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THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

AANS BULLETIN
The quarterly publication of the American Association of Neurological Surgeons

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FEATURES

DEPARTMENTS

COLUMNS

Note: Amendments to the AANS Bylaws are located on page 29-30.

Working Together

Fragmentation Within Our Specialty Benefits No One.

As AANS President for the past nine months, I have observed that some of the biggest threats to neurosurgery are not coming from outside our specialty. Rather, I am seeing mounting competition from within the family of neurosurgery that I believe, in the end, will benefit no one. We are seeing an increasing fragmentation within the specialty—and danger lurks there.

Danger of Fragmentation

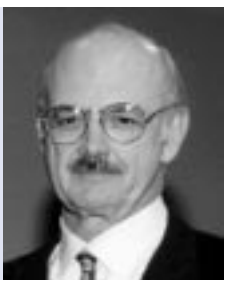
The question of segmentation is not new in neurosurgery. This is a battle we have been fighting among ourselves for nearly 20 years. We have seen the advent of special interests in pediatric neurosurgery, trauma and critical care, spine and peripheral nerve surgery, cerebrovascular and stroke care, and pain management to name a few. Our Sections have been successful in harnessing and enhancing these subspecialty interests and have certainly enriched the practice of neurosurgery. However, while this sub-specialization can help improve the quality of care for patients, there can be an unwanted side effect if we are not careful—the splintering of neurosurgery into narrow interest factions.

We face several big battles over the next couple of years including reimbursement and coding, research funding, manpower, and encroachment from other specialties. We also are seeing threats of fragmentation as a result of attempts to create subspecialty professional credentialing. The most recent manifestations of this have occurred in the area of spine surgery. You may have been solicited by the American Board of Spine Surgeons to pursue certification as a spine surgeon. Your Board of Directors opposes this program and has developed an official position statement on the topic (see page 32).

With other organizations lobbying hard and fast for influence and reimbursement advantage, it is up to organized neurosurgery to hold onto its own piece of the pie. We have to put away our individual differences and work together as colleagues for the benefit of the profession as a whole.

Working Together

Over the years, organized neurosurgery has worked very hard to come closer together and, as a consequence, the AANS and Congress of Neurological Surgeons (CNS) are now working together in stronger alliance. The result has been the development of many joint projects between the two groups including our Web site; the SMART marketing communications program; several outcomes projects; the Washington Committee; the CPT Coding Task Force; and the Fellowship Task Force. This is the direction in which I believe organized neurosurgery should continue to move and is the philosophy that I will continue to endorse as long as I'm an AANS Officer.



Russell L. Travis, MD, is President of the AANS and a neurosurgeon in private practice in Lexington, Kentucky.

The relationship between the AANS, CNS, and the Sections is complex and far from perfect. But, I believe that there is a place for each within neurosurgery and these groups should continue to work together.

I view organized neurosurgery as one big family. And, like most families, there are going to be sibling rivalries and rough moments. One of the most important jobs the President of a spokes-organization has is to encourage consensus. After taking the reigns of President last April, it did not take long to remember what I had learned through my years of service on the Council of State Neurosurgical Societies (CSNS) and the Washington Committee: The job of the AANS President is not just to express an opinion, but also to help blend the views of our members together and then speak for organized neurosurgery with one voice. I frequently remind myself of the much-quoted sentence from Emerson's Self Reliance, "A foolish consistency is the hobgoblin of little minds." The leadership of the AANS is committed to represent your best interest with a united voice, but only after careful debate.

Transitions

Looking to the future, we have undergone a number of changes at the national organization level that will improve service to members in the future. First, you will notice that the *Bulletin* has taken on a new persona. In response to changing member needs, it now has a greater emphasis on socioeconomic issues. My thanks and kudos go to John Popp, MD, and Jim Bean, MD—Editor and Co-Editor, respectively—for their vision and commitment to making our membership magazine one of the best in the field.

On a more somber note, the AANS National Office also has undergone some challenges. During 1998, we lost some key staff members, including Robert E. Draba, PhD, the AANS Executive Director. But, rest assured, the AANS is alive and well. My thanks to Laurie Behncke, Associate Executive Director of Programs, and Robert Cowan, Associate Executive Director of Administration, who have worked hard to keep the National Office services on track during this transition. If some of you have suffered inconveniences as a result of these recent changes, we appreciate your indulgence.

It will ultimately be the members, not the leadership who decides the fate of organized neurosurgery. Leaders are elected to represent the membership and we need to hear from you about the direction and focus you believe organized neurosurgery should be taking. This is a critical time for neurosurgery and for medicine, and we need your input. ■

NEWSLINE

News Members Trends Legislation

FROM THE HILL

- **AANS/CNS Sue HCFA Over Practice Expense Phase-in Rules** On November 4, 1998, The American Association of Neurological Surgeons and Congress of Neurological Surgeons, along with nine other national medical societies, filed suit in federal district court in Chicago, Illinois, challenging the government's just-released rules for phasing in the new practice expense component of the Medicare physician fee schedule. The lawsuit, which was brought against the Secretary of Health and Human Services (HHS) and the Health Care Financing Administration (HCFA), asked the United States District Court for the Northern District of Illinois to declare HCFA's practice expense transition formula unlawful and invalid. HCFA is the HHS agency responsible for administering Medicare and Medicaid. The Medicare physician fee schedule consists of three factors: physician work, practice expenses, and malpractice expenses. This lawsuit involves only the practice expense component.

- **Rules Finalized for Long-term Care Contracts** The Internal Revenue Service issued final regulations governing material changes to long-term care insurance contracts and implementing changes made by the 1996 Health Insurance Portability and Accountability Act. The final rules provide exceptions to the general rule that material changes on a contract issued before January 1, 1997 would be considered an issuance of a new contract.

- **Congress Battles Over Drug Costs** Congress has created a new Prescription Drug Task Force aimed at bringing down the retail price of drugs. Task Force organizers believe that there is a growing gap between what most favored buyers (i.e. managed care plans and federal agencies buying under the Federal Supply Schedule) and those without special access to these deals (i.e. the elderly) are paying for prescription drugs. One legislative proposal drafted by Representative Marion Berry (D-AR), co-chair of the Task Force, would let retail drugstores buy drugs for their Medicare patients at Federal Supply Schedule prices and pass on the savings to those over the age of 65 — a change projected to cut prescription prices for seniors by 40 percent.

- **HCFA Prepares for the Next Millennium** With the year 2000 fast approaching, the Heath Care Financing Administration (HCFA) is conducting a campaign to combat the millennium bug. The bug, which affects computers, devices, and software systems that use only two digits to represent the date, will cause systems on or after January 1, 2000 to mistake the year for 1900. This error could be devastating to the medical industry. To avoid a Y2K disaster, HCFA suggests that you assess your Y2K readiness in the following areas: bank debit/credit card expiration dates; banking interface; building access cards; claim forms and other forms; clocks; computer hardware and software; computer applications; diagnostic equipment; elevators; fire alarms; insurance/pharmacy coverage dates; membership cards; medical devices; monitoring equipment; smoke alarms; telephone systems; spreadsheets; treatment equipment; and safety vaults. *For more information on how the year 2000 will impact the healthcare industry, visit HCFA's Web site at www.hcfa.gov/Y2K or the Food and Drug Administration's Web site at www.gov/cdrh/yr2000/year2000.html.*

- **Legislation for Children** Legislation for the "Treatment of Children's Deformities Act of 1998" will be brought before the 106th Congress. The Act would protect children by requiring all insurers that provide coverage for surgical benefits to also cover outpatient and inpatient diagnosis of a child's congenital or developmental deformity, disease, or injury that, in the opinion of the treating physician, is medically necessary to return the minor child to a more normal appearance.

NEWSLINE

News Members Trends Legislation

NEURO NEWS

Specialist's Compensation Decreases. In 1997, the annual compensation for primary care physicians increased 0.86 percent to $135,791, while compensation for specialists decreased by 0.48 percent to $220,476, making this the second year of almost flat changes in salary, according to a report from the Medical Group Management Association (MGMA) published in the November 2, 1998 issue of *Health News Daily.* "Increased difficulty in collections, increased competition, managed care, reimbursement rates of third-party payers, escalating costs of care, and lower use of health care services are some of the reasons for the stagnation," said Robert Bohlmann, a consultant for MGMA, in his report. The report is based on MGMA's annual survey of 1,675 physician practices in various geographic areas, levels of managed care, and years in specialization.

"In 1997, the annual compensation for primary care physicians increased 0.86 percent to $135,791, while compensation for specialists decreased by 0.48 percent to $220,476."

Clinical Trials Data Bank in the Works. By the end of this year, the Food and Drug Administration (FDA) and the National Institutes of Health (NIH) will be well underway in creating a data bank of government and privately-funded clinical trials that test the efficacy of experimental treatments for serious or life-threatening illnesses. At that time, all NIH-funded trials testing the efficacy of new, developing drugs for serious or life-threatening diseases will be accessible through one Internet address.

HCFA Makes Y2K Commitment. The Health Care Financing Administration (HCFA) is incorporating a requirement into contracts and agreements with Medicare contractors to ensure that all contractors "are making the commitment and taking necessary action to meet our requirements" regarding the Y2K computer compliance, according the December 11, 1998 *Federal Register.* HCFA also is "requiring each contractor to certify…that it has made all necessary system changes and has tested its system in accordance to the guidelines we have established," the report states. The notice is effective immediately.

NINDS Supports Parkinson's Disease Research Centers. The National Institute of Neurological Disorders and Stroke (NINDS) will award investigators at Emory University, Massachusetts General Hospital, and Johns Hopkins University School of Medicine a total of $24 million for Parkinson's Disease and related movement disorder research. Over the next five years, the three university hospitals will explore the causes of Parkinson's Disease and seek new ways to diagnose and treat it. In addition, they will provide state-of-the-art, multidisciplinary training for young scientists preparing for research careers investigating neurodegenerative disorders.

Tribute to Henry G. Schwartz, MD. Henry Gerard Schwartz, MD, President of the AANS from 1967-68, died on December 24, 1998. Dr. Schwartz, a 53-year member of the AANS, was August A. Busch Professor Emeritus of Neurosurgery at Washington University School of Medicine (St. Louis, Missouri). Dr. Schwartz received his undergraduate degree from Princeton University and his medical degree from Johns Hopkins University, where he also served his residency in general surgery. In 1936, he completed his residency in neurological surgery at Washington University School of Medicine and, ten years later, was appointed Professor and Chairman of the Division of Neurological Surgery at Washington University. Dr. Schwartz served as Chair of the Editorial Board of the *Journal of Neurosurgery* (1968), as President of the Southern Neurosurgical Society (1952-53), as President of the Society of Neurological Surgeons (1968), and as the first Vice President of the American College of Surgeons (1972).

Physician Collective Bargaining:

Are Unions the Best Solution?

by Deia Lofendo

As dissatisfaction with managed care grows, so does interest in unions and other collective bargaining arrangements.

Many doctors see these arrangements as a means to regain leverage against hospitals, clinics and managed care groups, attain financial control, maintain physician autonomy, and increase the amount of time spent with patients. However, issues such as the impact of unionization on the medical profession, the possibility of striking, and the ethics behind collective bargaining remain a heated debate.

A Brief History

Following World War II, legislation was passed that exempted insurance companies from anti-trust laws and allowed them to share data and set prices. This positioned independent contractors as competitors and, as such, prohibited the contractors from fixing prices.

Physicians, at the time, didn't see a need for collective bargaining—they practiced independently, set their own fees, and determined which insurance plans they were going to work with on an assignment basis. However, during the 1970s and 1980s, as managed care started to rear its head, physicians' attitudes began to change.

With fees and reimbursement cut by HMOs and PPOs and an increasing trend toward interference in medical decision-making by prior approvals and utilization reviews, physicians began feeling a reduction in income and erosion in autonomy and clinical authority. Physicians started looking for a way to regain control of their practices by forming Independent Practice Associations (IPAs), including network model HMOs, as one way to negotiate as a group with insurers.

In the years that followed, as managed care grew and power became concentrated in fewer and fewer hands, doctors became increasingly frustrated and took their first steps toward unionization. Unions hoped to circumvent physicians from anti-trust laws and enable doctors to collectively bargain.

Today, interest in unions has intensified. More than 42,000 physicians — or 5 percent of the nation's doctors — are labor union members, many of which are interns or residents. Critics contend that with an increasing number of residents seeking the right to collectively bargain, medicine will see an unprecedented surge of doctors beginning their careers as card-carrying union members.

"To date, physician unions have not had a significant impact on organized neurosurgery," said Robert E. Florin, MD, Chairman of the AANS Physician Reimbursement Committee. "However, with the Health Care Financing Administration (HCFA) recently implementing practice expense relative value units (RVUs) that will reduce total neurosurgical income by 15-20 percent over the next five years, neurosurgeons may turn to unions as a means to gain leverage."

Why Unions?

Under current labor laws, only non-supervisory employees may form unions. Self-employed doctors are termed independent contractors and, as such, are barred from forming unions because of federal anti-trust laws against price-fixing and other collective actions.

Many physicians hope that representation through unionization will be an effective outlet for them to voice their anger over the intrusive control exercised by their payers. They say they are outraged at the insurance company bureaucrats who are "calling the shots" in the health care system, and argue that a physician's primary responsibility is to his or her patient, not to the managed care industry's bottom line. Through unions, physicians hope to bring their issues to the table when negotiating with health care contractors.

Arnold C. Lang, MD, and Guillermo A. Pasarin, MD, are two neurosurgeons who, frustrated with managed care and the corporatization of health care, joined a chapter of the Federation of Physicians and Dentists—a 3,500-member union based in Tallahassee, Florida, that is affiliated with the AFL-CIO. Today, they serve as the Vice Presidents of the Federation.

