NEUROSURGERY NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

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INSIDE THIS ISSUE

Evidence-Based Medicine 4
The Art and Business of Medicine 6
CNS Annual Meeting 6
CSNS News 10
Joint Section on Neurotrauma and Critical Care 14
WFNS News 17

President's Message: A Call to Leadership

Stephen Papadopoulos, M.D.
President, CNS

Last month I officially assumed the role of President of the Congress of Neurological Surgeons. I embraced the "Call to Leadership" several years ago, long before I began volunteer work for the CNS. Leadership may be sought or unexpectedly thrust upon us. Regardless, we all must be receptive and prepared for "the Call."

Great leaders are visible among us. Buzz Hoff has devoted his life to traditional leadership. He has been a leader in almost every group representing organized neurosurgery: President of the AANS, President of the Senior Society, President of the Academy, Chair of the ABNS … the list goes on. It is no coincidence that he is chairman of a department of leaders in neurosurgery: Bill Chandler (President, CNS; Board of Directors, AANS; Chair, Joint Tumor Section; President, MANS), John McGillicuddy (President, Society of University Neurological Surgeons; Executive Committee, Joint Spine Section), Karin Muraszko (President, WINS; Advisory Committee, ACS; Board Member, March of Dimes), Greg Thompson (Executive Committee, CNS; Board of Directors, AANS; Executive Committee, Joint CV Section), Oren Sagher (Chair Elect, Joint Pain Section)–this list also goes on. Dr. Hoff embraces leadership, he promotes it, and he believes that the call to leadership is the responsibility of all of us.

President George W. Bush sought leadership, he strategized to achieve it, and he fought for it relentlessly. His perhaps unanticipated "call" occurred on September 11, 2001. A new, unexpected, unrehearsed, unprecedented level of leadership was needed. Our President has embraced the call, demonstrating a quality of leadership many doubted that he possessed. Even the President's most fierce critics have voiced support and admiration for his skills, tenacity, and commitment. Perhaps President Bush's greatest talent is his ability to recognize great leaders and surround himself with them. Beyond that, however, is his acknowledgement of the ability of all Americans and his appeal for commitment and leadership.

Leadership was thrust on Jeremy Glick suddenly the morning of September 11, 2001. He led a heroic "army" of passengers aboard Flight 93, regaining control of that aircraft from the hijackers and saving hundreds, if not thousands, of lives. Mr. Glick was receptive, prepared, and instinctively embraced "the call" without hesitation.

In 1993, a small group of opportunistic lawyers specializing in product liability litigation led an organized effort against medical device manufacturers, the FDA, the CNS, the AANS, and even individual surgeons in the now famous pedicle-screw law suits. The CNS and AANS spent more than 1 million dollars in defense of these suits. Corporations spent several hundred million dollars. Ron Pickard, then CEO of Sofamor Danek, was called to leadership unfamiliar even to a businessman with a phenomenal record of success in the corporate world. Mr.

Continued on page 2

Cameras in the ED: Fame or Invasion of Privacy?

Are "real-life" television shows voyeurism and exploitation or a counter to misinformation put out by TV dramas?

Ruth SoRelle, M.P.H. and Anne Scheck

With television networks pitting man against nature to win the ratings war, the issue of when and where it is appropriate to allow television cameras has come to the fore. Nowhere is the issue more ticklish than when cameras seek to come into the emergency department.

Continued on page 2

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All correspondence on editorial matters should be addressed to:

Michael L. Levy, M.D.
Editor-In-Chief
Division of Pediatric Neurosurgery
Childrens Hospital Los Angeles
1300 North Vermont Avenue, Suite 906
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President's Message

Continued from page 1

Pickard organized an industry consortium to fight the accusations brought forth by the litigants. On the essential issue of patient safety, he vowed, "We would shut down the company in a moment, if we thought our products were jeopardizing anybody." In 1996, he wrote a letter to orthopedic surgeons and neurosurgeons, "We will not be intimidated and will not be coerced. We hope you will join with us as we continue to fight against extortion and for the advance of medical science and the care of patients." Mr. Pickard was a tenacious leader of the fight, refusing to give in, almost losing his own company from the weight of escalating defense costs in the process. The rest is history. The CNS, AANS, many individual surgeons, and more important, our patients owe a great deal to the leadership of this individual, found in the seemingly unlikely ranks of corporate America. Mr. Pickard was also receptive, prepared, and he, too, instinctively embraced "the call" without hesitation.

Religious leaders describe "the call" as exactly that: a call, a divine directive. Michael Lindvall, the pastor of First Presbyterian Church in Ann Arbor described it to me like this: the call is that intersection at which one's God-given talents and abilities meet the needs of society. In fact, he continued to say that a central tenant of Judeo-Christian theology is the assertion of the moral obligation for each of us to use our given talents for the good of mankind. We all must be receptive, prepared, and instinctively embrace the call without hesitation.

Neurosurgery is a wonderful profession. We as a group and each of us individually acknowledged our talent and our obligation when we chose this profession and took the Hippocratic oath. The call to leadership has been and always should be answered by each and every one of us. We must be receptive, prepared, and instinctively embrace the call without hesitation. ☐

Cameras in the ED

Continued from page 1

For Joel Geiderman, M.D., the question arose when producers for a "real" television program wanted to mount cameras in the emergency department where he worked. Dr. Geiderman is currently the chairman of emergency medicine at Cedars Sinai Medical Center in Los Angeles. The request gave him pause.

"At what point is it voyeurism? Is this another element of exploitation? Is it taking advantage of people in disadvantaged economic conditions? Patients who may say yes because of the duress of the situation may–after it is shown 10 times on TV–regret that they said yes. I've known people in that position," he said.

Patients in the emergency department are not in a great position to make these decisions, he said. The Joint Commission on the Accreditation of Healthcare Organizations has said filming can take place as long as it is not broadcast without getting permission from the patient or the patient's legal representative. "But when someone says 'no,' his or her confidentiality has already been violated," he said. "What right does the camera crew have to be in there when someone comes in to have catheters inserted and their clothes cut off? Don't they have the right not to be seen?"

In an article published last year on confidentiality in clinical education, the authors noted that all professional codes of ethics in medicine recognize the significance of maintaining confidentiality in practice, research, and education. Ensuring that protection is essential because "without such assurance, parents professional peers, research subjects, and students would be justifiably reticent, or even silent, about important sensitive disclosures," according to the publication (*J Allied Health* 2000;29:13).

A Feeling of Voyeurism

Kenneth Iserson, M.D., disagreed. He and Dr. Geiderman wrote opposing editorials in the February issue of the *Annals of Emergency Medicine* (2001;37:219 and 2001;37:222). He said he understands the feeling of voyeurism. "Relatives who are there for their own reasons get the same strange feeling of voyeurism. It's really another feeling that you are not acknowledging," he said. "It's, 'Gee, I'm glad it's [not] happening to [me].'"

He said the issue has been addressed by the ethics committee of the American College of Emergency Physicians. Most members said that they would not allow cameras in the emergency department, he said. "They are acting in a parental way," he said.

> *"It can counteract the misinformation put out by the doctor shows. Remember, in the first few sessions of ER, no one died. They finally got the idea that that was not how it works."*

Legally, confidentiality refers to the protection of unauthorized disclosure of information. But in recent years, the concept of "authorization" has become a source of discussion. Recently, the Bush Administration has called for stronger enforcement of current privacy laws, in particular, more safeguarding of patient records and health information.

Dr. Iserson said the JCAHO rules are fair and that most of the people with whom he has worked will abide by the rule not to air something without consent. "I have worked with a lot of people on the features channels," he said. "They are very careful."

He said there is a difference between reporters working on a deadline for a daily story and people involved in doing a long-term feature project. "News photographers do not get into the emergency department," he said. "They do for feature stories when they go ahead and ask if they can film. And I talk to news people pretty frequently in an empty room or in front of the ambulances. They get their information, and they probably have footage from somewhere else. We can't protect the patients until they come through our doors."

He said allowing cameras into the emergency department under controlled conditions can be beneficial. "It can counteract the misinformation put out by the doctor shows. Remember, in the first few sessions of ER, no one died. They finally got the idea that that was not how it works."

Dr. Iserson said reality television can generate a lot of questions from medical students who wonder if what they see on shows done in emergency departments is right. "It seems as though it serves a useful purpose," he said. "The public sometimes has a fear of what goes on in the emergency department. Seeing something that might acclimatize them to the situation would be helpful."

"From the feedback I've gotten, it's not the patients we should be concerned about. The patients are pleased that they have gotten their 15 minutes of fame. But some of the things the doctors have done–unbelievable," said Dr. Iserson. In fact, he said, he frequently uses such incidents in the bioethics courses he teaches. Dr. Iserson is director of the bioethics program at the University of Arizona School of Medicine as well as a professor in the emergency medicine division.

He said as far as patient privacy is concerned, all patients lose some privacy when they come into the emergency department, because of the department's layout and the necessity of delivering medical care. In his editorial, he pointed out that not everyone in the trauma bay is a doctor or nurse. There may be "police, students of various types, clerks, laboratory and radiography technicians, department volunteers, chaplains, social workers, housekeepers, medics, and even private citizens accompanying these individuals. … Such visitors might hear and see very private things. This is a part of emergency medicine, and is most common in teaching hospital EDs. How is filming without prior consent different from other common privacy breaches in the ED?"

Continued on page 3

Cameras in the ED

Continued from page 2

Patient Satisfaction

In a study conducted at Alameda County Medical Center where patients were filmed for a televised broadcast illustrating real-life events in the ED, surveys indicated that there was far more reluctance among the emergency physicians and nurses about the presence of cameras than among the patients involved in the filming. The survey included 80 patients and 78 providers who were evenly divided between physicians and nurses, according to Robert Rodriguez, M.D., an assistant professor of emergency medicine at the University of California, San Francisco.

Dr. Rodriguez and his colleagues conducted the study to determine whether filming would interfere with patient satisfaction. As it turned out, the cameras didn't affect patient satisfaction one way or the other, unless the worries about the medical personnel constitute a barrier, he said. "The doctors and nurses were more concerned than the patients were," he observed.

So why would such actions provoke such strong criticism–like the concerns expressed by Dr. Geiderman–given the results of the Alameda study?

