

About the Cover...

Denver, Colorado will be the site of the 65th Annual Meeting of The American Association of Neurological Surgeons. From majestic mountain scenery and outstanding cultural facilities, to world-class restaurants and museums, the mile-high city offers you and your family much to enjoy.

The 1997 Annual Meeting program will highlight opportunities for practice expansion and ideas for meeting the challenges of managed care. Scientific presentations will focus on contemporary advances in neurosurgery. There will be many new hands-on Practical Clinics from which to choose, along with the Decade of the Brain Symposium VII, and excellent Plenary, Scientific, and Section Sessions. You also won't want to miss this year's Cushing Orator, William J. Bennett, PhD, who will speak on "In Defense of Western Civilization."



Enclosed with this issue of the *AANS Bulletin* are the Annual Meeting Preliminary Program and registration materials. The detailed program section can be found in the center of this publication printed on tan paper.

Plan to join your colleagues in Denver April 20–25, 1997, for the meeting which has become the preeminent neurosurgical educational experience. To insure that you receive tickets to your preferred learning sessions, plan to register early.

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AANS Bulletin

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Ensuring Quality in Graduate Medical Education

The shrinking demand for specialty health care brings with it major implications for the quality of graduate medical education. In particular, the decline in the volume of surgical and other specialty procedures performed makes it increasingly difficult for some academic medical centers to continue to support their residency programs. Without a sufficient number of procedures, a residency program cannot provide adequate opportunities for advanced training.

Our system of voluntary private accreditation has long been relied upon by patients and by state and federal governments as the principal means of promoting the quality, reliability, and integrity of American medical education. For the system to remain effective, however, accrediting bodies, and the physicians who serve on them, must have the freedom to withdraw accreditation from academically deficient programs without undue risk of exposure to potentially debilitating litigation costs associated with having to defend antitrust or other litigation that is easily brought by a residency program that is denied accreditation.

Risks of Denying Accreditation

Since coming on the AANS Board, I have often heard from many of my physician colleagues about the legal risks faced by the Accreditation Council for Graduate Medical Education (ACGME) and its constituent Residency Review Committees (RRCs) when they attempt to withdraw or deny accreditation for residency programs.

Even though the accreditation entity will probably prevail, the risk of going through long and onerous legal proceedings and the costs associated with defending such a suit are far too high. The prospect of becoming embroiled in an enormously costly lawsuit, therefore, exercises a significant chilling effect on the willingness of the accrediting entities and the volunteer physicians who participate in the process to recommend non-accreditation of substandard programs.

At the same time, there is virtually no corresponding risk for the complainant. The chilling effect of this legal incongruity is twofold: First, the individuals invited to serve on



J. Charles Rich, Jr., MD

the resident review committees are giving second thoughts as to why they should put themselves and their families in jeopardy. Second, the ACGME and RRCs, which should be acting as advocates for quality education on behalf of the American public, are presently provided with persuasive liability arguments for not making the difficult quality decisions.

Managing the Risk

Two years ago, the Washington Committee decided to bring this problem to the attention of the federal government in search of a remedy. Since that time, representatives from the AANS and CNS have met with staff from the U.S. Department of Justice, the Federal Trade Commission, the White House, and Senator Orrin Hatch (R-UT)—Chairman of the Senate Judiciary Committee.

Senator Hatch recommended we develop a specific legislative proposal for his consideration. We took his advice and hired a lawyer who specializes in health care antitrust matters. With his assistance, the "Quality in Graduate Medical Education Act" was drafted.

The "Quality in Graduate Medical Education Act" is designed to encourage accrediting entities to make sound decisions in the interests of patients. Patterned after the Health Care Quality Improvement Act of 1986, the proposed legislation provides protection for good faith accreditation decisions designed to promote the quality of medical care. Specifically, our proposal would provide legal protection for

accrediting organizations and their volunteer members who participate in good faith, quality-based accreditation determinations. It would also provide that plaintiffs who sue accrediting entities, but ultimately cannot prove their case, would have to bear the costs and attorneys' fees of the defendants. The Act would not limit the ability of the federal or state governments to challenge any accreditation decision. Further, private plaintiffs would retain the right to sue an accrediting entity that has acted in bad faith. Most importantly, it would not expose the public to an increased potential for harmful conduct by accrediting entities.

Gathering Support

The AANS and the CNS are now in the process of garnering support for this draft legislation. Our first step is to gain broad-based backing for our plan within the medical community. We have sent it to a number of medical organizations, including the American Medical Association (AMA) and other medical specialty societies.

To date, the American College of Surgeons and the American College of Cardiology have endorsed our proposal. In addition, the AMA House of Delegates, at its December 1996 meeting, supported our approach. Once we get organized medicine on board, we will then identify a champion in Congress to shepherd the legislation through the legislative process.

The AANS and CNS believe accrediting organizations must be free to make hard decisions about educational quality without undue risk of legal liability and without fear of incurring burdensome expenses. We think the "Quality in Graduate Medical Education Act" provides the right solution to this vexing problem.

A handwritten signature in dark ink, appearing to read "J. Charles Rich, Jr., MD".

J. Charles Rich, MD
President

Federal Health Care Fraud and Abuse Efforts: New Concerns for Neurosurgeons

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

Just when you thought there couldn't be more problems to deal with, federal prosecutors have resurrected an obscure fraud law and have been bolstered by the new fraud and abuse provisions of the Kennedy-Kassebaum health reform bill (Health Insurance Portability and Accountability Act of 1996). Prosecutions for health care fraud have skyrocketed since 1992, when officials intensified their efforts. Recent data suggests that investigations are up 100 percent and we can expect more.

Strict enforcement of civil and criminal laws against fraud remains a politically popular form of health care cost control, one whose support will increase as large managed care systems grow in prominence. As in the defense industry, vigorous anti-fraud enforcement is likely to accompany more general failures in cost containment, particularly if the government is responsible for payment. This process is already being accelerated by "bounty-hunting" suits that can yield large recoveries to private plaintiffs.

Federal False Claims Act

Law enforcement officials are increasingly using the federal False Claims Act and its civil whistle-blower provision to pursue fraud allegations against physicians, hospitals, and other providers. The False Claims Act has only recently been applied to health care. Initially, it was aimed at curbing fraud by contractors who billed the Union Army for shoddy services during the Civil War. Congress amended the law in 1986 in an effort to encourage defense contractor employees to help stamp out fraudulent costs overruns. Congress made it easier for prosecutors to show that defendants "knowingly" acted to defraud the government. They also

allowed the government to seek triple damages for false claim violations, or double damages for offenders who voluntarily disclose all information about wrongdoing. The lawmakers also expanded the act's whistle-blower, or *qui tam*, provisions to allow whistle-blowers to collect a payoff in cases where the government intervenes.

In health care cases, enforcers typically build these cases around errant claims processing: billing for unperformed services, upcoding, billing for medically unnecessary services, unbundling, and cost report fraud. Prosecutors are becoming increasingly aggressive as they test the limits of the law.

In a first, the False Claims Act was recently applied to quality of care issues. The logic supporting the government's claim of liability is that any allegation of medical malpractice could give rise to a false-claims prosecution and its counterpart, a *qui tam* lawsuit. It is predicted that there will be a rash of prosecutions nationwide as doctors and other providers are pursued under this theory. This means that doctors could face new civil and criminal penalties for faulty medical decision-making and poor treatment outcomes.

“Strict enforcement of civil and criminal laws against fraud remains a politically popular form of health care cost control, one whose support will increase as large managed care systems grow in prominence.”

Fraud and Abuse Provisions of Kennedy-Kassebaum Health Insurance Bill

The government's fraud-busters got a further boost this summer when President Clinton signed the Health Insurance Portability and Accountability Act into law. This legislation created new fraud laws and expanded the coverage of the anti-kickback statute from Medicare and Medicaid to all payers. It also established a fraud and abuse expenditure account within the Medicare Trust. This account will in part be funded by fines and penalties collected from convictions for health care offenses.

The new law deals with physician-patient transactions of almost every sort, as well as related activities such as quality assurance. The law grants joint authority to the U.S. Department of Health and Human Services Inspector General (HHS/IG) and the U.S. Attorney General to "coordinate federal, state, and local law enforcement programs aimed at fraud and abuse with respect to health plans," and authority to "conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States." In short,

(continued on next page)

► Federal False Claims Act

(continued from page 3)

this legislation extends to all patient care activities. Even cash payments by uninsured patients may at least be scrutinized.

The law creates a new “federal health care offense” and expands current federal criminal statutes to apply to health care fraud. For example, the federal mail fraud statute will apply to anyone who knowingly and willfully defrauds, or attempts to defraud, any health care plan “in connection with the delivery of, or payment for, health care benefits, items, or services.” The penalty for a federal health care offense, in addition to fines, may be imprisonment for up to 10 years, or for 20 years if violation results in serious bodily injury. Violation resulting in death authorizes life imprisonment. A “materially false, fictitious, or fraudulent statement or representation, or a materially false writing or document knowingly made or used,” relating to a health benefit program, constitutes a “false statement” punishable by fines or imprisonment of up to five years.

The law also increases the amount of civil monetary penalties that can be imposed in health care fraud and abuse cases from \$2,000 to \$10,000 for *each* item or service involved. A civil penalty can be assessed for a claim the Health and Human Services Secretary determines “is for medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting, or causing to be presented, a claim for an item or service that is based on a code that the person knows, or should know, will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually

provided.” The phrase “know or should know” means that the person acts with either a “reckless disregard for” or in “deliberate ignorance” of the truth. Thus, each incorrectly coded service could be subject to a \$10,000 penalty.

Finally, the act establishes a new national health care fraud and abuse data collection program. Under this system, “final adverse actions” against health care providers would be reported to the data bank. This information would be available to federal and state government agencies and health plans.

Implications for the Future

U.S. Attorney General Janet Reno recently announced that the health care fraud and abuse initiative is the Department of Justice’s second highest priority, behind violent crime-related activities. Other recent initiatives by the HHS Inspector General and the Health Care Financing Administration (HCFA), such as the Physicians at Teaching Hospitals (PATH) initiatives, are proving very successful in recovering Medicare funds.

The PATH initiative is a national investigation of improper “upcoding” by teaching physicians of services provided by residents. Last December, PATH returned a \$30 million settlement from the University of Pennsylvania and its faculty plan. One medical school, Thomas Jefferson University in Philadelphia, has completed a voluntary compliance program and in August the school and its faculty practice plan agreed to pay the government \$12 million in damages. It is reported that five other teaching hospitals are completing similar arrangements, while another 10 have approached federal officials about voluntary disclosure.

Earlier this year, HCFA launched its new “Correct Coding Initiative,” which is aimed at preventing inappropriate unbun-

dling of procedure codes for Medicare services. The Medicare carriers are also increasing their payment audits and are sending physicians payment demand letters requesting immediate refunds of incorrect payments. For example, in California, several neurosurgeons have received such a letter for incorrectly billed and paid services using CPT code 61712 (microdissection, intracranial or spinal procedure).

The bottom line message is that neurosurgeons must keep scrupulous documentation of every service they provide so that there is clear guidance on every claim as to why it has been generated. Neurosurgeons must also give increased attention to how they code each service provided. While physicians should not be penalized for inadvertent behavior such as billing errors or mistakes, the new law leaves a sufficient amount of wiggle room to paint both honest and dishonest physicians with the same brush. Objections by the AMA did result in the inclusion of a “knowing and willful” standard governing criminal violations. However, that does not preclude investigations and harassment in matters that may go nowhere, or in which the physician is acquitted. Physicians need to understand that practices once described as “gaming,” which sometimes were a response to unreasonable restrictions, will be looked at in a new light.

ATTENTION ALL NEUROSURGEONS

If you have questions about the topic discussed here, or other public policy issues impacting neurosurgeons, please contact:

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

Board of Directors Holds Interim Meeting, Approve 1997 Budget

The Board of Directors convened in Chicago November 22-24 for its 1996 Interim Meeting. Although the primary focus of the meeting was the 1997 budget, a number of other key discussions took place. The highlights of the major actions taken are presented here.

Long Range Planning Committee

Edward Laws, Jr., Chairman of the Long Range Planning Committee (LRPC), presented a report detailing several committee recommendations for future action. Bylaw amendments will be proposed to accomplish the following:

- Develop stipulations regarding membership maintenance requirements for nurses and physician assistants in the Associate Membership category.
- Change the name of the Quality Assessment Committee to the Committee for the Assessment of Quality
- Use the term "AANS/CNS" to replace the term "joint" (where appropriate) with reference to committees and Sections.