"I believe that the practice of medicine should rest in the hands of those responsible for patient care—physicians," said Dr. Lang. "We have lost total control of our profession and unionization is about standing together to say 'no more."

Dr. Pasarin added, "In our specialty, patient care and medical services are increasingly being rationed by HMOs. Unions enable neurosurgeons to practice their craft without any extraneous factors."

The Downside to Unionization

Physicians who decide to unionize, however, face many difficulties. The laws that define who can and cannot unionize sometime inhibit physician unions from gaining government recognition, which is essential when negotiating with employers. And, for those that do receive acceptance, there is stiff resistance from other physicians who are adamantly opposed to the ultimate weapon of unionization: a strike.

> **"The Medicare allowable needs to be our minimum wage, and no one should be allowed to ratchet it down."**
>
> — ARNOLD C. LANG, MD

"While I understand the difficult working conditions we, as physicians, sometimes face, I do not see how a strike could ever benefit the best interest of our patients," said James R. Bean, MD, Chairman of the Council of State Neurosurgical Societies (CSNS). "To withhold patient care is not only an abandonment of our ethics but a stain on our image as professionals."

Critics also argue that instead of giving doctors more control over the practice of medicine, unions would result in medical and hospital services being administered via organized groups and paid for by funds obtained through assessments and taxation. They also contend that unionization would accelerate an erosion of the physician-patient relationship and drastically reduce health services.

"Widespread unionization is not the solution to the problem plaguing our health care industry, rather it would only serve to make the problem worse," said Dr. Bean. "Neurosurgeons joining unions must realize their limitations. The pressure to raise primary care income at the expense of specialty income will guide policy, just as it does in any current multispecialty medical organization."

Dr. Lang disagrees: "Neurosurgeons represent a small specialty and, as such, will benefit from a large, collective voice. Unions are not meant to be a substitute to organized neurosurgery, rather they are a means to help organized neurosurgery improve patient care."

Union Alternatives?

The American Medical Association (AMA) is exploring alternatives to help doctors stand up to insurers and employers. "We believe you can get the impact desired through collective bargaining without all of the philosophies and by-products of unionization," said AMA President Nancy W. Dickey, MD (*Physician's News Digest* , November 1997).

To demonstrate this, the AMA has publicly supported the Quality Health Care Coalition Act of 1998 drafted by Representative Tom Campbell (R-CA). The bill exempts self-employed health care professionals, including doctors in private practice, from anti-trust laws and allow them to collectively bargain with HMOs.

"The AMA has long believed an anti-trust exemption for self-employed physicians is needed to level the playing field," said AMA Trustee Donald J. Palmisano, MD, JD, in a recent testimony before the U.S. House of Representatives Judiciary Committee. "Too often, the individual physician and the individual patient stand alone against health plan bureaucracies. This must change. The Campbell bill improves patient care and redirects the medical decision making back toward the physicians and patients—where it belongs."

The Battle Intensifies

As managed care continues to challenge the way physicians practice medicine, the battle over unionization will intensify. Supporters are on a mission to reclaim their profession. They argue that as long as HMOs remain monopolistic, physician unions will continue to survive and thrive.

Critics, however, disagree and believe that unions are not the solution to improving negotiations with payers. They believe that supporters need to realize that putting down their patient charts in exchange for picket signs would not only be a disservice to their patients but to the medical profession as a whole. ■

The Pros and Cons of Physician Unionization

Issues Driving Physician Unionization: Some Reasons Why They Make Sense

JOHN A. KUSSKE, MD

YES! While physicians represent diverse groups who have many different interests, unions are seizing a common set of themes to promote physician unionization. Though the emphasis may differ depending on the campaign, unions attempting to organize physicians generally address the following issues:

1. Professional Authority. Concerns about maintaining professional authority are among the most common reasons physicians give for unionization. Physicians state that their professional authority to care for the patient has been blunted by the various managed care plans. Physicians see practices such as administrative review of decisions, limitations on the number or type of tests, limitations on the specialists to whom physicians can refer to, and gag rules, as anathema to physician's professional authority.

The unions are happy to market themselves to physician discontent. According to a Union of American Physicians and Dentists (UAPD) spokesperson, "The whole movement toward managed care is making doctors much more similar to employees and much less like independent contractors." Unions can leverage authority issues by casting physician unionization as the means to gain back the power and respect that physicians perceive themselves to be losing.

2. Job Security. Some of the job insecurity that physicians face related to mergers or closure of hospitals is a fertile ground for unions seeking to organize physicians. Physicians are used to being the employer or a highly valued employee—in either case not vulnerable to layoffs. With many institutions reducing workforce requirements for physicians, this will become more of an issue in the future.

3. Compensation. Compensation matters, while sometimes hidden behind other issues, are important in the drive to unionize physicians. Physicians are cognizant that falling wages are a threat to physicians' lifestyles, especially as the cost of medical education and the amount of loans needed rise. This is an important factor that physicians consider when they are contemplating unionization. As the percentage of employed doctors grew from 25 percent in 1985 to 45.4 percent of all doctors in 1995, unions have been looked at as a vehicle for protecting and enhancing income.

4. Benefits. The subject of benefits is another issue physicians focus on when considering unionization. This can be particularly important when it involves physician malpractice insurance. The mere perception of reductions in malpractice coverage is an issue that drives physicians to consider unionization.

The American Medical Association's (AMA) house of delegates provided further momentum for physicians organizing when on July 24, 1997 it voted for resolution 239. This states that the AMA is to "seek means to remove restrictions, including drafting of appropriate legislation for physicians to form collective bargaining units." The House of Delegates also adopted recommendations of the Board of Trustees Report 41, which calls for the AMA to form a Division of Representation "to work with state and county medical societies that also want to respond to physicians' desires to be represented more aggressively." Unfortunately, as presently structured, the AMA and other professional societies cannot enter into economic negotiations on behalf of their constituents.

Grace Budrys, PhD, in her book, *When Doctors Join Unions,* states that in the future doctors will have no alternative but to organize collectively to gain control over their work. "Whether unions or union-like organizations emerge is difficult to predict," she said. "That will depend on the number of physicians in an area, the extent of managed care penetration, the political and social environment, and whether the courts change their interpretation of labor law."

John A. Kusske, MD, is Professor of Clinical Neurological Surgery and Chief of Surgery at UCI Medical Center (Orange, California). A 23-year AANS member, Dr. Kusske currently serves as Southwest Regional Director of the AANS Board of Directors and as Chairman of the AANS Managed Care Advisory Committee.

Why Physician Unions Probably Won't Work

JAMES R. BEAN, MD

NO! Physician service contracts, whether with commercial insurers, managed care organizations, government sponsored programs (Medicaid/Medicare), or other payers have become so common as to be the rule, with charge-based or indemnity reimbursement the exception. This means that for most reimbursement for most physicians, the payment rate is determined by a fee schedule affected by the payer—take it or leave it.

Some physicians can negotiate, or haggle over the prices. But for the most part, the insurer, with the insured clients (potential patients) to offer or withhold, holds the upper hand and can set prices at a competitive market rate, regardless of the physician charge. Service contracts also include an array of other working conditions, such as timely submission of claims, appointments, balance billing restrictions, acceptance of pre-authorization and utilization restrictions, formal grievance procedures, and more. These conditions also leave some room for modification, depending on the size of the insurer and the physician's uniqueness or competition.

Thus bargaining, or the wish to bargain, has become a keystone of physicians' professional lives. The problem for physicians is large, organized insurers setting conditions, and individual, dispersed physicians accepting them. Physicians feel unfairly disadvantaged and seek a way to level the playing field. Since bargaining is necessary, and orga-

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nized bargainers have market power, physicians inevitably see the value of—if not the urgent need for—collective bargaining. Collective bargaining, in American parlance, means the emergence of physician unions. Not only is the movement not surprising, it is natural and predictable given the evolution of physician working conditions.

Why are Unions a Problem? Most physicians are not employees. Those who are, are not employees of the companies with whom they wish to collectively bargain. Collective bargaining is a legally recognized method for labor to deal with the concentrated corporate power of their employers. They work for one employer, their wages are fixed by one employer, their working conditions are set by one employer, and their livelihood depends solely on the relationship with that employer.

Physicians, or the organizations they work for, are not employees of the payers who are driving down their reimbursement. Physicians contract with numerous payers, accept a variety of fee schedules, agree to an array of working conditions, and rarely depend on a single payer for all payment. Their relationship with a health insurer does not fit the definition of employee-management relationship, and they do not qualify for the right of collective bargaining when dealing with health insurers or managed care organizations. They are independent contractors and, by antitrust law, may not collaborate—or in the language of the law—collectively conspire to fix prices, allocate markets, or refuse to deal.

Despite Representative Tom Campbell's (R-CA) bill to allow physicians to collectively bargain and balance the market power of health insurers, physicians do not qualify for collective bargaining rights, and federal anti-trust laws are unlikely to be altered to allow it. The argument by physicians that they are de facto employees of payers, rings hollow in the general business world. Modification of federal or state law to fit this concept, and benefit neurosurgeons or other physicians as a special group, is a wishful dream.

Do Unions Really Benefit Physicians? Physician unions can perform the same functions an Independent Practice Association (IPA) can for member physicians, when the members are self-employed, or employed by various organizations. Second, they can bargain on behalf of employed physicians with their employers, when salaried by their employers and not owners or managers of the business enterprise. Few physicians fit in this second category, and those who do rarely feel the collective need to trust or form or join a union.

Therefore, physician unions are usually IPA's by another name, constrained to negotiate by the messenger model if the subject is non-risk reimbursement. Is there an advantage a union has over an IPA? Yes, for the union: it can collect heavy dues. Is there a disadvantage? Yes, for the members: they have to pay them.

Will Unions Affect Neurosurgeons? There is concern that neurosurgeons joining unions may weaken or compete with organized neurosurgery, both on a local and national level. That worry is unfounded. Unions will never serve the purposes these organizations fill, nor will the need for these organizations disappear. Moreover, union interests are focused on wage, practice condition and contracting issues—all issues from which current neurosurgical professional organizations are excluded. There will be no conflicting overlap.

The Road Ahead Is there a future for physician unions? Maybe, but I doubt it. There certainly is not a future for unions as a bargaining agent for physicians in independent practices. As a transitional vehicle, they ease the traditional physician status change from sole proprietor and individual entrepreneur to employee of larger organizations. They help physicians under duress believe that they have gained a bargaining advantage, which they ultimately find to be elusive.

The interest in unionization of physicians will likely be brief: a flash in the pan. View it as a momentary reaction to change, to professional frustration, and to a sense of powerlessness, futility and gloom. As older physicians adjust to and younger physicians enter into the new world of contractual, market-driven fees, of greater professional competition, of tighter management of resources, and of limitlessly expanding technical capabilities, they will find a new economic equilibrium and an expanded sense of opportunity. Neurosurgeons are not yet ready to subordinate their independence, initiative, income, and self-image to the leveling discipline of trade union membership.

James R. Bean, MD, is a neurosurgeon in private practice in Lexington, Kentucky. Dr. Bean is a 10-year AANS member, Associate Editor of the *Bulletin,* and Chairman of the Council of State Neurosurgical Societies (CSNS). He also serves as CSNS liaison to the AANS Board of Directors.

Physician Union Resources on the Web

Go site seeing on the information super highway to learn more about physician unions.

Federation of Physicians and Dentists
http://www.fpdnu.com

The American Federation of State, County, and Municipal Employees
http://www.afscme.org/home/index.html

Office Professionals and Employees International Union
http://www.opeiu.org

Union of American Physicians and Dentists
http://www.uapd.com/index.html

University of California Association of Interns and Residents
http://www.igc.org/ucair

We Want to Hear From You

The American Association of Neurological Surgeons is interested in hearing your thoughts on physician unionization. Please post your comments, questions, and concerns on the official Web site of the AANS and CNS — NEUROSURGERY://ON-CALL®.

To access the N://OC® site, go to www.neurosurgery.org and click on the "Professional Pages." There, you will see a link for the Bulletin Board, select the link and tell us your views on physician unionization.

To Unionize or Not…

Why Do Doctors Join Unions?

As most physicians will tell you, unionizing means resorting to the ultimate weapon used by unions — the strike—and that is unthinkable. What's the point of joining a union if you do not intend to strike? Besides, it's all just so unprofessional.

However, an increasing number of doctors are saying that it has all, most notably managed care, gone too far and that joining a union is the one action that will capture the HMO bean counters' attention.

The recent wave of physician unionism across the country indicates that doctors are so angry and frustrated that they are willing to try unionizing as a last resort. Whether this turns out to be a good decision or not depends on whether those who join are able to move past their frustration and turn their energies toward creating an effective organization. But, that's getting ahead of the story.

A reasonable place to start in deciding whether unionism is a viable option is to consider what the alternatives might be. When one considers the situation more closely, one can see that doctors confront a difficult, forced choice between two alternatives, namely to opt for identifying with corporate management or with labor. In the past, doctors avoided the issue by asserting that medical professionalism required doctors to be responsible to their patients first, and to other authorities second. By law, doctors were defined as small businesspersons and there was no need to press the matter. Now, that has all changed.

How it all Started

It started to change, innocently enough, when doctors banded together into groups sometime after the World War II reconstruction period ended during the 1960s. Doctors moved away from solo, fee-for-service practice, which is the structure of practice central to the definition of medical professionalism. Establishing group practices was a rational response to the increasing cost of maintaining an office, especially the escalation of administrative demands associated with medical record keeping.

Grace Budrys, PhD, is Professor of Sociology at DePaul University in Chicago and the author of When Doctors Join Unions.

