shortly.

The brochures will be sold in packs of 200 for \$195. For information on how to order "Understanding Hydrocephalus" or "Understanding Problems with Your Cervical Spine," contact the Order Fulfillment Department at the National Office, (847)692-9500.



## Joint Section of Cerebrovascular Surgery Holds First Meeting

**T**he Joint Section of Cerebrovascular of The American Association of Neurological Surgeons and Congress of Neurological Surgeons held its first "stand alone" Annual Meeting in conjunction with The American Heart Association Stroke Meeting in San Antonio January 23-25, 1996. The meeting was a major success, thanks to the outstanding efforts of Issam Awad, MD, and his meeting committee. The program featured a number of invited speakers, along with oral presentations and a large poster session selected from submitted abstracts.

The overwhelming response to the meeting has encouraged the Section's Executive Council to proceed with plans for our 2nd Annual Meeting, which will again be held in conjunction with the Stroke Council meeting. In addition, we are looking into having a joint meeting with the American Society for Interventional and Therapeutic Neuroradiology. This endeavor is prompted by the close, collaborative relationship that exists between neurosurgeons and

interventional neuroradiologists nationwide. Next years' Annual Meeting Chairperson is Linda Sternau, MD.

The Executive Council of the Cerebrovascular Section is working closely with Marc Mayberg, MD, Chairman of the Carotid Endarterectomy Task Force, to help neurosurgeons become more involved in the management of carotid artery stenosis. The Joint Council recently sponsored a refresher course in carotid endarterectomy under the direction of Julian Bailes, MD, at Allegheny General Hospital in Pittsburgh. The course was well attended and well received. Any neurosurgeon wishing to learn more about the Task Force efforts should contact Dr. Mayberg for further information.

### Pharmacia-Upjohn, Inc. Fellowship

Pharmacia-Upjohn, Inc. has awarded the Joint Section of Cerebrovascular Surgery two resident research awards totaling \$20,000. These stipends of \$10,000 each

will cover a research period of six to 12 months, beginning July 1, 1996. A research preceptor is required, and research should be directed in the general field of cerebrovascular disease or pathophysiology related to cerebral ischemia.

Qualified residents in North American training programs will be eligible for this stipend during a designated research component of their training. Applications should be requested from Marc Mayberg, MD, Department of Neurological Surgery, Box 356470, University of Washington, Seattle, WA 98195. The deadline for applying is May 1, 1996.

Membership in the Cerebrovascular Section continues to mushroom under the leadership of our Membership Chairman Issam Awad, MD, and his successor Chris Ogilvy, MD. Anyone with an interest in cerebrovascular disease is encouraged to join the Cerebrovascular Section by contacting Dr. Ogilvy at Massachusetts General Hospital in Boston.

## Joint Section on Pain—Chairman's Report

**By Samuel J. Hassenbusch, MD, PhD  
Chairman**

The AANS/CNS Joint Section on Pain continues to be involved in a number of activities important to our neurosurgical colleagues.

### Satellite Workshop

One of the most exciting upcoming events for the Section on Pain is the satellite workshop to be held October 2-4, 1996 at the tail-end of the Congress of Neurological Surgeons Annual Meeting in Montreal. This workshop will have a faculty of 21 neurosurgeons and will cover ablative, augmentative, and trigeminal procedures.

To maximize faculty/participant interactions, the registration will be limited to only 50 post-residency neurosurgeons. There will be 50 additional tuition-free slots for neurosurgical residents. Kim Burchiel, MD, will contact each residency program director to have them each identify one resident in obtaining these skills.

At the upcoming AANS Annual Meeting in Minneapolis there will be a number of educational opportunities available to neurosurgeons with an interest in pain management. The Joint Section on Pain will offer its program on Wednesday afternoon, May 1. The main symposium topic will be "Persistent Pain after Spinal Surgery - What do I do now?" With David Kelly, MD, Joel Seres, MD, and John Loesser, MD, as speakers. In addition, the William H. Sweet Young Investigator Award will be presented to John G. Piper, MD, from the University of Iowa.

Also on the schedule are three practical clinics on pain topics, including a full-day session on "Neuroaugmentative Procedures for Pain Control" (#018) and half-day sessions on "Ablative Neurosurgery for Pain" (#008) and "Trigeminal Neuralgia." (#004). In addition, two breakfast seminars "Neurosurgical Management of Cancer Pain" (#114) and "Surgical Options for Trigeminal Neuralgia" (#416) will be offered.

### New CPT Codes

As of January 1st, new implantable pump CPT codes have been in effect. There are separate codes for spinal catheter placement (62350) and programmable pump placement (62362), with codes now available for catheter revision (62355) and pump revision (62365). The RVU values for each of these procedures matches closely those for spinal stimulation.

A Section mailing to all members of the AANS and the CNS is being sent to detail the available codes and RVU values for both implantable pump and stimulation procedures. The mailing also serves as a first notice for the satellite workshop at the Montreal meeting in October.

### Neurosurgical Pain Management Task Force

A special task force has been created under the leadership of Roberto Heros, MD, and

*(continued on page 32)*

## The Joint Section on Stereotactic and Functional Neurosurgery

**By L. Dade Lunsford, MD**  
**Chairman**

The Joint Section has charged four members of the Executive Council to form task forces with specific goals of providing practice guidelines, reimbursement strategies and defining training standards in stereotactic and functional neurosurgery. Leaders of the task forces include Douglas Kondziolka, MD (stereotactic radiosurgery), Lucia Zamorano, MD and Robert Maciunas, MD (image-guided neurosurgery), Roy Bakay, MD (movement disorders), and David Roberts, MD (epilepsy).

Reimbursement guidelines continue to be a challenging area. A recent preliminary ruling by the Health Care Financing Administration (HCFA) suggested that a stereotactic pallidotomy was an investigational procedure that would not be covered

by Medicare reimbursement. Richard Penn, MD, and Dr. Bakay met with HCFA representatives to relay the position of the Joint Section. The position of the Executive Committee of the Joint Section on Stereotactic and Functional Neurosurgery is that stereotactic pallidotomy is a recognized procedure with an appropriately assigned CPT code, which is beneficial for the management of medically refractory Parkinson's disease, especially when characterized by dyskinesia, rigidity and bradykinesia.

### Educational Programs

The Joint Section will present a special symposium on image-guided surgical microscopes at the 1996 AANS Annual Meeting in Minneapolis, Minnesota. David Roberts, MD, Richard Bucholz, MD, and James Ausman, MD will present the

symposium. A special resident award will be presented to Daniel M. Lieberman, MD, for his talk entitled "Selective Lesioning of Large Brain Structures using High Flow Microinfusion of Neurotoxins: Chemo-pallidotomy Reverses Experimental Parkinsonism." An open scientific session will follow.

The Joint Section will conduct a special symposium on the "Current Management of Metastatic Brain Tumors" at the 1996 Congress of Neurological Surgeons in Montreal. Ray Sawaya, MD, will present surgical strategies, and Michael Rutigliano, MD, will discuss cost-effective issues. Minesh Mehta, MD, will present the role of radiosurgery with and without fractionated radiation therapy. An open scientific session will follow.