One reason, borne out in the medical literature, is the fear that this kind of activity ultimately erodes patient trust, even if there is no evidence of that erosion at the time of the event. And some ethicists–and attorneys–have argued that patients may sign consent forms or release forms without fully knowing the possible ramifications. For example, some Catholic hospital emergency departments whose patients sign informed consent documents during rape treatment have come under scrutiny for failing to describe emergency contraception, allegedly because this is seen as undermining a patient's right to information by leaving out certain details (*Am J Public Health* 2000;90:1372).

The JCAHO has said filming can take place as long as it is not broadcast without permission from the patient or the patient's legal representative

Asked if the idea of securing authorization for a television broadcast might fall into a similar realm, Dr. Rodriguez said it's possible. After all, no one really knows until the segment airs what the impact of such a public appearance might be on a particular patient. Still, it's important to keep in mind that the patients in his study didn't seem to have that concern. "They just didn't seem to feel their privacy was invaded all that much," he said. "Overall, I would suggest that, in our hospital, patients didn't feel much loss of privacy."

"Cameras Seem Normal'"

Dr. Geiderman obviously feels that there is a difference. When he refused to let cameras in his emergency department, he derailed his hospital's participation in a citywide program that involved emergency medical personnel and other hospitals. In its wake, he said, many such programs have made allowing cameras in the emergency department seem almost normal.

"Unfortunately, in the United States, the notion of the ED has developed and flourished virtually unchallenged," he wrote. "What are these offerings anyway? Although news organizations argue that these programs help fulfill some societal 'right to know' or that these events are in the public domain, the actual fact is that reality-based shows provide low-cost programming to outlets hungry for original content with which to fill time slots. And for the public, these programs offer little more than titillation and escape. In the final analysis, what do these programs offer other than to move the scene of the freeway accident, prone to miles and miles of neck-craned, slowing motorists, into the home?"

Yet Dr. Geiderman said he sees some value to filming. For example, he said, a camera crew might want to follow a resident around the emergency department to see what that person experiences. "You can clearly follow them when they are paged to the ER. You can follow them in the hallways and see what they do as a public person. But then you have to stop when they go into an area with the curtain closed."

"There are stories that benefit the profession," he said. "You can use television as a medium to raise awareness of diseases, to do disease prevention, and to decrease fears around certain things. The public has a right to know where

Continued on page 6

Florida Brace

Will the Real Evidence-Based Medicine Please Stand Up?

**William H. Cordell, M.D.
and Carey D. Chisholm, M.D.**

It seems evidence-based medicine has struck a raw nerve. Dr. Joseph Zibulewsky voiced his obvious frustration about evidence-based medicine and its seeming oil-on-water immiscibility with clinical experience and common sense ("A Counter Argument to Evidence-based Medicine," Viewpoint, *EMN* March 2001, p. 4). And he is not alone in his criticism.

Critics claim that evidence-based medicine denigrates clinical expertise, patient values, and the "art of medicine" while promoting "cookbook medicine." They argue that evidence-based medicine is used as a cost-cutting tool, is an "ivory tower" concept, and will lead to therapeutic nihilism in the absence of evidence from randomized controlled trials.

But it seems a lot of bile is being spilled over what many critics incorrectly believe or perceive "evidence-based medicine" to be. We believe this originates from the term "evidence-based" being indiscriminately used as the medical "buzz word du jour"–"evidence-based guidelines," "evidence-based clinical pathways," "evidence-based approach," "evidence-based practice," and "evidence-based [insert name of a medical specialty here]." Before evidence-based medicine can be fairly criticized, we should at least be clear about what it is.

The most common misconception about evidence-based medicine is that it is making decisions based on research evidence alone. In fact, quite the opposite is true. Sackett and his colleagues (1) define evidence-based medicine as "the integration of best research evidence with clinical expertise and patient values." By clinical expertise we mean the ability to use our clinical skills and past experience in caring for patients. Jadad and Cepeda in a recent article in the evidence-based emergency medicine series in the *Annals of Emergency Medicine* (2) noted that human beings have developed powerful but nonscientific ways of knowing for more than thousands of years. These "hard-wired" primal knowledge tools include anecdotes, rules of thumb, tacit knowledge, "sixth sense," pattern recognition, and "hairs standing up on the back of the clinician's neck." Instead of demeaning clinical experience, evidence-based medicine expressly embraces and even celebrates its role in clinical decision-making.

Critics claim that evidence-based medicine denigrates clinical expertise, patient values, and the "art of medicine" while promoting "cookbook medicine."

Evidence-based medicine conceptualizes clinical decision-making and practice as the intersection of three circles –evidence, experience, and values. Practicing by any of the three "intersecting circles" alone is bad medicine. Practicing by experience alone (experience-based medicine) is practicing by habit or "flying by the seat of one's pants." This affords little opportunity for growth as a physician and makes it difficult to incorporate new knowledge into one's practice. Practicing by values alone (emotional-based medicine) is clearly not recommended. Furthermore, most would argue that practicing by evidence alone is fraught with problems. We are all very much aware that many of the patients we care for each day have problems that have not yet been "answered" by "hard science." It's the integration of all three that is evidence-based medicine's single most important gift to clinical practice and education.

Why have so many clinicians and educators embraced evidence-based medicine? Evidence-based medicine is one model for thinking about, continually learning, teaching, and practicing medicine. It is in large part a philosophy and skill set that articulates the clinical decision-making process. Evidence-based medicine is also about translation–the translation of research findings into clinical practice. Importantly, research findings also are translated into terms understandable by patients so they may be informed partners in the decision-making process. (For example, what does clinical evidence, derived from studies of large numbers of patients usually in a different locale, mean to the single patient now being cared for by me in my ED?) Evidence-based medicine is very patient focused and expressly includes the patient into the clinical decision-making process.

The application of evidence-based medicine skills begins and ends with a single patient and includes the following steps:

- Formulating answerable questions.
- Rapidly searching for best evidence to answer these questions.
- Critically appraising the evidence for validity and applicability.
- Integrating this appraisal with clinical expertise and patients' values, and applying it to the individual patient.

Evidence-based medicine is not an exercise for academicians, statisticians, or researchers. It is not about learning to do research. It is about learning to use research in clinical practice. As Straus and McAlister wrote in a recent article in *CMAJ* (3), surveys and audits of front-line clinicians clearly refute the pseudo-limitation that evidence-based medicine is an ivory-tower concept. Evidence-based medicine deplores dogma, experts, and medical divas. Because it insists that individual clinicians can and should learn to make up their own minds, evidence-based medicine is fundamentally about "critical thinking," a concept threatening to many.

There are many other myths about evidence-based medicine. To address but a few, evidence-based medicine is not a better way of reading a journal, "trashing" an article, or running a journal club. Evidence-based medicine does not insist that practice be guided by only meta-analysis or large randomized controlled trials. And evidence-based medicine is not synonymous with guidelines or clinical pathways.

But evidence-based medicine does come with a price. Clinicians and learners do need to acquire certain skills (e.g., computer skills, rapid searching, and analysis of evidence), learn new concepts (e.g., hierarchy of evidence, probability revision), and understand the basics of meta-analysis and clinical trials (e.g., randomization, intention-to-treat, baseline comparisons). Evidence-based medicine cannot be mastered by reading a few articles, attending a workshop, or discussing it once a month in a journal club. The principles and skills of evidence-based medicine must be incorporated into daily practice, and become part of the clinician's mindset toward patient care and continual learning.

Both of us have been learning and practicing evidence-based medicine ourselves for nearly 6 years. We are also part of a group of national and international evidence-based medicine collaborators who have been teaching the concepts and skills to students, residents, and clinicians in academic and community practice. We believe that the evidence-based medicine concept of incorporating evidence, clinical experience, and patient's preferences, values, and rights has been a significant advance in improving the incorporation of medical innovation into practice. Evidence-based medicine has transformed our thinking about how clinicians should be educated and continue to learn for the rest of their life. It is a much different way of learning, practicing, and even thinking about health care than what we learned in medical school or residency.

Evidence-based medicine deplores dogma, experts, and medical divas. Because it insists that individual clinicians can and should learn to make up their own minds.

Along with these positive changes, evidence-based medicine has brought opposition and criticism. We respect and support Dr. Zibulewsky's right and the rights of others to criticize evidence-based medicine. Criticisms about evidence-based medicine are desirable and essential. These debates help us better improve the practice and teaching of evidence-based medicine, and permit us to identify and dispel myths and misconceptions. Furthermore because evidence-based medicine is fundamentally anti-expert, anti-dogma, and anti-diva, it must be very careful not to become dogma itself.

However, let's be very careful that when we use the term evidence-based medicine, we are talking about the real thing. If it's not the integration of evidence, experience, and values into clinical decision-making, it is not evidence-based medicine. The jury should not convict the wrong defendant.