In a discussion of outcomes research the LRPC suggested initial outcomes efforts be directed toward carotid disease and spine surgery. However, it emphasized the importance of producing outcomes that can be directly utilized by neurosurgeons in their practices, and be of tangible benefit to them.

The concept of the AANS as spokes-organization for neurosurgery was discussed at length. It was agreed the AANS must continue this role by enlisting highly motivated individuals who are armed with information provided by the AANS to respond to questions from outside sources such as the media and insurance carriers.

Nominating Committee

Sidney Tolchin, MD, Immediate-Past President and Chairman of the Nominating Committee announced the recommended slate of Officers, Directors and Nominating Committee members for 1997. The Board of Directors approved the following slate of nominees which will be presented for consideration by the voting members:

President-Elect: Russell L. Travis, MD
Vice President: William Shucart, MD



1996-1997 Board of Directors

Seated (left to right): Martin H. Weiss, Sidney Tolchin, J. Charles Rich, Jr., Edward R. Laws, Jr., Stewart B. Dunsker, Russel L. Travis. Standing (left to right): Arthur L. Day, P. Robert Schwetschenau, Donald D. Sheffel, John A. Kusske, Roberto C. Heros, A. John Popp, Herbert M. Oestreich, R. Michael Scott, Karin M. Muraszko, Stanley Pelofsky. Not shown: William Shucart

Secretary: Stan Pelofsky, MD
Director-at-Large: Robert A. Ratcheson, MD
Member, Nominating Committee:
 Ronald I. Apfelbaum, MD
 Ralph G. Dacey, MDZ
 L. N. Hopkins, MD

In addition, Robert B. Page, MD, and William E. Mayher, MD, have been proposed by the Joint Council of State Neurosurgical Societies (JCSNS) as Northeast Quadrant Director and Southeast Quadrant Director, respectively.

In accordance with the Bylaws, the foregoing slate will be mailed to the voting members by mid-January. If no opposing candidates are proposed, this slate will be voted on at the Annual Business Meeting on Monday, April 14, 1997 in Denver, Colorado. In the event opposing candidates are proposed, written ballots will be distributed as prescribed in the Bylaws.

Membership Committee

The Board of Directors approved the membership applications of 28 Active Members, 24 Active (Provisional) Members, 24 Associate

Members, and 47 transfers from Active (Provisional) Membership to Active Membership. Twenty applicants for International Associate Membership were also approved.

The complete list of new members appears on page 90. Total membership for the AANS is now 4,920.

Coordinating Committee for Continuing Education

The Board approved the "AANS/CNS Guidelines for Commercial Support of Continuing Medical Education." These new guidelines were designed to clarify AANS and Congress of Neurological Surgeons (CNS) policies governing commercially-supported CME programs, such as those offered at Annual Meetings. The two key stipulations are:

- there must be full disclosure by the presenters or faculty of any relationships they may have with manufacturers, and;
- demonstrations of off-label products, or off-label use of these products, in hands-on workshops should be avoided.

(continued on page 8)

The AANS Makes Financial Plans To Meet the Needs of the future

By Stewart B. Dunsker, MD
Treasurer

As Treasurer, I have learned that the simple rules of economics affect not only our medical practices, but they also have an impact on service organizations like The American Association of Neurological Surgeons (AANS). As requests for services from our membership rise, so do expenses. Just like in our individual practices, the AANS must play a game of shifting priorities, adjustments, and systems reviews to try and keep revenues in line with the increasing expenses.

Dues are not cheap, but over the past few years they have been increased only at the rate of the cost of living. Still, they only account for 16 percent of our revenue. To avoid large dues increases, we have developed new programs, such as our professional development courses, that not only bring advances in surgical techniques to our members but also help to fund further educational activities.

AANS of the Future

In spite of increasing expenses, we all want the AANS to be strong. We believe that in the years ahead, there will be an even greater need and expanded role for our Association. Envision the future and picture the AANS:

- Establishing more programs and communications with other specialties so that neurosurgeons will be recognized as “the surgeons” for spinal, peripheral nerve, vascular, and other disorders.
- Teaching new surgical techniques, in addition to our traditional educational efforts, so neurosurgeons will be trained in surgery and well-armed in the current market place.
- Developing outcome and guideline instruments to provide neurosurgeons with the tools they will need to meet the challenges of the next decade.

- Being a resource for all members to receive professional practice information as well as scientific and clinical material/information.

- Responding to numerous requests for the “opinion of neurosurgery” on various topics.

Embracing all the elements of this picture would require more financial resources than we currently possess.

The AANS is a service organization. Consequently, over the past three decades, it has launched numerous programs for the benefit of its members. However, it is time to review and prioritize these activities. Just as important, we must coordinate them to be sure we are not duplicating our efforts. Some of the programs now in existence may have to be placed on the back burner, or even eliminated, while new, or higher priority, areas are addressed.

Strategic Financial Plan

To be in a better position to accomplish these changes, we are enhancing our financial plan. Two years ago, the Board of Directors developed a new strategic plan and began to implement it. This year, with the invaluable assistance of Robert Draba, PhD, AANS Executive Director, and of Robert Cowan, CPA, AANS Controller, we are marrying the strategic program plan with a strategic financial plan. Simultaneously, we are initiating an innovative way to approach the budgeting process. It is important for us to develop a dynamic budget so that we can expand our programs to meet the needs of the future.

To help us do that, in our new budgeting process revenue goals as well as savings goals will be identified early. In addition, the AANS will build its reserves so that we are well positioned to meet the financial challenges of the future. Presently, those reserves

are segregated (and invested separately) in our “board-designated fund.” In the months ahead, we will also develop two new designated funds: one for technological innovation, and a second to help us identify and obtain new sources of revenue:

Those of us who serve on the Board of Directors will, with the input of members, guide the AANS into the future. While we recognize that the AANS is an educational and a service organization, there is no question that the AANS is also a business. Our business is serving our members and the public.

The fuel that runs this organization is revenue. We are striving to maximize our resources to meet the current obligations of our members and of society, and to have enough financial resources to meet those needs in the future.

Test Your Knowledge of the History of the Harvey Cushing Society

QUESTION:

**How many people
served as President of
the Harvey Cushing
Society who were not
neurosurgeons?**

Turn to page 93 for the answer.

Neurosurgery Reaches Out to Family Physicians

In an effort to better inform family physicians about neurosurgical practice, The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) co-sponsored a special neurosurgery exhibit at the 1996 Annual Scientific Assembly of the American Academy of Family Physicians (AAFP), which was held October 3-5 in New Orleans. This project marked the first time that organized neurosurgery participated in such Pan outreach effort to other medical professionals.

The exhibit had as its mission to increase awareness of the scope of neurosurgical practice with family physicians, who frequently serve as managed care gatekeepers. The objectives were to reinforce neurosurgeons' expertise in spine care and stroke management.

Booth Design and Promotion

The exhibit concept, message and handout materials were developed with input from the Joint Section on the Spine and Peripheral Nerves, Carotid Endarterectomy Task Force II, and the Subcommittee for Continuing CME for Non-Neurosurgeons. The exhibit featured signage that highlighted the following:

- The scope of neurosurgical practice.
- The neurosurgeon's role in management of patients with low back pain.
- An update on acute stroke management, including the latest data on carotid endarterectomy.
- Information about the Brain Attack education initiative.

In addition to securing an excellent location within the exhibit hall, special efforts were made to encourage booth visits by meeting attendees. These efforts included:

- Utilizing neurosurgeons in the booth to communicate one-on-one with meeting attendees.
- Displaying a computerized self-paced spine learning module on a PC.
- Offering a variety of free informational materials on spine and stroke-related topics.



Lloyd Zucker, MD (left), and Warren Selman, MD (right), demonstrate a computer spine learning program for a family physician.

- Making a charitable donation to the AAFP humanitarian program "Feed the Need." Exhibitors who contributed to this cause received recognition through an Honor Roll listing in the on-site and post-convention issues of the *FP Report*. They also had their names listed in the slide shows between lectures in the main assembly hall, received counter cards for their exhibits and special badge ribbons for exhibit personnel. Neurosurgery's donation went to support the Louisiana State University Student Clinics, which are run by medical students, family physicians and pediatricians donating their time to treat homeless patients in the New Orleans area.
- Distributing several "giveaway" items, including a key chain attached to a model of a spinal column. (This item turned out to be a big traffic builder and much in demand!)
- Running a display ad in the convention newspaper, *FP Report*.

Neurosurgeon Participation

Three neurosurgeons volunteered to help design messages for the display itself and to staff the booth during the meeting. Warren Selman, MD, of Cleveland, Ohio, helped prepare the carotid endarterectomy portion of the exhibit and was present in the booth for

two days. Thomas Flynn, MD, of Baton Rouge, Louisiana, spent an afternoon in the booth. Lloyd Zucker, MD, of Boca Raton, Florida, not only developed hand-out materials and the computerized, self-guided, learning module on spine care for family physicians, but he also went to New Orleans to help set up and staff the booth for four days.

In addition to speaking with family physicians, AANS/CNS volunteers also took the opportunity to meet with representatives of other specialty organizations who were exhibiting, learning about their public information efforts.

Booth Response

Overall, the exhibit was well-received by family physicians. In fact, an AAFP Board member stopped by the booth to personally thank the neurosurgeons for participating in the meeting. Most gratifying of all, many attendees stopped by the booth to consult with the neurosurgeons, discussing specific cases or asking questions about the latest in neurosurgical treatments.

Based on the number of handouts and promotional items distributed, it is estimated approximately 500 family physicians visited the booth during the three days the exhibit hall was open. As a result of the stroke-related material on display, two requests for

(continued on next page)

► **Neurosurgery Reaches** (continued from page 7)

Brain Attack presentations by neurosurgeons were received.

What Family Physicians Said

Three primary comments were heard from family physicians visiting the neurosurgery booth:

1. Why are neurosurgeons at this meeting? (Dr. Zucker's response: "Because you see patients with back pain, neck pain, carpal tunnel, and stroke and they're our patients too. Most of all, we're here because we want to enhance our communication with family physicians.")

2. We want referral guidelines from neurosurgeons. (Family physician comment: "I need to know more about back pain and when it's appropriate to refer my patient for specialty care.")
3. We want closer working relationships with neurosurgeons. (Family physician comment: "I can't get the neurosurgeon at my hospital to return my calls. Sometimes I need a consult and can't get it, or I refer my patient to a neurosurgeon and don't get any feedback about the care he's given my patient.")

Continued Participation

The neurosurgeons who worked on the exhibit project stated they felt it was a

worthwhile effort and recommended continued participation in the AAFP assembly. In November, the AANS Board of Directors approved continued funding for the exhibit and the display is set to appear at 1997 AAFP meeting next September in Chicago.

To amplify neurosurgery's presence at the AAFP meeting, efforts are underway to place several neurosurgeons as speakers on the scientific program. Presentations that have been proposed would focus on stroke and management of spine disorders. In addition, work is underway on the development of spine and carotid endarterectomy referral guidelines, which could be distributed through the neurosurgery booth at the AAFP meeting.

► **Governance** (continued from page 5)

Future Meeting Sites Committee

A change in site for the 2002 AANS Annual Meeting from Nashville to Chicago was approved.

Professional Development Committee

Under the auspices of the Professional Development Committee, a training course will be developed to help neurosurgeons prepare for the American Board of Neurological Surgery (ABNS) oral certifying examinations. While this course will not provide an in-depth review, the Board felt that the program would provide participants with a valuable exchange of information, as well as an excellent rehearsal for the oral examinations.

Strategic Planning

Members of the Senior Staff presented a progress report to the Board of Directors on the development of a program plan to implement the AANS Strategic Plan. The points covered are too numerous to be reported here, however, the following resolutions regarding the plan's implementation were approved by the Board:

- The Long Range Planning Committee will follow the priorities of the Board and membership.

- Strategic areas of the long range plan should be specific, measurable, attainable, relevant and time-framed (S.M.A.R.T.).
- The strategic plan will be consistent with the resources provided by the long range financial plan through fiscal year 1999.
- The long range plan is to be embedded in the existing organization and structure of the AANS to facilitate implementation and accountability.

The AANS Executive Director is to update the long range plan annually.