## Joint Section on Pediatric Neurological Surgery—Chairman's Report

**By Harold L. Rekate, MD**  
**Chairman**

If the assessment forms that were turned in following the 1995 Annual Meeting in Pasadena are to be believed, the meeting hosted by Gordon McComb, MD, and his wife, Rhoda, was a complete success. The quality of the presented papers was extremely good, and attendees seem to feel they were helpful to their practices.

Respondents appreciated the effort that went into the breakfast seminars on "Neuroendoscopy," "Frameless Stereotaxis," and "Surviving Managed Care." As a result of the feedback from those attending, the use of prepared programs such as the seminars to update an area of importance to the attendee—whether it be new technology or economics and politics—will continue to be a part of our annual program.

On behalf of the Section, I wish to thank Dr. McComb for putting on an excellent program. Special thanks also goes to Bruce Kaufman, MD, who maintained proper documentation so that the meeting would be granted CME credit.

The work of the Annual Program Committee has grown considerably in the past few years and consequently will be restructured as the Annual Program and Continuing Education Committee to insure a close interaction between the meeting planners and those who are responsible for obtaining CME credit for the meeting.

Those of us who are responsible for planning the educational programs of the Section cannot over-emphasize the importance of the meeting assessment forms. If we are to make meaningful change or congratulate ourselves on the lack of need for change, we must decide based upon the feedback from our members.

### CPT Coding Questionnaires

Immediate-past chairman, Arthur Marlin, MD, remains the chairman of the ad hoc committee to revamp the pediatric neurosurgical sections of the CPT code. Vignettes have been supplied which will deal with the management of hydrocephalus in children, and a whole new set of codes has been formed dealing with neuroendoscopy.

A questionnaire will be sent to various knowledgeable neurosurgeons to help establish the validity of these modifications, as well as help to establish unit values for the work involved. This is an extremely important project and deserves all our support. Anyone who would be willing to help in this endeavor by taking the time to fill out these questionnaires (which will take between 12 and 20 hours of effort in a one-week period) should call Dr. Marlin directly at (210) 615-1218 or write him at Methodist Plaza, 4499 Medical Dr., #397, San Antonio, TX 78229.

### Section Participation at AANS 1996 Annual Meeting

This year's Donald D. Matson Lecture at The American Association of Neurological Surgeons (AANS) Annual Meeting will be given by Harold J. Hoffman, MD, on Tuesday, April 30, 1996 at 2:45 PM, and will be entitled "Separation of Cephalopagus Twins." A special seminar will follow, moderated by Derek Bruce, MD, and featuring work by Gordon McComb, MD,

*(continued on next page)*

### ► Reform on the Table

*(continued from previous page)*

and David Moss, MD, entitled "Diagnosis and Management of Occipital Plagiocapahly."

### Joint Section Annual Meetings

The 1996 Annual Meeting of the Joint Section will be held December 3-7 in Charleston, South Carolina and will be hosted by Bruce Storrs, MD. The 1997 meeting is slated for New Orleans, Louisiana, and the date is tentatively set for December 9-13, 1997. The meeting will be hosted jointly by Joseph Nadell, MD, and Richard Coulon, MD. The 1998 meeting will be held in Indianapolis, Indiana, hosted by Thomas Luerssen, MD.

### Education Committee Update

The Education Committee of the Joint Section, under the direction of Richard Coulon, MD, are developing two brochures intended for the education of our patients and their referring physicians. One of the brochures focuses on the Arnold Chiari Malformation (written by Dr. Coulon), and the other on the Dandy-Walker Malformation (written by Andrew Parent, MD). Both are in final editing.

They will be published in cooperation with the AANS Publications Committee. It is intended that these will be available at a low cost in bulk for distribution from the offices of our members.

The primary goal of the Joint Section is to educate neurosurgeons in dealing

with problems of the management of the child. Therefore, we are planning a variety of educational programs, including sessions at our own annual meeting and in conjunction with the AANS Annual Meeting and the Congress of Neurological Surgeons Annual Meeting.

We are also approaching the other Joint Sections within organized neurosurgery in an attempt to produce joint interactive programs to update the general neurosurgeon on the important advances in pediatric neurosurgery that impact on their care of children and the pediatric neurosurgeon in the other subspecialty disciplines within neurosurgery. We would appreciate receiving any suggestions or guidance along the way in achieving these goals.

## History Section to Hold Annual Dinner

The Section of the History of Neurological Surgery will hold its annual formal dinner at the Bakken Library and Museum in Minneapolis on April 29, 1996. A reception and museum tour of the exhibit, "It's Alive! The Science and Myth of Frankenstein" will begin at 6:00 PM. Following dinner, the guest speaker will be Michael Salcman, MD.

For more information contact:  
William Hanigan, MD, PhD, at (309) 655-2642  
or  
Glenn Pait, MD, PhD, at (501) 686-5270

### ► Section on Pain

*(continued from page 30)*

with the active involvement of Kim Burchiel, MD, to examine the role of neurosurgery in the field of pain management, specifically in relation to neurosurgical residency training, accreditation of neurosurgical pain management fellowships, and multi-specialty certifications in pain medicine via a conjoint board, for example the American Board of Pain Medicine.

### Implantable Device Standards

Richard North, MD, in conjunction with the Drugs and Devices Committee, has completed work on a set of voluntary standards for implantable stimulators. Similar standards are being developed for implantable, programmable infusion pumps.

### Other Activities

Efforts have begun to establish new codes for CPT '98 for thoracic and cervical facet block and facet denervation. The Section will be sending a representative to a Joint Section meeting on Neurosurgical Out-

comes, convened by Richard Toselli, MD. This meeting should lay the foundation for development of formal production of outcome studies in the various neurosurgical areas.

The Pain Section's chairmanship will soon be transferred to Robert Levy, MD. The Section will continue to emphasize use of work groups of neurosurgeons to improve working conditions in the field of pain management for all of our neurosurgical colleagues. If you have any questions or comments, feel free to contact me at any time by e-mail (samuel@neosoft.com) or by fax (713) 794-4950.





### Recent Actions of the American College of Surgeons

By Edward L. Laws, MD  
American College of Surgeons  
Regent for Neurosurgery

The Regents of the American College of Surgeons (ACS) met February 6th, 7th, and 8th in Chicago. Following is a summary of the actions taken and activities reported during that meeting.

It is important to note that, at this point, the ACS represents 60,000 surgeons and has an annual budget of \$36 million. Clearly it remains in the interest of neurological surgery to team up with an organization with this much influence, and I am happy to report that we, as neurosurgeons, continue to play a major role in a full range of ACS activities.

