

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS BULLETIN

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EMTALA

HOW CAN NEUROSURGEONS COMPLY?



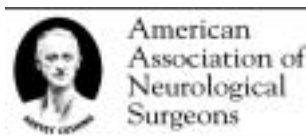
EMERGENCY
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American
Association of
Neurological
Surgeons



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VOLUME 10 NO. 4

AANS BULLETIN

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

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Eating My Words

Response to Terrorism Shows Compassion of Neurosurgeons

I owe you an apology: I was wrong and need to admit it. My presidential column in the last issue of the *Bulletin* chided members for not being more volunteer-minded and for not contributing more to their professional organizations. A recent survey that revealed that the majority of AANS members did not know the name of the organization's president had particularly disturbed me, so I went about exposing this formidable lack of volunteerism.

Sept. 11, 2001, changed everything. Within hours of the attacks on New York City and Washington D.C., I sent an e-mail to our members asking them to assist and support their colleagues on the East Coast. Although most of us were still reeling, unable to believe what had happened or trying to determine the remaining risks to ourselves and others, neurosurgeons from all over the world responded immediately. The number of replies I received from the United States, Canada, Europe, Asia, Australia and South America simply overwhelmed me.

A note from Kolya Khachatryan, Secretary of the Armenian Neurosurgical Association, was representative of the many letters of sympathy we received in the days following the disaster.

Dear Colleagues,

We were strongly shocked to hear of the terrorism in America. Our consolation to all the families who have injured victims and all the American people. Your sorrow is ours, too. We neurosurgeons feel this more because we have to deal with this in all life.

The Armenian neurosurgeons and Armenian people are with you with all their hearts.

Our consolation and our sincere spiritual wishes and the blessings of God to decry your sorrow.



President George W. Bush shakes hands with AANS President Stan Pelofsky at a June 11 meeting in the White House to discuss the importance of patients' access to specialty care.

Letters such as this one, as well your immediate responses to my call for volunteers, poignantly remind me that we are indeed a dedicated and compassionate group. More important, these gestures and actions demonstrate the extent to which we connect with our profession and with our unique ability to heal the sick and injured.

Prepared for Disaster

The AANS may call upon you to test this ability in ways never imagined just a few weeks ago. In fact, the events of Sept. 11 exposed our organization's need to develop a disaster readiness plan so that we can mobilize neurosurgeons within minutes of a national disaster. In response, I have asked our staff to compile, maintain, and update a list of neurosurgeons who are willing to remain on call for a national emergency.

These neurosurgeons are prepared to drop everything and travel to the site of a national crisis to provide neurosurgical services to victims. To add your name to the list of volunteers, contact Heather Monroe, AANS director of communications, at hlm@aans.org.

The days when I was troubled over whether or not AANS members knew the name of their organization's president seem far away now, but perhaps they are not as far as they seem. The purpose of any professional organization is to build a community that comes together for a common purpose, a purpose larger than any one of its members. The AANS is our neurosurgical community at a time when the value of such kinship is so apparent, and we must rededicate ourselves to its strength and purpose in times of crisis and of calm.

Strengthened by Adversity

I am inspired by the tremendous groundswell of volunteerism that arose from the unimaginable catastrophe that befell our country, and I thank all of you for responding with courage and compassion. I am confident that we can carry this volunteer spirit into the future. The resolve we have shown will serve us well in many ways when the current crisis subsides. I am very proud to serve as president of this outstanding group. ■

Stan Pelofsky, MD, is the 2001-2002 AANS president.

NEWSLINE

NewsMembersTrendsLegislation

FROM THE HILL

HCFA CHANGES NAME

The Health Care Financing Administration is now known as the Centers for Medicare and Medicaid Services (CMS). Tommy G. Thompson, the secretary of health and human services, said in June that the name was changed to symbolize the agency's commitment to improving the agency's services.

- **House Passes Medicare Regulatory Reform Legislation** On Tuesday, Dec. 4, the House of Representatives unanimously passed the Medicare Regulatory and Contracting Reform Act of 2001 (H.R. 3391). Adopted by a 408 to 0 vote, the bill is intended to provide regulatory relief and contracting flexibility under the Medicare program. Specifically, the bill will provide important protections to physicians who are audited. It also requires that the Centers for Medicare and Medicaid Services (CMS) conducts several pilot projects for new Evaluation and Management (E&M) Documentation Guidelines, including one pilot based on peer review of outliers. Physicians participating in these pilots would be granted immunity from audit based on claims submitted under the pilot. Finally, the bill includes several EMTALA provisions: Medicare payment for all EMTALA screening and stabilization services; requirement that CMS and/or the OIG notify providers when an EMTALA investigation is closed; requirement of peer review prior to terminating a provider from the Medicare program for an EMTALA violation; and establishment of an EMTALA Technical Advisory Group, which will, among other things, review current EMTALA regulations and make recommendations for changes to the Health and Human Services secretary. Neurosurgery has been allocated a seat on this task force. Attention now turns to the Senate, which has introduced a similar, but weaker measure. (For an in-depth look at EMTALA, see the cover story, page 7.)
- **AANS/CNS Protests Payment System** AANS and CNS sent a letter in October to Thomas Scully, Administrator of the Center for Medicare and Medicaid Services (CMS), regarding the proposed rule for changes to the hospital outpatient prospective payment system for 2002. Although the rule only affects payment to hospitals, not to physicians, the AANS and CNS expressed concern about CMS's payment policy for surgical procedures involving medical devices. Neurosurgery is concerned that hospitals may not be willing to allow certain procedures involving costly technology if the facility payment to the hospital is inadequate, thus preventing patients from having access to life-saving technologies. In the proposed rule, CMS stated that its analysis of hospital data indicated that a pro-rata reduction to pass-through payments for new technology might be required in order to stay within statutory limits for such payments. AANS and CNS questioned the validity of the data and recommended that the reductions be delayed until CMS is confident that the data reported was accurate. The letter is available under "Hot Topics" at www.neurosurgery.org/socioeconomic.
- **CMS Urged to Keep Advisory Committees** The AANS and CNS joined over 100 state and specialty societies in urging the Centers for Medicare and Medicaid Services to maintain the local carrier advisory committees for each state. These advisory committees provide one of the very few opportunities for the local medical profession to express its views about Medicare carrier administrative policies and coverage decisions. Neurosurgeons in nearly all states serve on these committees and have worked to ensure that local Medicare carriers cover the full range of neurosurgical services. This effective network of neurosurgeons has also served as a mechanism to alert the AANS and CNS of problems with Medicare coverage for certain services (e.g., pallidotomy for Parkinson's disease), enabling organized neurosurgery to assist in problem resolution.

For frequent updates to news from "From the Hill," check out the "Hot Topics" page at www.neurosurgery.org/socioeconomic/.

NEWSLINE

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NEURO NEWS

- **New Publication Rules** A dozen editors of the world's most prestigious medical journals declared in September that they will not publish scientific studies without assurance that the researchers had full responsibility for the trial, complete access to data and freedom to report the findings. They expressed concern that drug companies and other sponsoring entities are compromising the objectivity of clinical research. "Many clinical trials are performed to facilitate regulatory approval of a device or drug rather than to test a specific novel scientific hypothesis," read the editorial published jointly in the medical journals. "As CROs (contract research organizations) and academic medical centers compete head to head for the opportunity to enroll patients in clinical trials, corporate sponsors have been able to dictate the terms of participation in the trial, terms that are not always in the best interests of academic investigators, the study participants or the advancement of science generally." Among the journals with the new policy are the *Journal of the American Medical Association*, the *New England Journal of Medicine*, the *Canadian Medical Association Journal*, the *British Medical Journal* and the *Lancet*. The editorial can be read at <http://jama.ama-assn.org/issues/v286n10/full/jed10056.html>.
- **Partly Living Silicon Chips Created** Scientists for the first time have linked multiple cells with silicon chips to create a part-mechanical, part-living electronic circuit, according to the *Washington Post*. Scientists at the Max Planck Institute in Germany put snail neurons onto microscopic chips and showed that the neural network directly interfaced with the silicon chips. The ability to link nerve cells with electronics is a step toward assisting the blind in seeing and the paralyzed in walking as well as building ultra sophisticated computers and robots. The study by the Max Planck researchers was published in the Aug. 28, 2001, issue of the *National Academy of Science*.
- **Information Technology Pays Off** The nation's 100 most wired hospitals and healthcare systems connect better with patients for disease management and show greater productivity than the less wired among the nation's hospitals, according to the July issue of *Hospitals and Health Networks*. The magazine's survey covering 1,177 hospitals showed that the most wired hospitals fare significantly better than less wired hospitals in offering these patient services over the Internet: information retrieval, self-test results submission, self-reported health risk assessment, online self-triage and medication management. Moreover, 37.5 percent of the most wired hospitals rate in Standard & Poor's AA rating category, compared with the national hospital average of 15.6 percent. The survey also compared mortality rates in key service areas, but it was unclear whether the most wired did better than the less wired. View the list at: www.healthforum.com/hfpubs/asp/ArticleDisplay.asp?PubID=&ArticleID=15001.

Examining EMTALA

"Inconspicuous" Law Impacts Neurosurgeons On Call

John A. Kusske, MD, and Katie Orrico, JD

*Anger. Denial. Failure to comply.
It's time to design and enforce effective
on-call systems that reduce EMTALA
problems for everyone.*

Access to emergency care was the subject of federal legislation over 50 years ago, but the need for more rigorous requirements resurfaced in the early 1980s when numerous accounts of patient "dumping" received congressional attention. Out of this a new federal statute called the Emergency Medical Treatment and Labor Act (EMTALA) was conceived. It was a small amendment to a massive budget bill, the Consolidated Omnibus Budget Reconciliation Act (COBRA). This relatively inconspicuous piece of legislation and the 1989 and 1991 amendments to it, as well as final regulations published in 1994 by the Health Care Financing Administration (HCFA is now named the Centers for Medicare and Medicaid Services or CMS) and the large body of court decisions that have resulted from it, have made the scope of EMTALA so broad that now most of its provisions have little, if anything, to do with economically motivated patient transfers.

First, and foremost, EMTALA represents a right to emergency health care, an unfunded government mandate. As Robert Bitterman relates in his book *EMTALA: Providing Emergency Care Under Federal Law*, EMTALA provides far more than a guarantee of emergency department screening and stabilization for true emergency conditions. It is, in reality, catastrophic health coverage for any individual who comes to the emergency department regardless of whether they have insurance coverage or the ability to pay.

Congress also provided a private cause of action by individuals and facilities. Lawsuits brought by individuals who have suffered personal harm because of an EMTALA violation have become commonplace. Several years ago it became apparent that EMTALA might become a federal malpractice law and in many states an EMTALA lawsuit is not subject to the tort restrictions of malpractice actions. The courts have ruled that only hospitals, and not physicians, can be sued for damages under EMTALA. How-



ever, there are two ways physicians can become involved in EMTALA liability. First, state EMTALA equivalent laws allow harmed individuals to sue physicians. Second, hospitals may seek recourse against physicians whose actions resulted in the hospital's liability. In addition, significant fines and penalties can be levied against physicians for EMTALA violations including exclusion from the Medicare program. Managed care adds even more wrinkles to EMTALA compliance.

Managed care market practices have heightened the problem of declining reimbursements. At the same time managed care has not participated in providing care to uninsured or the underinsured people. In fact, as Bitterman stated in his book, the tenets of managed care are irreconcilable with EMTALA. Managed care payment practices pose disincentives for emergency department care, yet EMTALA mandates such care.

Patient "Dumping" and EMTALA

EMTALA is known as the "anti-dumping" law because it was enacted by Congress in 1986 to ensure that patients who come to hospitals

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13 Common EMTALA Violations

STEPHEN A. FREW, JD

The EMTALA law renders many common practices among physicians and hospitals illegal, even though physicians may think that what they are doing is prudent or simply good business. Physicians may view their actions as harmless, but substantial fines may result.

Here are 13 common errors by physicians on call to emergency departments (ED) and the situations pertinent to each.

When asked to come in to see an ED patient:

1. Debating with the ED physician over the necessity of coming in. Once the request is made to come in, the duty attaches. In addition, EMTALA places the decision power with the physician with “eyes on” the patient.
2. Refusing to come in and suggesting that the patient be seen by another specialist. The on-call physician must respond to all ED requests. A neurosurgeon’s refusal to come in based on a bona fide belief that another specialist would be better suited to the patient’s needs still will be cited.
3. Refusing to come in and ordering the patient transferred to another facility because of severity or scope of condition. EMTALA requires the requested physician to respond. Phone evaluation is not sufficient if the ED physician asks the specialist to come in to see the patient. If the patient is too serious after specialty evaluation, the duty of making the transfer belongs to the specialist. If the ED physician asks only for a phone consultation, then merely giving a phone consult is not a violation, but should be documented by the ED physician as a phone consultation.
4. Instructing the ED physician to admit or to run various testing and delaying coming in to see the patient until a later time. EMTALA requires prompt response within a “reasonable” time. These times are not extended by necessary or prudent testing or by admission. Delays in seeing admitted patients often lead to violations for failure to promptly stabilize the patient.
5. Declining the patient based on the patient’s apparent needs exceeding the physician’s scope of practice. EMTALA requires physicians to render care within their privileges, not their scope of usual practice. The physician specialist must come in and justify in writing any transfers and effect the transfer.
6. Declining the patient because of the payer plan status or self-pay status. EMTALA requires services to be rendered regardless of means or ability to pay. Where evaluation or stabilizing care, including surgery, is not complete, EMTALA prohibits seeking



advance approval from insurance companies or plans. (EMTALA does not, however, require the payer to make payment for the services.)

7. Declining the patient because he or she was previously discharged from the physician’s practice for prior litigation or non-compliance. While the patient has the right to decline the on-call physician, the on-call physician does not have the right under EMTALA to decline the patient.
8. Declining the patient on the basis that the specialist physician is “not interested” in a case of that type. The on-call specialist is required to respond to all patients presenting.

When contacted by another hospital seeking transfer of a neurosurgery patient:

9. Declining the patient because the neurosurgeon at the first hospital is not available or turned down the patient improperly. As noted above, there is a duty to accept. Where it appears the first hospital’s neurosurgeon may have violated EMTALA by not being available when required for call or refused to take the patient, the receiving hospital is required by EMTALA to report the incident to federal authorities within 72 hours.
10. Declining the transfer because the destination hospital is not the closest, or the designated center, or is not within the hospital’s indigent care zone under local law. EMTALA requires that

patients be accepted from anywhere within the boundaries of the United States, including Guam and Puerto Rico.

When asked to come in to see an ED patient or an in-house patient on an emergency consult to rule out an emergency medical condition or provide stabilizing care:

11. Declining because the patient is aligned with another neurosurgeon or physician who is unavailable or declined to come in. On-call obligations are not limited to unaligned patients. The U.S. Supreme Court, the statute itself and the leading cases under the Supreme Court's decisions indicate that the EMTALA requirements regarding stabilization, on-call, transfer, and acceptance are house-wide obligations and not limited solely to the ED.

When covering more than one hospital on call:

12. Asking that a patient be sent to the hospital where the on-call physician is currently seeing patients instead of going to the patient's location. EMTALA requires all care to be rendered in the hospital where the patient presents. The only circumstances where the request to transfer would be valid would be if the needs of the patient could not be met in timely fashion where the patient presented, the requested transfer would allow more timely intervention for patient safety and response of the on-call physician was not possible (i.e., currently involved in surgery). Thorough documentation would be important.

When contacted by another hospital that is without neurosurgery capability regarding transfer of a hospitalized patient and neurosurgical evaluation or definitive care may be necessary to stabilize the patient:

13. Declining the requested transfer when a bed could be made available at the destination hospital where the neurosurgeon is on-call. EMTALA requires any hospital with specialized capabilities that are greater than those of the sending hospital to accept all such patients in transfer, regardless of their means or ability to pay. The on-call physician is deemed to be within the capabilities of the hospital and must accept unless there literally is not one more space to put the patient, or some other circumstance, such as non-functional equipment, makes it impossible to deliver the needed service. ■

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Examining EMTALA

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for treatment of an emergency condition are neither turned away nor transferred to another facility for inability to pay. Dumping includes events that go well beyond inter-hospital patient transfers. In fact, it extends to any movement of a patient outside hospital facilities at the discretion of any person employed by or affiliated with the hospital. Thus discharging, referring, or removing a patient from the hospital building may constitute patient dumping. According to EMTALA "transfer means the movement (including the discharge) of an individual outside a hospital's facilities." All patient discharges from an emergency department are transfers. All patient discharges from a hospital after an inpatient stay, no matter how long, also are transfers. All traditional transfers from an emergency department or inpatient setting to another acute care facility, whether for further care or for testing, such as a CT or MRI scan, are transfers. Only those transfers of patients who have emergency medical conditions that have not been stabilized are controlled by EMTALA.

What Hospital Obligations are Imposed by EMTALA?

Hospitals that maintain an emergency department must comply with the following requirements. They have an obligation to provide an appropriate medical screening examination for determining whether a person has an emergency medical condition or is in active labor. They have an obligation to treat the emergency medical condition until stabilized or transfer the patient to an appropriate facility if they are unable to stabilize the patient. Hospitals with specialized capabilities or facilities are required to accept transfer of patients who require such specialized services, if the hospital has the capacity to treat the individual. Also, EMTALA requires hospitals to provide on-call physicians to enable the hospital to determine whether a patient has an emergency medical condition, to help stabilize emergency patients, and to accept patients in transfer from other facilities. The law also prohibits hospitals from delaying access because of an individual's insurance status. What this means is that hospitals under EMTALA must provide a screening examination to any individual who presents to the emergency department, provide treatment for any emergency and accept certain patients in transfer regardless of those patients' ability to pay or insurance status. Therefore, rights that did not exist at common law were created by EMTALA. Previously hospitals owed no duty to render any medical care, including emergency examinations and stabilizing treatment.

Under EMTALA, the hospital, not its medical staff or individual physicians, is responsible for maintaining an on-call roster for the emergency department. The hospital is required to "adopt and enforce a policy to ensure compliance with the requirements of [EMTALA]."

Why Should Neurosurgeons be Concerned About EMTALA?

Hospitals and neurosurgeons must find ways to comply with

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EMTALA legal mandates. Hospitals and medical staffs must acknowledge that EMTALA exists and is the law of the land. Many times, we have heard stories of anger, denial or failure by neurosurgeons, and other physicians, to take this step and not doing so thwarts meaningful compliance. Medical staffs and hospitals must design effective on-call systems so that those problems with EMTALA are minimized. Hospitals and medical staffs must define services that they will provide and those that they will not on a prospective basis. Physicians must learn the documentation paradigm required by EMTALA to protect their hospitals and themselves from liability. Neurosurgeons must become educated on the impact related to hospital on-call responsibilities. Neurosurgeons must concede that they become an agent of the hospital when they take call and no longer represent the interests of their practice or group affiliation.