Joint Spine Section

The AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves presented revised Rules and Regulations for approval by the AANS Board. The regulations provide for governance of the Section. They had already been approved by the CNS Executive Committee.

Public Relations Task Force

A special Ad Hoc Task Force on Communications was appointed in April to study the possibility of initiating a public relations effort which would better acquaint the public with what neurosurgeons do. The impetus for this endeavor arose out of recommendations made by the JCSNS last spring.

Dr. Laws, who served as Chairman of the task force, presented a proposal for a project entitled, "Getting S.M.A.R.T. - A

New Communications Program About the Nature and Benefits of Neurosurgery," that will, with assistance from a professional PR firm, develop activities and materials that will help tell the neurosurgery story. The Board approved this concept, and authorized the task force to proceed. The CNS is also considering participating in the program.

Joint Quality Assessment Committee

Robert Florin, MD, Chairman of the Joint Quality Assessment Committee, reported on its activities in recent months. He noted the Sections will be heavily involved in the work of the committee, and this will be invaluable for solving quality-related issues. Dr. Florin also mentioned the importance of training neurosurgeons to do outcomes as soon as possible.

Young Neurosurgeons

The Board of Directors welcomed a new liaison from the Young Neurosurgeons Committee, Co-Chairman Karin Muraszko, MD, who reported on the projects in which the committee is engaged at this time. She stated that the need for fellowships is being assessed, although the quality of the available fellowships has not been addressed as yet.

Next Meeting

The next meeting of the AANS Board of Directors will be held during the 1997 Annual Meeting.

Carotid Endarterectomy Task Force Report

By Marc Mayberg, MD
Task Force Co-Chairman

The Carotid Endarterectomy Task Force was established by the Joint Officers of the AANS/CNS in response to several recent trends in carotid endarterectomy (Figure 1). Following the publication of several editorials in the academic and public literature in the mid-1980s, there was a substantial decline in the overall number of carotid endarterectomies performed in the United States. Additionally at this time, several multi-center prospective randomized trials were initiated to determine the efficacy of carotid endarterectomy for patients with either symptomatic or asymptomatic carotid stenosis.

Coincident with the publication of three trials for symptomatic carotid stenosis in 1991 (NASCET, ECST, and VA Symptomatic Trial), there was a substantial increase in the number of endarterectomies performed in the United States from approximately 50,000 to 70,000 per year. Additionally, with the publication of the ACAS Trial for Asymptomatic Stenosis in 1994, there has been another increase in the performance of endarterectomy to more than 70,000 cases according to the most recently available data.

It can be assumed that this number has continued to increase in the interim with dissemination of the results of these trials. Throughout this interval, however, the number of endarterectomies performed by neurosurgeons has remained relatively constant at about 5,000 cases per year. From the standpoint of market share, therefore, endarterectomies performed by neurosurgeons have decreased from approximately 10 percent in 1990 to 6 percent in 1994. The basis for this

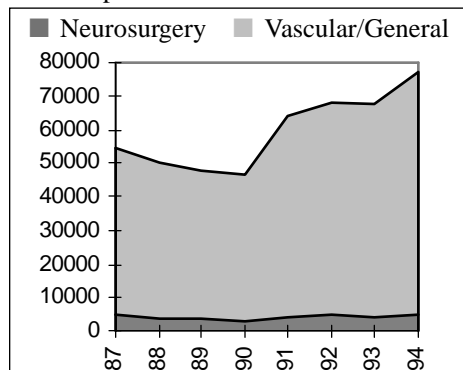


Fig. 1: U.S. Carotid Endarterectomies



Marc Mayberg, MD

discrepancy is uncertain, and represents one component of the Carotid Endarterectomy Task Force II effort.

Figure 2 shows the reimbursement per endarterectomy case for Medicare and private insurance. Medicare reimbursement has declined from approximately \$1,500/case in 1987 to current levels of \$1,200/case, which have been stable since 1992. Based on neurosurgical practice survey data, reimbursement for private insurance endarterectomy has increased from \$2,525 in 1987 to \$2,900 in 1992 (most recent data).

Because of the demographics of carotid artery disease, a significant proportion of cases can be assumed to be funded by Medicare. The overall impact of these trends for Medicare reimbursement are shown in Figure 3. In 1994, total Medicare reimbursement for carotid endarterectomy was \$92.33 million; neurosurgeons were reimbursed \$5.63 million and the remaining \$86.7 million was paid to vascular, general, and cardiothoracic surgeons.

Carotid Endarterectomy Task Force I

In 1993, the Joint Officers commissioned Robert Spetzler, MD, to head the Carotid Endarterectomy Task Force I. The mission of this task force was "to increase the volume and improve the quality of extracranial vascular surgery done by neurosurgeons in the United States." Surveys were sent to Program Directors and practicing neurosurgeons trained in carotid endarterectomy to identify particular problems and

potential means to accomplish this mission. In its final report, the first Task Force delineated the following recommendations.

1. The Residency Review Committee (RRC) and American Board of Neurological Surgery (ABNS) make training in carotid endarterectomy mandatory.
2. Neurosurgeons become actively involved in ongoing stroke studies.
3. Neurosurgeons become involved in vascular laboratories.
4. Programs for continuing education in carotid endarterectomy be developed for neurosurgeons.

Carotid Endarterectomy Task Force II

In 1994, the Joint Officers commissioned Robert Ojemann, MD, and myself to form Carotid Endarterectomy Task Force II. The directive to Task Force II was to continue the mission described above by implementing those specific recommendations. In conjunction with the Joint Section on Cerebrovascular Disease, the following sub-committees were established.

- a. RRC/ABNS (Robert Ojemann)
- b. Development of Training Standards in Endarterectomy (L.N. Hopkins)
- c. Assessment of Practice Patterns in Endarterectomy (Chris Loftus, Tom Oritano, Kevin McGrail)
- d. Development of Practical Courses in Endarterectomy (Julian Bailes)
- e. Education for Neurosurgeons (Issam Awad)
- f. Education for Non-Neurosurgeons (Warren Selman)
- g. Guidelines and Outcomes (Robert Harbaugh)
- h. Practice Management for Carotid Endarterectomy (Richard Roski)
- i. Public Relations (Linda Sternau)

A number of initiatives in each of these areas were developed.

Surveys of Practice Patterns in Carotid Endarterectomy

Over the past few years, two surveys were conducted to obtain a clearer picture of practice patterns with regard to carotid endarterectomy. In September 1994, a

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► Task Force

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questionnaire was mailed to Neurosurgical Program Directors. There were 91 respondents from 55 neurosurgical departments and 36 divisions. Among the respondents, 82 out of 91 Program Directors stated carotid endarterectomy was performed as a part of the residency training program. Among these 82 programs, 7 described neurosurgical involvement in carotid endarterectomy as “rarely” and an additional 7 initiated training in endarterectomy after 1990.

A more extensive survey was initiated in 1995 to determine details of endarterectomy training and identify specific impediments to performing endarterectomy at residency training programs in the United States. A total of 69 responses were obtained. In 58 percent of the programs, one or two faculty members performed endarterectomy, whereas only 16 percent of the training programs had more than three faculty members who trained residents in endarterectomy.

The estimated *percentage of endarterectomies done by neurosurgeons* compared to other services at training institutions formed a bimodal distribution (Figure 4). In most institutions, training directors estimated 15–20 percent of the total number of cases were performed by neurosurgeons. In about one-third of the training programs, neurosurgeons were estimated to be performing more than 50 percent of the cases at the institution. The *case volume for endarterectomy training* formed a similar distribution (Figure 5).

Most neurosurgical training programs performed less than 15–20 endarterectomies per year, with a second group of 18 institutions which reported performing more than 35 cases per year. A total of 47 out of 66 programs *certified their residents* in carotid endarterectomy (in one program neurosurgical residents were certified by vascular surgery). Nearly two-thirds of the respondents described vascular surgery as the *primary competition for carotid endarterectomy*, with the remaining one-third divided between cardiothoracic and general surgeons.

In most programs, endarterectomy was performed primarily for patients with symptomatic carotid stenosis. Only 40 percent of

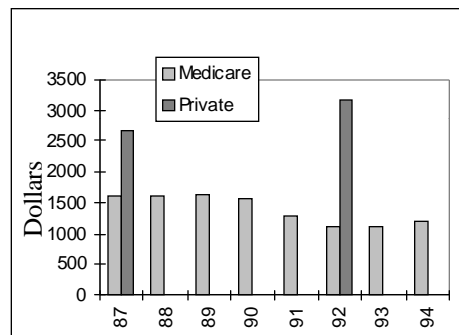


Fig. 2: Reimbursement per case

the respondents described routine *endarterectomy for asymptomatic carotid stenosis*. This observation may be explained by the *frequency of referrals* for endarterectomy, which were listed in decreasing order as 1) Neurology/Neurosurgery, 2) Family Practice, and 3) Cardiology. The relationship of neurosurgeons to a non-invasive vascular laboratory apparently played a major role in this referral pattern.

Only 4 percent of training programs had established *vascular laboratories* under the direction of neurosurgeons (Figure 6). In order of importance, the perceived *impediments described for establishment of vascular laboratories* included 1) presence of an existing laboratory—50 percent, 2) cost—21 percent, 3) time required—14 percent, and 4) experience—12 percent.

The **conclusions** of this survey can be summarized as follows:

1. Although most neurosurgical programs teach residents carotid endarterectomy, the overall volume is small and relatively few faculty members perform the operation. Despite low case volumes, about 70 percent of programs certify neurosurgical residents in carotid endarterectomy.
2. The main competitors for endarterectomy patients are vascular surgeons.
3. Self-referral and referral from neurologists represent the main sources of patients for neurosurgical training programs.
4. The majority of cases performed in training programs are for patients with symptomatic stenosis, although this survey preceded the publication of ACAS.

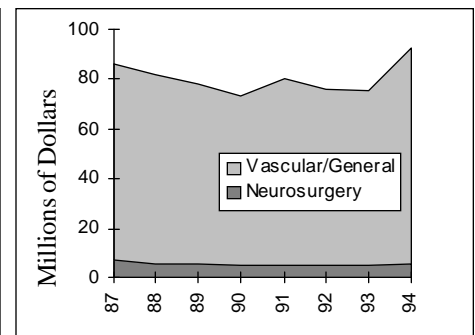


Fig. 3: Medicare funding for CEA

5. Few neurosurgical departments maintain vascular diagnostic laboratories. Development of new laboratories is constrained by the presence of existing laboratories, and to a lesser extent by cost and effort. Because of these constraints, training in non-invasive diagnosis may not increase neurosurgical participation in vascular laboratories.

Initiatives

Based on the results of this survey and the recommendations of the first Task Force, the following programs have been developed.

ABNS and Residency Review Committee—Task Force II requested that the Residency Review Committee (RRC): 1) enforce existing criteria for endarterectomy in U.S. training programs, and 2) ensure that administrative impediments do not inhibit resident training in endarterectomy. In response, the RRC agreed that:

1. The following language will be used in notification letters when carotid endarterectomy training is identified as non-compliant with program requirements: “*The committee wishes to call the Program Director’s attention to the requirement that residents must be afforded substantial experience in the management and surgical care of adult and pediatric patients which should include extracranial vascular disease.*”
2. A letter from the Program Director and hospital CEO is required as an attachment to program information forms stating that the educational experience for neurosurgery residents includes the

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opportunity to participate in carotid endarterectomy.

Education for Neurosurgeons—A central component of Task Force activity was the development of educational programs for neurosurgeons in training and in practice. Consequently, the practical courses were presented as follows:

- 1995 and 1996 AANS Annual Meetings
- 1995 and 1996 CNS Annual Meetings
- Allegheny General Hospital in June 1995
- St. Louis in January 1996

A variety of course formats were tried, including cadaver dissection, instruction in vascular non-invasive testing, observation of live procedures in the operating room, and small group case presentations. Experiences from these courses are being used in the current development of a Professional Development Program Course in carotid endarterectomy.

