

## AANS Bulletin

A quarterly publication of  
The American Association of Neurological Surgeons

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## AANS National Office

22 South Washington Street  
Park Ridge, Illinois 60068-4287

Telephone: (847) 692-9500

Telefax: (847) 692-2589

E-mail: [info@aans.org](mailto:info@aans.org)

Web site: <http://www.neurosurgery.org>

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## Send change of address to:

AANS

22 South Washington Street  
Park Ridge, Illinois 60068-4287

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



Volume 7 • Number 1  
Winter 1998

## Articles

- 7 AANS/CNS Outcomes Committee Plans National Pilot Study on Aneurysms
- 9 Lumbar Spinal Stenosis Communication Program Launched
- 14 Past President Appointed Chief Medical Officer of the 2002 Olympic Games
- 81 Council of State Neurosurgical Societies Report
- 82 Neurosurgery Continues Strong Presence in American College of Surgeons

## Departments

- 2 President's Message—Annual Meeting, Board Initiatives Show Impact of Neurosurgeons
- 3 Washington Update—Hot Congressional Topics for 1998
- 5 Governance—Board of Directors Holds Interim Meeting
- 16 Managed Care Update—IPAs, Independent Practice, and Health Benefits
- 83 Section News
- 85 Neurosurgical News
- 86 N:/OC®—Expands Chat Capabilities
- 88 Professional Development Opportunities
- 91 Research Foundation—1997 Campaign Update
- 92 Membership—Board Approves 258 New Members
- 93 Positions
- 95 Calendar of Events

# President's *message*

## Annual Meeting, Board Initiatives Show Impact of Neurosurgeons



Edward R. Laws, Jr., MD

Anyone who has doubts about the current-day vigor and impact of neurosurgery need only look at the preliminary program of the April 1998 AANS Annual Meeting. The scientific program of this, our 66<sup>th</sup> Annual

Meeting, offers exciting innovations in every field of neurosurgery. There is quite literally "something for everyone" and efforts are underway to make this the largest, most educationally effective and most international of any AANS meeting ever.

This will be our first visit to Philadelphia and the marvelous facilities, historic ambiance, and the incredible variety of activities, restaurants, art and culture should make this a memorable experience and one which will be enjoyed both by neurosurgeons and their families. The social program will include an integrated series of morning seminars focused around fine arts and collecting. The spouse/guest luncheon, in an elegant setting, will feature a lecture by Pauline Eversmann, of Winterthur.

The opportunities for families to take outstanding tours and to visit important sites related to the history of the United States of America represent an unparalleled opportunity. We certainly look forward to seeing you in Philadelphia and hope you will take advantage of all that this exciting meeting location has to offer.

### November Board of Directors Meeting

The AANS Board of Directors met in November of 1997, and continued with a number of activities that should be of interest to all of our membership.

### Get SMART Program

Efforts to increase the visibility and impact of neurosurgery in the areas of spinal disorders and cerebrovascular disease are progressing in a highly effective fashion. The AANS/CNS "Getting SMART About Neurosurgery: Lumbar Spinal Stenosis and the Aging Patient" marketing communications project has met with tremendous success and a large number of our members have taken advantage of the information kits, slide sets and media guides that the National Office Communications staff have made available. Initial evaluations of impact have been highly favorable and I encourage all of you to look into this superb way of letting the public and referring physicians know how neurosurgeons can benefit patients suffering from disabling spinal conditions. The next Get SMART program is currently being designed and will focus on a cerebrovascular topic.

### Outcomes and Guidelines

A major effort is underway related to the development of clinical guidelines and outcomes studies in a number of different areas. These are being coordinated through the AANS/CNS Joint Sections, and have benefited from the input of a large number of neurosurgeons interested in these critically important activities.

The Severe Head Injury Guidelines have been received with great enthusiasm and have been widely circulated. Other guidelines are under development and should serve as a fine mechanisms for primary care and other referring physicians to understand when neurosurgical problems are present and need to be referred to neurosurgeons for diagnosis and therapy.

### Recertification

The American Board of Neurological Surgery (ABNS) has endorsed a recertification process and the AANS and CNS will work together with the ABNS in order to provide the suitable infrastructure for individual neurosurgeons to meet the requirements of recertification. We are also carefully monitoring the AMA's program of accreditation, AMAP.

### Fellowships

The AANS/CNS Task Force on Fellowships has completed its report, and has succeeded in defining fellowships and in recommending some actions to be considered at the level of the ABNS and the Residency Review Committee. It is clear that fellowship training is a reality for a large percentage of our young neurosurgeons, and there are important issues relating to the quality of fellowship training and the impact on neurosurgical practice that need careful scrutiny and wise consideration.

### Cost Containment

A cost containment initiative continues under the leadership of Dr. John Kusske. Its goal is to help define those areas where neurosurgeons may not only cut costs and manage their own practice expenses, but practice in a more efficient fashion so that the costs of providing neurosurgical care to the public in general can be controlled while attempts are made to maintain a reasonable level of reimbursement for our neurosurgical services. Addressing these complex issues are a number of highly qualified neurosurgeons who have advanced degrees and expertise in management, and who have access to consultants throughout the managed care arena. Many of the ideas produced by this initiative will be discussed during the socioeconomic forum at the AANS Annual Meeting in April.

We hope that many of you will have the opportunity to meet and speak directly with Officers, the Board of Directors and the AANS staff at the Philadelphia meeting. We look forward to seeing you there.

A handwritten signature in dark ink, reading "Edward R. Laws, Jr." in a cursive style.

Edward R. Laws, Jr., MD, FACS  
President

# Washington *update*

## A Hot Topic For Congress in 1998: Should Managed Care Be Managed?

by Lori Shoaf  
Senior Washington Associate



The stage is set for a heated debate next year over the federal government's role in setting quality standards for patients. The recent flurry of activities surrounding "managed care" issues is a response to concerns over health plan restrictions and prohibitive practices. The proliferation

of managed care entities and other cost-containment mechanisms that limit the type and extent of care available to patients has generated concerns across the country. Proponents of federal standards believe legislation is necessary to ensure basic rights for health care consumers. Opponents of federal standards, including most insurance and employer groups, hold that the industry can monitor itself without federal intervention.

### The Players

A wide variety of organizations from physician and consumer groups to trade unions advocate some form of quality standards for patients. However, there is a diversity of opinion on precisely what federal protections are necessary. The trade unions and consumer groups, while supporting provisions advocated by physician organizations, generally envision a broader scope of protections. On the other side, powerful insurance and employer interests resist any quality of care mandates, regardless of how basic they may be. Some in the managed care industry, however, believe that minimum patient protections are a good idea because they legitimize cost-containment mechanisms espoused by managed care. In fact, three large HMOs (Kaiser Permanente, Group Health Cooperative of Puget Sound and HIP) joined two consumer groups (Families USA and the American Association of Retired Persons) in creating and

developing a "patient bill of rights" in September.

Recent polls conducted by the Kaiser Family Foundation suggest that a majority of citizens support minimal regulation of managed care plans. While Americans are not supportive of sweeping government regulation of the health care industry, there is extensive support for certain protections. These include ensuring that treatment options are not influenced by financial considerations as well as the right to appeal medical decisions made by insurance plans.

### Action on the Hill

Congress is concerned over public reaction to the changing health care environment. Recent stories in print and television media regarding the abuses of managed care entities have created an atmosphere ripe for reform. Illustrative of the impact of public reaction are the more than seventy bills seeking limits on health plans that have been introduced this year. Following are several of the proposals likely to be debated in the upcoming Congressional session.

#### "Gag-clauses"

Introduced in February by Congressman Greg Ganske, MD (R-IA) and Edward Markey (D-MA), the Patient Right to Know Act of 1997 (H.R. 586) currently has 296 cosponsors in the House of Representatives. This bill bans the use of "gag clauses," which prohibit physicians from discussing certain treatment options with their patients because of financial considerations. Although many health plans have voluntarily eliminated these types of clauses from physician contracts, it is imperative that legislation be enacted to ensure communications between physicians and their patients remain open and protected. Patients should never have to question whether their physician may be withholding significant information due to contractual obligations with health plans. Significantly, a provision in the Balanced Budget Act (BBA) of 1997 bans the use of "gag clauses" in all Medicare managed care contracts. The Ganske/Markey bill applies to **all health plans**, and has broad bipartisan support. Senators John Kyl (R-AZ) and Ron Wyden (D-OR) introduced companion legislation in the Senate (S. 449).

The AANS, CNS and Council of State Neurosurgical Societies have endorsed Dr. Ganske's bill.

#### Quality Assurance

Another bill likely to receive attention will be introduced early next year by

Senator James Jeffords (R-VT), chair of the Senate Labor Committee. Senator Jeffords is working with Edward Kennedy (D-MA) to draft bipartisan legislation addressing quality assurance in health care. Senator Jeffords' bill utilizes uniform guidelines and performance standards as an approach to ensuring quality care, rather than step by step mandates for health plans.

### ERISA Reform

A loophole that shields managed care companies from lawsuits is particularly vexing to Congressman Charles Norwood, DDS (R-GA). The Employee Retirement Income Security Act (ERISA) of 1974 preempts state laws that allow individuals to sue for wrongful death or injury resulting from the medical decisions of insurance companies. The evolution of managed care has created egregious instances where lawsuits have been dismissed, even though a medical director's decision, based on financial considerations, resulted in the death of a patient.

Representative Norwood is the sponsor of H.R. 1415—the Patient Access to Responsible Care Act (PARCA) of 1997—that strikes the federal preemption responsible for this loophole. The bill has 211 cosponsors and has gained widespread bipartisan support. Senator Alfonse D'Amato (R-NY) has introduced similar legislation in the Senate (S. 644). Other provisions in the PARCA bill require direct access to specialists, point of service options at the time of enrollment and continuity of care for chronic conditions. The bill prohibits prior authorization for emergency care in cases where a "prudent lay-person" would deem the situation an emergency, termination of physicians without cause and limitations on certain benefits.

Fearing that PARCA holds employers liable for decisions made by their health plans, employer groups opposed the bill. To allay these fears, Representative Norwood modified his proposal to specifically exempt employers from liability, as long as they are not making medical decisions. The modified proposal clarifies that insurance companies, if sued for malpractice, cannot file secondary suits against employers.

The AANS and CNS recently endorsed Dr. Norwood's bill.

### A Declaration of War on Patient Protections

While a majority of rank and file Republicans support limited managed care reform,

(continued on page 4)



the Republican Leadership has declared a "war" on patient protections. In a memo leaked to the *New York Times*, a Health Insurance Association of America (HIAA) lobbyist describes a meeting with staff for Senate Majority Leader Trent Lott (R-MS): *The message we are getting from the House and Senate Leadership is that we are in a war and need to start fighting like we're in a war. Republican Leadership is now engaged on this issue and is issuing strong directives to all players in the insurance and employer community to get activated.*...Lott told Senator Jeffords that he could not introduce his "Quality Bill" this session...Sen. Lott also said that Senate Republicans need a lot of help from their friends on the outside, "Get off your butts, get off your wallets."

The memo also referenced a directive from the Republican leadership that managed care and business interests should "write a definitive piece of paper trashing all these bills." In another leaked memo written by House Majority Leader Richard Armey (R-TX), Republicans are encouraged to resist any and all managed care reform provisions.

In response, Congressman Greg Ganske, MD (R-IA) sent a letter to his Republican colleagues describing abuses of managed care that have resulted in the deaths of patients. He also referred to testimony given before the House Commerce Committee by Linda Peeno, a former HMO claims reviewer, describing the focus of HMOs on financial profit over patient care. Ganske accused the Republican leadership of "being in the pocket of the HMOs," and pointed to the number of reform supporters from both parties as indicating popular support for patient protections.

The primary argument of those opposing reform is that these protections will drastically increase insurance premiums. Increased premiums would lead to large numbers of uninsured Americans (as employers no longer offer insurance to their employees), and thus government-run health care. It is important to note that the AANS and CNS did not endorse the Clinton Health Plan. What we do support is legitimate protections for access to specialty care and for the rights of the patients we serve. As Congress debates these issues, the key question will be the cost of the various provisions in these bills.

In a widely publicized actuarial analysis of the PARCA legislation, private-sector premiums were estimated in the range of 7-39 percent. However, a closer look at this analysis reveals that many of the protections

sought by the AANS and CNS are of negligible impact on insurance premiums. The mandatory point of service option, elimination of prior authorization for specialty referrals and limits on prior authorization for emergency services each raise premiums less than half a percent.

## A Bill of Rights for Health Care Consumers

The Clinton Administration has also entered the debate over health care quality. In March, President Clinton appointed an Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The President charged the Commission with reviewing the rapidly changing healthcare market, and making recommendations regarding consumer protections. The 34-member advisory commission is composed of health care providers, representatives from the business community, representatives from labor, consumers and health plan representatives.

This diverse group worked on a consensus basis to draft a "Health Care Consumer Bill of Rights." Completed in November, the Bill of Rights espouses the following principles: disclosure of health plan information on benefits and restrictions, access to networks with adequate numbers and types of providers, direct access to specialists for patients with chronic conditions, access to emergency treatment, the right to be told of all treatment options regardless of their expense, confidentiality of medical records, and the right to an external appeals mechanism for denials of care or reimbursement.