One of the most exciting outcomes of the Regents meeting was the decision to purchase a new headquarters building for the ACS. It is an elegant, modern, skyscraper located at 633 St. Claire Street, three blocks away from the current office and just steps away from the Magnificent Mile. The building is directly across the street from the new Northwestern Hospital complex, and was acquired under very favorable financial circumstances. The 28 floor building will be configured to serve as a home for all of the American College of Surgeons' activities, including publication of its Journal. Space not allocated to the ACS will be rented out and should provide a continuing source of income and support for this venture.

Activities to influence legislation pending in the Congress of the United States have been assisted by the efforts of Senator Bill Frist (R-Tenn) and Representative Greg Ganske (R-Iowa), both of whom are surgeons and who are very sympathetic to most of the issues related to the College. It is felt that at the Federal level there will be a decrease in indirect support for graduate medical education, however, the length of training time seems not to be under jeopardy at present.

The Committee on Young Surgeons in the ACS is planning programs related to Quality Improvement and Cost Control. This committee has been quite active and

*"The ACS represents 60,000 surgeons and has an annual budget of \$36 million.*

*It remains in the interest of neurological surgery to team up with an organization with this much influence."*

neurosurgeons continue to play a significant role in its leadership.

#### GME

The Graduate Medical Education Committee of the College has completed a study of Prerequisite Learning Objectives for residencies in all types of surgery. This report, when it is available, should provide an excellent template for making residency education more pertinent for neurosurgical trainees.

It is of some interest that the current figure of 810 neurosurgical residents in training represents 3.7% of all "core" surgical residents, and the 126 graduates of neurosurgical training programs in 1994 represented 2.8% of all finishing surgeons. It is important, perhaps, to note that in 1994 there were 655 orthopedists finishing training programs.

#### Advisory Councils

The Advisory Councils for the various surgical specialties play a major role in setting College policy. They have a number of joint concerns that cut across specialty lines. These include economic credentialing, patient education—particularly with regard to patient access to specialty care, and public relations in general for the benefit of all surgeons. There is an initiative on the part of the Advisory Councils to accomplish some of this publicity using the Internet. There is also an interest in expanding the focus groups that have been organized for

setting priorities in general surgery, and to use the same sort of process for the surgical specialties.

The Advisory Councils have a Task Force on Outcomes that is making excellent progress. The goal of this Task Force is to eventually develop an instrument that will be suitable for a large variety of outcome studies. This instrument will include a standardized method of recording demographic data; data regarding co-morbidity; pre-treatment health status; and outcome measure of quality of life, patient satisfaction and cost. There also will be specialty-specific and disease-specific components designed in response to the individual outcomes to be measured. Specialty-specific treatment and disease-specific outcome measures will be added onto the basic instrument. Once again, the possibility of using the Internet for these outcome studies is enthusiastically being pursued.

#### Board of Governors

The Board of Governors of the American College of Surgeons also has developed a number of initiatives. In their most recent meeting in October the Governors addressed the possibility of establishing a Surgical Political Action Committee (PAC). This was felt not to be a wise move at the present time for a variety of reasons, and three quarters of the Governors voted against forming a PAC.

*(continued on next page)*

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## JCSNS Announces Spring Meeting

**T**he Joint Council of State Neurosurgical Societies (JCSNS) will meet in Minneapolis, Minnesota on April 26 and 27, 1996. All neurosurgeons are invited to attend. The JCSNS is a joint committee of the AANS and CNS and deals specifically with socioeconomic issues as they affect all neurosurgeons.

At this meeting JCSNS resolutions will be presented, analyzed, and discussed on a wide range of economic, political and social issues which daily impact neurosurgeons. Special reports on manpower, reimbursement, quality assurance, neurotrauma and other issues will be presented by experts in the field. Delegates to the JCSNS from all state neurosurgical societies will be present, as well as the boards of the AANS and CNS.

A special luncheon will be held on Saturday, April 27 which will feature the Washington Committee's report and recommendations concerning the formation of a neurosurgical Political Action Committee (PAC). All neurosurgeons are invited to attend this stimulating and informative meeting.

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### ► Actions of the ACS

*(continued from previous page)*

There was an extensive report on several aspects of professional liability that should be of concern to all surgeons. It was felt in general that the outlook is not particularly good, with recent studies showing an increasing number of malpractice claims and a growing number of plaintiff verdicts with higher levels of financial damage. Attempts at achieving tort reform are continuing and these have concentrated primarily in the states; there are also some coalitions trying to achieve Federal tort reform, and the College is active in this effort. A number of publications related to professional Liability are available from the ACS.

#### Physician Reimbursement

Matters related to physician reimbursement were discussed at length. The American Medical Association did not support the concept of a separate volume performance standard for surgery and the merging of the two standards to a single conversion factor will be financially damaging to more surgeons. There has been significant effort to try to have this reduction accomplished during a phase-in period of two or three years, and we hope that this will be successful.

It is important for the neurosurgical community to note that the College has developed its own practice expense project trying to make some logic out of the way the Health Care Financing Administration (HCFA) reimburses the practice expense component of the various neurosurgical procedures. The College has spent \$450,000 on this effort and Neurosurgery is also playing a very active role in obtaining the necessary data.

#### Research Activity

Another exciting initiative of the College is a clinical trials proposal that is being submitted to the National Cancer Institute (NCI). Under the leadership of Sam Wells, MD, we are requesting a grant to fund clinical trials in surgical therapy which will be administered with the help of the American College of Surgeons. The first proposals would involve studies of the treatment of breast cancer and colon cancer, however, there is a Neurosurgical Task Force to look at clinical trials with regard to the management of brain tumors and we hope that this innovative project will be funded by the NCI.

The Scholarships Committee of the ACS granted seven Faculty Research Fellowship awards, and one of them went to R. Loch MacDonald, MD, of the Department of Neurosurgery of the University of

Chicago. Another neurosurgeon, Peter LeRoux, MD, of New York University has been named as an alternate.

#### Communications

The College has a very active Informatics Committee dealing with computerization on a number of different levels. The College has a web site up and running and it can be accessed at: <http://www.facs.org>.

The Communications Department of the American College of Surgeons has produced two useful patient-oriented booklets covering Low Back Pain and Carotid Endarterectomy. Recently a Practice Management Manual for young surgeons was published and was released initially at the College meeting in October in New Orleans. This manual has met with an enthusiastic response, particularly from finishing residents and young surgeons of all specialties. It will be made available to the Young Neurosurgeons Committees of both the AANS and the Congress.

It has been encouraging to see the effective activity of the American College of Surgeons as an umbrella organization, and to witness the many important aspects of the work of the College that are pertinent to our neurosurgical community.

## MEMBERSHIP

# AANS Welcomes New Candidate Members—Total Membership Reaches 4,739

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## Membership in The American Association of Neurological Surgeons

### What are the Benefits?

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- ◆ Reduced Annual Meeting registration fees
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- ◆ Continuing Medical Education in the specialized field of Neurosurgery
- ◆ Free *Directory of Neurological Surgery: US & Canada*
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- ◆ Opportunity to become involved on AANS Committees

### Categories of Membership

**Active:** ABNS, RCS of Canada, or Mexican Council of Neurological Surgery certified practicing neurosurgeons residing in North America.