One of the myths that permeates physicians' thinking regarding EMTALA is the so-called "three specialists rule." Many hospitals and medical staffs have conservatively defined their emergency department call requirements, as Bitterman illustrates in his book. His summary of the approach: "If you have three physicians on staff in any one specialty, you must provide uninterrupted emergency department on-call coverage for that spe-

"Neurosurgeons must concede that they become an agent of the hospital when they take call and no longer represent the interests of their practice or group affiliation."

cialty." This approach has been talked about so much that it is assumed it actually came from CMS, but CMS specifically denies that such a rule exists. According to Bitterman, however, CMS does expect full on-call coverage when three physicians in a specialty actively practice at the hospital. CMS regulators state that they review each hospital's activity on its own merit.

Federal law does not require an individual physician to serve "on call." Rather the responsibility to provide specialty coverage rests with the facility that offers emergency services. However, it is obviously the physicians on the medical staff who must provide professional services. Once a physician accepts on-call responsibilities the physician must comply with

EMTALA and may be liable for failure to do so. The laws prohibit an on-call physician from refusing to respond for any non-medical reason. When on call, the physician's duties mirror the hospital's three main duties under the law: medical screening, stabilization, and acceptance of appropriate transfers.

When on call, the physician represents the hospital, not a private practice or a faculty practice.

Hospitals that have the ability and capacity to treat patients' emergency medical conditions that another hospital cannot must accept patients in transfer, according to the Federal Patient Self Determination Act. The neurosurgeon must recall that when on call he or she is acting as the hospital's agent and must accept appropriate transfers whenever the hospital is required to accept them regardless of the effect on the physician's practice.

Bitterman clearly spells out the situation for the on-call neurosurgeon in his book. "If I'm a neurosurgeon on call for a tertiary facility, does that mean I'm on call for any neurosurgical emergency that presents to all the nearby hospitals that don't have a neurosurgeon? Yes, it does, and even for the not-so-nearby hospitals. If you have a skill a patient needs emergently and your hospital can handle the case, you have to accept the appropriate transfer of anyone from anywhere in the United States.

According to CMS regulations implementing EMTALA, "a participating hospital that has specialized capabilities or facilities may not refuse to accept from a referring hospital within the boundaries

NEUROSURGEONS CAN IMPROVE REIMBURSEMENT FOR ON-CALL SERVICES

The emergency medical services (EMS) system is in the midst of a growing crisis because of a recognized shortage of on-call specialists. This problem extends to the provision of emergency neurosurgical care. Neurosurgeons are a vital component of the EMS system, and appropriate reimbursement for their active participation in the EMS system is essential.

The AANS and CNS developed the following position statement to help neurosurgeons obtain reimbursement for providing on-call services.

IMPROVING ACCESS TO EMERGENCY NEUROSURGICAL SERVICES
Hospitals should provide neurosurgeons with reasonable compensation for serving on the on-call panel. This compensation should supplement any reimbursement the neurosurgeon receives for services rendered while serving on-call.

Neurosurgeons around the country are now successfully using this statement to negotiate with their hospitals the payment of on-call stipends. Additional information is available at www.neurosurgery.org/health/news/detail.asp?PressID=136.

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Neurosurgeons: Answering the Call

COLLEEN HORN

Every day in the United States, nearly 300,000 patients request care at hospital emergency departments. Many have serious illnesses or injuries that require consultation with medical specialists, hospitalization and/or surgical intervention.

Yet the emergency and acute care system is in the midst of a growing crisis because of a shortage of specialists who are willing to provide on-call coverage to hospital emergency departments. Many hospitals have huge gaps in specialty services available to emergency patients, particularly in the surgical subspecialties such as neurosurgery. An increasing number of on-call specialists in the United States is not willing or able to provide on-call services to hospital emergency departments because of inadequate reimbursement, increased patient volumes, and demands on personal time.

"Physicians should not be forced to take excessive calls or provide disproportionate amounts of health care without compensation," said Michael L. Carius, MD, FACEP, president of the American College of Emergency Physicians (ACEP). "However, to begin to solve the on-call problem, it is important that physicians and hospital medical staff recognize the shared ethical, moral and legal responsibilities to provide medical screening exams and to stabilize the emergency conditions of all patients who come to emergency departments."

The Emergency Medical Treatment and Labor Act (EMTALA) places responsibility on hospitals to ensure the availability of emergency care for all who need it, regardless of their insurance status, citizenship or ability to pay. As part of this obligation, hospitals offering emergency care must make specialists and sub-specialists accessible to treat and stabilize emergency medical conditions. Any service that the hospital routinely provides on a scheduled basis must also be available for patients in the emergency department. On-call duties come with the privileges of practicing in hospitals, and on-call physicians are responsible for EMTALA compliance.

Medical staff by-laws, policies, rules and regulations, and procedures therefore must be consistent with EMTALA requirements and define the responsibility of on-call physicians to respond, examine and treat patients. Although no physician is required to be on-call at all times, hospitals must develop contingency plans for on-call coverage when particular specialties are not available, or on-call physicians cannot respond.

Under EMTALA, physicians who do not respond to a call can face a federal fine of up to \$50,000 and exclusion from participation in the Medicare and Medicaid programs. Hospitals are required to report violations.

"EMTALA is not to blame for the difficulty emergency medicine professionals face with specialty backup, but the lack of funding for this mandated care is the underlying issue," said Brent R. Asplin, MD, MPH, a member of ACEP's Federal Governmental Affairs Committee. "This funding vacuum creates a climate in which it is difficult to support not only specialty backup, but also the care provided by emergency physicians and hospitals. It is not a question of

whether providing this care is the right thing to do; it is a question of whether the current funding structure is sustainable over the long run. From what we are seeing today, clearly it is not."

ACEP has been involved on many fronts to address issues related to implementation of EMTALA. ACEP was instrumental in having a study included in the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 to address the impact of EMTALA on hospitals, emergency physicians and on-call specialists.

Both the U.S. General Accounting Office (GAO) and the Department of Health and Human Services Office of Inspector General (OIG) continue to investigate the on-call problem. The GAO's first report, which was released in June 2001, focused on EMTALA enforcement. Its next report will examine uncompensated care. ACEP will work closely with the GAO on this report.

"It is important for all specialty organizations to continue to articulate that the EMTALA mandate represents a commitment by the United States to provide universal access to all emergency care services, regardless of a person's ability to pay," said Dr. Carius. "ACEP believes that physicians should be compensated for their services, but that providing quality medical care for patients is the physician's most important responsibility."

The OIG also has found that many hospitals have difficulty filling on-call rosters, particularly in the area of neurosurgery, among other specialties. This is particularly problematic in states with high managed-care penetration or a large proportion of uninsured people.

Some managed care providers are denying coverage and delaying payments for emergency care services. For example, they may refuse to pay physicians who provide emergency care to patients who are out of network, or outside the managed care contract. If a medical specialist employed by a patient's managed care organization is not available, hospitals are obligated under EMTALA to provide a specialist. However, managed care organizations are not required to pay for such services. While hospitals have absorbed those costs in the past by shifting them to patients who could pay, it increasingly has become difficult to recover those costs with the flat fees provided by managed care organizations.

When the California Medical Association and ACEP's California Chapter recently studied the shortage of physicians willing to participate on hospital on-call panels, they found that 60 percent of hospitals had at least a "somewhat serious" problem with on-call coverage.

"Since neurosurgeons are a vital component of emergency care, their active participation on on-call backup panels is essential," said Dr. Cairus. "Unfortunately there are just not enough neurosurgeons to provide on-call backup to every emergency department in the country. We hope specialists can work together in their local community to share the responsibility and burden of providing on-call backup to their local emergency departments to help keep America's safety net from unraveling." ■

Colleen Horn is public relations manager of the American College of Emergency Physicians.

EMTALA Fines Are Rare

JAY COPP

Chances are remote that a hospital or physician will be fined for an EMTALA violation. One hundred sixty-four hospitals agreed to pay civil monetary penalties to resolve an EMTALA violation from 1997 through April of 2001, according to Public Citizen, a consumer watchdog group. Thirteen physicians over that same time period agreed to pay civil monetary penalties to resolve dumping violations.

A Look at the Numbers

The average penalty paid by hospitals from 1998 to 2000 was \$29,631, an increase from the average penalty of \$17,904 in 1996. Penalties for the 13 physicians ranged from \$5,000 to \$45,000 and averaged \$19,967.

Five hundred twenty-seven hospitals (about 9 percent of all U.S. hospitals) had EMTALA violations basically from 1997 to 1999. Not every violation is penalized with a fine. The Office of Inspector General (OIG) considers the nature of the offense, history of prior offenses and other factors in deciding whether to assess a penalty. Since EMTALA was enacted in 1986, 261 of the 975 (26.7 percent) EMTALA violations by hospitals and physicians have resulted in monetary penalties.

Some EMTALA violations are of a minor nature such as simple documentation omissions. But all 13 physicians who have been fined violated a screening, transfer or stabilizing treatment provi-



sion, the most serious offenses. Ninety-one percent of hospitals cited for an EMTALA infraction violated one or more of the three most serious provisions.

Six hospitals with a highly serious EMTALA violation(s) have been prohibited from participation in Medicare. A termination can

be reversed if a hospital implements plans of corrections and shows compliance with EMTALA.

The statistics don't tell the whole story about EMTALA, of course. For one thing, no one knows how many violations go unreported. A patient transfer that may constitute an EMTALA violation must be reported by the receiving hospital to the Centers for Medicare and Medicaid Services, but that has happened just once since 1995.

Public Citizen officials have charged that the statistics show that hospitals are flouting the law. But emergency departments handle more than 100 million visits annually, and emergency room physicians and hospital officials say they take EMTALA seriously and try to comply with its complex provisions. ■

Continued from page 10

of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat that individual." In addition, if a hospital has generally accommodated a patient by whatever means (e.g., moving patients to other units, calling additional staff, borrowing equipment), then it has demonstrated the ability to provide services beyond its patient occupancy limit.

Neurosurgeons should recall that EMTALA enforcement is a complaint driven process. CMS does not investigate, the Department of Health and Human Services Office of Inspector General cannot prosecute, and the courts never get involved if there is no complaint from a patient, family member, whistleblower, or other interested person about the care delivered by a hospital. As Bitterman points out, a patient-centered approach to the delivery of emergency services can prevent complaints and EMTALA consequences. External issues such as managed care, hospital-physician relationships, and economic considerations are irrelevant. Acting only in the best interest of our neurosurgical patients is the only issue that matters. Finally, neurosurgeons must acknowledge that EMTALA exists and is now the law of the land. ■

John A. Kusske, MD, is a member of the Washington Committee and former chair of the AANS Managed Care Advisory Committee. Katie Orrico, JD, is director of the AANS/CNS Washington, D.C., Office

EMTALA-RELATED RESOURCES

Providing Emergency Care Under Federal Law: EMTALA, Robert A. Bitterman, MD, JD, FACEP. American College of Emergency Physicians, (800) 798-1822, touch 6. www.acep.org/bookstore/.

EMTALA: Interpreting and Complying With the Federal Transfer Law, Louise M. Joy, Esq. American Health Lawyers Association, (202) 833-1100.

The Emergency Medical Treatment and Labor Act: Survey of Hospital Emergency Departments, January 2001, Office of Inspector General, U.S. Department of Health and Human Services. Report no. OEI-09-98-00220. <http://oig.hhs.gov/oei/reports/a509.pdf>.

The Emergency Medical Treatment and Labor Act: The Enforcement Process, January 2001, Office of Inspector General, U.S. Department of Health and Human Services. Report no. OEI-09-98-00221. <http://oig.hhs.gov/oei/reports/a510.pdf>.

Emergency Care: EMTALA Implementation and Enforcement Issues, June 2001, U.S. General Accounting Office. Report no. GAO-01-747. www.gao.gov.

EMTALA Quick Reference Guide for On-Call Physicians, American Medical Association. www.ama-assn.org/ama/pub/category/2650.html.

EMTALA Interpretive Guidelines. Centers for Medicare and Medicaid Services. www.hcfa.gov/pubforms/07_5Fsom/somap_5Fv_5F01_3_5Fto_5F034.htm.

Reflections on a Tragedy

Military Neurosurgeon Recounts Pentagon Visit

LEON E. MOORES, MD, LTC U.S. ARMY

Getting up in the middle of the night for professional reasons is certainly nothing new to neurosurgeons. All of the images I had seen, every emotion I have, and all of my logical thought processes led me to believe that this night would be different. It was quite different.

Nearly one week after the incidents of Sept. 11 I had become used to the heightened security, and our increased security measures often caused the lines at the hospital gate to be quite extensive. At 2 a.m., however, this was not the case. As we boarded the bus that would transport us to the Pentagon, I introduced myself to the rest of the team that would be working this shift. Accountability for each member of the team was essential, and the updated list was called into the command center as we pulled out. Military and District police vehicles escorted the bus in what was just another of so many surreal scenes over the preceding week. It is rare, even in the District of Columbia, to have four squad cars with lights and sirens activated through an entire transit of the city limits.

Since I had chosen not to join the crowd of people that routinely gathered each day along the highways adjacent to the Pentagon, this was to be my first direct view. As we exited the bus, golf carts drove us to security, where U.S. Secret Service personnel performed

"Despite exhaustion in some and overwhelming emotions in all, [everyone] remained focused and accomplished their tasks as a team."

their check-in procedures. We headed to the crash site in less than 15 minutes.

Upon rounding the corner, we saw the bright white illumination contrasting sharply with the surrounding night, bringing out every detail of the torn and flame-scarred Pentagon. As we approached the site, I was struck by the enormity of the scene. Huge cranes, front-end loaders, bucket lifts, tents and hundreds of personnel were fully employed clearing debris and recovering remains. This thought was immediately followed by the realization that as horrific as this scene was, the scale of the New

York site must have been orders of magnitude greater.

The human response left the most lasting impression. The cacophony nearly ceased each time remains were noted. Word spread quickly, all machinery except generators and the idling diesel motors of the big cranes stopped, and nearly every eye turned to the point on the site where the FBI investigators were dwarfed by the surrounding wreckage as they photographed, mapped and catalogued the remains. The torso, limb or other portion of what was once a human life, taken away in a fraction of a second by a heinous act of cowardice, was removed by Army Mortuary Affairs soldiers, some of them 18-years-old and just weeks out of basic training. The chaplain performed last rites, and I would make a viability determination in the refrigerator truck as the big machinery wound back up for another search.

Despite exhaustion in some and overwhelming emotions in all, the rescue workers, support volunteers, military and federal agency personnel—male, female, white, African-American, Hispanic, Christian, Muslim, Jew, Hindu—remained focused and accomplished their tasks as a team. While we all sincerely hope nothing like this will ever happen again, I cannot imagine that any country in the world could be better equipped to handle a tragedy of this magnitude. I don't feel like it is a cliché at all to say that I am proud to be an American. ■

Leon E. Moores, MD, LTC U.S. Army, is director, Pediatric Neurosurgery, Walter Reed Army Medical Center, Washington, D.C.

AANS Responds to Sept. 11 Tragedy

Nationwide Call Issued for Neurosurgical Volunteers In the immediate aftermath of the Sept. 11 terrorist activity in New York and Washington, D.C., Stan Pelofsky, MD, through the AANS National Office, issued a call for volunteers to AANS members across the country. The response was remarkable, with over 100 AANS members from around the world immediately offering their time, resources and medical expertise. Within minutes of the tragedy, a number of New York and district-area members were already volunteering their time to aid survivors. AANS immediately contacted the Federal Emergency Management Agency (FEMA), Volunteer Doctors of America and the American Red Cross, to offer the membership's help, involvement and support. Although the circumstances required only minimal neurosurgical medical assistance for this tragedy, the AANS will forward the comprehensive list of volunteers to FEMA for future reference. Your name can be added to the volunteer list by contacting AANS Director of Communications Heather Monroe at hlm@aans.org. ■

Surviving Complications

Don't Suffer in Silence

ROBERT M. CROWELL, MD

Imagine a really terrible complication—say an aneurysm case gone sour. You're dissecting a large middle cerebral aneurysm and it ruptures. With temporary clips you manage to control the hemorrhage and then clip the broad-necked aneurysm sac. The brain swells, and in the ICU the patient is hemiplegic. That night you awaken in the night to a gnawing in the gut—you remember your devastated patient.

How can you deal with such a result?

The Traditional Way: the Armor of Aequanimitas

The standard way is simple: You deny that it hurts. You intellectualize it: The aneurysm was difficult, sometimes this happens. This is what we do. We're tough and we can take it. The unwritten code.

This approach was epitomized by Harvey Cushing. Beginning in 1901, Cushing tackled the problem of brain tumor surgery. He used new understanding of brain swelling, meticulous technique learned from Halsted, and the backing of Johns Hopkins.

But things did not go well. His first 10 cases all died. He wrote to his wife, "Every one I touch dies." How did Cushing deal with such crushing catastrophes? He developed the armor of *aequanimitas*—cool logic in the face of chaos. Cushing eventually lowered the mortality for brain tumor surgery to 7 percent from 65 percent. He led the world in brain surgery—the image of a brilliant, dauntless operator.

We've copied Cushing: *aequanimitas* distances the neurosurgeon from the patient and thus eases the pain of complications. But there is a downside: Suppressed yet unresolved grief may lead to deadening of feelings, depression, substance abuse, alienation from family and friends, even suicide. In addition, detachment from the patient undermines the surgeon's connection to patient and family, a connection crucial to weathering the complication. Rarely unchecked *aequanimitas* can grow into pure arrogance—the surgeon-god who cares not at all about the patient.

The best way to deal with complications is to prevent them before they occur. Preventing complications requires the highest levels of technical skill and surgical judgment. That's why neurosurgical residency is the most demanding apprenticeship on earth. As a neurosurgeon, you will hurt some patients, and it is going to hurt you. To minimize your pain you'd better train as long and as hard as you can to be sure you've done your very best to avoid complications. No matter how brilliant your technique, you'll still have complications, and thus technique alone can't shield you.

Traditional morbidity and mortality conferences bring us face to face with our failures. The style is formal: We intellectualize and

rationalize. What can we do better next time? Usually the emotional stress of a bad complication is not addressed; we don't talk of vulnerability, culpability and forgiveness. Still, these sessions may present an opportunity to "forgive and remember," as recommended by Daniel Bosk a generation ago.