Drs. Cordell and Chisholm are emergency physicians at Methodist Hospital and faculty in the department of emergency medicine at Indiana University School of Medicine in Indianapolis. They are 1996 graduates of the Evidence-Based Medicine Workshop at McMaster University in Hamilton, Ontario, and have conducted evidence-based medicine and information technology workshops in the U.S. and Canada. Dr. Cordell designed with Peter C. Wyer, MD, the Evidence-Based Emergency Medicine series in Annals of Emergency Medicine. *The* Annals of Emergency Medicine *Evidence-Based Emergency Medicine series can be accessed electronically (including PDF format) from the Mosby Web site by keying in "Evidence-Based Medicine" in the "Articles" search field. The URL for Mosby is www.harcourthealth.com/Mosby/index.html. Click on "Periodicals," then choose* Annals of Emergency Medicine. *This is a subscription site.*

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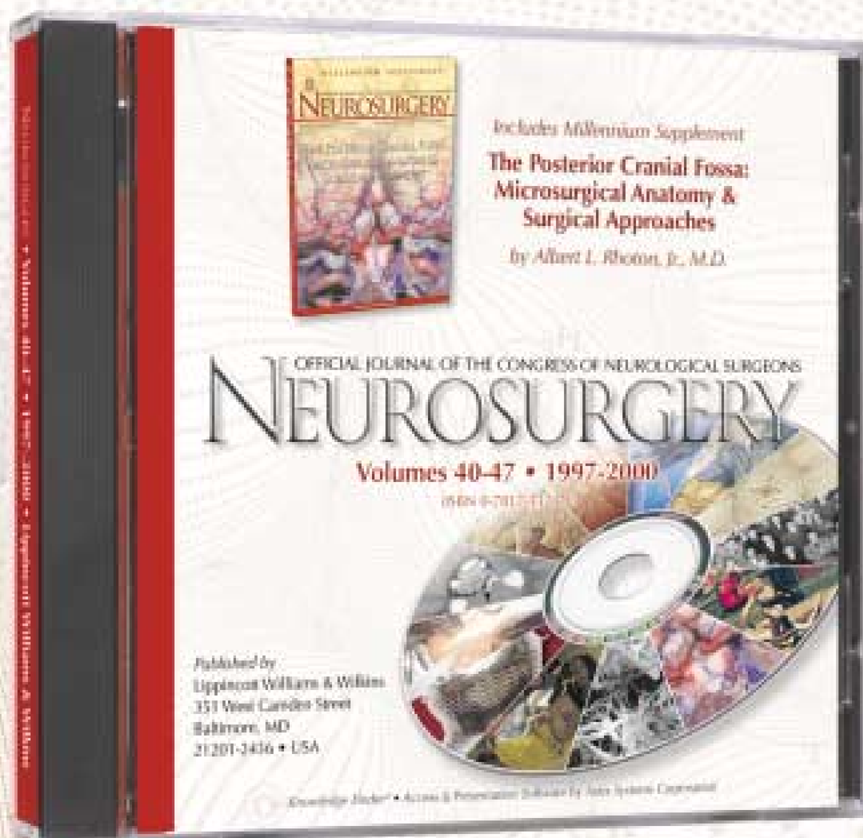

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THE ART AND BUSINESS OF MEDICINE

It's My Turn

Doug Johnson
Executive Director
Surgical Management Professionals

The not-for-profit hospital industry has its considerable challenges in today's market. Some of their problems, however, have been of their own making. A number of years ago, someone came down from the mountain and proclaimed, "Thou shalt vertically integrate." That proclamation spread far and wide. It has now turned shortsighted and deep as systems are scrambling to unload physicians and sell or close their managed care shops.

With the increase in ambulatory surgical centers, office-based surgical suites and surgical specialty hospitals, a new proclamation has come down from the mountain: "Thou shalt not compete with a not-for-profit hospital." This strategic imperative broadcast from local boardrooms, system headquarters, and the AHA burning bushes is as inappropriate and misguided as the first proclamation. Perhaps we should consider a few new proclamations:

Thou shalt not mandate or legislate away the very energy and motivation that has kept health care for our communities on the cutting edge of clinical and managerial excellence.

In all sectors of our economy, we believe and preserve the sacredness of competition. In health care, competition is alive between hospitals, regional systems, suppliers, and physicians. The desire to be "Top of Mind" in one's next marketing survey brings lower prices, new services, and a broader variety of physicians and associates specialties. The barriers to entry in the health care market are the same as in any market: expertise, capital, and confidence.

Thou shalt create an economic platform that supports the recruitment and retention of high-quality health care professionals.

The soul of the health care industry is in the hands, heads, and hearts of the practitioners.

These are the same practitioners that are seeing a decline in practice reimbursement, intrusions into their medical judgment, and a workplace managed by allied professionals that are increasingly downsized, reengineered, and restructured. We need to create and support income-enhancing opportunities for these professionals. More and varied professionals will care for all aspects of the health care community.

Thou shalt plan, partner and position our future health systems together.

Hospitals and health systems play a critical role in the infrastructure of our community health systems. Those enlightened ones have incorporated physicians into their leadership, governance, and even equity structures. In the past few years as margins have diminished, hospitals have begun to notice that the thrill of owning and managing doctors is gone. They have also learned that owning and attempting to run a managed care company represents an entirely different set of business skills.

Competition, economic opportunity, and new partnerships when energized on a community-wide basis bring about lower prices, better products, and increased services. Neither the medical practitioners nor the hospitals and health systems have a license to unilaterally dictate the community's interests. The community expects us all to work in the best interest of their health.

Thou shalt do that.

Douglas V. Johnson is the Executive Director of Sioux Falls Surgical Center and Surgical Management Professionals. The company is in the business of health care consulting and the development of ambulatory surgical centers and surgical specialty hospitals. □

Cameras in the ED

Continued from page 3

it can receive exemplary care. Trauma is underfunded."

Dr. Geiderman also said he could envision talking to the cameras about the problems with trauma care in Los Angeles in the halls of his emergency department while people walked back and forth in the public areas. "It draws attention to something that needs drawing attention to," he said.

In the final analysis, he said, "My goal is to protect the patients, not to ban all cameras. " Dr. Iserson's goal is not much different, but he sees those who operate the cameras as professionals who understand and obey the rules. "I believe that these people are professionals and they are honest," he said. "I do work with these people, and I have found them to be aboveboard."

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CNS Annual Meeting: The First San Diego Convention after Terrorist Attacks

Douglas Kondziolka, M.D.
2001 Annual Meeting Chairman

Between the terrorist attacks on September 11 and the beginning of the Congress of Neurological Surgeons meeting on September 29, the downtown San Diego core and Convention Center area had been empty. All scheduled conventions prior to the CNS meeting had been canceled and the economic ramifications significant. When the Annual Meeting Team arrived the week before the CNS meeting, we found the Marriott Hotel and Marina virtually empty (the whole North Tower had been closed) and an array of taxi drivers, restaurateurs, and convention center staff who all welcomed our arrival. When I walked into the Convention Center on Thursday morning before the meeting, I was greeted by the center manager (a person I otherwise never usually would meet) thanking the CNS for holding their meeting and not canceling. All of you who attended the meeting know what I am talking about. We were thanked by taxi drivers, limo drivers, hotel staff, convention center staff, cleaning staff, and restaurant workers who avoided being laid off during the week of our meeting. Had the CNS canceled the San Diego convention, the economic effect on so many lives could not have been measured. The CNS is grateful to all of you who attended and helped to create one of the most successful CNS meetings ever.

The CNS also is indebted to our corporate sponsors. Of the companies who exhibited at the meeting, almost all honored their business commitments and attended. In the weeks prior to the meeting, the telephone messages and e-mails spanned the entire spectrum of human response. Some called for the meeting to be canceled, others emphatically stated that it must continue. From the beginning, the CNS officers agreed that our societal mission should not be interrupted whatsoever by the work of terrorists. Our goal was to be cautious but steadfast.

The CNS membership and its corporate partners should be proud that they continued their mission of education and business in the midst of a national tragedy. I know that our patients will benefit because of our commitment to education. I also know that the people of San Diego thank you as well. □

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For Our Patients

Managed Care Reform Comprehensive managed care reform legislation has been passed by the House and Senate and will now go to a conference committee to reconcile the differences between the two bills. ANS PAC supported candidates have ensured that the following key provisions benefitng neurosurgeons and their patients are included in the bill:

- Direct and timely access to specialists and coverage of emergency services under prudent lay person definition of emergency
- Choice of physician through mandatory point-of-service option
- Expedited internal and external appeals process
- Protections for physicians from liability for injuries caused by treatment delays and denials

Stem Cell Research Legislation to support federal funding for stem cell research for neurologic and other diseases has been sponsored by ANS PAC supported candidates. Continued pressure from these Members of Congress resulted in President Bush signing an executive order requiring NIH to fund stem cell research from currently existing stem cell lines.

Stroke Prevention and Treatment ANS PAC supported candidates have introduced legislation to appropriate funds to states to create comprehensive stroke treatment systems to promote stroke prevention and immediate treatment. States are required to utilize the standards of the "Brain Attack Coalition," of which neurosurgery is a founding member, when developing the stroke protocols.

For Our Practice

HCFA Run Amok To expose the ongoing problems that physicians are having with the Health Care Financing Administration, ANS PAC supported candidates have held numerous congressional investigative hearings, which have led to the introduction of comprehensive regulatory reform legislation. This increased pressure caused HHS Secretary Tommy Thompson to begin a complete overhaul of HCFA, starting with changing the name to the Centers of Medicare and Medicaid Services (CMS). The final legislation will likely include Medicare contractor reforms, change to the audit process, changes to the regulation process, and reduction in Medicare paperwork.

EMTALA Relief At neurosurgery's request, Congress is taking action to provide physicians EMTALA relief. Members of Congress have requested that Secretary Thompson revise EMTALA regulations to ensure that they are consistent with the original intent of the statute. A joint Senate/House hearing on EMTALA is being planned and following this, ANS PAC supported candidates will send a letter to Thompson outlining specific EMTALA reforms and will introduce EMTALA reform legislation.

E&M Documentation Guidelines Reform Legislation requiring CMS to cease using the current onerous E&M documentation guidelines has been introduced by ANS PAC supported candidates. The bills require CMS to develop new guidelines that are clinically relevant and reduce unnecessary documentation. CMS will be required to pilot test a system based on peer review of outliers, and physicians participating in the pilot tests will be immune from audits.

Antitrust Relief for Physicians ANS PAC supported candidates are redrafting legislation that will allow physicians to jointly negotiate with health plans without such activities being "per se" legal. The bill will require the Department of Justice to conduct pilot projects based on the Campbell bill.

Brain Lab

LETTER TO THE EDITOR

2000 Charles Plante Public Policy Fellow Reports from Washington, DC

This is a letter to update the CNS Fellowship Committee on my experience in the first 5 months of the Charles Plante Public Policy Fellowship in Washington, DC.

I am serving as a majority (i.e., Republican) staff member for Senator Arlen Specter (R-PA). Sen. Specter is chairman of two health care committees/subcommittees that I have been assigned to. For the first 6 months of the fellowship (September 2000–February 2001), I worked on the Senate Veterans Affairs Committee. This committee has oversight over all VA health care and benefit programs. I spent the second 6 months on the senate appropriations subcommittee for labor, health, and human services that Sen. Specter also chairs. This committee appropriates money for Medicare, Medicaid, and the National Institutes of Health.