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**Active (Provisional):** Neurological surgeons who have completed a neurosurgery training program approved by the ACGME or the RCS of Canada within the last five (5) years, and have not yet met the certification requirements of the ABNS or the RCS of Canada.

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**Associate:** Non-neurosurgeons who have shown distinction in related medical disciplines and are board certified by a national board in their field of specialty. Associate Members include certified neuroscience nurses and physician assistants.

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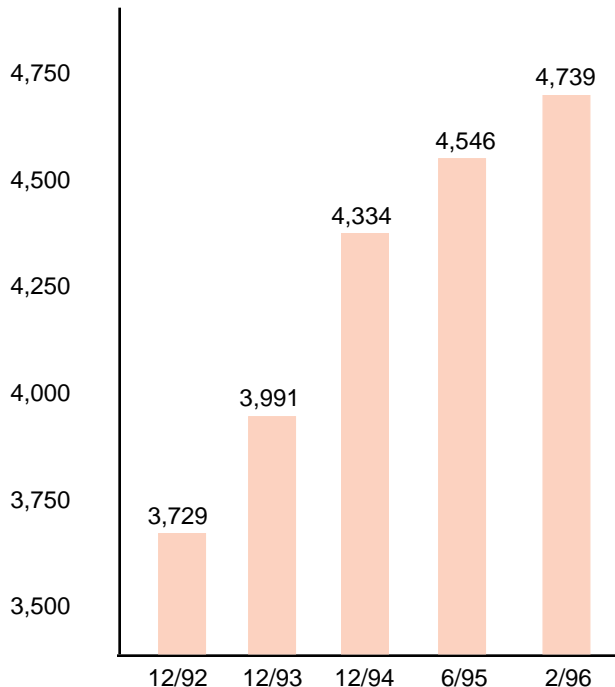
**Honorary:** Individuals who are recognized internationally for their outstanding education, research, or clinical contributions to neurological science. Candidates for Honorary membership must be proposed by three (3) AANS voting members.

For more information and/or an application for membership, please contact the AANS National Office at:

22 South Washington Street  
Park Ridge, Illinois 60068-4287  
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## Membership Growth

Number of Members



# RESEARCH FOUNDATION

## Research Foundation 1995 Annual Campaign Donors Recognized

The Executive Council of The American Association of Neurological Surgeons (AANS) Research Foundation gratefully acknowledges the following individuals, groups, and corporations for their generous contributions to the Foundation's 1995 Campaign. These donors have set exemplary standards for the entire neuroscientific community by demonstrating the power of philanthropy to expand scientific knowledge. They deserve the highest recognition.

Their support will also be noted on the Foundation's new "Donor Wall" which will be displayed for the first time during the AANS Annual Meeting in Minneapolis. In addition, these Annual Campaign donors have received distinctive lapel pins which can be proudly worn throughout the year.

The following list represents gifts of \$100 or more received from January 1, 1995 through February 15, 1996. The number appearing in parentheses following each individual's name indicates the number of years of Research Foundation Annual Campaign support from that individual.

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L.N. Hopkins, MD (7)  
Peter J. Jannetta, MD (5)  
Hae-Dong Jho, MD, PhD (4)  
Paul M. Kanev, MD (1)  
Howard H. Kaufman, MD (9)  
Anthony M. Kaufmann, MD (2)  
Ellis B. Keener, MD (11)  
Yong Kie Kim, MD (2)  
Thomas A. Kingman, MD (5)  
Douglas S. Kondziolka, MD (4)  
Dr. & Mrs. Edward J. Kosnik (5)  
William B. Kuhn, MD (2)  
Alexandra C. Kunz, MD (2)  
(*A Tribute to Dr. John Shillito, Jr. on his Retirement 6/95*)  
Arnold Chester Lang, MD (4)

Mark Steven LeDoux, MD, PhD (2)  
Veetai Li, MD (1)  
Dr. & Mrs. N. Scott Litofsky (1)  
Sean R. Logan, MD (2)  
Lucy Carole Love, MD (4)  
Thomas J. Lovely, MD (3)  
L. Dade Lunsford, MD (5)  
Joseph R. Madsen, MD (2)  
Asim Mahmood, MD (2)  
Ghaus M. Malik, MD (2)  
Ronald E. Manicom, MD (4)  
(*A Memorial Tribute to Dr. George Ehni*)  
James B. Mansfield, MD (11)  
Donald W. Marion, MD (4)  
Joseph C. Maroon, MD (9)  
Dr. & Mrs. John J. McCloskey (8)  
Bruce M. McCormack, MD (1)  
Michael W. McDermott, MD (2)  
Thomas J. McDonald, MD (2)  
Thomas F. Mehalic, MD (5)  
Tom Mikkelsen, MD (1)  
Frank M. Moore, MD (2)  
John J. Moosy, MD (4)  
Bradford B. Mullin, MD (1)  
Swami Nathan, MD (4)  
Russell P. Nockels, MD (2)  
Georg Noren, MD (2)  
G. Robert Nugent, MD (7)  
Thomas E. O'Hara, Jr., MD (3)  
Clark J. Okulski, DO (4)  
Frank T. Padberg, MD (1)  
(*A Tribute to Dr. John Martin*)  
Dwight Parkinson, MD (11)  
Wayne S. Paullus, Jr., MD (2)  
Ms. Chris Ann Philips (4)  
Lawrence H. Pitts, MD (9)  
Robert J. Plunkett, MD (2)  
Ian F. Pollack, MD (3)  
Matthew R. Quigley, MD (3)  
Joseph Ransohoff, MD (5)  
Dr. & Mrs. Justin W. Renaudin (3)  
Howard Anthony Richter, MD (10)  
Michael H. Robbins, MD (3)

Jack P. Rock, MD (1)  
William S. Rosenberg, MD (1)  
Mark L. Rosenblum, MD (4)  
Stephen C. Saris, MD (4)  
Thomas G. Saul, MD (4)  
Robert E. Schultz, Sr., MD (11)  
R. Michael Scott, MD (3)  
Leslie Ann Sebring, MD (1)  
Ricardo Segal, MD (4)  
Donald M. Seyfried, MD (1)  
Yucel Sezgin, MD (4)  
Charles P. Shank, MD (3)  
Stephen L. Skirboll, MD (1)  
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Mark A. Spatola, MD (4)  
Alfred Abe Steinberger, MD (3)  
Philip E. Stieg, MD, PhD (2)  
Charles H. Tator, MD (9)  
John M. Tew, MD (6)  
Lee L. Thibodeau, MD (2)  
William D. Tobler, MD (4)  
A. Roy Tyrer, Jr., MD (7)  
Harry R. Van Loveren, MD (4)  
Joseph L. Voelker, MD (4)  
Beverly C. Walters, MD (3)  
Ronald E. Warnick, MD (3)  
Philip R. Weinstein, MD (9)  
William C. Welch, MD (3)  
William L. White, MD (8)  
Jack E. Wilberger, MD (3)  
Donald W. Wilson, MD (1)  
John A. Wilson, Jr., MD (1)  
S. Randy Winston, MD (12)  
Hwa-shain Yeh, MD (5)  
Howard Yonas, MD (5)  
Mario Zuccarello, MD (1)

+ Deceased

(continued on next page)

# RESEARCH FOUNDATION

## ► RF Donors

(continued from previous page)

### SCIENTIFIC SOCIETY

The following list consists of university programs, foundations, groups, and organizations that have contributed \$500 or more within the last year. Individual members of these groups are listed within the giving category that corresponds to their individual portion of the total gift.