A Better Way: Strengthening the Bonds of Loyalty and Community

Talk to the family. Do it in depth. Don't just give the bad news and run. Sit down with the next of kin in a private room. Tell them in plain language what happened to their loved one. You can say you are sorry that this is happening, without any implication of malpractice. If you see they are in distress, you may well take their

hand or put an arm around their shoulders. Comforting words from a neurosurgeon to family in the ICU waiting room lessen the suffering all around, as illustrated in Marc Flitter's memoir *Judith's Pavilion: The Haunting Memories of a Neurosurgeon*. When natural bonds of community with patient and family are nurtured, the neurosurgeon can experience gratitude and forgiveness even in the face of serious complications.

Talk to your neurosurgical peers. They know what you're feeling, and they will support you. Talk to your spouse or significant other: You can't hide your pain from them. Share it, and you will be supported, with strengthened bonds of love and loyalty instead of deepening isolation.

If you made a mistake, it may be even more painful, whether the mistake is recognized or not. Discussion with a peer may help, but eventually you will have to forgive yourself to go on with surgical work. This process is described by Frank T. Vertosick, Jr., in his memoir *When the Air Hits Your Brain*. The resident narrator operates on an aneurysm, it ruptures, and the patient dies. The resident feels profoundly guilty and depressed, even considers leaving neurosurgery. In desperation, he calls a former senior resident who tells him:

"We've copied Cushing: *aequanimitas* distances the neurosurgeon from the patient and thus eases the pain of complications. But there is a downside."

You have to care about the patients, but not too much. ... Patients want us to care about them, but they want us to perform with the nerveless demeanor of someone slicing bologna in a deli at the same time. ... Enough bullshit. Clip the aneurysms and take what happens.

This hardnosed commentary, based in *aequanimitas*, but shared, seemed to help the resident. Note that he had maintained contact with the patient's wife, whose unexpected thank-you note also helped. Eventually the narrator managed to put his catastrophe behind him and get on with residency and practice.

Get a Life!

A satisfying personal life, replete with relationships and leisure activities, can ease the pain of complications. In *The Paradox of Success and the Neurosurgeon*, Joseph Maroon, MD, wrote about the importance of attaining balance of career, social, physical and spiritual components in a neurosurgeon's life. The fabric of everyday life and practice is the backdrop for the resolution of grief for the catastrophic complication. It should be nurturing to the vulnerable neurosurgeon.

HMOs, malpractice and high-tech developments all tend to pressurize and depersonalize medicine today. However, there are some signs that medicine has begun to rehumanize itself. At Yale, a Program for Humanities in Medicine has become a model for this process. Programs in medical ethics have sprouted up in most of the nation's medical schools. In some high-stress areas, such as pediatric oncology and interventional neuroradiology, physicians have benefited from the presence of a psychiatrist attached to the practice group.

One thing that Cushing did not have to deal with was high expectations: In 1901 if you were diagnosed with a brain tumor, you expected to die. Thus the patient, offered some slender chance of benefit from surgery, had nothing to lose by choosing surgery. But now, 100 years later, with great strides made in brain surgery, the patient expects not only to survive the operation, but indeed to be cured by it. Here perfectionism gets way out of hand, and so does stress on the surgeon. The reality is stark and simple: We can't provide cures for everybody, we can't do perfect operations every time, we are human beings and we are fallible.

In the context of patient-doctor understanding, preoperative informed consent prepares the patient, family and neurosurgeon. Be sure you explain all of the complications you can think of in a way lay people can understand. People deserve to know what they are getting into. The discussion will also remind you of what complications you may be getting into.

As we enter the 21st century, scientific inquiry—the quest for *veritas*—has been amazingly fruitful, giving us MRI, microsurgery, neuronavigation and so much more. Successful application of this armamentarium to daunting neurosurgical problems often requires *aequanimitas* to palliate and cure patients. However, even high-tech methods have their limits. You won't cure glioblastoma often, and the eventual mortality of the human condition is 100 percent. When technique fails, then compassion—the Latin term is *caritas*—should be offered by the neurosurgeon to patient and family.

Caritas can help heal the patient, the family and the neurosurgeon as well. It's not a bad credo for neurosurgeons facing a new millennium: a balance of *veritas*, *aequanimitas* and *caritas*. ■

Robert M. Crowell, MD, is a neurosurgeon affiliated with Berkshire Medical Center, and is professor of surgery (neurosurgery) at the University of Massachusetts Medical School.

A Call for Compassion

Compassion is Needed When Patients are Passionate

MARK GORNEY, MD, AND JOAN BRISTOW, RN, MA

This is the third article in a series from The Doctors' Company (TDC) on risk management. For any questions or comments on liability issues, call TDC at (800) 421-2368, ext. 243.

All malpractice claims have anger as a root cause. Whether anger is emitted from the patient, the doctor, or both—it is always present. Virtually every patient contemplating medical treatment experiences some degree of anxiety. In seeking a physician, patients also seek reassurance against their uncertainties. An unfavorable treatment outcome evokes feelings of despair and helplessness that can quickly turn into hostility. Regardless of the true cause, the anger will be focused on the most convenient and visible target—the doctor.

Let Them Vent

When faced with someone who is upset or angry, it is best to remain silent and to let that person talk about the problem. Respond with noncommittal comments such as “yes” or “uh-huh” until the patient has calmed down. This technique of attentive silence often defuses angry people. Once the patient has finished expressing dissatisfaction, calmly ask him or her to reiterate part of the message, even though you may have understood it. Requesting additional information or an explanation reinforces the importance you attach to the patient's message.

One of the worst errors you can make in dealing with angry or dissatisfied patients is to try to avoid them. Although such a reaction is understandable, avoidance is the surest way to hasten a patient's visit to the attorney. As difficult as it may be, the more you talk and listen to an angry patient, the more likely you are to avoid converting an incident into a claim. Assuming responsibility for at least 55 percent of the effort necessary for effective communication will substantially improve your chances for successful doctor-patient relationships.

Your Own Anxiety

An unfavorable outcome also produces anxiety in a physician. More often than not, patient complaints are interpreted as personal affronts that strike at your sense of professionalism, pride and competence.

When you perceive a complaint as unwarranted, communication with the patient may quickly degenerate into mutual hostility. A vicious cycle is then established: Your anxiety, guilt, hostility and arrogance are countered by the patient's hostility, which causes your hos-

tility to mount. In such a climate, the possibility of a lawsuit quickly becomes a probability. Regardless of the nature of a complaint, all malpractice actions are preceded by these negative emotions.

It is very difficult, if not impossible, to be objective when it seems that a lawsuit soon may be hanging over your head. Therefore, controlling the course of events prior to the onset of mutual hostility is key to avoiding malpractice actions. The pretreatment or postoperative consultations during which informed consent is obtained provides an excellent opportunity to establish a positive doctor-patient relationship that can weather an unfavorable outcome.

Sharing Uncertainty

Much has been written on the therapeutic effects of full informed consent. Simply stated, the very act of disclosure results in less anxiety, increased trust in the integrity of the physician, a smoother clinical course and better patient understanding should anything go awry. Experience has shown, however, that unless both doctor and patient fully understand the significance of the transaction, both can be lulled into a false sense of security.

Many physicians are reluctant to use consent forms for fear of calling attention to a long list of potential complications that could unnecessarily heighten a patient's unspoken anxieties. Conversely, the ritualistic but meaningless signing of a document (reading a list and obtaining a signature) can give you the false assumption that all bases have been covered and that an unpleasant but necessary formality has been completed.

Ideally, the informed consent session should be viewed as an opportunity to dispel uncertainty, allay anxiety and help fill the gap between patient ignorance and supposed physician omnipotence. By sharing uncertainty, you can transform a potentially adversarial relationship into a therapeutic alliance.

Presenting a Human Image

The essence of rapport lies in patient confidence in his or her physician. In many therapeutic situations, the patient's principal defense mechanism against uncertainty is to endow you with a certain omnipotence. Thus, according to psychiatric authors, an irrational yet real relationship evolves in which the patient is totally dependent on you, the doctor. In this state of physical and emotional dependence, patients are unwilling or unable to accept any disavowals that intrude on the illusion.

Furthermore, if an unfavorable outcome shatters the magic, disillusionment might increase the dependent state. Patients may also refuse to accept prior knowledge of the possibility of such an out-

come or to even assume partial responsibility for self-care. At that point in the patient's regressive state, the treating physician becomes a target.

Logically, you should try to dispel any fantasies or unrealistic expectations before treatment begins. However, confronting such expectations directly may irreparably damage the patient's sense of confidence in you. This approach may even impair a successful therapeutic outcome.

How can you prepare patients without sabotaging their confidence? Consider, for example, the following statements:

"Here is a list of complications that could occur during your treatment or operation. Please read the list carefully and sign it. If you don't understand something, ask me."

"I wish I could guarantee that there will be no problems during your treatment or operation, but that wouldn't be realistic. Sometimes there are problems that cannot be foreseen, and you need to know about them. Please read about them and let's talk about it."

By using the second statement, you can reduce the omnipotent image the patient has of you to that of a more realistic and imperfect human being. The patient will see that you are facing, and thus sharing, the same uncertainty. The implication is clear: "We—you and I—are going to cooperate in doing something to your body that will make you better, but there are no guarantees on how your body will respond."

Sense of Participation

Be cautious, however. In an effort to ease anxiety, your reassurance to the patient may overreach and create unwarranted expectations and an implied guarantee. Note the difference in the following statements:

- *Don't worry about a thing. I've taken care of hundreds of cases like yours. You'll do just fine.*
- *Barring any unforeseen problems, I see no reason why you shouldn't do very well. I'll certainly do everything I can to help you.*

Again, by using the second statement, you will gently deflate the patient's fantasies of you to realistic proportions, while remaining reassuring and helping the patient accept reality.

The therapeutic objective of informed consent should be to replace some of the patient's anxiety with a sense of participation and some control. This strengthens the therapeutic alliance between the patient and the physician. Instead of regarding each other as potential adversaries, both come closer in the shared

acceptance of the uncertainties involved in clinical practice. Discussing consent forms will allow you and your patients to know each other better. Your patients will also realize they are in the care of a concerned physician.

How Patients Cope

It is entirely appropriate for patients to feel a sense of bewilderment and anxiety when medical treatment does not go smoothly. The borderline between anxiety and anger is very tenuous, with fear of the unknown as the critical factor.

How do people cope with uncertainty? Blaming someone else places the responsibility elsewhere and gives a sense of control that, however inappropriate, is easier to cope with psychologically. A patient who is frightened by a postoperative complication and is uncertain about the future can gain a distorted sense of security by blaming the physician. The logic of this distortion is: "If it is the doctor's fault, it is the doctor's responsibility to correct." Thus, the scenario is set: A frightened patient, unaware of the underlying reason for his or her anger, lashes out at the physician with the subconscious perception that such action will get matters under control and force the doctor to produce a favorable result.

Encourage Trust

A patient's distorted perceptions may clash head-on with your understandable anxieties and wounded pride. The patient blames you and, in turn, you feel defensive. At this critically delicate juncture, your reaction can either set into motion or prevent a chain reaction of increasing hostilities.

You are probably dealing with a frightened patient who is using anger to gain control of the situation. Make a supreme effort to put aside natural feelings of disappointment, anxiety, defensiveness and hostility. The entire mood and subsequent developments in your doctor-patient relationship can be affected by the amount of understanding, support and encouragement you can lend to the situation. A patient's perception that you understand his or her uncertainty and that you will help conquer it can be the deciding factor in whether or not the patient will seek legal counsel.

By creating an atmosphere of trust and partnership, you can relieve your patients' anxieties and diffuse their anger. Without anger or hostility, you and your patients can work together as partners to decide their medical care plans. ■

Mark Gorney, MD, is a plastic surgeon and medical director of The Doctors' Company. Joan Bristow, RN, MA, is vice president of TDC Risk Management. TDC offers malpractice insurance at a reduced rate as a benefit of AANS membership.

Learning From Adversity

How One Medical Center Responds to Tragic Outcomes

POLLY CAMPION, MS, RN

Imagine a patient, stable preoperatively and for whom you expected an uncomplicated recovery, suddenly experiencing cardiac arrest upon transfer from the OR to the recovery area. What could have gone wrong? What did you miss? This fictional scenario may not lie far from reality in any medical center in the United States. *To Err is Human: Building a Safer Health System*, an Institute of Medicine report in 1999, exhorted hospitals to study adverse events and the systems that allow their occurrence. Prior to its publication and in concert with standards of the Joint Commission on Accreditation of Healthcare Organizations, Dartmouth-Hitchcock Medical Center (DHMC) sought to develop a blame-free methodology to identify adverse events. The goal was to discover how these events were emblematic of system inadequacies and to implement risk reduction strategies to prevent future occurrences. The process was begun in 1998 and is available to all the center's clinical staff and faculty.

A Careful Review

The significant adverse event review process is directed by an interdisciplinary committee known as SEARCHES (Significant Adverse Event and Root Cause Analysis of Hospital Systems). Chaired by the executive medical director, the committee includes four physicians from neurosurgery, plastic surgery, hematology and anesthesia, four clinical nurse specialists from psychiatry, oncology, critical care and pediatrics, a pharmacist, a risk manager and a quality adviser.

Adverse events are generally reported to either the risk management or clinical quality department. If merited, the quality adviser convenes a review team, a subgroup of the SEARCHES Committee. A full root cause analysis (RCA) is conducted for any adverse event that may have contributed to or resulted in permanent patient harm or death, unrelated to the patient's underlying condition. A root cause analysis is considered for other cases that also appear to represent significant systems breakdown.

The risk manager and quality adviser create a high-level flow diagram of the event as it unfolded. This flow diagram and a brief narrative description of the event are used at a meeting to discuss the event. The medical director invites every individual involved in the care of the patient in question. The attendees always include physicians and nurses and often include pharmacists, physical therapists or others.

These meetings are cofacilitated by one of the physician members of the SEARCHES Committee and the quality adviser. This tandem leadership has been very effective in providing two unique perspectives. The meetings are opened with a statement outlining the confidential, nonjudgmental nature of the process. The leaders

"The greatest success of DHMC's review process has been in switching the focus from whom to blame to seeking to uncover systemic barriers to the best possible care."

are very skilled at maintaining a blame-free environment.

The meeting's first step is to explicate the facts about what occurred. Participants describe their actions during their involvement with the patient. Secondly, participants identify any factors they may have observed that contributed to the unanticipated event. Lastly, the group generates potential strategies that would address the contributing factors identified.

Significant follow-up work is generated from each RCA meeting. A subgroup of participants works with the co-leaders of the process to further develop, implement and evaluate risk

reduction strategies. The strategies are designed to eliminate the risk, mitigate the risk or reduce the risk. The SEARCHES Committee reviews each risk reduction plan and determines the appropriateness of planned strategies. Summary reports are submitted to the Quality Council and senior management on a periodic basis.

Uncovering Systemic Problems

The greatest success of DHMC's review process has been in switching the focus from whom to blame to seeking to uncover systemic barriers to the best possible care. Participants in the RCA meetings routinely report feeling supported in their sharing of sometimes troubling information. They also say that they often make changes in individual practice to decrease the probability of recurrence. A tribute to the success of the process is that many individuals who have been involved in one RCA have begun to refer an increasing number of cases for review.

Many RCAs have spawned improvement efforts. Positive changes include implementing standard order sets for high-risk cohorts of patients; clearly delineating urgency codes for communicating patient status and assuring timely response to emergent needs of other patients; altering medication labeling and storage to decrease confusion; and making changes in the cardiac arrest response team to more clearly identify the person in charge. ■

Polly Campion, MS, RN, is director, Clinical Quality Resources, Dartmouth-Hitchcock Medical Center.

Neurosurgical Nirvana

Spectacular Scientific Sessions at AANS' 70th Annual Meeting

JAY COPP

If outstanding museums, theater, restaurants and nightlife don't start your engine, there are still three great reasons to come to Chicago in April for the AANS' 70th Annual Meeting. Highly accomplished neurosurgeons Patrick J. Kelly, MD, Edward R. Laws, Jr., MD, and Richard G. Fessler, MD, PhD, will deliver the special lectures, certain to inspire and enrich.

- Dr. Kelly will speak on Monday, April 8, on "Vietnam 1968-1969: A Place and a Year Like No Other" as the Richard C. Schneider Lecture. Dr. Kelly is the Joseph P. Ransohoff Professor and Chairman of the Department of Neurosurgery at New York University. A pioneer in computer-assisted neurosurgery, he has taught the marriage of navigation and neurosurgery to generations of residents.
- Dr. Laws will present the 2nd Annual Hunt Wilson Lecture on Tuesday, April 9, "The Outcome From Surgical Management of Gliomas of the Brain—The Role of Radical Resection." Dr. Laws is the W. Gayle Crutchfield Professor of Neurosurgery and Professor of Medicine at the University of Virginia in Charlottesville. He is past president of the AANS and the CNS and has authored more than 400 scientific papers and eight books. During his surgical career he has operated upon more than 5,000 brain tumors, of which 3,400 have been pituitary lesions.
- Dr. Fessler will give the 1st Annual Rhoton Family Lecture on Wednesday, April 10, "The '90s Revolution in Spine Surgery: Was the 'Decade of the Brain' also the 'Decade of the Spine'?" Dr. Fessler is the medical director of the Institute for Spine Care, a division of the Chicago Institute of Neurosurgery and Neuroresearch. He is a leading authority on microendoscopic and endoscopic spine surgery and has pioneered many of the field's techniques including microendoscopic cervical discectomy and microendoscopic decompression of lumbar stenosis.

These lectures are in addition to the usual scientific program at the Annual Meeting. Choose from more than 38 hands-on practical clinics, 76 breakfast seminars and more than 100 oral presentations.

Scientific Program and Practice Management Seminar Highlights

The scientific program is comprehensive and cutting-edge. Some of the breakfast seminar highlights are "Stroke Centers: Strategies for Developing an Effective Program in Your Practice," "Cutting Edge Strategies for Spine Stabilization," "Evaluation and Management of Peripheral Nerve Entrapment Syndromes" and "State-of-the-Art Transplantation." Practical clinics include "Craniovertebral Junction:



Surgical Approaches, Stabilization Techniques, and Complications" and "Craniofacial Approaches: Deconstruction and Reconstruction."

A full range of practice management seminars will tell neurosurgeons what they need to know outside the operating room. Among the sessions are "The Buck Stops Here: Improving Your Bottom Line in Today's Neurosurgical Practice," "Practice Paradigm in Neurosurgery" and "What Now: Retirement and the Neurosurgeon."

New Women in Neurosurgery Careers Program

A new program, the Leadership Skills and Career Development Conference, developed by Women in Neurosurgery (WINS), will be held on Sunday, April 7. Sessions include "Negotiation and Conflict Resolution," "Marketing and Promotion in Private Practice," "Building a Successful Academic Career" and "Time Management and Organization." This program is aimed at all levels of training and practice and is open to all medical registrants.