Thus far I have split my time between VA health care issues and medical-legal-political issues related to neurosurgery. During September, October, and the first half of November, the time leading up to passage of the Veterans Affairs bill for FY 2001, I worked mainly on VA issues. This included preparing for and attending policy meetings with other staff members of the Senate Veterans Affairs Committee, constituency groups, lobbyists, and minority (i.e., Democratic) staff members of the Senate Veterans Affairs Committee. These meetings were for the purpose of either including or excluding provisions in the Veterans Affairs bill of particular concern to those individuals. Once those provisions were negotiated, we then met with the staff members from the House Veterans Affairs Committee to negotiate the final terms of the bill. I also attended hearings for the Veterans Affairs bill and drafted memos to Sen. Specter on VA health care issues such as Agent Orange and Gulf War Syndrome.

The last half of November and December I spent working mostly on medical-legal-political issues related to neurosurgery. I have submitted two papers, “Expert Witness Testimony in Neurosurgery” and “Informed Consent for the Neurosurgeon,” to *Surgical Neurology*. In addition, I have researched and drafted three other papers (“Modern Malpractice Liability in the Operating Room,” “Physician Unions and Collective Bargaining Units in Neurosurgery,” and “Patient Privacy in Neurosurgery”) that will be submitted for publication. I have also attended both AANS/CNS Washington Committee meetings (September and December) and drafted a letter for the AANS/CNS endorsing the veterans’ constituency groups’ policy and budget proposal for FY 2002.

This fellowship has been an excellent experience for me. I have learned a great deal about the inner workings of politics on Capitol Hill, especially as it affects health care. I am eager to convey the knowledge I have gained from this experience to others in neurosurgery who are interested in these issues.

Alan M. Scarrow, M.D., J.D. ☐

FUTURE MEETINGS—CONGRESS OF NEUROLOGICAL SURGEONS

The following are the planned sites and dates for future annual meetings of the Congress of Neurological Surgeons:

2002	Philadelphia, PA	September 21-26
2003	Denver, CO	October 18-23
2004	San Francisco, CA	October 16-21

FUTURE MEETINGS—AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

The following are the planned sites and dates for future annual meetings of the American Association of Neurological Surgeons:

2002	Chicago, IL	April 6-11
2003	San Diego, CA	April 26-May 1
2004	Orlando, FL	May 1-6

Sponsored Fellowships of the CNS

The CNS offers several fellowships for residents, neurosurgeons who have recently completed training, and established neurosurgeons. Sponsored fellowships remain an important part of the educational mission of the CNS. By sponsoring fellowships, the CNS aims to enhance the education of neurological surgeons at all stages of their careers. Fellowships represent a strategic investment by the CNS on behalf of the specialty. To maintain quality fellowships, the Congress is interested in providing funding for suitable applicants to receive fellowship training at centers that can provide a worthwhile learning experience. The fellowship supervisor should be qualified in the area of sought expertise, be interested in teaching, and provide a suitable environment for the applicant. Although the attainment of a postgraduate degree is not necessary during the fellowship, the Congress supports the most formal educational experience possible. This can include training in basic science, clinical, economic, and public health and policy pertinent to neurosurgery. The CNS shall request that the fellow provide a detailed description of their completed fellowship experience, as well as a listing of all peer-reviewed journal and book chapter publications in progress, submitted, or already accepted for publication. Similarly, a listing of all attended meetings and lecture topics that stemmed from the fellowship experience shall be made known.

There shall exist a standardized fellowship to be reviewed by the specific fellowship committee. Similarly, there will be a postfellowship evaluation form returned to the CNS for review. Although the value of the fellowship will not be measured by numbers of publications or presentations, the CNS is interested in tracking where the fellow practices afterwards and understanding the impact the sponsored fellowship has on that individuals career. Although specific fellowships are tailored to subspecialty interests (i.e., the neuroendovascular surgery fellowship), specific applications may receive additional merit by the research or clinical topic chosen and by the importance of that topic to the field of neurosurgery.

The CNS acknowledges that a sponsored fellowship is not followed by a certification process nor does the CNS offer any level of accreditation to the specific fellowship.

For further information, contact:

Richard G. Ellenbogen, M.D.
Chairman, CNS Resident Committee
Children’s Hospital Medical Center
Department of Neurosurgery
4800 Sand Point Way, NE
Seattle, WA 98105-0371
206-526-2039, *rellen@chmc.org*

CNS Clinical Fellowship Awards

- **The CNS Cushing Clinical Fellowship Award**
- **The CNS Dandy Clinical Fellowship Award**

The CNS Fellowship Awards provide financial assistance to resident and recent graduates to help facilitate the acquisition of clinical skills and knowledge. Application may be made to cover travel and housing expenses for a 3 to 6 month elective rotation at an institution outside the primary training program. Such a rotation might provide in-depth clinical and surgical experience in a subspecialty area. International travel is acceptable.

All resident members of the CNS that have completed at least 3 years of neurosurgical training are eligible for the awards. Awards made during the final year of training may be used during the first 12 months after completing residency training. The Congress will not fund an individual who is participating in a formal funded fellowship. Up to $10,000 is provided for each award. Two awards are usually given per year.

- **The CNS/De Puy AcroMed Clinical Fellowship in Spinal Neurosurgery**

One fellowship (1 year) in spinal neurosurgery ($50,000) is offered for training beginning in July of the calendar year. Applications are currently being accepted.

- **The CNS Clinical Fellowship in Syringomyelia and Chiari Malformation**

One fellowship in clinical or basic research on this topic is offered per year. Up to $10,000 is provided for each award. One award is given per year.

- **The CNS Margot Anderson Foundation Fellowship in Brain Restoration Research**

One fellowship in clinical or basic research in the field of brain repair is offered per year.

Research may include restorative approaches to brain injury, stroke, or neurodegenerative disorders. The application should submit an investigative plan. Up to $10,000 is provided for each award. One award is given per year and is open to neurosurgical residents or graduates within 5 years of training completion.

- **The CNS Elekta Clinical Fellowship in Radiosurgery**

This fellowship provides financial assistance to resident and recent graduates to help facilitate the acquisition of clinical skills and knowledge in stereotactic radiosurgery. The purpose of the

Continued on page 9

Fellowships

Continued from page 8

fellowship is to obtain the neurosurgical skills required in radiosurgical procedures. The sponsoring institution and supervisor(s) must show evidence of a high-volume neurosurgical radiosurgery (single-session irradiation) program to meet the needs of the applicant. The program must perform a spectrum of radiosurgery procedures that can include vascular malformations, tumor, and functional disorders. Application may be made to cover travel and housing expenses for a 3- to 6-month elective rotation at an institution outside the primary training program. International travel is acceptable.

All resident members of the CNS that have completed at least three years of neurosurgical training are eligible for the awards. Awards made during the final year of training may be used during the first 12 months after completing residency training. The Congress will not fund an individual who is participating in a formal funded fellowship. Up to $10,000.00 is provided for each award, and one award is given per year.

- **CNS Charles Plante Public Policy Fellowship (not offered in 2002)**

The goal of the CNS Public Policy Fellowship Program, established in 1998, is to develop neurosurgical leadership in health policy. Training individual neurosurgeons in health policy will enable those individuals and organized neurosurgery to educate and influence federal and state policy makers on health related issues, particularly those with neurosurgical implications. This fellowship is offered every 2 years, although an application can be made for support at any time. Please contact the CNS Fellowships Chairman for more information on timing.

The fellowship provides opportunities for neurosurgery residents and practicing neurosurgeons, whether in academia or private practice, to gain an understanding of health policy issues and how they are addressed by the nation's political system. One fellow will be selected each year (provided there is a qualified applicant). The fellow selected will participate in a one-year supervised training experience in Washington, D.C., working in a Congressional office or committee or in the Administration.

- Timetable: The 1-year fellowship runs from September to August.
- The deadline for applications will be March 1.

This fellowship is offered every two years.

Fellowship Program Description

Once the fellow has been selected, a decision will be made about where the fellow will serve. If the fellow already has identified an office in which he/she would like to work, the Director of the AANS/CNS Washington office will assist the fellow in securing the position. If not, the Director will assist the fellow in identifying an office where the fellow might work. After a series of interviews, the fellow will be assigned as a physician staff member to a Congressional or Executive Branch office or committee that is involved in health related issues.

The fellowship program will begin with an orientation period. The fellow will meet with key staff and advisors in Congress and the Administration, including top administrators of agencies responsible for health activities, congressional committee staff and representatives of health interest groups–the people who influence and help formulate national health policy.

The fellow will then begin serving in an area of public policy as a working staff member and will perform such tasks as developing and drafting legislative proposals, planning and arranging legislative meetings and committee sessions, and meeting with interest groups. Fellows will attend a wide variety of forums and meetings such as those sponsored by the National Institutes of Health, Medicare Payment Advisory Commission, and the Institute of Medicine.

The fellow will be required to attend the AANS/CNS Washington Committee meetings to meet with the leaders of organized neurosurgery and to participate in the development of organized neurosurgery's health policy agenda.

As part of the fellowship year, the fellow will also prepare a formal presentation on a policy oriented research issue in which he/she has been involved, which may then become part of the CNS Annual Meeting or included in selected CNS publications.

Qualifications and Application

Practicing neurosurgeons (from academia or private practice) and neurosurgical residents (PGY4 or greater) are eligible to apply for the fellowship. Candidates will be considered on the basis of their professional achievement as well as their potential for academic growth and leadership in organized neurosurgery, regardless of political affiliation. Previous involvement in organized neurosurgery and a demonstrated commitment to public policy activities are desirable. Special attention will be given to the nomination letter that accompanies the application. The applicant must come from a sponsoring institution, such as an academic institution or group practice.

The application should include the following:

A letter from the candidate describing the reasons for the application, the expected benefits from a fellowship, and the ways in which the fellow plans to use the experience for career development. The applicant must demonstrate his/her interest in promoting the health policy priorities of organized neurosurgery and for assuming and maintaining a leadership role within organized neurosurgery. The letter may be structured to answer the following questions:

1. Why do you want to be a CNS Charles Plante Public Policy Fellow?
2. What do you consider to be your major strengths and qualifications for the program?
3. What do you consider to be your most significant community-related outside activity or activities that utilize your professional expertise?
4. What do you expect to do with the fellowship experience in the near future and longer term?

A current curriculum vitae and a one-page biographical sketch of the candidate should accompany the application letter. The candidate should supply a list of the names, addresses, phone, and fax numbers of three references whom the candidate has asked to comment on his or her qualifications for the fellowship.

