AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

BULLETIN

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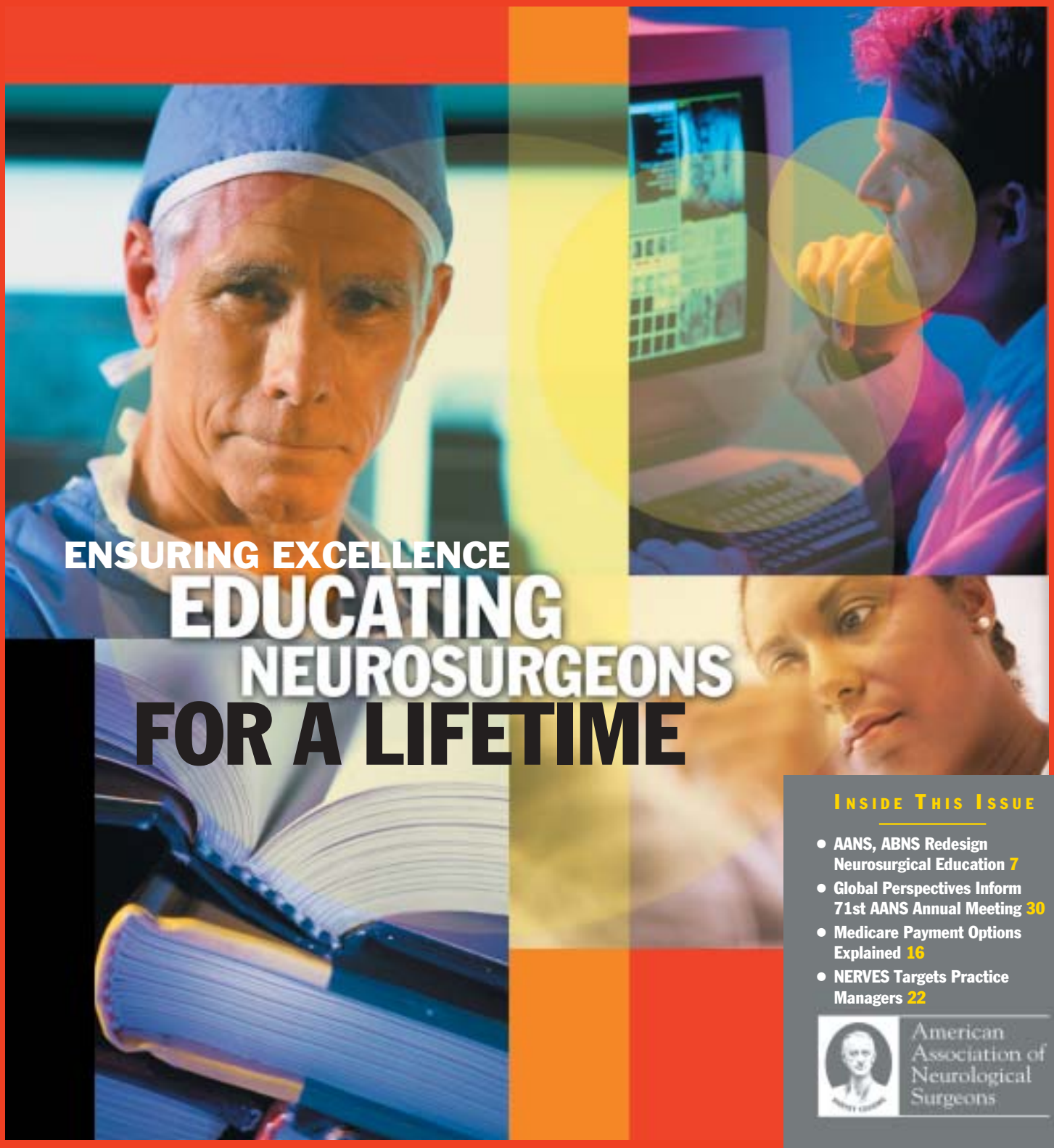

ENSURING EXCELLENCE
EDUCATING NEUROSURGEONS FOR A LIFETIME

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American Association of Neurological Surgeons

American Association of Neurological Surgeons

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VOLUME 11 NO. 4

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

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

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Letters to the editor are welcomed, as are comments and suggestions regarding the *Bulletin*. Send correspondence to bulletin@aans.org. Your correspondence may be included in a future issue edited for length, clarity and style. Submission of correspondence is assumed to be for publication unless otherwise specified.

Potential Articles
Submit a story or a story idea to the *Bulletin*. Writing guidelines are available at www.neurosurgery.org/aans/bulletin.

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A Moment's Reflection

How Is the AANS Meeting Members' Needs Today?

As the old year gives way to the new, a moment's reflection on the American Association of Neurological Surgeons—how it has served its members since inception as the Harvey Cushing Society in 1931 and how it continues to meet our changing needs today—certainly is worthwhile.

The touchstone of our progress is our stated mission: to advance the specialty of neurological surgery in order to provide the highest quality of care to the public.

Education Is at the Core

Education is at the core of the AANS mission. As the needs of our members and our specialty grow increasingly complex in today's healthcare environment, the AANS is dedicated to responding appropriately. A significant restructuring of our education component is what is called for currently.

Why? The body of neurosurgical knowledge was amassed primarily in the 20th century. Assisted by advances in technology, this body of knowledge continues to evolve at a furious pace. At the same time, neurosurgery continues to work for advancements that will lead to better outcomes for our patients. While our profession always has held neurosurgeons to the highest standards of excellence, of which continuing education has played a significant part, recently the public has called for a concrete demonstration of our ongoing commitment to quality care. In response, as Volker K.H. Sonntag, MD, and Robert A. Ratcheson, MD, explain in this issue's cover section, the American Board of Neurological Surgery is developing a comprehensive protocol—the Maintenance of Certification Program—that provides a framework for lifelong learning.

Realizing that our members would benefit from a complementary interplay between the ABNS requirements and the AANS educational structure, we resolved to redouble our educational efforts and commit to appropriate restructuring. To this effect, Dr. Ratcheson, AANS secretary, was commissioned to chair the blue ribbon Educational Policy Task Force. Dr. Ratcheson's career-long commitment to education made him the right person for this important job. As the educational requirements for neurosurgeons continue to evolve, I hope it is clear to all that AANS is absolutely committed to making the necessary opportunities for neurosurgical education easily accessible to our members.

An educational opportunity that neurosurgeons and related professionals should not miss is the 71st AANS Annual Meeting, "Cultural Connections: Bringing Global Perspective to Neurosurgery," beginning April 26. For the past several months, a team led by Ralph G. Dacey, MD, and William T. Couldwell, MD, has been working to create an exemplary event. In addition to the important educational opportunities that fulfill numerous continuing education requirements, participants will find invaluable opportunities to meet face-to-face with colleagues from across our country and around the world.

One aspect of this premier annual event to which I look forward with particular pleasure is the Japanese-American Neurosurgical Friendship Symposium. Planned in the United States by Christopher M. Loftus, MD, and in Japan by Shigeaki Kobayashi, MD, and Kiyonobu Ikezaki, MD, this event follows last year's inaugural intercultural program, the Francophone Symposium. By building relationships with our international colleagues, we lay a foundation that will allow the bar to be raised for neurosurgery in the United States and around the world. To this end, I heartily encourage your participation in this event on Friday, April 25, and in the 2003 AANS Annual Meeting.

New Year: Education and More

In addition to continuing to serve as the premier forum for presentation of the most important scientific and clinical advances in neurosurgery, the 71st Annual Meeting will feature a diversity of invited presentations by renowned national and international scientists and neurosurgeons. Topics that affect our livelihoods and our patients' access to care will also be addressed. Among these, Medicare no doubt will be one. Because the rules are confusing for many, the AANS believes it is critical that neurosurgeons have all the necessary information at their disposal to make individual practice decisions. This includes information about the various options for participating in the Medicare program, as described in the Washington Update column within this issue. I want to make clear, however, that the AANS does not endorse, encourage or support one particular option over another. It is up to each individual neurosurgeon to make his or her own decisions about which option best meets the needs of their practices and their patients.

Medicare reimbursement, the professional liability crisis, and issues affecting neurosurgical research are among the topics that the AANS continues to monitor and act upon as deemed appropriate, frequently working jointly with the CNS through our Washington Committee. Our success in making progress toward resolution of these concerns turns in large part upon your participation in organized neurosurgery. I hope you will take a moment to reflect upon how well the AANS is serving you, and to let us know how we can serve you and our profession better in the new year and into the future.■

Roberto C. Heros, MD, is the 2002-2003 AANS president. He is professor, co-chairman and program director of the Department of Neurosurgery at the University of Miami. Read more about Dr. Heros on page 31.

AANS Advances Lifelong Learning

The AANS Bulletin *Plays an Integral Part*

When I began my neurosurgical residency, a faculty member introduced me to the concept of lifelong learning. The gist of his not-so-delicate suggestion was that if I ever wanted to amount to anything, I would strive to learn something new each and every day for my entire career.

At that time the goals of education were strictly personal: to be an excellent physician in the long term, and in the short term, to pass the oral board examination of the American Board of Neurological Surgery. The educational material used to attain these goals seemed more than adequate—the *Journal of Neurosurgery,* a few classic texts, a hands-on lab experience, a national meeting, and immersion in clinical care of patients with neurosurgical disorders.

Move this simpler and admittedly idealized time forward more than two decades: Now it seems that neurosurgical education is everyone's business! The Accreditation Council of Graduate Medical Education, the Institute of Medicine, the federal government, state licensing boards, consumer groups, and resident unions are among those with a say in this subject. Furthermore, the available educational opportunities have multiplied—more journals, more meetings, more societies, more texts—all important developments as our specialty becomes more complex and as documentation of competence becomes the standard by which all neurosurgeons will be measured.

What should we as neurosurgeons do? How can we maintain our edge and a sense that lifelong learning is imposed primarily by personal standards, and at the same time meet the regulatory requirements dictated by those outside of neurosurgery?

These are among the questions addressed in this "education issue" of the *Bulletin.* The cover story provides a comprehensive view of the revolutionary developments in continuing neurosurgical education, now a lifelong prospect in a formal sense. Representing the American Board of Neurological Surgery and the American Association of Neurological Surgeons—Volker K.H. Sonntag, MD, and Robert A. Ratcheson, MD, respectively—detail the rationale for the ABNS Maintenance of Certification Program and the AANS' targeted response to it.

A. John Popp, MD, is editor of the Bulletin, *president-elect of the AANS, and Henry and Sally Schaffer Chair of Surgery at Albany Medical College.*

Education, a core value of the AANS as Roberto C. Heros, MD, observes in his President's Message, also is an integral precept of the *Bulletin.*

Our primary aim for this and every issue of the *Bulletin* is to inform AANS members about socioeconomic, professional and association issues. Further, the *Bulletin* seeks to enhance understanding—to educate—by providing a context for the facts through expert opinions provided by colleagues and others with knowledge of specific topics.

For example, in this issue's Governance column Dr. Heros is joined by Mark N. Hadley, MD, and Robert E. Harbaugh, MD, in a discussion of the International Subarachnoid Aneurym Trial. Representing organized neurosurgery, they take a stand on the conclusions drawn from the ISAT's evaluation of clipping versus coiling and issue a call for further study.

Similarly, the Medicolegal Update column in this issue discusses the latest developments with regard to the professional liability crisis, an issue that returns to the front burner at this time of year with the arrival of every premium increase notice. The article provides an overview of recent legislation passed in a few states with the intent to combat the crisis and additionally offers a frontline view of what can be expected at the federal level in 2003. It also suggests ways for neurosurgeons to effect change and become part of the solution.

In my own work with neurosurgical residents, I often am reminded first hand of the value of experiential education—learning by doing. Extrapolating this experience to participation in resolving problems relating to our medical practice and our livelihood is not a great stretch. While neurosurgeons are not always able to participate in the various activities that organized neurosurgery is involved in today, all can participate in our profession's developing dialogue as expressed in every issue of the *Bulletin.*

To this end, I encourage you to see where we've been and where we're going as a profession and as a professional association by reading through this issue, as well as past issues available at www.neurosurgery.org/aans/bulletin. I urge you to consider participating in the *Bulletin* by writing a Letter to the Editor (bulletin@aans.org), or by contributing an article idea for an upcoming issue.

At its best, the *Bulletin* does more than inform. Articles can engage the mind and inspire dialogue, debate, ideas and action. With your help, the *Bulletin* will continue to serve effectively as our primary organ of information, communication and education. ■

NEWSLINE

News Members Trends Legislation

FROM THE HILL

DR. FRIST LEADS THE SENATE Heart surgeon Bill Frist, R-Tenn., was elected majority leader of the U.S. Senate in December. However, the Senate lost two physician members following the November election: John Cooksey, R-La., an opthamologist, and Greg Ganske, R-Iowa, a plastic surgeon. The U.S. House of Representatives gained two new physician members, both obstetrician-gynecologists: Phil Gingrey, R-Ga., and Michael Burgess, R-Texas.

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

Congress Adjourns Without Fixing Medicare Physician Payment Update Problem The 107th Congress adjourned *sine die* without completing action on Medicare legislation that would have halted an additional 4.4 percent across-the-board payment reduction for physician services in 2003. These cuts are in addition to the 5.4 percent reduction in 2002, and without Congressional action, further cuts in 2004 and subsequent years are also anticipated, for a cumulative reduction of approximately 15 percent over a four-year period. The reductions are due to various accounting errors that the Centers for Medicare and Medicaid Services (CMS—formerly HCFA) made in 1998 and 1999 as well as a payment update formula that ties physician spending to the gross domestic product rather than medical inflation indexes. Unless the 108th Congress or the president intervenes in January, these reductions will go into effect on or about Feb. 1, 2003.

HIPAA Enforcement Next on HHS Agenda With compliance dates for the Health Insurance Portability and Accountability Act of 1996 passed or looming—the date for Electronic Health Transactions and Code Sets Standards was Oct. 16, 2002, although it was extended by one year for those who filed a compliance plan by Oct. 15, and the Privacy Rule compliance date remains April 14, 2003—the attention of the Department of Health and Human Services (HHS) turned to enforcement. On Oct. 15, the HHS named the Centers for Medicare and Medicaid Services (CMS) as the entity to enforce the transaction and code sets standards. The HHS Office for Civil Rights (OCR) will enforce the privacy standards. The HHS said that its "enforcement activities will focus on obtaining voluntary compliance through technical assistance." Meanwhile, in a November letter to the HHS, the National Committee on Vital and Health Statistics stated, "There is an extremely high level of confusion, misunderstanding, frustration, anxiety, fear and anger as the April 14, 2003, compliance date nears." On Dec. 4, the OCR posted guidance explaining significant aspects of the Privacy Rule. The document, available at www.hhs.gov/ocr/hipaa/privacy.html, includes Privacy Rule citations for easy reference.