President Clinton subsequently issued a directive that all federal health plans adopt these policies immediately. He then instructed the Department of Health and Human Services (HHS) and the Department of Labor to review the document to determine which rights are enforceable under current law. Rights that are not enforceable under existing law will be included in a legislative package the President will submit to Congress.

The AANS and CNS, along with over 100 other organizations, sent a letter to President Clinton calling for federal standards to ensure access to quality care. The letter noted concerns regarding barriers to care patients face because of health plan restrictions, and pointed to the Health Care Consumer Bill of Rights as a framework for standards that will ensure access to quality care and all available treatment options.

## What is Organized Neurosurgery doing?

To address many of these issues, the AANS and CNS are working with the American Medical Association (AMA), the American College of Surgeons (ACS), and the Patient Access to Specialty Care Coalition (PASCC). We are founding members of the PASCC, which will serve as our primary mechanism for addressing access to specialty care issues. The coalition seeks minimum protections to ensure that care will not be arbitrarily denied, and that physicians will not be required to withhold information regarding various treatment options because of financial considerations.

Most recently, the coalition supported the Medicare Patient Choice and Access Act of 1997, H.R. 66. The bill, sponsored by Tom Coburn, MD (R-OK) and Sherrod Brown (D-OH), includes patient protections that ensure Medicare beneficiaries have access to specialty care in Medicare managed care plans. Specifically, the bill allows a point-of-service option so that Medicare beneficiaries can select a plan with coverage for out-of-network services, ensures timely and appropriate in-network access to specialists, prohibits the use of financial schemes that reward providers for not referring patients to specialists, and ensures a timely and objective appeals process for disputes between patients and health plans. A similar bill (S. 701) was introduced in the Senate by Charles Grassley (R-IA) and Kent Conrad (D-ND).

Many of these provisions were incorporated in the Balanced Budget Act (BBA) of 1997. The PASCC will now turn its attention to the private insurance market, and will draft a bill similar to H.R. 66 that applies to all health plans.

## A Call to Action

**As a primary point of contact with patients, it is important that you communicate your concerns regarding health plan practices to your members of Congress.**

Please point out that these issues are real, and not merely "a few horror stories" portrayed in the media. Please remember to report any contacts with members of Congress to the Washington office so that we may follow up on your efforts. You may do so by contacting Lori Shoaf at (202) 628-2072, via fax at (202) 628-5264, or via E-mail at LoriShoaf@aol.com. If you have questions or concerns regarding managed care or other federal government issues, please contact Katie Oricco or Lori Shoaf in the Washington office at (202) 628-2072.

## Board of Directors Holds Interim Meeting

The AANS Board of Directors convened in Chicago November 19-22 for their 1997 Interim Meeting. Although the meeting focused on several substantive financial issues, a number of other key discussions took place as well. The highlights of the major actions taken are summarized here.

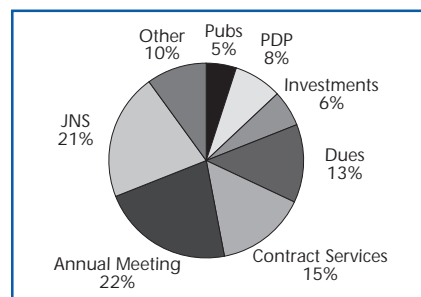
### Finance Committee

Stewart Dunsker, MD, Treasurer and Chairman of the Finance Committee, reported that the AANS had an outstanding year financially, projecting 1997 revenues at \$13.4 million against expenses of \$11.99 million, leaving a net revenue of \$1,425,205. He stated the revenue represented across the board improvements in all program areas, along with larger than anticipated investment revenue, resulting from the growth in value of AANS investments in mutual funds.

Dr. Dunsker recommended, and the Board approved, a proposed fund allocation for 1997 net revenues as follows:

Board Designated	
Fund (reserve)	\$ 551,000
Replacement Fund	\$ 471,000
Technology Fund	\$ 41,000
New Business	
Ventures Fund	\$ 41,000
Capital	
Equipment Fund	\$ 321,000
<b>Total</b>	<b>\$1,425,000</b>

Overall, the Association is in good financial health, with diversified sources of revenue. The accompanying charts show the sources of revenues as follows:



It should be noted that dues represent only 13 percent of overall revenues for the AANS. This compares favorably with other medical associations, which obtain 40 percent of their revenue from dues. Development of new programs, such as the Professional Development Program (PDP) courses and publication of various textbooks, have allowed the AANS to maintain very diversified revenue sources. This not only helps the Association to bring advances in surgical techniques to members in a timely way, but also helps to fund new educational activities.

In April 1997, at the recommendation of the Finance Committee, the Board of Directors approved a change in fiscal year from a calendar year (January through December) to July 1 through June 30. This change was made for several reasons:

- Shift the annual audit from the busiest time of the year, thus reducing staff overtime and lowering the cost paid to the outside auditing firm.
- Coordinate the AANS fiscal year with that of the Congress of Neurological Surgeons, thus improving financial reporting for joint projects.

To bring the budget process into compliance with the new fiscal year, two budgets were presented to the Board for review – a six month budget covering the period January 1, 1998 through June 30, 1998 and a one-year budget covering July 1, 1998 through June 30, 1999. The Finance Committee projects modest growth for the AANS during the 18-month period covered by the two budgets and recommended a conservative plan for both revenues and expenses.

Several years ago, the AANS began the process of upgrading the Association's computing systems. The Association's hardware and software were at that time more than six years old and beginning to show their limitations. The AANS now stands midway through the conversion process. The hardware upgrade was principally accomplished in February and March of 1996, although an occasional small expenditure occurs, as technology continues to evolve and improve.

The software conversion is now underway and occurring in two segments: Association management software (management of the membership database) and Accounting/Finance. At the recommendation of the Finance Committee, the

Board approved immediate purchase of new financial software. It is anticipated the system will be tested and ready for implementation at the beginning of the new fiscal year on July 1, 1998. A proposal for new association management software is being prepared for a decision at the beginning of 1998 and implementation by year's end.

### Nominating Committee

J. Charles Rich, Jr., MD, Immediate Past President and Chairman of the Nominating Committee, announced the recommended slate of Officers, Directors and Nominating Committee members for 1998. The Board of Directors approved the following slate of nominees, which will be presented for consideration by the voting members:

**President-Elect:** Martin H. Weiss, MD

**Vice President:** Stewart B. Dunsker, MD

**Treasurer:** Roberto C. Heros, MD

**Directors-at-Large:**

William F. Chandler, MD, Volker K.H.

Sonntag, MD, Fremont P. Wirth, MD

**Nominating Committee Members:**

Richard A. Roski, MD, James R. Bean, MD

In accordance with the Bylaws, the foregoing slate will be mailed to the voting members in late January. If no opposing candidates are proposed, this slate will be voted on at the Annual Business Meeting on Monday, April 27, 1998 in Philadelphia, Pennsylvania. 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 96 Active Members, 57 Candidate Members, 94 Active (Provisional) Members, and 11 Associate Members. In terms of Membership class transfer requests, the Board approved 40 transfers from Active (Provisional) Membership to Active Membership, three transfers from Lifetime to Active, one transfer from Active to Active (Foreign), one transfer from Active (Foreign) to Lifetime (Inactive), two transfers from International Associate to Lifetime (Inactive), and 52 transfers from Active to Lifetime. In addition, the Board accepted two resignations, one from Active Membership and one from Associate Membership, as the individuals are no longer working in the field of neurosurgery.

The complete list of new members appears on page 00. Total membership for the AANS is now 5,177. Finally, the Board received notice of the deaths of 23 members and observed a moment of silence in their honor.

## ABNS

The Board reviewed the report of John C. VanGilder, MD, Chairman of the American Board of Neurological Surgery (ABNS), which described ABNS activities during the 1996-97 academic year. Some of the major issues highlighted in his report were:

- **Resident Numbers**—There are presently 98 neurological surgery training programs in the United States. There were 130 positions offered in the 1997 Neurological Surgery Matching Program and all positions were filled from the 240 individuals who submitted a ranking list. The number of positions offered was 10 less than 1996.
- **Primary Examination**—The ABNS administered the 1997 primary (written) examination on Saturday, March 22, 1997 to 567 examinees at 107 test centers. Of these examinees, 263 were candidates for certification and 304 were self-assessment examinees. The pass rate for those taking the examination for credit was 79 percent.
- **Oral Examination**—Seventy four candidates were examined in November, 1996 and 75 candidates were examined in May, 1997. The pass rate was 81 percent. The Board has certified 4,542 neurological surgeons since its incorporation in 1940, and approximately 3,420 are in active practice.

The ABNS Directors have been unanimously of the opinion that the oral examination should be more standardized. Yet they wish to maintain the flexibility of utilizing personal cases to further probe the candidate's knowledge. Consequently, a new examination format has been created in which each candidate receives 18 ratings from each examiner in relation to clinical assessment, acute management and complications (long-term management) of tasks selected by the examiner. In addition, based on greater than 45 ratings throughout the examination, a statistical measurement of examiners severity is developed.

This modified grading system was used simultaneously with the standard

format during the November 1995 and November 1996 examinations and the pass/fail incidence was similar with both approaches. In addition, the new grading format was tested for the May, 1997 oral examination, with a similar outcome in the pass/fail rate to previous years. The ABNS will likely adopt this new grading system to enhance standardization and add statistical weight to the pass/fail score of the oral examination.

- **Time Limited Certificates and Recertification**—The ABNS is considering issuing a ten-year, time-limited certificate beginning in 1998 and recertification in 2005. Recertification criteria being discussed includes a current valid medical license, verification of satisfactory clinical performance, completion of 90 hours CME activities in the three-year period immediately preceding the recertification application and successfully passing a written examination.

At the May, 1997 ABNS Board meeting, Robert H. Wilkens, MD, and Burton M. Onofrio, MD, completed their six-year terms on the ABNS and new directors were elected, including R. Michael Scott, MD and David G. Piepgras, MD. New officers elected were John C. VanGilder, MD, Chairman, and Fremont P. Wirth, MD, Vice Chairman. Donald O. Quest, MD, continues as Secretary and Stewart B. Dunsker, MD, Treasurer.

## CPT Coding Committee

In light of increasing complexity of physician reimbursement, particularly with regard to CPT coding, the Physician Reimbursement Committee recommended that a separate committee to deal with CPT issues be created. It was further recommended that shared membership be maintained between the new CPT Committee and the Physician Reimbursement Committee.

The nature and scope of activities relating to reimbursement have become more technical and detailed than five years ago and require a major volunteer commitment. The complexity of some of the policies proposed by the Health Care Finance Administration (HCFA) that require a detailed response has escalated steadily, not to mention the growing number of inquiries from members and managed care organizations seeking information.

Agreeing that creation of a separate committee for CPT issues would be a useful step in the specialization of efforts to deal with problems that relate to the relationships between CPT and reimbursement, the Board approved establishment of the committee. It was suggested that the committee be joint with the CNS under the direction of Richard Roski, MD, and, therefore, will require approval of the CNS Executive Council to implement.

## Professional Conduct

One case, which involved a member who presented expert witness testimony,

(continued on page 15)



*1997-98 Board of Directors*

*Seated (left to right): Stan Pelofsky, Stewart B. Dunsker, Russell L. Travis, Edward R. Laws, Jr., J. Charles Rich, Jr., William Shucart. Standing (left to right): Roberto C. Heros, A. John Popp, William A. Friedman—CNS President, Robert A. Ratcheson, P. Robert Schwetschenau, Karin M. Muraszko, William E. Mayer, R. Michael Scott, Arthur L. Day, John A. Kusske, James R. Bean, Robert E. Draba, PhD—Executive Director. Not Shown: Robert B. Page*





# AANS/CNS Outcomes Committee Plans National Pilot Study on Aneurysms

"What are the chances I will recover?" It's the question every patient asks, every managed care company gambles with and every physician needs to answer. How do you monitor a patient's outcome for a certain condition following a specific procedure? For better or worse, outcomes studies are one of the "hottest" topics in medicine and are popping up nationwide.

To address outcomes, guidelines, standards and quality issues within neurosurgery, The American Association of Neurological Surgeons and Congress of Neurological Surgeons created the Committee on Assessment of Quality, chaired by Robert Florin, MD. The Outcomes Committee, chaired by Robert E. Harbaugh, MD, falls under the direction of the Committee on Assessment of Quality (CAQ) and is dedicated to producing outcomes instruments for neurosurgeons to use within their own practices.

"The basic function of the CAQ is to measure or assess how well a component of quality approaches some standard of reference in healthcare delivery," Dr. Florin said. "The ability to actually measure quality, defined as the degree of conformance to a standard, requires that such a standard exist and be available for comparison to the component of quality under examination. Assessment of quality becomes a tool to evaluate how well an intervention approaches such a standard, and translates into a judgment of how well the intervention worked considering the benefits, risks and costs."

## Background on the AANS/CNS Outcomes Committee

Outcomes studies started to appear during the 1980s as third party payers and patients began to question why there were such variations in health services delivery in different parts of the country, or even from physician to physician in the same city. Outcomes studies set out to improve the health of a patient or community in the

most cost-efficient manner by analyzing the way care was delivered, the clinical standard for a specific condition, patient satisfaction and the overall cost of the patient care.

"Outcomes studies are a controversial issue in medicine," Dr. Florin said. "But, other organizations, like third party payers, are conducting these studies on their own and drawing conclusions from their data. If we feel it is appropriate to question these studies, we must have data of our own to counter with."