New this year are expanded question-and-answer periods and increased discussion time at the breakfast seminars.

Sessions for Residents

Back again are a number of sessions tailored to residents. Among the seminars are "How to Evaluate a Job: Navigating Unfamiliar Territory," "Basics of Spinal Stabilization, Fusion and Instrumentation," "Peripheral Nerve Injuries, Entrapments and Tumors: Examination and Evaluation" and "A Multimedia Experience in Surgical Anatomy." Dr. Kelly will be the featured speaker on Wednesday, April 10, at the Young Neurosurgeons Luncheon.

Chicago is a world-class city and the AANS' 70th Annual Meeting promises to be a world-class event. For more information, visit www.aans.org. ■

Don't Shake the Baby

Neurosurgeon's Project Saves Lives and Dollars

JAY COPP

Most new mothers and fathers in Buffalo and Western New York don't leave the hospital without a sobering lesson: Don't under any circumstances shake your baby. That message as well as advice on how to cope with a crying infant is delivered to them via a short video, a leaflet and posters hanging in the maternity ward.

The warning apparently has been heeded. Deaths from Shaken Baby Syndrome have decreased significantly in the Western New York region since the program began in December 1998.

"People know they're not supposed to shake a baby. Our premise is not that we need to educate people," said pediatric neurosurgeon Mark S. Dias, MD, who originated the program. "We believe that people need to be reminded of the danger at the right time—when they're holding their baby in their arms for one of the first times."

Dr. Dias, formerly chief of pediatric neurosurgery at Children's Hospital in Buffalo, began and expanded the program with a small amount of money, without creating new materials or compromising his other neurosurgical commitments. Yet the Shaken Baby Syndrome project has potentially saved lives and millions of dollars (considering the care for a shaken baby can easily top \$1 million).

"My friend, Michael Partington, [a neurosurgeon in St. Paul, Minn.], told me that I could save more lives with this program than I might in my entire career as a neurosurgeon. That's incredible," said Dr. Dias.

Inspired by Personal Experience

Dr. Dias was inspired to begin the program following his own frustrations in calming his infant son. "I would get up in the middle of the night when he cried, lie him back down and he would start to cry again," he recalled. "I'd give him to my wife, who has a lot more patience, and ask her to 'make him stop.'"

"Even with the resources we had—and two parents—it was still frustrating, and I began to understand how parents could get more and more frustrated."

"Even with the resources we had—and two parents—it was still frustrating, and I began to understand how parents could get more and more frustrated."



About the same time Dr. Dias was dealing with his own crying son he treated three babies suffering from shaken baby syndrome, cementing his desire to find a way to help stressed-out parents cope.

Dr. Dias funded the program for the first two years with \$20,000 in grant money from the William B. Hoyt Memorial Children's and Family Trust. After viewing several videos, he decided that the Midwest Children's Center Resource Center had the best one and secured their permission to use it. He also purchased for a small price a leaflet from the American Academy of Pediatrics. "Everything we use in the program is put out by other people," he said.

Nurses are asked to present the materials at a separate time from information about care of the umbilical cord, the use of car seats and other safety information. This way, the warning about shaking is not lost in the shuffle.

All the materials are available in English and Spanish.

In the program's first two years, 15 of 16 hospitals in an eight-county region around Buffalo agreed to participate in the program by asking new parents to view the materials. Most also had parents sign an affidavit attesting to their having received the material and understanding the risks of shaking a baby. Forty-seven percent of the live births in the hospitals were followed by a signed affidavit from one or both parents. Since December 2000, a total of 35 hospitals in 17 counties have been participating, and nearly 80 percent of live births have been accompanied by a signed affidavit.

The average annual number of shaken babies in the counties around Buffalo before the program began was 6.5 cases. There were five cases overall the first two years after the program was introduced, and three of these children were born before the program had begun. (Of the other two, one involved a father who had signed the affidavit and in the second neither parent had signed the affidavit.)

Exact numbers on how many U.S. babies are killed each year from forceful shaking are hard to come by because state health and

criminal justice agencies often lump them with other traumatic brain injuries. Estimates range from 1,000 to 1,400. The mortality rate is believed to be about 25 percent, meaning as many as 5,600 babies are severely injured each year from shaking.

Widespread Interest

Dr. Dias has received calls from hospitals and child abuse agencies across the country interested in imitating his program. Inspired by Dr. Dias' program, hospitals in the Salt Lake City area already are showing a video on shaken baby syndrome.

Unfortunately, Dr. Dias has yet to receive much interest from neurosurgeons. "Hopefully, this [story] will energize some neurosurgeons to take a more active role in this most neglected area of our specialty," he said.

The program was a relatively easy sell to hospitals and the nurses themselves, even though nurses are stretched thin today with increased duties, said Dr. Dias. "People realize it's worth the effort. It saves lives," he said.

The extra work it imposed on him also was manageable, he said.

Once he decided to plunge ahead with the project, he changed his research interest from the development of the spinal cord and brain to abusive head injury.

Plus, like other necessary tasks, the administrative duties of the program melded into the rest of his workday. "You find the time," explained Dr. Dias, who took a new position with Penn State Hershey Medical Center in July but continues to coordinate the program.

The program's day-to-day administration is run by two nurses, hired this year thanks to \$130,000 in funding by the Hoyt Foundation. One of the nurses, Kim M. Smith, left her job as manager of the mother/baby unit at Children's Hospital to help oversee the program.

"I just love it. It's unbelievably valuable," she said.

Dr. Dias' goal is to see the program used throughout New York. A key ally is Sam Hoyt, a state representative whose father's trust funded the program's first phase. Assemblyman Hoyt has recently petitioned Governor Pataki and the state legislature to provide enough funding to take this program statewide. ■

Introducing the eBay Twist

Young Neurosurgeons' Fourth Annual Silent Auction

During the 2002 AANS Annual Meeting in Chicago, set for Saturday, April 6, through Thursday, April 11, the Young Neurosurgeons Committee will host the Fourth Annual Silent Auction, benefiting the Neurosurgery Research and Education Foundation (NREF). All auction proceeds help fund promising neurosurgical research through the 2002 NREF Research Fellowships and Young Clinician Investigator Awards. NREF is very appreciative of the Young Neurosurgeons Committee's support.

This year two auction events—and a new twist—increase the convenience of

contributing to a worthwhile cause in a festive fashion.

On Saturday and Sunday, the Silent Auction will be located near registration in the convention center. A grand assortment of gift certificates and items from premier Chicago restaurants, attractions, and upscale retail stores will be up for bid. The bidding will close on Sunday so that the certificates can be used during the purchasers' stay in Chicago.

From Monday through Wednesday, the second Silent Auction will occur in the AANS resource center in the exhibit hall. This year's event will offer highly desirable

items, such as electronics, leisure experiences, airline tickets, golf clubs, and many more gifts donated by generous exhibitors.

The eBay Twist

Through the assistance of Griff Harsh, IV, MD, a member of the NREF Executive Council, the 2002 YNC Silent Auction will feature an eBay twist. NREF currently is setting up a Web site with eBay's charity fundraising program. The eBay connection will allow the extra ease of viewing auction items and bidding online. More details will be available as this opportunity evolves.

Building on the highly successful 2001 Silent Auction, with your participation we all can look forward to a lively, record-breaking benefit in April. Come and join in the spirited bidding and support NREF! ■

Bobbi Burgstone is the NREF/AANS director of development.

CPT 2002 Modifier Changes

Cosurgery and Unusual Procedural Services

Two modifier changes involving use of the -62 cosurgery and -22 unusual procedure modifiers were accepted by the Editorial Panel for Current Procedural Terminology (CPT) 2002. The changes were accepted after several years of discussion among representatives of the panel, American College of Surgeons, and Society of Thoracic Surgeons, in cooperation with orthopedists and neurosurgeons from five additional specialty societies. Both changes impact payment by the Centers for Medicare and Medicaid Services (CMS) for additional physician work in surgery.

Expanded Use of -62 Cosurgery Modifier

Surgical representatives presented the Panel in February 2001 with a consensus proposal for expanded application of the -62 cosurgery modifier. For the last several years, the -62 modifier could be used only once per operative session. Since the approach has been considered part of the work value of the decompression and arthrodesis codes by the Relative Value Update Committee (RUC) and by the CMS, it was proposed that the additional level codes, which describe adjacent segment decompression and/or arthrodesis, must also contain a component representing the work of exposing additional level(s).

After raising concerns about the financial impact of expanding the use of the -62 cosurgery modifier, CMS reviewed data regarding the current use of -62 as well as a summary of actual claims data for anterior thoracolumbar surgery. It found that use of -62 was less frequent than expected. More importantly, serious concerns were raised about actual payments made on claims. For example, the correct method for reporting cosurgery requires both the approach surgeon and the spinal surgeon to submit the same code (though not the same bill)

appended with the -62 modifier. However, CMS identified claims in which one surgeon used the modifier, but the other did not. Rather than pay both surgeons 62.5 percent of the Medicare allowable, only the surgeon coding correctly with the modifier was paid 62.5 percent of the allowable. The other surgeon was paid 100 percent of the allowable. CMS has suggested that these claims will receive increased scrutiny.

The CPT Editorial Panel accepted the consensus proposal to expand the use of the -62 modifier to allow reporting of the additional physician work involved in approaching adjacent segments for decompression and/or arthrodesis. The modifier will not be applicable to instrumentation or bone graft harvest codes. However, the exclusion of two instrumentation codes was an error. Several instrumentation codes describe reinsertion or removal of instrumentation and have 90-day global periods. Both codes 22849 (reinsertion) and 22855 (anterior removal) may involve anterior thoracolumbar spine approaches. The guidebook to changes for CPT 2002 includes an editor's note that these codes should not be excluded from -62 usage if they are appropriate and that the panel will review this point for revision in CPT 2003.

Cosurgery or Assistant at Surgery?

CMS has maintained some concerns over expanding the use of the -62 modifier and included its comments in the *Federal Register*. One concern focused on cosurgery in thoracoscopic and laparoscopic procedures. Although in some circumstances endoscopic techniques require less physician work (particularly in terms of postoperative care) than open techniques, in comparison the current use of anterior thoracolumbar endoscopy supports at least equivalent physician work. In addition, CMS request-

ed clarification of the difference between assistant at surgery (-80) and cosurgery (-62). The AMA has defined cosurgeons as two surgeons working together as primary surgeons performing distinct parts of a procedure. Both surgeons are required to dictate separate operative notes describing the portion of the procedure performed.

Unusual Services Modifier -22 Returns

After several years of discussions on the best method for describing the additional physician work involved in surgery performed in an altered anatomical field, CPT 2001 included a change in the use of the -22 unusual services modifier to exclude altered surgical fields. Instead, a -60 altered surgical field modifier was developed for use in circumstances of surgery performed in areas of adhesions, scarring, trauma, prior radiation, or infection. However, CMS published a payment policy that did not recognize the -60 modifier, suggesting that the prior -22 modifier had adequately described this additional service. Consequently, CPT 2002 has reverted to the -22 unusual services modifier.

In summary, modifier usage changes for CPT 2002 include expanded use of the -62 cosurgery modifier for additional levels of decompression or arthrodesis in anterior thoracolumbar spine surgery, as well as a return to use of the -22 unusual procedural services modifier for describing services performed that exceed those performed in the typical patient. It will continue to be important to differentiate between the work of cosurgery and that of assistant at surgery (-80 modifier) when reporting the services of two surgeons. Finally, increased scrutiny regarding anterior thoracolumbar spinal surgery is anticipated, which reinforces the importance of correctly using CPT to describe the work performed. ■

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Every Practice Needs a Retreat

Differences and Tensions Can Be Smoothed Over

Physician groups are notoriously deficient in planning for future growth and in using accepted business procedures to make quality decisions. Neurosurgery groups fare no better than their other surgical colleagues. Businesses with revenues equal to those of small- to mid-sized neurosurgical groups expect to invest time and money at an annual retreat to plan. Yet, mention the word “retreat” or “plan” to an action-oriented group of neurological surgeons and there is likely to be a range of responses from an enthusiastic “We’ve needed to do this for a long time!” to eye rolling among the skeptics who argue, “Why give up free time? Everything is just fine.” Still others will complain, “We did that before and nothing happened.”

All of these attitudes merely demonstrate why “retreating” is as important to physicians as it is to business people. The Chinese have a saying, “If you don’t know where you are going, then any road will take you there.” Medical groups need to periodically, if not annually, revisit their assumptions about budgets, personnel issues (both professional and administrative), recruiting options, relationships with hospitals, competition in the market and perhaps, most importantly, governance of their group.

Working Out Problems

Here are some specific reasons for holding a strategy and planning retreat.

- **Leadership changes.** Consider, for instance, when a senior “founding father” who has successfully led the group announces plans to retire within the next few years. With a leadership vacuum clearly in sight, developing a transition plan should be a priority. After all, it takes time to groom successors. For some, a wise option is to retain the



senior doctor as group managing partner, allowing him or her to discontinue clinical duties and call and to receive compensation for managing the business. This allows the younger doctors to practice full time, undistracted by business. Waiting until the senior respected leader unexpectedly retires due to a health problem is a risk to many groups. The challenge of recruiting other neurosurgeons and qualified nurses and the perception that long-time managers are no longer able to “take the practice to the next level” are other reasons to invest in planning time.

- **Group tensions.** Group practices formed out of fear of managed care plans or hospital politics may begin to feel their relationships fraying. Because the groups’ clinical and business styles were inherently different, they never truly meshed. With reduced threats from plans and hospitals, some groups may be questioning the value of their combined group. Others, at the very least, are troubled by the dysfunctionality.

Necessary changes in the compensa-

tion plan and the employment buy-in and buy-outs are other hot issues that simmer and boil over when not discussed and resolved in a comprehensive business-like fashion. Partners whose sole measure of “satisfaction” is based on take-home pay and vacation time, with little consideration for patient satisfaction, actual measurement of clinical outcomes, and meaningful investment in practice infrastructure, contribute a negativity that threatens the ongoing success of the group.

- **Differing world views.** There are bound to be big problems if some group members believe that moving aggressively into clinical activities, such as neurovascular centers in cooperation with radiology, is a must, while others object just as strenuously. If some members believe that a spine group is a must, while their partners consider this a potential political faux pas despite the impressive revenue projections, the chance for conflict increases. Instituting recognized dispute resolution methodologies is essential to good governance.

Pushing differences and dissenters into the background has never worked for other organizations; it's unlikely to succeed for medical groups. Often such disagreements arise out of a persistent lack of ongoing, meaningful dialogue with one another. In part, schisms among group members grow because not all physician members are equally aware of the various socioeconomic choices and positions open to their group. Absent ongoing education and dialogue, making big decisions is painful. Decisions will be delayed and opportunities missed because options are never debated openly, nor are outside experts brought in to present differing points of view, thus preventing everyone from ever getting to the "same page." Retreats can provide the right forum to develop a common understanding of big issues and choices.

Revisiting the physician attitudes mentioned above and the differences among factions could be perilous. For example, the visionary doctors who see the value of planning are likely to grow restive about partners who think in the short term, preferring the adrenaline rush of crisis management. If not yet partners, the visionaries may decide to explore opportunities with other, more proactive groups. The eye-rolling skeptics—who object to all business processes—clearly need education to appreciate, if not participate more, in the group's business. Physician partners solely interested in clinical practice can create a vacuum by abdicating involvement in the business side of the practice. Such individuals, if not already partners, might best maintain their employee status. Interestingly, some groups have different classes of stockowners—giving some more voting rights to account for assuming key roles in group governance.

Lastly, there are organizational benefits to heeding the complaints of group members who recall and resent the lack of follow-through from previous retreats. Their perception of having made an expensive mistake and not wishing to repeat it is a call for leaders to lead. Paralysis by procrastina-

tion and over-analysis are costly to doctors and represent a lost opportunity.

Do It Right

Thorough planning can result in a successful retreat, advancing the group's interests and ensuring ongoing enthusiastic responses and participation. Groups can get better results from strategy planning sessions by following these guidelines:

- **Use an outside facilitator.** No one can do their own therapy and much of group dynamics is a lot like therapy. Plus, group members often lack the neutrality to keep their hot buttons from coloring their perspective. Someone knowledgeable about physician culture and group process can help from the beginning to organize a successful experience. Additionally, a facilitator familiar with neuroscience issues and who has worked with many groups brings new options and insightful information to the group's deliberations.
- **Focus on specific issues and outcomes.** One group focused their retreat on referral building and practice growth. Specific topics pertained to the hospital contracts, relationships with primary care doctors and new ways of tracking business. Ownership of implementation was assigned along with deadlines.
- **Do the homework.** Taking off on a Saturday and then beginning to collect opinions on a flip chart is not going to make for a satisfying retreat. Begin at least six weeks ahead of time by asking members to complete questionnaires that solicit opinions on the key issues. Use that information to develop an action agenda. The advantage of collecting opinions before the event also means that everyone's voice is heard. Typically, the opinions are collated into one document with no names on any idea. Using this methodology, one can see how strongly views are held and how common some perceptions are.

This gives the group the advantage of celebrating their unanimity on some points, confident that there is a base for dealing with more contentious issues. Using the dictated and collated opinion polls, even the most introverted doctor's thoughts are captured. Anonymity provides a mechanism for expressing criticism that is often difficult to verbalize. Good facilitators edit out personal attacks, vitriolic comments or unnecessary verbiage to keep things positive.

- **Hold the retreat in the right environment.** For some groups this means booking at the local country club with nice meeting rooms, comfortable chairs and good food. Other groups will use the boardroom of a local hotel. Some groups cover their call, and head away from home base to a nice location with recreation. There's no single right option, but comfort counts.
- **Set up the rules for engagement.** How the retreat will be conducted needs clarification. Is speaking on cell phones to be permitted? Or will no phones be allowed and telephone breaks scheduled? One group paid their physician assistant to monitor all calls and in rare cases to interrupt. What happens if people straggle in whenever they want delaying start times? Several groups publish rules and violators are fined. The point is that strategic planning retreats cannot be run like the typical monthly or group business meeting. The group is making a substantial, collective time commitment and should expect a strong return on their investment.

To move their practices forward, many neurosurgeons will benefit by "retreating" with their partners and articulating a cohesive plan for future growth. ■

Karen Zupko is the president of medical management consulting group, KarenZupko & Associates. KZA works with neurosurgical practices and participates in the AANS Coding and Reimbursement Workshops.