Advisory Committee Tries to Bring Sense to Healthcare Regulations In November the HHS Secretary's Committee on Regulatory Reform, of which neurosurgeon Gary C. Dennis, MD, is a member, issued its report, Bringing Common Sense to Health Care Regulation, available at www.regreform.hhs.gov/meetinginfo/finalreport.htm. The report delivers 255 recommendations and includes 10 recommendations regarding Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. Among the HIPAA priorities were adoption of a defined schedule for modification and notice to the privacy standards, and establishment of a Privacy Rule advisory panel.

Nevada Will Revisit Tort Reform in 2003 Tort reform legislation that took effect Oct. 1 didn't go far enough, according to Nevada doctors and citizens. In December the Keep Our Doctors in Nevada petition was validated with more than 77,000 signatures, forcing a vote by the legislature within 40 days of the new session that begins in February 2003. According to a report in the *Las Vegas Review-Journal*, the petition contained five points, among them abolishment of exceptions to the cap of $350,000 for pain and suffering damages and a limit on attorney fees. The *Review-Journal* reported an "exodus of Las Vegas doctors" based on the fact that "nearly 150 doctors either have left town, retired early or are considering leaving … because they cannot find medical liability insurance or afford the skyrocketing rates." The Nevada State Medical Association's position in support of the petition is available at www.nsmadocs.org/newsletters/pliupdates/pli_43.pdf. The legislation that took effect in October was signed Aug. 7 after the state's only level 1 trauma center closed for 10 days in July because its doctors could not afford liability insurance.

NEWSLINE

News Members Trends Legislation

NEURO NEWS

TBI Facts for Spanish-Speaking Patients
The Centers for Disease Control and Prevention recently released a Spanish language brochure about traumatic brain injuries titled "Informacion Acerca de la Lesion Cerebral Leve," or "Facts About Concussion and Brain Injury." Copies of the free brochure can be ordered or downloaded at www.cdc.gov/ncipc/lesion_cerebral/lesion_cerebral.htm. The brochure also is available in English. More information is available from the CDC at (770) 488-1506.

If you come across an item you think other neurosurgeons should see, mail it to Neuro News at the *Bulletin,* or tell us about it by e-mail, bulletin@aans.org.

Neurosurgeon's License Summarily Suspended The North Carolina Medical Board summarily suspended a neurosurgeon's license for performing craniocervical decompressions in patients with chronic fatigue syndrome and/or fibromyalgia. In March 2000, the American Association of Neurological Surgeons issued a position statement regarding craniocervical decompressions on patients with chronic fatigue syndrome. According to the statement, available at www.neurosurgery.org/aans/media/detail.asp?PressID=65, the "AANS does not recognize [craniocervical] decompression as a treatment alternative for chronic fatigue syndrome." Since the statement was issued there has been no substantial scientific information to alter the AANS position on this topic, according to the AANS Executive Committee.

Institute Lambastes U.S. Healthcare System The Institute of Medicine issued a new report criticizing the current U.S. healthcare system as "incapable of meeting the present, let alone the future needs of the American public." The Fostering Rapid Advances in Health Care: Learning From System Demonstrations report recommends a series of demonstration projects in 2003 to point the way for fundamental reforms in key areas, including access to primary and chronic care, communications technology, health insurance coverage and professional liability. With regard to medical liability, the IOM recommends creating "injury compensation systems outside of the courtroom that are patient-centered and focused on safety, while also addressing provider concerns about rapidly rising liability insurance premiums." The report is available at www.nap.edu/books/0309087074/html.

Lasers May Regrow and Repair Severed Nerves Weak optical forces can direct nerve cells along a specific path, changing their course up to 90 degrees, Allen Ehrlicher and colleagues reported in the *Proceedings of the National Academy of Sciences,* www.pnas.org. "In actively extending growth cones, a laser spot is placed in front of a specific area of the nerve's leading edge, enhancing growth into the beam focus and resulting in guided neuronal turns as well as enhanced growth," they explained. This technique coaxes the lamellipodium, in contrast to the "optical tweezer" technique that grasps and pulls it. While the fiber optic technique is experimental and the research team cannot explain why it works—they theorize that it may trick the actin polymerization process—it holds promise for eventually helping people with spinal cord and peripheral nerve injuries regain mobility.

IT Adoption Chiefly Motivated by Business Performance Improvement of business performance remained the No. 1 reason why physician executives adopt information technology, but improvement in clinical quality was close behind, according to results of the 2002 *Modern Physician*/PricewaterhouseCoopers survey, released in November. Compared to 2001 data, the survey showed increases in physician use of computer-based systems in almost every category, with the largest increases recorded in prescription writing (1.8 percent to 23.2 percent), and clinical protocols (16.2 percent to 30.2 percent). The primary uses of computer-based symptoms remained billing/claims submission and scheduling. Survey results are available at www.modernphysician.com.

New Guidelines for Physician-Patient E-mail The eRisk Working Group for Healthcare, a consortium of insured physicians, medical liability insurance carriers and medical societies, recently announced new guidelines for e-mail communications between doctors and their patients. The 2002-2003 eRisk Guidelines for Online Communications and Fee-Based Consultations at www.medem.com/corporate emphasize the need for secure online messaging—with authentication and encryption in compliance with the Health Insurance Portability and Accountability Act of 1996—as opposed to the use of standard office e-mail.

Toward Lifelong Learning

New AANS Educational Structure Is Built on EMC²

By Robert A. Ratcheson, MD

"Education is at the core of the AANS mission. As the needs of our members and our specialty grow increasingly complex in today's healthcare environment, the AANS is dedicated to responding appropriately. A significant restructuring of our education component is what is called for currently." — Roberto C. Heros, MD, AANS President

The American Association of Neurological Surgeons continually strives to develop programs that meet the challenges to neurosurgery that are posed by a healthcare system of ever increasing complexity. Because it is neurosurgeons' knowledge and skills that define our success in serving our patients, the educational programs of the AANS represent the very core of the association and are its single most important function.

In recognition of its obligation as the leading provider of neurosurgical continuing medical education (CME), the AANS is expanding its role in the design and delivery of education services for members. This expansion entails restructuring its education program to help neurosurgeons satisfy new requirements that are being phased in by the American Board of Neurological Surgery (ABNS).

The Certification Evolution

In years gone by, a neurosurgeon's certification by the ABNS was good for a lifetime. But as recently as March 2000, the American Board of Medical Specialties (ABMS), which oversees the ABNS and 23 other specialty boards, voted to evolve recertification into a process known as maintenance of certification. The goal of this process is to provide evaluation and documentation of the continuing competence of practicing physicians. Much of the impetus for this evolution originated with an Institute of Medicine challenge to demonstrate competence and verify performance throughout a physician's career by the demonstration of lifelong learning and ongoing improvement of practice.

In answer to this challenge, the ABNS, after extensive deliberation, now is well along with plans that will benefit its diplomates and their patients. The new ABNS Maintenance of Certification (MOC™) Program is outlined by Volker K.H. Sonntag, MD, in this issue of the *Bulletin*. The article details the six core competencies necessary for MOC: 1) medical knowledge, 2) patient care, 3) interpersonal and communication skills, 4) professionalism, 5) practice-based learning and improvement, and 6) systems-based practice. It additionally describes the methods that the ABNS has selected for assessing these competencies, including evidence of professional standing, evidence of commitment to lifelong learning and periodic self-assessment, evidence of cognitive expertise, and evidence of evaluation of practice performance.

Although the ABNS has not yet fully developed its MOC Program, it is expected that the new program will inspire significant changes to the current CME programs. These changes, both in volume and design, will help prepare neurosurgeons to satisfy the new ABNS requirements. By virtue of the AANS requirement for its Active

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members to be certified by the ABNS to maintain AANS membership, these members in particular will be affected by future modifications in educational and practice requirements.

AANS Evolution Begins With Evaluation

The AANS, in anticipation of the impending release of the ABNS requirements and in recognition of the need to be prepared to help members meet them, formed the Educational Policy Task Force in April 2002. Its charges were to:

- carry out a far ranging analysis of the AANS' current educational policies;
- develop a strategy to enable the AANS to provide educational services to its membership for the purpose of enhancing patient care;
- meet ABNS requirements for MOC;
- satisfy state and local requirements for licensure, hospital staff membership, and credentialing; and
- maintain and satisfy the educational requirements for membership in the AANS.

AANS Awards Neurosurgical CME The task force's initial job was to review current AANS policies regarding the award of continuing medical education credits and the provision of CME tracking services.

The AANS rules and regulations state that, "Active and Active Provisional members shall be required to document receiving the Continuing Education Award in Neurosurgery (requiring at least 60 hours of neurosurgical CME credit) at least every three years." The AANS Continuing Education Award in Neurosurgery serves as proof of specialty specific CME and is intended to be accepted as an integral part of a nationwide credentialing process.

It is primarily specialty specific CME that provides the mechanism to maintain and enhance neurosurgery's internal educational system, and will enable the specialty to cope with future MOC and credentialing requirements. The AANS Board of Directors has approved the awarding of specialty specific neurosurgical credits to neurosurgeons who attend:

- AANS sponsored or jointly sponsored meetings;
- AANS education and practice management courses;
- Congress of Neurological Surgeons (CNS) annual meetings; and
- AANS/CNS section meetings.

This policy will maintain and ensure the high quality of neurosurgical CME.

AANS Tracks CME Credit The AANS automatically tracks credit for these activities for all of its members except for the CNS annual meeting, although it may be able to do so in the future. Currently, members can forward their CNS certificates of attendance to the AANS for processing and inclusion in their CME tracking records. Providers of neurosurgical CME courses can obtain joint sponsorship and the awarding of neurosurgical CME credits by contacting the AANS (see "Educational Requirements for AANS Membership," on page 9).

AANS Tracks Category 1 AMA/PRA For meeting activities not indicated above, the AANS will continue to track Category 1 credits for the American Medical Association's Physician's Recognition Award, primarily for the purpose of state licensure and local requirements. To add Category 1 AMA PRA credits to a file, a member must forward certificates of attendance to the AANS for processing. However, these credits are not eligible toward the Continuing Education Award in Neurosurgery, and they will not be applicable toward the 60 neurosurgical credit hours to be earned during the three-year cycle required for maintenance of AANS membership.

"Our annual meetings and professional education courses… have served as an effective mainstay of neurosurgical continuing education."

Your Personalized Transcript The AANS Member Services Department annually mails personalized transcripts to Active and Active Provisional members. This helps members monitor their progress toward reaching the required 60 neurosurgical credit hours and facilitates use of the transcript for other purposes: evidence for maintaining a valid license, unrestricted hospital privileges and assisting in confidential peer review, for example.

The task force also reviewed the requirement for each member to attend at least one of every three AANS annual meetings and recommended that this requirement remain unchanged.

Although medical oversight and governmental regulatory agencies may provide valid frameworks for the skills expected of a practicing physician, it remains obvious that only neurosurgeons possess the necessary knowledge and insights to design neurosurgical educational programs for their colleagues. Recently, some educational professionals have stated that traditional CME has been unsuccessful in educating physicians and in improving the quality of patient care. That has not been the case in neurosurgery. Our annual meetings and professional education courses have kept practicing neurosurgeons current with the latest concepts and technical developments and have served as an effective mainstay of neurosurgical continuing education. For example, it was this traditional method of CME that allowed neurosurgery to educate practicing neurosurgeons in transsphenoidal pituitary surgery and to regain its leadership role in spinal surgery.

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CME Opportunities

Continuing medical education credit is available for AANS-sponsored meetings and courses and for meetings jointly sponsored by AANS with other organizations. AANS automatically tracks credit for these courses and meetings as a service for AANS members.

Upcoming AANS Annual Meeting and Sponsored Courses

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

71st AANS Annual Meeting

Cultural Connections: Bringing Global Perspective to Neurosurgery

April 26-May 1, 2003	San Diego, Calif.

Beyond Residency: The Real World

Oct. 4, 2003	Los Angeles, Calif. (UCLA)

Managing Coding & Reimbursement Challenges in Neurosurgery

Jan. 31 - Feb. 1, 2003	Tampa, Fla.
Feb. 21-22, 2003	San Antonio, Texas
March 14-15, 2003	Seattle, Wash.
May 16-17, 2003	Chicago, Ill.
Aug. 22-23, 2003	Charlotte, N.C.
Oct. 31 - Nov. 2, 2003	Maui, Hawaii
Nov. 21-22, 2003	Baltimore, Md.

Advanced Coding Course

Sept. 26-27, 2003	San Francisco, Calif.

Neurosurgical Review by Case Management: Oral Board Preparation

May 11-13, 2003	Cincinnati, Ohio
Nov. 9-11, 2003	Houston, Texas

Advanced Endoscopic Surgical Procedures

Jan. 31-Feb. 1, 2003	Memphis, Tenn. (MERI)

Basic Principles of Anatomy and Terminology for Neurosurgery Office Staff

Jan. 30, 2003	Tampa, Fla.
Feb. 20, 2003	San Antonio, Texas

Neurosurgical Practice Management

May 18, 2003	Chicago, Ill.
Sept. 28, 2003	San Francisco, Calif.

Innovations in Spinal Fixation

July 26-27, 2003	Memphis, Tenn. (MERI)

2003 Jointly Sponsored Meetings

Additional 2003 Jointly Sponsored meetings are to be announced.

Richard Lende Winter Neurosurgery Conference

Feb. 1-7, 2003	Snowbird, Utah

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

Feb. 16-19, 2003	Phoenix, Ariz.

Southern Neurosurgical Society

March 12-13, 2003	Orlando, Fla.

Interurban Neurosurgical Society Annual Scientific Meeting

March 7, 2003	Chicago, Ill.

Neurosurgical Society of America with the SBNS 55th Annual Meeting

June 8-11, 2003	Sunriver Resort, Ore.

Educational Requirements for AANS Membership

Keeping Track of Your CME

- At least every three years, AANS Active and Active Provisional members are required to document receipt of the Continuing Education Award in Neurosurgery (requiring at least 60 hours of neurosurgical CME credit); and attend an annual meeting of the AANS.
- The current CME cycle is Jan. 1, 2002, through Dec. 31, 2004. During this period, specialty specific neurosurgical credit is offered to individuals who attend AANS-sponsored or jointly sponsored meetings, AANS/CNS section meetings, CNS annual meetings, or participate in the AANS Neurosurgical Topics Home Study Exam program.
- The AANS automatically tracks credit for all of these activities, except for the CNS annual meeting. However, CNS certificates of attendance can be forwarded to the AANS for inclusion in the CME tracking record, which the AANS maintains for all of its members.
- To assist members in meeting state licensure and local requirements, the AANS tracks Category 1 credits for the American Medical Association Physician's Recognition Award, or AMA PRA, for meetings and activities not mentioned above. To add these credits to your file, certificates of attendance must be forwarded to the AANS. These credits are not applicable toward the 60 neurosurgical credit hours required for maintaining membership.
- The AANS Member Services Department annually mails personalized transcripts to Active and Active Provisional members for use in documenting their CME hours and to assist them in monitoring their progress towards reaching this 60 neurosurgical credit hour requirement for members.