The AANS/CNS Outcomes Committee consists of representatives from each of the Joint Sections and various consultants. The committee has created two outcomes measurement instruments and has slated other projects for 1998. Most of the projects use **NEUROSURGERY://ON-CALL®** as the data submission point.

The goals of the Outcomes Committee are:

- To serve as a resource for information regarding outcomes studies
- To educate the neurosurgical community regarding the value and methodology of outcomes studies
- To supply generic and disease-specific outcomes reporting instruments to neurosurgeons interested in this work
- To conduct national outcomes research in a cost-effective manner
- To develop a data management mechanism for neurosurgery that could be used at a national level with minimum expense.

"One problem with many outcomes studies is that they are being conducted by people who know little or nothing about the disease process being evaluated," Dr. Harbaugh said. "This is why it is critical that professional organizations, like the AANS and CNS, be involved in neurosurgical outcomes studies. We are clearly the ones who have the best understanding of the conditions, the procedures, the patients and how different variables can affect outcome."

Third-party payers, healthcare organizations and other groups have been conducting outcomes studies that affect neurosurgical procedures for at least the past 5 years.

"Our membership should be aware of the possibility that their practice behavior resulting from the applications of various monitoring methods is being assessed," J. Charles Rich, MD, said as President of the AANS in 1996. "They should also become better informed as to how that evaluation occurs and for what purposes. In one way or another, it is going on all around us."

Physiatrists, orthopedic surgeons and neurological surgeons, for instance, sometimes differ in their approach to the diagnosis and treatment of cervical and lumbar radiculopathic syndromes.

"Because a given Health Plan Physician Board is likely to increasingly employ the reasonable criteria of value = quality of outcome divided by cost, in deciding about referral patterns, who will end up providing an accurate definition for the numerator on the right side of that equation and to whose advantage that definition derives becomes very important," Dr. Rich said. "Like it or not, this is an area we need pay close attention to."

## Aneurysm and Carotid Endarterectomy Local Outcomes Database

Currently, members can download aneurysm and carotid artery disease outcomes measurement instruments from **NEUROSURGERY://ON-CALL®**.

These instruments allow neurosurgeons to keep a local database of aneurysm and carotid patients from their own practice. Information is not submitted to a national database.

"These are the first steps and the most basic of outcomes studies," Dr. Harbaugh said. "It helps document patient risk factors, location and size of aneurysms, and patient outcome. It allows a neurosurgeon to

(continued on page 8)

present data on how many cases he or she treats and the patient outcomes.”

Once national data has been compiled for a specific condition, physicians can use local databases to see how they compare on length of stay, complications, patient satisfaction, and other factors.

“These are meant for self-assessment,” Dr. Harbaugh said. “By including risk factors and patient information, it makes the studies more credible. Obviously, a neurosurgeon who treats high risk patients would be expected to have less favorable outcomes.”

## Aneurysm Outcomes Pilot Study

The Outcomes Committee has arranged for an national intracranial aneurysm outcomes study to begin in January of 1998. The study includes 11 centers from around the United States and will measure clinical, lesional and functional outcomes in patients treated with microsurgery or neuroendovascular procedures.

“This is a pilot study for us,” Dr. Harbaugh said. “We want to test out the submission process and data analysis to see what our capabilities are. We need to actually start collecting data to see where the problems lie. We are hoping to make this is a very meticulous study.”

The study will analyze patient risk factors; aneurysm risk factors, such as size and location; length of hospital stay; complication rates; quality of life/functional health status measures; and patient satisfaction. The SF-36 form, which tests the patients perception of quality of life, will be used to measure functional outcome. The GHAA 9 will be used to measure patient satisfaction.

The neurosurgery centers involved in the study include both academic and private practice groups. Patients will be enrolled over a six month period and followed for an additional six months. It is anticipated that about 300 patients will be involved in the study.

“We don’t expect every neurosurgeon to be interested in keeping such a detailed database on all patients,” Dr. Harbaugh said. “Our goal is to develop basic, generic instruments such as a neurosurgical ‘report card’ that can easily be used to help in negotiating with third party payers, and

also to develop more complex, disease specific instruments that will permit meticulous neurosurgical outcomes research to be done on a national basis.”

## The Future of Outcomes Studies

Neurosurgeons have already presented scientific abstracts and articles showing how an outcome study, clinical pathway or guideline has improved patient care or reduced cost.

“Reliable outcomes studies can lead to meaningful practice guidelines and clinical pathways which subsequently lead to improved outcomes,” Dr. Harbaugh said. “They are all tied together with the goal of providing efficient, effective patient care based on reliable data. At present we are pursuing a system that will allow national outcomes studies to be done via the **NEUROSURGERY://ON CALL**® Web site. Eventually such a system can be used for self-assessment and perhaps for re-accreditation.”

In a poster presented at the 1996 CNS Annual Meeting, physicians KL Saban and Michael J Caron concluded that “implementation of a clinical pathway for lumbar microdiscectomy decreased average length of stay without significant changes in patient outcome or satisfaction.” The poster showed morbidity, mortality, readmission rate, length of stay and

patient satisfaction before and after a clinical pathway was implemented and showed a 24 percent decrease in LOS after the pathway took effect.

*The Guidelines for the Management of Severe Head Injury* were developed by the AANS and Joint Section on Neurotrauma and Critical Care in 1995. These are the only national practice guidelines relating to neurosurgery that have been released. According to a recent Trauma Section survey, 93 percent of neurosurgeons polled were familiar with the Guidelines. Over 45 percent of those polled said the *Guidelines* have changed their practice.

“The results of the survey show that it appears the *Guidelines* have had significant impact on the care of severe head injury patients in North America,” Donald Marion, MD, one of the authors of the Guidelines, said. “Clearly, however, neurosurgeons also treat patients in ways that they feel are most appropriate, irrespective to the *Guidelines*.”

There are several other practice guidelines currently under development by the Sections, including severe head injury in children, mild head injury, spinal cord injury, and gliomas.

“No matter if it’s outcomes studies, guidelines or some other tool, our overall goal is the same,” Dr. Florin said. “We must create and bring a standard of quality to the healthcare field.”

## IN MEMORIAM

Orlando J. Andy  
John T.B. Carmody  
David Cleveland  
William Druckemiller  
John A. Eisenbeiss  
J. Garber Galbraith  
John P. Gallagher  
Gerard Guiot

John A. Hetherington  
Chester B. Powell  
David B. Roth  
Ronald Smith  
Richard M. Swengel  
Henk Verbiest  
Manus Vimolchalao  
Shelley Wernick





# Lumbar Spinal Stenosis Communications Program Launched

By Stan Pelofsky, MD  
Chairman, AANS/CNS Communications Initiative

Last spring, The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) announced they were joining forces to develop a marketing communications campaign specifically for neurosurgical spine surgeons. The program, "Getting SMART About Neurosurgery: Lumbar Spinal Stenosis and the Aging Patient," was launched in late September and has quickly garnered support from members, patients, referring physicians and the media.

Member participation in this first-ever communications initiative has exceeded expectations and public awareness of lumbar spinal stenosis (LSS) and the neurosurgeon's role in treating it has increased. By all measures, the program is an unqualified success.

## Why the Program was Created

This program was created because 50 percent of our members reported they aren't busy enough—surgeries are down and competition is up—and they wanted help in responding to the challenge. The result was an innovative national and community-based communications and educational effort that focused on the topic of lumbar stenosis. This disorder was chosen for four basic reasons:

- It is a common neurological condition not well understood.
- It has a large enough patient base to warrant coverage.
- The aging patient base will result in an increasing number of cases.
- This is a surgical area where neurosurgeons can exert leadership.

The program objectives are to:

- Increase awareness of the scope/benefits of neurosurgery.
- Associate neurosurgeons with the treatment of backs and spinal disorders.

- Educate the public about lumbar spinal stenosis.
- Encourage patients to seek neurosurgical evaluation.
- Create opportunities for expanded referral relationships.
- Promote the timely, appropriate application of neurosurgical solutions to health needs.
- Help neurosurgery enhance and expand its role as a valued provider of health care.

What sets this communications program apart from other public information efforts is that it asks neurosurgeons, themselves, to become spokespersons, or Ambassadors, for the specialty. We want to do more about lumbar spinal stenosis because we know our services can help thousands of people who are living with unnecessary pain. This is both a public health issue and a quality of life issue for hundreds of thousands of older people. The key messages the program delivers are:

- LSS is a hidden neurological condition. As many as 400,000 Americans may have symptoms, however, most have not been diagnosed with the condition.
- Neurosurgeons say Americans need to know more about LSS because it's frequently misdiagnosed or under-diagnosed and, as a result, many people suffer needlessly and for longer than necessary.
- Treatment is available so sufferers can resume active lives.
- Patients are urged to listen to their bodies, describe the symptoms, and ask their primary physicians if a neurosurgical consult is in order.

This is an important initiative for American neurosurgery, as reflected by the leadership team that put this program together.

## Activities Thus Far

The LSS communications initiative was launched at the end of September with distribution of a media kit to health writers nationwide. In addition, a video news release (VNR) was made available to network television stations throughout the country by satellite download.

In just a little more than two weeks 25 television stations aired the VNR a total of 36 times. We reached a total of 220 television markets and an estimated audience of 5,201,290 viewers.

We were gratified to note that the VNR was aired in decent time slots—5:00 PM or 11:00 PM, which means they were most likely used during the evening news broadcasts. We also reached some top markets, including Chicago, Miami, Pittsburgh, Boston, Denver, and New Orleans.

During the same time, a neurosurgical exhibit featuring the LSS campaign materials was displayed at the 1997 Annual Scientific Assembly of the American Academy of Family Physicians held in Chicago, where more than 1,000 family physicians received the referral brochure.

A few weeks later all those neurosurgeons who had enrolled as Ambassadors received their shipments of educational and professional outreach materials for distribution to patients and referring physicians in their communities. Thus far, approximately 325 neurosurgeons have enrolled as Ambassadors for the program. They are using the slides to give presentations to civic groups and medical organizations, giving interviews to local media, doing mailings of the physician referral brochures to colleagues, and providing the public education brochures to patients visiting their practices.

Lloyd Zucker, MD, of Boca Raton, who had provided input for some of the LSS material, made a presentation using the professional slides during a plenary session at the Southern American Academy of Family Physicians Annual Meeting attended by approximately 300 family

(continued on page 13)

physicians. "The slides were very well received. The family physicians were very interested in the topic and asked a lot of questions," Dr. Zucker said. "Family physicians are an audience that more neurosurgeons need to reach. The slides and syllabus made it easy."

Overall, members have purchased more than 60,000 patient brochures and 33,000 physician referral booklets. In fact, it was necessary to print additional quantities of the physician referral brochure and produce more slide sets in order to keep up with demand.

## Putting the Program to Work for You

The LSS program is an easy-to-use public education and practice-building tool that directly responds to the challenges of today's healthcare marketplace. It allows you to use your knowledge as a specialist in spine surgery to serve as a spokesperson for neurosurgery while, at the same time, enhancing the visibility of your practice in the community.

The materials in the program are comprehensive, but also allow room for individual neurosurgeons to tailor the program to fit their practice needs. All of the program materials and key media messages are of very high quality and have maximum impact. They focus on both the specific patient benefits of the services offered and why neurosurgery is the "provider of choice." These materials include the following:

- **Ready-to-Use Slide Presentations on LSS (patient and professional):** Two slide sets, with accompanying syllabi. The professional slide set is designed for presentations to family physicians, internists, physician assistants or other healthcare professionals. The patient slide set is designed for presentations to patient groups and the general public.
- **Referral Source Booklet** This full-color, 12-page booklet describes the disease pathophysiology and pathogenesis, recommended diagnostic tests, treatment and surgical options, and when it's appropriate to refer a patient for neurosurgical consultation. They can be used as leave-behinds at presentations or in mailings to primary care providers and other referral sources. Also provided is a sample letter you can send to primary care physicians, physical therapists, chiropractors and

other who often see lumbar spinal stenosis sufferers before you do.

- **Patient Brochure:** This full-color, 12-page brochure contains a simple but complete discussion of the causes and treatment options for lumbar spinal stenosis. It includes information on understanding the disease, symptoms, treatment options, surgical criteria, and explanations of various operative procedures, expected outcomes and risks.

The materials can be purchased separately but are also available as part of a special Ambassador Package which includes all of the above materials (200 patient brochures and 100 referral source booklets), along with a media kit, sample referral letters, and a video news release. As an Ambassador, you become a spokesperson for neurosurgery, educating patients and referring physicians about the problem of lumbar spinal stenosis and the neurosurgeon's role in treating it.

The media kit is especially helpful as an aid in helping you to build a working relationship with the reporters in your community. It includes press releases, fact sheets and tips on working with the press. Aimed at reporters and editors who specialize in health care issues, the media kit encourages them to do stories on spinal stenosis and to contact you for comment. The media materials are ready to be photocopied and distributed by your office staff; you may also provide them to the Public Relations office at your medical center for follow up.

I am using this material here in Oklahoma City and can personally attest to their

usefulness. We distributed the professional booklet to a number of colleagues who had previously referred patients to our practice but, for one reason or another, were no longer doing so. Within a month we could see an increase in referrals for stenosis consultations in our practice.