Berman Family Philanthropic Foundation, New York, NY  
Brown University Neurosurgical Foundation, Providence RI  
Cleveland Clinic Foundation, Cleveland, OH  
Harvard Medical School, Brigham & Women's and Children's Hospitals, Boston, MA  
Henry Ford Hospital, Detroit MI  
Keller Foundation, Dix Hills, NY  
Long Island Neurosurgical Associates, New Hyde Park, NY  
Louisiana Neurosurgical Society, New Orleans, LA  
Massachusetts General Hospital, Boston, MA  
Mayfield Neurological Institute, Cincinnati, Ohio  
Neurosurgical Institute of Kentucky, Louisville, KY  
New York Medical College, Munger Pavilion, Valhalla, NY  
Southern Maine Neurosurgical Associates, Portland, ME

SUNY/Buffalo, NY  
SUNY/Syracuse, NY  
Tres Marias, LaVale, MD  
Tri-State Neurosurgical Associates, Pittsburgh, PA  
University of California, San Diego, CA  
University of California, San Francisco, CA  
University of Florida, Gainesville, FL  
University of Minnesota, Minneapolis, MN  
University of Pittsburgh, Pittsburgh, PA  
University of Southern Florida, Tampa, FL  
University of Virginia, Charlottesville, VA  
Wayne State University Neurosurgical Associates, Detroit, MI  
West Virginia University, Morgantown, WV

### CORPORATE ASSOCIATES ROSTER

The Executive Council of the Research Foundation asks that you join with them in applauding the efforts of the following companies. These companies have set the highest example of industry leadership by being the first to step forward and join the Foundation's newly implemented "Corporate Associates Program".

#### **Sustaining Associate**

(Gifts of \$50,000 to \$75,000)

Pharmacia and Upjohn, Inc.  
Synthes Spine/Synthes Maxillofacial Divisions

#### **Supporting Associate**

(Gifts of \$25,000 to \$50,000)

Codman/Johnson & Johnson Professional, Inc.  
Elekta  
Leibinger LP

#### **Contributing Associate**

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

Zimmer/Hall Surgical

#### **Associate**

(Gifts of \$5,000 to \$10,000)

Aesculap  
Howmedica, Inc.  
Midas Rex Institute  
PMT® Corporation

## GIVE MORE BY GIVING EARLY!

Giving your Research Foundation 1996 Annual Campaign gift early in the year adds value to your gift.

### HOW?

Your gift is "put to work," earning interest, almost immediately! Your donation, which goes in its entirety to the endowment fund, begins to earn interest early in the year, thereby increasing the dollars available for the next funding cycle of grants and awards.

Help to ensure a bright future neuroscientific research. Send your 1996 gift today. For your convenience, a Research Foundation gift envelope has been inserted in this copy of the *AANS Bulletin*.

## New Electronic Neurosurgical Journal Announced

The American Association of Neurological Surgeons and the *Journal of Neurosurgery* are pleased to announce the creation of a new electronic journal entitled *Neurosurgical Focus*. This innovative publication is designed to provide for timely electronic publication of original contributions in various areas of neurosurgery and as a preview forum for select articles from the *Journal of Neurosurgery*. *Neurological Focus* will be published under the auspices of the *Journal of Neurosurgery* and indexed in Index Medicus.

Each monthly issue of *Neurological Focus* will be devoted to the exploration of a topic of interest to neurosurgeons. The focus of the first issue will be "Pituitary Disease and Endocrine Problems." We are currently soliciting original contributions, which will be peer reviewed by members of the editorial board of the *Journal of Neurosurgery* who will also serve as topic editors for *Neurosurgical Focus*. A variety of articles will be considered for publication, including brief basic science reports,

clinical studies, case reports with specific lessons to be learned, methodology and technical reports, protocols for management and assessment of outcome, and clinical "pearls."

*Neurosurgical Focus* will be hosted on the **NEUROSURGERY://ON-CALL™** web site at <http://www.neurosurgery.org>.

Manuscripts should be prepared using the published guidelines of the *Journal of Neurosurgery* and be submitted to: John A. Jane, MD, Editor, *Journal of Neurosurgery/Neurosurgical Focus*, 1224 West Main Street, Suite 450-B, Charlottesville, Virginia 22903. Telephone and facsimile inquiries may be made to: (804) 924-8727 and (804) 982-1396, respectively. Email address: [jneuro@virginia.edu](mailto:jneuro@virginia.edu).

**The deadline for submission of manuscripts on Pituitary Disease and Endocrine Problems for the premier issue of *Neurosurgical Focus* is MAY 31, 1996.**

### Topics and Deadlines for Upcoming Issues of *Neurosurgical Focus*:

#### Issue 1: Pituitary Disease and Endocrine Problems

Topic Editor: Edward R. Laws, Jr., MD  
Submission Deadline: May 31, 1996  
Publication Date: July 31, 1996

#### Issue 2: CRANIAL NERVE SURGERY

Topic Editor: Robert H. Wilkins, MD  
Submission Date: June 15, 1996  
Publication Date: August 15, 1996

#### Issue 3: FUNCTIONAL IMAGING

Topic Editor: Charles J. Hodge, Jr., MD  
Submission Date: July 15, 1996  
Publication Date: September 15, 1996

Look for additional topics and dates in upcoming issues of the *Journal of Neurosurgery*.



Available Fall 1996

## A History of Neurosurgery

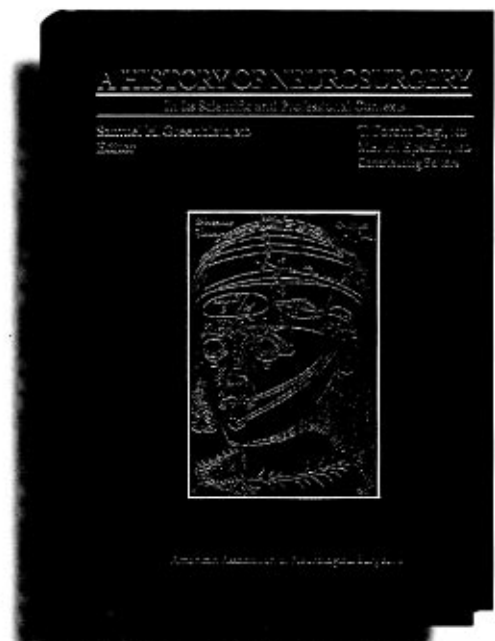
*In its Scientific and Professional Contexts*

Editors: Samuel H. Greenblatt, MD,  
T. Forcht Dagi, MD, and Mel H. Epstein, MD

This is the first thorough history of neurosurgery published since 1951. It is organized around a specific historiographic framework which traces the advancement of the specialty. Included are chapters on ancient trepanation, MacEwen's first use of the combined technologies of anesthesia, antisepsis, and cortical localization in 1879 to plan and perform craniotomies, the emergence of Harvey Cushing's leadership, the evolution of modern neurosurgical techniques and technology, and much more.