Initially, office managers, together with one or two clerks, could handle the administrative load for a group of physicians. However, things not only got more complicated, they began to change at a rapid pace. That brought in an entirely new occupational group—practice managers, who soon evolved into entirely new kinds of organizations, known as Physician Practice Management companies.

At the same time, managed care organizations were entering into a particularly active phase, expanding, merging, and changing in the tireless pursuit of efficiency. That shift appears to have made doctors less efficient. Physicians responded in a perfectly rational and reasonable manner, by joining together to form even bigger groups to deal with the increasingly larger and more centralized, therefore more powerful, health care delivery organizations.

And, that in a nutshell explains why doctors now confront a forced choice in how they are defining themselves. It is because doctors' organizations suddenly became so large that they began to attract the government's attention.

The government became concerned that doctors' groups were becoming monopolistic. It started with one or two doctors who were asked to leave such groups and responded by taking the groups to court, arguing that they were being prevented from earning a living. That touched off government anti-trust legislations.

Managed care organizations were quick to take advantage of the same argument. The fact that most participants (doctors, patients, and health centers) in the health care delivery system are now involved in contractual arrangements with large organizations means that the stakes have been raised, and more disagreements leading to legal disputes have come before the courts. This has put pressure on everyone to make their organizational objectives clear and put into contractual language.

The effect of this has forced doctors to choose between the available legal options in identifying the nature of the organizations that they chose to form to represent them and their occupational interests.

One option is to assume a corporate, business identity. And, many doctors have done just that. They have accepted the designation assigned to them by the government—as businesspersons—and operated under the rules governing commercial entities. They have contracted with managed care organizations over covered lives, accepting a high level of financial risk as an incentive arrangement, in setting the per patient per month payment. The government, meaning the Justice Department and the Federal Trade Commission, has supported this approach. It considers joining a group that competes with other physicians' groups to be an excellent arrangement allowing the market for physicians' services to operate based on fundamental supply and demand principles. That is

Continued on next page

good business practice, which is, of course, the essential problem in the view of others. Critics argue that good business practice is not the same as good medical practice.

Profit Versus Patient

The critics say that competition, in this case competition among doctors, requires holding costs down to keep prices down. Holding costs down is not bad in and of itself. It becomes objectionable, however, when it is achieved through the restriction of services — more precisely, restriction of efficacious services. While drawing the line on what is or is not efficacious is clearly debatable, the principle remains. The problem that a number of medical professionals have pointed out is that doctors who choose to embrace business principles which place greater value on efficiency rather than efficacy, risk being viewed as having a greater commitment to maximizing their profit than to their patient's health.

"When one considers the situation more closely, one can see that doctors confront a difficult, forced choice between two alternatives, namely to opt for identifying with corporate management or with labor."

The other forced-choice option is aligning oneself with workers rather than management. How is this an improvement, especially given that talk of unionizing brings to mind factory workers with smutty faces on the picket line with the threat of violence hanging heavy in the background? That has certainly been a problem for doctors. The imagery associated with unionism in this country brings industrial unionism to mind, which includes the tactics used by industrial unions to achieve better wages and working conditions for their members.

This is not the image of unionism held by people in other highly industrialized countries. In European countries people treat unions instrumentally. Whether they are professionals or not, they see themselves as having a legitimate interest in improving their wages and working conditions. Union representatives carry on those negotiations. The idea that members of a prestigious occupation will lose status if they join unions and use them to carry out negotiations with the organizations that determine wages and working conditions is not an issue. Indeed, virtually all European countries have strong doctors' unions.

It is worth considering when and why European physicians formed unions. They did so as fee-for-service practice began to disappear. There was really little alternative. Everyone understood that large organizations, whether it was the central government as in Sweden or locally established sickness funds as in Germany, were not interested in negotiating with doctors on an individualized basis. As health care organizations in the U.S. become larger and more centralized, they, too, expect to deal with physician groups and organizations rather than individuals. Thus, the only question left is what kinds of organizations do physicians wish to assemble or, more precisely, which set of laws do they wish to be governed by. The choice is either antitrust legislation or labor law.

Choosing to be governed by anti-trust legislation is not as complicated as choosing to be governed by the law. Since the law defines doctors as businesspersons, they are automatically covered by antitrust legislation unless they wish to argue otherwise. Getting the doctors to treat their peers as employees protected by labor law and entitled to bargain collectively, even when they are salaried, is not nearly as easy to achieve.

Picking Sides

Is the fight to be defined as an employee or someone working under employee-like conditions worth it? Isn't joining a union just replacing one set of problems with a new set? If the primary purpose is to achieve higher pay and better benefits for its members, won't the public think that is inappropriate in the case of medicine?

We have not had enough experience to answer these questions conclusively, but the evidence thus far seems to indicate that the public usually supports the doctors rather than the organizations, usually managed care organizations, with which doctors have been negotiating. When disagreements over pay, benefits, plus all the other issues that the doctors find troubling about managed care restrictions have come before the public, the public has generally sided with the doctors. Doctors have rarely had to resort to strike threats. Managed care organizations have generally capitulated in the face of public support for the doctors' cause.

This actually is not all that surprising when you consider how the public might perceive such events. Consider the context in which negotiations go on between unionized workers and management in contrast to negotiations between a managed care organization and doctors who operate as a corporate entity. In the former, everyone pretty much understands the issues that management and workers are bargaining over, but are more interested in the other issues (such as gag clauses, restrictions on referrals to specialists, and so on) that doctors have made public under such circumstances. By contrast, contracts between the managed care organization and doctors who operate as a corporate entity are never made public, are therefore more mysterious, and more likely to be suspect. It is not that the public is so eager to know how much money doctors make, it is that the public doesn't know

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Turmoil in the HMO Market

Will the Trend Toward More Consumer Choice (and Rising Costs) Continue?

Every month, HMOs loosen up their controls over patient choice and movements take place among providers. In many ways, it looks like we might be going back to the way we were.

Recently, WellPoint's subsidiary, UniCare Life and Health Insurance Co., announced several new plans for individuals and small businesses in certain types of markets. According to data in *Integrated Healthcare Report*, these products, known as the "No Deductible PPO Plans," will combine the cost-saving features of an HMO with the open access network of a PPO.

Individual members, for example, can select a $20, $30, or $40 co-payment for an office visit, and with this co-payment there is no annual deductible and no prescription drug deductible. Members are not restricted to a narrow network of providers, and may choose from a range of doctors and hospitals, and access network specialists without prior authorization.

Will this trend toward more consumer choice, which will raise costs, play out with larger numbers of lives enrolled? No one knows. Will such plans take the steam out of efforts by physicians and hospitals to organize into systems that can go at risk under capitation agreement? Maybe.

HMO Profit Plunges Reported

Reports continue to point to financial hard times for HMOs. Profits dropped for New England-area HMOs for the first half of 1998, according to a report in the November issue of *Integrated Healthcare Report*. Medical and administrative costs were the culprit and 72 percent of the region's HMOs reported a net loss. Of the approximately 60 licensed HMOs in New England, only four were marginally profitable.

Kaiser Permanente also could face a bigger loss this year than 1997's deficit of $266 million. *Modern Healthcare* reports that the annual loss may approach $500 million and Kaiser officials have stated that this amount is fairly accurate. Just two years ago, Kaiser posted a profit of $265 million.

John A. Kusske, MD, is Chairman of the AANS Managed Care Advisory Committee.

A new series of reports in the *Integrated Healthcare Report* reveal the results of Medicare risk contract terminations and service area reductions. A total of 371 U.S. counties were affected on January 1, 1999. More than 400,000 Medicare risk beneficiaries in 29 states will no longer have access to HMOs. This is because the Health Care Financing Administration (HCFA) is pushing hard to move Medicare beneficiaries into managed care, but at the same time is reducing reimbursements to HMOs. The economic pressure comes from the Balance Budget Act of 1997, which mandates 2 percent increases annually to Medicare HMOs while costs are rising at about 5 percent.

Steep HMO Premium Increase Ahead

HMOs and other managed care organizations will hit businesses with some of the steepest rate hikes in years, which will probably mean more out-of-pocket costs for employees. After several years of little or no rise in rates, average HMO premiums next year are expected to increase by at least 6 percent, double the average increase during the mid 1990s. PPOs will see average increases of 9.3 percent, compared with previous increases averaging 3.5 percent. According to a report published in the November 28, 1998 issue of the *New York Times*, many employers will pass along some, or all, of the additional costs to their workers. Factors pushing up costs include: rising drug prices, earnings concerns, demand for reimbursement, and new laws.

Although HMOs are increasing premiums, it should be anticipated that providers will see very little money as a result. Medicare costs will further erode resources. It's not a time to consider going back to the way we were. Solo practice is dead, the days of the independent hospitals are numbered, and there are far too many specialists.

Additionally, a recent poll by Louis Harris and Associates revealed that 92 percent of the employers surveyed would reduce health coverage and hire more part-time workers who are not eligible for health benefits. Eighty-eight percent of the respondents believed that the government should provide health insurance to children and 74 percent want coverage for adults as well.

Health Care Costs and the Future

With health care costs on the rise again, and the first generation of managed care having matured itself into market gridlock, it is inevitable that there will be a second employer revolt.

The timing of this second employer revolution is anyone's guess, but it is likely to occur on the heels of a major and sustained correction in the global market. Employers will be moving volume to organizations that can offer the best value. From the private sector point of view, if doctors are willing to listen, and become committed to accountability and measurement, employers believe that those closest to the customer (i.e. patient) are best able to manage. Whether provider systems can rise to this challenge is unclear. But the stakes have never been higher. ■

Outcomes Initiative

Concepts and Strategies for Implementing an Outcomes Initiative.

MEGAN MORGAN

The world of medicine has changed and physicians must become well versed in a new set of skills in order to survive and prosper. Despite the growing interest in outcomes, relatively few organizations have become involved in developing outcomes initiatives to improve quality and cost effectiveness. The reasons cited for this lack of involvement vary, however, moving from the conceptual to implementation is clearly a challenge shared by all.

Following are some compelling reasons for surgeons to implement outcomes initiatives into their practice:

- Achieve improved clinical outcome;
- Reduce costs and improve cash flow;
- Increase patient satisfaction and patient retention;
- Improve efficiency;
- Collect data to support negotiations with managed care; and
- Improve management skills through the collection and analysis of data.

Challenges in Implementation and Facilitating Change

Physicians were trained to practice medicine. They have not been trained in total quality management, and implementing an outcomes initiative requires new skills. Internal resources within practices are already stretched. The perception that implementing an outcomes initiative is too burdensome must be overcome.

Most significantly, the development and implementation of a broad outcomes initiative represents change and requires commitment. The causes for the failure in implementation can most often be found in a lack of commitment by the leadership and a failure to manage the change process. Although an in-depth analysis of leadership and change go outside the scope of this discussion, the following basic concepts should be kept in mind:

Organizational commitment must be present. Regardless of the size of your practice, commitment by the leadership for implementation of an outcomes initiative is crucial.

Identify champions at all levels. Without the support and input from physicians, an outcomes initiative is impossible. Likewise, without the support and involvement of key non-physician staff (i.e., nurses, administrators, etc.) any data collected will be, at best, incomplete. Identifying both physician and non-physician champions will assist in motivating others and provide momentum to move the process along.

Establish a sense of urgency. Everyone resists change. A major factor in overcoming resistance is to create a sense of urgency. Organizations that fail to implement systems to assess and improve outcomes will not be able to remain profitable, survive and prosper.

Develop a vision and strategy. There are a number of reasons to collect outcome data. The vision developed for the outcomes initiative should include as many reasons as possible for its implementation. The strategies created should directly link to that vision. Lastly, and most importantly, the vision and strategies must be communicated frequently to all staff, at all levels of your practice.

Remove obstacles. Even with the most motivated clinical staff, there are obstacles to implementing outcomes initiatives in every practice. For example, the sign-in process might not support distributing patient reported outcome instruments. Financial data may not be linked electronically to patient records. Whenever possible, review those obstacles and find ways to remove them. The processes within your practice must be recreated to support the systematic collection of outcomes data.

Generate short-term successes. Select projects at the beginning of the implementation process that will yield meaningful data in a relatively short period of time. For example, implementing a report card for selected outcome indicators or a patient satisfaction survey can produce an early success that yields useful data.

The implementation of an outcomes initiative, in any setting, represents a continuum. Each step along the continuum must be carefully planned for and developed prior to implementation. Beginning an outcomes initiative also requires both a significant planning process and a willingness to change. Although the process seems daunting, it is possible to develop an outcomes initiative that yields valid data in a cost-effective, efficient manner.

Phase I: Planning

Developing an effective plan is the most critical segment of implementing an outcomes improvement system. Key elements of the planning phase include:

Assessing your practice and your health care marketplace. In order to effectuate meaningful improvement and to keep your efforts small and simple, look at your practice and the marketplace you are practicing within.

Review the following questions: 1) Is there a disease process or procedure for which we see significant variance in outcome? 2) Do we know whether our patients are satisfied with the care they are receiving? 3) Are we being faced with negotiating capitating contracts? If so, do we have the data that will allow us to have an accurate picture of our patients and the cost of their treatment? 4) Are we required to obtain approval from managed care plans prior to implementing treatment? Would the collection and presentation of data circumvent that process? 5) How will looking at the process of care within our practice increase profitability? 6) Are there variations in the treatment process among the physicians in our practice which lead to difficulty in the care process and/or variances in outcome?

In order to survive and thrive, practices must measure their outcomes and seek to implement improvements. Decisions must be data driven to negotiate with managed care.