The Lowdown on PDAs

What to Look for in a Personal Digital Assistant

Thinking back to the days of the first personal computer (PC), only a few imagined how pervasive they would become in today's society. We have become accustomed to having ready access to vast amounts of data and processing power by way of these devices. Portability became the impetus for the laptop. At the cost of lugging around a few pounds, we now carry tremendous amounts of data with us along with the ability to execute sophisticated applications on the bus, airplane, or in a remote workplace.

However, it is cumbersome to turn on or start up a conventional computer to just look up a phone number or appointment time. This notion led to the development of the predecessors of the personal digital assistant (PDA). These were small devices that could store hundreds of contact names, numbers and eventually more data. As technologies advanced, it became apparent that a device no larger than those providing only contact information could run numerous applications that allowed a person away from his or her desktop or laptop computer to access a vast quantity of data. The newer PDAs combine this rapid access with substantial memory and moderate processing power.

The handheld PDA is a wonderful tool, but we must understand what it does well and where it falls short. To do this, look first at how the PDA is used. It is carried unobtrusively by its owner, who can pull it out in a flash, turn it on and in an instant access an item of interest. The average PDA is off again in less than one minute, according to Palm, Inc., the industry's leader. Conversely, most PCs are used in sessions lasting 15 to 20 minutes or longer. The PC is slow to start and cumbersome, but has the ability to maintain a tremendous number of complex applications, graphics and data files.



The PDA is fast and easy to use, small and easily portable, great with text and simple applications, but has a hard time presenting graphics effectively or running complex applications such as photo editing.

Types of PDAs

Current PDAs fall into two predominant categories: Pocket PCs (those running the Windows CE operating system) and Palm Operating System (OS) devices. The Windows CE devices tend to be larger, have more memory and a brighter screen, and drain their batteries daily if frequently used. Palm OS is much more efficient, requiring little power and allowing for far superior battery life. The screens are generally less impressive than the Windows CE devices. However, the Palm OS devices themselves are slimmer and lighter.

Both types of devices store applications and data in RAM rather than on a hard drive. This enables rapid access and is less cumbersome. The obvious limitation is the amount of memory available. Some devices offer an expansion slot or digital media slot for extra memory. All of these

devices come with an infrared (IR) port for local communications. On the horizon are devices that incorporate Bluetooth communications, a wireless protocol utilizing 2.4 GHz frequency band that will allow data transfer without requiring cables or line-of-sight connection.

Every user needs the device for something a little different. With all of the various configurations available, you should be able to find a PDA that fits your needs. There are numerous devices currently offered, with new models being introduced almost weekly. The following is a brief review of some of the features to be considered when choosing a Palm OS PDA. This is not an exhaustive review. For more information, CNET (www.cnet.com) and the devices' sites provide excellent resources.

Choosing a PDA

Before choosing a PDA, you should think about how you want to use the device. Will it be simply an address book/phone book/memo pad? Or will you keep track of your patients, schedules, operations, billing, etc. How much data do you need to keep track of? Do you need wireless communication? Are you going to use the device primarily indoors or outdoors? Do you have specific applications that you will need to run on the device? Do you want a color screen or black and white?

If you are simply interested in an organizer that you can synchronize with your desktop or laptop calendar/date book/address book/e-mail, one of the less expensive devices should suffice. These should have 8 MB of RAM, although for the most limited users, 2 MB may be adequate. Palm OS devices in this category include the Palm m100, m105, the new m125 and the Handspring Visor Deluxe, among others. Also consider the Xircom Rex 6000, which

has fewer bells and whistles, but is about the size of a credit card and thus is by far the most unobtrusively portable of the devices.

For the more aggressive user, the new Palm m500 and m505 provide a svelte package with expandable memory slot, and in the case of the m505, a color screen. If you need more RAM, the Visor Pro has 16 MB and leads the pack right now. If processor speed is an issue, the Visor Pro, Visor Platinum, Palm m500 and m505, and the Sony devices have a 33 MHz processor, while most other Palm OS PDAs have 20 MHz processors. If you want even faster processor speed, you can use Tornado V, software developed by IS/Complete that doubles the processor speed.

Handspring's Visor devices come with a unique expansion slot. This allows the addition of many "Springboard" modules. These modules include telephone and wireless modem attachments, numerous global positioning system and sports attachments, cameras, voice recorders, universal remote control, e-books and productivity tools. Other devices have some of these types of modules available, but they must attach to the external port of the device and tend to be clunky and not as streamlined as the Visor Springboard modules. The Visor Edge is Handspring's thin, stylish PDA. Because of its streamlined shell, it requires an attachment to use the Visor modules.

The Sony CLIE devices are packed with features. The PEG-S320 is Sony's entry model with a black and white screen, 8 MB RAM, and a "jog dial" for easy scrolling through the screen. The PEG-N610C adds a high resolution color screen, while the PEG-N710C also adds an MP3 player. The new Sony PEG N760C is similar to the 710, but adds the latest Palm OS, 4.1. All the CLIE devices have slots for Sony's Memory Stick, allowing expanded storage.

Most of the Palm OS devices have backlit LCD screens. This makes them excellent indoors, but difficult to see outdoors in sunlight. Frontlit screens are much easier to

view outdoors. The Sony CLIE PEG-N610C and N710C, for example, both have reflective, frontlit color LCD screens, while the Palm m505 has a backlit color screen. The Sony color screens are 320 x 320 pixels, rivaling the Windows CE devices.

The Kyocera Smartphone combines a Palm OS PDA and a cellular telephone into one compact device. The screen is somewhat smaller than that of most PDAs, while, as a cell phone, it is larger than most available today. However, if you need both, the Smartphone is hard to beat. Samsung has recently come out with the SPH-1300, a competitor for the Smartphone. While the Smartphone is a cell phone with a PDA in it, the Samsung is more a PDA with a cell phone in it.

If you need to present, edit, or review images, movies, or other graphics files, the Windows CE devices are head and

modems, dictation features, and expandable memory up to 5 GB or greater.

The Future

As technology advances, PDAs will get more and more powerful, at the same time maintaining the slim format we enjoy. These devices may even supplant the laptop. Already, the Windows CE units allow the user to carry a tremendous amount of data, make presentations directly from the PDA and run complex applications. As the Palm OS technology advances, similar features will be available, while maintaining Palm's tenet that the devices should be slim, easily portable and have long battery life. Bluetooth connectivity, technology which offers a wireless personal area network, will make information exchange much easier and faster.

Already, many healthcare professionals carry PDAs. Companies have developed

"If you need to present, edit, or review images, movies, or other graphics files, the Windows CE devices are head and shoulders above the Palm OS devices. Applications are available to synchronize the Palm OS devices with your MS Office programs, but the native Windows environment that the CE units have still seems to work better."

shoulders above the Palm OS devices. Also, if most of the demands you place on a handheld include MS Excel spreadsheets, Word files or other Office documents, the CE units are probably a better choice. Applications are available to synchronize the Palm OS devices with your MS Office programs, but the native Windows environment that the CE units have still seems to work better.

The Windows CE devices also allow you to run PowerPoint slide shows or make other types of presentations directly from the PDA. Also available are wireless

mobile applications that allow physicians to access patient information on the fly, get updated appointment or operation schedules while out of the office, and code and bill at the point of service. Currently under development are applications that will allow physicians to access information about patients in real-time from the hospital information system, including demographic, chart, and laboratory data, write orders, and potentially even create or dictate chart notes directly from the PDA. ■

Harold Pikus, MD, practices neurosurgery at Mountain Neurological Center in Asheville, N.C.

It's Time to Try Again

Neurosurgical Curriculum Needed in Medical Schools

Many neurosurgical disorders, if not properly recognized and treated early, can lead to less than desirable patient outcomes and increase the cost of care. Therefore, neurosurgical education beginning in medical school is important. It can improve medical professionals' understanding of neurosurgical disorders, provide early recognition of neurosurgical disorders that may require referral or treatment and increase recognition of neurosurgical disorders by primary care physicians acting as "gate keepers" for neurosurgical care.

Yet, neurosurgeons have had difficulty gaining access to the medical school curriculum and as a result many physicians receive little or no educational training in neurosurgical disorders. This article will review surveys conducted to evaluate neurosurgery education in medical schools, review a successful neurosurgical curriculum currently in use, and outline a curriculum that neurosurgical educators can utilize.

Faculty Participation

Motivation for a neurosurgical curriculum in medical schools comes from the results of surveys conducted over the past 20 years. In 1982 Foltz, Kusske and Greenblat conducted a survey that looked at neurosurgery faculty participation in undergraduate medical education in American medical schools. They concluded that 32 percent of medical schools with neurosurgery programs have no required clinical neuroscience curriculum.¹ In fact, one in three medical students had graduated with no formal clinical neuroscience course experience.

Almost 20 years later Daniel Resnick, MD, published an article in the *Journal of Neurosurgery* that identified the role of



neurosurgeons as undergraduate medical educators. This article presented data from a survey sent to medical school deans and neurosurgery program directors. They were asked from whom does the average medical student at their institution learn about the management of head and spinal cord injury, headache, carotid disease, and low back pain and sciatica. The survey results found that neurosurgery ranked first in educating medical students about head and spinal cord injury. Neurosurgery ranked second behind neurology in the education of headaches, subarachnoid hemorrhage, and hydrocephalus. Neurosurgery ranked fourth behind neurology, internal medicine and vascular surgery in teaching about carotid disease. Neurosurgery came in only fifth in educating medical students concerning low back pain and sciatica.

Thus it is not surprising that much of the public and some medical professionals do not realize that neurosurgeons do spine surgery. When asked if neurosurgeons

should teach undergraduate students, a majority of deans and program directors said yes; however, the participation of neurosurgeons in the medical school curriculum has increased only minimally from 53 percent to 57 percent over the 18 years between the two studies.

Concrete Action Needed to Gain Curriculum Access

Why has neurosurgery been unsuccessful in gaining access to the medical school curriculum? And more importantly, what can be done now and in the future to improve undergraduate neurosurgical education? Perhaps some insight lies in a second article published by Dr. Resnick in the *Journal of Neurosurgery* that sought to improve medical student exposure to neurosurgical issues by developing an effective neurosurgical course curriculum based on the AANS/CNS Education Committee's core curriculum, which was sent to medical school deans (www.neurosurgery.org/education/curriculum.html). The course is

a compact, seven-lecture curriculum developed to teach third-year medical students about spine disease, carotid artery disease, hydrocephalus, head and spine injury and subarachnoid hemorrhage.

The key to this program's success is emphasis on training primary care physicians and even specialists in the basic management of commonly seen neurological disorders. In addition, the success of this program is dependent upon neurosurgeons continuing to develop and advance the curriculum by involvement in medical school administration, including education policy council and dean's committee.

Resistance to change in the curriculum should always be anticipated since adding neurosurgical education may result in shortening or deleting other lectures in the curriculum. Finding allies in a combined neuroscience curriculum has helped to strengthen this program.

Improved medical student test scores for the recognition and management of common neurosurgical disorders demonstrates the effectiveness of the proposed curriculum. Students who went through the neuroscience curriculum were better able to recognize symptoms of obstructive hydrocephalus and spinal abscess and to interpret CT scans. These important and valuable skills learned from the medical school neuroscience core curriculum will likely improve the recognition and management of neurosurgical disease by practicing physicians.

How can a program of neurosurgical undergraduate medical educators be implemented? There needs to be a comprehensive and concise program that allows feedback to identify areas for improvement. There must be dedicated academic and private practice neurosurgeons willing to give these lectures. This effort must be supported by individual neurosurgery program directors to allow more faculty members the time and support to teach students. This program can be easily modified to educate primary care residents as well as community physicians

"The key to this program's success is emphasis on training primary care physicians and even specialists in the basic management of commonly seen neurological disorders."

who are currently in the position of identifying patients with neurosurgical disease and making appropriate referrals.

More specifically, a program package can be developed to include the following:

- A two-hour PowerPoint program on common neurosurgical disorders,
- Course evaluation forms that allow for student/instructor feedback to improve weaknesses and provide information to curriculum committees,
- A pocket-size plastic card containing information such as Glasgow Coma Score, dermatome sensory pattern and basic muscle group innervations. The card could be prepared as a service from the AANS/CNS with appropriate contact information included.

Patient Care Will Improve

Why should we care about educating medical students about neurosurgical disorders?

- Patients will benefit by early recognition and appropriate treatment.
- Neurosurgery will benefit from the increased exposure which reflects favorably on the services that the profession provides.
- All medical students will now have exposure to the field of neurosurgery, and some of them may seek additional training or inquire about neurosurgical residencies.
- Interest in neurological disorders and their treatment will increase.

- Primary physicians will have more exposure to neurosurgical disorders and this will help them provide appropriate patient care and refer patients to specialists.

In conclusion, our goal should be to center discussion on how to effectively gain access to medical school curricula. We need a plan to get neurosurgeons involved in this process who have the energy, willingness and time to undertake these new tasks. We must develop a concise education program based on an effective and proven curriculum. Lastly, we need to emphasize that this program's importance is ultimately improving patient care.

Although we have not been very successful at gaining access to the curriculum in the past, it is time to try again. ■

Mick Perez-Cruet, MD, MSc, is chairman, Ad Hoc Committee on Undergraduate Neurosurgical Education, Council of State Neurosurgical Societies.

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A Brain Tumor Treasury

The Online Select Review Presents Latest Research, Therapy

We live in a time of unprecedented access to information. While the Information Age has created unique opportunities for individuals to gather and use data relevant to their lives, the management of the extraordinary amount of data now available has created unique challenges for busy professionals.

Nowhere are the challenges of information management more apparent than in healthcare. Although physicians can access an almost unlimited amount of information on highly specific topics through the Internet, it is unusual to find such information presented in a truly useful format.

Within the practice of medicine, brain tumor therapy presents an especially difficult challenge in data management. The rapid development of novel therapies has made it necessary for physicians to possess some knowledge of experimental medicine as it applies to brain tumor patients. Additionally, therapeutic decision-making for these patients generally involves the integration of opinions from individuals in multiple disciplines, making it essential for clinicians to have a basic understanding of current therapies in related specialties, in addition to solid understandings of their own literatures.

Select Review is sponsored by the AANS/CNS Section on Tumors and is endorsed by the Society for Neuro-Oncology. The first issue was released in 1999. Since then the Review has received an overwhelmingly positive response. Other groups are using this unique multidisciplinary format as a model for Web-based educational resources.

Recognizing the unique information management challenges facing clinicians treating brain tumor patients, the AANS/CNS Section on Tumors set out in 1997 to develop a comprehensive yet manageable online resource for those interested in brain tumor research and therapy. The result, the *Select Review in Neuro-Oncology* (www.neurosurgery.org/tumor/selectreview), is a periodic summary of information in the literature related to brain tumors. The review features both traditional content and an organizing structure designed to increase its usefulness to busy clinicians. A distinct and important feature of this effort is its multidisciplinary focus. Individuals from across the country in 13 different disciplines including the basic sciences have pledged to support this effort.

Packed With Content

The *Select Review* is published biannually and posted on the NEUROSURGERY://ON-CALL® Web site. Content is divided into four sections: journal article reviews, abstracts from various national meetings, invited comments from authors of selected articles and original contributions from experts who summarize current areas of interest in neuro-oncology.

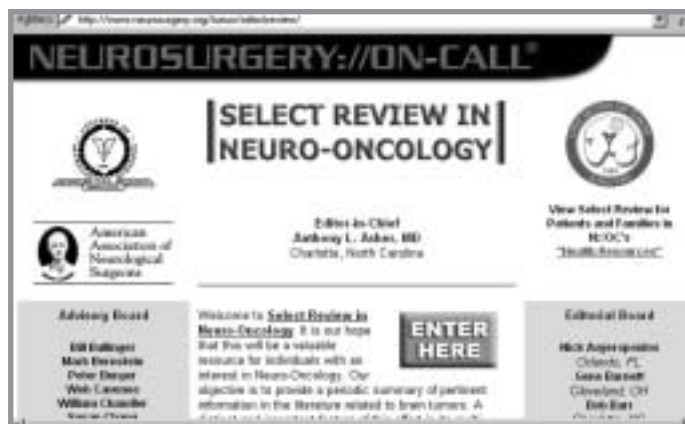
Literature analysis is the principal feature of the *Select Review*. Specialists in selected fields are asked to examine their own literature and identify papers and abstracts containing particularly important concepts related to brain tumor research and treatment. Concise summaries of papers along with reviewer commentaries are presented according to specialty in the "Journal Article Review" section. Abstracts are listed in a separate section. Readers have the option to view submissions from one or more specialties. Moreover, a detailed search mechanism allows viewers to review specific submissions from previous issues.

Two additional sections contain original content. In the "Featured Article" section, the authors of particularly noteworthy papers are invited to comment on the broader significance of their work. The "What's Hot" section is a forum for national experts to give their perspective on topics of interest in neuro-oncology.

New features that have been incorporated into the *Review* since its initial release in 1999 have included a graphic option that enables users to print the entire *Review* in a journal-like format and an online subscription service. Additionally, an abridged companion journal called the *Select Review in Neuro-Oncology for Patients and Families* is available through the "Health Resources" area of N://OC. Efforts are under way to develop online CME capabilities.

In summary, *Select Review* is an effort to make the vast literature related to brain tumors easier to access, easier to use and most importantly, pertinent to the practice of busy clinicians. The AANS/CNS Section on Tumors and the *Select Review* Editorial Board welcome your comments. ■

Anthony Asher, MD, FACS, is editor-in-chief, *Select Review in Neuro-Oncology*. He can be reached at tonyasher@cnsa.com.



CSNS Highlights

Seven Resolutions Discussed at San Diego Meeting

The most recent meeting of the assembly of the Council State Neurosurgical Societies (CSNS) took place in San Diego on Sept. 28 and 29, 2001, immediately preceding the CNS Annual Meeting. Although the meeting took place only 17 days after the tragic events of Sept. 11, delegate attendance at the meeting was relatively normal compared to previous attendance. Overall, the meeting was successful and several important actions were accomplished. Gary Bloomgarden, MD, was elected to recording secretary of the Council, and Mark Linskey, MD, was appointed chairman of the Medical Practices Committee. A number of important issues and topics were discussed, debated, and voted upon at the meeting. The delegate members submitted a total of seven resolutions to the assembly. The following is a summary of the resolutions and their disposition.

RESOLUTION I: ROLE OF MID-LEVEL PRACTITIONERS IN THE CSNS

Assembly adopted substitute resolution:

Be it resolved, that Mid-level Neurosurgical Practitioners (PA-C and APRN) be invited as guests of the CSNS to attend committee meetings, quadrant meetings, luncheons and plenary sessions. The Association of Neurosurgical Physician Assistants (ANSPA) and the American Associate of Neuroscience Nurses (AANN) may each appoint two representatives to attend the CSNS at their own expense. These representatives must be associate members of the AANS or CNS. The attendance will be limited for two years, after which the Executive Committee will provide recommendations for future attendance. Therefore, with acceptance of this Resolution, the assembly is formally inviting our professional colleagues to participate in the deliberative process of the Council. Their input will be most welcomed.