A letter of nomination from a CNS officer, board member or committee chair evaluating the candidate's qualifications, and explaining how the candidate might serve organized neurosurgery upon completion of the fellowship.

A letter of recommendation from the applicant's sponsoring institution or practice, detailing its commitment to support the applicant during the fellowship and after its completion. This commitment must include the continuation of benefits and insurance coverage during the fellowship.

The application material, including reference and nomination letters, should be sent directly to the CNS Fellowship Committee Office, so that all the material is received by no later than March 1. The material will be reviewed by the selection committee and finalists will be interviewed. Applicants will be informed in February of the final selection.

Selection/Oversight Committee

The Selection Committee will be comprised of appointees from the CNS, the Chairman of the Washington Committee, the previous health policy fellow, and the Director of the Washington Office (advisor). Other members of the committee may include the Chairman of the CSNS and an appointee from the Senior Society. The committee will meet to discuss applicants during the CNS Annual Meeting.

Stipends and Benefits

Fellows will be paid a stipend commensurate with their level of training up to a maximum of $75,000. Fringe benefits are maintained at existing levels through the fellow's sponsoring institution. Salary may be supplemented by the sponsoring institution. Up to $5,000 of documented travel and other relocation expenses will be reimbursed.

CNS Wilder Penfield Clinical Investigation Fellowship

The CNS Clinical Investigation Scholarship is meant to assist neurosurgeons in obtaining formal training in the field of clinical investigation. The scholarship is open to all neurosurgical residents, and fully trained neurosurgeons at any stage of their career. The scholar will spend 6 to 12 months in formal training under the direction of a specific mentor to acquire expertise in the techniques of scientific investigation of clinical neurosurgical practice. This training may encompass fields such as clinical epidemiology, clinical trials, outcomes research, health services research, or other related disciplines. The simple application of a new drug, device, or procedure in the clinical arena would not be an appropriate project for funding although the process of designing, conducting, and analyzing data from such a study as part of the acquisition of new clinical research would be appropriate.

The amount of support will depend on the location and duration of the scholarship. Salary and travel support of up to $40,000 and $10,000, respectively, is available. The scholarship may also provide up to $10,000 of direct project costs.

CNS Sean Mullan Neuroendovascular Surgery Fellowship

The CNS and AANS each sponsor one Fellow annually in neuroendovascular surgery. This is a 1-year fellowship to provide hands-on training in the treatment of cerebrovascular disorders by neurointerventional techniques. Applicants are generally graduates of a North American neurosurgical training program who have previously received training in basic neuroradiology, including radiation physics, diagnostic radiology, and femoral catheterization. Emphasis is given to individuals who are planning academic careers in neuroendovascular surgery, and especially individuals for whom the fellowship would not be possible without additional funding. Each applicant should provide information as described on the application form including letters of support from his or her program director and the director of the proposed neuroendovascular program.

Solicitation for applications occurs in October, and the deadline for receipt of application is December 1. Selection is performed by a committee determined by the Joint Section on Cerebrovascular Surgery Executive Committee, and recipients will be notified by January 15 of the year of the

Continued on page 10

CSNS NEWS

Chairman's Corner: The Resolution

David Jimenez, M.D., F.A.C.S.
Chairman, CSNS

Being a representative assembly, the Council of State Neurosurgical Societies uses parliamentary procedure to conduct its business in an orderly and efficient fashion. However, parliamentary procedural rules are not intuitive and consist of many complex concepts and ideas that may be challenging to grasp and remember. Nevertheless, according to Robert's Rules of Order (1), these rules "enable an assembly, with the least possible friction, to deliberate upon questions in which it is interested, and to ascertain and express its deliberative sense or will on these questions." Every group, organization, or institution has the right to create its own rules and regulations and to adopt a parliamentary authority that will follow in its discussions and deliberations. To that end, the resolution is the fundamental concept that allows the CSNS assembly to conduct its business. The resolution is in concept like a legislative statute, being derived by a similar process. According to our own Rules and Regulations (2), "a resolution should be a directive disciplined in is subject, intent, and development process and format. The subject should be important beyond personal agendas, well researched by the sponsors, pertinent to the neurosurgical practice, and within the realm of influence of the organization. The intent should be the improvement of the organization or an aspect of neurosurgical practice in relation to the socioeconomic environment."

Design of the Resolution

"The resolution should be in two parts, the first part is the rationale for the directive and contains all of the reasons necessary to justify consideration of the issue by the assembly. The rationale should contain the information necessary to persuade a voting delegate of the virtue of the proposal and the need to support it. The rationale is recognized by a series of 'Whereas...' conjunctions introducing the supporting or justifying statement.

"The second part is the *Resolve*, containing the specific position, belief, or actions proposed by the sponsor. The resolve may be a single statement or multiple logically separate statements, each proceeded by the directive 'Resolve, that...'. The resolve(s) should be clear, derived logically from the rationale, reasonably possible to achieve, and within the ability and authority of the organization to accomplish."

Although only CSNS member delegates or AANS/CNS appointees may introduce resolutions, any neurosurgeon in the country may address an issue of concern by working with his or her state delegate to introduce an appropriate resolution. These resolutions should deal with the practice of neurosurgery and any socioeconomic issues which may affect it (reimbursement, medicolegal, work force, cost control, etc.). Drafted resolutions should be sent to the Corresponding Secretary 6 weeks prior to the next semiannual assembly immediately preceding the AANS or CNS annual meeting. During the Plenary Session, the delegates and appointees may discuss, debate, and vote to adopt or defeat the resolution. In this process, the resolution may be editorialized, amended, or substituted for another resolution. Following debate and vote, these resolutions are returned to the CSNS Executive Committee for appropriate action if pertaining to matters within its jurisdiction or are forwarded to the Board of Directors of the AANS and the Executive Committee of the CNS for approval. Final decisions by the parent organizations are relayed back to the CSNS delegates at the following semiannual meeting.

Thus, like a bill introduced in Congress which may become law, a well-crafted and developed resolution introduced in the CSNS may lead to a series of events that may ultimately affect and improve the way we practice neurosurgery. For a list of the names of your state delegates, you may access the CSNS portion of the *Neurosurgery://On-Call* Web site or you may contact Melany Thomas at *Mthomas@kyneurosurgeons.com*.

References

1. Robert HM. Robert's Rules of Order. Glenview: Scott, Foresman, 1876.
2. Council of State Neurosurgical Societies of the American Association of Neurological Surgeons and Congress of Neurological Surgeons. Rules and Regulations, August 2000.

Fellowships

Continued from page 9

fellowship. The award provides for $40,000 total funding over 1 year.

CNS International Fellowships

- **The CNS Elekta/Lars Leksell International Fellowship**
- **The CNS George Ablin International Fellowship**
- **The CNS Kenichiro Sugita International Fellowship**

The International Fellowship Award has been established by the CNS to extend educational opportunities to neurosurgeons from developing countries. CNS International Fellowships are offered with the hope that the participating Fellow will acquire training that will enhance the quality of care provided in his/her home country. The fellowship consists of a. primarily clinical experience, including observation of office, hospital and operating room activities. However, some research experience may also be included in the Fellowship. Applicants must have completed their formal neurosurgical training and have been in practice for 5 years or less. A North American sponsor who is a member of the CNS must be identified by the Fellow, and agree to mentor the educational activities during the Fellowship. Fellowships are considered for 3 to 6 month's duration.

The International Fellowship Award includes round-trip coach airfare and any other travel expenses, and a monthly stipend of $1,000. Awards will not exceed a total of $5,000 for a 3-month Fellowship or $10,000 for a 6-month Fellowship. Fellows attending the Annual Meeting of the CNS during the period of their Fellowship will have their meeting and registration fees waived.

For further information, contact:

Douglas S. Kondziolka, M.D.
Chairman, CNS Committee on Fellowships
University of Pittsburgh Medical Center
Department of Neurosurgery
200 Lothrop, Suite B-400
Pittsburgh, PA 15213-2582
phone: 412-647-6782,
fax: 412-647-5559
kondziol@neuronet.pitt.edu

NLDC Report

Lyal Leibrock, M.D.

The first of hopefully many similar efforts, the Neurosurgical Leadership Development Conference, was held in Washington, DC July 22–24, at the Washington Court Hotel close to the nation's capitol and the congressional and senatorial office buildings.

The conference was attended by 80 actively practicing neurosurgeons interested in the ongoing political efforts of neurosurgery for the success of the specialty. The attendees received the benefit of having an exceptional office practice management course presented to them on Sunday under the direction of Dr. David Jimenez with Dr. Sam Hassenbusch, Dr. Greg Pryzblyski, Dr. John Kusske, and Kimberly Pollock providing practical information on day-to-day issues in coding, E & M documentation, and other matters of benefit to individuals in the practice of neurosurgery. This was followed by a wine and cheese reception sponsored by Sofamor Danek.

The following day, instruction on how to present oneself and issues regarding health policy to elected representatives and staff in the nation's capitol was provided. This was lead by Joel Blackwell, a leading expert on grassroots advocacy. Training was provided by a member of the health care staff of one of the physician congressmen, Dr. Cooksey from Louisiana. These individuals provided information on how to make presentations of issues to obtain the most positive response from the people we would be dealing with the following morning.

The next speaker was Melinda Ferris who taught people how to communicate successfully with individuals in a political environment. She explained the mistakes individuals might make in presenting their case to get adequate attention for the issues important to them as individuals, to their patients specifically, and to the patients' families more peripherally.

Congressman Cooksey spoke at lunch and stated that many congressmen like to hear from individuals in their district or state so that they actually know how an individual who is a working, practicing, taxpayer thinks about issues. He stated many times that they are inundated by high-paid marketing and legal staff for corporate entities and collective groups, as well as high-paid political lobbyists, and they do not know if those individuals truly express the thoughts of the people that live and work in the district they represent. They are delighted to see and hear from someone not performing a job they have to do for the economic well being of their corporation or focus group. He said these efforts are extremely valuable not only for neurosurgery, but for surgery as a whole and medicine in general. The congressman suggested that more efforts like this should be made.