Create a team to create goals and objectives, as well as overall strategies. Make certain that members include representatives of the leadership within the practice. Once the team is created, begin to develop a written plan that clearly sets out the approach being used; the reasons for implementing an outcomes initiative; the assignment of responsibility for various tasks; and how you will measure success. An important part of the plan will be the development of goals and objectives that answer the following questions: 1) What are we trying to measure? 2) What process are we trying to improve? 3) How will we measure change? 4)How will we improve the process once the data is collected? 5) What will we do with the data once it is collected?

Reducing these concepts into a written plan will enable you to continuously evaluate the effectiveness of your plan and keep the team on track during the implementation process.

Phase II: Implementation

During this phase, the team will finalize what data will be collected, what measures will be used, and how the collection of data will be integrated into the clinic routine. It is suggested that the final implementation design be tested on a small group of patients (10-15) to see how the process works and if there are modifications that will streamline the process. Typical issues dealt with during this phase include: 1) Do we need outside help in designing this plan and analyzing the data; 2) What outcome measures will be collected; 3) Which instruments or measures will we use; 4) Which patients will we collect the data from and over what period of time; and 5) Once we have the data, how will we analyze it?

Phase III: Analysis

Data analysis is a key factor in achieving utility. If you have collected simple, useful measures, analysis should lead to answering the questions posed during your planning phase. Typical questions include: 1) Does the patient population differ so that risk stratification is required? 2) How can the data be analyzed in a way that answers the questions we have posed? 3) How can the analysis be displayed in a way that leads to a prompt understanding of the results? 4) What does the data analysis reveal about areas requiring improvement or change within our practice?

Phase IV: Feeding the Data Back

Once the data analysis is complete, the data should be distributed to all members of the practice in an effort to decide what areas require improvement. Implement changes to improve the areas targeted and continue to measure the outcomes overtime to assess the effectiveness of the changes.

In addition, developing a reporting mechanism to payers is often valuable. For example, if one of the managed care plans is critical of your length of stay, a report showing length of stay information will be beneficial in challenging their position.

Practices often view the collection of outcomes data and the implementation of an outcomes initiative as an overwhelming burden. The truth is that it does take time and resources; however, it can be done effectively and lead to receiving invaluable information.

In order to survive and thrive, practices must measure their outcomes and seek to implement improvements. Decisions must be data driven in order to successfully negotiate with managed care. The growing demand for data and the increasing level of accountability will continue. Practices that proactively begin to implement outcome improvement systems will be able to prosper in a competitive health care marketplace. Practices that fail to address the need to collect outcome data will find themselves continually reacting — a time consuming and ineffective response. ■

Megan Morgan is the Project Manager for the AANS/CNS Outcomes Initiative—a team convened to provide tools to AANS/CNS members for use within their practice to measure, monitor, and manage selected outcomes; and provide the capacity to store outcomes data on a national level through a data repository which will allow for aggregation of data and individual comparison against a national benchmark.

Documentation Audits

Advice on How to Minimize Your Chance of a Documentation Audit.

The rules and regulations for accurate coding and documentation are becoming more complex. New American Medical Association-Health Care Financing Administration (AMA/HCFA) guidelines for Evaluation and Management (E&M) documentation were proposed in 1997 only to be tabled for further revision. However, if your documentation is audited now by Medicare, their 1997 rules will apply.

Current Procedural Terminology (CPT) describes the rules for coding procedures and patient encounters. Insurance carriers, Medicare, Medicaid, managed care plans, and worker compensation carriers are all at liberty to interpret these rules. Where CPT guidelines are unclear, Medicare administrators, in particular, might choose to apply their own interpretation.

Both Medicare and private payers have stepped up their documentation audit efforts to prevent both fraudulent activities and overpayments. Although any practice may be audited through random sampling, there are certain coding and documentation behaviors that can send up the "audit me" red flag to payers. Minimize your chances for an audit by following these recommendations.

Recommendations

- **Code correctly based on your documentation.** Both noncompliance and documentation requirements and aberrant coding patterns can be red flags for audits. One example for a red flag is overuse of a particular category of E&M code (i.e. 9924x). Carriers expect physicians to utilize all categories of E&M codes; however, sometimes an aberrant coding pattern is legitimate. For example, most neurosurgeons see patients only at the request of another physician. The neurosurgeons over-utilization of the outpatient consultation codes might send up a red flag to the payer, but they would be an entirely appropriate use of codes.

In addition to looking at the category of E&M code, payers also analyze the level of code for over-utilization patterns. If a level four code is chosen on all outpatient consultation codes, a red flag is raised at the carrier, as they expect to see the utilization of E&M codes to follow a bell-shaped curve. Since neurosurgeons typically see patients with complex problems, their utilization of higher level codes might be justified.

- **Require physicians to code and document services.** The neurosurgeon who is in the exam room or operating room knows best what happened and why. The cashier, or secretary, does not have the medical education or understanding to make coding judgements. Similarly, the billing clerk may not adequately understand what was done, even when attempting to code from an operative report.

In our experience, the involvement of the physician is directly related to successful reimbursement. The neurosurgeon who codes typically experiences higher reimbursement and less risk for submitting incorrect codes. The accuracy rate for the support staff coding from the physician chart notes was less than 20 percent at one practice we recently visited. Therefore, coding and documentation are the steps in the reimbursement process that should be performed only by the neurosurgeon.

- **Use appropriate code combinations.** Unbundling, or breaking down an all-inclusive CPT code into two or more codes, may send up the "audit me" flag. When you bill for incorrect code combinations, such as the 63030 (posterior lumbar discectomy) with a 22630 (posterior lumbar interbody fusion), one code is usually denied by the carrier as "part of another code." Medicare's Correct Coding Initiative (CCI) is an attempt by a payer to reject certain coding combinations.

- **Understand how and when to use modifiers.** Certain modifiers are red flags to carriers and overuse of these modifiers may result in an audit. Anytime you use a modifier and increase your fee accordingly, you will alert the payer. For example, the use of the -22 modifier (unusual services) normally will trigger a documentation review.

Stay On Top of Coding Issues

It is important for the neurosurgeon and key office staff to have a thorough understanding of coding and reimbursement issues. To stay aware of and comply with such changes, the neurosurgeon should attend refresher courses, read publications, and keep up-to-speed with coding changes published in the *Federal Registrar.* ■

Kim Pollock, RN, MBA, is an instructor for the AANS PDP Courses on Coding and Reimbursement, and a consultant specializing in coding and reimbursement issues for neurosurgeons at Karen Zupko & Associates, a medical practice management consulting firm based in Chicago.

UPCOMING AANS CODING AND REIMBURSEMENT COURSES

Foundations Course

- March 25-27, 1999, Baltimore
- June 10-12, 1999, San Francisco
- August 26-28, 1999, Chicago

Advanced Course

- May 14-16, 1999, Palm Beach Gardens
- August 5-7, 1999, Boston
- November 19-21, 1999, Phoenix

For information call (847) 692-9500.

Questions and Answers

The AANS/CNS Task Force on CPT Coding Answers Some Common Coding Questions.

Q: I have been coding 61790-52 for percutaneous glycerol bathing of the trigeminal ganglion, which I term a neurolysis. However, I'm not sure that this is the correct code given that it is not a stereotactic procedure. Do you have any coding suggestions?

A: There are two possible codes for a glycerol injection to the gasserian ganglion—usually 64610, where glycerol is considered a form of chemical neurolytic agent or possible 61790. Some might consider facial landmarks and intraoperative fluoroscopic guidance as a form of stereotaxis, thus reporting 61790. The latter coding approach is a gray matter that could be interpreted either way, so we suggest using 64610 for safe coding.

Q: I have some discrepancies with coding surgery done with two other physicians for corpectomy and fusion. There is usually a general surgeon for approach, a neurosurgeon for his portion and an orthopedic surgeon for the fusion and instrumentation. There is a question as to whether this is assisted surgery, co-surgery or team surgery. Depending on this, I would then have a question as to the codes to use.

A: The issue of several surgeons operating is simply resolved by having the surgeon code for his part of the operation. The general surgeon should code the main operative code with a –62 modifier to address the issue of the approach. The neurosurgeon would code for his part (discectomy, corpectomy, etc.) which may have a –62 modifier attached. The orthopedic surgeon should code for the arthrodesis and the instrumentation. Under Medicare rules, the orthopedic surgeon and the neurosurgeon cannot use –80 modifier to describe their assisting on the other parts of the operation since they are billing a full operative code on that patient at the same operative session. The –66 surgical team modifier is risky to use because there is not set reimbursement rules for that modifier and you are therefore leaving it up to the discretion of the insurance company to decide the reimbursement. Beginning in 1999, the CPT rules will only allow use of the -62 modifier on a single code per operative session. However, one will now be able to use the -80 modifier on any other code in which one surgeon assisted the other.

Q: What coding procedures should be used for anterior cervical discectomy and fusion with iliac autograft?

A: See examples in the chart shown in figure 1. Several important observations should be made regarding these examples. In the last example, the payor identification number will not allow the carrier to differentiate between the two neurosurgeons. Since subspecialists are not recognized, one of the partners should expect a 50 percent reduction in either 63075 or 22554, as seen in the first example. There are no examples of two neurosurgeons as co-surgeons since the -62 modifier applies to surgeons of different specialties.

Also, there are no examples of one surgeon acting as the primary surgeon for the discectomy while the other is assisting and, then, vice versa. One surgeon must either be the primary or assistant in a single operative session, but not both. ■

Greg Przybylski, MD, is a neurosurgeon at Thomas Jefferson University and a faculty member for the AANS PDP Course on Reimbursement Foundations.

The neurosurgeon performing the entire procedure would code:

22554	Anterior Cervical Arthrodesis 41.95 RVU
63075-51	Anterior Cervical Discectomy with Osteophytectomy 20.10 RVU
20938	Harvest Structural Autograft 6.37 RVU
	TOTAL 68.42 RVU

The neurosurgeon performing the discectomy and orthopaedist performing the graft harvest and arthrodesis would code:

NEUROSURGEON	
63075	Anterior Cervical Discectomy with Osteophytectomy 40.19 RVU
ORTHOPAEDIST	
22554	Anterior Cervical Arthrodesis 41.95 RVU
20938	Harvest Structural Autograft 6.37 RVU
	TOTAL 48.32 RVU

The neurosurgeon and orthopaedist working together as co-surgeons would code:

22554-62	Anterior Cervical Arthrodesis 26.22 RVU
63075-51,62	Anterior Cervical Discectomy with Osteophytectomy 12.57 RVU
20938-62	Harvest Structural Autograft 3.98 RVU
	PER SURGEON TOTAL 42.77 RVU

Two neurosurgeons working together with one assisting would code:

PRIMARY NEUROSURGEON	
22554	Anterior Cervical Arthrodesis 41.95 RVU
63075-51	Anterior Cervical Discectomy with Osteophytectomy 20.10 RVU
20938	Harvest Structural Autograft 6.37 RVU
	TOTAL 68.42 RVU
ASSISTANT NEUROSURGEON	
22554-80	Anterior Cervical Arthrodesis 10.49 RVU
63075-51,80	Anterior Cervical Discectomy with Osteophytectomy 5.03 RVU
20938-80	Harvest Structural Autograft 1.59 RVU
	TOTAL 17.11 RVU

A general neurosurgeon performing the discectomy and the partner spinal neurosurgeon performing the arthrodesis and graft harvest would code:

GENERAL NEUROSURGEON	
63075	Anterior Cervical Discectomy with Osteophytectomy 40.19 RVU
PARTNER SPINAL NEUROSURGEON	
22554	Anterior Cervical Arthrodesis 41.95 RVU
20938	Harvest Structural Autograft 6.37 RVU
	TOTAL 48.32 RVU

FIGURE 1

Getting SMART

Cerebrovascular Disease Program Launches in April.

SUSAN A. NOWICKI, APR

The "Getting SMART About Neurosurgery" education and practice marketing program was created in 1996 to respond to the many changes impacting neurosurgical practice – particularly the challenges arising from competing specialties that have expanded the scope of their practices to include many procedures and services once the primary domain of the neurosurgeon. It's primary focus is to increase awareness with referring physicians, patients, and the media about the role neurosurgery plays in treating common medical conditions.

The first SMART program, which focused on lumbar spinal stenosis (LSS), was launched in September of 1997 and has exceeded its enrollment, financial and materials distribution goals. In fact, a recent survey of Ambassadors revealed that program users were satisfied with the quality of the materials and their usefulness, and that they have received patient referrals as a result of their participation in the Getting SMART initiative.

Now, the AANS and CNS are building upon the success of the lumbar stenosis program to begin Phase II of the Getting SMART program, "Getting SMART About Cerebrovascular Disease: An Educational Program on Stroke."

Bruce Kaufman, MD, was selected as the overall Project Chairman and Warren R. Selman, MD, serves as Scientific Chairman.

Getting SMART About Cerebrovascular Disease

In broad terms, stroke is a growing threat to the well being and productivity of aging Americans, including those who are now entering middle age. Each year, more than 700,000 people suffer a stroke – a number equivalent to the entire population of Wyoming. It is the third leading cause of death in America. Just as important, stroke also is the number one cause of disability, with more than 3,000,000 people currently living with physical and mental impairment from brain damage caused by a stroke.

The AANS and CNS want to help healthcare professionals identify patients who are at high risk for stroke, and to recognize patients who are in need of urgent care for stroke. Stroke is preventable and it is treatable. Educating the public and healthcare professionals about preventative therapies and the urgency of treatment is the key to reducing stroke incidence and its disastrous outcomes.

Neurosurgeons, as cerebrovascular specialists, are unique in their ability to evaluate, use, and recommend medical management, microsurgery, endovascular surgery, and stereotactic radiosurgery to treat or prevent all types of strokes and the complications of each form of treatment. In order to be in a position to have their opinions sought after, neurosurgeons must be viewed as stroke specialists, and not solely as technicians with a narrow skill.