## Success Measures

When we first developed the LSS program, we established a list of goals against which we could measure our success. I am pleased to report that we are well on our way to achieving most of them and, in fact, have already surpassed several of them. Following is a summary of our progress toward achieving program goals (please note that some goals require that the materials be in circulation for awhile before results can be known. These goals are marked N/A)

## Join Now

It is vital that we speak up and remind consumers, referring physicians, third-party payers and even the media about the value and contributions of neurosurgical care to the well being of patients.

If you have not yet enrolled to participate in this unique, high-quality program, we urge you to act now. More than 300 of your colleagues have already purchased materials and are using them in their practices today.

For more *program details*, contact Susan Nowicki, APR, Director of Communications at the AANS National Office, (847)692-9500, ext. 45. To *order* program materials, contact Laura Weiss in the AANS Publications and Orders Department, ext. 39.

Goal	Achieved to Date
Recruit a minimum of 150 LSS Ambassadors	325
Distribute Professional Brochure to a minimum of 15,000 potential referral sources	33,000
Obtain video news release placements on at least 30 local TV stations	25
Obtain at least 15 million media impressions for LSS and neurosurgery in general	5, 201,290
Obtain LSS coverage in 20 major national news outlets	N/A
Conduct a minimum of 150 presentations to public and/or professional audiences	N/A
Increase Neurosurgery's "share of voice" among back surgery stories found in the DataTimes media database to 50 % during 1997-98	N/A
Make a "noticeable impact" on patient/referral inquiries on LSS for at least 20% of members participating in the program	N/A



# Past AANS President Appointed Chief Medical Officer of Olympic Games

J. Charles Rich, Jr., MD, immediate Past President of the AANS, was appointed the Chief Medical Officer of the 2002 Olympic Winter Games in Salt Lake City, Utah. Dr. Rich was President of The American Association of Neurological Surgeons in 1996 and remains on the AANS Board of Directors.

As Chief Medical Officer, Dr. Rich will assume a leadership role in assuring the Salt Lake Olympic Organizing Committee's medical service time lines, objectives and medical-related issues are accomplished. He also will play a vital role in the International Olympic Committee Medical Commission over the next four years. The *Bulletin* recently asked Dr. Rich about his new role and what it means for him and organized neurosurgery.

## How did you initially become interested in the Chief Medical Officer position for the 2002 Winter Olympic Games?

For many years I consulted with and treated college athletes who had sustained head or spine injuries while representing the University of Utah. Elite caliber athletes, particularly those who compete in the Olympic Games, must have access to able, as well as ethical, medical doctors.

Because of that background and those concerns, I inquired as to the exact job description of the XIX 2002 Winter Olympic Games Chief Medical Officer. That inquiry, in turn, brought about an invitation to attend a three-day meeting of the International Olympic Committee (IOC Medical Commission held in Monaco). The experience there confirmed, to my satisfaction, the important mission of that panel and the high quality of the individuals who comprise it. They are an impressive group with whom I feel comfortable serving and sharing considerable responsibilities.



*J. Charles Rich, Jr., MD*

## Over the next 3 years, what will be your responsibilities as the Chief Medical Officer?

For the present time my responsibilities are two-fold. First, with a good deal of staff support from Intermountain Healthcare, Inc. (IHC) and the Salt Lake Organizing Committee (SLOC), detailed plans are underway to accurately project and then meet the potential medical needs of the three thousand Olympic athletes, hundreds of Olympic officials and the estimated more than a hundred thousand spectators and journalists who will visit our city during February of 2002.

Intermountain Healthcare, Inc., a respected not-for-profit medical care organization (MCO) with more than twenty hospitals in our region, has committed its staff, facilities and financial support to help ensure that we, as a medical community, succeed. All of the medical services will be provided on a voluntary basis and will require consensus-building within public health, nursing, EMT, paramedic, dental and physical therapy groups in addition to the large number of medical doctors whose contributions of time and talent will be essential if we are to achieve our goal.

A second duty relates to my role as a member of the IOC Medical Commission. At the Nagano Winter Olympic Games this coming February, 1998, for instance, I will have direct responsibilities for the supervision of drug testing of

athletes. The same will be true at the Sydney Summer Olympic Games in 2000. The IOC, through its Medical Commission, takes a firm stance against "doping" of athletes under any guise. Positive urine tests are rare, but the testing continues to be rigorous and is scientifically credible. The Medical Commission is adamant about this issue and their stance is both justifiable and admirable. I will have no hesitancy advocating their policies and helping to enforce them.

## When the job becomes full-time the six months before the Olympics and during the Games, what will your role be?

For the six month period just preceding the 2002 Winter Olympic Games in Salt Lake City, it may be difficult to maintain my usual practice of neurological surgery, but I will try. That is how I earn a living. On the other hand, the capable administrative staff provided to me by IHC and SLOC cannot do what will be most needed just before and during the Olympics: the enlistment, encouragement and organization of willing, capable medical coverage personnel for the multiple competitions venues and the emergency medical needs of participants and spectators. That may be a full-time job.

At the recent IOC Medical Commission Meeting, Dr. John Cantrell, Chief Medical Officer (CMO) of the 1996 Atlanta Summer Games, delivered a compelling slide presentation and report which vividly portrayed the enormity of the medical obligations and responsibilities which were carried out just one and one-half years ago. The Atlanta medical community set a high standard of cooperation and generosity for others to follow. Like Dr. Cantrell, I will need enthusiastic, dedicated assistance from many others if we are to have comparable



success. Our excellent University of Utah Health Sciences Center has volunteered, for example, to construct the facilities and then provide medical services at the Olympic Village Polyclinic, which is to be located on campus. We will need assistance from individuals and groups across our entire medical community spectrum.

### How does your training as a neurosurgeon prepare you for this position?

The Chief Medical Officer (CMO) for the Nagano 1998 Winter Olympic Games is also a neurological surgeon. A member of the American Association of Neurological Surgeons (AANS), Shigeaki Kobayashi, an internationally recognized skull base neurosurgeon trained at the Mayo Clinic and residing in Marumoto, Japan, has proven to be an excellent planner and administrator.

We are a small yet differentially important surgical subspecialty. In virtually every aspect of our practice, we have to work with others. It is a practical necessity. Therefore, it should come as no surprise that neurosurgeons tend to become involved with and assume other organizational responsibilities. Willingness to cooperate and collaborate are common neurosurgical attributes. As an illustration, since I will depend upon close cooperation between IHC and our academic medical center, it is advantageous that the new Dean of our University of Utah School of Medicine is a neurosurgeon, Peter Heilbrun. Needless to say, that is just fine with me.

Actually, if this entire venture turns out to have been anything other than great fun, wonderfully informative and thoroughly enjoyable experience, I will be very surprised!

## CONFERENCE ADDRESSES NEUROLOGICAL SPORTS INJURIES

"Sports Related Concussion and Nervous System Injuries" Conference will be held March 6-8, 1998 at the Caribe Royale Resort Suites, in Orlando, Florida. This meeting, the only one to specifically address the evaluation and management of athletic concussions, and head, spine, and spinal cord injuries, will be sponsored by the Orlando Regional Healthcare System. As previously, endorsement has been obtained from the AANS/CNS Joint Section on Neurotrauma and Critical Care, the National Athletic Trainer's Association, and the National Football League Players' Association. Course directors are Julian E. Bailes, MD, Mark Lovell, PhD, Barth Green, MD, and Michael Ray, MD. The timely subject of concussions in sports will be addressed from various viewpoints and by national experts, as well as other topics of interest.

This conference is designed for physicians, neuropsychologists, athletic trainers, coaches and others interest in the evaluation and management of sports-related concussion and central and peripheral nervous system injuries. The conference consists of didactic sessions, panel discussions, free papers, poster presentations and hands-on workshops. With these formats, it is hoped that maximal interaction between

registrants and faculty will be possible.

Informative lectures will be presented covering a variety of athletic head injury topics ranging from concussion classification, spinal cord injuries and helmet design to neuropsychological evaluation, major and minor head injury, and the NFL and NHL concussion policies. Also, a panel of professional athletes addressing their views on repetitive concussive injuries is expected. The panel will allow registrants to hear first-hand the experiences of the professional athlete and also to participate in an open discussion.

A hands-on workshop will allow interested registrants the opportunity to work directly with NFL and NCAA trainers using the equipment and procedures currently used to evaluate and manage on-field injuries at those levels.

As the neurosurgeon becomes more active in consulting for cases of athletic head and spinal injury, educational seminars such as this assume importance in the dissemination of the most current information available for both amateur and professional levels of competition. For more information, please contact: Orlando Regional Healthcare System, Continuing Medical Education, Patti Devlin, Program Coordinator, (407) 841-5111, Ext. 8217.

### Board of Directors continued from page 6

was presented by the Professional Conduct Committee for review. The Committee recommended that, on the basis of their findings in the facts of the case, the physician's membership in the AANS be suspended for six months, and that this information be forwarded to the National Practitioner's Data Bank. The Board approved the recommended action.

### Endovascular Fellowships

The Board agreed to support, in conjunction with the Congress of Neurological Surgeons, two one-year endovascular Fellowships. The Fellowships will be funded for the next two years at a cost of up to

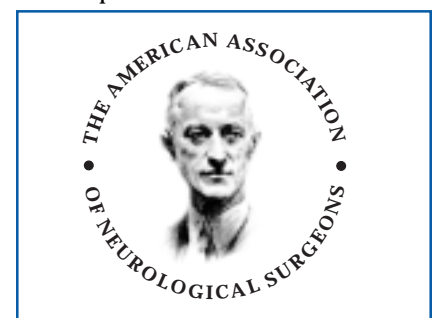
\$40,000 per year, per organization.

At the urging of AANS President Edward R. Laws, Jr., MD, the AANS logo was updated to include an enhanced image of Harvey Cushing, MD. The new image is based on an original black-and-white crayon portrait drawn by John Singer Sargent. Dated 1924, the drawing was given to the Historical Library at Yale University in 1949 by Mrs. Harvey Cushing. The image is being used with Yale's permission.

The Board reviewed a number of graphic treatments utilizing the new Cushing image and selected a new logo design, which is depicted to the right.

### Next Meeting

The next meeting of the AANS Board of Directors will be held Thursday, April 23, 1998 during the 66<sup>th</sup> Annual Meeting in Philadelphia.



*Revised AANS Logo*

# MANAGED CARE *update*

## IPAs, Independent Practice, and Health Benefits



By John A. Kusske, MD

Despite skepticism about the long-term viability of Independent Practice Associations (IPAs), enrollment in them is growing rapidly according to recent data published in *Medical Economics*. HMOs built around IPAs accounted for 43 percent of HMO enrollees as of July 1,

1996—the largest share of the HMO model—and have seen a 47 percent enrollment increase since July 1, 1994. Second generation IPAs are embracing global capitation for all medical services, including hospital inpatient care. The goal of these IPAs is to remain independent, but add business acumen to ensure their survival. Part of the reason for their rapid growth is the advent of physician management companies, described in earlier parts of this series, which have picked up the administrative and cost management functions for many physician groups. PhyCor, for example, currently manages IPAs covering 17,600 physicians and 1.1 million enrollees.

Examples are also available of IPAs that collect and disseminate performance-based data on their physicians, with names included, creating better accountability. Other key success factors for IPAs include the use of accrual accounting to retain earnings for capital investments such as new computer systems.

### Specialty "Teams"

Meanwhile Oxford Health, despite all its recent problems on Wall Street, is implementing an innovative plan to assemble teams of physicians by specialty. According to *Modern Healthcare*, the team is responsible for coordinating all the care for a particular illness or condition, including lab work and hospitalization. Teams are paid a predetermined rate per case and reimbursed over time as specific treatment steps are taken.

Stop-loss coverage is provided to ensure that providers are not bankrupted. Performance profiles are being built for each specialist so patients can choose among the teams. To date, more than 600 New York-area physicians have signed up for the program. Oxford indicated that the plan is saving about 15 to 20 percent on the plan's specialty contracts. The physician specialist teams hope to offer their services in the future to other plans. It is essential that neurosurgeons take note of this process and become informed about it, for other plans may emulate it. Oxford also hopes to market these networks of specialists as a separate point-of-service product, particularly to self-insured employers or plans outside its region that lack the medical management expertise to develop such networks themselves.

### Managed Care "Report Cards"

The National Committee for Quality Assurance (NCQA) recently released its first "State of Managed Care Quality" report and "Quality Compass 1997", a national database of comparative information about the performance of 329 managed care plans covering 37 million Americans. The two reports show that the performance of the nation's HMOs and other managed care organizations varies greatly in terms of patient satisfaction, keeping people healthy, treating selected illnesses, providing access to care, and delivering high quality service.

"The range of health plan performance across the country, and even within regions, is striking," said NCQA president Margaret O'Kane. She said, for example, that studies have repeatedly shown that treating heart attack patients with beta blockers saves lives, but fewer than 30 percent of such patients in some plans receive them as compared to more than 90 percent in others.

This year's version of Quality Compass, which was introduced last year, includes health plans NCQA accreditation status and 1996 results from NCQA's current version of the Health Plan Data and Information Set (HEDIS 3.0). HEDIS is a standardized set of performance measures that includes measures related to smoking cessation, member satisfaction, cancer screening, cardiovascular disease, diabetes, asthma and other public health issues.