This point was further emphasized by Dr. Fletcher (Representative) who visited in the evening to discuss the

Continued on page 12

State Neurosurgery Society Meeting Information

William E. Bingaman, M.D. and Ann Warbel, R.N.

The information below has been gathered via direct contact with state organizations. All information is deemed accurate, but subject to change. Anyone interested in submitting their state's annual society meeting information for publication should forward it to Dr. William Bingaman, Desk S-80, Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio 44195. Alternatively, e-mail to *Bingamb@ccf.org*.

STATE	PRESIDENT	PHONE	E-MAIL	MEETING SCHEDULE	WEBSITES
Alabama	John C. Fraser	(256) 386-7499	None	Annual	
Arizona	William L. White	(602) 406-3466	busterwink@uswest.net	Spring, Fall	
Arkansas	Mark E. Linskey	(501) 686-5270	linskeymarke@exchange.uams.edu		
California	Thomas Hoyt	(916) 457-2267	drhoyt@hoytneuro.com	Annual	www.cans1.org
Colorado	John McVicker	(303) 788-4000	johnmcvicker@rmna.net	Spring, Fall	
Connecticut	Isaac Goodrich	(203) 781-3400	None	Annual	
Delaware	J. Rafael Yanez	(302) 674-9100	None	Q2-3 months	
Florida	Philip Tally	(941) 794-3118	ptally@aol.com	Fall	
Georgia	Gerald Kadis	(912) 226-8880	gkadis@rose.net	Spring, Fall	
Hawaii	Jon Graham	(808) 550-4939	jgraham@nettricitymd.com	Quarterly	
Idaho	Christian Zimmerman	(208) 367-3500	None	Informal	
Illinois	Patrick Tracy	(309) 676-0766	None	Annual	
Indiana	Jeffrey Crecellius	(765) 448-8000	crecelij@arnett.com	Annual	
Iowa-Midwest	John Treves	(402) 559-4301	J.Treves@Home.com	Annual	
Kentucky	John J. Guarnaschelli	(502) 584-4121	ngglsiwb@thepoint.net	Annual	
Louisiana	C. Babson Fresh	(318) 443-4576	None	Annual	
Maine	Thomas Doolittle	(207) 873-6615	None	Summer, Winter	
Maryland	Thomas Ducker	(410) 224-0545	None	2-4 times per year	
Michigan	Murali Guthikonda	(248) 569-9467	MGuthikonda@neurosurgery.wayne.edu		
Minnesota	Fredric Meyer	(507) 284-5317	witts.marylin@mayo.edu	None	
Mississippi	Philip Azordegan	(601) 354-8895	zsozso@bellsouth.net	Spring	
Missouri	David F. Jimenez	(573) 882-4908	jimenezd@health.missouri.edu		
New England Neurosurgical Society	Robert Harbaugh	(603) 650-8732	robert.e.harbaugh@hitchcock.org	Annual, Fall, Winter	
New Jersey	Edward Zampella	(973) 635-2597	drzampella@msn.com		
New Mexico	Erich Marchand	(505) 988-3233	emarchand@neurosurgerynm.com	PRN	
New York	Paul Spurgas	(518) 377-2642	SpurgasP@shine.org		
North Carolina	C. Scott McLanahan	(704) 376-1605	None	Annual	
Ohio	Alan Cohen	(216) 844-5741	alan.cohen@uhhs.com	Annual	
Oklahoma	Robert Remordino	(405) 748-3300	stanp@neurosurg.org	1-2 times per year	
Oregon	Edmund Frank	(503) 494-4314	franke@ohsu.edu	None	
Pennsylvania	Robert Rosenwasser	(215) 928-7004	rosenwal@jeflin.tju.edu		
Rhode Island	Beverly Walters	(401) 421-4703	Beverly_Walters@brown.edu		www.rinsonline.com
Tennessee	Clarence Watridge	(901) 260-0712	_mpannell@semmes-murphey.com	Annual	
Texas	Haring Nauta	(409) 772-1500	hjnauta@utmb.edu	Annual	www.texmed.org
Utah	Bryson Smith	(801) 479-9119	brysonsmithmd@earthlink.net		
Virginia	Anthony Caputy	(202) 994-2210	neuase@gwumc.edu		
Washington	Timothy Steege	(206) 623-0922	tsteege@aol.com	None	
Wisconsin	Spencer Block	(414) 438-6500	mniinfo@execpc.com		

CSNS News

Continued from page 10

Patient's Bill of Rights. In his bill, individuals in his district were solicited regarding their opinions to craft this compromise bill. The bill appears to have an excellent chance of passing the House and Senate and getting the President's signature. A neurosurgeon who lives in Dr. Fletcher's district has been an active participant in his campaigns and, in working with him, has had reasonable access to issues important to neurosurgery.

The conference adjourned to another reception, and participants heard from Congressman John Shimkus who spoke about the Patient's Bill of Rights and its current status on Capitol Hill. He further spoke about regulatory relief, one of the issues dear to the heart of many surgeons. Many foolish rules and regulations encumber physicians when trying to work and take care of their patients so some "high-schooler" can come and check off dots on your evaluation and management documents.

Regulatory relief will allow reimbursement for efforts recognizing how much training, thought, and skill were placed into the evaluation. Many understand physicians can perform an evaluation of a serious medical condition in minutes, depending on the situation, such as a bleed into a pituitary tumor with rapid loss of vision. The neurosurgeon is not going to spend hours doing a review of systems of the pancreas or liver. The surgeon is going to get the patient as quickly and safely as one can into an operating room and decompress the pituitary clot and chiasm so the person does not lose vision. Those decisions are critical and should be reimbursed even though they take but minutes, not hours. Therefore, regulatory relief is an important area for neurosurgeons, and this was one of the areas to be stressed on Capitol Hill as well as EMTALA reform. The attendees were given detailed instruction on neurosurgery's position by the Washington Office, specifically Katie Orrico. Ms. Orrico did an excellent job preparing all 80 neurosurgeons for their personal visits to their senators, congressional representatives, or health care staff.

The following day, I and the other participants had the personal experience of visiting our congressional representative's offices. I and my partner, Dr. John Treves, visited both of our senators' offices, meeting with their health policy staff. The congressman in our area and his health policy staff were not available. We did forward letters to him stating that we were sorry we missed him, and I subsequently received a call from his office. The health policy staffer in Senator Hagel's office was a bright, talented young lady who paid close attention to our issues in relationship to EMTALA, regulatory relief, the Patient's Bill of Rights, and support for the Fletcher Bill in the House. In Senator Nelson's office, we met another member of the health policy staff, a young man, who was receptive and listened to us. He was sympathetic, particularly in the area of regulatory relief to which both our senators in Nebraska have already signed on as cosponsors.

On reviewing the comments of the neurosurgeons who participated in the Neurosurgery Leadership Development Conference, discussing the usefulness of it and whether we need to continue the conference there, there was uniform support for continuing this effort. The effort will be to identify individual neurosurgeons in each state and congressional district that could be a liaison to each senator and congressperson so that neurosurgery can get the information regarding our position on specific issues to these legislators. The next step is to develop a relationship as a person they look at as someone who works, pays taxes, and votes in their district. They are more willing to communicate with you and pay attention to you if you are in this position, rather than a lobbyist who is hired by a group to come and talk to them. I think that is the critical lesson I personally learned through the leadership development conference.

Organized neurosurgery needs a neurosurgeon to be in touch with each single senator and congressperson in the United States so that the Washington Committee can prepare people to communicate with them on issues important to neurosurgery and sometimes vital to the preservation of the practice of neurosurgery. The CSNS hopes to have the ongoing support of the CNS and the AANS to continue this meeting under the direction of the Washington Committee and the Council of State Neurosurgical Societies. I see it as a vital effort for all practicing neurosurgeons.

ATRA Liaison Report

W. Ben Blackett, M.D., J.D.

The American tort reform association (ATRA) was formed in Washington, DC, in 1986 to advocate for improvements in American tort law. Tort law in the United States is constantly changing–driven by public attitudes, judicial philosophy, and incessant nudging by both the plaintiff and defense bars. The impetus to founding ATRA was pragmatic, although legal theorizing was in the background. Throughout the 1960s and 1970s, appellate courts had expanded theories of liability and causes of action. The plaintiff bar (represented by the American Trial Lawyers Association [ATLA]) had also become much more aggressive politically. Negligence and proximate cause (once strictly required for recovery in tort) had declined in importance and were being discounted by a theory that where there was an injury, the party most able to pay should pay regardless of degree of fault. Tort law appeared to be undergoing a transition toward a specie of social insurance (which had advanced considerably further in certain states than in the federal courts). ATRA saw its mission as restoring balance and bringing greater fairness to the tort laws of the United States and of its various states.

The California MICRA legislation of 1975 exemplifies an early response to the medical malpractice litigation crisis of that time and place. There gradually developed a number of organizations that focused on specific reforms, but it became clear that most organizations were too small to be politically effective by themselves. Most of the successful tort reform efforts had been the product of coalitions of organizations, each with its own particular reform agenda. The initial efforts were in the state legislatures, and (as in California) there were some notable successes, which had yet to be challenged in the state appellate courts. By the mid-1980s, the established tort reform groups in the states and the fewer national counterparts generally concentrated upon the agendas of specific interest groups. It was during this period in 1986 that ATRA was founded with the promise of offering the various states and the more narrowly focused national groups a single large parent organization.

During 1991 and 1992, the AANS was engaged in a strategic planning review, which, among other things, involved opinion sampling from the membership. Among the conclusions of the sampling and of focus groups was a consensus that marginal medical malpractice lawsuits without merit were among the major problems facing neurological surgeons in most parts of the country (needless to say, neurological surgeons were not alone and shared this concern with most other physicians). One of the decisions made by the AANS Board of Directors in 1992 from the strategic planning discussions was to accept an invitation to be represented on the ATRA Board of Directors. The AANS/CNS have been continuously represented on the ATRA Board of Directors since 1992. The CSNS has been represented on ATRA since 1999.