National Meetings Presentations—To increase exposure of all neurosurgeons to this topic, a major effort has been undertaken to include carotid endarterectomy as session topics in plenary sessions of the AANS, CNS, and CV Section Annual Meetings. Following is a list of presentations done thus far:

1. Carotid Endarterectomy - CNS 1994
2. Maximizing a Cerebrovascular Practice - CNS 1994
3. Developing a Stroke Center - CNS 1995
4. Carotid Endarterectomy - 1996 CV Section Meeting

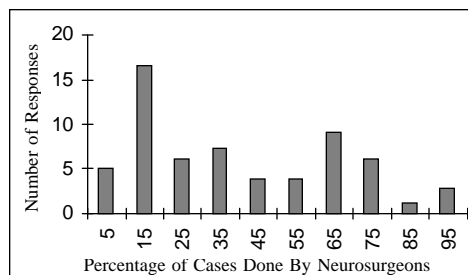


Fig. 4: Percent CEA by Neurosurgeons

5. Carotid Endarterectomy (Special Course) - AANS 1996
6. Patient Selection in Carotid Endarterectomy - CNS 1996
7. Technique of Carotid Endarterectomy - CNS 1996
8. Outcome Analysis in Carotid Endarterectomy - CNS 1996
9. Carotid Endarterectomy - (CV Section) - CNS 1996

Training Standards, Outcomes, and Guidelines—A draft was developed to establish uniform standards in the training of neurosurgeons for endarterectomy. The Task Force considered that training standards beyond current RRC requirements might have a negative impact and be used in adverse credentialing situations. Several guidelines for carotid endarterectomy have been published, but did not incorporate current data for clinical trials and did not reflect neurosurgical consensus for patient management.

Task Force members are participating in new carotid endarterectomy guidelines through the American Heart Association Stroke Council. Outcome measures specific to carotid endarterectomy were identified as a means by which neurosurgeons could document surgical efficacy in local and national arenas.

Robert Harbaugh, MD, is participating in the *New York State Consortium for Evaluation of the Effectiveness of Carotid Endarterectomies*. This program (headed by John Popp, MD) may serve as a model for the development of national guidelines and outcome measures related to carotid endarterectomy.

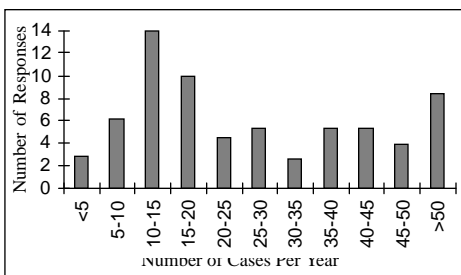


Fig. 5: Total CEA/Program

The CV Section is developing a similar outcome instrument for carotid endarterectomy. A database has been created that will enable neurosurgeons to quantify details of procedures and pertinent outcomes following surgery. This database will be adapted for use on **NEUROSURGERY://ON-CALL™**.

Stroke Center Development—Several neurosurgical centers (UCLA, Case Western, Dartmouth) have successfully increased their exposure to stroke patients and the volume of carotid endarterectomies through the establishment of multi-disciplinary stroke centers and implementation of Brain Attack programs.

The methodology of Stroke Center development was described in the *AANS Bulletin* (August 1995; R. Harbaugh). Materials to facilitate Stroke Center development (National Stroke Association, American Heart Association) were identified for access by interested neurosurgeons.

Education for Non-Neurosurgeons—Dissemination of material concerning stroke and cerebrovascular disease, results of clinical trials in endarterectomy, and current indication for surgery from practicing neurosurgeons to local physicians was identified as a critical component in establishing local referral patterns.

As a consequence, a brochure was developed for neurosurgeons to mail to referring physicians. "Update Carotid Endarterectomy" lists the results of recent trials in carotid endarterectomy and current indications for surgery. The brochure is in its second printing with more than 7,000 sold. In addition, a teaching slide set with a syllabus has been developed for neurosurgeons to use at hospital grand rounds and other public presentations. It describes an overview of the operative technique, results of clinical trials, and indications for surgery.

In addition, several neurosurgeons have become members of an American Heart Association Speaker Bureau, which subsidizes presentations of carotid endarterectomy and stroke prevention at meetings for internists, emergency physicians, family practitioners, etc.

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► Task Force

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Practice Management—An attempt was made to organize a management plan that would help neurosurgeons include carotid endarterectomy in managed care contracts. However, no action was taken because of the complexity of this project.

Screening for Carotid Disease—Several measures were considered to counteract the diversion of endarterectomy patients to other surgeons through non-neurosurgery vascular laboratories. Therefore, instruction in duplex and Transcranial Doppler Ultrasound (TCD) has been included in endarterectomy practical courses since 1994. Further, several neurosurgeons have been active in the International Committee for the Accreditation of Vascular Laboratories (ICAVL), which determines quality standards for laboratories. In addition, manufacturers were contacted regarding the development of low-cost magnetic resonance angiography (MRA) carotid imaging protocols or a low-cost office Doppler. Unfortunately, there has been little interest to date.

Public Relations—A marketing program was considered to improve public perception of the neurosurgeon's role in treating carotid artery disease. However, informal consultation with a public relations firm suggested that national media exposure would be very expensive and that more effective measures could be undertaken on a local level. No further action was taken.

Liaisons with Stroke Neurologists—Because stroke neurologists were identified as the primary referral source for neurosurgical endarterectomies, strategies to ensure close relationships with these individuals were promoted. Several stroke neurologists were recruited as adjunct members of the Cerebrovascular Section. Tom Brott, MD, was appointed to the CV Section Executive Committee as an *ex-officio* member. In addition, Dr. Mayberg was appointed vice-chair of the American Heart Association Stroke Scientific Program. The CV Section Annual Meeting was planned to coincide with the American Heart Association Stroke Meeting to

promote attendance and scientific presentation by neurosurgeons at AHA.

Future Considerations

A number of activities remain on the Task Force's agenda. In the months ahead, some of the projects we hope to address include the following:

Carotid Angioplasty and Stenting—This new technology may potentially have a profound impact on carotid endarterectomies. Several Task Force members are involved in an effort to maintain neurosurgical presence in carotid angioplasty and stenting through initiatives of the Washington Committee and the CV Section.

A position paper on carotid angioplasty and stenting was forwarded to HCFA and the FDA, and will be published in *Neurosurgery*. Neurosurgeons will be encouraged to actively partner with radiologists or cardiologists in angioplasty/stenting IRB protocols at their own institution, and participate in a forthcoming NIH trial.

Assessment of Task Force Efficacy—The Task Force will annually monitor the number of endarterectomies performed each year in neurosurgical training programs (ABNS data) and nationwide (Medicare data).

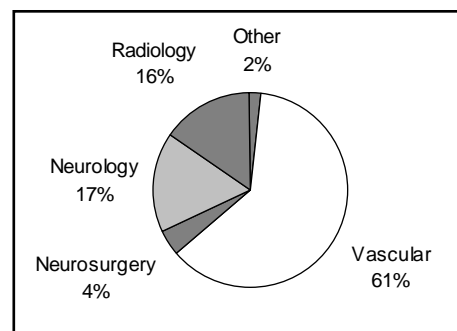


Fig. 6: Control of Vascular Labs and General Surgery

PDP Course in Carotid Endarterectomy—Using experience from prior courses in endarterectomy, a Professional Development Program course is now under development by Chris Loftus, MD.

Presentation of Task Force Initiatives to Senior Society—The ultimate success of efforts to increase the volume and improve the quality of extracranial vascular surgery by neurosurgeons lies in training a generation of residents who are technically capable and will aggressively seek to establish carotid endarterectomy referrals in practice. This mission should require the full understanding and support of Neurosurgical Program Directors.

Educational Materials Available from Carotid Endarterectomy Task Force

Brochure for referring physicians—

This brochure summarizes the results of recent clinical trials in carotid endarterectomy and current indications for surgery. It is designed to be mailed to referring physicians with an accompanying introductory letter.

Slide Set and Teaching Syllabus—

This binder contains slides and a lecture syllabus designed for presentations to physician groups (i.e., hospital grand rounds) or the public. It summarizes stroke evaluation and management, indications for surgery, and technical aspects of carotid endarterectomy.

To order either or both of these items, contact the
AANS national office at (847)692-9500.

NEUROSURGERY://ON-CALL™ Update

Site Enhancements, New Editorial Board Announced

Recently, the **NEUROSURGERY://ON-CALL™ (N://OC™)** Task Force recommended certain changes in project organization, administration, and financing to the AANS/CNS Joint Officers. The Task Force believes the changes under this plan will make **N://OC™** a more a cost-effective, valuable resource for AANS and CNS members.

New Editorial Board Appointed

The new Editor of **N://OC™** is William A. Friedman, MD, with John Oro, MD, chosen to serve as Associate Editor. Editorial Board members include Drs. A. John Popp, Brad Walters, Richard Bucholz, William Rosenberg, Robert Harbaugh, Mark Dias, Gene Barnett, Cavett Roberts, Joel MacDonald, Thomas Ellis, Julian Bailes, Dominic Esposito, Warren Selman, and Sidney Tolchin. Each Editorial Board member will oversee a specific **N://OC™** section, develop new content, and recommend new technology uses. AANS staff most involved with **N://OC™** include Allison Casey, Erin Flachsbart, and David Reid.

Site Enhancements

Multiple enhancements are planned for the site over the coming year. These changes will make **NEUROSURGERY://ON-CALL™** even more valuable to members.

New Library Features — In order to reach the full spectrum of information available through the National Library of Medicine database — Medline—the Library will begin offering links to the very best of the Internet sites that currently offer full Medline access. You will see some differences in the organization of the **N://OC™** library page as a consequence of this enhancement, but increased access to research information will be the result.

Opening the site — Password protection has been removed from all areas of **N://OC™** except the Outcomes Section, Chat Rooms, and *Neurosurgical Focus™*. Eliminating password protection from most site segments will make **N://OC™** easier for



members to use and provide wider access to the site for the non-neurosurgical physician community, patients, and the international neurosurgical community.

New Technology Additions—**N://OC™** plans to utilize Internet technology to provide new services to members. Real Audio “slide shows” will be available soon. These narrated slide presentations on selected neurosurgical topics will use streaming audio for excellent audio reception, even for low bandwidth users. Additionally, a visual tour of Denver — the site of the 1997 AANS Annual Meeting — is now available. These video clips utilize VivoActive and QuickTime plug-ins and are an exciting way to preview the meeting location.

Outcomes Research — Several of our Editorial Board members are hard at work on the first of what we hope will be many online outcomes research projects. You’ll be hearing more about this enhancement to the **N://OC™** site in the coming months.

Public Information

One goal of the new Editorial Board is to provide new sections on the site with

information for patients, non-neurosurgical physicians, and other medical professionals. We hope that **N://OC™** will become a valuable resource for people seeking neurosurgical patient education resources and learning opportunities.

Feedback Encouraged

NEUROSURGERY://ON-CALL™ welcomes your comments and suggestions. We are hard at work to implement these new features and appreciate your feedback. To contact the Editorial Board with your suggestions, e-mail: info@neurosurgery.org or write: c/o The AANS National Office, 22 South Washington Street, Park Ridge, IL 60068-4287.

Remember—take advantage of this valuable resource and visit us often at www.neurosurgery.org.

Did you know?

NEUROSURGERY://ON-CALL™

- is the only place to search for and print out abstracts from the AANS, CNS, and Joint Section meetings.
- is the only place to access *Neurosurgical Focus™*, an online journal that publishes peer-reviewed articles and other neurosurgical information.
- is your one-stop resource for AANS, CNS, and Joint Section meeting dates, location and program information.
- provides links to more than 100 neurosurgery-related Web site resources.

ACS Board of Regents Holds Fall Meeting

**By Edward R. Laws, Jr., MD, FACS
Regent for Neurosurgery
American College of Surgeons**

The American College of Surgeons (ACS) Board of Regents had a highly effective meeting October 4-11, 1996, in San Francisco, California, under the chairmanship of Seymour Schwartz, MD. The ACS represents some 60,000 surgeons and neurosurgery makes up 5 percent of this group, though we are certainly represented out of proportion in some of the most important activities undertaken by the College.

College Finances

The treasurer's report revealed the College's finances to be in excellent condition. The finances are such that no recommendations were made for any dues increases this year, and the College has been able to keep its dues structure stable for the past five years.

The purchase of the new ACS headquarters building at 633 St. Clair Avenue, just off Chicago's Magnificent Mile, has been completed and the development of the floors to be occupied by the College is well underway. There are optimistic projections for renting out the rest of the space in the building, and there is the potential for other surgical subspecialty societies who wish to occupy office floors in this building to do so at very favorable rates.