RESOLUTION II: FACILITATION OF THINK FIRST

Assembly adopted amended resolution:

Be it resolved, that the CSNS will help facilitate communication between the State Neurosurgical Societies and the Think First

Chapter Directors by:

- Writing a letter to the state neurosurgical societies asking that they include a representative of Think First at their annual meetings.
- Asking the state societies to designate a liaison to the state/regional Think First program.
- Encouraging members to participate in active Think First programs in their area.
- Encouraging members to help establish new programs in their state with the assistance of the State Chapter Director.

RESOLUTION III: DISCIPLINARY ACTION FOR CNS AND AANS MEMBERS

Not adopted.

Be it resolved, that the CSNS recommend that the AANS and CNS act jointly in the censure of physicians, ideally through the formation of a single committee, and

Be it further resolved, that if a single professional conduct committee can not be formed, that the procedures and time sequence followed for the evaluation of a physician under review be essentially the

same for the two organizations.

RESOLUTION IV: REIMBURSEMENT METHODOLOGIES

Assembly adopted substitute resolution:

Be it resolved, that the CSNS task the CSNS Medical Practice Committee and CSNS Reimbursement Committee to work jointly with the AANS-CNS Coding and Reimbursement Committee to study the feasibility and details for:

- Organizing representative practice managers.
- Defining their status with our parent organizations.
- Allowing for collection of practice costs and reimbursement information across geographic regions on a regular and ongoing basis.

Be it further resolved, that the CSNS Medical Practice Committee and CSNS Reimbursement Committee should report back to the CSNS on this feasibility and details at the next CSNS meeting. This is an extremely important resolution that both committees will be exploring and reporting to the CSNS Executive Committee. Organizing neurosurgery practice managers so that important practice data can be adequately collected and studied should prove invaluable to neurosurgery.

RESOLUTION V: CUBAN NEUROSURGEONS

Referred to committee.

Be it resolved, that the AANS and CNS actively recruit and promote membership from the Neurosurgical National Association of Cuba, in an appropriate category, and

Be it further resolved, that the AANS and CNS do so gratis for a period of five years, including *Journal* subscriptions to be renewed at their discretion.

RESOLUTION VI: JOINT LOBBYING FOR INJURY PREVENTION

Not adopted.

Be it resolved, that organized neurosurgery through its representative leadership of the AANS and CNS, approach Think First to establish a state legislative lobbying package promulgating the reduction of traumatic injuries through state supported, school run, educational programs.

RESOLUTION VII: WEAPONS OF MASS DESTRUCTION

Referred to the Joint Committee of Military Neurosurgeons for Further Development

Be it resolved, that the CSNS, CNS and AANS support all urgent efforts aimed at

domestic preparedness for attack by Weapons of Mass Destruction (WMD), and

Be it further resolved, that the CSNS, CNS and AANS urgently call on all neurosurgeons to educate themselves regarding the management of victims of WMD and educate themselves regarding the domestic preparedness system for WMD, and

Be it further resolved, that the CSNS, CNS and AANS urgently call on neurosurgeons to assist in and support the education of all physicians and health care professionals in their community regarding domestic preparedness for attack by WMD, and

Be it further resolved, that the CSNS, CNS and AANS urgently communicate to its membership the need for domestic preparedness for attack by WMD using all means at its disposal, and

Be it further resolved, that all American neurosurgeons, the CSNS, CNS and AANS insist that their local hospitals fully implement all federal programs for domestic preparedness for attack by WMD, and Be it further resolved, that the CSNS, CNS and AANS consider participating in state and federal lobbying efforts to fully fund such efforts for domestic preparedness for attack by WMD. ■

David F. Jimenez, MD, FACS, is the chairman of the CSNS, jimenezd@health.missouri.edu.

CSNS State Society Corner

WILLIAM E. BINGAMAN, MD, AND ANN WARBEL, RN

Arizona The Arizona Neurosurgical Society held its fall meeting in Tucson on Oct. 13, 2001. Five residents presented papers in competition for the John Green Award Resident. The first place paper received \$500, and the second place paper, \$250. The first place paper, "Interactive Stereoscopic Virtual Reality: A New Technique for Neurosurgical Education," was presented by Jeffrey Henn, MD. There was a tie for second place: "Anterior Lumbar Interbody Fusion (ALIF) 110 Consecutive Cases" by Gregory Lekovic, MD; and "Cranial Vertebral Junction Fixation with Transarticular Screws: Biomechanical Analysis of a Novel Technique" by L. Fernando Gonzales, MD. Both received the cash award. The business meeting included reports from representatives who attended the CSNS and AMA meetings and the National Leadership Conference. Also, the officers elected to take office in 2002 were announced: President Stephen Ritland, MD; President-elect Philip Carter, MD; Treasurer Joseph M. Zabramski, MD; Secretary Hillel Baldwin, MD; CSNS Delegate Cameron G. McDougall, MD; CSNS Alternate Marc A. Letellier, MD; CSNS Alternate Randall W. Porter, MD; ArMA Delegate Eric P. Sipos, MD; ArMA alternate Bradley D. Noblett, MD; and ArMA Alternate Arash G. Vishteh, MD. — William L. White, MD

Arkansas The Arkansas Neurosurgical Society, also known as The Robert Watson Society, held its reorganizational meeting Aug. 24, 2001. Preliminary bylaws for reorganization were worked out and approved and an interim slate of officers was elected: President Kenneth Tonymon, MD; Vice President Ali F. Krisht, MD; Secretary Mark E. Linskey, MD; Treasurer Kelly R. Danks, MD; South Regional Director

Freddie L. Contreras, MD; Central Regional Director Tim Burson, MD; North Regional Director Anthony L. Capocelli, MD; and Acting Immediate Past President Thomas M. Fletcher, MD. — Mark E. Linskey, MD

New England The New England Neurosurgical Society met on Sept. 21, 2001, at the Norman Rockwell Museum in Stockbridge, Mass. The potential merger of New England state neurosurgical societies into the New England Neurosurgical Society was discussed. The society's Annual Resident Award was named in memory of its first president, William B. Scoville, MD. Upcoming noon lectures were named the Sweet, Donaghy, and Whitcomb lectures in honor of neurosurgeons who have been active in the society. The scientific session started at noon, with a special lecture by Lycurgus Davey, MD, on the research he has done regarding the Hippocratic oath. Presenters included: Steven Kalkanis, MD; Peng Chen, MD; Vasillious Zaras, MD; Peter Catalano, MD; Edward R. Smith, MD; James Kryzanski, MD; Henry Pallatoni, MD; Hulda Magnadottir, MD; and Robert E. Harbaugh, MD. The winter meeting will be held March 1, 2002, at the Killington Grand Hotel in Killington, Vt. Thomas A. Marshall, executive director of the AANS, will make a presentation at noon regarding the activities of the AANS. The summer meeting will be held on June 7 at the Colonial Inn in Concord, Mass. A. John Popp, MD, will give a special noon presentation on the activities of the Washington Committee. He will be available following the presentation to answer any questions about this very important committee of the AANS and CNS. The autumn meeting will be held Sept. 13, 2002, in Newport, R.I., at the Newport Marriott. — Robert E. Harbaugh, MD

Thoughts and Travels

LYAL G. LEIBROCK, MD, FACS

I have been asked to communicate to the members of our neurosurgical community my thoughts and ideas since stepping down as Chairman of the Council of State Neurosurgical Societies (CSNS). I have traveled to some practices around the country as a senior member of the Council and found these experiences to be very enlightening and useful.

Traveling to Tallahassee

I recently traveled to Tallahassee, Fla., to give a talk on head injury and was able to meet with members of a young, motivated, aggressive neurosurgery staff at the Tallahassee Memorial Hospital. These neurosurgeons, Drs. Romano, Crawford, and Cuffe, allowed me the opportunity to ascertain what issues were important to them and what they were trying to accomplish in neurosurgery in the panhandle of Florida compared to issues we face in my state, Nebraska. I found there are local interests specific to a geographic area. However, there are many collective areas of interest that involve neurosurgery as an entire community.

Linac vs. Gamma Knife

One of the topics we discussed was what to do when making a decision about the productivity and usefulness of Gamma Knife versus Linac radiosurgery considering the cost of the two and how the hospitals and physicians can afford to use it. We had an interesting discussion about this, with no conclusion being reached other than the fact that one is certainly much more expensive than the other. In addition, hospitals can use the Linac in so many other ways if they are not using it specifically for stereotactic radiosurgery.

Onerous Malpractice Premiums

We also discussed an issue that is currently common among neurosurgeons and the medical community as a whole: elevated malpractice premiums. This issue, at crisis point 30 years ago, has simmered over the years, and now its specter has risen again in many states, including Florida and Nebraska. I also have friends in Philadelphia telling me their malpractice premiums are approaching \$125,000 to \$150,000 per year, onerous sums for anyone in any profession. The national organizations for neurosurgery and the AANS/CNS Washington Committee are going to have to take a very aggressive posture in bringing the issue to the attention of federal and state legislators. A multifaceted approach is required to resolve this issue. Neurosurgeons need to be involved in their local state societies, state neurosurgical organi-

zations, and the CSNS because resolution of these issues is best handled at the local level. Nationally, issues in relationship to tort reform need to be worked on again and again until some sense is brought to the area of malpractice. Educating neurosurgeons in the methods of influencing state and national legislators is vital to prevailing in the malpractice battle. The organizing committee of next year's National Leadership Development Conference in Washington, D.C., is investigating ways to accomplish this.

Neurosurgeons: Take Action!

Neurosurgeons also are aware that the government is going to lower reimbursement to physicians, particularly in the area of Medicare, at a time when malpractice premiums are rapidly increasing. How Congress could possibly think this is a good idea in relation to access to medical care for patients is beyond my comprehension. I have written and communicated with my local congressmen and senators to convey to them my angst at how these changes could be considered at this particular moment in time. I welcome feedback from anyone regarding this issue and how we can address it. Certainly it needs to be aggressively addressed through the American College of Surgeons, the American Medical Association, and physicians, or there are going to be some dramatic changes to healthcare access for people who need it the most—those in their senior years of life and the uninsured population—if the reimbursement reductions are carried forward by CMS. I reiterate the sentiments of the AANS/CNS Washington Committee and call neurosurgeons to action: Every neurosurgeon needs to support the Physician Payment Fairness Act of 2001, introduced Nov. 8, 2001, by Senators James Jeffords (R-Vt.) and John Breaux (D-La.).

I continue to plan trips to other areas around the country and will provide thoughts in the future regarding these visits.

Lyal G. Leibrock, MD, FACS, is immediate past chairman of the Council of State Neurosurgical Societies.

Editor's Note: For more information on the Physician Payment Fairness Act of 2001 and tips on contacting your representatives, go to the AANS Web site at www.neurosurgery.org/socioeconomic/2002feeschedulealert-2.pdf.

Finding the Right Job

Study Yourself Before Studying the Job Market

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To find the right job in medicine, you've first got to know who you are. What revs your motor? What drives you to distraction? How hard do you want to work? What demands will family life place on you, and how will those demands mesh with a particular practice? What do you need from your work to thrive rather than struggle?

Until you know the answers, you're not ready to begin your search. Look at it this way: A career in medicine is challenging enough. The more your job turns you on, the easier it will be to put the unavoidable daily hassles in perspective. But if you're in the wrong practice situation, minor irritants will loom large. As frustration mounts, your performance can suffer, and your self-esteem along with it.

"It's commonly known among recruiters and industrial psychologists that success in a new job depends 20 percent on technical skill and 80 percent on the behavioral-cultural fit with the organization," said psychiatrist Gigi Hirsch, MD, founder of MD IntelliNet, a Brookline, Mass., consulting and placement company.

But fit isn't something that happens by chance. You have to make it happen, through a series of intelligent choices. The first step is a thorough self-assessment, followed by some market research to find out what the most attractive opportunities are really like for the people who work there.

Know Who You Are

When doing your self-assessment, there are five key areas:

- **Values:** What motivates you? What



would make you feel you were devoting your time and talents to something extremely worthwhile?

- **Skills:** What's your strong suit? Which strengths do you have that complement your medical skills? Are you skilled at something you don't enjoy doing? If so, you'll want to de-emphasize it so you don't gravitate toward something you won't like.

- **Behavioral style:** How do you approach problems, people, rules and procedures? What kind of pace do you like to keep?

- **Cultural preferences:** Do you like the intimacy of small medical groups or the anonymity afforded by a larger organization? Are you a traditionalist, or an innovator who prefers a fast-moving, entrepreneurial culture?

- **Lifestyle:** Are you family- and community-oriented? An outdoor enthusiast who needs the right setting to pursue other passions? A travel bug who needs to take vacations on your own schedule?

There are several ways to approach your self-exploration. You can make this a do-it-yourself project, talk with someone you

trust, or pay a career counselor or coach to help you. Anesthesiologist Jan C. Horrow, MD, found that simply talking to a long-time colleague crystallized for him what made him happiest at work. Others who made dramatic changes say they couldn't have done it without a coach.

To get started on your own, "ask yourself what the ideal nature of your work would be if you had no constraints whatsoever and anything were possible," said pediatrician Todd D. Pearson, MD, director of the Center for Physician Renewal in Bellevue, Wash.

One way to zero in on your skills is to recall the work or volunteer experiences you've found most satisfying, and note the skills they required. If you look at a range of experiences, going back to jobs you held while you were in school, you may find a pattern—something you've always gravitated toward and been a natural at.

Consider supplementing your efforts with self-assessment tools. These can give feedback on how you learn, relate to others, think, lead, work and manage. You can purchase these tools from career counselors, or you can find some of them on the Web, including the Keirsey Temperament Sorter (www.keirsey.com), the Myers-Briggs Type Indicator, and The Personal Interests, Attitude and Values scale and the Personal Insights Profile (www.ttidisc.com). There are also books like *Career Renewal* by Stephen Rosen and Celia Paul, which was written for scientists, engineers and medical professionals.

Reality Check

Once you know your preferences, gather "market intelligence" before you formally begin your search. This is the best way to test your assumptions about particular kinds of opportunities and communities. What you learn may surprise you, shifting you in an even more fruitful direction. If you don't take this step, you risk projecting your desires onto a situation that is anything but what you imagined.

Start by talking with people in the

know. Consider scheduling brief informational interviews with leaders in your areas of interest or clinicians in the practice settings you intend to pursue. The information you gain during these interviews can help you sharpen your CV and make you a more attractive candidate.

Create Your Ideal Job

What do you do if there's a gap between your vision and available opportunities? Create something new. Plenty of physicians have.

Perhaps you can create your own opportunity within a practice where others are sympathetic to your vision. Or perhaps you'll find a company that needs your expertise, as internist Francine R. Gaillour, MD, of Kirkland, W. Va., did. She was able to talk a healthcare technology software company into hiring her as medical director so she could participate in product development and serve as a liaison to the company's customers, health system physicians. She went on from there to create her own technology-oriented consulting firm, Ki Health, in Bellevue, Wash.

The Right Setting

Okay, doctor, you've done your self-exploration. Now it's time to apply your knowledge to specific practice settings. How do you figure out where you'll thrive?

To help you think about where you might fit best, we turned to practice management consultants Judy Bee and Jeffrey J. Denning, and former emergency physician Peter Farmer, a performance coach who has studied workplace dynamics. Bee and Denning are principals in the Practice Performance Group in Long Beach, Calif. Farmer is director of the Center for Performance Dynamics in Rancho Santa Fe, Calif. We asked them to create a profile of the type of person who best fits into each of the practice settings below.

■ **Solo practice.** Bee's shorthand for folks suited to this kind of practice: "Control freaks." But they're usually right to be so, she added. "They've got great instincts and know that if they follow their instincts,

things will work out. These people have little tolerance for negotiation. They're apt to think, 'I know I'm right,' rather than 'the majority rules.'"

According to Farmer, the kind of doctor who would be happiest in solo practice has a strong desire to achieve a position of influence and use it to affect others. This physician finds it essential to get a good return on his time and money. Other adjectives that might apply: ambitious, pioneering, strong-willed.

If you're just out of residency and interested in solo practice, Bee advises working in a group practice first, so that you've got steady income to pay off your debts and get a chance to learn about the workings of an office.

■ **Small-group partnership (typically single-specialty groups).** "These physicians have to be willing to give up personal desires—such as when they're permitted to come off call or how many vacation days they have—for the good of the group," said Bee. A good fit here also requires diplomacy, plus flexibility in one's personal life, she observed.

An advantage of single-specialty groups, said Denning, is that they institutionalize call coverage routine and allow for ongoing professional contact with colleagues in your field. This style of practice can also give physicians the security of a formalized buy-out arrangement in the event of death, disability, and normal retirement.

■ **Large group (typically multispecialty or staff HMOs).** "In some respects, large groups can be very inflexible," said Bee. According to Farmer, physicians who'd be happiest in large groups aren't interested in achieving power or influence. Unlike soloists, they enjoy give and take with others. They prefer predictability and a steady, consistent work pace.

Such groups offer three main advantages, said Denning: a built-in referral network, the marketing boost from community visibility, and the professional stimulation afforded by cross-specialty col-

leagues. A fourth advantage, said Bee, is that it's possible to work part time.

■ **Academic practice.** "Although the environment is usually very structured, most physicians I know who practice in this setting are able to keep relatively short hours," said Bee. "They're almost never on call." But they do have to put up with a lot of bureaucracy and political infighting, she said.

The kind of physician who thrives in academia, said Farmer, is someone who places the highest value on knowledge, whether discovering something new, systematizing information or analyzing it.

■ **Hospital-based practice.** "This can be hard work," said Bee. "The advantage is that it provides steady income and a good introduction to the community. If you're a foreign doctor and you want to see how welcome you'd be in an area, this might be the way to go. If things don't work out, it's much easier to leave a job like this than to sell a practice." Physicians who are happiest here are comfortable following rules and procedures set by others, said Farmer.

■ **Hospitalist practice.** You've got to be excellent at communicating with patients, families, and the referring physician," Bee said. "Otherwise, nobody will send you patients." Physicians suited to this work, said Farmer, really enjoy people, but don't need to be leader of the pack. They tend to be careful and exacting. ■

Deborah Grandinetti is a former career guide editor of *Medical Economics* magazine.

NEUROSURGERY://ON-CALL® offers a number of networking and job search opportunities. The "Young Neurosurgeons" section at www.neurosurgery.org/yns/ links to the AANS Young Neurosurgeons Committee, the Job Placement Service and the Young Neurosurgeons listserv.