Online CME Will Speed the Process

Online CME will debut on "My AANS"—the new members-only, secure area at www.aans.org—in early Spring 2003. This new feature will allow members to print out their CME transcripts and review their progress toward reaching the 60 neurosurgical credits required to receive the Continuing Education Award in Neurosurgery. Attendees of AANS annual meetings and meetings that are jointly sponsored by AANS also will be able to reprint copies of their certificates of credit. An at-a-glance listing of AANS jointly sponsored meetings will illustrate upcoming meeting opportunities, dates, locations, and specialty interests.

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New Educational Structure Built on EMC²

In order to maintain organized neurosurgery's position as the primary provider and director of high quality neurosurgical education, the task force recommended the formation of an AANS educational structure which will better serve to expand and focus our activities and meet anticipated regulatory requirements. This activity will require a more active role for AANS education volunteers and staff.

In September 2002, the AANS Board of Directors established the Education and Maintenance of Certification Committee, known as EMC². Roberto Heros, MD, president of the AANS, appointed Christopher Loftus, MD, to lead and develop this entity. This committee will construct a framework for the establishment of subcommittees, which in turn will bear the responsibility of expanding the CME activities of the AANS in response to MOC and external requirements. It will be responsible for directing the development and delivery of CME programs and courses and other activities that respond to the educational needs required to satisfy ABNS requirements, such as preparation for a cognitive examination in general neurosurgery and subspecialty areas, and for creating programs that assist neurosurgeons with the development of data to show satisfactory practice outcomes. It also will assist in developing satisfaction assessment evaluation instruments and a verifiable peer review process.

EMC² will develop appropriate instruments to provide neurosurgeons with the opportunities for lifelong learning and its documentation, not only through traditional CME venues, but also through the development of practice data and audits and in electronic, print and simulator CME. It will also develop programs to assist in the documentation of professionalism and explore the development of new self-assessment options, while supporting the highly successful Self-Assessment in Neurological Surgery program known as "SANS," which was originally developed by the AANS and the CNS and now is under the direction of the CNS.

New requirements and regulations must be appropriate and pertinent to every neurosurgeons' goal of excellence in the delivery of neurosurgical patient care. The enactment of the core competencies will provide an opportunity for expansion and redesign of the AANS role in addressing the educational needs of practicing neurosurgeons. This effort may be one of our most important ventures of the 21st century. Under Dr. Loftus' leadership, these activities are taking shape in a manner that will anticipate the changes dictated by Accreditation Council for Graduate Medical Education and ABNS mandates. It remains important, however, to remember that we not allow prescribed requirements to dictate the entirety of the AANS educational efforts. The association's past CME offerings, including our annual meetings, remain highly effective and greatly valued. They have been and will continue to be a vital part of neurosurgeons' education. ■

Robert A. Ratcheson, MD, is secretary of the AANS and chair of the AANS Educational Policy Task Force. He is chair of the Department of Neurological Surgery at Case Western University and at University Hospitals of Cleveland.

EMC² Promises Member Ease

"Our aim is to make it a simple matter for AANS Active members to fulfill the Maintenance of Certification requirements as they evolve," said Christopher Loftus, MD, chair of the newly established AANS Education and Maintenance of Certification Committee known as EMC². "It may be tempting to view MOC requirements as another onerous burden, but the 'membership advantage' is that the AANS, through EMC², is taking on the burden."

Dr. Loftus said that a primary focus of EMC² is creating an accessible, member-friendly mechanism that will manage the process and eliminate the guesswork—Have I met current the requirements? What do I need to do and how long do I have to do it?—and the attendant worry.

"I envision our members logging into 'My AANS' on the AANS Web site, viewing an accounting of their own continuing medical education credits that tells them what they need to accomplish and the timeframe for doing so, reviewing a listing of pertinent CME opportunities, and clicking and registering for a needed course or meeting," he explained. "A simple, effective, all-encompassing CME management process that is tied into ABNS requirements will free members to concentrate on practicing neurosurgery rather than scrutinizing the details of the MOC process."

"Our aim is to make it a simple matter for AANS Active members to fulfill the Maintenance of Certification requirements as they evolve."

Throughout his career, Dr. Loftus has been involved with various aspects of incorporating neurosurgical education into neurosurgical practice. At present he serves as chair of neurosurgery at the University of Oklahoma and chair of the AANS Publications Committee.

Seeking Joint Sponsorship of Your Program? How to Apply

Many organizations are interested in providing educational activities related to neurosurgery. Understandably, the ability to offer continuing medical education (CME) credits to program participants is an important component. For a meeting organizer whose resources are limited, pursuing CME accreditation through joint sponsorship is a common and mutually beneficial route to take during the meeting planning process.

AANS Can Help

The American Association of Neurological Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to plan, develop and implement CME activities and to jointly sponsor programs.

In order to jointly sponsor a program, the AANS must work in partnership with the organization to ensure that the ACCME Essential Areas and the Standards for Commercial Support of Continuing Medical Education have been met. Only requests for joint sponsorship that meet these requirements can be considered.

The following is a summary of services provided and reviews conducted by the AANS in conjunction with the process of jointly sponsoring a meeting:

Pre-Meeting Items

- Processing of meeting application
- Review and approval of needs assessment documentation
- Review and approval of learning objectives
- Review and approval of all promotional material including abstract request information
- Review of faculty disclosure and commercial support documentation and acknowledgements in program material. Appropriate Food and Drug Administration unlabeled product use disclosure management
- Management or delegation of management of corporate sponsorship and educational grant funds
- Review and approval of program agenda
- Counting and granting of CME credits
- Review and approval of evaluation form
- Review of meeting budget
- Ongoing correspondence with joint sponsored organization regarding process education and requests for information
- Display and distribution of meeting flyers or registration brochures at AANS Education and Practice Management courses
- Promotion of jointly sponsored meetings on the AANS Web site

Post-Meeting Items

The ACCME requires collection and review of the following items to officially close a meeting file and grant CME credits. Failure to meet the requirement would result in loss of accreditation for the organization.

- Verification of physician attendance (attendance rosters, sign-in sheets)
- CME certificate processing
- All on-site materials (program book, handouts)
- Final financial accounting
- Participant evaluation summary report
- The AANS can provide a tabulating service for meeting evaluation. (This would entail an additional fee, directly charged to the meeting.)
- Final meeting budget

The Process

The joint sponsorship process involves submitting a written request to AANS and requires completion of the Joint Sponsorship Application Form at least six months in advance of the meeting date.

Upon receipt of the application, the AANS will provide a set of the joint sponsorship guidelines to interested organizations and an education representative, who will be responsible for designating the meeting with CME credit in accordance with the Essentials and Standards of the ACCME and the Standards for Commercial Support of Continuing Medical Education, will be designated to answer questions about the joint sponsorship process.

A sponsoring organization annually pays a $300 processing fee for submission and review of its application. This fee is nonrefundable. A flat fee, based on the size of the meeting, also is charged to the organization 60 days after its meeting date.

Additional Information

Additional information regarding the joint sponsorship process, including the Joint Sponsorship Application Form, is available at www.neurosurgery.org/aans/meetings/epm/jointsponsorship.html or by contacting Vanessa Garlisch, AANS education manager, at (847) 378-0550 or vlg@aans.org.

Making MOC a Meaningful Process

By Volker K.H. Sonntag, MD

ABNS Announces Its Maintenance of Certification Program

The American Board of Neurological Surgeons is committed to implementing its new Maintenance of Certification (MOC™) Program. The MOC process has been developed under the auspices of the American Board of Medical Specialties (ABMS) in response to the public's call for increased accountability in many sectors. Recent revelations, such as the Institute of Medicine's report on medical errors, have given rise to expectations of greater physician accountability. The American public asked for—and as consumers justly deserve—assurance that physician specialists are held accountable to high standards of care.

"MOC will dramatically change the way neurosurgeons are credentialed."

The intent of MOC is to demonstrate to the public and our profession that diplomates of the ABNS maintain their knowledge and skills to provide quality care in neurosurgery throughout their professional practice careers. The new MOC Program will provide increased value to our diplomates and the public by promoting and sustaining the integrity, quality, and standards of training and practice of neurosurgery with an overriding emphasis on improvement of practice. Over the last three years, the ABNS has been working diligently to develop its MOC Program and soon will be ready to submit its proposal to the ABMS for approval.

Like the ABNS, the 23 other ABMS member boards must decide how to implement the process of MOC. The existing recertification programs of several boards have been reviewed as possible options available to the ABNS for incorporation into its MOC structure. The recertification programs of the other boards have varied widely: about half of the boards utilize secure written examinations while others have used self-assessment exams. A few boards have offered oral examinations as an alternative, but few physicians have chosen this option. Approximately half of the boards have required completion of continuing medical education (CME) requirements.

More Than Recertification

In 1999 the ABNS embarked on its own recertification program, awarding time-limited certificates that must be renewed every 10 years, conditional on passing a written examination of neurosurgical knowledge. In contrast, the MOC Program will be much more comprehensive through maintenance and assessments of basic competencies throughout a 10-year cycle. The ABMS has formulated and adopted six essential competencies for the practicing physician: 1) medical knowledge, 2) patient care, 3) interpersonal and communication skills, 4) professionalism, 5) practice-based learning and improvement, and 6) systems-based practice.

Unlike recertification, the MOC Program is an ongoing process in which a diplomate's credentials, licensures, and professional standing are verified, and practice-related knowledge and performance are evaluated. The MOC Program will evaluate each physician on the six general competencies. All physician specialists will be required to develop these competencies during their medical education and residency training, to confirm them as part of initial certification, and to maintain them throughout their professional careers in practice.

The ABMS and the Accreditation Council for Graduate Medical Education have defined the six competencies as follows:

1) Medical Knowledge: To demonstrate knowledge of established and evolving medical, clinical, and social sciences and the application of that knowledge to patient care and education of others.

2) Patient Care: To provide compassionate patient care that is appropriate for the promotion of health, prevention of illness, and treatment of disease.

3) Interpersonal and Communication Skills: To demonstrate interpersonal and communication skills that enable the physician to establish and maintain professional relationships with patients, families, and other members of healthcare teams.

4) Professionalism: To demonstrate behavior that reflects commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and a responsible attitude toward patients, profession, and society.

5) Practice-Based Learning and Improvement: To use scientific evidence and methods to investigate, evaluate and improve patient-care practices.

6) Systems-Based Practice: To demonstrate both an understanding of the context and systems in which healthcare is provided and the ability to apply this knowledge to improve and optimize healthcare.

Diplomates will be required to demonstrate that they have met the competency standards established by the ABMS and adopted by the ABNS. In addition to a secure cognitive examination every 10 years after initial certification, diplomates will be required to maintain their certification by fulfilling each component of the MOC Program and to do so on a continuing basis.

Implementing MOC

The ABNS will plan and implement MOC as a fair and credible process; one that we expect will pass public and professional scrutiny, will properly consider the concerns and responsibilities of our diplomates, and will preserve the high standards of our specialty. A specific requirement for participation in the ABNS MOC Program will be forthcoming for those diplomates certified in the near future and also for those with time-limited certificates issued by the ABNS in 1999 and thereafter. The program will be offered on a voluntary basis to all diplomates of the ABNS certified before 1999. The ABNS

will have responsibility to determine a diplomate's admissibility for MOC and will set the specification requirements and standards of our MOC Program.

MOC will dramatically change the way neurosurgeons are credentialed. MOC adds a new dimension of continually maintaining skills and keeping knowledge current. It means ongoing attention to requirements for maintaining one's good standing within the profession.

Some details of the ABNS program remain to be developed. Like other specialties, the ABNS is free to turn away from the broad requirements of the ABMS for participation in MOC, although to do so would jeopardize its status as an ABMS-member board. Nevertheless, the ABNS is free to implement the principles of MOC in a manner that is most appropriate for neurosurgeons with the provision that they incorporate the basic ABMS structure. This MOC process must meet four requirements:

- Evidence of Professional Standing
- Evidence of Commitment to Lifelong Learning and Periodic Self-Assessment
- Evidence of Cognitive Expertise
- Evidence of Evaluation of Practice Performance

The ABNS has been and is continuing to formulate its requirements and standards within these four components.

Professional Standing With slight modification the ABNS has accepted the ABMS basic requirement for evidence of professional standing as:

- A full and unrestricted license to practice medicine in all jurisdictions in which the diplomate is licensed to practice (letters of concern or reprimand are not considered restrictions).

The ABNS additionally is considering requirements for hospital admitting privileges to practice neurosurgery, recommendations from peers or chief of staff of primary hospitals, and confirmation of these credentials every two years.

The ABNS has not finalized its requirements for the last three MOC components, but is considering the following alternatives:

Lifelong Learning and Self-Assessment For lifelong learning and self-assessment, a diplomate could be required to complete practice-related CME, which would be coordinated with ABNS neurosurgical society and association programs. Exercises and examinations produced by sponsoring societies could be used to satisfy portions of CME as well as self-assessment requirements. Completion of open-book examinations for knowledge assessment and education may contribute to fulfilling these requirements as well as preparation for the periodic secure examinations. Besides general neurosurgery topics, subspecialty modules such as vascular, spine, or pediatrics will likely be offered in such an examination.

Cognitive Expertise In assessment of cognitive expertise, diplo-

Possible Model for Incorporation of Competency Assessment Into the Four Components of MOC

COMPONENTS OF MOC:	PROFESSIONAL STANDING	LIFELONG LEARNING	COGNITIVE EXPERTISE	PRACTICE PERFORMANCE
COMPETENCY: Medical Knowledge		• Open-book exam • Approved CME	• Secure exam	
COMPETENCY: Patient Care	• Hospital privileges?		• Open-book exam • CME	• Case analysis
COMPETENCY: Interpersonal and Communication Skills	• Peer/patient assessment?			
COMPETENCY: Professionalism	• State licensure • Hospital privileges? • Peer assessment?			
COMPETENCY: Practice-Based Learning and Improvement		• Self-directed study • Approved CME		• Case analysis • Key case/outcome analysis to benchmarks
COMPETENCY: Systems-Based Practice		• Performance review	• Pertinent questions on open book and secure exam	• Case analysis

Continued from page 13

mates will be required to pass a secure examination every 10 years. It is intended that this examination will be offered in a module format that matches the diplomate's practice profile as evidenced by practice data or the neurosurgeon's preference. As an example, each examination might consist of 200 questions, 50 of which pertain to basic knowledge common to all examinees, while the remaining 150 questions would be specific to the selected module(s). The exam content will be based on the pool of questions from the self-assessment examinations. We anticipate this computer-based exam will be offered at regional testing centers and open to diplomates starting three years before the 10-year anniversary of the last certification. Diplomates who fail the knowledge-based test may repeat the examination an unlimited number of times. Also, many states no longer recognize recertification in lieu of a state licensing examination unless the examination is performed in a secured setting. Consequently, the cognitive component of the MOC Program will take the place of possible onerous state examination.