Clinical Congress

The scientific program at the ACS Clinical Congress was extraordinary, with one of the highlights being an address by H. Ross Perot. Statistics for the meeting revealed that the total registration reached 19,795.

Each year, the Neurosurgical Advisory Council sponsors a lecture on the history of surgery and the 1997 lecturer, Peter Cruse, did a brilliant job. The event was very well received and he spoke to a full house. Although attendance at this meeting by neurosurgeons tends to be limited by its proximity to the meeting of the Congress of Neurological Surgeons, there was an excellent turnout in San Francisco. The Surgical Forum Session, which was moder-



Edward R. Laws, Jr., MD

ated by Michael Rosner, MD, was very interesting and well attended.

GME Committee

The Graduate Medical Education (GME) Committee of the College is continuing with its project to make recommendations for pre-residency training for medical students and PGY-1 fellows. I raised this issue before the Board of regents after former Regent Edward L. Seljeskog, MD, gave his report on the activities of the American Board of Neurological Surgery (ABNS). It was met with mixed reaction and there was, of course, a continuing degree of opposition from general surgery program chairmen who do not wish to allow neurosurgery to have "special" rotations in PGY-1, including the two to three months of neurology recommended by the ABNS.

There does seem to be some softening of this opposition, but it continues to be a problem, and hopefully the report of the GME Committee will help us in this initiative.

The Committee on Young Surgeons continues to have significant influence, and neurosurgery is well represented on this committee. It was decided the Advisory Councils could participate in the "Group of 100" programs, which basically are focus groups that previously had been run primarily for the benefit of general surgery. Neurosurgical participation in this focus group project will be important, and should represent a good opportunity for many concerns to be aired.

Clinical Concerns

There was a long discussion prompted by the Committee on Emerging Surgical Technology about stereotactic breast biopsy. The concern here is that radiologists will be doing these procedures. Also, under development is an automated lesion resection system linked to the stereotactic breast biopsy system that could allow non-surgeons to actually remove breast lesions.

The hope, of course, is that surgeons and radiologists would work together for the benefit of the patient. However, there is significant concern that the numbers of such biopsies will escalate sharply once radiologists are able to do them, and there will be continued problems in this area.

The Board of Regents approved an extensive revision of the Guidelines for Standards in Cardiac Surgery, which is fairly basic and might serve as an example for guidelines for some very specialized aspects of neurosurgery that require significant institutional resources.

There was major discussion with regard to the Advisory Council Chairmen's Task Force on Outcomes. A good bit of basic work has been done and the ACS is now in a position to provide a validated template to cover most aspects of outcomes research, with the exceptions of the disease-specific outcomes, which are to be developed specialty-by-specialty and procedure-by-procedure. These will be reviewed by the AANS/CNS Quality Assessment Committee with appropriate feedback to the College of Surgeons.

Governance Matters

The ACS participates in the Joint Council of American Health Organizations (JCAHO) and Robert Herman, MD, is going to replace Dr. Kridelbaugh as our representative. The College has resisted strongly a move to add an eighth public member to the Board of Commissioners, an action which, if approved, would change the balance on the Board.

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► ACS Fall Meeting

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A report was heard from the Council of Medical Specialty Societies (CMSS) and there is no reason to think that it would be in the interest of neurosurgery to rejoin this organization.

The Board of Governors of the American College of Surgeons has been very active in dealing with a variety of issues, primarily socioeconomic. Neurosurgery is well represented on the Board of Governors, both among the membership and in the executive body.

Specific responses of the ACS to the problems raised by the Board of Governors include the following: 45 workshops and seminars on managed care issues, a newsletter of health systems reform, several articles in the *ACS Bulletin*, the publication of a manual on practice management for the young surgeon, the development of a surgeon's "report card" for self assessment, and the activities of the Advisory Council Task Force on Outcomes.

Socioeconomic Activities

In the professional liability arena, there is a revision of the Risk Management Manual for Surgeons, a variety of courses and educational materials, and participation with tort reform associations. With regard to reimbursement issues, the College works very closely with HCFA, and has been organizing the surgical specialties in lobbying in the House and Senate for appropriate legislative relief. A number of workshops on coding are presented by the College similar to those initiated by the AANS and CNS.

In the area of Graduate Medical Education, the College continues to oppose legislative proposals that limit GME support to the first three or four years of residency training. The College sponsors a Young Surgeons as Investigators Conference and is funding ACS scholarships and fellowships totaling \$820,000 a year. Statements have been produced by the ACS with regard to credentialing for emerging surgical technology and the College effectively monitors physician work force issues.

The Washington office of the ACS has been effective and works very well in concert with the AANS/CNS Washington representatives and the ACS Washington Committee.

The ACS Development Program moves along steadily and recently has received an additional gift of \$40,000 from Ethicon for scholarship support. The neurosurgical lectureship on the history of surgery has been endowed, but still lacks approximately \$15,000 to reach independence, and it is hoped that these funds can be developed from the neurosurgical community.

There was an update on professional liability activities and a good bit of enthusiasm for cooperation with an expert witness research firm called IDEX. This company performs in a manner similar to the expert witness file of the AANS, and might be something that could expand and enhance these activities. This is under investigation by the College, and a report to the Professional Liability Committee will be forthcoming.

With regard to the National Practitioner Data Bank, significant lobbying efforts are being made to prevent residents from being named in suits and then having their names placed in the data bank if the suits are lost or settled. It remains necessary to lobby vigorously to prevent public access to the material that exists in the National Practitioner Data Bank.

The ACS continues to work for tort reform using a number of coalitions. It is felt that the most effective is the Health Care Liability Alliance (HCLA), which is sponsored by the American Medical Association (AMA). The National Medical Liability Research Council (NMLRC) has insufficient funds to make a significant impact. American Tort Reform Association (ATRA) works hard at the state level but, unfortunately, a number of the tort reforms achieved have not withstood challenge in the Supreme Court.

With regard to state activities, the state of Massachusetts has initiated a profiling of physicians, which includes a process by which physician liability claims would be available to the general public. They would

be grouped by specialty and the report cards involved are in early stages of development.

It is felt that the best state-by-state strategy is to continue to work hard for legislation that will allow achievable goals culminating in bills placed before the state legislatures and to force the process so that they receive approval from the state supreme courts.

John Cooksey, MD, a Republican from the state of Louisiana, who also was responsible for the passage of the Louisiana Malpractice Act, was elected to the House of Representatives in November. Martin B. Camins, MD, produced a report on radiographic studies and cost-effectiveness in head injuries that was very well received.

Physician Reimbursement

In the area of physician reimbursement, current strategies include reassessment of the evaluation and management (E+M) component of the surgical fee. It is hoped these values can potentially be increased; however, this outcome is unlikely, and a request has been made for some sort of interim adjustment.

With regard to fee schedule updates and volume performance standards, it looks as if there will be no Congressional action and, therefore, the update for surgical services will include an increase of 2.1 percent with a 2.7 percent update for primary care, and a negative 0.6 percent change in other physician services.

It was emphasized that the highly effective testimony of the ACS Director, Paul Ebert, MD, was primarily responsible for the current guidelines on Medicare payment to teaching physicians. It is anticipated the new Congress will not seriously address the Medicare budget until 1999, and the interim changes in the new Congress will be damaging both to hospitals and to physicians, but more so to hospitals.

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► ACS Fall Meeting

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Managed Care

Some statistics on aging of the population were presented and there are currently 53,000 over 100 years of age and in 2030 it is projected that 324,000 Americans will have passed the century mark. The College has objected strongly to the Health Care Financing Administration's (HCFA) initiative to create Medicare-participating Centers of Excellence. These centers will be designated for joint replacement, for cardiac surgery, and for ophthalmic surgery. The experience of ophthalmic surgery was highly negative in every respect, and so there is really little in the way of support for this concept.

The College continues to take steps to eliminate "gag clauses," but legislation has not yet passed with regard to this issue. The legislation that did pass included health insurance portability and a demonstration project for Medical Savings Accounts (MSA). With regard to state activities, there was concern expressed over some state bills that had been introduced suggesting that modified radical mastectomy should be done as an outpatient procedure. Most state activities currently center on patient rights, gag clauses, and how to deal with Medicaid.

A pediatric surgeon from Washington, D.C., Kurt D. Newman, MD, has been appointed to the National Committee for Quality Assurance. Various attempts are being made to ensure the quality of managed care plans, and a Presidential Committee on Quality is being formed, and a number of surgeons have been proposed for membership.

President Clinton signed the Traumatic Brain Injury Act, which provides significant funding for research on the problem of brain injury. Some of the money came from a previous allocation to studies on firearm violence.

HCFA is attempting to establish a DRG-like system for ambulatory surgery, and these

activities are being watched closely. Attempts are being made to improve liaisons with the U.S. Food and Drug Administration in the hopes of improving the speed and efficacy of its drugs and devices. The National Institutes of Health received a 6.9 percent increase in funding over fiscal year 1996.

The ACS in Washington organized a Day in Surgery Program that takes Congressional staffers and shows them the day-to-day work of surgeons in Washington. They also have the opportunity to tour trauma centers and participate in Grand Rounds. Some actually traveled to the University of North Carolina and the University of Texas for these educational ventures. This is something organized neurosurgery might wish to do both at the national and state level with legislative staff people involved in health care legislation.

The report of the Practice Expense Study, due out at year's end, is eagerly awaited.

AMA Governance

Reports were received from the representatives of the American College of Surgeons to the AMA. The Surgical Caucus at the AMA has been quite effective under the leadership of the ACS and, at the House of Delegates, their efforts resulted in approval of a resolution to delay implementation of both the practice expense readjustments and the single conversion factor.

The Board of Regents received a report on attempts to restructure the governance of the AMA with a federation that would provide more representatives from organized surgery and surgical subspecialties. No specific action was taken. However, it was recognized that a number of the surgical specialties are participating in the Committee to Develop the Federation. Currently, there are 130 surgeons in the AMA House of Delegates, whose total number is 340. Of the 19 trustees of the AMA, there are currently three surgeons serving.

The ACS has moved forward with its clinical trials project at the National Cancer

Institute and a fully-funded and effective grant proposal is anticipated with initial studies directed toward prostate, colon, and breast cancer. A task force for neurosurgical clinical trials is under development.

The *Journal of the American College of Surgeons* continues to be successful, both in terms of content and advertising, and has moved to new quarters. Seymour Schwartz, MD, will assume the editorship—succeeding Sam Wells, MD—who in turn is the candidate to follow Dr. Ebert as Director of the College, with this appointment to begin in June of 1988.

The ACS reacted negatively to an initiative on the part of the American Board of Otolaryngology for a CAQ (Certificate of Added Qualification) in Facial Plastic and Reconstructive Surgery. Reports from all of the various surgical specialty boards were received, and it was interesting to hear of their re-certification mechanisms.

Communications

The Committee on Informatics is moving forward with a new ACS Web site on the Internet, which is developing in a fashion similar to **NEUROSURGERY://ON-CALL™**.

At the ACS meeting in San Francisco, the Communications Department was kept busy coordinating the reporters who were on hand for Ross Perot's address, and they continue to be active in various media campaigns to heighten the awareness of the general public with regard to what surgeons do.

With regard to marketing initiatives similar to those of the AANS/CNS, a breast cancer kit has been developed. There are numerous brochures and publications, and a variety of video tapes have been produced. The manual on "Practice Management for the Young Surgeon" will be revised and expanded as the initial print run is sold out.

New ACS Leadership

The new President of the American College of Surgeons is David Murray, MD, an

(continued on next page)

Decade of the Brain Symposium to Focus on Obstacles to Cure



Michael Apuzzo, MD

Since its inception in 1990, the Decade of the Brain Symposium has served as an important platform for showcasing critical topics in neurosurgery. The 1997 symposium, which will be held at the AANS Annual

Meeting in Denver, has the title "The Fundamental Enigmas: Neurosurgery's Principle Challenges and Progress Toward Solutions."

Considering neurosurgery's important clinical specialties, there have been, and remain to be principle obstacles to achieving cure. These fundamental enigmas will be examined in the light of today's science and evolutionary thought with a view toward identification of key potential avenues of solution from the perspective of both laboratory and clinical science.

Moderated by Michael L.J. Apuzzo, MD, and co-moderated by Charles J. Hodge, MD, principle areas of focus will include craniocerebral and spinal cord injury, degenerative spinal column disease, neoplasia, vascular disease, nervous system malformations, functional afflictions, and pain-related disorders. Each area will be addressed by a neurosurgeon with a broad and perceptive view of the specific problem. They will stress recent innovative concepts and methods that offer promise for substantive insights and resolution of these important barriers to progress to cure.