"The key issue is not whether an individual neurosurgeon can or should practice all the techniques used in the treatment of stroke, but rather neurosurgeons as a group must be perceived as stroke specialists, or their influence on the treatment of these diseases will be lost," said Dr. Selman.

As with the LSS SMART program, distribution of the CV SMART materials will be accomplished through recruitment of neurosurgeon Ambassadors. This approach will allow neurosurgeons the opportunity to establish new referral patterns for CV patients, as well as re-establish contact with old or diminishing referral sources.

Objectives

The CV Program objectives include:

- Raise awareness of the neurosurgeon's expertise in preventing and treating stroke and cerebrovascular disorders;
- Position neurosurgeons as the best resource to teach family physicians and first-responders about the treatment of stroke;
- Increase CV/Stroke case referrals to neurosurgeons; and
- Establish neurosurgeons as leaders in the organization of stroke teams and stroke centers.

Program Materials

As with Phase I, the CV program will include the materials aimed at referring physicians, as well as patients. The materials include two comprehensive presentations (with teaching syllabi) for both professional and patient audiences; 200 patient and 100 referring physician brochures; sample letters to referral sources; and press releases.

The print materials can be used as leave-behinds at presentations and in mailings to primary care providers and other referral sources. All materials will cover hemorrhagic and ischemic stroke; warning signs and risk factors; the role of carotid endarterectomy in prevention; aneurysm procedures; conservative and surgical treatment options; and the neurosurgeon's role—as an integral member of the stroke team—in assessing the patient.

The Ambassador kit also will include guidelines for developing a stroke team at your medical center.

Joining the Program

A brochure on the program will be mailed to AANS and CNS members in March. To purchase the program,use the order form enclosed with the brochure, call AANS Customer Service at (847) 692-9500, or download the order form at www.neurosurgery.org. The program is $300, plus shipping. Program materials will be available in April. ■

Fall Meeting Highlights

Highlights from the AANS Board of Directors' Fall Meeting in Chicago.

The AANS Board of Directors gathered in Chicago, Illinois, on November 20-21, 1998 for their fall meeting. Some of the highlights of their actions are presented here.

Executive Director

The Board accepted the resignation of Robert E. Draba, PhD. Dr. Draba had been the Executive Director of The American Association of Neurological Surgeons since May 1, 1996.

"It is with great regret that we accepted Dr. Draba's resignation," said Russell L. Travis, MD, President of the AANS. "We are grateful for his leadership over the past two-and-a-half years and wish him well in his future endeavors."

Norman Broadbent International, Inc., an executive recruitment firm, has been hired to conduct the search for a new AANS Executive Director.

CSNS

James R. Bean, MD, Council of State Neurosurgical Societies (CSNS) Liaison to the Board presented the following two resolutions for review and approval:

- Request that the Committee on the Assessment of Quality make the Committee's Report Card on performance measures, as well as new performance measures specific to neurosurgery, available to members of The American Association of Neurological Surgeons and Congress of Neurological Surgeons, to compare with performance measures, as defined by health care plans.
- Recommendation that the Chairman of the CSNS appoint an Ad Hoc Committee, composed of members from the Executive Committee, the Young Physicians Committee, and the Assembly, to present a methodology to encourage and promote neurosurgery resident participation in the CSNS and at the next CSNS meeting.

FAME

Endorsement of the American Medical Foundation's concept program called the Foundation for Advancement of Medical Education (FAME) was approved. The proposed FAME Specialty Society Program is an outgrowth of FAME's experience in peer review of surgical outcomes.

It is designed for Board-certified or Board-eligible neurosurgeons and orthopedic surgeons who wish to obtain a "Certificate of Completion" as evidence of completion of a prescribed course to use interbody fixation devices in Lumbar Interbody Fusion (LIF). The program represents an enormous opportunity to improve the current ad hoc training in new technologies and procedures.

Membership

Eighteen applications for Active membership were approved, as were 30 applications for Active (Provisional) membership, 12 applications for Associate membership, and 16 applications for International Associate membership. Sixty-eight requests for membership class transfers from Active (Provisional) to Active membership also were approved.

In addition, one transfer from Associate to Lifetime (Inactive) was approved, as well as one transfer from Active (Foreign) to Lifetime (Inactive), and one transfer from International Associate to Lifetime.

Lastly, 34 transfers from Active to Lifetime membership were approved.

Notice of AANS Membership Suspension

On November 21, 1998, The American Association of Neurological Surgeons (AANS) Board of Directors approved the recommendation of the Professional Conduct Committee that an Indiana neurosurgeon's membership in the AANS be suspended for a period of six months due to unprofessional conduct while giving testimony in a civil action. The Board of Directors agreed that in his testimony, the Indiana neurosurgeon misrepresented his level of expertise in the subject of lateral mass lumbar fusion with instrumentation, failed to adequately research the subject of lateral mass lumbar fusion with instrumentation, assumed the role of an advocate for the party who paid for his services, and failed to present the broad spectrum of neurosurgical thought on the issues involved in the case.

New Orleans:

Annual Meeting Promises an Outstanding Scientific Program.

Preparations are nearing completion for the 67th Annual Meeting of The American Association of Neurological Surgeons, to be held April 24-29, 1999 in New Orleans, Louisiana. L.N. Hopkins, MD, 1999 Annual Meeting Chairman, said, "The Planning Committee has set the stage for an energetic and educational program, while the Local Arrangement Chairs, Dr. and Mrs. Lucien Miranne, have organized some fabulous social activities."

"The meeting promises to be spectacular," Steven L. Giannotta, MD, 1999 AANS Annual Meeting Scientific Program Chair added. "The Scientific Sessions and exhibits will showcase contemporary innovations and research advances from all realms of neurosurgery."

Program Highlights

- **Opening Reception** Sunday, April 25 at 6:30 p.m. The AANS will welcome members to New Orleans with an exciting evening in the Grand Ballroom of the New Orleans Hilton and Towers. The gala event will be the perfect place for you to visit with old and new friends. Shuttle buses will be provided from each hotel and hors d'oeuvres and beverages will be served.

- **Presidential Address** Monday, April 26, 12:20 p.m. Russell L. Travis, MD, will deliver his Presidential Address to the AANS membership and pay tribute to some of organized neurosurgery's past and present heroes, as well as discuss their role in leading this specialty to the forefront of medicine.

- **Cushing Oration** Tuesday, April 27, 11:30 a.m. The 41st President of the United States, George Herbert Walker Bush, has been invited to deliver this year's Cushing Oration.

Creole Queen Riverboat. Photo courtesy of New Orleans Paddlewheel.

Musicians on the Mississippi River. Photo courtesy of Riverview Photography.

- **Schneider Lecture** Tuesday, April 27, 12:15 p.m. AANS members are invited to attend an exclusive presentation by Mahlon R. DeLong, MD, the William Timmie Professor and Chairman of the Department of Neurology at Emory School of Medicine, and the 1997 recipient of the Alfred E. Winterer Award. Dr. DeLong will discuss "The Neurosurgical Treatment of Movement Disorders: Past, Present, and Future."

- **Special Lecture III** Wednesday, April 28, 11:15 a.m. Steven Ramee, MD, will discuss the move among international specialists to pool their talents and create programs that address the care of the whole patient in his talk, "Global Revascularization: A Paradigm for the 21st Century." His presentation will explore the growth of endovascular therapy and the role of clinicians in the management of vascular patients throughout the world. He also will touch upon the potential for the development of a new breed of endovascular neurosurgeon.

- **Special Socioeconomic Symposium** Wednesday, April 28, 11:45 a.m. Senator John Beaux of Louisiana will discuss "The Future of Medicine," and immediately following, David Kelly, MD, and Sidney Tolchin, MD, will debate whether there are too few or too many neurosurgeons being trained.

- **Annual Reception and Dinner** Wednesday, April 28, 7 p.m. Join your colleagues for a spectacular evening of dinner and dancing at this year's Annual Reception and Dinner. The site of this year's event is the Armstrong Ballroom in the New Orleans Sheraton Hotel—a spectacular space that houses a retractable skylight. The evening includes a reception, followed by a world-class dinner and the musical talents of Chris Clifton—an exceptional trumpeter and student of Louis Armstrong. Reserve your tickets for this one-of-a-kind event on your Annual Meeting advanced registration form.

- **Special Course I: Video Surgical Tutorial** Thursday, April 29 at 9:45 a.m. Expert faculty will discuss surgical techniques for a variety of intracranial approaches in video format. Presentations will emphasize microsurgical anatomy and operative technique. Attendees will observe a variety of intracranial surgical procedures, as performed by experienced neurosurgeons, in order to solidify their comprehension of the pertinent microsurgical anatomy and learn specific techniques helpful in limiting morbidity and optimizing outcome.

- **Special Course II: Treatment Algorithms in Complex Intracranial Disease** Thursday, April 29 , 9:45 a.m. This course will present a sequential treatment decision analysis for patients with complex intracranial pathologies, including complex aneurysms, acoustic neuromas, arteriovenous malformations, and large pituitary tumors.

- **Special Course III: Advances in Spinal Fusion and Reconstruction** Thursday, April 29 , 9:45 a.m. This state-of-the-art course will discuss future directions of minimally invasive fusion and stabilization, interbody implants, biological and electrical enhancement of fusion and bone growth, graft extenders, and artificial disc replacement.

New Orleans Jazz and Heritage Festival

While you're in town for the AANS Annual Meeting, set aside time to experience the New Orleans Jazz and Heritage Festival. An international food and entertainment extravaganza organized by the New Orleans Jazz and Heritage Foundation, Inc., the festival will take place at the city's Fair Grounds Race Course April 23-May 2, 1999. The festival is famed for its cornucopia of musical performances, including jazz, gospel, rockabilly, country, and blues, as well as its creative craft fairs. Each year, the 10-day festival attracts more than 300,000 visitors. To learn more about this one-of-a-kind party, visit the New Orleans Jazz and Heritage Festival Web site at http://www.nojazzfest.com.

Technology Pavilion Offers Advanced Computer Classes

If you are interested in learning how the latest computer technology can help you build your practice, stop by the Annual Meeting Technology Pavilion, located inside the Exhibit Hall. The Technology Pavilion will provide a hands-on learning opportunity for Annual Meeting attendees. There will be a computer learning center with Internet access; e-mail stations; a NEUROSURGERY://ON-CALL® demo area; online literature searches/PubMed help booth; and several technology information booths. In addition, leading technology-oriented companies will exhibit their products and services in the booths surrounding the Technology Pavilion. ■

1999 Annual Meeting Highlights At-A-Glance

Saturday, April 24

Practical Clinics	8 a.m. - 5 p.m.

Sunday, April 25

Practical Clinics	8 a.m. - 5 p.m.
Opening Reception	6:30 - 9 p.m.

Monday, April 26

Breakfast Seminars	6:45 - 9:30 a.m.
Exhibit Hall Open	9 a.m. - 4:30 p.m.
Plenary Session I	9:45 - 11:40 a.m.
Special Lecture	11:40 a.m. - 12:20 p.m.
Presidential Address	12:20 - 1 p.m.
Scientific Sessions	2:45 - 5:15 p.m.
Business Meeting	5:15 - 6:15 p.m.

Tuesday, April 27

Breakfast Seminars	6:45 - 9:30 a.m.
Exhibit Hall Open	9 a.m. - 4:30 p.m.
Plenary Session II	9:45 - 11:30 a.m.
Cushing Oration	11:30 a.m. - 12:15 p.m.
Schneider Lecture	12:15 - 1 p.m.
Section Sessions	2:45 - 5:30 p.m.

Wednesday, April 28

Breakfast Seminars	6:45 - 9:30 a.m.
Exhibit Hall Open	9 a.m. - 3:30 p.m.
Scientific Sessions	9:45 - 11:15 a.m.
Special Lecture	11:15 - 11:45 a.m.
Socioeconomic Symposium	11:45 a.m. - 1 p.m.
Young Neurosurgeons Session	1 - 2 p.m.
Poster Viewing	2 - 2:45 p.m.
Section Sessions	2:45 - 5:30 p.m.
Reception/Dinner	7 - 10:30 p.m.

Thursday, April 29

Breakfast Seminars	6:45 - 9:30 a.m.
Special Courses	9:45 a.m. - 12 p.m.

Commitment to Education

Thanks to a Dedicated Teacher, the AANS Oral Boards Review Course Holds Its Fifth Session in May.

Julius M. Goodman, MD, is Chairman of the AANS Oral Board Review Course

In 1997, Julius M. Goodman, MD, proposed that the AANS Professional Development Program include an Oral Boards Review Course. He felt that there was a need for such a course and that it would be of the best quality if sponsored by organized neurosurgery. The purpose of the course would be to familiarize candidates with the mechanics of the Board examination and, at the same time, provide a broad review of clinical neurosurgery.

The AANS Board approved the concept, and the first course was held in San Diego, California, in May 1997. The three-day course, which met with resounding success, had 40 participants (course capacity) and immediately preceded the Oral Board examination. Since then, a total of four courses have taken place with the most recent being held in November 1998 in Houston, Texas.

Reflecting on the courses, Dr. Goodman said, "Initially, I felt the attendees would be mostly neurosurgeons in private practice who did not have the opportunity to attend weekly neurosurgical conferences. However, to my surprise, a large number of academic neurosurgeons and subspecialists have enrolled, and their evaluations have been extremely complimentary. Many have asked to be faculty for future courses."

When describing the course, he said, "What I like most about the course is that the format is entirely interactive with no lectures. The days are long and intense, but the attendees stay awake and seem to enjoy the case scenarios. Even though they are under great pressure, most have indicated that the course was fun and valuable, and that they would consider taking a similar course again, even after they are certified."