Practice Performance ABNS evaluation of practice performance will undoubtedly evolve in the coming years. One proposed method would require the neurosurgeon to submit a surgical case log of select (key) cases specific to the physician's type of practice. In a large database from participating neurosurgeons, certain measures related to these cases could be used to establish benchmarks, providing the individual neurosurgeon with valuable information regarding his or her individual performance and areas for improvement. Alternatively, diplomates could be required to submit practice data using an Internet program.

Whatever methodologies are used in meeting the four required components, the MOC Program must encompass within its cycle evaluation of the six general competencies.

In association with its diplomates and organized neurosurgery, the ABNS is working hard to develop a meaningful process of MOC that conforms to the ABMS guideline. The ABNS acknowledges that adopting the MOC Program and process will significantly change professional requirements and at the outset generate considerable frustration. The ABNS, however, is committed to making this new program accessible, affordable, and professionally enhancing for all of its diplomates, and thereby a more meaningful certification process. ■

Volker K.H. Sonntag, MD, is a director of the ABNS and chair of the MOC Committee. He is the program director of neurosurgery at Barrow Neurological Institute.

Life After Residency

Prepare With "Beyond Residency: The Real World"

A course focusing on the business side of neurosurgery brought a group of residents a little closer to a productive launch of their careers. The second annual AANS "Beyond Residency: The Real World" course was held on Saturday, Oct. 26, 2002, at Rush-Presbyterian-St. Luke's Medical Center in Chicago. Residents from Midwestern and Eastern states were in attendance.

"Given the environmental pressures we encounter daily as practicing neurosurgeons, it is vital that our residents begin practice equipped with basic business acumen," remarked Leonard Cerullo, MD, course chair. "This seminar was a step in the right direction, providing an overview of critical non-clinical issues." Educational topics included:

- basic coding;
- how to evaluate a job and establish a practice;
- practice management;
- medical malpractice issues; and
- academic versus private practice paradigms.

The residents were afforded the opportunity to ask questions of some of the most knowledgeable neurosurgeons regarding these topics. In addition to Dr. Cerullo, faculty included: James Bean, MD; William Couldwell, MD; Mick Perez-Cruet, MD; Catherine Gilmore-Lawless, MBA; Robert Goodkin, MD; Mark Gorney, MD; Samuel Hassenbusch, MD, PhD; Dean Karahalios, MD and Gregory Przybylski, MD. The Doctors Company, Aesculap Inc., and NS Recruitment supported the course along with several exhibitors.

"The course covered many topics that are extremely helpful for neurosurgery residents in selecting a practice or staff position and then starting in that practice," said Dr. Hassenbusch, who chaired the first "Beyond Residency: The Real World" course last year and participated as faculty this year. "The information provided by the panelists and speakers will prove invaluable for neurosurgery residents as they complete their residencies; I know they recognized this fact because many of them said that this was the best course they've ever attended."

Catch the Next Program in October

Plans are already underway for the next "Beyond Residency: The Real World" course, which will be hosted by Donald Becker, MD, at the University of California-Los Angeles on Saturday, Oct. 4, 2003. Information about the 2003 course and photos taken during the 2002 course can be viewed at www.neurosurgery.org/aans meetings/epm/residency.html.

"I would encourage program chairs to consider sending their residents to this course in the future," said Dr. Cerullo.

This is one course that residents will never forget—years from now they will reflect on the importance of this opportunity and the friendships they made that will have lasted throughout their careers. ■

Vanessa Garlisch is education manager in the AANS Education and Practice Management Department.

Especially for Residents

AANS Beyond Residency: The Real World

Oct. 4, 2003 . . . . . .Los Angeles, Calif. (UCLA) . . .(888) 566-AANS

www.neurosurgery.org/aans/meetings/epm/epmcourses.html

Chicago Review Course in Neurological Surgery

Jan. 31–Feb. 9, 2003 . . . . . .Chicago, Ill. . . . . .(773) 296-6666

www.chicagoreviewcourse.com

AANS Neurosurgical Review by Case Management: Oral Board Preparation

May 11-13, 2003 . . . . . .Cincinnati, Ohio . . . . . .(888) 566-AANS

Nov. 9-11, 2003 . . . . . .Houston, Texas . . . . . .(888) 566-AANS

www.neurosurgery.org/aans/meetings/epm/epmcourses.html

71ST AANS ANNUAL MEETING

April 26-May 1, 2003
San Diego, Calif.
(888) 566-AANS

- **Attend courses for free by participating in the AANS Marshal's Program.**
- **Visit the Residents Lounge in the AANS Exhibit Hall.**
- **Attend the Young Neurosurgeons' Luncheon, April 30, 2003 1-2 p.m.**

www.neurosurgery.org/aans/meetings/2003

KATIE O. ORRICO, JD

Medicare Payment Options

Selecting the One That Works Best for You

In mid-December, Medicare carriers are sending a letter to each physician with information about Medicare's payment rates for 2003 and a "Medicare Participating Physician/Supplier Agreement." Physicians will then have 45 days to decide whether or not to sign or continue Medicare participation agreements for 2003. Physicians who wish to maintain their current status need not take any action upon receipt of this information. Physicians who wish to change their status from participating ("PAR") to non-participating ("non-PAR") or vice versa, must take affirmative action during this open enrollment period.

Once made, Medicare participation and non-participation decisions are binding for the entire year, unless the physician relocates to a different geographic location or practice group. The purpose of this article is to provide neurosurgeons with some basic information on the various Medicare participation options so they can evaluate which is the most appropriate for their practices and their patients.

"The AANS does not endorse, encourage or support one particular Medicare option over another. It is up to individual neurosurgeons to make their own decisions about which option best meets the needs of their practices and patients."

—Roberto C. Heros, MD, AANS President

Three Basic Options

Physicians have three basic choices with respect to their Medicare status.

1. **They can sign participation agreements** and agree to accept Medicare's allowed charge as payment in full, accepting "assignment" for all of their Medicare patients.

2. **They can decline to sign participation agreements**, which will allow them to accept assignment on a case-by-case basis; for those claims for which they do not accept assignment, they can bill patients for more than the Medicare allowable ("balance bill"), subject to limits imposed by Medicare and/or state law.

3. **They can opt out of Medicare altogether** and enter into "private contracts" with Medicare beneficiaries.

Participation PAR physicians agree to take assignment on all Medicare claims, which means that they must accept Medicare's approved amount (the 80 percent that Medicare pays *plus* the 20 percent patient co-payment) as payment in full for all covered services. Medicare pays the physician 80 percent directly, and the patient or the patient's secondary insurer (Medigap plans, for example) is still responsible for the 20 percent co-payment, but the physician cannot bill the patient for amounts in excess of the Medicare allowed fee. Having a Medicare participation agreement does not, however, require physicians to accept every Medicare patient who seeks treatment from them. Medicare provides a number of incentives for physicians to participate:

- The Medicare payment amount for PAR physicians is 5 percent higher than the rate for non-PAR physicians;
- Medicare provides directories of PAR physicians to Medicare beneficiaries and senior citizen groups; and
- Medicare carriers provide toll-free claims processing lines to process claims more quickly.

Non-Participation Non-PAR physicians receive only 95 percent of the Medicare approved amount. Non-PAR physicians may decide on a case-by-case basis whether to accept assignment. If the non-PAR physician accepts assignment for a claim, Medicare pays 80 percent of the non-PAR Medicare approved amount directly to the physician and the physician collects the remaining 20 percent from the patient. If the non-PAR physician does not take assignment on a particular claim, he or she may balance bill the patient an additional 15 percent of the non-PAR rate. In this case, however, even though the physician is required to submit the claim to Medicare, the carrier pays the patient directly and the physician must therefore collect his or her entire fee from the patient; thus physicians must "chase the money." Physicians therefore need to evaluate whether the ability to balance bill and collect a higher fee from the patient is

worth the potential extra billing and collection costs. Furthermore, some hospitals and states—including Minnesota, Pennsylvania, Vermont and New York—prohibit or limit balance billing, so physicians must ascertain whether or not these restrictions apply before making a Medicare participation/non-participation decision.

Private Contracting Physicians and their Medicare patients are also permitted to privately contract for healthcare services outside the Medicare system. Provided certain requirements are met, this allows physicians to charge whatever amount they wish for a given service as long as the Medicare beneficiary agrees to the fee arrangement. Medicare will continue to cover hospital and other non-physician services provided incident to the physician service. Physicians may not enter into private contracts for emergency services, but in this instance, physicians may bill Medicare directly and receive the Medicare allowable for these services. Once physicians have opted out of Medicare, they cannot submit claims to Medicare for any of their patients for a two-year period. There are fairly detailed rules and requirements for private contracting, among them:

- The physician must sign and file an affidavit agreeing to forgo receiving any payment from Medicare for items or services provided to any Medicare beneficiary for a two-year period (although the physician has 90 days to revoke the opt-out and return to Medicare).
- The contract must be in writing and must be signed by the beneficiary before any item or service is provided.
- The beneficiary must acknowledge in writing that he or she gives up all Medicare payment for services provided by the opt-out physician.
- The beneficiary must acknowledge that he or she is liable for all of the physician's charges and that Medigap or other supplemental insurance will not pay toward the services.

Additional requirements of private contracts and information on the procedure for opting out are available at www.cms.hhs.gov/manuals/14car/3b3026.asp#r1639_1.

For further information on all of the Medicare program options, neurosurgeons should contact their local Medicare carrier.■

Katie O. Orrico, JD, is director of the AANS/CNS Washington Office.

What Will Each Option Pay Me?

Example: A service for which the Medicare Fee Schedule (MFS) amount is $100

PAYMENT ARRANGEMENT	TOTAL PAYMENT RATE	PAYMENT AMOUNT FROM MEDICARE	PAYMENT AMOUNT FROM PATIENT
PAR physician	100% MFS = $100	$80 (80%) carrier direct to physician	$20 (20%) paid by patient or supplemental insurance (Medigap)
Non-PAR Physician			
• Assigned claim	95% MFS = $95	$76 (80%) carrier direct to physician	$19 (20%) paid by patient or supplemental insurance (Medigap)
• Unassigned claim	115% of Non-PAR MFS = $109.25	$0	$109.25 paid by patient
Private Contract	Negotiated with patient after completing opt-out procedure (except for emergencies, which are paid at MFS amount)	$0 (except for emergencies, which are paid at MFS amount)	Depends on negotiations with patient (except for emergencies, which are paid at MFS amount)

Et tu, Brute?

Injury, Pseudoinjury and Litigation

Professional liability litigation in our specialty continues at a significant rate, yet claims for personal injury and product liability far exceed those for malpractice in our present litigation explosion.

Many physicians blame the medicolegal litigation morass on the proliferation of lawyers in our country during the last 25 years, and in particular on the "ambulance chasers" in search of employment.

My personal experience having reviewed over 1,000 personal injury cases, in addition to several hundred malpractice cases, confirms that much of injury-related disability and prolonged symptoms are exaggerated or feigned when associated with litigation. However, the cause of unscrupulous lawyers would be worthless were it not for physicians whose reports to attorneys support their patients in the presence of exaggerated symptoms.

My case reviews and testimony have been requested primarily by attorneys representing insured or self-insured corporations, as well as by a small number of plaintiffs' attorneys. This experience has enabled me to follow 886 personal injury cases to conclusion during an eight-year period. Of these, 681 (77 percent) were settled; the average settlement was significantly less than plaintiff demands after the degree of injury had been accurately documented. Disposition of the remainder of the cases included a defense verdict in 138 (16 percent), a plaintiff verdict in 26 (three percent), and dismissal in 41 (five percent).

The majority of the cases stemmed from motor vehicle accidents; of these, almost half were rear-end collisions for which liability is seldom challenged, and the major question is the degree of physical injury sustained. Next in frequency were slip-and-fall accidents, followed by other

types of injury and industrial accidents.

I found that authentic and supportable injuries—including closed-head injury, skull and spinal cord fractures, acute and chronic subdural hematoma—accounted for approximately 20 percent of the 886 cases. Many other people were injured—moderate or severe muscular strain, for example—but required minimal or no treatment and achieved full recovery in a short time with no disability. A small number had injury-related herniated discs, with some requiring surgery but most recovering spontaneously. But surgery deemed inappropriate was done on 15 percent of the 886 cases, invariably resulting in Failed Spinal Surgery Syndrome.

Overwhelming numbers of people displayed symptoms that were entirely out of proportion to objective findings. My observation is that a number of these patients, under the guidance of their attorneys, simply magnified their symptoms. Others were obviously in a malingering or conversion group, often with extensive prior similar histories and ongoing disability.

Most physicians understandably are supportive of their patients, yet from my observation some doctors have accepted merely the fact of an injury itself without any clear understanding of how it may have occurred. Worse yet are unprincipled reviews and testimony lacking in medical facts.

While tort reform is one remedy to the proliferation of professional liability litigation, in the meantime neurosurgeons should not underestimate what can be accomplished by objective, science-based case review and testimony, coupled with ethical, professional behavior.

As irrational as it may seem, instead of behaving with rancor toward the judicial system, neurosurgeons would do well to maintain a greater presence in the courtroom. I have even found that educating attorneys and jurors can be personally satisfying!

— Charles A. Fager, MD, Burlington, Mass.

Editorial Note

The award-winning AANS Professional Conduct Program is one way the AANS helps to sustain the public's confidence in neurosurgery. The program and the AANS Code of Ethics, Expert Witness Guidelines, and more, are highlighted in the Spring 2002 issue of the *Bulletin*, available at www.neurosurgery.org/aans/bulletin.

Solo Voce: Let's Get Together and Speak Up, Says Neurosurgeon

I was quite pleased to see that one of our distinguished neurosurgeons was elected to the Board of Trustees of the American Medical Association ("Speaking for Neurosurgery," Fall 2002). For all the years that I have been in practice, which is over 32 years, I have been disappointed with the AMA and its lackadaisical attitude toward the representation of physicians and surgeons.

Next to the AMA, the most negligent group is the American College of Surgeons, which has only recently begun to open its eyes to our problems. If the exorbitant and intolerable liability insurance cost isn't enough, both Medicare and the HMOs cut our reimbursement and tell us how to practice our trade. At least the AANS has been active and has kept abreast of all the problems through our Washington Office. I am hoping that while Dr. Carmel is on the board of the AMA, he can build on the momentum toward stronger political action so that we can take control of our lives.

I would like to commend the doctors in Nevada for their work stoppage that eventually led to the politicians finally getting the message. I have found in our hospital that it is very difficult to call for even a two-day work stoppage because this reimbursement and liability problem does not affect primary care physicians or internists as much as it affects us. So, as chief of staff, whenever I bring up the subject at the executive committee meetings and tell them that we have to take a hard stance on this problem, I do not get a unanimous response. When a 20-member executive committee cannot come together in agreement, then it is unlikely that 400 people will come together. As a result of this divisiveness, we continue to fail.

I am hoping the leadership in our association, the ACS, and the AMA will get together and speak up with a strong voice. Certainly all neurosurgeons are waiting for this kind of voice to come down the pike.

— David A. Yazdan, MD, Brick, N.J.