Charles Hodge, MD

Graham Teasdale, MD, will discuss methods for retrieval and protection of the neuronal population after craniocerebral injury. Charles H. Tator, MD, will examine the important issue of spinal cord injury in view of new developments related to neuronal regeneration and factors for enhancing functional recovery. Richard G. Fessler, MD, will explore the topic of degenerative spinal diseases with a view toward innovative techniques for management and molecular aspects of the new therapies.

The problem of tumor invasiveness and heterogeneity with molecular keys for solution will be discussed by Peter McL Black, MD. Complexities of stroke, vasospasm, atherosclerosis, and the molecular biology of the cerebrovascular wall will be presented by Ralph G. Dacey, Jr., MD. David G. McLone, MD, will discuss fundamental aspects of the evolution, advanced management, and prevention of central nervous system anomalies.

The exciting topic of molecular neurosurgery and the realm of possibilities for restoration to normalcy in the spectrum of functional disorders will be detailed by L. Dade Lunsford, MD. Finally, Kim J. Burchiel, MD, will discuss issues related to the resolution of chronic pain syndromes through complex systems applications and the evolving comprehension of neural circuitry.

► ACS Fall Meeting

(continued from page 82)

orthopaedic surgeon from Syracuse, New York. Seymour Schwartz, MD, will continue as Chair of the Board of Regents, and Tom Krizek, MD, a plastic surgeon from Tampa, Florida, will serve as Vice Chair.

Jack Wilberger, MD, has been appointed to the Executive Committee on Trauma, and I was appointed to the Central Judiciary Committee. Neurosurgery continues to have

effective representation on the majority of the ACS committees and has vigorous input into development of the scientific program of the Clinical Congress as well as the Surgical Forum.

The American College of Surgeons remains a strong and effective voice for all of surgery in the United States, and it is our goal to continue the prominent position of neurosurgery in its activities.

1997 Decade of the Brain Symposium

April 16, 1997; 2:45–5:30 PM

"A Multiplicity of Gordian Knots"

Michael L.J. Apuzzo, MD - Los Angeles

"Craniocerebral Trauma: Factors and Methods of Retrieval and Protection of the Neuronal Population After Craniocerebral Injury"

Graham Teasdale, MD - Glasgow

"Spinal Trauma: The Biology of Recovery and Functional Restoration After Spinal Cord Injury"

Charles H. Tator, MD - Toronto

"Spine: Biological and Clinical Factors in the Management and Mitigation of Degenerative Spinal Diseases"

Richard G. Fessler, MD - Gainesville

"Tremor: Molecular Biology and Genetics in the Comprehension and Control of Neoplastic Invasion and Heterogeneity"

Peter McL. Black, MD - Boston

"Vascular: Molecular Keys to the Problems of Cerebral Vasospasm, Atherosclerosis and the Functional Retrieval of the Ischemic Penumbra"

Ralph G. Dacey, Jr. - St. Louis

"Pediatrics: The Biological Resolution of Malformations of the Central Nervous System"

David G. McLone, MD - Chicago

"Stereotactic and Functional: Opportunities and Methods for the Restoration of Function in the Acquired, Degenerative, and Idiopathic Neurological Diseases"

L. Dade Lunsford - Pittsburgh

"Pain: Resolution of Chronic Pain Syndromes: Systems and the Definition of Circuitry"

Kim J. Burchiel, MD - Portland

"Opportunities for Acquisition of a Contemporary Perspective"

Charles J. Hodge, Jr., MD - Syracuse

RESEARCH FOUNDATION

1996 Campaign Update

By Robert G. Ojemann, MD,
Chairman, Executive Council, and
Joan Vaughan, Development Officer

The final months of the 1996 Campaign are here and, with your help, the 1996 Campaign can achieve new levels of support. If your gift has already been sent, we thank you for your generosity. If you have not yet made a decision regarding your commitment, we urge you to consider the benefits of Research Foundation support.

Research is the driving force behind the treatment advances we have come to expect in the specialty of neurosurgery. Your gift, which will be directed toward the Foundation's endowment, will help the Foundation to continue to support the research projects of some of the best and brightest young researchers in the specialty. As the endowment continues to grow, additional funds will become available to expand the number of projects supported.

Almost all past Research Foundation grant recipients have continued in full-time faculty positions with neuroscientific research as an important component of their careers. Research Foundation support has served as a bridge to the next level of funding for these investigators, enabling them to develop pilot data and prepare more extensive applications for external funding. Since completion of their Research Foundation grants, these investigators have generated an additional \$18 million in external research support.

We encourage you to consider a gift that will enroll you in the Cushing Scholars Circle (see below). However, please be assured that gifts at all levels are most sincerely appreciated. Donors to the Foundation are listed on the Foundation's "Donor Wall" that will be displayed during the AANS Annual Meeting in Denver. In addition, members of the Foundation's different giving clubs will also receive distinctive lapel pins that can be proudly worn throughout the year.

Help us ensure a future dedicated to hope and healing by making your Research Foundation commitment today!

Annual Giving Levels (Gifts from Individuals)

Cushing Scholars Circle

Summa Cum Laude	\$5,000—up
Magna Cum Laude	\$2,500—4,999
Cum Laude	\$1,000—2,499

Other Annual Giving Levels

Honor Roll	\$500—999
Sponsor	\$250—499
Supporter	\$100—249

Scientific Society

(Gifts from Groups and Organizations)

A gift of \$500 or more that is received from an organization or group of donors will be recognized within the Scientific Society category.

Research Foundation Corporate Associates Roster

The Executive Council of the AANS Research Foundation gratefully acknowledges the Annual Campaign support given by the following companies:

Sustaining Associates

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

Pharmacia & Upjohn Inc.
Synthes Spine/Synthes Maxillofacial

Supporting Associates

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

Codman/Johnson & Johnson
Professional, Inc.
Elekta
Leibinger
Sofamor Danek Group, Inc.

Contributing Associates

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

Zimmer/Hall Surgical

Associates

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

Aesculap
Depuy Motech
Midas Rex Institute
PMT® Corporation

JOINT COUNCIL

By Stanley Pelofsky, MD
Chairman, JCSNS

The Joint Council of State Neurosurgical Societies (JCSNS) will hold a very important session just prior to the Annual Meeting of The American Association of Neurological Surgeons (AANS). The JCSNS delegates will debate and vote upon major resolutions concerning neurotrauma,

subspecialty boards, and fellowship programs. In addition, a new chairman, vice chairman, recording secretary, and treasurer will be elected.

During the meeting, major changes in reimbursement, Medicare, managed care, tort reform, etc., will be discussed at length. All delegates and appointees are expected to attend this very important

meeting and all neurosurgeons are invited to witness and participate in the debate. It is at this meeting where leadership and membership meet to discuss the major political, social, and economic issues that affect all neurosurgeons. Please plan to attend and present your thoughts, concerns, and opinions.

1997 Course Schedule

Professional
Development

W I T H

The American Association of Neurological Surgeons



Socio-Economic Courses

1997 Reimbursement Update for Neurosurgeons

February 7–8 Dallas, TX
February 28–March 1 Las Vegas, NV
August 22–23 Chicago, IL
October 24–25 Philadelphia, PA
November 16–19 Maui, Hawaii

A Proactive Approach to Managed Care: Strategies and Solutions

January 16–17 San Diego, CA
June 21–22 Cleveland, OH
November 7–8 Palm Beach, FL

Clinical Skill Courses

Neurosurgical Critical Care for Neurosurgeons, Neuroscience Nurses & Physician Assistants

January 26–30 Snowbird, UT
June 5–7 Philadelphia, PA

Microsurgery of the Brain, Cranial Nerves & Skull Base—Hands-On

February 14–16 St. Louis, MO

Interactive Image-Guided Neurosurgery (Frameless Stereotaxy)—Hands-On

March 14–15 Memphis, TN
November 21–22 Memphis, TN

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

May 12–18 Albuquerque, NM

Surgery of the Cervical Spine— Hands-On

June 27–29 Memphis, TN

Current Topics in Lumbar Spine Management: Lumbar Disc Disease—Hands-On

October 31–November 2 Chicago, IL

Minimally Invasive Neurosurgery: Neuroendoscopy—Hands-On

November 14–15 Cleveland, OH

Stereotactic Neurosurgery

November 7–8 New Orleans, LA

NEW COURSES!

Surgery and Management of the Brachial Plexus—Hands-on

February 14–15 New Orleans, LA

Extracranial Carotid Reconstruction—Hands-On

May 30–31 Rancho Mirage, CA

Surgical Management of Movement Disorders

June 27–29 Orlando, FL

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

The American Association of Neurological Surgeons designates these educational activities for the designated hours in category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

For more information or to register, please call the Professional Development Department at 847-692-9500, or e-mail us at info@aans.org or visit our Web site at www.neurosurgery.org

1996 Professional Development Program Faculty Appreciation

The Professional Development Committee would like to thank all the faculty who gave their valuable time and energy during the past year to help neurosurgeons obtain the highest quality educational experience available. The faculty members are presented below.

'96 Reimbursement Update for Neurosurgeons

Kathleen Redelman, RN, BSN, CNRN
*Richard A. Roski, MD, FACS**

How to Prosper in Managed Care for Neurosurgeons

T. Forscht Dagi, MD
*John Kusske, MD**

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

John A. Anson, MD
Nevan G. Baldwin, MD
*Edward C. Benzel, MD**
Timothy I. Cohen, MD
Kevin T. Foley, MD
Andrea L. Halliday, MD
Iain H. Kalfas, MD
Russel P. Nockels, MD
Michael Schneier, MD
Eric J. Woodard, MD

Carolyn Coulter, RN, BSN, CNRN, CNOR
Theresa A. Hadden, RN, BSN, CNRN
Denise Miller Lemke, RN, BSN, CNRN

Neurosurgical Critical Care for Neurosurgeons, Neuroscience Nurses & Physician Assistants

Perry A. Ball, MD
Fady Charbel, MD
Kevin J. Gibbons, MD
Andrea Halliday, MD
*Michael J. Rosner, MD**

Surgery of the Cervical Spine—Hands-On

Edward C. Benzel, MD
*Regis W. Haid, MD**
Iain H. Kalfas, MD
Gerald E. Rodts, MD
Maurice C. Smith, MD
Vincent C. Traynelis, MD
Eric J. Woodard, MD

Advanced Thoracic and Lumbar Spine Management—Hands-On

Paul Arnold, MD
*Edward C. Benzel, MD**
Michael Gallagher, MD
Iain H. Kalfas, MD
Paul C. McCormick, MD
Noel Perin, MD
*Charles B. Stillerman, MD**
Dennis G. Vollmer, MD
*Eric J. Woodard, MD**

Microsurgery of the Brain, Cranial Nerves & Skull Base—Hands-On

Peter J. Jannetta, MD, DSC
*Albert L. Rhoton, Jr., MD**
Laligam N. Sekhar, MD
*Kenneth R. Smith, Jr., MD**
Perry A. Ball, MD
Fady Charbel, MD
Kevin J. Gibbons, MD
Andrea Halliday, MD
*Michael J. Rosner, MD**

Image-Interactive Neurosurgery (Frameless Stereotaxy)—Hands-On

Gene H. Barnett, MD
Richard D. Bucholz, MD
*Kevin T. Foley, MD**
*Barton L. Guthrie, MD**
Iain H. Kalfas, MD
Robert J. Maciunas, MD
Michael W. McDermott, MD
Jon H. Robertson, MD

Minimally Invasive Neurosurgery: Neuroendoscopy—Hands-On

Jacques Caemaert, MD
*Alan R. Cohen, MD**
Carl B. Heilman, MD
Axel Perneczky, MD

* Indicates course Chairmen



Richard Roski, MD, has played a pivotal role in the success of the AANS Professional Development Program, "Reimbursement Update for Neurosurgeons." This highly popular program was held six times during 1996 and is designed to assist neurosurgeons with coding and billing issues.

A recognized expert on coding and reimbursement, Dr. Roski has volunteered

countless hours as faculty for the PDP courses, and has been an articulate advocate for neurosurgeons on coding issues. He is a member of the AANS/CNS Joint Managed Care Committee, the AANS Reimbursement Committee, and the AANS Guidelines and Outcomes Committee. He also serves as the AANS representative to the CPT Advisory Panel of the American Medical Association.