Unification Discussions Begin

AANS Executive Committee Meeting Highlights

The AANS Executive Committee met Sept. 28, 2001, in San Diego during the CNS Annual Meeting. The highlights are summarized here.

■ **Center for Advanced Technical Training.**

AANS is pursuing plans to establish a neurosurgical training center. The center would be a place for neurosurgeons to learn the latest neurosurgical techniques.

■ **AANS Forms International Advisory Committee.** This committee was developed to increase international involvement of neurosurgeons on every level.

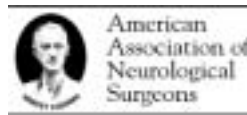
■ **Neurosurgical Leadership Conference.** The conference will be held in July 2002.

■ **Unification Discussions.** The AANS and CNS have agreed to begin discussions on models of unification. The President of each association, the attorney for each association and a third party mediator/negotiator will meet and commence discussion. They will report to the governing bodies in 12 months.

■ **Financial Report.** The AANS Executive Committee expressed gratitude to staff members for a clear presentation of the AANS budget and their efforts at achieving the goal of reducing the general and administrative portion by 10 percent.

Seven CSNS Resolutions

A total of seven resolutions were submitted, debated and voted upon at the Council of State Neurosurgical Societies Meeting, Sept. 28-29, 2001. (See the CSNS report on page 31 for a summary of resolutions.)



September 25, 2001

PROPOSAL FOR UNIFICATION DISCUSSIONS BETWEEN THE AANS AND CNS

To benefit the respective members of the American Association of Neurological Surgeons (AANS), the Congress of Neurological Surgeons (CNS) and the specialty of neurosurgery, we propose to embark on serious discussion of models of unification of the two organizations. Any proposal of unity would maintain the integrity, cultures, and philosophy of the two parent organizations (AANS and CNS), and would explore establishing a third entity owned, shared, and governed equally by the AANS and CNS. We request the authority from the AANS Board and the CNS Executive Committee for the president of each organization or his designee, along with the general counsels of each organization to work with a mutually selected third party-professional mediator/negotiator, to examine the range of options acceptable to both groups. We would return to the governing bodies of both organizations within 12 months with a report on these discussions.

Respectfully,

Stan Pelofsky, M.D.
AANS President

Issam Awad, M.D.
CNS President

Shelley Nien-Chun Chou, MD, PhD, the 1996 Cushing Medalist, died July 21, 2001, at his home in Rio Verde, Ariz. He was 77.

Dr. Chou was head of the Department of Neurosurgery at the University of Minnesota Medical School from 1974–1989. He was a world-renowned educator, holding more than 40 visiting professorships in locations such as Taipei, Taiwan; Seoul, Korea; Perth, Australia; and Hanover, New Hampshire. He served as president of several professional societies and served as vice president and as a board member of the AANS.

Born in Chekiang, China, Dr. Chou received his undergraduate degree from St. John's University in Shanghai while serving as a liaison with U.S. forces in China during World War II. He emigrated to the United States in 1948 and received his medical degree from the University of Utah Medical School. He served his residency at the University of Minnesota Hospitals and worked at the University of Utah and the National Institutes of Health before joining the faculty of the University of Minnesota in 1960. Although he retired in 1992, Dr. Chou served as interim dean of the University of Minnesota Medical School from 1993–95.

He is survived by his wife, Jolene, and three children.

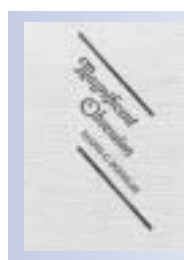
Munir H. Abbasy, MD, of Springfield, Mass., died July 29, 2001, in an airplane crash.

Dr. Abbasy was the chief of Neurosurgery at Baystate Medical Center and member of a local group practice. A pioneer in non-invasive surgery, he helped establish performing lumbar microdiscectomies on an outpatient basis at Baystate in 1996. He graduated from Liaquat Medical College in Pakistan in 1969. He served residencies at Northwestern University Medical Center in Chicago and the University of Pittsburgh. He later taught in the neurosurgery department at Tufts University.

Dr. Abbasy died after the single-engine plane he was piloting crashed at a Western Massachusetts airport while landing.

A Magnificent Obsession

Classic Novel Should Resonate With Neurosurgeons



Magnificent Obsession by Lloyd C. Douglas, 1929, Willett, Clark & Company, New York, 330 pp.

M*agnificent Obsession* was written by the Rev. Lloyd C. Douglas, the well-known author of *The Robe*. He was the minister at the Congregation Church in Ann Arbor, Mich., which is only a few blocks from the University Hospital. It has always been a poorly kept secret in Michigan that Edgar A. Kahn, MD, was the neurosurgical inspiration for *Magnificent Obsession*.

The novel tells the story of Bobby Merrick, a neurosurgeon who is given the secret journal of his mentor that contains the magic formula for success. The journal is written in code, which is miraculously solved by the young neurosurgeon. He learns of a "particular investment of himself as a high altruism." Dr. Merrick finds that fulfillment is best achieved by providing secret service for others. He experiences the joy of doing wonderful things for people in need. He requires secrecy and suggests, if possible, the good deed be passed on to someone else in need. Douglas preaches a very religious sermon with this novel. In addition, to the main theme of this book, there is a lot of romance thrown in.

Magnificent Obsession was made into a movie starring Rock Hudson as Dr. Kahn. It strongly emphasized the romantic side of the story more than the neurosurgeon's obsession with giving of himself to others.

Dr. Kahn was my hero and he made me a neurosurgeon. It has always been my goal to emulate Dr. Kahn in my practice of neu-

rosurgery. He certainly passed on his magnificent obsession to all of his residents. We were amazed at his ability to give of himself to his patients. Even when Dr. Kahn reached retirement age, he lost none of his passion for his patients. Dr. Kahn spent his entire career at the University Hospital in Ann Arbor and always worked for \$1 per year.

When I moved to Denver in 1970, Dr. Kahn called to wish me well. He said that if I ever needed help that I should call on his good friend, Dr. K. K. Mammel, a plastic surgeon in Colorado.

I never had occasion to do that, but shortly after arriving in Colorado, I became friends with a banker who had his own magnificent obsession. He was known for being customer friendly and for giving loans to people whom other bankers considered to be bad risks. As a friend, he would always go the extra mile. My friend recently died of metastatic colon cancer, but before he died, the owner of his bank established a \$1 million fund for people who would not ordinarily qualify for a mortgage loan. That fund is called the Gary Mammel Memorial Fund. My friend with the magnificent obsession was Dr. Mammel's son.

This book review column is intended to be about books that deal with the socio-economics of healthcare. I think this novel fills that criteria. We all have our obsessions as neurosurgeons and we pass them on to our students, our residents and our children. I pray that your obsessions will be magnificent and that Dr. Edgar Kahn's magnificent obsession will be the mark of neurosurgeons everywhere. ■

Gary VanderArk, MD, is a member of the AANS Board of Directors, a senior partner of Rocky Mountain Neurosurgical Alliance, Englewood, Colo., and past president of the Colorado Medical Society. He is the recipient of the 2001 AANS Humanitarian Award.

Young Neurosurgeons Announce New Listserv

Members of the Young Neurosurgeons Committee and CSNS Young Physicians Committee, as well as interested neurosurgery residents and fellows, can join this list to facilitate communication with one another. The discussion list will include information on upcoming activities, meetings, training and opportunities, as well as updated information on the "Young Neurosurgeons" and "Residents Corner" pages. To join the listserv, visit www.neurosurgery.org/listserv, select "Subscribe" and "Young Neurosurgeons" from the list.

Section News

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Section on Pediatric Neurological Surgery This is the edited version of a story by Robin P. Humphrey, MD. It appeared in the Fall 2001 *Pediatric Short Cuts*. E. Bruce Hendrick, MD, died in August at the age of 76.

It may have occurred to more than one neurosurgeon while operating on a cerebral Galenic venous malformation that it was "like sitting beneath Niagara Falls in a basket of quivering serpents." At least that is how E. Bruce Hendrick, MD, once described his experience with the lesion. There are few surgeons who have been able to articulate their surgical vistas or instructive *bon mots* in quite the colorful but memorable terms as this founder of Canadian pediatric neurosurgery.

Bruce Hendrick was a rare Torontonion who was actually born in the city in which he practiced and resided. He was neurosurgeon-in-chief for 22 years at The Hospital for Sick Children.

Bruce brought originality to the daily conduct of pediatric neurosurgery, as typified by a question to a patient with a spinal cord tumor and paresthesia. He asked the patient if "your legs feel like ginger ale looks?" The Hendrick aphorisms will remain with students and residents longer than the logical sequences of thought that the rest of us teach.

Forever the generous Good Samaritan, Bruce opened his wallet and his home to a variety of old friends and new visitors. Newly arrived residents who had not yet found accommodations would be housed temporarily at Leggett Avenue. And, if later on one of them or their family suffered from a winter illness, they would likely find Bruce at their doorstep ready to reactivate his family practice skills.

Bruce had been part of the nascence and maturation of the specialty of pediatric neurosurgery. He was on the founding committees of the International Society for Pediatric Neurosurgery and the American Society of Pediatric Neurosurgeons. He was a past president of the Canadian Neurosurgical Society and was a board member of the AANS, which in 1998 honored him as the first recipient of the Franc D. Ingraham Lifetime Achievement Award.

Bruce's greatest and lasting devotion was to his

small patients. He brought joy to the children for whom he cared, and fatherly counsel to young parents seeking hope and reassurance.

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Women in Neurosurgery This is the edited version of a story by Jamie Leigh Wells, MD, that appeared in the Fall 2001 *Women in Neurosurgery News*.

"So, have you met any other females on the neurosurgery trail?" he asked with a smirk while we sat in the generic conference room waiting to be called for our next interview.

To that I said, "Not yet. Why? Have you?"

His response, was, as I would soon discover, anything but rare: "Yeah, I met one and she was *crazy*. You wanna know why? Because she talked."

Initially, I was stunned. Could he possibly be serious? Sadly, yes. Having not encountered such attitudes when interviewing for medical school, I was surprised when I encountered them in pursuit of neurosurgical training. But I quickly realized that, while these situations were routine, their impact was absolutely within my control. Understanding this fundamental tenet early on made the remainder of the interview trail rather enjoyable. I began to revel in the acquisition of newer and funnier interactions. Ultimately, it taught me to remain true to myself and encouraged me to forge ahead with confidence and fortitude. I understood that the responsibility was mine to portray myself in the best possible light and focus on my record, a history that no one could dispute.

I have gleaned some useful insights that I would like to share: 1) It is necessary for women to be almost 5,000 percent certain of their decision or the end result might not be worth the means required to accomplish the goal. 2) There are gems among the adversarial masses who do wish you to succeed. 3) Women, more often than not, are compelled to be exponentially better than average. 4) Most importantly, be yourself and let no individual dissuade you from pursuing your dream.

Only as time passes and women assume more senior positions will the pendulum shift toward a ubiquitous solidarity that disposes of gender lines. Till then, quiet effectiveness is the most formidable defense.

Section on Tumors The following story by E.A. Chiocca, MD, PhD, of Massachusetts General Hospital first appeared in *Tumor News*.

A number of preclinical studies have showed promising anticancer effects by oncolytic viruses (OV). These are attenuated viruses that have been genetically mutated so that they will grow, destroy and spread only in glioma cells, sparing normal cells in the brain.

At least three Phase I clinical trials of such viruses have or are in the process of being completed for recurrent malignant glioma. One such trial, initially performed at the University of Alabama at Birmingham (UAB) and Georgetown University, stereotactically injected an OV (based on herpes simplex virus) into the brain tumor. Doses were escalated in serial cohorts of patients until the final group received a tumor dose of 3×10^9 infectious viruses. There were no serious adverse events attributable to the OV injection. Another type of herpes OV was injected into the brain tumors of patients in Glasgow, Scotland. In this trial, much lower doses of OV were used (105 infectious viruses) due to regulatory mandates. Again, no evidence of viral toxicity was reported.

As part of the NABTT (New Approaches to Brain Tumor Therapy) consortium, a trial of injection of a

third type of OV (based on adenovirus) is being conducted at MGH, Emory University (Atlanta), Henry Ford Hospital (Detroit), UAB, Johns Hopkins, University of Texas (San Antonio) and Moffitt Cancer Center (Tampa). Twelve patients have been treated so far without serious adverse events attributable to the OV and additional patients are being enrolled to determine a safe dose for this particular OV.

The future of OV therapy seems promising because it could provide the oncologist with a weapon against these tumors that is completely different in its anticancer action than that displayed by current standard treatments. Clearly, the possibility of toxicities with these types of agents (brain inflammation, edema, meningitis or encephalitis) mandates careful analysis of results and characterization of non-toxic doses.

The future of OV therapy also includes: a) combining with standard radiation/chemotherapy, b) using intravascular routes (superselective catheterization) to administer the OV to multiple sites within the brain, and/or c) using increasingly more tumor-selective OVs. Since OVs have also been shown to possess the capacity of delivering anticancer genes, this strategy can also be used to augment their efficacy, at least in animal models.

Changed your Address?

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

Notice of Censure

The Board of Directors of the American Association of Neurosurgeons (AANS) has issued a Letter of Censure to a Montreal neurosurgeon for unprofessional conduct in connection with his affidavit and deposition testimony in a medical malpractice case. The Professional Conduct Committee found, and the board concurred, that the neurosurgeon's affidavit that the defendant surgeon's decision to proceed with removal of a large pituitary tumor after inadvertent intraoperative transcribiform plate and brain laceration by his ENT co-surgeon deviated from the prevailing professional standard of care, violated the AANS' Expert Witness Guidelines, the AANS' Position

Statement on Testimony by Expert Witnesses and failed to represent the broad spectrum of neurosurgical thought and practices required by the Expert Witness Guidelines. In addition, his deposition testimony criticizing the techniques and extent of tumor removal was in violation of Position Statement No. 1, Expert Witness Guideline 16a, failed to recognize different viewpoints, and failed to represent the broad spectrum of neurosurgical practice. The board indicated however, that censure should not be taken as approving the care provided to the patient in the underlying case, but rather for the manner in which the neurosurgical expert provided his testimony.

AANS News

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Former Van Wagenen Fellow Publishes Article The research a New York neurosurgeon did under AANS sponsorship was published in *Nature Medicine* in September. Theodore H. Schwartz, MD, of Weill Medical College of Cornell University cowrote the article based on the work he did as a William P. Van Wagenen Fellow in 1999.

Dr. Schwartz co-authored "In Vivo Optical Mapping of Epileptic Foci and Surround Inhibition in Ferret Cerebral Cortex." The article describes a novel application of a technique for mapping epilepsy.

Sponsored by the AANS, the Van Wagenen Fellowship allows a post-neurosurgical resident to spend six months in a foreign country for research in preparation for an academic career in neurological surgery. Dr. Schwartz used his fellowship to study optical imaging under Tobias Bonhoeffer, MD, at the Max Planck Institute for Neurobiology in Germany. Dr. Schwartz, an assistant professor in the Department of Neurosurgery at Cornell, credited the AANS and the Fellowship in his article. He is a current NREF Young Clinician Investigator.

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PR Efforts Stepped Up The AANS Public Relations Committee continues to educate audiences about neurosurgery. A public service announcement (PSA) developed in conjunction with *Think First* tells the public that bike helmets not only prevent severe head injuries, but they save lives. The PSAs are scheduled to run in national consumer magazines, which may include *Good Housekeeping*, *Ladies Home Journal* and *Family Circle*. This call to action will also be shown in AMC theaters in major cities.

The public also will learn about neurosurgery through the AANS neurosurgery statistics report. This comprehensive report speaks volumes about the AANS membership by outlining the numbers of procedures our members performed in 1999. The report will be distributed to medical reporters nationwide. The reports are available for AANS members at \$15 each; \$25 each for nonmembers.

The AANS and CNS neurosurgical marketing booth was available to more than 11,000 attendees on the exhibit floor of the American Academy of Fam-

ily Physicians Meeting in October 2001 in Atlanta. Atlanta-area members Paul King, MD, Brian Subach, MD, Gordon Tang, MD, and resident Prithva Narayan, MD assisted. Inquiries from family physicians included specific questions about procedures, such as when to refer to a neurosurgeon or an orthopedic surgeon for back pain and how to order patient education materials on neurosurgery. Patient education brochures on low back pain and neck pain are available to AANS members for \$50 for a pack of 50 brochures.

To order the report or brochures, call the membership department at (888) 566-AANS.

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Free Outcomes Studies Offered To help neurosurgeons define and document the success of their interventions, the AANS and CNS now offer four outcomes studies available for participation, at no cost to members. Study topics are lumbar discectomy, treatment of carotid artery disease, treatment of acute subdural hematoma and a neurosurgical report card. Participation in the studies is easy and allows members to compare their surgical outcomes to the outcomes of all patients in the database. To learn more about the studies, contact Francine Byrnes of the Department of Education and Practice Management at (888) 566-AANS or epm@aans.org.

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Course Helps Residents Plan for the "Real World" Residents from 11 states and Europe attended "Beyond Residency: The Real World," held Saturday, Nov. 17, 2001, at Johns Hopkins Hospital in Baltimore, Md. Samuel Hassenbusch, MD, PhD, served as course chair. The course, the first of its kind for AANS, discussed how to evaluate a job and establish a practice; medical malpractice issues for neurosurgeons; coding and reimbursement issues; and academic vs. private practice paradigms. "This is exactly what I needed. It was a great course," said one resident. A junior resident said he plans to take the course again as a senior resident and that he would recommend the course to his colleagues. Plans are underway to present the course again in the upcoming year.

For additional information or to express interest in becoming a host site, contact AANS Education Manager Vanessa Garlisch, (847) 378-0550 or vlg@aans.org.

Informed Consent Guide For Sale In both frequency and severity, neurosurgery ranks among the top three medical specialties in malpractice claims. While most medical specialists experience an average of one claim every five years, actuarial data shows that neurosurgeons experience one claim every two years. Experts emphasize reducing risk by communicating and documenting the risks, benefits and alternatives to the procedure a patient is about to undergo. The new *AANS Guide to Informed Consent* was developed to help members reduce the risk of malpractice claims by improving patient communication and office documentation. In addition to sample consent forms for common neurosurgical procedures (available on diskette for easy editing), the *Guide* explains how to develop an informed consent program and how to avoid the common causes of malpractice claims and other special issues. To order, visit the AANS Online Marketplace at www.aans.org. For more information, contact Kathleen Craig at ktc@aans.org.