Editorial Note

Nevada's only level I trauma center closed for 10 days in July because its doctors couldn't afford liability insurance. In August the state passed tort reform legislation that took effect Oct. 1, but some think it didn't go far enough. See Newsline in this issue for more information.

EMTALA: The Straw That Broke the Camel's Back

EMTALA has become a household word in all medical neighborhoods. An outgrowth of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Emergency Medical Treatment and Active Labor Act is a federal law that prohibits the "dumping" of patients based on their inability to pay for medical care. It makes sense that Medicare participating hospitals provide a medical screening examination to any individual, irrespective of their payment status, who comes to the emergency department for a needed assessment of a medical or surgical condition. The impact of this statute for the last decade has increased exponentially with the growth of both its regulatory and judicial arms, often reaching beyond the emergency department setting.

Unfortunately, the burden of this uncompensated care has been placed squarely on the shoulders of physicians and hospitals. This has been particularly problematic for the medical and surgical specialists who have to provide this coverage. The crisis brought on by the implementation of EMTALA should have been predicted considering the conservative estimate of 38 million Americans who are uninsured, many of whom are children. It is not surprising that our emergency rooms across this nation are besieged with patients needing medical assistance with absolutely no means of paying for any aspect of their care.

What makes this even more unfair is the fact that the EMTALA requirements are excessively placed on the physician with no similar funded mandate being directed at the managed care organizations. This adds another layer of complexity, for payment will be denied by such insurance carriers if they determine (after the fact) that a patient did not have an emergency. The physician again has to absorb the financial loss, although he or she has already rendered the service.

There is a loud call for the oversight organizations, including the Office of Inspector General and the Centers for Medicare and Medicaid Services, to address this discrepancy. While it used to be considered a safety net for patients in an emergency setting, EMTALA has become a "dragnet" for physicians. Under this current condition, it is expected that hospitals will continue to lose support of their medical staff. Difficulty in staffing on-call panels will continue, especially in the specialties of neurosurgery, orthopedics, cardiothoracic, pediatrics, and obstetrics and gynecology.

The unfunded mandates of EMTALA have been the straw that has broken the camel's back. Faced with increase in regulatory burdens, a steady decrease in reimbursements, along with a corresponding increase in administrative responsibilities, the physicians are now throwing in the proverbial towel.

Perhaps the easy answer is the only answer; universal health insurance.

— L.D. Britt, MD, MPH, Norfolk, Va.

YOUR VOICE

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International Subarachnoid Aneurysm Trial

Position Statement by the AANS, CNS and AANS/CNS Section on Cerebrovascular Surgery

The International Subarachnoid Aneurysm Trial (ISAT), a prospective, randomized trial comparing surgery (craniotomy for clipping) to endovascular therapy (coiling) in the treatment of *ruptured* intracranial aneurysms, was recently published in *The Lancet*[1]. The study results demonstrate that, for a particular subset of aneurysm patients cared for in designated study centers mostly outside of the United States, patients with ruptured aneurysms treated with coiling fared better at one year than patients with ruptured aneurysms treated by clipping. We congratulate the organizers and participants of the ISAT for their critical thinking and dedicated clinical work. We believe, however, that the ISAT study results have been inaccurately reported in the media and that specific data from the trial have been and will be inappropriately applied and generalized to all patients with intracranial aneurysms. The purpose of this position paper is to identify points that we believe warrant emphasis and clarification. These points are meant to educate fellow neurosurgeons about the ISAT study, its results and the concern many have about the potential misrepresentation of the ISAT results to the public and our patients.

The reported ISAT data demonstrate that patients with ruptured intracranial aneurysms treated with craniotomy for clipping had a 30.6 percent chance of a poor outcome at one-year follow-up. Patients with ruptured aneurysms treated by endovascular coiling had a 23.7 percent chance of a poor outcome at one-year follow-up. Therefore, the absolute risk reduction, at one-year follow-up, when comparing aneurysm coiling to aneurysm clipping was 6.9 percent. Media reports have attributed a 22.6 percent risk reduction to endovascular coiling compared to craniotomy for aneurysm clipping. The figure of 22.6 percent, the overall study relative risk reduction, suggests there was a dramatic reduction in the number of poor outcomes among patients whose aneurysms were treated with coiling as compared to those patients whose aneurysms were surgically clipped. This is not the case. It is the absolute risk reduction that is of greatest importance to patients. Importantly, the absolute risk reduction of 6.9 percent reported by the ISAT authors should not be inappropriately generalized.

"... We believe ... that the ISAT study results have been inaccurately reported in the media and that specific data from the trial have been and will be inappropriately applied ..."

Most centers involved in ISAT were located in Europe (particularly England) Australia and Canada. Only two patients were entered into the study from a single center in the United States. The results from ISAT may not be applicable to patients in the United States where practice patterns, particularly in reference to the degree of sub-specialization of neurovascular surgeons in major centers, are different.

It is essential to know how many practitioners in ISAT performed craniotomies for aneurysm clipping and how many practitioners performed endovascular procedures for aneurysm coiling. If the number of coiling cases per endovascular practitioner is significantly greater than the number of clipping cases per neurosurgical practitioner, the better outcome at one-year follow-up for patients who were treated with aneurysm coiling (6.9 percent absolute risk reduction) could be completely explained by a difference in practitioner experience and expertise. The numbers of craniotomies per neurosurgeon and the number of coiling procedures per endovascular specialist involved in the ISAT study have not been (but should be) published.

Most importantly, physicians and surgeons involved in ISAT felt that one form of treatment was preferred in almost 80 percent of patients considered for study. Of 9,559 patients with ruptured intracranial aneurysms assessed for ISAT eligibility, only 2,143 were randomized. In those 7,416 patients not randomized, more patients underwent craniotomy for aneurysm clipping than endovascular aneurysm coiling. Over the course of the ISAT study, neurovascular teams in the participating centers felt that surgery was the best option for the majority of patients with ruptured aneurysms who were not randomized. Therefore, if an experienced vascular neurosurgeon thinks that craniotomy for aneurysm clipping is the best option for a patient with a ruptured intracranial aneurysm, the patient should continue to be offered surgery as the treatment of choice. The results of ISAT do not apply to this larger group of patients, as they were excluded from the randomized trial. Disappointingly, outcomes and follow-up were not provided for the non-randomized patients.

Neurosurgeons await with interest the long-term follow-up data on the 2,143 ISAT patients. It is crucial to determine whether or not aneurysm coiling will be as effective as craniotomy for aneurysm clip-

ping after subarachnoid hemorrhage in preventing re-bleeding over the lifetime of the patient. During the short follow-up period of the interim report, 2.6 percent of patients whose aneurysms were treated with coiling suffered a hemorrhage after treatment as opposed to 0.9 percent of patients treated with craniotomy for aneurysm clipping. Although re-bleeding more than one year after treatment was low in both ISAT treatment groups, if the early differential rate of hemorrhage were to persist, the 6.9 percent absolute risk reduction attributed to endovascular aneurysm coiling at one year follow-up in the ISAT study would soon disappear. In addition, more than four times more patients treated with aneurysm coiling required additional treatment for their ruptured aneurysm than did patients treated with craniotomy for aneurysm clipping. The 2,143 randomized patients in the ISAT study will need to be followed for many years before legitimate conclusions can be drawn about whether aneurysm clipping or aneurysm coiling is the preferred form of treatment for ruptured intracranial aneurysms in patients suitable for either form of therapy.

We believe that an accurate interpretation of the ISAT study would be:

> In a patient whose ruptured aneurysm is considered suitable for clipping or coiling, and for whom the neurovascular surgeon and the endovascular surgeon do not know, after considering all factors, which treatment option is better, at the centers involved in the ISAT study, aneurysm coiling yielded a 6.9 percent chance of a better functional outcome at one year follow-up compared to similar patients with ruptured aneurysms treated with craniotomy for clipping. Long-term follow-up of these patients will be essential to determine which of these two forms of treatment is safer and more effective for this subgroup of patients over their lifetimes.

The ISAT report is an important step in defining the roles of endovascular and microsurgical treatment of patients with ruptured intracranial aneurysms. The points noted above are raised to remind all of us that much more study is needed to develop definitive medical evidence on this issue. To extrapolate the early results of this study to all patients with intracranial aneurysms (ruptured or not) would be a misinterpretation of the ISAT data and a serious disservice to our patients and our profession.

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Chairman, AANS/CNS Section on Cerebrovascular Surgery

[1] International subarachnoid aneurysm collaborative group. International subarachnoid aneurysm trial (ISAT) of neurosurgical clipping versus endovascular coiling in 2,143 patients with ruptured intracranial aneurysms: a randomized trial. *The Lancet* 360: 1267-1274, 2002.

Answers May Be Found in NATURE

A new study may shed light on questions left unanswered by the International Subarachnoid Aneurysm Trial (ISAT). NATURE—the North American Trial for Unruptured and Ruptured Aneurysms—promises further study of the "clip vs. coil" controversy.

According to L.N. Hopkins, MD, principal investigator, NATURE is a prospective randomized trial that will focus on comparing clipping to coiling of ruptured aneurysms.

"There are several competing trials in development, but NATURE is the one neurosurgeons need to support," said Dr. Hopkins. "The team behind NATURE includes cerebrovascular neurosurgeons, neuroradiologists, neurologists, and others so that a fair and accurate result for our patients can be ensured."

He explained that the executive committee of NATURE was chosen by the executive committee of the AANS/CNS Section on Cerebrovascular Surgery, members of the American Society of Interventional and Therapeutic Neuroradiology (ASITN), and members of the American Academy of Neurology.

"We are working with the leadership of the ASITN to ensure that the concerns of interventional neuroradiology will be equally represented with those of cerebrovascular neurosurgery," Dr. Hopkins stated. "We believe that NATURE is absolutely necessary, and we are committed to leaving no stone unturned in garnering the expertise of all appropriate parties."

The executive committee of NATURE also is working toward the development of a protocol for the study with input from the National Institute of Neurological Disorders and Stroke and plans to submit a proposal to NINDS in the summer of 2003.

"We hope that every neurosurgeon will share our concern and our commitment to successful implementation of NATURE," he said.

Launching NERVES

Neurosurgery Taps a Valuable Resource: Practice Managers

Whether we as neurosurgeons remain economically solvent (let alone thrive) in a foreseeable future of ever increasing regulatory obligations, shrinking reimbursements, and rising medical liability and regulatory compliance overhead costs, is largely a matter of effective practice management. Until recently, efforts to study practice management issues and promote an agenda to improve the economic environment for us all were limited to Herculean volunteer efforts of a few neurosurgeons, among them Byron C. Pevehouse, MD, Ben W. Blackett, MD, John A. Kusske, MD, and Robert E. Florin, MD.

More recently, the Council of State Neurosurgical Societies (CSNS) has led organized neurosurgery in a concerted effort to address the improvement of neurosurgical practice management. These important efforts came to fruition with the Sept. 20, 2002, organizational meeting of the new neurosurgery practice managers' society called NERVES (Neurosurgery Executive's Resource, Value, and Education Society).

The 28 neurosurgery practice managers at the Philadelphia meeting represented a cross section of types of neurosurgery practices, including private practice, academics, small groups, large groups, and multispecialty groups. The only practice type not represented was solo practice. Twenty-eight visionary neurosurgery groups in 17 states—representing approximately 7.2 percent of practicing U.S. neurosurgeons—supported the formation of NERVES by sponsoring the attendance of their practice manager at the organizational meeting.

At the initial NERVES meeting preliminary bylaws were approved, and members of the Interim Executive Committee were elected, including:

- Interim President
  Mark Mason, Nashville, Tenn.
- Interim Vice President
  Cheryl Harris, Arlington, Texas
- Interim Secretary
  Barbara Hurlbert, Jacksonville, Fla.
- Interim Treasurer
  Johanna Hartigan, New Haven, Conn.
- Interim "President Emeritus"
  Robert Rosso, Columbus, Ga.
- Interim Western Regional Director
  Tammy Marr, Omaha, Neb.
- Interim Northeastern Regional Director
  Nicholas Green, Southfield, Mich.
- Interim Southeastern Regional Director
  Mary Cloninger, Charlotte, N.C.

A timeline for further society development and evolution was established, and the first annual meeting of NERVES, along with the new society's first business meeting—at which new officers and the bylaws will be ratified—is scheduled for April 2003 in San Diego. The group's major initiative is to lay the groundwork for the first neurosurgery practice management survey in 2004.

NERVES Matters

The proposed 2004 survey will provide the AANS/CNS Coding and Reimbursement Committee, AANS/CNS Washington Committee, and individual neurosurgeons struggling to manage their own practices with crucial data for making informed decisions and intelligent future plans regarding a host of practice management issues. All need current and accurate practice management data, as well as knowledge of trends over time.

It is important to recognize that while socioeconomic and practice management issues obviously are of concern to every neurosurgeon, they are the actual "bread and butter," day-to-day fare of our own practice managers. Their knowledge of staffing needs, customary salary ranges, overhead costs, productivity ranges, coding details, third party and governmental agency regulatory constraints and processes, and fee and reimbursement rates renders them a critical, and until now, untapped and unorganized resource for neurosurgery.

History of a Historic Venture

The first NERVES meeting was an important and historic event that grew out of a CSNS feasibility study exploring different strategies for investigating reimbursement methodologies. The study, performed between September 2001 and April 2002, revealed that the key to obtaining reliable and relevant practice management data on which individual neurosurgeons, the Coding and Reimbursement Committee, and the Washington Committee could base decisions would be the organization of neurosurgery practice managers into their own society. The new society would provide needed services for its members, but would also serve as a critical practice management research "data mine" for the neurosurgery specialty as a whole.

Two different strategies for addressing the needs identified in the CSNS survey were carefully explored. The first involved strengthening neurosurgery participation in the Medical Group Management Association by encouraging neurosurgeons to enroll their practice managers in the

MGMA's Neuroscience Assembly. It was quickly recognized that this approach would be not meet neurosurgery's objectives, in part because of the low numbers of neurosurgery practice managers involved in the Neuroscience Assembly. Of greater concern was the fact that the MGMA survey provides data specifically for physician compensation, administrator and employee compensation, practice costs, productivity and staffing. No coding, billing, third party billing process, or actual reimbursement data is collected. The MGMA data is generalized because it must apply equally to all types of medical practice, and year-to-year longitudinal trends in data results are not analyzed.

The CSNS decided instead to support a second strategy of establishing a brand new, independent, but closely affiliated neurosurgery practice manager society. The idea was not unprecedented for specialty societies, as exemplified by the American Academy of Orthopaedic Surgeons (BONES Society, Inc.) and the American Academy of Otolaryngology—Head and Neck Surgeons (Association of Otolaryngology Administrators), among others. This approach was undertaken to provide greater flexibility and autonomy for potential members, allow for more concentrated focus on issues of greatest importance to neurosurgery, and encourage stronger and more effective affiliation and cooperation between the new society and the CSNS.