Dr. Roski points out that it has never been more important for neurosurgeons to be current about coding requirements. "Recently, there has been an increase in the number of Medicare fraud investigations so it is important that physician offices have a good understanding of proper coding and material handling to avoid investigations and fines," he says. "One of the most common miscodings in neurosurgery is for office visits and consultations, and there have recently been some large judgments against billings like these.

"What we are focusing on in this program is teaching ethical ways of billing so physician offices don't inadvertently or deliberately open themselves up for investigation. It is also important that physicians properly know how to obtain maximum billings for their services. This is achieved by learning information in areas such as the structure of the office set up, the process of documentation and proper coding."

Management of Pain and Movement Disorders To Be Focus of 1997 Archives Exhibit

Among the most humane of procedures neurosurgeons can do for their patients are those designed for the management of pain and movement disorders. Procedures for sufferers have taken many different approaches for years. The Archives exhibit planned for the 1997 AANS Annual Meeting in Denver will attempt to provide an overview of some of these approaches.

Irving Cooper's cryosurgery unit will be exhibited as well as acupuncture techniques presented via videotape from neurosurgeons at the Peking Union Medical College Hospital in Beijing, China.

Two instrumentation companies, Howmedica/Leibinger and Radionics, have agreed to develop their histories into a display to be shown in the 1997 Archives exhibit. In addition, Medtronic and Electa have indicated they are seriously considering participation. Eight other exhibitors have been invited to participate as well.

If you have items you would like to lend for the exhibit, or if you would like to be involved in the development of the exhibit, please contact Chris Ann Philips, Archives Coordinator, The American Association of Neurological Surgeons, 22 South Washington Street, Park Ridge, IL 60068; telephone: (847) 692-9500.



Support the AANS Archives and the History Section by having your photograph taken with life-size images of Walter Dandy (left) or Harvey Cushing (right) in the Archives Booth.

FOCUS ON CONTINUING MEDICAL EDUCATION

AMA Physician Recognition Award Revisions

To assist neurosurgeons in providing the best medical care possible, the AANS offers a variety of continuing medical education (CME) activities. To ensure that we offer the best CME, we follow guidelines and procedures set by organizations that govern the quality of CME. To make you more aware of some guidelines for quality CME programs, we are introducing a series of *Bulletin* articles that focus on this topic. In this issue, we will address the increased emphasis the American Medical Association (AMA) Physician's Recognition Award (PRA) is now placing on self-directed physician education and how that will impact member participation in all CME activities.

The PRA is structured to enable physicians to participate in and report two types of continuing medical education:

- Formally organized and planned educational meetings, such as annual meetings and courses (category 1).
- Less structured learning experiences, such as consultations, with peers and experts concerning patients, self-assessment activities, teaching health professionals, medical writing and preparation of educational exhibits (category 2).

A review of the PRA requirements illustrate how the focus has shifted to self-directed endeavors. There are now two AMA PRA certificate options: a standard certificate and a certificate with commendation for self-directed learning. Reading authoritative literature an average of 2 hours per week is required for all certificates. The specific requirements are as follows:

AMA PRS standard certificate

3-year certificate: 150 hours

60 hours category 1

90 hours category 1 or 2

2-year certificate: 100 hours

40 hours category 1

60 hours category 1 or 2

1-year certificate: 50 hours

20 hours category 1

30 hours category 1 or 2

Reading is reportable as category 2 for the standard certificate.

AMA PRA certificate with commendation for self-directed learning

3-year certificate: 150 hours

60 hours category 1

60 hours category 2

30 hours category 1 or 2

2-year certificate: 100 hours

40 hours category 1

40 hours category 2

20 hours category 1 or 2

1-year certificate: 50 hours

20 hours category 1

20 hours category 2

10 hours category 1 or 2

Reading is not reportable as category 2 for the certificate with commendation.

The AMA also changed the CME designation statement found on all CME promotional materials. The AANS and CNS have adopted this new language, which appears here in bold: "The (AANS/CNS) designates this educational activity for a maximum of (or, "for up to") X hours in category 1 credit toward the AMA Physician's Recognition Award. **Each physician should claim only those hours of credit that he/she actually spent in the educational activity.**"

The option of earning a greater portion of your CME requirements as category 2 credits is important because there is a greater variety of activities that qualify as category 2. For example, while time spent viewing commercial exhibits at the Annual Meeting will no longer receive CME credit, you will be able to apply for category 2 credit for the time you spend attending poster sessions.

MEMBERSHIP

Board Approves 194 New Members, Total AANS Membership Reaches 4,960

ACTIVE

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Gordon Hirsh Baltuch
Linda I. Bland
Frank H. Boehm, Jr.
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Dale E. Braun
*Gerardo F. Zambito Brondo
Michael J. Caron
Lawrence S. Chin
Young Chung
*Francisco Cuevas-Salazar
Mark James Cuffe
*Roberto V. DeLeo
*David del Pozo Reyes
*Ruben Ramirez del Toro
Luis E. Duarte
Robert A. Gettleman
Mark A. Gold
Thomas W. Grahm
Christopher Guerin
Petra Gurtner
Michael G. Hartman
Christopher Dabney Heffner
*Heriberto Herrera Gomez
Steven Joe Hess
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Alan S. Van Norman
Eugenio F. Vargas
Ronald E. Warnick
John P. Weaver
John A. Wilson
Christian G. Zimmerman

**elected under grandfather provision*

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Dal-Soo Kim
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Kyung Jin Lee
Vicente C. Maldonado
Antoine Nachanakian
Jose M. Roda
Omed Sebba
Geun-Sung Song

(continued on next page)

AANS MEMBERS RECEIVE:

- ♦ Reduced Annual Meeting Registration Fees
- ♦ Reduced Professional Development Course Fees
- ♦ Continuing Medical Education in the specialized field of Neurosurgery
- ♦ Free *Directory of Neurological Surgery*
- ♦ Quarterly *AANS Bulletin*
- ♦ Special *Journal of Neurosurgery* subscription rate
- ♦ Discounts on AANS publications
- ♦ Free Access to **NEUROSURGERY://ON-CALL**
- ♦ Opportunity to become involved on AANS Committees
- ♦ Free *Fellowship Manual for Neurosurgeons* (Candidate members)
- ♦ Free *Criteria for Review of Neurosurgical Procedures* (Active members)
- ♦ Voting privileges (Active and Active Provisional members)
- ♦ Free *Guidelines for the Management of Severe Head Injury in Adults*
- ♦ Annual Continuing Medical Education (CME) transcript
- ♦ Opportunity to participate in subspecialty Sections

Categories of Membership

Active - for the ABNS, RCS of Canada, or MCNS certified practicing neurosurgeon residing in North America.

Active (Foreign) - for the ABNS, RCS of Canada, or MCNS certified practicing neurosurgeon residing outside North America.

Active (Provisional) - for the neurosurgeon who has completed a neurosurgery residency training program approved by the ABNS, RCS of Canada, or MCNS within the past five years and has not yet met the certification requirements of the ABNS, RCS of Canada, or MCNS.

Candidate - for residents who are enrolled in a neurosurgery residency training program approved by ABNS, RCS of Canada, or MCNS.

Associate - for those who are not neurosurgeons but have shown distinction in related medical disciplines. Eligible individuals include certified neuroscience nurses (CNRN, CNOR, CCRN) and physician assistants (PA-C). Associate members are nominated for membership by three voting members of the AANS.

International Associate - for those who reside beyond North America but do not qualify for Active (Foreign) membership. International Associates are nominated by three members of the AANS and must be board certified (or the equivalent) in their country of residence.

Honorary - for those who are recognized internationally for their outstanding education, research, or clinical contributions to neurologic science. The Honorary member must be proposed by voting members in good standing and approved by the Board of Directors and the voting membership.

► New Members

(continued from page 22)

CANDIDATE

Cary D. Alberstone
Cargill H. Alleyne, Jr.
Sepideh Amin-Hanjani
Rein Anton
Ethan A. Benardete
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David M. McKalip
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Vikram C. Prabhu
Mark J. Puccioni
Srinivasan S. Purighalla
John S. Sarzier
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Ran Vijai P. Singh
Clifford B. Soultz
Christopher D. Sturm
Kevin R. Teal
Kimberly D. Terry
Yashail Y. Vora
Ned E. Weiner
Charles L. Wolff, III
Sasan Yadegar
Kevin M. Zitnay



Chairman's Message — "... A Dollar a Day for THINK FIRST"

My Fellow Neurosurgeons,

The THINK FIRST Foundation is embarking upon some new directions. Our educational programs are now being implemented in elementary schools and we are reaching out to other medical specialties, offering them a chance to embrace and sponsor our educational programs.

In a similar fashion, we are redirecting our fund-raising efforts in a way that will allow us to reach a broader base of future financial supporters. Dr. Michael Caron is leading the Resource Development Committee, which is composed of several sub-committees. Collectively, these sub-committees execute the fund-raising strategies developed by the Executive Committee of the Foundation in consultation with James Yunker, EdD, of Smith Beers Yunker, Inc., the Foundation's fund-raising consulting firm.

These strategies call for some significant changes in our approach. We are reaching beyond Neurosurgery for financial support. In the near future we will solicit major national corporations for funding and offer opportunities for them to partner with THINK FIRST to spread our prevention message. We also are hoping to institute a direct-mail solicitation to the general public. This, however, is dependent on our ability to procure several highly visible, immediately recognized spokespersons for our Foundation.

Another change is how we are approaching our fellow neurosurgeons for financial support for *their* premier brain and spinal cord injury prevention program. This year we are implementing our first Annual Fund Drive. While we have certainly recognized that we must seek funding from beyond Neurosurgery, we still know that the neurosurgeons in this country have more reason to support our Foundation than any other segment of our society:

- Neurosurgeons founded THINK FIRST!



*Thomas G. Saul, MD
Chairman, THINK FIRST Foundation*

- The two national Neurosurgical organizations solely supported THINK FIRST from 1986 to 1990 and continue to provide support.
- Neurosurgeons see the devastation and heartbreak of brain and spinal cord injury every day.
- Neurosurgeons know the benefits the THINK FIRST Program offers to our society.

When we neurosurgeons look at the solicitations we receive for various causes throughout the year, THINK FIRST stands out as the most logical cause to which a neurosurgeon can contribute.

THINK FIRST leadership understands the realities of today's economy and the ever-changing status of our healthcare environment. We know that neurosurgeons' reimbursement is dropping precipitously. Therefore, our solicitation must be realistic. We should ask neurosurgeons to contribute an amount that we know all neurosurgeons can afford to contribute comfortably. Too often we are hesitant to contribute to a cause where we think the expectation is that we must pledge a large sum of money over a multi-year period. That is why we have started the Annual Fund Drive. That is why

we are now asking every neurosurgeon in the United States to give...

... a "Dollar a Day" for THINK FIRST!

Think about it. I know that I personally drop \$3-\$5 a day at Starbucks Coffee. I ask each of you to consider your own daily and weekly "spending routine." When you do that exercise, it becomes apparent how, without even thinking, we drop a dollar here or a dollar there. It also becomes clear how easy and unburdensome it would be to write one check each year for \$365 and send it to THINK FIRST.

Then, consider how much that would mean to THINK FIRST. If there are approximately 3,000 neurosurgeons in the United States and each one gave a "Dollar a Day" to THINK FIRST, that would be $\$365 \times 3,000 = \$1,095,000!$

With that money, the leadership of the THINK FIRST could — each year — provide for its annual operating budget; continually revise and develop new educational programs; put money into its endowment; and begin to develop mechanisms to funnel money back toward the local chapters. With that yearly influx of contributions from America's neurosurgeons, THINK FIRST could then concentrate most of its fund-raising efforts on major corporations and the general public. The incredible program that neurosurgeons founded could be well on its way to self-sufficiency and self-perpetuity.

It would be so easy if, each year, every neurosurgeon wrote that tax-deductible check for \$365 to THINK FIRST.

Think about it... a "Dollar a Day" for THINK FIRST!

On behalf of the thousands of children who benefit from these programs, Thank You for supporting *your* premier injury-prevention foundation.