The next course is slated for May 12-15, 1999, in Baltimore, immediately preceding the spring Oral Board exam.

Dr. Goodman has had a career-long interest in medical education. In addition to serving as Chair of the Oral Board Review Course, he is Clinical Professor of Neurosurgery at Indiana University School of Medicine and a member of the Indianapolis Neurosurgical Group.

If you would like to learn more about the Oral Board Review Course, please contact the Professional Development Program at (847) 692-9500. ■

1998 Professional Development Program Faculty Appreciation

The Professional Development Program would like to thank the following faculty members who participated in the 1998 Professional Development courses:

Bizhan Aarabi, MD
Mark S. Adams, MD
John Adler, MD
Cary Alberstone, MD
Robert Alonso, MD
Ronald Alterman, MD
Bruce J. Anderson, MD
Issam A. Awad, MD*
Julian E. Bailes, MD
Roy A.E. Bakay, MD
Nevan Baldwin, MD
Perry A. Ball, MD
Gene Barrett, MD
Tom Baumann, PhD
Edward C. Benzel, MD*
Joel C. Boaz, MD
Jessica Borne, MD
Julie Broderson, RN
Richard Bucholz, MD
Kim J. Burchiel, MD, FACS*
Jacques Caemaert, MD
Fady Charbel, MD
Jefferson Chen, MD
Alan R. Cohen, MD*
Christopher H. Comey, MD
G. Rees Cosgrove, MD
Jeffrey W. Cozzens, MD
William T. Couldwell, MD*
Carolyn Coulter, RN, BSN*
Gayle Dasher, RN, MSN
Dzung Hong Dinh, MD
Daryl Di Risio, MD
Eldan B. Eichbaum, MD
Marc E. Eichler, MD
Lisa A. Ferrara, MS
Enrique Ferrer, MD
Nancy J. Fischbein, MD
Winfield Fisher, MD
Kevin T. Foley, MD
Kenneth A. Follett, MD, PhD
Herbert E. Fuchs, MD
Regan Gallaher, MD
Deborah Garcia, RN
Remo Gay, JD
John German, MD
Steven L. Giannotta, MD
Kevin J. Gibbons, MD
Julius Goodman, MD*
Ziya Gokaslan, MD
Jeremy Goodwin, MD
John P. Gorecki, MD
David Gostnell, PhD
Scott Grafton, MD
Mark S. Greenberg, MD
Jeffrey D. Gross, MD
Robert G. Grossman, MD*
Regis W. Haid Jr., MD
Andrea L. Halliday, MD
Robert E. Harbaugh, MD
Haynes L. Harkey III, MD
Samuel J. Hassenbusch, MD, PhD*
Cary B. Heilbrun, MD
Mary Heinricher, PhD
Brett Henderson, MD
Jamie M. Henderson, MD
Charles Hodge, MD
Matthew A. Howard, MD
Karen Hutsel, RN
Larissa Jeffreys, RN
Patrick J. Johnson, MD
Frederick Junn, MD
Iain H. Kalfas, MD
Yucel Kanpolat, MD
Prabhakar Kesava, MD
John C. Kincaid, MD
Ken Krantz, PhD
David J. Langer, MD
Thomas J. Leipzig, MD
Denise Miller Lemke, RN, BSN
Christopher M. Loftus, MD, FACS*
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Paul Matz, MD
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Harring Nauta, MD
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Steven Ojemann, MD
B. Joe Ordonez, MD
Thomas C. Origitano, MD
Richard K. Osenbach, MD
T. Glen Pait, MD
Troy D. Payner, MD
Axel Perneczky, MD
John Piper, MD
Greg Przybylski, MD
Jesse R. Rael, MD
Diane Ralston, PhD
Kathleen Redelman, RN, BSN
Richard A. Roski, MD, FACS*
Michael J. Rosner, MD*
Oren Sagher, MD
Daniel Scodary, MD
Joel L. Seres, MD
Mitesh V. Shah, MD
Peter M. Shedden, MD
Brett Stacey, MD
Charles B. Stillerman, MD
Jamal M. Taha, MD
Robert Tiel, MD
William Tobler, MD
Susan Tolle, MD
Richard Tosselli, MD
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Dennis Vollmer, MD
Andy Wakefield, MD
M. Christopher Wallace, MD, FACS
Stuart M. Weil, MD
G. Alexander West, MD, PhD
Eric J. Woodard, MD
Paul A. Young, PhD
Paul H. Young, MD

** Indicates Course Chair or Co-Chair*

1998 Campaign Update

There's Still Time to Contribute to the 1998 Research Foundation Campaign.

Even though we have entered 1999, there is still time to make a contribution to the 1998 Research Foundation of the AANS campaign. Your name can still be included on the donor wall at the AANS Annual Meeting in New Orleans. We also will publish the names of all of our donors in the next issue of the *Bulletin*, and on our Web site, NEUROSURGERY://ON-CALL®. Make sure your name is included along with those of your peers who have helped provide for the future of our specialty with a generous contribution. We hope this year's campaign is our best ever, both in terms of total funds raised, and in the number of members who contribute.

Endowment Fund

Donations are placed in the Foundation's board-designated endowment fund. The earnings from that endowment are used to provide Research Fellowships and Young Clinician Investigator Awards. Over the past 15 years, this Foundation has provided more than $2 million to 50 promising young researchers. In addition,

- These "seed grants" have generated approximately $20 million in subsequent research funding;
- Fourteen of our past winners are now, or have been, directors of research laboratories; four are program directors;
- An estimated 35 prominent Universities or major medical facilities have had staff neurosurgeons receive Research Foundation funding;
- Past grant recipients serve on the editorial boards of more than 50 peer-reviewed journals; and
- There have been more than 90 journal publications and 10 book chapters published with Research Foundation funds.

More than 85 percent of all contributed funds have been spent directly on funded research. And, total expenses over the last five years have averaged less than 13.5 percent of total revenues.

Yet, last year, only 4.4 percent of AANS members made a contribution to the Research Foundation. Of the 39 applications we received, 34 were rejected due to our lack of funds. Imagine what more we could do with greater member participation.

Make Your Contribution Today

Earlier this year, five grants were made covering topics related to brain tumors, gene transfers, and our first Outcomes Study. This year, I am happy to report the applications again are of the highest caliber, and hold exciting prospects for even greater discoveries in our specialty. Unfortunately, most of these promising studies will not receive funding due to low member support. I urge you to make a generous contribution to the Research Foundation.

Gifts in memory of a deceased family member, loved one, or personal colleague, as well as honorary gifts are encouraged. You might consider making a gift of securities, such as appreciated stock. Creative giving may help you to avoid certain taxes. And don't forget, a gift by your will or trust to the Research Foundation, or naming the Research Foundation as the beneficiary of a life insurance policy, provides for neuroscience research long after your death.

Please join with us to ensure a future of significant advances in our field. Make your generous contribution to the AANS Research Foundation today! ■

Julian T. Hoff, MD, Chairman, Executive Council, and **John R. O'Connell,** Fund Development Director, contributed to this report.

Annual Gifting Levels

The Harvey Cushing Scholars Circle
(Gifts from individuals)
- Summa Cum Laude: $5,000 or more
- Magna Cum Laude: $2,500 to $4,999
- Cum Laude: $1,000 to $2,499

Other Gifting Levels
- Honor Roll: $500 to $999
- Sponsor: $250 to $499
- Supporter: $100 to $249

Neurosurgical Group Supporters
(Gifts from groups and organizations)
A gift of $1,000 or more that is received from an organization or group of doctors will be recognized within the Neurosurgical Group category. Individuals also will be listed at their gift level.

Corporate Associates Roster

The Executive Council of the Research Foundation of the AANS gratefully acknowledges the financial support given by the following companies.

Superior Associate
(Gifts of $75,000 to $100,000)
Rhone-Poulenc Rorer Pharmaceuticals

Supporting Associate
(Gifts of $25,000 to $50,000)
Codman/Johnson & Johnson Professional, Inc.
Elekta
Pharmacia & Upjohn
Sofamor Danek Group, Inc.
Synthes Spine/Synthes Maxillofacial

Contributing Associate
(Gifts of $10,000 to $25,000)
Depuy Motech
Medtronic
Sulzer Spinetech, Inc.

Associates
(Gifts of $5,000 to $10,000)
Aesculap
Baxter
Bayer Corporation
Brainlab
Carl Zeiss, Inc.
Leica, Inc.
Midas Rex Institute
NMT Neurosciences
PMT Corporation
Radionics
Surgical Dynamics

AANS Membership Reaches 5,387

The Board of Directors Recently Approved the Following New Members.

ACTIVE MEMBERS

Lon F. Alexander
James M. Alvis
Arthur G. Arand
Ramesh P. Babu
Perry A. Ball
Deborah L. Benzil
Charles Palmer Bondurant
Kevin L. Boyer
Douglas L. Brockmeyer
James D. Callahan
Bayard Bryon Campbell
Pedro Mario Caram
Jefferson W. Chen
W. Bruce Cherny
David William Cockerill
Orlando De Jesus
Lawrence D. Dickinson
Donald D. Dietze, Jr.
E. Hunter Dyer
Eric H. Elowitz
Daniel P. Elskens
Scott P. Falci
Randy C. Florell
Paul K. Gerdner
John William Gianino
Scott I. Gingold
Ziya L. Gokaslan
Todd M. Goldenberg
John A. Grant
George M. Greene
Donald L. Hilton, Jr.
James P. Hollowell
Timothy J. Johans
Stephen H. Johnson
Walter D. Johnson
Kevin D. Judy
Abraham Kader
Daniel F. Kelly
Robin F. Koeleveld
Mark J. Kotapka
Richard S. Kyle
Roderick G. Lamond
Howard Lantner
Peter David Le Roux
David I. Levy
Michael Lee Levy
Veetai Li
Asim Mahmood
David G. Malone
Bruce McCormack
B. Theo Mellion
Richard C. Mendel
Mark S. Monasky
Matthew R. Moore
Jay More
John C. Mullan
Brian James O'Grady
Sean O'Malley
Eric Philip Omsberg
Conrad T. E. Pappas
Troy D. Payner
Robert G. Peterson
Joseph A. Petronio
Luis A. Ramos
Patrick A. Roth
Jackson B. Salvant, Jr.
James Leonard Sanders, Jr.
Steven Allen Sanders
Daria D. Schooler
James M. Schumacher
Donald M. Seyfried
Magdy S. Shady
Mitesh V. Shah
Christopher I. Shaffrey
Peter M. Shedden
Erick Stephanian
Dale M. Swift
Samuel Tobias-Milwer
Rudolfo Uy-Ham
Daryl E. Warder
Richard M. Westmark
Thomas A. S. Wilson, Jr.
Ravi Yalamanchili
Ahmad Zakeri

ACTIVE (PROVISIONAL) MEMBERS

Cynthia Zane Africk
Timothy Irvin Cohen
Michael Copeland
Paul Francis Davis
Duc Hoang Duong
Thomas Schroeder Ellis
Seyed Mohammad Emadian
Kenneth Dewayne Eubanks
Javier Garcia-Bugochea
William Brian Gormley
Mitchell R. Gropper
John Edward Harpring
Martin D. Herman
Randy Lynn Jensen
James Alexander Killeffer
Adam Nathaniel Mamelak
Frederick Francis Marciano
Mahmood Moradi
Kevin J. Mullins
Fariborz Nobandegani
Daniel Pieper
Michael N. Polinsky
Bradford A. Selland
Allen Kent Sills, Jr.
Mitchell Lewis Supler
Shelly Diane Timmons
Victor C. K. Tse
Jon J. Viola
Gary A. Zimmerman
Bernhard Zunkeler

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Bret B. Abshire
M. Serdar Alp
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Christopher Cai
Jeffrey E. Catrambone
Melissa R. Chambers
Victor R. DaSilva
Princewill Ehirim
P. Charles Garell
Subrata Ghosh
Steven E. Hysell
Walter Jean
Michael G. Kaplitt
Stanley H. Kim
David L. Kirschman
Steven P. Leon
Jeffrey R. Leonard
Efstathois Papvassiliou
Vishal J. Makker
Lisa P. Mulligan
Thomas M. McCutchen
Eric W. Nottmeier
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Ravish V. Patwardhan
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William H. Slattery, III
George P. Teitelbaum
Van Russell Wadlington

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Koang-Hum Bak
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Kazuhiro Nomura
Giorgio Rubin
Hirotoshi Sano
Tomikatsu Toyoda
Keisuke Ueki
Alberto A. R. Valarezo
Joao B. Valladares
Peter A. Winkler

For more information or a membership application, contact Chrystine L. Hanus at (847) 692-9500.

AANS Bylaws

Proposed Amendments - 1999 • Article IX — Standing Committees

CURRENT BYLAWS

Section 2.
Standing Committees. There shall be the following Standing Committees of the Association with the stated duties.

A Annual Meeting Committee
B Archives Committee
C Awards Committee
D Bylaws Committee
E Cushing Orator Committee
F Membership Committee
G Nominating Committee
H Professional Conduct Committee
I Public Relations Committee
J Publications Committee
K Van Wagenen Fellowship Committee

Article IX, Section 3
Joint Committees. From time to time for specific purposes as may be deemed necessary by the Board of Directors, the Association may form one or more joint Committees with one or more other neurosurgical organizations.

There shall be the following Joint Committees of the Association with the stated duties.

PROPOSED AMENDMENTS

Section 2.
Standing Committees. There shall be the following Standing Committees of the Association with the stated duties.