ISBN: 1-879284-17-0

List Price: \$95



**Call 847-692-9500 to place your order!**

THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS



## THINK FIRST Celebrates Tenth Anniversary

The year 1996 marks the 10th anniversary of the THINK FIRST Foundation's National Brain and Spinal Cord Injury Prevention Program, founded by E. Fletcher Eyster, MD, and Clark Watts, MD. Since inception of the program 4.1 million people have heard this invaluable injury prevention message.



In 1995 the THINK FIRST Programs were surveyed to determine their level of activity and other pertinent program information. In the survey 175 local programs reported 6,039 presentations which reached 717,815 people. The majority of the programs were presented in:

- ◆ high schools (49%)
- ◆ middle schools (25%)
- ◆ elementary schools (15%)
- ◆ other settings, i.e., service clubs, military, and health fairs (10%)

### **Presentations were conducted in the following areas:**

- ◆ urban (32%)
- ◆ suburban (48%)
- ◆ rural (20%)

### **Presentation format included:**

- ◆ classroom settings (77%)
- ◆ assembly settings (23%)

### **Guest speakers by gender were:**

- ◆ male (78%)
- ◆ female (22%)

### **Guest speakers by injury discussed were:**

- ◆ spinal cord injury (72%)
- ◆ traumatic brain injury (28%)

### **Of the 657 guest speakers who speak on behalf of their THINK FIRST program, of them sustained injury from:**

- ◆ a vehicular incident (57%)
- ◆ a water incident (15%)
- ◆ violence (11%)
- ◆ sports and recreational incidents (7%)
- ◆ bicycle incidents (3%)
- ◆ other sources, i.e., falls, pedestrian incidents, etc. (7%)

The local programs are the "back bone" of the Foundation. We applaud all the local coordinators and sponsoring neurosurgeons for their dedication and commitment to this injury prevention effort.

## THINK FIRST . . . A Gift for All Occasions

THINK FIRST's Tribute Program now offers the opportunity to make a gift in memory or in honor of someone special for every important occasion throughout the year. In lieu of flowers, THINK FIRST will send a tastefully designed "*In Memory*" card to the family of a deceased individual notifying them of your contribution.

More meaningful than a token birthday, anniversary or wedding present or off-the-rack retirement, graduation or job promotion card, THINK FIRST will send a special "*In Honor*" card and include your personal message. (The gift amount is not disclosed). Companion cards will acknowledge receipt of these generous gifts THINK FIRST will also convey your holiday wishes to everyone on your gift list in a specially designed card announcing your contribution in their name.

The amount of your gift may vary just as it would if you were to select a card or present for that special person. In addition, *Memory* and *In Honor* gifts will be recognized in THINK FIRST's biannual Honor Roll of Donors and annual report. Best of all, these special gifts are tax deductible to the extent allowed by law.

### SAMPLE (Front)



A generous contribution has been made  
in your honor on the occasion of

\_\_\_\_\_ to advance the life-saving work of THINK FIRST  
the National Brain and Spinal Cord Injury Prevention Program  
given by

Donor Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

### SAMPLE (Back)

THINK FIRST is a not-for-profit foundation dedicated to the prevention of brain and spinal cord injuries. Founded in 1986 by The American Association of Neurological Surgeons and the Congress of Neurological Surgeons, THINK FIRST's programs have reached more than 4 million young people.

THINK FIRST Foundation  
22 South Washington Street  
Park Ridge, Illinois 60068  
(847) 692-2740





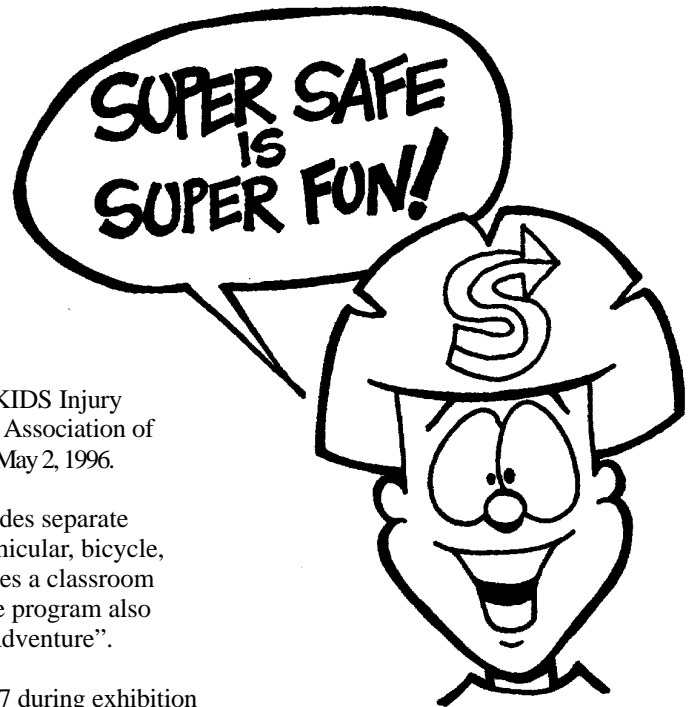


## Injury Prevention Program Now Available

The THINK FIRST Foundation announces that the THINK FIRST For KIDS Injury Prevention Program will be available for purchase during The American Association of Neurological Surgeons Annual Meeting in Minneapolis, Minnesota April 27-May 2, 1996.

THINK FIRST For KIDS targets Grades 1-3 or ages 6-8 years. It includes separate curriculums for each grade which cover five safety modules: water, vehicular, bicycle, sports and recreational safety, and violence. Each safety module includes a classroom poster, a comic strip, and multiple in class reinforcement activities. The program also includes an animated video entitled, "Street Smart: A THINK FIRST Adventure".

Samples of the program will be displayed at THINK FIRST Booth #1437 during exhibition hours. Program packets and components will be for sale in the Associations' registration area at the convention center. Please stop by our booth, we will be happy to answer any questions you may have regarding this outstanding injury prevention program.



## THINK FIRST Foundation Builds for the Future through Planned Giving

What we do today counts for tomorrow. This is true in terms of both physical and financial health. For this reason, the THINK FIRST Foundation has established a planned giving program to encourage donor support through bequests and other types of planned gifts.