The report on the state of quality in managed care plans, which the NCQA intends to publish annually, compiles national and regional averages and benchmarks for plan performance. It also

shows not only how well plans are performing, but what level of performance is actually possible. For example, in New England, 81 percent of children under age two receive appropriate immunizations, but in the Mountain region, the rate is only 59 percent. As the report points out, these differences are likely to reflect cultural, demographic and public policy differences.

Information in Quality Compass, which is available on CD-ROM or as electronic data files, is a decision support tool for employers and other purchasers of health care. It allows users to compare plans with one another, against national and regional averages and against the top-performing plans identified as "benchmarks."

"Getting the data into the hands of our employees puts real pressure on the plans to compete based on quality and satisfaction," said Maureen Coleman, manager of benefits at Allied Signal, as reported in Integrated Healthcare Report. Many employers will use Quality Compass data to generate customized report cards to show their employees how well each of their offered plans performed in each area of concern.

As so often stated, once cost concerns began to be sorted out, plans would begin to compete on quality as demanded by the payers. This is some of the first evidence for this and neurosurgeons should become aware of these efforts.

### EARN EXTRA CME CREDITS

#### Home Study Examination

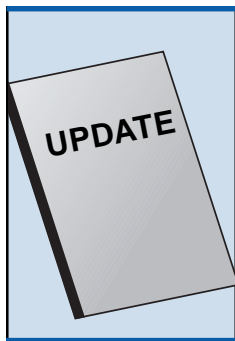
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# Council of State Neurosurgical Societies Report

by James R. Bean, MD

The interim report from the AANS/CNS Task Force on Fellowships was the featured presentation at the Council of State Neurosurgical Societies (CSNS) September meeting held in New Orleans. The Council heard an update from the Washington Committee on the Medicare practice expense adjustment, the effects of the 1997 Balanced Budget Act, and the federal enforcement of evaluation and management documentation guidelines. Robert Harbaugh, MD, chairman of the Outcomes Committee of the Joint Committee on Assessment of Quality (JCAO), reported on the reorganization of the committee and new outcomes measurement instruments adopted for carotid and aneurysm surgery. The Council also acted on seven resolutions.

## Task Force on Fellowships

The CSNS approved a resolution in April 1997 requesting appointment by the Joint Officers of a Task Force on Fellowships to "examine the issues surrounding minimum standards for maintaining the quality of fellowship training programs." The Task Force, appointed in April, includes Julian Hoff, MD (chairman), James Bean, MD, Hunt Batjer, MD, Frederick Boop, MD, (Vice-chair), Kim Burchiel, MD, Stewart Dunsker, MD, Steven Haines, MD, and David Jimenez, MD. After two teleconferences and background research on the prevalence of fellowship training, several resident and fellow surveys, and information on fellowship training in other specialties, the Task Force reached preliminary conclusions. Dr. Boop presented a summary of the Task Force's background information and preliminary recommendations to the CSNS lunch session Saturday, September 27. Dr. Jimenez presented an updated survey of neurosurgeons who have recently taken fellowships. Preliminary Task Force conclusions and recommendations included: 1) a definition of fellowships, 2)

Joint Section development of fellowship program criteria, 3) fellowship program accreditation, 4) fellowship affiliation with an institution sponsoring an ACGME-approved training program, and 5) certification of completion of fellowships by sponsoring institutions, without ABNS subspecialty certification. Task Force members presented individual viewpoints to the CSNS audience and listened to comments, criticisms, and concerns from CSNS members to guide final recommendations to be made to the AANS/CNS Joint Officers in January, 1998.

## Resolutions—The CSNS Reviewed and Acted on the Following resolutions:

### Expert Witness File

The Council urged wider notification of AANS/CNS members of the existence of the Expert Witness File. A resolution passed requesting periodic publication of the existence of the file in the AANS *Bulletin*, the CNS Newsletter, the Socioeconomic Section of **NEUROSURGERY ON-//CALL**®, the *Journal of Neurosurgery* and *Neurosurgery*.

The Expert Witness File contains plaintiff deposition testimony given by expert witnesses who have testified in past neurosurgical malpractice actions. The file is available via attorney to attorney request from the AANS office. The purpose of the file is provide information to malpractice defense attorneys regarding neurosurgical expert witnesses who testify repeatedly against neurosurgeons and the character of the past testimony.

### Peer Review Guidelines

A resolution asked for the identification of guidelines for local institutional peer review regarding indicators of competence for performing aneurysm surgery. The request was referred to committee for report. The unavailability of information on general competency guidelines or of

standardized outcome data for peer review of neurosurgeons prevented direct action.

### Unions and Neurosurgery

Unionization of doctors for negotiating power has appeared in reports scattered from New England to Florida to Arizona. The New England Neurosurgical Society requested a report on the practicality and implications of neurosurgeons forming or joining unions. The report will be returned to the Council in April 1998.

### Delay in Board Certification

Neurosurgeons recently completing residencies have experienced problems contracting with managed care organization (MCO's), which require board certification as a credentialing criterion. The problem stems from the interval between completion of residency and board certification caused by the American Board of Neurological Surgery (ABNS) requirements for one year of practice data, 3 months follow-up, submission of cases; and a backlog of applications for the oral board examination. An interval of 3 years or more is common between completion of residency and board certification.

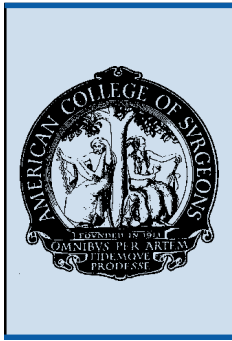
The number of MCOs adhering to the policy and the number of newly practicing neurosurgeons affected is not yet known, but the problem appears to be common and growing according to anecdotal reports heard by the CSNS. The Council approved a resolution requesting the AANS and CNS to support action by the ABNS to resolve the problem created by the delay in certification. The Young Physicians Committee of the CSNS will collect survey data documenting the extent and severity of the problem.

### Case rate malpractice defense

The Council approved a motion to alert all AANS and CNS members to a method of malpractice legal defense reimbursement currently employed on a trial basis by the

(continued on page 84)





# Neurosurgery Continues Strong Presence in American College of Surgeons

by Edward Laws, MD

Regent for Neurosurgery, American College of Surgeons

The Annual Clinical Congress of the American College of Surgeons took place on October 12 - 17, 1997. There were meetings of the Regents, the Governors and the various advisory councils, including the Advisory Council for Neurological Surgery. The financial status of the ACS is quite satisfactory. The new building at 633 St. Clair in Chicago has been fully committed with five floors for the ACS, including the new Clinical Trials Unit. There will be several floors occupied by an advertising company and the first 17 floors by a Wyndham Hotel.

Neurosurgery continues to be active in almost all areas of the College.

## Clinical Congress

The Clinical Congress Meeting was a great success with some 12,000 attending. The program was well designed with most of the presentations pertinent to neurosurgery occurring on Monday and Tuesday during the meeting, as usual. Dr. Eugene Flamm gave the History of Surgery Lecture, supported by the Advisory Council for Neurological Surgery, and it was an outstanding lecture, which was very much appreciated by the membership. The Panel on Current Standards in the Management of Acute Head Injury, organized by neurosurgery, was a huge success and this type of interdisciplinary program has been highly successful at the College previously.

On Tuesday, there were panels relating to peripheral nerve entrapment and injury, and to the methodology for the evaluation of carotid occlusive disease. The Neurosurgical Motion Picture Session was outstanding and the Surgical Forum Session devoted to neurosurgery was most impressive with a large number of highly sophisticated scientific presentations. John Atkinson, MD, is our neurosurgical liaison to the program committee of the ACS and continues to provide excellent input into these educational sessions.

## Surgical Research and Education Committee

The Surgical Research and Education Committee has put on conferences and courses on clinical trials methods and also sponsors the Young Surgical Investigators Conference, both of which have been well received and over subscribed. There is a course on Surgeons and Educators that is sponsored by the Graduate Medical Education Committee and this committee has also put forth a series of prerequisite objectives for Graduate Surgical Education broken down into subspecialty areas, including neurosurgery. Philip Gutin, MD, serves on the Surgical Research and Education Committee, and Howard Eisenberg, MD, on the Graduate Medical Education Committee. The Committee on Young Surgeons has a separate meeting as well, and will produce a program in conjunction with each of the Clinical Congresses. The Courses given by the ACS for teaching new technology require a certain degree of oversight similar to that which we have provided for practical courses and professional development courses in neurosurgery. A series of principles has been established very similar to those that we have adopted.

## Socioeconomic Issues

With regard to professional liability activities, the ACS is attempting to negotiate with the National Practitioner Data Bank to keep residents from being listed. The current compromise is that residents listed will be removed from the list if they successfully complete their training.

With regard to reimbursement issues, a prediction was made that the conversion factor will be \$31 by the year 2007 and the suggestion was also made that restructuring Medicare may be the best new initiative to maintain satisfactory reimbursement levels for surgical services.

## Specialty Board Concerns

Reports were heard from each of the Boards of the specialties covered by the ACS, and many of the concerns were shared. John Van Gilder, MD, gave the report of the American Board of Neurological Surgery. Most of the boards are using a test consultant with the hopes of making the oral examinations more objective, and virtually all of them have utilized the same method that the ABNS is currently testing. Each of the boards discussed its re-certification procedures, most of which involved maintaining an active license, obtaining adequate evidence of CME activity, some sort of practice review, and a test usually given in a modular fashion so that individuals could appropriately tailor their tests to their practice situations.

The AMA Accreditation Program was discussed, and most of the specialty boards were a bit skeptical about it and noted that there were 100,000 AMA members who are not board certified for whom this program is of considerable interest. In Urology, there had been a decrease noted in the number of cases done by candidates during their first 18 months in practice and this decrease was attributed to the impact of managed care. The American Board of Urology is wrestling with a request for a CAQ in Pediatric Urology.

## Neurosurgeon Involvement

The program of the ACS meeting included the following neurosurgeons as presenters of papers: Eugene Flamm, Joseph Maroon, Issam Awad, David Kline, Chris Ogilvy, Jack Wilberger, Laurence Dickinson, Alex Valadka, Joseph Hahn, Richard Rovit, Hunt Batjer, Ivan Ciric, David Frim, Gerard Dr Brun, John Shea, John Atkinson, Gordon Deen and Bryce Weir. The Surgical Forum in neurosurgery had 11 scientific papers. Among the leadership of the ACS we count Edward Laws as Regent, Charles Drake as Past

(continued on page 84)

## Joint Section of Stereotactic and Functional Neurosurgery

**Douglas Kondziolka, MD, MSc, FRCSC**

The American Association of Stereotactic and Functional Neurosurgery has been planning its next meeting to be held in June, 1999, at Snowbird Resort in Utah. The meeting will be chaired by Joint Section President, Dr. David Roberts, and includes Dr. Peter Heilbrun, as Local Arrangements Chairmen and Dr. Douglas Kondziolka, as Scientific Program Chairman. Further notification will be sent by mail regarding meeting information and abstract submission.

Board members of the Joint Section have been working on movement disorder surgery guidelines; reimbursement guidelines for radiosurgery and pallidotomy; and CPT code clarifications in image-guided surgery. The Section is represented by Douglas Kondziolka on the Outcomes Committee of the AANS/CNS. Work is underway on the design of outcomes instruments for pallidotomy and metastatic tumor radiosurgery.

Dr. Richard Lehman will host a "2<sup>nd</sup> Pallidotomy Accord" in April, 1998. Further information on this New Jersey meeting will be forthcoming.

For membership inquiries, please contact the Secretary/Treasurer office: Douglas Kondziolka, MD, Department of Neurological Surgery, Suite B400, University of Pittsburgh Medical Center, 200 Lothrop Street, Pittsburgh, PA 15213.

## Joint Section on Tumors

**Mark Bernstein, MD, FRCSC**

The Joint Section on Tumors of the AANS/CNS remains a vital, busy Section with a stable membership of about 630 members. Planning of the Scientific Program for the AANS Meeting in Philadelphia is completed and will feature guest presentations on tumor vaccines and anti-angiogenetic approaches to glioma therapy. Awards will be given in the categories of best resident paper (the Pruess Award), best clinical research by a neurosurgeon (the Mahaley Award), best research by a neurosurgeon within the first 6 years of

practice (the Young Investigator Award), best translational research by a practicing neurosurgeon (National Brain Tumor Foundation) and contributions by an established investigator to neuro-oncology (the Farber Award).

Our Section's Satellite Symposia, which have facilitated invaluable information networking, have been very successful and the next one will follow the AANS Meeting in April, 1998, in Philadelphia. Planned topics for invited speakers and platform presentations include: Tumor promoters and suppressors; meningiomas; futuristic therapies; and angiogenesis and invasion; as well as a special lecture on pituitary tumors by AANS President Ed Laws.

Currently there are a number of special projects the Section is undertaking. A book on the *Essentials of Clinical Neuro-Oncology* will be published by Thieme Medical and Scientific Publishers and co-edited by Mark Bernstein and Mitch Berger, with significant input from members of the Section. This book will feature chapters on most aspects of neuro-oncology and will incorporate special features such as pearls and pitfalls in highlighted text.