To further the creation of a new society, the Ad Hoc Neurosurgery Practice Manager and Administrator Organization Committee (PMAOC) was established at the April 2002 CSNS meeting in Toronto. The committee was charged with: 1) initiating, guiding, advising and mentoring the establishment of the envisioned new society, 2) supervising the funding of the new organization for three years, or until it becomes financially solvent for routine non-research-related operations based on its own dues and meeting fees, 3) dissolving once the new organization becomes firmly established and self-sustaining.

The PMAOC members—James R. Bean, MD, Samuel Hassenbusch, MD, Cheryl Muszynski, MD, John A. Wilson Jr., MD, and co-chairs Mark E. Linskey, MD, and Gregory J. Przybylski, MD—together with committee consultants representing the AANS Education and Practice Management Department, the AANS/CNS Washington Office, Karen-Zupko and Associates, and NeuroSource, Inc., identified a nucleus of motivated and enthusiastic neurosurgery practice managers to serve as an initial "critical mass" for the society's organizational efforts.

New Beginnings

Now that NERVES has launched, neurosurgeons are asked to consider the new society's importance to neurosurgery as a whole as well as the potential benefit to their own practices. That 28 people from 28 neurosurgical groups in 17 states participated in the initial meeting is very encouraging. Now focus turns to the states which are not yet represented, including populous states such as California, Massachusetts, New Jersey, and Ohio and large urban centers such as New York City, Chicago, Los Angeles, the San Francisco Bay area, Boston, Baltimore, Cleveland, Philadelphia, Pittsburgh, St. Louis, and Washington, D.C.

The active support of all U.S. neurosurgeons will be absolutely critical to the success of NERVES. Support can take the form of encouraging your practice manager to join the new society, agreeing to pay their membership dues and/or meeting travel and fees as a practice expense, or even just granting them the time away from the practice for organization-related activities.

We are asking you to actively support and encourage membership and participation of your own practice managers and administrators in the new organization. Ultimately, we need to see every neurosurgery practice in the United States represented in NERVES. ■

Mark E. Linskey, MD, University of Arkansas–Little Rock, and **Gregory J. Przybylski, MD,** JFK Medical Center Neuroscience Institute in New Jersey, are co-chairs of the CSNS Ad Hoc Neurosurgery Practice Manager and Administrator Organization Committee.

BENEFITS OF NERVES MEMBERSHIP

- Continuing education specifically tailored to a neurosurgical practice
- A mechanism for service and professional recognition for neurosurgery practice managers
- An up-to-date and accurate directory of contact information for professional colleagues across the country
- Annual meetings designed to provide collegial social interaction and networking and benchmarking opportunities, as well as updates on specialty-specific coding and reimbursement issues and regulatory changes, the latest advances in business management strategies and tools, and the latest data regarding current management practices, structures and models
- Networking infrastructure facilitates immediate advice on specific practice management issues
- Newsletters designed to present practical solutions to common business problems and alerts regarding changes in relevant coding and reimbursement rules as well as regulatory policies
- Web sites designed for access to useful information as well as immediate answers to member questions and concerns
- Accurate, relevant and current practice data, updated annually via society research through member surveys, for use in benchmarking and making data-based business decisions

For information on how to add your name and your practice to the list of NERVES supporters at www.neurosurgery.org/csns, contact Mark Mason, interim president of NERVES, Neurological Surgeons PC, 2410 Patterson St., Suite 500, Nashville, TN 37203, (615) 515-1190 or mmason@neurosurge.com.

Get Your Office Software Out of First Gear

Effective Employee Education Is the Key

A 17-doctor ob-gyn group in Florida discovered two keystrokes in its practice management software that helped boost revenue by $600,000 a year.

The group had struggled to collect from patients in the office. Staffers knew only one way to determine what somebody owed—looking up balances from past visits and services recorded in their program from IDX Systems, and adding them on a calculator. The process took so long that on hectic days, staffers gave up and let patients leave without paying, said Vic Arnold, a professional services manager for IDX. IDX representatives showed the group how to produce a grand-total patient balance on the computer screen by hitting "F4" on the keyboard while pressing "Alt." Suddenly, collecting from patients became immensely easier.

Arnold's story illustrates a common scenario: Physicians pay thousands of dollars for practice management software, but staffers don't use the most basic features. It's like buying a $225,000 Ferrari and driving it only in first gear.

Why the ignorance about software capability? Usually it's because cost-conscious physicians don't spend enough on training. Even when initial training is picture-perfect, doctors blow it when it comes to teaching new hires about the software or getting the staff educated about upgrades.

Short-term thinking also contributes to undercomputing. Employees caught in the daily grind don't take the time to master software functions beyond scheduling patients, entering charges, and posting payments.

In an era of shrinking reimbursements, you can't afford to waste the firepower of your practice management software. The following advice from consultants and vendors—focusing on features that are standard on virtually all products—will help you get your money's worth from the technology.

Are You Missing Out on These Functions?

Some programs come with a default template that consists of 15-minute visits, but you can create templates that better suit your workflow. Jennifer Bever, a consultant with KarenZupko & Associates in Chicago, recalled how a Georgia surgical group made more work for itself by not learning how to customize its scheduling template. Staffers made appointments with their computer but scheduled surgeries on paper.

"They didn't want to fill in eight 15-minute slots on the computer screen for a two-hour surgery," said Bever. As a result, staffers had to share a single scheduling book, which wasn't always at their fingertips. And they couldn't automatically monitor whether a bill went out after a hand-scheduled surgery.

Electronic claims submission dramatically speeds up payments, but consultants say that many doctors use this only for one or two big payers, such as Medicare. Of course, not all payers accept e-claims yet, but whenever one begins to offer that option, physicians are slow to switch over, said Belleville, Ill., consultant Jerri Weith. Sometimes that happens because staffers don't update payer profiles in their systems to indicate that they accept electronic claims. Without an updated payer profile, the system will continue to print paper bills, said Weith. She advises doctors to review these profiles every six months to keep them current.

A similar story plays out with line-item payment posting, a function that breaks down a lump-sum payment into dollar amounts for individual CPT codes on a claim. To use this function in IDX software, you must activate it for each payer with a few keystrokes, said Peter Butler, a consultant with Hayes Management Consulting in Redmond, Wash. "Many practices don't take the time to turn it on."

Is the payment you post the amount you expected to receive? The best software programs can tell if you're being shorted. They'll compare the dollar amounts listed on the explanation-of-benefits form to the fees that the insurer agreed to fork over for the CPT codes. The trick is, you first have to enter these fee schedules into your computer, said Butler. "I hear office managers say they're too busy to load the fee schedules," he said. "So they don't catch a lot of underpayments."

Without Reports, You Can't Manage

Insurers that take three or four months to pay claims will dry up your cash flow. The typical practice management program can identify these laggards so you can take remedial action. One basic tool is a report that "ages" accounts receivable in incre-

ments of 0 to 30 days, 31 to 60 days, and so on. That's not enough detail, though. You need a report showing aged A/R receivable by payer. Slowpokes will stand out like the sore thumbs they are.

The ability to slice and dice data is one reason they call it practice management software. The popular Medical Manager program can spit out more than 150 standard reports in addition to custom jobs. All this information can overwhelm a staff and induce paralysis, said Bever. "We help clients sort through the stack and choose 10 reports that they need to show their doctors each month."

Off-Site Training May Be the Best Bet

Wasted software capabilities usually point to subpar training. Sometimes it's the vendor's fault. "Trainers may not give practical examples of why a practice needs a particular report," said Weith. By all accounts, though, the blame for software illiteracy falls mostly on doctors.

Vendors commonly prescribe five days or so of training at about $1,250 a day when they install their product. Doctors often negotiate to shave off a day or two, arguing that they're smart enough to teach themselves and their staff, said Jerry Schulz, director of sales and marketing at NextGen Healthcare Information Systems. "I tell them they're buying more than a billing machine."

Tammy Swanson of Misys said her company once scaled back training for bargain-seeking doctors, but now resists these requests. "We realized that we did clients a disservice when we reduced training. They'd get frustrated and say the system didn't work."

Doctors also shoot themselves in the foot by holding computer classes during office hours. "Employees become distracted because they still have to deal with patients," said Curtis Mayse, a St. Louis consultant with LarsonAllen Health Care Group. He advocates training office staff on weeknights or weekends—and paying them for their time.

New employees need to go to software school, too. The in-house approach—letting old-timers teach rookies—makes sense, consultants say, only if the software vendor has trained a key employee, like the office manager, to teach others. Even then, you should limit in-house training to lower-level employees and cover only rudimentary tasks such as scheduling appointments, said Bever.

Vendor training is a must when you hire a new office manager or billing department chief, said Bever. She recalled one ear, nose and throat group that did it right. The group sent a new office manager out of town for two days of vendor training before he reported for work. And the practice made sure his first two weeks overlapped the last two of the outgoing office manager, who showed her replacement more about the system.

Software upgrades also require physicians to invest in ongoing staff training. The pace of upgrades will quicken as the Health Insurance Portability and Accountability Act standardizes how healthcare information is transmitted electronically, making such transactions more commonplace, predicted Bever.

Continuing education from vendors isn't cheap. Misys and IDX charge $1,250 a day—plus expenses—to send a trainer to your office. NextGen gets $1,520 a day. Training at a vendor site may shrink your bill considerably. A day of classes at NextGen's facilities in Atlanta, Philadelphia, and Newport, Calif., costs $760.

You also can trim costs by dispatching employees to national and regional meetings sponsored by software vendors. To accommodate doctors who don't want their staff to travel, more and more vendors are offering Internet-based training.

Learn From—and Lean on—Your Vendor

If you believe that your staff isn't taking full advantage of your practice management software, contact your vendor. Software companies have internal consultants who can assess how well you're using their products. These analysts can be just as pricey as on-site trainers, but if you let them know that you're unhappy with the software, the vendor may not charge for a visit, said Rosemarie Nelson, a computer consultant in Syracuse, N.Y. "They'd rather help you than lose a customer."

While vendors can help you find the treasures of your computer system, sometimes you have to hound them to do so. "I've seen medical offices give up on their software because they got poor response from the vendor when they asked for help," said Terri Fischer, another Larson-Allen consultant in St. Louis. "Sometimes the company will blow them off by saying, 'You're the only practice I know that has this problem.' "

No matter why your software doesn't perform as advertised, don't let up on the vendor, emphasized Fischer. "It takes perseverance to get them to make the system work."■

"Software upgrades also require physicians to invest in ongoing staff training. The pace of upgrades will quicken as the Health Insurance Portability and Accountability Act standardizes how healthcare information is transmitted..."

Robert Lowes is staff editor of *Medical Economics*.

Advocacy May End the PLI Crisis

Enacting Legislation at the State and Federal Level Is the Goal

It is no secret to neurosurgeons that we are once again facing a professional liability insurance crisis. Whether it is obstetricians no longer delivering babies or neurosurgeons no longer providing trauma care, the effects of the PLI crisis are being felt across the country. This time around, however, advocates working to end the crisis have created a heightened awareness on the part of the media, public and policymakers with regard to the detrimental effects is the crisis is having on patients' access to care.

The AANS and CNS have developed a comprehensive strategy for tackling this critical issue, and a campaign to enact legislation that will combat this crisis is well underway. To this end, the Washington Committee has established the special Professional Liability Task Force, chaired by Stewart B. Dunsker, MD, a past president of the AANS. Through this mechanism, neurosurgery will attempt to influence the debate at both the state and federal levels.

States Lead the Way

As is often the case, individual states, rather than the federal government, are better equipped to act quickly to address healthcare issues. This year several states enacted medical liability reforms in an attempt to avert a meltdown in their healthcare systems. Whether or not the courts will uphold these new laws remains to be seen, but passage of the reforms demonstrates the ability of physicians to raise public awareness and get legislative action.

Three states, in particular, merit highlighting: Pennsylvania, Nevada and Mississippi. The key provisions of the new laws in each follow.

Pennsylvania

- Allows malpractice damages to be paid over time
- Sets higher expert witness standards
- Creates a patient safety authority
- Phases out a jury award pool into which doctors must pay
- Establishes a seven-year statute of limitations in most cases
- Requires plaintiffs to file in the county where the alleged malpractice occurred

Nevada

- Sets a $350,000 cap on non-economic damages in most cases and a $50,000 limit on damages for hospitals and physicians treating trauma patients
- Implements expert witness standards
- Holds doctors financially liable only for the damages for which they are responsible
- Allows judgments to be paid over time

Mississippi

- Caps non-economic damages at $500,000 until 2011. The cap then goes to $750,000 until 2017 and $1 million after that.
- Holds physicians responsible only for their portion of the non-economic damages
- Requires lawsuits to be filed in the county where the alleged malpractice occurred and ensures that lawyers notify physicians at least 60 days before a lawsuit is filed

Obviously, none of these laws identically mirrors California's MICRA (Medical Injury Compensation Reform Act of 1975)—the ultimate legislative prize—but they are nevertheless steps in the right direction. In fact, that Mississippi (described by some as "tort hell") passed any caps on non-economic damages at all is a significant victory for physicians. More work remains, however, and extensive state-based activity is anticipated in 2003 as numerous state medical societies are gearing up to pursue reforms. Neurosurgeons need to keep abreast of these developments and work with their state societies to help advance reform legislation.

Neurosurgeons Are Needed to Help the Cause

The AANS and CNS cannot be successful in achieving effective medical liability reforms without the help of neurosurgeons around the country. We need to develop:

- a list of neurosurgeon spokespersons on this topic;
- information about how this crisis is impacting neurosurgeons and their patients; and
- a grassroots network of neurosurgeons ready, willing and able to contact their state and federal legislators in support of reform.

Neurosurgeons must become part of the solution. If you are willing to participate in our medical liability reform campaign, contact Katie Orrico in our Washington Office at korrico@neurosurgery.org or (202) 628-2072.

U.S. House Comes Through, but Senate Stumbles

For the fifth time in recent years, the U.S. House of Representatives passed a comprehensive medical liability reform bill known as the HEALTH Act (Help Efficient, Accessible, Low Cost, Timely Health Care). Unfortunately, as has been the case in the past, the bill died in the Senate. Despite the failure of the Congress to send a bill to the president, however, significant strides were made in demonstrating the need for reform. The key provisions of the HEALTH Act as passed by the House, follow.

- Healthcare lawsuits can be filed no later than three years after the date of injury (with an exception for minors injured before age 6).
- Damages are allocated in proportion to each party's degree of fault.
- Non-economic damages are capped at $250,000, unless a state has enacted a different limit in which case the state cap remains in effect.
- Punitive damages are capped at the greater of two times the amount of economic damages or $250,000.
- Periodic payment of future medical expenses, rather than payment in one lump sum, is allowed.

The HEALTH Act passed by a vote of 217 to 203, with 203 Republicans and 14 Democrats voting in favor of the measure. Fifteen Republicans, 187 Democrats and one Independent voted against the bill, and four Republicans and eight Democrats did not vote. To see how your representative voted, go to: http://clerkweb.house.gov/cgi-bin/vote.exe?year=2002&rollnumber=421. Neurosurgeons are encouraged to write thank-you letters urging the legislators who supported the bill to vote the same in 2003, when the bill is reconsidered.