ATRA is made up of over 300 members, including professional organizations such as AANS/CNS, large and small businesses, municipalities, and service and charitable organizations. Although the members obviously have varying priorities, collectively they have backed both generic and specifically focused reforms. There has been an overriding unity of purpose of the ATRA membership during the 10 plus years that I have been a board member. This has obviously required some periodic give-and-take and recognition of the common goal. There needs also to be recognition by all of the constituent members that there will probably not be a "final victory." Nearly all of the tort reforms that have been proposed would have as a side effect some diminution of plaintiff attorney incomes. The plaintiff bar is well financed, and tort reforms are a pocketbook threat to them. They do not take kindly to proposals that threaten their incomes, and no one realistically expects them to acquiesce. The tension between tort reform advocates and the plaintiff bar will continue into the foreseeable future. The sometimes forgotten party in all of this conflict is the general public, which pays a "tort tax" as a percentage of everything that is purchased. Much of what ATRA does is to educate the public about the benefits of greater efficiency and fairness in dispute resolution.

The recently amended ATRA by-laws limit the terms of directors, and I will leave the ATRA Board sometime in 2002. I strongly recommend, however, that AANS, CNS, and CSNS maintain membership in ATRA. It is in our best interests as well as ATRA's that we do so.

State Society Corner

William E. Bingaman, M.D. and Ann Warbel, R.N.

The **Colorado Neurosurgical Society** held its June meeting in Manitou Springs on June 6, 2001. Dr. D. James Sceats reported on the election of new officers. John McVicker was elected President. D. James Sceats is Vice-President. Adair Prall is the Secretary/Treasurer. The next meeting is scheduled for September 12, 2001 at the Cherry Hills Country Club.

The **Georgia Neurosurgical Society** held its spring meeting at The Cloister, Sea Island, Georgia. The scientific meeting included presentations on various research, patient management, and socioeconomic topics from surgeons around the state. The Honored Guest Presentation was provided by Dr. Ali Rezai on brain stimulation and functional brain imaging.

Election of new officers also took place at the meeting. Gerald Kadis was elected President. President-Elect is Ann Marie Flannery. Secretary/Treasurer is Nelson M. Oyesiku.

Dr. Gerald Rodts submitted the following report from this meeting:

"Dan Suh was awarded the Resident Award for his paper titled 'Delivery of Recombinant Human Bone Morphogenetic Protein-2 (rhBMP-2) Using a Compression Resistant Matrix in Posterolateral Spine Fusion in the Rabbit

and in the Non-Human Primate. Authors: Suh DY, Boden SD, Louis-Ugbo J, Mayr M, Murakami H, Kim HS, Minamide A, Hutton WC.'

In this study, the effectiveness of using a ceramic carrier for bone morphogenetic protein was proven. In the form of biphasic ceramic phosphate granules (BCP), this ceramic implant was proven to effectively carry the fusion protein rhBMP-2 to the posterolateral region in rabbit and rhesus monkey fusion models. The BCP carrier is more resistant to compression than the previously tested collagen sponge and proved to achieve successful bone fusion that was biomechanically stiffer than fusion with autograft bone. Furthermore, the space maintained for the fusion was superior to that obtained with compressible collagen sponge carriers.

The excellent study design, scientific methods, and rigorous analysis were unanimously graded as most superior of the potential resident papers. Also, because of its very important clinical relevance to the practice of spine surgery, we felt unanimously that it should receive the Spring 2001 Resident Award."

The **Florida Neurosurgical Society** has announced the first joint meeting with the Neurosurgical National Association of Cuba. The meeting is at the invitation of the president of the Cuban Association for the purpose of opening a scientific dialogue and beginning joint research projects. The meeting is scheduled for November 15–18, 2001 in Havana, Cuba. For further information, please contact Dr. Philip Tally, President of the Florida Neurosurgical Society at *ptally@aol.com* or (941) 795-0547 or fax (941) 761-0712.

The **North Carolina Neurosurgical Society** is planning its meeting for November 10 2001. Dr. Scott McLanahan writes "a Brain Tumor Symposium emphasizing newer techniques in brain tumor management is being planned by Dr. Tony Asher with participation from other Tarheel neurosurgeons and a guest speaker to be determined."

Upcoming Meetings

November 2001

10 North Carolina Neurosurgical Society
Grandover Resort and Golf Club
Greensboro, NC
Contact: Dr. C. Scott McLanahan
Phone: (704) 376-1605

15-18 Florida Neurosurgical Society Joint Meeting with the Neurosurgical National Association of Cuba
Havana, Cuba
Contact: Dr. Philip Tally
Phone: (941) 795-0547
E-mail: *ptally@aol.com*

21 Connecticut Neurosurgical Society
New Haven, CT
Guest Speaker: Michael Apuzzo
Contact: Dr. Isaac Goodrich
Phone: (203) 781-3400

January 2002

18-20 California Association of Neurosurgeons (CANS)
Renaissance Park 55 Hotel
San Francisco, CA
Contact: Janine Tash
Phone: (916) 457-2267
E-mail: *Jt4ns@aol.com*

April 2002

18-20 Texas Association of Neurosurgeons (TANS)
Adam's Mark Hotel
Dallas, TX
Contact: Melissa Wilson
Phone: (512) 370-1566
E-mail: *melissa.wilson@texmed.org*

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JOINT SECTION ON NEUROTRAUMA AND CRITICAL CARE

Chairman's Report

Ross Bullock, M.D., Ph.D.

There has been substantial activity within the AANS/CNS Section on Neurotrauma and Critical Care during recent months. By the time this newsletter goes to press, every neurosurgeon in the United States should have received a mailing containing information intended to facilitate the negotiation of reimbursement contracts for emergency room coverage in their hospitals. The mailing includes background information to this issue, an overview of EMTALA and COBRA laws governing emergency room coverage, and the Position Statement of the AANS/CNS on this issue. We have also included a sample of CPT codes for neurotrauma procedures and sample contracts which may be modified to suit the circumstances of individual physicians.

The Trauma Section Executive Committee thought that this would be one of the most powerful measures by which the quality of neurotrauma care for patients with head and spinal injuries could be improved, while at the same time substantially improving the practice circumstances for individual neurosurgeons. The Trauma Section Executive Committee is keen to obtain feedback from neurosurgeons who have practical experience with negotiating such contracts with hospitals and emergency rooms so that useful information can be shared as it becomes available in this rapidly changing area.

We recognize in particular that such contracts will be especially difficult to negotiate within the context of large teaching hospitals. In such environments, residents are usually the first responders to the emergency room, and residents are frequently paid by the hospitals themselves, rather than by the neurosurgical group practice. Nevertheless, the demands upon the time of the academic neurosurgeon to provide optimal neurotrauma care in accordance with federal requirements are considerable. Such commitments include resident supervision, numerous patient care quality audit meetings, and teaching commitments to trauma-affiliated groups such as EMS personnel, emergency room staff, and trauma surgeons in training, to name but a few.

Furthermore, academic neurosurgeons in large teaching hospitals that provide care for uninsured patients will carry a far larger trauma load than those working in purely private practice. When teaching institutions receive state stipends to cover indigent care, neurosurgeons need to factor this aspect into neurotrauma coverage negotiation.

ICP Monitoring

Recent surveys have shown that only 40% to 50% of those head-injured patients who would benefit from ICP monitoring are actually being monitored in intensive care units throughout the United States. Although the reasons for this low rate remain unclear, increasing the amount of ICP monitoring would both increase the quality of care for head-injured patients and also improve remuneration for neurosurgeons.

Since the *Guidelines for the Management of Severe Head Injury* recommended ICP monitoring, a variety of other non-neurosurgical groups, such as trauma surgeons and critical care medicine physicians, have expressed interest in performing these procedures. If this were to begin to take place, then neurosurgeons may have their leadership role in the care of the head-injured patient eroded irrevocably. Unfortunately, many neurosurgeons are already fully committed within their practices and find the prospect of taking on more ICP monitoring to be unappealing.

It is my *personal view* that the logical alternative route for neurosurgeons to take under these circumstances is to train and encourage suitably qualified individuals such as nurse practitioners and physician assistants (in the same way that those of us in academic hospitals train neurosurgical residents). In this way, ICP monitoring will be kept within the province of the neurosurgeon. If we are to move forward in this direction, the AANS and CNS need to show a leadership role in teaching not only insertion of ICP monitors, but also aggressive ICP management for head-injured patients. The Trauma Section is ready to undertake this.

The Case for "Supra-Regional" Severe Head Injury Centers in the United States

Recent surveys have indicated that of the approximately 900 hospitals throughout the United States that accept severely head-injured patients, about 50% refer such patients directly on to other centers and do not manage them. The increasing use of air transfer makes distance between centers a less important factor except in those very few head-injured patients who are acutely deteriorating from acute epidural or subdural hematomas.

It has also been shown in recent surveys that only about 50% of Level I trauma centers are fully compliant with the *Guidelines for the Management of Severe Head Injury*, reflecting the interest and expertise of their staff in the management of these demanding patients. Moreover, outcome has been shown to be better in centers that have residents in training, because severe head injury is highly demanding of resources and time, particularly as management plans become increasingly complex with adjunctive therapies such as decompressive craniectomy, experimental pharmacological therapies, and management of other concomitant systemic injury.

Many years ago, a survey of 7,912 head-injured patients in 41 hospitals clearly showed that the outcome of severely head-injured patients varies tremendously from center to center, ranging from 52% better than expected to 43% worse than expected. Quality of care is thus a major determinant of outcome. Moreover, recent declines in the overall incidence of severe head injury means that each center sees fewer patients. Like myocardial infarction and many other serious, acute medical conditions, severe head injury is managed best in those centers with high volumes of cases.

Collectively, therefore, these factors strongly suggest that neurosurgeons should consider establishment of "supra-regional centers" with a declared interest and special expertise in managing severe head and spinal cord injury. Such centers are relatively easy to identify already around the country. Such centers may need to upgrade their ICU bed availability in order to deal with increased case loads, and third-party payors will need to be reeducated regarding the justification for longer helicopter flight distances in order to give patients the best possible quality of care.

Who Wants to Be an EMTALA Surveyor?

(with apologies to ABC and Regis Philbin)

Thomas (don't call me Regis) Hoyt, M.D.

Welcome, ladies and gentlemen, to "Who Wants To Be an EMTALA Surveyor?" This is the game show where some lucky player may win the chance to apply to HCFA* for the job of EMTALA surveyor. If you answer all of the following questions correctly, you may send an application to the HCFA region of your choice. Won't HHS be thrilled to have a neurosurgeon in its employ!