THINK FIRST Introduces Its New Web Site

A TF Foundation Web Site on the Internet is now under development and soon will be up and running! Thanks to the hard work of THINK FIRST board members Paul Bremer and Albert Buscaino (with the assistance of AdTech Communications), this unique and innovative site will feature a wealth of knowledge on THINK FIRST and its programs, and, best of all, it will be accessible 24 hours a day, 365 days a year!

The site will feature general information on the Foundation, "News Facts," information for teens and young adults, THINK FIRST For KIDS, "hot links" to other injury prevention or related organizations and companies, and sponsor and donor information. Also to be included is a catalog of THINK FIRST merchandise complete with pictures, samples, and an order form. Interested visitors to the site can post memos, bulletins, and correspondence in a

special section that only registered users can access. If you do not presently subscribe to an Internet service provider, we encourage you to do so, otherwise, you can visit the site via your local public library.

You will be able to access our Web site at: <http://www.thinkfirst.org>. The TF Foundation welcomes your visit to the site and looks forward to interfacing with you on the World Wide Web.

THINK FIRST Receives Grant from American Legion

The TF Foundation announced that it received a \$25,000 grant from The American Legion Child Welfare Foundation, Inc. This grant was received for a project entitled "THINK FIRST For KIDS: A Brain and Spinal Cord Injury Prevention Program."

With the \$25,000 grant, THINK FIRST will be able to distribute 125 THINK FIRST For KIDS curriculum packets throughout the United States, which will be divided into five regions each receiving 25 packets. Based on a conservative estimate, one THINK FIRST

For KIDS packet reaches at least 150 children. Consequently, during the 1996-97 school year, distribution of 125 packets will have an impact on 18,750 or more first-, second-, and third-grade children. Considering the timeless nature of the message, THINK FIRST For KIDS materials can be used again and again, reaching thousands of children year after year.

The TF Foundation will call on its coordinators to distribute the packets directly to state boards of education and/or

school administrators, depending on the state, and to target inner city school districts and others serving large numbers of economically disadvantaged children who need to hear the safety message. Often, schools within these districts have limited funding and cannot afford to purchase the THINK FIRST For KIDS curriculum packets.

For more information on this grant, or if you are interested in participating in this "giving" program, please contact THINK FIRST at 1-800-THINK.56.

ANSWER TO QUESTION ON PAGE 6

The formation meeting for the Harvey Cushing Society was held on October 10, 1931, at the Hotel Raleigh in Washington, DC, with Temple Fay, R. Eustace Semmes, R. Glen Spurling, and William P. Van Wagenen in attendance. It was at this meeting they decided this new society was to encompass the disciplines of neurosurgery, medical neurology, neurophysiology, neuropathology, and roentgenology. Six non-neurosurgeons have held the post of President from these specialties. They were:

1933-34	John F. Fulton - Neurophysiology
1935-36	Merrill C. Sosman - Roentgenology
1938-39	Louise Eisenhardt - Neuropathology
1940-41	Cornelius G. Dyke - Roentgenology
1941-42	Tracy J. Putnam - Neurology/Neuropathology
1950-51	W. Edward Chamberlain - Roentgenology

POSITIONS

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

NEUROSURGERY OPPORTUNITY

An exceptionally skilled neurosurgeon is needed to become a partner in a thriving, busy private practice. Enjoy the luxury of practicing medicine while an MSO provides all of your administrative needs. Enjoy a competitive compensation and benefit package. Full privileges are available to a BC Neurosurgeon at North Iowa Mercy Health Center, Mason City, Iowa, a private, not-for-profit, 350-bed medical facility that services a 14+ county region in North Central Iowa. Mason City, Iowa, represents the best of the Midwest.

For more information on this desirable opportunity, contact:

Laura E. Weis, Representative
NIMHC/Mercy Health Services
4500 Westown Parkway, Suite 250
West Des Moines, IA 50266
515-224-3260 or fax 515-224-3546



Looking For A Neurological Surgeon?

Academic or Private Practice

If you anticipate adding a physician to your practice in the next 18 months, this service was designed for you. The most effective approach to finding a qualified physician to join your practice when you have time to do so is to advertise, write letters, and make personal calls. Each year, NS Incorporated has already been screened and has a high degree of interest in your practice. Practicing physicians and residents call us daily looking for practice opportunities.

We attended the AAN Annual Meeting in April, 1997, and would like to schedule interviews for your practice prior to that time.

For further information about this service, contact:

Joyce A. Campbell
Executive Director

888-673-6096 (toll free)

502-451-0040 (fax)

nsincorp@ayc.net (e-mail)

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University of Michigan Medical Center

Clinical Track II Faculty Appointment

Practice location at Oakwood Hospital & Medical Center

Discover the ideal environment for success with the University of Michigan Medical Center and its affiliation with the Oakwood Healthcare System, located in the rapidly expanding metro Detroit and Ann Arbor areas. Access a ready source of patients arising from a large primary care base, nursing home, and busy Emergency Department. Consider these advantages:

- Two strong and comprehensive integrated health care delivery systems serving a significant metropolitan population of 1.2 million well-insured individuals in the greater Michigan area.
- Progressive commitment to the state-of-the-art delivery of quality medicine in state-of-the-art facilities with the latest medical technologies.
- The closest atmosphere to a 315-bed community hospital with the state-of-the-art technologies of a progressive medical teaching facility, creating an ideal environment for career growth and success.

Join the faculty of the University of Michigan Medical Center reporting to Dr. Julian Hoff with a practice located at Oakwood Hospital and Medical Center Dearborn in association with Dr. Julian Rolter.

Drs. Hoff and Rolter will jointly coordinate the search process with Nancy Welch, recruiter at Oakwood Physician Support Services. To pursue this exciting opportunity, contact Nancy at 1.800.222.1054. Equal Opportunity Employer.



OAKWOOD HEALTHCARE SYSTEM

FELLOWSHIP POSITIONS AVAILABLE

The Dept. of Neurological Surgery at the University of Miami School of Medicine is now accepting applications for three fellowship positions in neurosurgery for 1997 and 1998.

The spine fellowship provides exposure to a broad spectrum of spinal pathology and experience in the latest techniques of spinal instrumentation and complex surgical exposures. A close working relationship with the Orthopedic Spine Team and the Miami Project Research Unit makes this a unique clinical and research opportunity.

The cerebrovascular and skull base fellowship provides experience in the surgical management of neoplastic and vascular pathology. This fellowship allows close interaction with interventional neuroradiologists and ENT.

The neurotrauma and critical care fellowship encompasses all aspects of neurotrauma and critical care from the operating room to the ICU. The neuro intensive care unit is totally computerized with the latest, state-of-the-art equipment, including jugular bulb monitoring and laser Doppler cerebral blood flow catheters. Treatment of severely injured patients includes hypothermia and brain protective agents.

Applicants should send cv or contact:

Glen Manzano, Dept. of Neurosurgery (M813), University of Miami School of Medicine, P.O. Box 016960, Miami, FL 33101; 305-585-5100 or fax 305-243-3931.

Names in the News

H. Hunt Batjer, MD

H. Hunt Batjer, MD, who joined Northwestern University in 1995 as professor and chief of the division of neurological surgery at the Medical School, has been named the Michael Marchese Professor of Neurosurgery. A fellow of the Stroke Council of the American Heart Association, Dr. Batjer also serves as secretary of the Congress of Neurological Surgeons. He has published widely on basic and clinical research regarding the surgical treatment of cerebrovascular disease.

Educational Opportunities

University of Texas Course to Focus on Severe Head Injury Management

The University of Texas - Houston Medical School will sponsor a two-day course on "Management of Severe Head Injury" March 7-8, 1997, at the Four Seasons Hotel in Houston. For more information, contact Beverly A. Osterloh, Conference Coordinator by phone at (713)792-5346, fax at (713)794-1707, or by e-mail: osterloh@dean.med.uth.tmc.edu.

Johns Hopkins Sponsors Alzheimer's Disease Update

Johns Hopkins Medical Institutions will sponsor a one-day seminar on "Update on Alzheimer's Disease and Other Dementias," Saturday, April 12, 1997, at Renaissance Harborplace Hotel in Baltimore, Maryland. Registration costs are \$145 for physicians and \$90 for residents, fellows, and allied health professionals. The Johns Hopkins University designates this continuing

Have You Seen?

The following members have relocated without a forwarding address. If you have any information leading to the location of these members, please contact the AANS Membership Department at (847)692-9500 or write us at the AANS National Office at 22 South Washington Street, Park Ridge, IL 60068-4287. Thank you.

Member:	Last Located:
Jack L. Barlass, MD	Calgary, AB, Canada
Albert D. Bartal, MD	Tel Aviv, Israel
John T.B. Carmody, MD	Ponte Vedra Beach, Florida
David Cleveland, MD	Peoria, Illinois
William H. Cook, MD, PhD	Shelton, Connecticut
Jose A. DeChou, MD	Hato Rey, Puerto Rico
Michel R. Decarie, MD	Pierre Fonds, PQ, Canada
Gerd Dieckmann, MD	Gottingen, Germany
William G. Evans, MD	Slaton, Texas
Nicholas Gotten, MD	Memphis, Tennessee
Everett G. Grantham, MD	Louisville, Kentucky
Stephen Francis Kornyei, MD	Budapest, Hungary
Jean Lecuire, MD	Lyon, France
Wylie McKissock, MD	London, England
Howard E. Medinets, MD	South Orange, New Jersey
Harold O. Peterson, MD	Longwood, Texas
Frederick R. Pitts, MD	Madison, Wisconsin
John M. Potter, MD	Roxburghshire, Scotland
Robert P. Singer, MD	Richmond, Virginia
Jean Talairch, MD	Paris, France
Pierre Wertheimer, MD	Lyon, France

medical education activity for up to 7 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

For more information, contact the Conference Coordinator at (410)955-2959 in the Office of Continuing Medical Education, Johns Hopkins Medical Institutions.

CNS to Offer Mock Board Exam

The Certification Committee of the Congress of Neurological Surgeons will sponsor a

mock oral board exam at the AANS Annual Meeting in April, 1997. The exam is directed toward helping physicians who have previously failed the oral board exam.

For further information, you may contact Howard Kaufman, MD, Chairman, Department of Neurosurgery, West Virginia University School of Medicine, Morgantown, West Virginia 26506. Please call (304) 293-5041 and ask for Joyce or Robin.

(continued on next page)

ANNOUNCEMENTS

Moving?

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

AANS Member Services
22 South Washington Street
Park Ridge, Illinois 60068-4287

You can reach the AANS by
email
info@aans.org

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

IN MEMORIAM

International Associate

Aaron J. Beller, MD
March 19, 1996

Lifetime

Arthur F. Battista, MD
December 13, 1995

George A. Berglund, MD
July 23, 1996

Dominic G. Gioia, MD
January 2, 1996

Robert F. Hetherington, MD
March 22, 1996

Bert H. McBride
September 12, 1996

Frederick H. McBride, MD
June 16, 1996

Claude McClure, MD
February 24, 1995

Herbert Parsons, MD
March 27, 1995

Announcements for the *AANS Bulletin* should be mailed to :
AANS Bulletin, 22 S. Washington Street, Park Ridge, IL 60068
or faxed to: (847) 692-2589

CALENDAR OF NEUROSURGICAL EVENTS

**1997 Annual Meeting of the AANS/
CNS Joint Section on
Cerebrovascular Surgery**
February 4–6
Disneyland Hotel
Anaheim, California
Contact: Meeting Services Department
(847)692-9500

**1997 Annual Meeting of American
Academy of Pain Medicine
Radisson Resort Scottsdale**
February 14–16, 1997
Scottsdale, Arizona
Contact: Eric J. Penne
(847)375-4830

**1997 Annual Meeting of the AANS/
CNS Joint Section on Disorders of the
Spine and Peripheral Nerves**
February 19–22
Newport Beach Marriott
Newport Beach, California
Contact: Meeting Services Department
(847)692-9500

**Third International Society for
Pediatric Skull Base Conference**
April 9–10, 1997
Sheraton Park Central Hotel
Dallas, Texas
Contact: Derek Bruce, MD
(214)788-6640

**1997 Annual Meeting of The American
Association of Neurological
Surgeons**
April 12–17
Colorado Convention Center
Denver, Colorado
Contact: Meeting Services Department
(847)692-9500

**Second World Congress on
Brain Injury**
May 10–14, 1997
Hotel Melia Los Lebreros
Seville, Spain
Contact: Alice Demichelis
(202)835-0580