Another project is the Glioma Outcomes (GO), sponsored by Rhone-Poulenc-Rorer and featuring an instrument designed to facilitate collection of prospective outcome data, including comprehensive quality of life information on patients with malignant gliomas. Central data collection and analysis will be done at the Center for Outcomes Research at the University of Massachusetts. The Section has also taken a leadership role in the development of practice parameters for low-grade glioma, which is nearing completion, and brain metastases, which has just started.

## Joint Section on Pain

**Jeffrey Brown, MD**

The Joint Section on Pain awarded the Ronald Tasker Award for a young investigator in pain neurosurgery to Jan J. Gouda, MD, Medical College of Ohio, for his paper presented at the 1997 CNS Annual Meeting entitled: Behavioral Evidence of Glycerol Induced Trigeminal Neuropathic Pain in Sprague-Dawley Rats. The Award was for \$1000.

The Pain Section will be hosting a Satellite Symposia April 24 and 25 in Philadelphia, PA. Please watch for more details.

## Young Neurosurgeons Committee

**David Jimenez, MD**

The committee was established in 1991 under the guidance of Dr. Roberto Heros and the leadership of Dr. Emily Friedman. The original goals included: 1) to be the representative group for all young neurosurgeons within organized neurosurgery; 2) to encourage early involvement of young neurosurgeons in all AANS activities; 3) to develop future leadership by promoting early participation of young neurosurgeons within the committee structure; 4) to work closely with the council's state neurosurgical societies and encourage participation of young neurosurgeons in socioeconomic issues; 5) to actively recruit and promote young neurosurgeons' participation in the annual scientific program and AANS publications; and 6) to convey and summarize to all the young neurosurgeons concise and pertinent information regarding the AANS Board of Directors, the CNS, Washington Committee and other key committee activities.

The committee has been active under the leadership and chairmanship of Drs. Emily Friedman, Paul Camarata, Ian McCutcheon and Karin Muraszko. Most recently, significant reorganization of the committee has taken place. The membership has been expanded to resident physicians and fellows. Elections are held yearly by mailed ballots to the entire young neurosurgery constituency. Interest in the committee has been at an all time high as evidenced by 54 nominations for six positions in our most recent elections. The elected committee members for 1997 are Drs. Mitesh Shah, Assistant Professor at Indiana University; Craig Rabb, Assistant Professor at Oregon Health Sciences, Portland; Eric Nussbaum, Assistant Professor at the University of Minnesota; Adam Lewis, Assistant Professor at the University of Mississippi at Jackson; and Isabelle Germano, Associate Professor at Mt. Sinai in New York. Resident candidates elected are Drs. John D. Davis, Mark McLaughlin, Laurie A. McBride and John K. Park. The elected officers are: David F. Jimenez, MD (2 years); Vice-Chairman: Greg Thompson, MD (2 years); and Secretary: Mitesh Shah, MD (1 year).

Liaisons are maintained with the entire infrastructure of the AANS. Currently, the Young Neurosurgeons Committee has liaisons to the AANS Board of Directors, AANS Research Foundation,

(continued on page 84)

Scientific Programs Committee, Publications Committee, Stereotactic and Functional Section, Tumor Section, Spine Section, Cerebrovascular Section, Pain Section, Neurotrauma and Critical Care Section, Pediatric Neurosurgery, Council of State Neurosurgical Societies, and the American College of Surgeons. In addition a representative to the AMA Young Physicians Section is elected from committee membership. Serving on the committee is an excellent way for young neurosurgeons to develop leadership skills and become involved in organized neurosurgery.

Several projects are presently being addressed. The most important one centers on the issue of delay in board certification in the first several years following completion of residency. The effects of this delay on the young neurosurgeons' ability to access managed care contracts and organizations are being studied. A subcommittee has been established to look at this issue and gather the necessary data. The work is being done in conjunction with the young physicians section of the Council of State Neurosurgical Societies.

A luncheon will be hosted by the committee at next year's AANS Annual Meeting in Philadelphia. The honored speakers will be Russell Travis, MD, (president elect of the AANS) and

Arthur Day, MD, (Chairman of the Washington Committee).

All young neurosurgeons attending the meeting are encouraged and invited to attend this free lunch. However, tickets must be obtained when registering for the meeting. For more information regarding the committee and any of its activities, please contact David F. Jimenez, MD, at the University of Missouri Hospital and Clinics, 1 Hospital Dr., Columbia, MO 65212 or e-mail: djimenez@surgery.missouri.edu.

A graphic with a light blue background. At the top, it says "When moving remember to send your change of address to:". Below this is a circular logo for "THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS" with a portrait of a man in the center. Below the logo, it says "AANS Member Services" and "22 South Washington Street Park Ridge, Illinois 60068-4287".

**When moving  
remember to send  
your change of address to:**

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

## Neurosurgery Continues Strong Presence at ACS

continued from page 82

President, Frank Padberg as a senior member of the executive staff of the ACS, John Atkinson on the program committee, Herbert Engelhard on the Commission on Cancer, Jack Kushner and Richard Penn on the Committee on Emerging Surgical Technology and Education, Howard Eisenberg on the Graduate Medical Education Committee, James Boggan and Edward Laws on the Committee on Medical Motion Pictures, Michael Rosner of the Pre and Postoperative Liability, Edward Laws on the Scholarships Committee, Fran Conley on the Committee on Surgical Education in Medical Schools,

Philip Gutin on the Surgical Research and Education Committee, Thomas Luerssen and Raj Narayan along with Howard Eisenberg, Jack Wilberger and Tom Saul on the Committee on Trauma, and Iain Kalfas on the Committee on Young Surgeons. He will be joined by Steve Haines on this committee. Edward Laws is also a member of the Central Judiciary Committee of the ACS. Issam Awad, Glen Morrisson, Bryce Weir and Richard Winn all serve the College as Governors.

The impact of neurosurgery is quite visible and hopefully will continue to benefit all of organized American Surgery.

## Council of State Neurosurgical Societies Report continued from page 81

Doctors' Company in California. The program is termed the Progressive Litigation Program (PLP), and pays the defense legal firm at a predetermined fee for each phase of the litigation (discovery, pretrial, and trial phases), rather than on a fee for service basis. Proposers of the resolution expressed concern that a defense attorney may not be motivated to expend maximum necessary effort in physician defense if the stipulated fee is fixed. The payment method was compared to fixed case rates or capitation rate payment for surgeons. The trial program currently exists only in California, but the resolution was approved to alert all neurosurgeons to be aware of their malpractice carrier's legal reimbursement methodology.

### Medicare Private Contracting

The Federal Balanced Budget Act of 1997 (passed in August) included a provision allowing private contracting between a physician and a Medicare-eligible patient. However, the physician electing the private contracting option must submit an affidavit to the Health Care Financing Administration (HCFA) agreeing to be excluded from participation in the Medicare program for 2 years.

The initial provision by Senator Kyl of Arizona aimed to remedy restrictions under Medicare law on balanced billing and a citizen's right to privately contract. The addition of the 2-year Medicare program exclusion was added in a late legislative compromise. The Council approved a resolution supporting proposed legislation to repeal the 2-year exclusion provision.

### Neurosurgery Capitation Rates

The Council approved a request for the AANS and CNS to explore means for making information on regional neurosurgical capitation rates available to their members. Although accurate estimation of a capitation rate requires health plan specific data and knowledge of practice costs, the request for regional information was made to help neurosurgeons who are first encountering specialty capitation.

Implementation of the request will require legal opinion regarding the antitrust implication of providing pricing information to members, determination of the cost of acquiring third party actuarial information, and the cost to a member for capitation information provided at a discount from a third party actuary.



## Pedicle Screw Update by Russell Pelton, General Counsel for the AANS

The following actions have occurred since the last report on the Pedicle Screw Multi-District litigation now pending in Philadelphia.

### Defendants' Appeal Denied

As reported previously, in April of this year Judge Louis Bechtle, the multi-district presiding judge in Philadelphia, entered an Opinion and Order denying the defendant's Motion to Dismiss the "Omni" amended complaints against them. The AANS, together with three other defendant medical associations (American Academy of Orthopaedic Surgeons, North American Spine Society and Scoliosis Research Society) filed a Petition for Mandamus asking the Federal Third Court of Appeals to overturn Judge Bechtle's ruling. The medical associations were supported in their appeal by Amicus Briefs filed on behalf of the American Medical Association and numerous other professional and educational associations.

The appeal was argued before the Third Circuit on September 23, 1997, together with appeals filed by several of the manufacturer defendants. Extensive briefs had previously been filed on behalf of all parties.

On November 10, 1997, the Court of Appeals issued its Memorandum Opinion denying all the appeals. The Court's opinion focused on the fact that, although the litigation has been pending for several years, it is still technically at an early stage of proceedings, since none of the "Omni" cases have gone to trial with a resulting verdict being entered. As a result, the Court held the plaintiff's allegations in the "Omni" complaints must be taken true for purposes of a Motion to Dismiss, particularly the allegations that the associations' educational seminars were in essence sales events conducted for the benefit of the manufacturers. That characterization of the seminars content as "commercial speech" arguably reduces the Freedom of Speech protections afforded by the First Amendment. The Court of Appeals urged Judge

Bechtle to expedite the remand process so that one or more test cases can be tried in the near future to better resolve the plaintiff's allegations.

### Remand of Cases

Following the entry of the Third Circuit's Memorandum Opinion, Judge Bechtle initiated the process to remand approximately 300 pedicle screw cases for trial in the District Courts where they were originally filed, including 54 "Omni" cases. Interestingly, none of the first wave of cases being remanded includes the AANS as the defendant. This is a result of the fact that the AANS has been named as the defendant in fewer than any of the other medical associations in the litigation. Judge Bechtle also held that any Motions for Summary Judgment should be brought on a case-by-case basis after remand.

### Summary Judgment For Defendant

In one of the earliest cases remanded, *Theriot v. Danek*, Judge Feldman of the United States District Court for the District of Louisiana, on December 4, 1997, granted summary judgment for Sofamor-Danek. The *Theriot* case was a straightforward products liability case, and did not include any of the conspiracy allegations that involve the medical associations of the "Omni" complaints. In ruling on a Motion for Summary Judgment, unlike a Motion to Dismiss, the Court may consider evidence presented by both sides prior to trial, and Judge Feldman held that the plaintiffs had presented no credible evidence that Sofamor-Danek's pedicle screw device was inherently defective. It is

likely that all the defendants, including the medical associations, will file Motions for Summary Judgment in the individual cases as they are remanded.

### Acromed Settlement Approved

On October 17, 1997, Judge Bechtle approved the \$100 million Acromed settlement previously reported, over the objection of Sofamor-Danek and a number of plaintiffs. The objecting plaintiffs complained that they would be forced to accept unfairly small compensation for their injuries under the Acromed settlement. Those plaintiffs, as well as Sofamor-Danek, are appealing Judge Bechtle's approval of the Acromed settlement to the Third Circuit Court of Appeals. Final approval or disapproval by the Third Circuit is not expected until Spring of 1998.

### FDA Reclassification Pending

As of this writing, the FDA has yet to rule on the Citizens Petition filed by AANS President Edward R. Laws, Jr., MD, individually and on behalf of the AANS, asking the agency to act on its long pending reclassification of pedicle screw systems from Class III to Class II. That petition was filed on May 12, 1997, and, under FDA regulations, within 180 days the petition must be either granted, denied or an explanation issued by the FDA as to why it can do neither. When the 180-day period passed without action by the FDA, counsel for the AANS reminded them of the regulatory deadline, and asked that a decision be entered. That matter is still pending.

## NEUROSURGEON FEATURED IN TIME

Neurosurgeon Keith L. Black, of Cedars-Sinai Special Medical Center, in Los Angeles, was featured on the cover of *Time Magazine's* Heroes Of Medicine issue, published in December, 1997. The 5-page feature article on Dr. Black focused on his work with brain tumors. Black was recognized for his extraordinary work in the OR and for his research in brain tumors.

The article also focused on recent advances in tumor research, and how new diagnostic tests are helping neurosurgeons pinpoint the size and location of tumors more accurately.

Fifteen physicians nationwide were recognized for their patient care, dedication and research in the medical field.

## N://OC® Expands "Chat" Capabilities

by John Oro, MD

**NEUROSURGERY://ON-CALL®** is pleased to announce a new and improved online chat section. This enhanced section uses iChat's ROOMS server software to make real-time communication and collaboration more effective and easier. Under the development guidance of Dr. David McKalip, N://OC® Editorial Board member, online chat has been expanded to offer a more user-friendly interface.

N://OC® Chat offers the following topic oriented rooms:

- Cerebrovascular Surgery
- Pain
- Pediatrics
- Spine/Peripheral
- Nerve
- Stereotactic/Functional
- Trauma/Critical Care
- Tumor

- Resident's Room
- Socioeconomic
- Young Neurosurgeons

Additionally, an auditorium has been created to host online presentations. Speakers will be able to show slides and interact with participants in a moderated forum. A schedule of presentations will be available soon. You can also use N://OC® Chat for private meetings by creating individual conference rooms. Instructions for doing this are located in the HELP area of the chat section.

You can use N://OC® Chat in one of three ways: with the iChat plug-in, with the Java client, or with the HTML client.

### ICHAT Plug-In

For best results, we recommend that you download and install the iChat plug-in (for Windows 95/NT 4.0, Windows 3.1, MAC 68K and MAC PPC users). This is available for downloading through a link on the main N://OC® chat page. You can also go directly to the iChat site to download the plug-in. The Web address is <http://www.ichat.com/download/client.html>.