A Annual Meeting Committee
B Archives Committee
C Awards Committee
D Bylaws Committee
E Cushing Orator Committee
F Membership Committee
G Nominating Committee
H Professional Conduct Committee
I Public Relations Committee
J Publications Committee
K Van Wagenen Fellowship Committee
L Coordinating Committee on Continuing Education
L The Coordinating Committee on Continuing Education (CCCE) shall be composed of a Chairman, appointed for three years by the President, with a minimum of 5 members, each serving staggered terms with new members appointed annually with the approval of the Board of the Association. A member of the Committee may serve more than three years only with the unanimous consent of the Board of Directors. Liaison members to the CCCE from other neurosurgical organizations may be appointed to the Committee with the approval of the Board of the Association.

It shall be the duty of the CCCE Committee to develop and pursue, with the approval of the Association, the highest educational standards possible for neurological surgery and thereby, to foster the delivery of superior care to patients with disorders of the nervous system.

The CCCE shall determine, with the approval of the Association, the requirements for the Continuing Education Award in Neurosurgery.

Article IX, Section 3
Joint Committees. From time or specific purposes as may be deemed necessary by the Board of Directors, the Association may form one or more Joint Committees with one or more other neurosurgical organizations.

There shall be the following Joint Committees of the Association with the stated duties.

EXPLANATION

The Committee on Education (Joint with the Congress of Neurological Surgeons) was felt to be redundant as most of the duties o the Committee are being more actively performed by the CCCE. Therefore, the Board of the AANS has recommended that the Committee on Education be eliminated, with the CCCE taking over its duties. The CCCE is currently a Special Committee. The Board of the AANS recommends that the CCCE be made a standing Committee of the Association.

The Committee on Education (Joint with the Congress of Neurological surgeons) was felt to be redundant, as most of the duties of the Committee are being more actively performed by the CCCE. Therefore the Board of the AANS has recommended that the Committee on Education be eliminated, with the CCCE taking over its duties.

Continued on page 30

Amendments to AANS Bylaws Proposed

The proposed amendments to the AANS Bylaws presented here on pages 29-30 will be presented for discussion at the AANS Annual Business Meeting, April 26, 1999, in New Orleans. Voting on proposed amendments will be by mail ballots, which will be sent to the voting membership no more than 45 days following the Annual Business Meeting. If you require a Bylaws book, contact Christine R. Williams, (847) 692-9500.

CURRENT BYLAWS	PROPOSED AMENDMENTS	EXPLANATION
~~A Committee on Education~~ B Committee for the Assessment of Quality C Washington Committee for Neurological Surgery D Committee of Military Neurosurgeons ~~A. Committee on Education (Joint with the Congress of Neurological Surgeons). The Committee on Education shall have a Chairman and an Associate Chairman. The Associate Chairman shall be appointed jointly by the Officers o the AANS and the CNS and shall not be eligible for reappointment. The Associate Chairman shall serve for a term of two years and shall then become Chairman of the committee for an additional term of two years. The Associate Chairman shall also serve as Secretary Treasurer of the Committee.~~ ~~It shall be the duty of this Committee to develop and pursue, with the approval of the parent executive bodies, the highest educational standards possible for neurological surgery and, thereby, to foster the delivery of superior care to patients with disorders of the nervous system.~~ ~~The Committee on Education shall determine, with the approval o the parent executive bodies, the requirements for the continuing Education Award in Neurosurgery.~~	A Committee for the Assessment of Quality B Washington committee for neurological Surgery C Committee of Military Neurosurgeons	
Section 2 Continued Education Merit Award in Neurosurgery. There shall be established a Continuing Education Award in Neurosurgery.~~The Committee on Education,~~ with the approval of the Board of Directors, determine the requirements for achieving that Award. The ~~Committee on Education~~ will present the Award attesting to that achievement to Members of the Association who have completed the requirements for the Continuing Education Award.	**Section 2** Continued Education Merit Award in Neurosurgery. There shall be established a Continuing Education Award in Neurosurgery. The Coordinating Committee on Continuing Education, with the approval of the Board of Directors, determine the requirements for achieving that Award. The Coordinating Committee on Continuing Education will present the Award attesting to that achievement to Members of the Association who have completed the requirements for the Continuing Education Award.	The Committee on Education (Joint with the Congress of Neurological Surgeons) was felt to be redundant, as most of the duties of the committee are being more actively performed by the CCCE. Therefore, the Board of the AANS has recommended that the Committee on Education be eliminated, with the CCCE taking over its duties.

PROPOSED AMENDMENTS - 1999 • ARTICLE IX — FISCAL YEAR

CURRENT BYLAWS	PROPOSED AMENDMENTS	EXPLANATION
Article XIII – The Fiscal Year of the Association The fiscal year of the Association shall be from ~~January 1 through December 31.~~	**Article XIII – The Fiscal Year of the Association** The fiscal year of the Association shall be from July 1 through June 30, or as agreed and voted upon by the AANS Board of Directors.	The fiscal year July 1 through June 30 more accurately reflects the natural year-end of the Association with relation to Annual Meeting activities. The change will enable more efficient record keeping for joint programs since the new fiscal year will coincide with that of the Congress of Neurosurgeons. This change will also result in reduced audit fees and staff overtime, since the yearly audit will take place in the fall instead of the spring during Annual Meeting preparations.

NEWS.ORG

Sections Committees Associations Societies

Section News

Section on Cerebrovascular Surgery The CV Section hosted its 4th Annual Meeting January 31-February 3, 1999 in Nashville, Tennessee. The meeting, which was held in conjunction with the American Society of Interventional and Therapeutic Neuroradiology and preceded the American Heart Association's 24th International Joint Conference on Stroke and Cerebral Circulation, brought together cerebrovascular experts to discuss the latest advances emerging in cerebrovascular care. Topics discussed included cerebrovascular revascularization, arteriovenous malformations, and stroke management.

Section on Disorders of the Spine and Peripheral Nerves The Spine Section recognized Steven Casha, MD, resident at the University of Toronto, as the 1999 Basic Science Mayfield Award winner, and Nicholas Theodore, MD, senior resident at Barrow Neurological Institute, as the 1999 Clinical Science Mayfield Award recipient, at this year's Section Meeting. The meeting was held February 10-13, 1999 at Disney's Yacht and Beach Club Resorts in Lake Buena Vista, Florida.

Section on Neurotrauma and Critical Care With increasing socioeconomic and political concerns emerging in the practice of neurosurgery, the Executive Committee of the AANS/CNS Section on Neurotrauma and Critical Care has established a liaison with the Council of State Neurosurgical Societies (CSNS) through the CSNS Neurotrauma Committee. As the Neurotrauma Committee is moved from ad hoc status to a permanent standing committee of the CSNS, improved interaction, information exchange, and the development of neurotrauma policy can be anticipated. This will better equip neurosurgeons with the information needed to interact with our hospitals, trauma systems, governments, patients, payers and peers with greater competence and confidence. The interaction between the Section's leadership and the CSNS should provide for more timely socioeconomic communication and broader interaction with grassroots neurosurgeons.

Section on Pain The AANS/CNS Section on Pain, along with The American Association of Neurological Surgeons, will jointly sponsor a Pain Satellite Workshop on April 22-23, 1999. The Workshop will immediately precede the 1999 AANS Annual Meeting, and include both didactic and hands-on sessions. It is targeted at neurosurgeons wishing to become more familiar with the various neurosurgical pain procedures and to provide more service to pain multidisciplinary groups.

It is designed to facilitate comprehensive and intensive learning of interventional therapies for pain management and will cover augmentative and ablative therapies at spinal, trigeminal, intracranial, and peripheral nerve levels. The faculty is composed of 20 leading U.S. pain management neurosurgeons, as well as faculty representation by a pain psychologist and a pain anasthesiologist.

For more information about the Workshop, contact Samuel Hassenbusch, MD, (713) 792-2400, samuel@neosoft.com.

Section on Pediatric Neurological Surgery At the Section's meeting in December, the first Franc Ingraham Lifetime Achievement Award was presented to E. Bruce Hendrick, MD, Neurosurgeon Emeritus at the Hospital for Sick Children in Toronto. The Award, established in 1996, was created to honor individuals who have dedicated their careers to pediatric neurosurgery and have contributed noteworthy service to the specialty. A graduate of the University of Toronto, Dr. Hendrick conducted his fellowship at the Children's Medical Center and Peter Bent Brigham Hospital under the guidance of Franc Ingraham. He is a 41-year member of the AANS.

Section on Tumors In an effort to determine the number of neuro-oncology research opportunities available within neurosurgery residency programs, the AANS/CNS Section on Tumors developed two surveys and mailed one to all North American neurosurgery program directors (112) and the other to all North American neurosurgery residents (872). The surveys were mailed in May 1997 and a follow-up survey was sent in June 1997 to all non-responders. Overall, 77 program directors (69 percent) and 279 neurosurgery residents (32 percent)

Continued on next page

NAMES IN THE NEWS

The American Association of Tissue Banks (AATB) has recognized **Donald J. Prolo, MD, FACS,** of San Jose, California, as the recipient of its 1998 Distinguished Service Award. The Award is presented annually to an individual who has made a significant contribution to tissue banking or transplantation medicine, whether in research, education, or laboratory improvement, or who has served the AATB or the field of transplantation in a unique way. An active member of the AANS since 1973, Dr. Prolo is a clinical professor in the Department of Neurosurgery at Stanford University.

Samuel J. Hassenbusch, MD, PhD, of Houston, Texas, was recently presented with the American Medical Association's (AMA) Burgess Gordon Awards. The Award is presented annually to a member of the AMA's CPT coding advisory panel who demonstrates superior coding practices. Dr. Hassenbusch is an Associate Professor of Neurosurgery at the University of Texas M.D. Anderson Cancer Center and a five-year member of the AANS. He has served as a neurosurgery representative on the AMA CPT Advisory Committee since 1995 and is a faculty member for the AANS PDP Advanced Reimbursement Course.

responded to the survey. Following are some of the highlights:

- Eighty-seven percent of all respondents reported neuro-oncology research rotations (usually less than 12 months) available in his or her residency program.
- Research funding was well distributed among departmental (27 percent), federal (24 percent), institutional (22 percent), and private (19 percent) sources.
- Common basic research areas included molecular biology, gene therapy, and pathology, while image-guided surgery was the most frequent area of clinical research.
- Approximately one-third of responding residents had completed a neuro-oncology research rotation, primarily in an area of basic science, which resulted in an average of two publications and three presentations.
- The most common challenges for residents pursuing neuro-oncology research were concurrent clinical responsibilities, lack of faculty mentors, and insufficient research funding.

The survey results identify several ways the Section can enhance neuro-oncology research opportunities, including:

- encouraging resident participation at national meetings through awards;
- posting neuro-oncology fellowship opportunities and neuro-oncology research funding sources on the Internet; and
- organizing Annual Meeting seminars that address the importance of basic research to clinical practice.

Committee for Military Neurosurgeons The AANS/CNS Committee for Military Neurosurgeons, which promotes and inspires communication and collaboration between organized neurosurgery and the Department of Defense, will host its next meeting on Sunday, April 25, 1999, in conjunction with the AANS Annual Meeting, and every attendee is invited to participate. For information, contact James Ecklund, MD, Chairman, at (202) 782-9804, ecklund@vs.wramc.amedd.army.mil.

AANS AND CNS DO NOT RECOGNIZE, ENDORSE, OR SUPPORT THE AMERICAN BOARD OF SPINE SURGERY

A number of members of The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) have received invitations to apply for membership in, and to sit for the certifying examination by the American Board of Spine Surgery. The Board of Directors of the AANS and the Executive Committee of the CNS wish to notify their members that the American Board of Spine Surgery is NOT a member of the American Board of Medical Specialties (ABMS); is NOT authorized by the ABMS; and is NOT recognized, endorsed, or supported by the AANS or CNS.

The AANS and CNS encourage Board Certification for all neurosurgeons. Within the United States, the AANS and CNS recognize only the ABMS as the organization that ensures quality in the Board Certification process across medical specialties. Board Certification of AANS and CNS members is secured through examination by the American Board of Neurological Surgery (the recognized agent of the ABMS). This Board does not recognize or certify any subspecialty Board or Certificate in Neurological Surgery. Neurological Surgery includes the diagnosis and surgical treatment of disorders of the spine, the central and peripheral nervous systems, the vascular supply of these structures, the cranial vault, and the neuroendocrine system in adult and pediatric populations.

The AANS and CNS recognize focused interests of individual neurosurgeons by their support of the AANS/CNS Sections, but this recognition is inclusive rather than exclusive for all Board Certified neurosurgeons. The AANS and CNS do not support, recognize, or endorse the development of independent or alternative Boards, or the issuance of any Board Certificates that are not underwritten by the American Board of Neurological Surgery, the Royal College of Physicians and Surgeons of Canada, the Mexican Council of Neurological Surgery, or other agent Boards of the American Board of Medical Specialties. ■

CSNS Recommends AANS Directors

Regional Directors for the Northwest and Southwest quadrants to the AANS Board of Directors were selected by mail ballot election prior to the fall meeting and forwarded to the AANS Nominating Committee. These Directors will take office in the spring, following election at the AANS Business Meeting in April 1999. Nominated were **Gary VanderArk, MD,** for the Southwest region and **Jeffrey Brown, MD,** for the Northwest region.

Cerebrovascular Disease Funding Available

The AANS/CNS announce the Pharmacia-Upjohn Resident Research Awards in Cerebrovascular Disease:

- Funding Available July 1, 1999
- Up to $15,000 to Support a Specific Research Proposal
- Open to Residents in North American Training Programs
- Research Related to Cerebrovascular Disease
- Deadline for Applications: 3/31/99
- Contact: Issam A. Awad, MD, Yale University School of Medicine, (203) 737-2096. Fax: (203) 785-6916.