Medical Liability Reform Tops GOP Healthcare Agenda

Immediately after the Congressional elections Nov. 5, Republicans, who now control the House, Senate and the White House, announced that medical liability reform will be one of the GOP's top healthcare priorities during the 108th Congress. When the House reconvenes in January, it is expected to quickly reintroduce the HEALTH Act.

Quick passage will allow us to turn our attention to the Senate, where there is a lot of work to be done. Even though the GOP now controls the Senate and will put the issue on the front burner, the margin of control is slim, and the 60 votes necessary to end debate and pass the bill are lacking at present. However, given the worsening crisis and the changed political landscape, a new federal medical liability reform law could find its way to the president's desk before too long. ■

Katie O. Orrico, JD, is director of the AANS/CNS Washington Office.

NEUROSURGEONS HOLD PRESS CONFERENCE, CALL FOR MEDICAL LIABILITY REFORM LEGISLATION

In September in Philadelphia, the AANS and CNS convened a press conference to highlight the impact that the medical liability crisis is having on patient access to neurosurgical services. James R. Bean, MD, David F. Jimenez, MD, Stephen M. Papadopoulos, MD, and Gregory Przybylski, MD, spoke on behalf of the AANS and CNS. Brian Homes, MD, representing the Pennsylvania Medical Society, and Peter W. Carmel, MD, representing the American Medical Association, also participated in the event.

Dr. Jimenez called for federal legislation to address this national crisis and noted organized neurosurgery's support of HR 4600, the Help Efficient, Accessible, Low cost, Timely Health Care (HEALTH) Act of 2002. "The HEALTH Act is modeled after California's Medical Injury Compensation Reform Act, which, after nearly three decades, has brought stability to the professional liability insurance market, while at the same time fully compensating injured patients for their legitimate injuries," he said. "In a similar manner, passage of the HEALTH Act will ensure that patients and doctors nationwide will reap the benefits of this rational approach to solving the liability crisis."

Dr. Papadopoulos unveiled the results of the national professional liability insurance survey conducted by the Council of State Neurosurgical Societies. "The impact that this crisis is having on patients cannot be overstated," he said. "Many neurosurgeons are no longer performing high-risk neurosurgical procedures in an attempt to lower their professional liability insurance costs and minimize their risk of suit. Based on this survey data, it seems that brain surgeons are no longer performing brain surgery."

For a copy of the survey report, "Neurosurgery in a State of Crisis: Report on the State of Professional Liability Insurance Rates and the Impact on Neurosurgeons and their Patients," go to www.neurosurgery.org/csns/csns surveyreport092502.pdf.

Be It Resolved

Neurosurgeons Unite, Tackling Challenges to Their Livelihood

The most recent meeting of the Council of State Neurosurgical Societies in Philadelphia Sept. 20-21 provided an excellent opportunity for neurosurgeons to delve into a variety of issues affecting our specialty. Salient topics included the status of the professional liability insurance crisis, issues in coding and reimbursement, particularly recent changes to the evaluation and management guidelines, and declining Medicare reimbursement.

The results of the 2002 CSNS professional liability insurance survey bear witness that the concerns related anecdotally by neurosurgeons across the country are founded on fact. As reported at the September meeting, the 2002 survey data indicate that fully 50 percent of respondents experienced at least a 20 percent increase in premiums between 2000 and 2002; 25 percent experienced at least a 64 percent increase; and 10 percent, a 141 percent increase. The median percent of increase for neurosurgeons' premiums was 34 percent for the same two-year period.

Liability Premiums May Affect Patients' Access to Care

Of even greater concern is how the challenge of neurosurgeons' rising premiums may affect patients' access to care. Of all neurosurgeons responding to the survey, 14 percent said they were planning to or are considering moving, while one quarter said they were planning to or are considering retiring. One third said they already are, or are considering restricting their practices. This information documenting neurosurgery's professional liability insurance crisis already is forming the basis of organized neurosurgery's plan for resolution of the crisis. The complete summary of survey results, together with liability "hot spots" and "success stories" can be found at www.neurosurgery.org/csns.

Reimbursement issues continue at the forefront of the CSNS agenda. Troy Tippett, MD, who served on the American Medical Association's evaluation and management workgroup, reported on changes to E&M documentation guidelines recommended by the workgroup, including replacing the "bullet" system with a "clinical vignette" system by 2004.

Declining Medicare reimbursement and organized neurosurgery's response combating the downward trend have been a focus of the AANS/CNS Washington Committee's recent efforts, as James R. Bean, MD, the committee's chair, reported. He noted that joining with the Coalition for Fair Medicare Payments has strengthened the committee's advocacy efforts with respect to this timely topic.

Second NLDC Deemed a Success

Neurosurgery's advocacy efforts were enhanced by the second Neurosurgical Leadership Development Conference held in July. The successful conference readied neurosurgeons to tackle the socioeconomic issues that affect their livelihoods every day by teaching them how to effect change in both the state and federal legis-

RESOLUTION VII SPARKS DEBATE: AANS STANDS FOR UNIFICATION

When the CSNS Executive Committee submitted Resolution VII, which called for the American Association of Neurological Surgeons and the Congress of Neurological Surgeons to create "a 501(c)(6) neurosurgical organization," that "allows for no limitation in the amount of lobbying activity, may operate a PAC as a 'special segregated fund,' creates no limitation on socioeconomic business promotion activities while still maintaining an educational and research mission," it didn't go far enough, according to the AANS Caucus.

The AANS Caucus submitted a substitute resolution that proposed creation of the 501(c)(6) organization "as an integral part of a true merger of the two organizations to meet the critical needs of our profession." Representing the past, present and future leadership of the AANS, Immediate Past President Stan Pelofsky, MD, President Roberto C. Heros, MD, and President-Elect A. John Popp, MD, urged passage of the substitute resolution.

With 38 delegates indicating support, Substitute Resolution VII passed.

"When AANS President Stan Pelofsky signed the Proposal for Unification Discussions Between the AANS and CNS in September 2001, he pledged that the AANS would act in the best interest of neurosurgery," remarked Dr. Heros. "Since that time, further consideration of an AANS/CNS merger has lent credence to the wisdom of complete unification."

He cited the November 2000 CSNS survey to which two-thirds of grassroots neurosurgeons reported their support of complete merger of the AANS and CNS. "Altogether, the evidence supports unification," he stated. "The AANS stands unwavering in its support of a true merger that will consolidate neurosurgery's resources and increase our impact in the national arena."

latures. Updates on critical issues—the Emergency Treatment and Labor Act (EMTALA), the Health Insurance Portability and Accountability Act (HIPAA), declining Medicare reimbursement and more—were followed by advocacy training, a media workshop, and a visit to Capitol Hill. The next NLDC is scheduled for July 2004.

CSNS Launches NERVES

As the complexity of the various issues involved in successful practice management has increased, harnessing the expertise of neurosurgical practice managers has become an essential ingredient in maintaining a thriving practice. Recognizing this reality, the CSNS voted to provide initial support of NERVES, Neurosurgery Executive's Resource, Value, and Education Society, a new society of neurosurgical practice managers championed by Mark Linskey, MD, and Gregory Przybylski, MD. At the organization's inaugural meeting held in September, officers were elected and bylaws established, while planning for the first annual meeting in April 2003 was initiated. All neurosurgeons are encouraged to actively support this group by sponsoring their practice managers' attendance at the upcoming April meeting. (See related story, "Launching NERVES," in this issue.)

During the Plenary Session on Sept. 21, unification of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons remained a hot topic, with two of the eight resolutions directly addressing that issue. Physician workforce concerns, including resident work hour regulations, were covered by three separate proposed resolutions that were combined into one in Substitute Resolution II. The final resolutions follow. The original proposed resolutions and other information relating to the meeting can be found at www.neurosurgery.org/csns.■

David F. Jimenez, MD, is chair of the Council of State Neurosurgical Societies.

FINAL RESOLUTIONS

Resolution I: CMS and Medicare Attitudinal Survey

Adopted Substitute Resolution I

Be it resolved, that the attached survey, or future modifications thereof, be approved by the general CSNS body for use in periodic attitudinal surveying of the CSNS Membership, and

This survey be administered during CSNS registration by the CSNS Meeting Coordinator as part of the registration process at each subsequent CSNS meeting beginning in 2003, or by other means deemed appropriate by the committee with the completed forms turned over to the Medical Practices Committee for formal collection, analysis and generation of a survey report for timely transmission to the Washington Committee, and

The biannual survey reports be safely and faithfully kept in a database or spreadsheet by the Chairman of the Medical Practices Committee for ongoing use in longitudinal result trends analysis.

Resolution II: Neurosurgery Resident Work Hour Regulations

Adopted Substitute Resolution II

Be it resolved, that the Young Physicians Committee of the CSNS be directed to determine a master plan to obtain useful data, potentially with the aid of the Senior Society, that could result in amelioration of the potential neurosurgery problem with resident work hour restrictions.

Be it further resolved, that the gathered data from such master plan be reported back at the next CSNS meeting and to the Washington Committee and that a budget of $3,000 be provided from the CSNS State Society Voluntary Contribution plan.

Resolution III: Restricted Physician Workforce

Adopted Substitute Resolution II

Resolution IV: Pay Shortfall for Neurosurgeons in the United States Military

Adopted Substitute Resolution IV

Be it resolved, that the CSNS petition the AANS/CNS through the Washington Committee, with input from the Military Neurosurgeons Committee, to send a letter to the Surgeon General of the Military Services supporting the increase in compensation to active duty neurosurgeons to make it feasible for long-term retention of qualified neurosurgeons.

Resolution V: Reserve Medical Officer Civilian Practice Insurance

Adopted Amended Substitute Resolution V

Be it resolved, that organized neurosurgery work through its representation to broad national organizations such as the American Medical Association to decrease the disincentive to participate in reserve duty in the Armed Forces.

Resolution VI: Neurological Surgery Resident Hour Survey

Adopted Substitute Resolution II

Resolution VII: Creation of a New 501(c)(6) Tax Exempt Organization For Neurosurgery

Adopted Substitute Resolution VII

Be it resolved, that the AANS and CNS create a 501(c)(6) organization for all of neurosurgery, not only to support the Washington Committee and the Neurosurgical PAC, but also as an integral part of a true merger of the two organizations to meet the critical needs of our profession.

Resolution VIII Merger of AANS and CNS

Not Adopted

Be it resolved, that the leadership of the AANS and CNS be asked to form a committee which will act directly or through the CSNS to contact the leadership of the ACP/ASIM for the purpose of our benefiting from their experiences.

Global Perspectives

Annual Meeting's Special Lectures Offer Excellence, Experience, Wisdom

With the 71st Annual Meeting on the horizon, renowned speakers from around the world prepare to deliver special lectures during "Cultural Connections: Bringing Global Perspective to Neurosurgery," to be held April 26-May 1, 2003, in San Diego. This year, in addition to the Cushing Oration, delivered by Henry A. Kissinger, PhD, five lectures highlight the comprehensive scientific program of 42 practical clinics, 76 breakfast seminars 121 oral papers, and more than 550 posters. "We canvassed the globe to find the right mix of excellence, experience and wisdom," said AANS President Roberto C. Heros. "We are honored to welcome these exceptional individuals to our meeting and look forward to hearing the unique perspective of each."

Richard C. Schneider Lecture—Monday, April 28

Madjid Samii, MD, PhD, a neurosurgeon from Hanover, Germany, is currently president of the International Neuroscience Institute , and honorary president of the World Federation of Neurosurgical Societies. His fields of research and academic interest include surgery of peripheral nerves, cranial nerves, vertebral column, skull base pathology and syringomelia. Dr. Samii received his medical degree from the Medical School University of Mainz, Germany, in 1963, and completed his residency in 1970 at the Neurosurgical Department of the University of Mainz, Germany, where he served as associate professor, professor and vice director and chairman of the Neurosurgical Department.

First Annual Van Wagenen Lecture—Thursday, May 1

Neal F. Kassell, MD, is the distinguished professor and co-chairman of the Department of Neurosurgery at the University of Virginia. Dr. Kassell specializes in patients with cerebrovascular disease, and his research focuses on intracranial aneurysms, as well as information technology. In addition to U.Va. neurosurgery residents, he has trained more than 50 research fellows from 11 countries. He is a member of numerous medical societies in the United States and abroad and has been a recipient of the McKenzie Memorial Award of the Canadian Neurosurgical Society.

Take Note! Special sessions for neuroscience nurses and physician assistants are being offered this year. Nursing contact hours for two practical clinics and four breakfast seminars for nurses will be awarded.

Registration and housing for the Annual Meeting will be available in January 2003. The advance registration deadline is March 28, 2003. For up-to-date meeting information go to www.aans.org.

Hunt-Wilson Lecture—Tuesday, April 29

Fred H. Gage, PhD, is a professor in the Salk Institute's Laboratory of Genetics. He currently is studying the cellular, molecular, and environmental influences that regulate neurogenesis in the adult brain and spinal cord in the belief that, by understanding the basic mechanisms that control and regulate adult neuronal adaptability, rational approaches to repair may be possible. Dr. Gage, who received his PhD in 1976 from Johns Hopkins University, has been with the Salk Institute since 1995. He has been the recipient of numerous awards, among them the 1993 Charles A. Dana Award for Pioneering Achievements in Health and Education, the Christopher Reeve Research Medal in 1997, and the 1999 Max Planck Research Prize.

Rhoton Family Lecture—Wednesday, April 30

James A. Johnson, MD, is rear admiral of the Medical Corps, United States Navy, and commander, Naval Medical Center San Diego/Lead Agent, TRICARE Region Nine. He earned his medical degree at the University of Rochester in New York and served both his internship and residency at the University of California at Los Angeles. Before assuming command of the Naval Medical Center San Diego—the largest, most technologically advanced medical center in the military—Rear Admiral Johnson served in critical positions at a variety of afloat and ashore commands. He is the recipient of numerous military decorations recognizing his meritorious service.

First Annual Kurze Lecture—Wednesday, April 30

M. Gazi Yasargil, MD, considered one of neurosurgery's pioneers, is professor of neurosurgery, College of Medicine, at the University of Arkansas for Medical Sciences, and professor and chairman emeritus, Department of Neurosurgery at University Hospital in Zurich, Switzerland. Dr. Yasargil was involved with the development of cerebral angiography and he introduced stereotactic surgery and high-frequency coagulation technique in Switzerland. He developed the counter-balanced operating microscope and numerous microsurgical instruments, and pioneered microsurgical approaches and treatments. The six-volume publication *Microneurosurgery* (1984-1996) is the comprehensive review of his broad experiences. Dr. Yasargil has received major awards and prizes, among them the highly regarded Marcel Benoit Prize from the Swiss Federal Government in 1975 and the "Man of the Century 1950-1999" honor by *Neurosurgery*. ■

E Pluribus Unum

72nd AANS President Urges One Voice for Neurosurgery

By Manda J. Seaver

One of the first duties of a newly elected AANS president is setting the tone for the coming year and for the Annual Meeting that will serve as the presidency's capstone. Roberto C. Heros, MD, chose "Cultural Connections: Bringing Global Perspective to Neurosurgery" as the 71st Annual Meeting theme, drawing upon his Latin American roots, as well as his abiding interest in advancing neurosurgery throughout the world and particularly in developing countries.