### Java Client

If you are using a Java enabled browser, you may use the iChat Java client without downloading additional software. Be sure to indicate the Java option when signing on.

### HTML Client

If your browser does not support Java, plug-ins or ActiveX controls, you may use N://OC® Chat using iChat's HTML Client. The HTML Client supplies you with the fundamental chat features of ROOMS. However, you will need to continually "refresh" your screen to see all of the conversation. iChat includes a submit button that is used to send your comments and to refresh the information displayed.

A link to N://OC® chat can be found in the Professional Pages section, in the Communications Center section of the side bar on the "Hot Topics" page. The first time you visit N://OC® Chat, you will be asked to create a username and password. You may use your existing N://OC® username and password or create a new one. Make sure you write down your username and password for later use. After registering, you may enter the chat site and go to any of the various rooms for chat, or to the auditorium for scheduled events.

## CAN YOUR PATIENTS FIND YOU ONLINE?

**NEUROSURGERY://ON-CALL®** (<http://www.neurosurgery.org>) is pleased to present Find A Neurosurgeon, a new feature that will help you reach the people who want to know about you and your practice.

This online resource, in the Public Pages section of the web site, is a directory of AANS and CNS members searchable by name, city/province, and area code.

In Find a Neurosurgeon, a basic directory listing is free and includes your name, address and phone number. However, you may choose to upgrade your member listing to provide people with more details about yourself and your practice. Two expanded profiles are available:

### Option 1

If you don't have a personal web site, this option is for you. This profile includes

- photo
- contact information
- education and training experience
- subspecialty expertise
- 500 word description about your practice, research interests, etc.

Cost: \$500.00—one time fee

### Option 2

You may want to consider this option if you already have a personal web site.

This profile includes:

- photo
- contact information
- subspecialty expertise
- a hypertext link to your Web site.

Cost: \$125.00—one time fee

As more and more people turn to the Internet for health related information, N://OC® is poised to help them find neurosurgical information, specifically *you!* For more information or to request an application, please contact Allison Casey by phone at 847-692-9500 or by e-mail at [avc@aans.org](mailto:avc@aans.org).

## Chatting Online is as easy as 1, 2, 3

**Step 1:** Visit **NEUROSURGERY://ON-CALL®** Online Chat (<http://www.neurosurgery.org>). The Chat link is in the Professional Pages section, on the "Hot Topics Page", in the Communications Center sidebar.

**Step 2:** Create a username and password. You'll be asked to fill out a short registration form and decide how you will use N://OC® Chat (with the iChat plug-in, Java browser, or HTML client).

**Step 3:** Enter the Chat site using your username and password and begin chatting.

For further assistance with N://OC® Chat, please contact Allison Casey at the National Office by e-mail at [avc@aans.org](mailto:avc@aans.org), or by phone at (847) 692-9500

## 1997 Professional Development Program Faculty Appreciation

The Professional Development Committee would like to recognize all the faculty who, by volunteering, gave their valuable time and expertise during the past year to help neurosurgeons obtain the highest quality educational experience available.

*Thank you* to the following faculty members who participated in 1997 Professional Development courses:

### A Proactive Approach to Managed Care: Strategies and Solutions

John Kusske, MD\*

### Microsurgery of the Brain, Cranial Nerves and Skull Base – Hands-On

Ralph G. Dacey, MD

Albert L. Rhoton, Jr., MD\*

Kenneth R. Smith, Jr., MD\*

Harry Van Loveren, MD

### Neurosurgery Review by Case Management: Oral Board

#### Preparation

Nevan G. Baldwin, MD

Joel C. Boaz, MD

Israel P. Chambi-Venero, MD

Randall M. Chesnut, MD

Winfield S. Fisher, III, MD

Herbert E. Fuchs, MD, PhD

Ziya Gokaslan, MD

Julius M. Goodman, MD\*

Mark S. Greenberg, MD

Thomas J. Leipzig, MD

Christopher M. Loftus, MD

Ian E. McCutcheon, MD

Thomas C. Oritano, MD, PhD

Richard Osenbach, MD

T. Glenn Pait, MD

Robert Pascuzzi, MD

Troy Payner, MD

William R. Taylor, MD

Michael S. Turner, MD

Hoi-sang, U, MD

Ronald E. Warnick, MD

### '97 Reimbursement Update for Neurosurgeons

Samuel J. Hassenbusch, MD, PhD

Kimberley Pollock, RN, MBA

Kathleen Redelman, RN, BSN, CNRN

Richard A. Roski, MD, FACS\*

### Surgery and Management of the Brachial Plexus: Hands-On

Allan Belzberg, MD

Allan Friedman, MD

Alan Hudson, MD

David G. Kline, MD\*

John McGillicuddy, MD

Robert Tiel, MD

Suzie Tindall, MD

### Image-Interactive Neurosurgery (Frameless Stereotaxy): Hands-On

John R. Adler, MD

Gene H. Barnett, MD

Richard D. Bucholz, MD

Kevin T. Foley, MD\*

Douglas S. Kondziolka, MD

Robert J. Maciunas, MD\*

Lucia Zamorano, MD, PhD

### Spine Surgery — Hands-On: A Comprehensive Approach for Neurosurgeons

Nevan G. Baldwin, MD

Perry A. Ball, MD

Edward C. Benzel, MD\*

Kevin T. Foley, MD

Regis W. Haid, Jr., MD

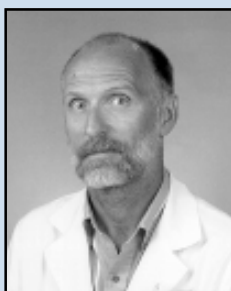
Iain H. Kalfas, MD

Russ P. Nockels, MD

Charles B. Stillerman, MD

Simcha J. Weller, MD

Eric J. Woodard, MD



Edward C. Benzel, MD, has volunteered significant time to the AANS Professional Development Program hands-on spine courses. Since the courses began in 1991, he has been chairman or faculty at nearly every spine course the AANS Professional Development Program has offered. In addition, he acts as chairman for the week-long *Spine*

*Surgery—Hands-On: A Comprehensive Approach for Neurosurgeons & Neuroscience Nurses*. This is a highly popular program, held every year since 1994.

"I became interested in participating in PDP courses through my interest in teaching. It, however, soon became evident to me that teaching at the PDP course level is also an extremely educational process for the faculty," Dr. Benzel said. "It provides a continued source of information and high-level intellectual conversation with my peers. Therefore, it is as valuable for me as it is for the 'participants.'"

In 1998, another week-long spine course, *Spine Review—Hands-On: For Young Neurosurgeons*, will be held with Dr. Benzel and Russ Nockels, MD, acting as course co-chairmen.

"The original spine course (Spine Surgery: Hands On) was

and is designed to provide a comprehensive hands-on learning experience that conceptually covers the entire spine and emphasizes fundamentals, particularly biomechanics. Nurses as well as physician assistants attend this course," Dr. Benzel said. "The new *Spine Surgery for Young Neurosurgeons* course is designed for surgeons that are within two years of completion of a 'training' program and those in practice for less than two years. This translates into an increased surgeon-to-cadaver ratio. Furthermore, this course is a bit more oriented toward the basic sciences and board examination than its counterpart."

In addition to his work with the spine courses, Dr. Benzel was appointed Chairman of the Professional Development Committee in 1996. He is responsible for the general oversight of all the AANS PDP courses.

"In the next couple of years, comprehensive practice management topics will be included in many of the PDP courses. Courses encompassing surgical technique will also include discussion regarding: non-operative management strategies, billing, coding, collection, practice structure and personnel selection and management," Dr. Benzel said. "The Professional Development Program is committed to designing a course curriculum that is valuable, timely and, most importantly, of significant interest to the neurosurgical community. This requires a dynamic program that varies in response to the needs of practicing neurosurgeons."



### Extracranial Carotid Reconstruction—Hands-On

Issam A. Awad, MD\*  
Steven L. Giannotta, MD  
Robert E. Harbaugh, MD  
Christopher M. Loftus, MD, FACS\*  
Marc R. Mayberg, MD  
Frederic B. Meyer, MD

### Surgical Management of Movement Disorders

Ronald L. Alterman, MD  
Roy A. E. Bakay, MD  
G. Rees Cosgrove, MD, FRCSC  
William T. Couldwell, MD, PhD\*  
Scott Grafton, MD  
Robert G. Grossman, MD\*  
Charles B. Stillerman, MD  
Jerrold Vitek, MD

### Stereotactic and Imaging-Guided Neurosurgery

David Andrews, MD  
Philip L. Gildenberg, MD, PhD\*  
Allan J. Hamilton, MD  
Douglas S. Kondziolka, MD  
Andres Lozano, MD, PhD  
William Tobler, MD

### 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\*

### Spine Surgery — Hands-On: A Comprehensive Approach for Neuroscience Nurses

Carolyn Coulter, RN, BSN, CNRN, CNOR\*  
Denise Miller Lemke, RN, BSN, CNRN

### Minimally Invasive Neurosurgery: Neuroendoscopy Hands-On

Jacques Caemaert, MD  
Alan R. Cohen, MD\*  
Carl B. Heilman, MD  
Tenoch Herrada-Pineda, MD  
Axel Perneczky, MD

\* Indicates course chairpersons

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## Two Levels of AANS Reimbursement Courses in 1998...Which One Is Right for You?

Escalating managed care regulations. Ballooning receivables. Skyrocketing overhead. If any of these issues sounds familiar, your practice is in the throes of change. Dealing with these concerns, and the ever-changing E&M code guidelines are a constant challenge. Register for an AANS "Reimbursement Update" course to gain a better understanding of how to handle the turmoil.

*"But I've been to a course before,"* you say. Great. What you learned probably increased the bottom line ten times more than the cost of the course. To accommodate you and other past participants, this year's programs are offered at two levels: "Foundations" and "Advanced." If you've attended in the past, the Advanced Program will sharpen your coding, reimbursement, and financial analysis skills even further.

Here's what you can expect from each program:

- The **Foundations** course covers reimbursement cycle basics and related business systems, CPT and ICD-9-CM coding principles for neurosurgery, 1998 Medicare changes, subspecialty case coding, and the use of modifiers. This course is designed for anyone who is newly hired in billing, doctors new to coding, or anyone who needs a coding refresher.
- The **Advanced** course begins with an assessment of your individual coding IQ, then continues with topics such as RVU financial analysis, subspecialty case coding, reducing audit risks through better coding and documentation, and troubleshooting denials and delays. The basics will *not* be covered!! In order to ensure an underlying knowledge-base of the participants, it is required that you have attended an

AANS "Reimbursement Update" course in 1995, 1996, or 1997 in order to attend.

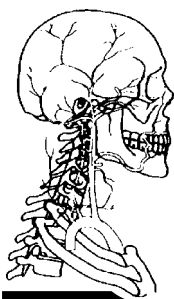
Be sure to register early for whichever course is right for you. Maximum benefit is gained from the courses if all members of your office team attend. To receive a course brochure or to register, call the AANS Professional Development Department at (847) 692-9500.

The Foundations Programs will be held four times in 1998:

February 19-21 in Costa Mesa, CA  
March 5-7 in Boston  
June 11-13 in Minneapolis  
and August 27-29 in Chicago.

The Advanced Program will be held twice in 1998:

May 29-31 in Orlando, and  
November 13-15 in Cancun.



## Socio-Economic Courses

### *1998 Reimbursement Update for Neurosurgeons...*

#### **Reimbursement Foundations: Neurosurgical Billing and Coding for Efficiency**

February 19-21 Costa Mesa, CA  
March 5-7 Boston, MA  
June 11-13 Minneapolis, MN  
August 27-29 Chicago, IL

#### **Advanced Coding and Reimbursement Concepts in Neurosurgery**

May 29-31 Orlando, FL  
November 13-15 Cancun, Mexico

## Clinical Skill Courses

#### **Re-introduction to Neurosurgical Critical Care for Neurosurgeons, Neuroscience Nurses, and Physician Assistants**

June 4-6 Chicago, IL

#### **Extracranial Carotid Reconstruction— Hands-On**

March 27-28 Rancho Mirage, CA

#### **Spine Surgery—Hands-On: A Comprehensive Approach for Neurosurgeons & Neuroscience Nurses**

May 16-22 Albuquerque, NM

#### **Neurosurgery Review by Case Management: Oral Board Preparation**

May 24-26 Iowa City, IA  
November 8-10 Houston, TX

#### **Surgical Management of Movement Disorders**

March 6-7 New Orleans, LA  
June 26-27 San Francisco, CA

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

November 13-14 Cleveland, OH

#### **Advanced Techniques and Successful Strategies in Image-Guided Neurosurgery: An Intensive Review**

November 13-14 Memphis, TN

## NEW Courses!

#### **Topics in Neurosurgical Critical Care**

January 24-27 San Juan, PR

#### **Brain Anatomy for Nurses**

March 21-22 St. Louis, MO  
April 18-19 San Antonio, TX  
June 27-28 San Francisco, CA  
November 21-22 New Orleans, LA

#### **Advanced Surgical Pain Management**

September 11-12 Portland, OR

#### **Spine Review—Hands-On— For Young Neurosurgeons**

August 15-21 Albuquerque, NM

*Dates and locations are subject to change*

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](mailto:info@aans.org) or visit our web site at [www.neurosurgery.org](http://www.neurosurgery.org)**



# Research foundation

## 1997 CAMPAIGN UPDATE

Robert G. Ojemann, MD,  
Chairman, Executive Council  
and John R. O'Connell, Fund  
Development Officer

As we enter 1998, it is still not too late to support the Research Foundation of the AANS. The Executive Council is hoping for our best year ever, both in terms of actual funds raised, and in the proportion of our members who become contributors. One important goal for this year's campaign is to substantially increase our member participation. If your gift has already been sent, our thanks for your generosity. If your support is still pending, we invite you to reflect on how your gift benefits our specialty.