Heading the Planned Giving Council is Vice Chairman of the Foundation's Board of Directors, Edward S. Connolly, MD,

a practicing neurosurgeon in New Orleans. Dr. Connolly emphasizes that planned giving offers benefits to both the Foundation and the donor. "It gives donors greater flexibility in making large gifts," he says, "and enables

THINK FIRST to receive many times more than donors might give if they had to take it out of their cash flow." The flexibility inherent in planned giving also allows donors to leave gifts other than money. Personal and real property, appreciated stocks, or proceeds of life insurance policies are excellent ways to make substantial gifts while reducing income and estate tax liability.

The first step in the process involves making a will. "We encourage everyone to have a will," Dr. Connolly explains. "Once the amount of the taxable estate is determined, donors can devise methods to help the charities of their choice while reducing the estate tax burden." Leading by example, Dr. Connolly has made a substantial bequest to the THINK FIRST Foundation in his will. He cites THINK FIRST as a "major health prevention movement that is dear to the hearts of neurosurgeons and others who are dealing with people who have sustained brain and

spinal cord injuries. "THINK FIRST is providing education to high school and grade school children to build consciousness of activity that could lead to irrevocable injury to the brain or spinal cord."

Through his personal gift and leadership of the Planned Giving Council, Dr. Connolly is helping to ensure the long-term financial stability of the THINK FIRST Foundation and the perpetuation of its vital prevention programs.

The THINK FIRST Foundation is pleased to announce receipt of its first bequest from the estate of Suzanne A. Snively, MD of Sacramento, CA. Advice and further information on planned giving may be obtained by calling the Foundation office at 800-THINK56. When considering a gift, it is wise to consult legal and tax advisors to determine the most advantageous method of giving.

## POSITIONS

Although the AANS believes the classified advertisements to be from reputable sources, the Association does not investigate the offers made and assumes no liability concerning them.

### **R: Explore New Practices, STAT**

**New Jersey/Five Minutes to Fun and Sun**—Become an associate of busy Neurosurgeon performing equal mix of Adult and Spine. Handsome compensation and full benefits. Leisurely stroll along the Jersey shores! Contact Lance Brooks, 800-365-8901, ext. 111.

**Mississippi/Opportunity Knocks!** Great financial rewards; few risks. Ideal for Neurosurgeon to develop a practice. Based in an idyllic family location near Jackson; laden with recreational activities and civic pride. Strong referral base. Contact Derek Thomas, 800-365-8901, ext. 157.

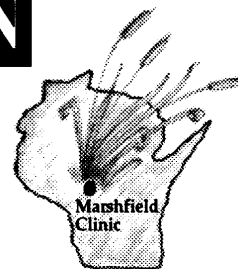
**Indiana/\$275,000 Minimum**—Enjoy the southern Indiana lifestyle and the freedom of independent status! Join forces with a 250+ bed regional referral center with service area of 200,000 to develop a Neurosurgery program. \$275,000 guarantee. Secure your future. Contact Michelle Diskin, 800-365-8901, ext. 136.

**Weatherby Health Care, Division of Surgery**  
3230 West Commercial Boulevard  
Fort Lauderdale, FL 33309

In 1995, Weatherby placed 670 physicians nationwide, more than any other physician recruitment firm, period. Call now for other available positions nationwide. Visit Weatherby on the World Wide Web at: <http://www.weatherbyhc.com>

## WISCONSIN

### **A Blend Of Clinical Excellence And Quality Living**



At Marshfield Clinic, a 450-physician, multispecialty group practice, you'll leave time consuming business and administrative concerns behind while enjoying a special blend of clinical excellence, dedication to patient care, and a friendly, safe community which lends itself to an informal, family-oriented lifestyle.

Specifically, we are seeking a Neurosurgeon with emphasis and interest in spine and spine instrumentation. By accepting this rewarding opportunity, you'll join an existing staff of three Neurosurgeons and sixteen Neurologists, complemented by staff in Neuroradiology, Neuropathology, Neuropsychology, and Epileptology. You will find an efficiently managed, financially stable practice well positioned for the future, enhanced by an outstanding compensation package.

Enjoy the quality-of-life Marshfield offers and the outstanding resources of a premier health care system. Send your C.V. and references to: Cindy M. Schuster, Physician Recruitment Manager, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449, or ☎ 1-800-782-8581, ext. 9-3725; Fax: (715) 387-5240; Internet: [schustec@mfdclin.edu](mailto:schustec@mfdclin.edu)



**MARSHFIELD CLINIC**

EOE M/F/H/V

## **5 Person Neurosurgery Group Practice—Southeast**

A dynamic group of four young neurosurgeons seeks a **fifth partner**. This active, conservative practice of over **230 new patients per month**, associated with 3 large, progressive hospitals is located in Knoxville, TN, a beautiful, **university** community of 600K, noted for its accessible lake system and close proximity to the Smoky Mountains, cultural amenities, **no state income tax**, SEC sports, sound housing values, nationally recognized school systems, and welcome lifestyle. Immediate referral base in place. Appropriate candidates will have extensive spine training in order to compliment the practice's heavy spine volumes. The practice will also consider sponsoring the spine fellowship training of an interested candidate. This thriving community based practice awaits your inquiry.

Contact Mary Wynkoop, the search agent for  
Neurosurgical Consultants of East Tennessee, at:

**Tyler & Company**  
1000 Abernathy Road, Suite 1400, Atlanta, GA 30328.  
Phone 770-396-3939 or 800-883-8803,  
or Fax CV to 770-396-6693.

## **POSITION LISTING SERVICE**

Do you have a vacancy to fill in your hospital or practice?

By listing your vacant position in the *Bulletin*, more than 4,400 neurosurgeons across North America will be advised of it.

Quarter page listings cost \$275 each.  
Call the AANS Marketing Department at (847) 692-9500 for more information, or fax or mail your descriptions to:

Steven L. Serfling  
Director of Marketing  
AANS  
22 South Washington Street  
Park Ridge, Illinois 60068-4287

Fax: (847) 692-6770

## TECHNOLOGICAL ADVANCES

*The following product descriptions, submitted by medical suppliers, are published to highlight recent technological advances in the neurosurgical field. Publication of these brief summaries should not be construed as indicating endorsement by the AANS.*

### A New Tray for Balloon Compression in Management of Trigeminal Neuralgia

Cook Incorporated recently introduced the Mullan Percutaneous Trigeminal Ganglion Microcompression Set (MTNS). This set was developed under the direction of Sean Mullen, MD, at the University of Chicago and is the first such set to be specifically approved for use in the percutaneous treatment of trigeminal neuralgia.

The set is supplied in a sterile tray which holds the components required for this procedure. Included in the tray is a 14G needle with a blunt stylet for penetrating the foramen ovale to access Meckel's cave. The balloon catheter, provided in the set, was specifically developed for this procedure and is clearly marked to indicate when the balloon is fully extended beyond the cannula. In addition to these primary components, the tray also contains the necessary blade, syringe, gauze pads, and skin-preparation materials to allow the procedure to proceed quickly and efficiently.