Angel Circle Spreads Its Wings When an angel gets wings, a bell rings, or so the saying goes. Thanks to the new Angel Circle, it might be said: When AANS rings, its "Angels" give wings—to neurosurgical research and education, the cornerstones upon which the AANS was established.

AANS established the Angel Circle in 2001 to provide an opportunity for corporate America to sponsor research and education in furtherance of the association's mission: The AANS is dedicated to advancing the specialty of neurological surgery in order to provide the highest quality of neurosurgical care to the public. Guilford Pharmaceuticals Inc. is the first Angel Circle partner.

Angel Circle opportunities are available for 2002 (including Annual Meeting participation). For information, contact AANS Development Director Bobbi Burgstone at (847) 378-0540 or bjb@aans.org.

Readers Respond

Roiled About Recertification

The troublesome issue of recertification has been lingering for many years (*Bulletin* cover story, Summer 2001). Now pressure has been put upon associations to put in place some kind of recertification. One of the main problems with this issue is that between 30 and 35 percent of practicing neurosurgeons in this country were never certified to begin with. How can you subject the people who have already passed their boards to undergo another gruesome exam while the other 35 percent don't give a damn what you or anybody else says? Are you going to recommend that the state board revokes their licenses?

The second major problem with recertification is that the public and the legal profession correlate certification with competence. This is totally erroneous. In my 30 years of practice I have seen many certified neurosurgeons who are incompetent and I have seen many who are not certified who are pretty good. I am saying this because I have observed these people perform surgery. Nothing can determine the competence of a neurosurgeon more than watching him during surgery. The individual might be pretty good in his didactic examination but be a lousy surgeon. Does that mean he is competent and meets the requirements? Exactly how will you determine that without a lawsuit?

Speaking of lawsuits, I also read the medicolegal update ("Status of Unprofessional Conduct Complaints," Summer 2001), and the problem is more widespread than the 15 complaints received by the AANS. During the past 30 years I have been on a peer review committee. Some of the cases I saw were completely outrageous. Some of these individuals do this on a full-time basis. They are for the plaintiff because that is where the money is.

I am pleased the AANS is taking action against these people even though I know that the Professional Conduct Committee is quite lenient and only takes disciplinary action in the most serious cases. The AANS should not be afraid of frivolous lawsuits that will be eventually thrown out of court.

— David A. Yazdan, MD, FACS, Brick, N.J.

EDITOR'S NOTE: Eighty-six percent of respondents to the AANS' practice survey in 1995 said they were board certified.

At Risk

In the Fall 2001 AANS *Bulletin*, "A Profession at Risk—The Medical Liability Crisis," John Popp, MD, brought forth a momentous issue for neurosurgeons. Indeed, neurosurgery has been a profession at risk for quite some time, and many neurosurgeons are quitting rather early, rather than becoming grist for the trial lawyer's mill. This medical liability problem is number one for neurosurgeons and the AANS, yet it's not so at all for the umbrella organization, the AMA, which politically claims to represent all physicians.

— Miguel A. Faria, Jr., MD, Macon, Ga. He is editor-in-chief of the *Medical Sentinel of the Association of Physicians and Surgeons*.

Name Mirrors Mission

Think First! National Injury Prevention Foundation Expands Program

Think First has a new name so people won't have to think twice about the organization's purpose. The new name is Think First, National Injury Prevention Foundation. Think First is neurosurgery's injury prevention education program. The national office is located near Chicago in the same building as the AANS headquarters, and it is supported and endorsed by the AANS and CNS.

Board Approves Name Change and More

The name change was approved by the Think First Board of Directors in April in Toronto. The Board also voted to:

- Adopt a new logotype in red and black.
- Continue use of Think First for Kids and Think First for Teens to describe its programs, but with revised logos in red and black.
- Continue use of its tag line—Think First, Use Your Mind to Protect Your Body.
- Discontinue use of Oscar as its trademark.

Ten Years Strong—and Growing

Think First celebrated its 10th anniversary last year. The number of young people reached by the foundation since its inception has steadily increased, and one million participated last year. More than nine million young people have been educated since 1986.

Think First offers Think First for Teens (TFFT) and Think First for Kids (TFFK) programs. TFFT is an assembly-based program that provides background information on brain and spinal cord anatomy, mechanisms of injury and issues of prevention. Also, a survivor of a serious injury teaches the young people the "facts of life" following an injury.

TFFK is a curriculum-based program for children in grades one through three that is taught in schools by classroom teachers or TFFK-trained health professionals. The six-week module provides injury prevention tips for bicycle, pedestrian and vehicle safety, recreational sports and gun safety in an age appropriate manner.

Think First programs are offered in 43 states through a network of 215 local chapters. International chapters are also in existence or are being formed in Australia, Canada, Jamaica, Korea, Lebanon, Mexico, and Singapore.

The goal is to expand to all 50 states and to other countries around the world through recruitment of volunteers, program directors and donors.

ThinkFirst
National Injury Prevention Foundation

"The next few years will be an exciting time for the foundation as it expands its educational initiatives. The continued support of neurosurgery is especially important to those initiatives."

The foundation is supported by the generosity of individuals, including many neurosurgeons, corporations and foundations.

Think First plans to educate three million young people per year by 2002 and five million per year by 2005. Part of this expansion will be provided by development of a new program for those who presently do not benefit from either the TFFT or the TFFK programs. Think First is in the early stages of developing a program for those in this "gap," grades four through six. Development of the curriculum is estimated to cost more than \$1 million.

The existing programs, TFFK and TFFK, need to be updated and expanded as well.

To achieve all of these initiatives, the foundation plans to build an initial endowment fund of \$3 million within the next three years to help offset operational expenses and enhance further curriculum development.

The next few years will be an exciting time for the foundation as it expands its educational initiatives. The continued support of neurosurgery is especially important to those initiatives.

If you are interested in developing a chapter in your community, or in supporting the injury prevention education efforts of Think First, contact William Biebuyck, CEO, at (800) THINK 56. ■

Part of this article was adapted from a story by P. David Adelson, MD, FACS, FAAP, that appeared in the December 2000 issue of the AANS/CNS Section on Pediatric Neurosurgery's newsletter.

New Spin on the Spine

Introducing the Decade of the Spine Initiative

EDWARD BENZEL, MD, ERIC MUEHLBAUER, MD, AND KATIE ORRICO, JD

Disorders of the spine represent one of the largest public health problems in the United States, costing billions of dollars each year. As the population ages, the incidence of spinal disorders will continue to grow, adding to the already overburdened healthcare delivery system. The Decade of the Spine was initiated to promote awareness of the spine, spine care and spine research.

Spawned in part by the Bone and Joint Decade initiative, the Decade of the Spine campaign was conceptualized, developed, and nurtured by the Council of Spine Societies (COSS), in conjunction with the North American Spine Society (NASS), the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS). Conceived to build also on the successes of the Decade of the Brain, the Decade of the Spine campaign will highlight the many aspects of spinal disease and serve to provide a framework within which the lives of citizens will be enhanced. Over the course of the decade, this major spine initiative will meet its mission "to improve the quality of spinal care worldwide."

One Mission, Two Components

The Decade of the Spine campaign encompasses two major components: the Decade of the Spine advocacy, visibility and education efforts, and World Spine II, a second international spine meeting.

Decade of the Spine: To enhance the visibility of the spine and spine care, NASS, AANS and CNS are taking a multifaceted approach that includes:

Decade of the Spine Action Committee: Edward Benzel, MD, chairman, Council of Spine Societies; Eric Muehlbauer, MD, executive director, Council of Spine Societies; Katie Orrico, JD, director, AANS/CNS Washington Office.

Council of Spine Societies Member Organizations: American Association of Orthopaedic Surgeons, American Association of Neurological Surgeons, American Spinal Injury Association, Cervical Spine Research Society, Congress of Neurological Surgeons, North American Spine Society, American Association of Physical Medicine and Rehabilitation, Scoliosis Research Society

Council of Spine Societies Board of Directors: Drs. Edward Benzel, chairman; Courtney Brown, Secretary; Tom Mayer, Andrew Cole, Richard Fessler, Ronald DeWald, Stephen Papadopoulos, Steven Garfin, Volker Sonntag, Jack Zigler, Edgar Dawson, Neil Kahanovitz, Arnold Menezes, Casey Lee, Harry Herkowitz.

World Spine II Organizing Committee: Drs. Edward Benzel, meeting chairman; Mario Brock, honorary chairman; Richard Fessler, and Hansen Yuan, scientific program co-chairmen; Regis Haid and Vincent Traynelis, neurosurgeons; Courtney Brown, Keith Bridwell and Hallet Mathews, orthopedic surgeons; Joel Press and Jerome Schofferman, non-operatives. Lisa Ferrara represents basic science.



■ Government Advocacy:

Increasing funding for spine research; ensuring patients direct access to spine specialists through legislation; and improving the process for approval of new spine related technology.

■ Public Awareness:

Engaging in a public relations, marketing and education campaign; and creating patient information and brochures, such as the

AANS/CNS "Getting SMART with Lumbar Spinal Stenosis" campaign, which was launched in September 1997.

■ **Provider Education:** Reaching out to physicians through scientific meetings and journals.

World Spine II: World Spine I has its roots in the successful World Spine I meeting, which was spearheaded by Mario Brock, MD, of Munich, and held in Berlin, Germany, in July 2000. Sponsored by the AANS/CNS Section on Spine and Peripheral Nerves and the NASS, World Spine II is planned for Chicago, Ill., in the Summer of 2004 or 2005.

Spinning the Image

The logos for Decade of the Spine and World Spine II embody the respective visions, as well as meaningful histories, of the two programs. The World Spine II logo is a minor modification of the World Spine I logo. It features a red "S," representing the spine, superimposed over a globe. The Decade of the Spine features an athlete supporting the globe with the red "S" of the World Spine II logo incorporated as the spine of the athlete.

How Can Spine Surgeons Participate?

Spine surgeons are encouraged to employ the Decade of the Spine logo on their letterhead and business cards to help promote awareness of the initiative. The logo can be downloaded from www.neurosurgery.org or from www.spine.org. Throughout the decade, there will be additional opportunities for spine surgeons to participate in Decade of the Spine, including lobbying members of Congress, attending the World Spine II meeting, and distributing patient education materials, as well as pursuing and enhancing avenues for spine and spinal cord research and research funding. ■

Edward Benzel, MD, is chairman of COSS; Eric Muehlbauer, MD, is executive director of COSS. Katie Orrico, JD, is director of the AANS/CNS Washington Office.

EVENTS

Calendar of Neurosurgical Events

Intraoperative Imaging in Neurosurgery Meeting

January 11-13, 2002
Zurich, Switzerland
www.congressorg.ch/iin

Southern Clinical Neurological Society Annual Meeting

January 18-25, 2002
Puerto Vallarta, Mexico
milliefayew@aol.com

California Association of Neurological Surgeons Annual Meeting

January 18-20, 2002
San Francisco, California
www.cans1.org

Lende Winter Neurosurgical Conference

February 2-9, 2001
Snowbird, Utah

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

February 3-6, 2002
Dallas, Texas
(847) 378-0500

European Association of Neurosurgical Societies Winter Meeting

February 7-10, 2002
Rome, Italy
dirocco@iol.it

American Academy of Orthopaedic Surgeons Annual Meeting

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

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

February 27-March 5, 2002
Orlando, Florida
(847) 378-0500

American Academy of Pain Medicine Annual Meeting

February 27-March 3, 2002
San Francisco, California
(847) 375-4731

Neurosurgery in the Rockies

March 2-6, 2002
Vail, Colorado
(303) 764-8228

Southern Neurosurgical Society Annual Meeting

March 6-9, 2002
Savannah, Georgia
(901) 259-5321

Japanese Congress of Neurological Surgeons Annual Meeting

March 15-17, 2002
Osaka, Japan
81-6-6833-5012

American Association of Neuroscience Nurses Annual Meeting

March 16-19, 2001
Chicago, Illinois
(888) 557-2266

AANS/CNS Section on Pain Interventional Therapies in Neurosurgical Pain Management Symposium

April 4-5, 2002
Chicago, Illinois
(847) 378-0500

AANS 70th Annual Meeting

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

2002 AANS/CNS Section on Tumors Fifth Biennial Tumor Satellite Symposium

April 11-12, 2002
Chicago, Illinois
(847) 378-0500

American Academy of Neurology Annual Meeting

April 13-20, 2002
Denver, Colorado
(651) 695-1940

Neurosurgical Society of America Annual Meeting

April 21-24, 2002
Kiawah Island Resort,
South Carolina
(203) 785-2791

American Surgical Association

April 25-27, 2002
Hot Springs, Virginia

Third Arctic Stereotactic Conference

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

Society of Neurological Surgeons Annual Meeting

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

International Society for the Study of the Lumbar Spine Annual Meeting

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

American Medical Association Annual Meeting

June 16-20, 2002
Chicago, Illinois
(312) 464-4504

Endocrine Society Meeting

June 19-22, 2002
San Francisco, California
www.endo-society.org

International Congress on Neuromuscular Diseases

July 7-12, 2002
Vancouver, Canada
(604) 681-5226

Congress of Neurological Surgeons Annual Meeting

September 21-26, 2002
Philadelphia, Pennsylvania
(877) 517-1267

American College of Radiology Annual Meeting

September 28-October 2, 2002
Miami, Florida
(800) 227-5463

American College of Surgeons Annual Meeting

October 6-11, 2002
San Francisco, California
(312) 202-5244

American Association of Electrodiagnostic Medicine Annual Meeting

October 9-13, 2002
Toronto, Canada
www.aaem.net/registration_brochure_online.htm

American Society of Anesthesiologists Annual Meeting

October 12-16, 2002
Orlando, Florida
www.asahq.org

American Neurological Association

October 13-16, 2002
New York, New York
www.aneuroa.org

International Society for Pediatric Neurosurgery Annual Meeting

October 27-31, 2002
Kyoto, Japan
81-3-3433-1111

American Board of Neurological Surgery Meeting

November 12-15, 2002
Houston, Texas
(713) 790-6015

Association of Military Surgeons of the United States Annual Meeting

November 10-15, 2002
Louisville, Kentucky
meetings@amsus.org

2002 Education and Practice Management Course Schedule

● Managing Coding & Reimbursement Challenges in Neurosurgery

January 25-26, 2002 Las Vegas, Nevada
February 8-9, 2002 Orlando, Florida
March 1-2, 2002 New Orleans, Louisiana
May 10-11, 2002 Anaheim, California
August 16-17, 2002 Boston, Massachusetts
September 6-7, 2002 Chicago, Illinois
November 15-16, 2002 Washington, DC

● Neurosurgical Review by Case Management:

Oral Board Preparation

May 26-28, 2002 Hartford, Connecticut
November 10-12, 2002 Houston, Texas

For more information or to register call (888) 566-AANS or visit
www.neurosurgery.org/aans/meetings/epm/epmcourses.html.

www.neurosurgery.org/calendar

Connections

The Washington Neural Network

There are numerous connections in this world. Some are obvious and others are subtle; some are planned and others are accidental; some are physical and others are metaphysical; and some are inherent, while others must be developed. The connection between this editorial and the cover story on the Emergency Medical Treatment and Active Labor Act (EMTALA) in this issue is no accident. It is intended to demonstrate how organized neurosurgery can address the many aspects of an important health policy such as EMTALA.

As neurosurgeons we pride ourselves on service, round-the-clock availability and rigorous commitment to patient care. However, we are only human. At some point, we need to decide when we've reached the limit of our ability to provide safe and effective care for our patients and then we need to let Washington know when legislation exacts obligations beyond our limits. EMTALA represents a dangerous intersection between our commitment to service and our ability to physically deliver that service.

EMTALA was enacted to prohibit patient "dumping" based on inability to pay. That reprehensible practice deserved to be prohibited. But the EMTALA requirements are broad enough and the penalties steep enough that the law has an effect on physicians far greater than the lawmakers could have envisioned.

Committee Powers "Neural Network"

The Washington Committee for neurosurgery, made up of the AANS and CNS presidents, presidents-elect, and six appointees, is charged with responding to the external political environment as it affects the delivery of neurosurgical care. As such, the committee interacts with the White House, Congress, federal agencies, the court system,

the American Medical Association (AMA) and other organizations.

To meet its charge, the Washington Committee serves as a nexus for other neurosurgical entities, such as the AANS/CNS Coding and Reimbursement Committee, the various AANS/CNS joint sections, the Council of State Neurosurgical Societies, and the individual state neurosurgical societies. All of these organizations have been pivotal in the Washington Committee's strategy concerning EMTALA.

Here is one example of how the Washington Committee has addressed EMTALA

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through this virtual "neural network": Codes that determine how neurosurgeons are paid for services, such as emergency care services mandated by EMTALA, are established through the AMA's RVS (Relative Values for Physician Services) Update Committee and Current Procedural Technology (CPT) processes. The AANS/CNS Coding and Reimbursement Committee (CRC), chaired by Jim Bean, MD, reports through the Washington Committee. Through the CRC, the AANS and CNS worked with the AMA to establish an "on-call" CPT code that aids neurosurgeons in gaining reimbursement for on-call services.

Another example of a connection that achieved a positive result for neurosurgeons: Representatives from various AANS/CNS sections attend Washington Committee meetings, keeping the commit-

tee connected to specialty-specific concerns on the socioeconomic and political fronts and providing the committee with each section's expertise. Recently Don Marion, MD, from the trauma section brought the section's concern about EMTALA's effect on reimbursement for neurosurgical emergency room care to the committee's attention. In response, the committee drafted and facilitated the adoption of an AANS/CNS position statement on reimbursement for on-call services. This statement now is being used by neurosurgeons around the country to negotiate on-call stipends from their respective hospitals.

The Washington Committee also is plugged into the socioeconomic activities of the Council of State Neurosurgical Societies (CSNS). Committee members attended the July 2001 leadership development conference in Washington sponsored by the CSNS, which was then under the chairmanship of Lyal Leibrock, MD, a liaison to the Washington Committee. Concluding the conference was a trip to Congress. Approximately 80 neurosurgeons trekked to the "hill" and met with their congressmen and senators to discuss concerns about health care delivery, EMTALA in particular. Their effort ultimately has led to the inclusion of EMTALA reforms in several bills now pending before Congress.

Committee's Efforts Continue

Many other important strands can be woven into this skein of activities. Currently the Washington Committee leads the effort to prevent additional onerous EMTALA regulations from being implemented, and it is responsible, in part, for Health and Human Services Secretary Thompson's directive to the Centers for Medicare and Medicaid Services to reevaluate EMTALA.

While these connections might seem "too political," the fact is, organization and mobilization of our activities in a coordinated way enhances our small specialty's ability to bring our message to the right constituency at the right time. It seems that now may be the right time for EMTALA. ■