Gifts are used for the Foundation's board-designated endowment. Earnings from that endowment are used to provide Research Fellowships and Young Clinician Investigator Awards. Our long-term goal is to have an endowment that can support an expanded awards program, providing for a broader range of basic, and ultimately, clinical research. In the past 14 years, over \$1.8 million has been provided to 46 promising researchers. Earlier this year, four grants were made covering topics related to brain tumors and NF-1 peripheral nerve tumors, strokes

and neural regeneration. Historically, the vast majority of our funded grantees have maintained academic, productive research careers, and have used our awards as the basis for broader grant applications from other external funding sources.

Our appeal for funds is not only to our members as individuals, but to both academic and private practice groups. Groups that contribute a minimum of \$1,000 will be recognized for their group contribution, and individuals will also get credit in their corresponding individual level category. Recognition will be announced in our Spring issue of the *Bulletin*, as well as displayed on the "Donor Wall," visible at the AANS Annual Meeting in Philadelphia, and on our Website, **NEUROSURGERY://ON-CALL®**.

We ask you to consider a gift that will enroll you in the Cushing Scholars Circle (see chart), with a minimum individual donation of \$1,000. This year, as a unique incentive to our members, we are inviting all Cushing Scholar circle contributors to the Cushing Orator Luncheon. This program, one of the most prestigious events at the AANS Annual Meeting, will feature renowned Molecular Biologist Eric Weischaus, Ph.D., of Princeton University. Seats are limited, so hurry to qualify for this special invitation.

### ANNUAL GIVING LEVELS

#### The Harvey Cushing Scholars Circle (Gifts from Individuals)

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

#### Other Giving Levels

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

As always, donors to the Research Foundation will receive distinctive lapel pins, colored by category, that can be proudly worn throughout the year.

#### Gifts from Groups and Organizations

A gift of \$1,000 or more that is received from an organization or group of donors will be recognized in a special Group Gift Category. Individuals will also be recognized at their giving level.

Gifts in memory of a deceased family member, loved one or personal colleague, as well as honorary gifts, are encouraged. Gifts of securities, such as appreciated stock, may help you to avoid certain taxes. And don't forget, a gift by your will or trust to the Research Foundation provides for neuroscience research indefinitely.

Join with us to ensure a future of bright advances and hopeful healing. Make your generous contribution to the Research Foundation of the AANS today!

The Research Foundation of the AANS acknowledges with gratitude the generous gift from the estate of Ruth Mount, wife of past president of the AANS, Dr. Lester Mount. We appreciate very much all of the support of the Mount family, and send them our most sincere condolences on the loss of Mrs. Mount.

### RESEARCH FOUNDATION CORPORATE ASSOCIATES PROGRAM

The Executive Council of the Research Foundation of the AANS gratefully acknowledges the Annual Campaign support given by the following companies. These companies have set the highest example of leadership by their commitment to neuroscientific research. Please join the Executive Council in applauding their efforts.

#### SUSTAINING ASSOCIATES (GIFTS OF \$50,000 TO \$75,000)

Synthes Spine/Synthes Maxillofacial

#### SUPPORTING ASSOCIATES (GIFTS OF \$25,000 TO \$50,000)

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

#### ASSOCIATES (GIFTS OF \$5,000 TO \$10,000)

Aesculap  
Depuy Motech  
Midas Rex Institute  
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Pmt Corporation

If you haven't  
already,  
be sure to visit  
N://OC® at:  
[www.neurosurgery.org](http://www.neurosurgery.org)

You can email  
us at:  
[info@aans.org](mailto:info@aans.org)



# Membership

winter '98

## Board Approves 258 New Members, AANS Membership Now Totals 5,177

### ACTIVE

Daniel Acosta Diaz De Leon\*  
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\* Election to membership under Grandfather Provision which allows neurosurgeons certified by the Mexican Council of Neurological Surgery, A.C. to apply for Active membership without sponsorship.

## Cerebrovascular Neurosurgeon

Board eligible neurosurgeon sought for entry-level position in a dynamic Southeast clinical and academic program. Clinical and research development opportunities exist for recent fellowship-trained neurosurgeon with interest in cerebrovascular and interventional neurosurgery within a multidisciplinary sub-specialty group.

Successful candidates will have completed their graduate education in neurosurgical surgery and have a demonstrated interest in the etiology and treatment of cerebrovascular disorders. Completion of a recognized cerebrovascular fellowship. Related publications experience desired. Georgia medical licensure required. Employment begins July 1, 1998. Excellent compensation and support package available.

Qualified applicants should send an introductory letter and curriculum vitae by March 1, 1998 to:

Bob Davies, Coordinator  
Faculty Search Committee  
Department of Neurosurgery, EUSM  
Room B-6498, Building B  
Emory Clinic  
1365-B Clifton Road, N.E.  
Atlanta, GA 30322  
Fax (404) 778-4472

EEO/M-F Employer  
#5711783

## Neurosurgery Position Available

Board eligible/certified neurosurgeon sought for established rural community/regional hospital-based general and spine neurosurgery practice affiliated with a dynamic S.E. clinical and academic training program.

Successful candidates will have completed their graduate education in an accredited neurosurgery training program and have a demonstrated ability and interest in clinical practice with an academic program affiliation. Academic program and/or private practice experience preferred. Georgia medical licensure required at time of employment. Exceptional compensation and support package available.

Applicants should send an introductory letter and curriculum vitae by March 1, 1998 to:

Bob Davies, Coordinator  
Faculty Search Committee  
Department of Neurosurgery, EUSM  
Room B-6498, Building B  
Emory Clinic  
1365-B Clifton Road, N.E.  
Atlanta, GA 30322  
Fax (404) 778-4472

EEO/M-F Employer  
#5711784

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

## **Midwest Neurosurgery Practice**

Busy and thriving Neurosurgery practice in premier Midwest metro area. State-of-the-art 600+ bed medical center with superb neuro-radiology services. Substantial cranial and spine work, excellent productivity incentives, early partnership track. Congenial group environment teaching opportunities.

Your family will thrive in this area known for its terrific schools and splendid quality of living.

Cultural attractions are many and include colleges, universities and a medical school. Outdoor sporting/recreational activities abound.

Contact Bill Sherriff  
Sherriff & Associates  
10983 Granada Suite 202  
Overland Park, KS 66211  
800-533-0525 • Fax 913-451-3931  
Email: sherriff@worldnet.att.net

## **Neurosurgery Faculty Position**

Board eligible neurosurgeon sought for entry-level faculty position in dynamic S. E. clinical and academic training program. Clinical and research opportunities with a spine focus are available in a multidisciplinary group setting.

Successful candidates will have completed their graduate education in neurosurgery and have a demonstrated interest in the treatment of spine injury and disease. Related academic publications experience desired. Georgia medical licensure required. One-year Instructor (Clinical Track) faculty employment starting July 1, 1998. Competitive compensation and support package available.

Applicants should send an introductory letter and curriculum vitae by March 1, 1998 to:

Bob Davies, Coordinator  
Faculty Search Committee  
Department of Neurosurgery, EUSM  
Room B-6498, Building B  
Emory Clinic  
1365-B Clifton Road, N.E.  
Atlanta, GA 30322

EEO/M-F Employer  
#5711796



# Calendar of Events

## winter '98

### 24<sup>th</sup> Annual Symposium - Barrow Neurological Institute

Recent Advances in Neurology,  
Neurosurgery and  
Neuroradiology  
March 8–11, 1998  
Barrow Neurological Institute  
Phoenix, Arizona  
Denise Eskildson, (602) 406-3067

### North American Skull Base Society

March 13–17, 1998  
Kamuela, Hawaii  
(301) 654-6802

### American Academy of Orthopaedic Surgeons

March 19–23, 1998  
New Orleans, Louisiana  
(847) 823-7186

### 1998 National Conference on Hydrocephalus for Families and Professionals

March 26–29, 1998  
Washington, DC.  
Doubletree Hotel, Arlington,  
Virginia  
(415) 732-7040

### Pennsylvania State Neurosurgical Society

April 3, 1998  
Philadelphia, Pennsylvania  
(717) 558-7750

### 1998 AANS/CNS Joint Pain Section Satellite Symposium

April 23–24, 1998  
Philadelphia, Pennsylvania  
(847) 692-9500

### 1998 Pallidotomy Accord

April 25, 1998  
Princeton, New Jersey  
Princeton University

### 1998 AANS/CNS Joint Section on Tumors Satellite Symposium

April 30–May 1, 1998  
Philadelphia, Pennsylvania  
(847) 692-9500

### Texas Association of Neurological Surgeons

May, 1998  
(817) 465-7764

### Southern Neurosurgical Society

May 6–10, 1998  
Hot Springs, Virginia

### Society of Neurological Surgeons

May 10–12, 1998  
St. Louis, Missouri  
(617) 636-5858

### Neurosurgical Society of America

May 13–17, 1998  
Quebec, Canada  
(210) 567-5625

### Georgia State Neurosurgical Society

May 22–24, 1998  
Sea Island, Georgia  
(404) 876-7535

### Society of University Neurosurgeons

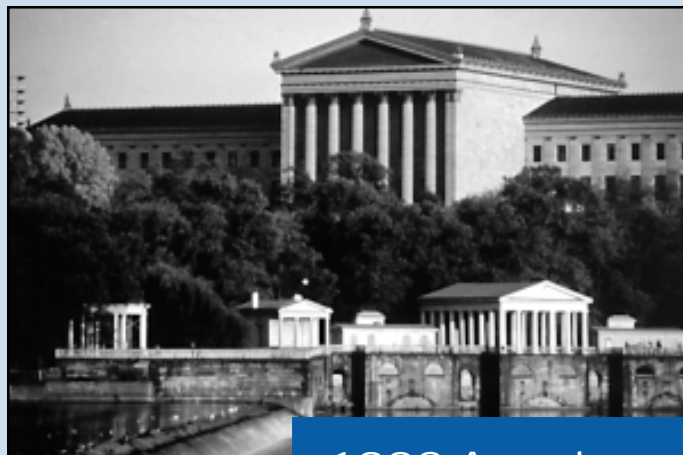
May 23–31, 1998  
Ann Arbor, Michigan  
(206) 368-1626

### American Board of Neurological Surgery

May 25–28, 1998  
Iowa City, Iowa  
(713) 790-6015

### Iowa-Midwest Neurosurgical Society

May 26–29, 1998  
Iowa City, Iowa  
(402) 559-4301



*Philadelphia Museum of Art.  
Photo courtesy of the  
Philadelphia Convention  
and Visitors Bureau.*

## 1998 American Association of Neurological Surgeons Annual Meeting

April 25–30, 1998  
Philadelphia, Pennsylvania  
(847) 692-9500

(continued on page 96)

# Calendar of Events

## winter '98

### International Society for the Study of the Lumbar Spine (ISSLS)

June 9–14, 1998  
Brussels, Belgium

### American Medical Association Annual Meeting

June 14–18, 1998  
Chicago, Illinois  
(312) 464-5000

### Rocky Mountain Neurosurgical Society

June 14–18, 1998  
Vail, Colorado

### Canadian Neurosurgical Society

June 16–20, 1998  
Montreal, Quebec

### Residency Review Committee for Neurological Surgery (ACGME)

June 26–27, 1998  
Durango, Colorado

### Pituitary Society

June 28–30, 1998  
Naples, Florida

### American Board of Medical Specialties

September 17, 1998  
Chicago, Illinois  
(847) 491-9091

### Western Neurosurgical Society

September 12–15, 1998  
Napa, California

### American College of Surgeons Annual Meeting

October 25–30, 1998  
Orlando, Florida  
(312) 202-5000

### North American Spine Society (NASS)

October 28–31, 1998  
San Francisco, California  
(847) 698-1630

### American Academy of Neurological Surgery

November 3–8, 1998  
Santa Barbara, California  
(313) 936-5015

### American Pain Society

November 3–9, 1998  
San Diego, California  
(847) 375-4715

### American Heart Association Annual Meeting

November 8–11, 1998  
Dallas, Texas  
(214) 373-6300

### Society for Neuro-Oncology

November 13–15, 1998  
San Francisco, California

### AANS/CNS Pediatric Section Meeting

December 1–4, 1998  
Indianapolis, Indiana  
(847) 692-9500

### Cervical Spine Research Society

December 3–5, 1998  
Atlanta, Georgia

### American Epilepsy Society

December 4–10, 1998  
San Diego, California  
(860) 586-7505

## 1988 Congress of Neurological Surgeons Annual Meeting



October 3–8, 1998  
Seattle, Washington

Information: Annual Meetings Service Department  
(847) 692-9500

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

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

or fax to:  
(847) 692-2589

### Don't Miss an Issue!

When moving  
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