CSNS Debates Practice Expense Report Cards

James R. Bean, MD

The Council of State Neurosurgical Societies (CSNS) met in Seattle, Washington, October 2-3, 1998. The number of formal resolutions debated by delegates was small, but the volume of information exchanged was vast and the quality of dialog compelling.

Practice Performance Report Cards

Attention was focused on neurosurgeons' practice performance report cards created by health plans, and how they are used to rate physician performance and make bonus awards. A resolution from Calvin Kam, MD was debated, questioning the validity of quality, cost, and patient satisfaction criteria as chosen by Blue Cross/Blue Shield of Hawaii for calculating physician bonuses. Like most plans proposing measurable indicators of quality, the criteria were broad, meager and primitive proxies for quality included: patient mortality, post-operative mortality, post-operative wound infection, and readmission rate.

The resolution originally asked for the AANS/CNS Committee on Assessment of Quality (CAQ) to accept such proposals for review and critique. The CSNS learned from Robert Florin, MD, that work on model clinical report cards is in progress under the CAQ, and should be available to members for use within the next year. The CSNS passed a substitute resolution requesting the CAQ model performance measures be accessible to AANS and CNS members when finalized, to use in assessing the validity of commercial health plan performance.

CSNS Resident Membership

A second resolution sponsored by the CSNS Young Physicians Committee sought to create a neurosurgical resident category of delegate to the CSNS. After debating the problems of resident interest, time availability and cost, a substitute resolution passed, directing the appointment of a CSNS ad hoc committee to develop recommendations for promoting resident participation in the CSNS. The hope is to build interest and experience in socioeconomic issues among future neurosurgeons while early in their career, to develop future leaders, and to benefit from residents' viewpoints in CSNS discussions about the impact of current socioeconomic changes on their future.

Practice Expense Survey

Robert Florin, MD, Chairman of the AANS Reimbursement Committee, spoke about the AANS/CNS Practice Expense Survey being gathered and analyzed to develop a database of neurosurgical practice costs. The purpose of the survey is twofold: 1) Build a valid database to correct inaccuracies in the AMA SMS database used by HCFA to determine neurosurgeon practice expenses for the new resource-based practice expense RVUs, implemented January 1, 1999; and 2) Develop benchmark costs for categories of office expense within individual office practices to use in comparing an office's practice expenses with other neurosurgical practices.

With falling reimbursement requiring that practice costs be reduced by making office processes more efficient, this database can show where costs exceed the average and where to focus on reducing expenses or increasing efficiency.

Medical Record Guidelines

The CSNS passed a resolution in April demanding that any medical record guidelines for neurosurgeons conform to the practice of neurological surgery. In follow-up discussion, Troy Trippet, MD, who has represented neurosurgery in AMA-HCFA discussions, described the odyssey of the Evaluation & Management Documentation Guidelines, begun in 1995, and still the subject of dispute between physicians and HCFA. The disagreement hinges on whether the medical record should be used as an auditing and accounting document, with minimum numerical requirements for elements included in each category of history, physical, and medical decision-making.

Luncheon Focuses on Political Action

Michael Dunn, President of Michael E. Dunn & Associates in Washington, D.C., made a compelling presentation at the CSNS luncheon. With graphic clarity and spellbinding rhetoric, Mr. Dunn took the audience on a journey into the labyrinth of politics, showing why personal involvement in candidate support at the local level, and Political Action Committee financing at the national level, are irreplaceable necessities for gaining favorable legislation. ■

Quality Patient Service

Oklahoma Practice Learns the Power of Good Service.

Name of Practice: Neuroscience Specialists

Location: Oklahoma City, Oklahoma

President: Stanley Pelofsky, MD

Number of neurosurgeons: 14

Other physicians: 4 physiatrists, 1 pain specialist

Number of employees: over 50

Number of medical centers served: 8

Practice philosophy

Patient service and a "you bet" attitude is at the very heart of this very busy practice. We make an effort to see referred patients as quickly and efficiently as possible. We also make a very real and conscious effort to communicate with our patients, our referring physicians and third party payers. If we have any problems, we pick up the phone and solve the problems quickly. We all diligently try to dictate our consultations and follow-up notes to our referring doctors the same day.

Most innovative back office management solution

We develop our leadership from within and empower our area managers and staff to identify problems, develop solutions and then implement them. We have found that when you give the right people the power to create change, the results are rather remarkable. We hire bright, intelligent employees and develop some of them into area managers if they show the talent and desire. Once a week, I try to meet with our area managers to discuss problems that need to be solved in a coordinated effort with the practicing neurosurgeons. We pay our employees very well and have an exceptionally low turnover rate. This is a very high pressure, high volume, and high stress practice. We place enormous responsibility on our staff and expect them to perform.

Most innovative approach to managing external relationships

We use the telephone. A personal conversation often is critical to getting things done quickly and efficiently. When a neurosurgeon picks up the phone and makes a call, constructive things usually happen. A neurosurgeon can accomplish in minutes what often takes an employee hours or days to get done. We try to use our office time in the most efficient manner. Neurosurgeons need to see patients in the office. Occasionally, however, they need to advocate for a patient or for their practice. The phone works wonders.

Stanley Pelofsky, MD, President of the Neuroscience Institute and 23-year AANS member.

Biggest investment in the practice in recent years

Our group is developing the Neuroscience Institute in Oklahoma City, which specializes in the treatment and diagnosis of neurological disorders. This 50,000 square foot pyramid facility has been architecturally tailored to serve the needs of our patients, as well as our own. We currently lease space in this facility and will move into it in the next three months.

Advice for neurosurgeons starting their own practice

Neurosurgery is not only a profession, it is also a business. Along with an individual neurosurgeons' talents, skills, education and expertise, he or she also must develop business acumen and run an efficient, cost-contained business operation. The neurosurgeon entering practice should certainly become involved in their state neurosurgical societies as well, most importantly, the Council of State Neurosurgical Societies — where more business knowledge is exchanged in the field of neurosurgery than anywhere else in the universe. Young neurosurgeons must take professional development courses in office management, building a neurosurgical practice, coding, etc. They also must make certain that a professional who is knowledgeable in the day-to-day workings of a busy surgical practice is managing their office.

Future of neurosurgical private practice

Bigger is not only better but may be the only way. In this day and age, large groups cannot only accomplish economy of scale but also can develop contracting advantages. The solo practitioner and small practice groups will find it very difficult to compete against the large groups in the future.

Closing thoughts

My partners and I respect and admire each other. We work hard and we share profits equally. We are very happy to be practicing in Oklahoma City. ■

This is the first in a series of profiles that highlight an AANS member and his or her innovative practice-building techniques.

EVENTS

Calendar of Neurosurgical Events

Britspine 1999
March 3-5, 1999
Manchester, England
44-161-787-4706

25th Annual Symposium — Barrow Neurological Institute
March 4-6, 1999
Phoenix, Arizona
(602) 406-3067

15th Anniversary Meeting of the Egyptian Society of Neurological Surgeons
March 8-12, 1999
Cairo, Egypt
00-202-3906095

1st South Asian Neurosurgical Congress
March 12-14, 1999
Katmandu, Nepal
009-77-1-221988

Neurosurgical Society of America Annual Meeting
March 27-31, 1999
Scottsdale, Arizona
(317) 278-7672

American Association of Neurological Surgeons Annual Meeting
April 24-29, 1999
New Orleans, Louisiana
(847) 692-9500

Southern Neurosurgical Society Annual Meeting
May 19-23, 1999
Memphis, Tennessee
(601) 984-5702

15th Annual Meeting of the German Society of Neurosurgery and Joint Meeting With the Swiss Society of Neurosurgery
June 5-9, 1999
Munich, Germany
89-7095-2590

11th International Symposium of Brain Edema and Mechanisms of Cellular Injury
June 6-10, 1999
Newcastle-upon-Tyne, England
191-2738811

Congress of the Asian Society for Stereotactic, Functional, and Computer-Assisted Neurosurgery
June 13-16, 1999
Seoul, Korea
82-2-393-9979

2nd Symposium of the International Society for Neuroemergencies
July 4-9, 1999
Abano Terme, Italy
39-49-8213090

15th Mexican Congress of Neurological Surgery
July 25-31, 1999
Cancun, Mexico
52-5-5430013

Western Neurosurgical Society Annual Meeting
September 18-21, 1999
Coeur d'Alene, Idaho
(619) 268-0562

11th European Congress of Neurosurgery
September 19-24, 1999
Copenhagen, Denmark
45-3452390

Congress of Neurological Surgeons Annual Meeting
October 30 - November 4, 1999
Boston, Massachusetts
(847) 692-9500

4th World Stroke Congress
November 25-29, 2000
Melbourne, Australia
61-3-9682-0288

To Unionize or Not …

Continued from page 12

what incentives doctors are being encouraged to respond to. When doctors tell a patient that they are not recommending particular tests, procedures, or treatments that he or she may have heard about, is it because they aren't really necessary or because the doctor will lose income by recommending it? After all, when a patient, as a buyer of services, sees himself or herself entering into a commercial relationship, it's a matter of buyer beware. From the medical perspective, the problem is that the treatment plan may suffer when the patient doesn't trust his or her doctor.

Since they have had so much more experience, it is worth considering how well the European physicians' unions serve their members' interests. Doctors win gains in negotiations when the public agrees with their cause, and lose when the public does not agree. The fact that particularly thorny negotiations are likely to be carried out in the public arena increases public confidence in the profession rather than detracting from it, precisely because there are no private agreements and hidden incentives to suspect. Doctors enjoy public trust, which makes medical work more rewarding whether that involves the doctor/patient relationship or efforts to attain funding for research on technical advancements.

This appears to be true even when they strike. From what we know, there is no evidence that they abandon patients who require emergency care and the mortality rate does not increase during strike periods. Routine medical care is suspended, which the public apparently regards as undesirable, but tolerable.

In summary, treating physician unionism as a radical statement growing out of frustration will produce a flashy, but unstable organization that is sure to lose steam as those who join it expend their energies in protest. It is far more likely to serve as an effective tool if one understands that its potential lies in being shaped into a carefully legal instrument, designed to permit collective bargaining with large and powerful organizations over the long term. ■

Grace Budrys, PhD, is Professor of Sociology at DePaul University in Chicago, Illinois, and the author of *When Doctors Join Unions*, which charts the history of the Union of American Physicians and Dentists. Her book can be purchased online through Amazon.com (www.amazon.com) for $14.95.

The Quest for Empowerment

Viable Alternatives to Unionization.

This issue of the *Bulletin* discusses a topic of considerable interest to many neurosurgeons in today's chaotic healthcare environment—physician unionization. We have made a special effort throughout the publication to bring you viewpoints and information that have bearing on this timely subject. While the potential leverage gained for physicians by unionization has appeal, the issues involved are complex and have ethical, financial, and professional implications for neurosurgeons.

The level of interest in unionization by neurosurgeons is related to several variables: one's position as an "employed" or private practitioner, the local managed care environment and the available options for bargaining with third parties. In fact, federal law currently prohibits union representation for all neurosurgeons except those who are employees of an organization. This, coupled with many physicians' natural aversion to unions and pressure by colleagues and professional societies against strikes and unionization, leads to a search for other solutions.

It is my personal perspective that while the current healthcare environment in many parts of the country may justify the debate about unions, the impetus to unionization is merely the response to a perceived threat—more of a retort than a solution. It is the responsibility of neurosurgeons who oppose the concept of unions and their professional societies to be innovative in identifying viable alternatives to unionization.

The Messenger Model IPA

One alternative to physician unions is the messenger model IPA, or independent practice associations of self-employed physicians who use a "so-called" messenger to negotiate on behalf of the group. Messenger models allow physicians to address issues that are more patient-oriented rather than physician-oriented, thereby enabling doctors to remain committed to the vision and mission of the medical profession. Messenger model IPAs allow physicians to use some of the tools of collective bargaining in negotiating with managed care organizations without using more radical methods, like strikes, that are an anathema to physicians.

A. John Popp, MD, Editor of the AANS Bulletin, is the Henry and Sally Schaffer Chair of Surgery at Albany Medical College.

Broadening the Influence of Neurosurgery

With organized medicine actively developing advocacy strategies that support physician's rights in the marketplace, doctors should expect support from their professional and educational organizations. In fact, one of the primary goals of the AANS is to enhance the competitiveness of its members via several strategies.

By maintaining liaisons with other groups in organized medicine, such as the Practice Expense Coalition, the American Medical Association and the American College of Surgeons, the AANS broadens the influence of neurosurgery in Washington. By collaborating with the Congress of Neurological Surgeons in the Council of State Neurosurgical Societies and the Washington Committee, the AANS analyzes and develops tactics pertaining to legislative, regulatory and socioeconomic issues facing our specialty. Through projects, such as the Outcomes Initiative, Practice Expense Survey, Cost Containment Initiative and the Getting SMART marketing communications project, the AANS assists neurosurgeons in building their practices, improving practice efficiency and negotiating with third-party payors. The success of such endeavors, however, often correlates with the neurosurgeons interest in actively participating in such programs.

Many neurosurgeons feel powerless and frustrated by the radical changes occurring in the health care environment and they need an effective means to counteract these pervasive influences. Even if legalized for self-employed physicians, unions that focus on salary, benefits and working hours, have serious limitations. While the programs cited above do not fully counteract all of the negative influences presently impacting health care, they are part of the strategy by the AANS to empower neurosurgeons to re-establish their autonomy, rebuild their physician-patient relationships and regain control over their profession. ■

TALK TO THE EDITOR

The Editors of the AANS Bulletin are interested in hearing your comments or queries on this issue, as well as your ideas for future issues.

Write to Dr. Popp, care of the AANS, at 22 S. Washington St., Park Ridge, IL 60068; fax (847) 692-2589 or e-mail info@aans.org

We want to hear from you!