For more information about the Mullan Percutaneous Trigeminal Ganglion Microcompression Set, call Cook Incorporated at (800)457-4500.

### Spine Models Available from National Biological Labs

National Biological Labs now offers two spine models for use by neurosurgeons. The lumbar model shows two healthy lumbar vertebrae with five interchangeable discs: healthy, compressed, lateral, central and internal herniations. Additional vertebra with spondylo and stenosis are represented. Trays sit on top of each other and snap shut.

The cervical vertical column model is easy to handle and excellent for showing specific anatomy of the cervical spine. The spinal cord, nerve endings, vertebral artery and discs are all represented. The cervical column is mounted on a stand and is natural size.

For more information about the lumbar model (Item #F0313-8) or the cervical model

(Item #F0308) contact National Biological Labs, Inc. at P.O. Box 2496, Jackson, WY 83001 or call (800)248-8830.

### Educational Compact Discs on CT Published

Picker International has published five interactive, educational compact discs on computed tomography (CT) techniques. Topics covered include fusing multimodality data sets for diagnostic and oncologic use; CT oncologic simulation and localization for therapy and radiosurgery; 3-D virtual endoscopic reformations for noninvasive visualization of the bronchus, esophagus, colon and vasculature; CT 3-D visualization that allows opacity adjustments showing the transparent diameter of a vessel; and an overview of spiral CT technology. Actual case studies and movie loops are programmed into each CD.

For more information about these educational CD's, contact Picker International, P.O. Box 739, Berea, OH 44017.

## IN MEMORIAM

### Active

Harry Moore Rogers, MD February 1996

### Lifetime (Active)

Bert G. Leigh, MD January 9, 1996

### Lifetime (Inactive)

Maxwell M. Andler, Jr., MD	January 8, 1996
Norman L. Chater, MD	January 1994
Gale G. Clark, MD	February 29, 1996
William H. Faeth, MD	1995
John W. Hanbery, MD	January 14, 1996
Forrest L. Johnson, MD	January 1996
Harry A. Kaplan, MD	November 30, 1994
William G. Lockhart, MD	December 17, 1995
Henry Wigderson, MD	1992

### International Associate

Adam Kunicki, MD	Date unknown
James Douglas Miller, MD	August 22, 1995

### Honorary

Willem Luyendijk, MD	Date unknown
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## Moving?

Don't forget to send your  
change of address to:

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Park Ridge, Illinois 60068-4287

You can reach the AANS online  
at  
hcushing@interaccess.com

You may access  
**NEUROSURGERY://ON-CALL™**  
at  
<http://www.neurosurgery.org>

# ANNOUNCEMENTS

## EDUCATIONAL OPPORTUNITIES

### GWU Offers 22nd Annual Program

The George Washington University (GWU) Center for Microscopy and Image Analysis, in Washington, DC, will offer a course entitled "Protocols in Microscopic Imaging, Immunocytochemistry and Image Analysis" June 4-7, 1996. It will provide in-depth training for research scientists and technical staff in the basic and clinical sciences, as well as the biotechnology industry. The most contemporary instrumentation will be utilized to explore protocols in tissue preparation for confocal and electron microscopy, image analysis and image archiving.

Lectures, demonstrations and hands-on experience will cover such topics as conventional fluorescence, confocal and electron microscopy, cryo-fixation and sectioning, fluorescent and gold/silver labeling, quantitative image analysis, reflection imaging and applications in cellular physiology.

For more information, contact Fred G. Lightfoot, The George Washington University, CMIA (Suite 406), 2300 I St. NW, Washington, DC 20037, or call (202) 994-8885 or fax (202) 994-2881. The E-mail address is:

FredL@INDY.CMIA.GWUMC.EDU.

### AAPS Launches New Journal

The Association of American Physicians and Surgeons (AAPS) is launching a new, peer-reviewed scholarly journal that is set to debut April 15, 1996. *The Medical Sentinel* will be published quarterly in Macon, Georgia by Hacienda Publishing, Inc. Miguel A. Faria, Jr., a neurosurgeon and Adjunct Professor of Medical History at Mercer University School of Medicine will be editor-in-chief.

*The Medical Sentinel* is committed to publishing scholarly in the defense of the practice of private medicine, the tenets of

## HAVE YOU SEEN . . . ?

The following AANS members have relocated without a forwarding address. If you have any information leading to the location of these members, please contact Chrystine Hanus, Member Services Manager, at (847) 692-9500 or write her at the AANS office at 22 S. Washington St., Park Ridge, IL 60068-4287.

Member:	Last Located:
Jack L. Barlass, MD	Calgary, AB, Canada
Albert D. Bartal, MD	Tel Aviv, Israel
David Cleveland, MD	Peoria, Illinois
William H. Cook, MD, PhD	Shelton, Connecticut
Jose A. DeChou, MD	Hato Rey, Puerto Rico
Michel R. Decarie, MD	Pierre Fonds, PQ, Canada
William G. Evans, MD	Slaton, Texas
Stephen Francis Kornye, MD	Budapest, Hungary
Jean Lecuire, MD	Lyon, France
Antonio V. Marques, MD	Lisbon, Portugal
William J. Nelson, MD	El Paso, Texas
Seong-Hoon Oh, MD	Seoul, South Korea
Harold O. Peterson, MD	Longwood, Texas
John M. Potter, MD	Roxburghshire, Scotland
Kenneth J. Strully, MD	New York, New York
Zia Edin Taheri, MD	Boca Raton, Florida
Jean Talairach, MD	Paris, France
Pierre Wertheimer, MD	Lyon, France

Hippocratic medicine, individual-based medical ethics, and the sanctity of the patient-doctor relationship. AAPS members will receive the publication as part of their membership dues. Non-members can subscribe for \$35 per year. Medical students and Residents can subscribe for \$15 per year. Institution subscriptions are \$75 per year. Foreign subscriptions are \$100 per year (U.S. currency only).

For further information, write Hacienda Publishing, Inc., P.O. Box 13648, Macon, Georgia 31208, or call Helen at (912)757-9873.

## CHANGES

### Howmedica, Leibinger Merger

Pfizer, Inc. recently completed the acquisition of Leibinger GmbH of Freiburg, Germany and Leibinger LP of Dallas Texas.

The combined Leibinger companies will be merged with Howmedica's Maxillofacial business as part of Pfizer's Hospital Products Group.

Sharon Lucas-Schulzki, who managed the introduction of the Luhr product line into North America 10 years ago, has been appointed Senior Vice President of Marketing and Product Development, Howmedica Leibinger, Inc. Additionally, the Howmedica Luhr Marketing and Product Development groups will be merged with Leibinger Product Management and Engineering. For more information, contact Sharon Lucas-Schulzki at (214) 392-3636.

Announcements for the *AANS Bulletin* should be mailed to:

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22 South Washington Street  
Park Ridge, Illinois 60068-4287  
or fax to:  
(847) 692-2589