Born and raised in Cuba, Dr. Heros remembers wanting to be a neurosurgeon from the age of nine, inspired by an uncle who was a neurosurgeon. His ambition seemed to come to an end when Fidel Castro came to power. "I was involved in the Bay of Pigs as a paratrooper platoon commander," he said. "Afterward, the two years I spent in prison gave me a lot to think about; I was locked up, falling behind in my studies, but fortunately I was able to read a fair amount about history and work on my English."

He came to the United States as part of President Kennedy's exchange of prisoners for food and medicine. "At that point, my dream seemed unrealistic," Dr. Heros said. "Not having gone to college, what were my chances of becoming first a doctor, then a neurosurgeon?"

Resourceful and Hardworking

Not ready to abandon his childhood dream, Dr. Heros continued on an unconventional route to becoming a neurosurgeon. "I needed a job, and just then a lot of Cubans needed insurance," he remembered. So… "I called an insurance company and said I was an insurance salesman." He sold insurance for a year, saving enough to attend college for one year and a half and meet his premed course requirements. He then entered medical school at the University of Tennessee, graduating first in his class in 1968. He served his surgical internship and neurosurgical residency at Massachusetts General Hospital/Harvard Medical School.

Reflecting on his 34-year career, Dr. Heros remarked, "I have loved every minute of it, including my internship and residency." He added with a laugh, "Maybe it's selective memory."

He cited the intellectual challenges and the opportunities to help patients and teach residents as the high points of the profession. "It is a privilege to be a neurosurgeon," he said. "And there is nothing better than to take care of a patient and be able to tell the family that there will be a full recovery."

Along the way to becoming "one of the top five vascular surgeons in the county," in the words of William Brody, the Academic Health Center provost at the University of Minnesota where

Dr. Heros once served as the chair of neurosurgery, he authored or co-authored more than 200 scientific journal articles and book chapters, as well as four textbooks on topics including intracranial aneurysms, carotid endarterectomy, cerebral arteriovenous malformations, and skull base and brainstem tumors.

He has been a visiting professor at nearly 40 universities in the United States and abroad, and he is a member of numerous professional societies, among them the World Federation of Neurosurgical Societies, for which he is founding chair of the Neurovascular Committee, and the Academy of Neurological Surgeons, of which he is past president. Dr. Heros also holds honorary memberships in a number of neurosurgical societies abroad, particularly in Latin America.

Committed to Neurosurgery at Home and Abroad

One of the aspects that attracted him to the University of Miami, where he currently serves as professor and co-chair of neurosurgery, was the opportunity to create the International Health Center there, which facilitates bringing patients to the United States for treatment and providing educational opportunities for physicians from abroad. Dr. Heros estimates that 20 percent of his patients come from Latin America.

His commitment to international patients and the neurosurgeons who treat them doesn't end there. "Every day one or two of my Latin American colleagues e-mails MRIs or angiograms to me," he said. "It feels good to be able to share immediate advice with them."

Currently practicing in Miami, an area where doctors are known to pay some of the highest rates in the United States for professional liability insurance, Dr. Heros has felt the heat of the crisis. "This issue is just one of many that would benefit from the unification of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons," he said. "Unification is logical, and the time is right for a truly equal merger that will foster neurosurgery's objective of speaking with one voice."

A former vice president of the CNS, Dr. Heros said, "I loved my time with the Congress; it was my initial experience with organized neurosurgery. Whatever unification looks like, one thing that must be preserved is access to leadership for young neurosurgeons." He concluded, "It is the responsibility of each of us to give back to the profession in valid ways, whether at the local, state, or national level." ■

NEWS.ORG

AANS/CNS Sections Committees Associations Societies

Resident Research Award in CV Disease The AANS/CNS Section on Cerebrovascular Surgery is offering up to $15,000 to residents in North American training programs in support of research related to cerebrovascular disease. Funding is available July 1, 2003. The application, available at www.neurosurgery.org/cv/residentaward.html, is due March 1.

New AANS Panel Aids State Boards, the Public When a complaint of a medical nature is levied against a neurosurgeon, who is available and qualified to evaluate its validity? The American Association of Neurological Surgeons believes it is in the public interest, as well as in the interest of neurosurgery, that medical complaints against neurosurgeons are evaluated by neurosurgeons. To this end, the AANS is working with the Federation of State Medical Boards to establish a national panel of neurosurgeons that would be available to provide expertise to state medical boards when they are evaluating complaints against neurosurgeons. As the largest association of neurosurgeons in the United States and an organization in the forefront on issues of national interest to the specialty, the AANS is committed to ensuring the highest standards of integrity and professionalism for neurosurgery in this country.

Active members of AANS who are interested in participating on the panel may obtain a registration form from Adriane Lewis at adl@aans.org, or (847) 378-0507. Members who have been the subject of AANS disciplinary proceedings for unprofessional conduct are not eligible to participate.

AANS will furnish state medical boards that request assistance with a list of three to five neurosurgeons serving on the panel, as well as with the neurosurgeons' pertinent licensure and subspecialty data. State medical boards then can contact the neurosurgeons directly and communicate specific procedures to each individual. Participating neurosurgeons will be considered volunteers for those states, and will be held harmless by the respective state boards from any liability arising out of their participation in a case.

Advanced Spine Course Available on DVD and VHS Lectures and practical labs from the June 2002 AANS *Innovations in Spinal Fixation: An Advanced Course* are available as DVD or VHS videos. The videos offer close-up views of cadaveric instruction and navigation. Instructors who are international leaders in orthopedic deformity surgery and neurosurgery perform advanced spinal fixation techniques from the occiput to the pelvis. To review an article about the course ("Spine Course Initiates Clinical Ed Program," *Bulletin,* Fall 2002) go to www.neurosurgery.org/aans/bulletin. To preview course clips or to order videos, visit the AANS Online Marketplace at www.neurosurgery.org/marketpl/default.asp or contact AANS at (888) 566-2267.

AANS Van Wagenen Fellow Named Odette A. Harris, MD, has been named the American Association of Neurological Surgeons 2003 Van Wagenen Fellow. The annually awarded Van Wagenen Fellowship, designed to give freedom in scientific development without the restrictive limitations imposed by many research grants and fellowships, provides a $45,000 stipend for living and travel expenses during post-resident neurosurgical study in a foreign country for a period of six to 12 months. Dr. Harris will examine the current protocols and practices of traumatic brain injury management in the developing world and compare outcomes to those in the developed world. She plans to complete part of the study at the University of the West Indies in Jamaica and part in an urban indigent setting in the United States. Dr. Harris is a resident at the Department of Neurosurgery, Stanford University Medical Center. More information about the Van Wagenen Fellowship is available at www.neurosurgery.org/aans/research/vanwagenen.

NEUROSURGERY://ON-CALL® Contest Winner Bahaa E. Hafez, MD, is the winner of the first contest soliciting patient education articles for the Disorder of the Month feature in the N://OC® Health Resources area at www.neurosurgery.org. He was awarded publication of "Brain Metastasis" as the featured January 2003 Disorder of the Month, as well as free admission to The Chicago Review Course in Neurological Surgery. Dr. Hafez is a post-doctoral fellow with the Neurosurgery Department at The University of Texas in Houston and instructor of neurosurgery at Menofyia University, Shebin, El-kom, Egypt. Articles by additional contest entrants subsequently will be published as Disorder of the Month features. More information about the contest is available at www.neurosurgery.org/contest.html.

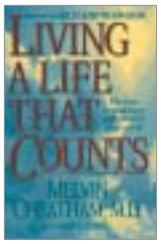
A Neurosurgeon's Service to Others

What's at the Heart of a Life That Counts

It's not often that a neurosurgeon writes a book on the socioeconomics of healthcare. This book, written by one of our own, asks the basic question, What are you going to do with the rest of your life? That question ought to get everyone's attention.

In his book, Melvin Cheatham, MD, reports that "asking and living this question have taken me from pursuing a life of success, defined by status, performance, and increased emptiness, to discovering a life of significance, which, in the last 10 years, has been shaped and guided by everything opposite from what I had been taught to follow." He discovered the timeless truth that serving other people is at the heart of living a life that counts.

Dr. Cheatham is a Christian and that motivates everything he does. He outlines what must happen when faith, motivation, and action come together. He frankly recounts the story of his life and the events that transformed his thinking. The diagnosis of hypercholesterolemia at an early age made him think seriously about his mortality. He discovered, through examples of others committed to living lives of service, that there is more to life than trying to please oneself.



Living a Life that Counts by Melvin Cheatham, MD, with Mark Cutshall. Thomas Nelson Publishers, Nashville, 1995, 212 pp.

You will enjoy the stories about neurosurgeons Bill Williamson, Charlie Brackett and Bill James as mentors, but will identify most readily with examples that Dr. Cheatham tells from his own life as a neurosurgeon. He cites thrilling episodes of adventure while serving in Somalia, Rwanda and Bosnia, as well as comparatively mundane tales from his practice in southern California. Through his own stories and the testimony of others who have touched his life, you will learn of people who overcame adversity to live lives that count.

Although the book reads quickly and easily, this is not a book that can be skimmed. Each of the 10 chapters is followed by a page of hard, soul-searching questions for the reader to answer. Questions such as: When was the last time one of these three consequences caused you to say, "I can't?"

- The challenge that comes with trying
- The sacrifice that comes with giving
- The loss that comes with risking oneself

Dr. Cheatham's advice is earthshaking, but it's also practical. You and I can't serve an entire country, a city or even a group all at once. But we can serve one person. Serving one person at a time gives us a realistic finish line we can see and run toward with confidence. He believes the adage that a ship in harbor is safe, but safety is not what ships are for. He says, "We were created to sail, and the only way I know to do that is to be willing to trust God who will guide us to the people He's prepared for us to meet and serve."

I haven't enjoyed a neurosurgeon's book this much since Edgar Kahn, MD, wrote *Journal of a Neurosurgeon.*

Mel Cheatham is the recipient of the 1995 AANS Humanitarian Award. Thank you, Mel, for writing this book. We all need to answer your questions. We all need to periodically pause in our rat race and ask ourselves the question, "What am I going to do with the rest of my life?"■

Gary Vander Ark, MD, is 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.

EVENTS

Calendar of Neurosurgical Events

American Association for Hand Surgery Annual Meeting
Jan. 8-11, 2003
Koloa, Kaua'i Hawaii
(312) 236-3307
www.handsurgery.org

7th Advanced Techniques in Cervical Spine Decompression & Stabilization
Jan. 10-12, 2003
St. Louis, Mo.
(314) 535-4000
pawslab.slu.edu/cme/cspine

American Society for Peripheral Nerve Annual Meeting 2003
Jan. 11-12, 2003
Koloa, Kaua'i, Hawaii
(312) 236-3307
www.handsurgery.org

American Society for Reconstructive Microsurgery Annual Meeting 2003
Jan. 11-14, 2003
Koloa, Kaua'i, Hawaii
(312) 236-3307
www.microsurg.org

Neuro-Oncology 2003: Current Concepts
Jan. 11-13, 2003
Orlando, Fla.
(216) 445-3449
tobinm@ccf.org

California Association of Neurological Surgeons Annual Meeting
Jan. 17-19, 2003
Newport Beach, Calif.
(916) 457-2267
www.cans1.org

Clinical Trials in Neuroprotection
Jan. 23-25, 2003
Key Biscayne, Fla.
(215) 898-8708
www.savethebrain.org

Lende Winter Neurosurgical Conference
Jan. 31–Feb. 7, 2003
Snowbird, Utah
(801) 581-6554

Chicago Review Course in Neurological Surgery
Jan. 31–Feb. 9, 2003
Chicago, Ill.
(773) 296-6666
www.chicagoreviewcourse.com

ASPN Annual Meeting 2003
Feb. 3-7, 2003
Hawaii
(205) 939-6914
www.aspn.org

American Academy of Orthopaedic Surgeons Annual Meeting
Feb. 5-9, 2003
New Orleans, LA
(847) 823-7186
www.aaos.org

Microsurgical Approaches to the Brain, Ventricles, and Skull Base
Feb. 10-14, 2003
Gainesville, FL
(352) 392-4331
www.neurosurgery.ufl.edu/clin-spec/course.html

AANS/CNS Section on Cerebrovascular Surgery & American Society of Interventional & Therapeutic Neuroradiology
Feb. 16-19, 2003
(847) 378-0500
info@neurosurgery.org

Dissection Workshop
Feb. 19-20, 2003
Memphis, Tenn.
(301) 654-6802
www.nasbs.org

14th Annual Meeting of the North America Skull Base Society
Feb. 22-25, 2003
Memphis, TN
(301) 654-6802
www.nasbs.org

International Society for the Study of the Lumbar Spine
Feb. 24-28, 2003
Madras, India
(416) 480-4833
www.issls.org

41st Annual M. Earle Memorial Neuropathology Review
Feb. 24-28, 2003
Bethesda, Md.
(202) 782-2637
www.afip.org/edu

Microsurgery of Aneurysms: Recent Advances
March 3-7, 2003
St. Louis, Mo.
(314) 535-4000
pawslab.slu.edu/cme/aneurysm

AANS/CNS Section on Disorders of the Spine and Peripheral Nerves
March 4-8, 2003
Tampa, Fla.
(888) 566-2267
www.neurosurgery.org/spine

26th Annual Meeting American Society of Neuroimaging
March 5-9, 2003
New Orleans, La.
(952) 545-6291
www.asnweb.org

6th International Conference on Stroke & 3rd Conference of the Mediterranean Stroke Society
March 12-15, 2003
Monte Carlo, Monaco
972 (3) 514-0018/9
www.kenes.com/stroke6

Southern Neurosurgical Society Annual Meeting
March 12-15, 2003
Orlando, Fla.
(407) 824-3000

American Academy of Neurology Annual Meeting (AAN)
March 29-April 5, 2003
Honolulu, Hawaii
(651) 695-1940
www.aan.com

AANN 35th Annual Meeting
April 5-8, 2003
Atlanta, Ga.
(888) 557-2266
www.aann.org

American Academy of Neurology Annual Meeting and Exhibition
April 5-12, 2003
Nashville, Tenn.
(612) 623-8115

Surgical Approaches to the Skull Base
April 24-26, 2003
St. Louis, Mo.
(314) 535-4000
pawslab.slu.edu/cme/cspine

2003 Annual Meeting of the American Association of Neurological Surgeons
April 26-May 1, 2003
San Diego, Calif.
(847) 378-0500
www.neurosurgery.org/aans/meetings/2003

For a frequently updated, comprehensive listing, go to www.neurosurgery.org/aans/calendar.