Allow me to remind you of the rules of the game. You will be presented with a series of cases involving the transfer of emergency room patients from one hospital to another. As a neurosurgeon on emergency room call at the receiving hospital, you are to decide whether or not to accept the patients in transfer to your facility. Justifying your decision is very important. A number of possible responses to each scenario will follow. Select the single best answer. Many of these cases are based on genuine EMTALA complaints. Keep in mind HCFA's main criterion for review–"the best interest of the patient"–when answering. The correct answers are derived from existing EMTALA regulations and are based on actions of HCFA surveyors in prior audits. Are you ready to begin?

Case Number One

A 28-year-old male victim of a motorcycle accident presents to Elsewhere Community Hospital Emergency Room comatose and decerebrate, with cerebral contusions and a small subdural hematoma on CT scan. There are three neurosurgeons on staff at Elsewhere Community Hospital, but none are on call this night. At 11:00 pm you are called and asked to take this patient in transfer. You are not on staff at Elsewhere Community Hospital, but you are on call for the emergency room tonight at your parent facility.

A. You accept the patient in transfer.
B. You refuse to accept the patient because you are not on staff at Elsewhere Community Hospital.
C. You accept the transfer but plan to file a complaint with HCFA against the three neurosurgeons on staff at Elsewhere Community Hospital for not being available tonight.
D. You pull the telephone from the wall and throw it across the room.

Case Number Two

A 33-year-old male victim of an assault with a baseball bat to the head presents to Elsewhere Community Hospital Emergency Room lethargic, with right hemiparesis and a left frontal depressed skull fracture. The patient subscribes to an HMO for which you are not a provider. There is a neurosurgeon on-call at Elsewhere Community Hospital who is on the HMO panel, but after more than an hour of phone calls and pages, this neurosurgeon still cannot be found by his own emergency room. You receive a call from Elsewhere Community Hospital Emergency Room asking you to accept the patient in transfer.

A. You accept the patient in transfer.
B. You refuse to accept the patient in transfer because you are not on the

Continued on page 16

* HCFA has recently changed its name to CMMS. The acronym stands for the "Center for Medicare and Medicaid Service." Personally, I prefer the old name, "Hell Can Find Anyone."

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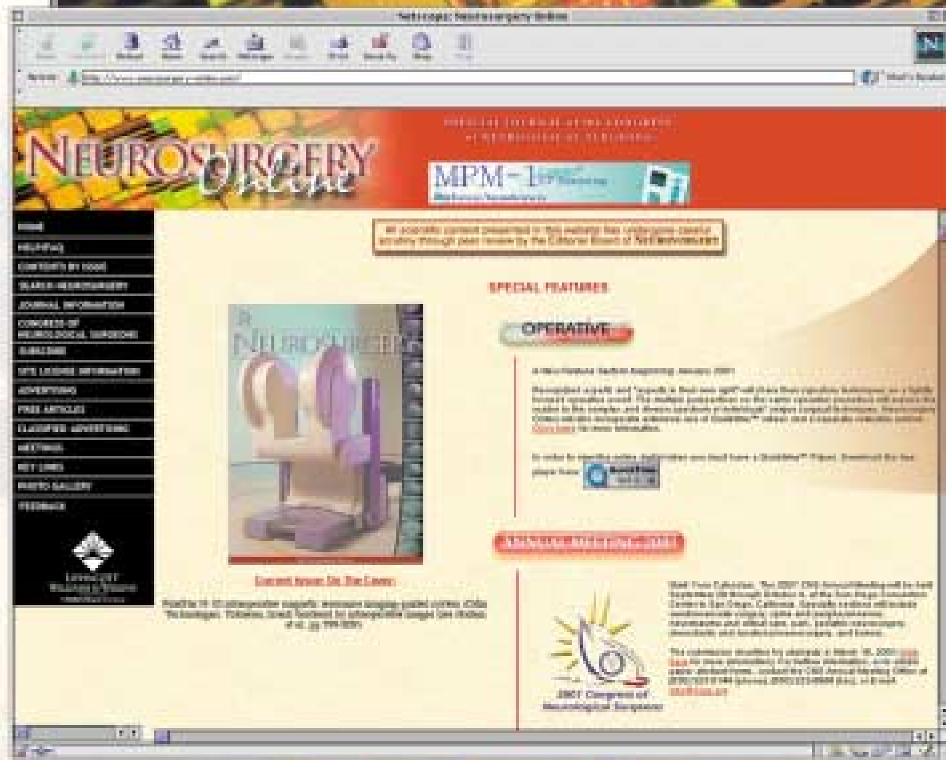

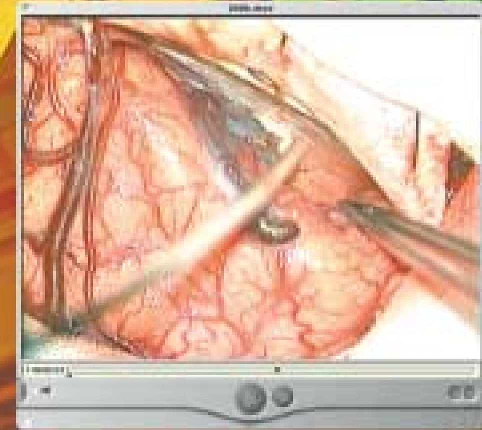

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Abstracts

Joint Section

Continued from page 14

patient's HMO panel.

C. You accept the patient and report the neurosurgeon at Elsewhere Community Hospital to HCFA as an EMTALA violation.

D. None of the above.

Case Number Three

A 75-year-old hypertensive female cardiac patient on Coumadin presents to Marginal Memorial Emergency Room comatose and hemiplegic, with a large intracerebral hemorrhage. Her cardiologist responds to the emergency room and then calls for a neurology consultation. There are no neurosurgeons on staff at Marginal Memorial Hospital. The neurologist advises that the patient be transferred to a hospital with a neurosurgeon. PT and INR reveal the patient to be fully anticoagulated. You have been requested to accept the patient in transfer.

A. You refuse the transfer, insisting that Marginal Memorial Hospital first reverse the effects of the Coumadin and call you back once the coagulopathy has been corrected. You explain to the ER physician that a craniotomy cannot be performed on a fully anticoagulated patient, but you will accept the patient once this problem is corrected.

B. You accept the patient "as is," planning to reverse the Coumadin yourself or call in a consultant.

C. You refuse the transfer altogether, stating to the ER physician that you consider the case to be hopeless.

D. You accept the patient and leave town before the patient arrives.

Case Number Four

A 22-year-old male victim of a rollover motor vehicle accident is found at the scene, having been ejected from the vehicle. He presents to the emergency room at Elsewhere markedly lethargic, with a Glasgow Coma Scale score of 5 and multiple contusions on head CT scan, as well as a fracture of C4. An Elsewhere Emergency Room physician calls you in a panic. The patient has not changed neurologically while in the ER. No chest x-ray has been done, hemoglobin is 9, blood pressure is 80/palpable with a heart rate of 120, and the patient is tachypneic. The emergency room physician, obviously inexperienced in neurosurgical trauma, calls you, panic-stricken, screaming that you immediately take the patient in transfer.

A. You accept the patient in transfer, telling the ER physician to expedite the transport as fast as possible.

B. You refuse the transfer, telling the ER physician not to call you again until he is more experienced and better able to control his emotions.

C. You refuse the transfer until the chest and abdomen have been properly assessed and the patient is stabilized.

D. The problem with society today is that too few people have proper telephone etiquette.

Is that your final answer?

Case Number Five

You receive a call from a general surgeon on staff at Marginal Memorial Hospital Emergency Room. He is seeing a 56-year-old male motor vehicle accident victim with compression fractures of T5 and T6. CT scan of the spine reveals simple compression fractures with no retropulsed fragments. The patient is totally normal neurologically, complaining only of localized pain to the thoracic spine. The hospital has three orthopedists on staff but no neurosurgeons on staff. The patient has a dropping hemoglobin and a positive abdominal CT scan and is in obvious shock. The surgeon suspects a ruptured spleen and calls you for advice regarding the thoracic spine fractures. You offer suggestions for management of the thoracic spine and advise the surgeon to proceed with an exploratory laparotomy. Later the surgeon calls you back. He has done the operation, taken out the spleen, and successfully stabilized the patient. Now what do you advise him to do?

A. Offer the surgeon suggestions for treating the patient at Marginal Memorial Hospital, assuring him you will take the patient in transfer if he becomes uncomfortable with management.

B. Ask the surgeon to send the patient to your office tomorrow.

C. Suggest that one of the orthopedists at Marginal Memorial Hospital see the patient.

D. Tell the surgeon to send the patient to you in transfer.

You can call your lifeline now.

Case Number Six

You are in the operating room of your hospital performing a craniotomy for brain tumor. You are using computer-assisted neuroimaging and plan to use a microscope. Unfortunately for you, you are on call for your own hospital's ER. You are starting to open the dura when you receive a call from Elsewhere Community Hospital Emergency Room requesting to transfer a patient to you. They have a 19-year-old female victim of a motor vehicle accident who is comatose, decerebrate, with a fixed pupil and obvious epidural hematoma on CT scan. She was initially conscious upon arrival to the Elsewhere Emergency Room. Your partner is out of town, and you have no neurosurgical backup. What do you do?

A. Accept the patient in transfer despite the fact that you are scrubbed in on another case.

B. Because this is a true neurosurgical emergency where time is of the essence, direct the ER physician to bypass you and call a different hospital.

C. Have your circulating nurse tell the ER physician that you are on a plane to Hawaii.

D. None of the above.

It may be time to poll the audience.

Case Number Seven

You are not on call. Your name is not listed on the on-call roster. No neurosurgeon is listed as being on-call for the emergency room today. A call comes from your own emergency room asking you to come and see a 72-year-old female who fell and fractured C2. Her primary physician is a good referring source to you and also happens to be one of your golfing partners. The primary physician asks the emergency room physician to call you about the patient. For various reasons, you decide to respond, see the patient in the emergency room, and subsequently admit the patient to the hospital. Later that night, at 11:30 pm, the emergency room calls you again. This time they have a 58-year-old, unassigned homeless person, intoxicated, who has been struck by a car while staggering into the street. He has a Glasgow Coma Scale score of 5 and a small subdural hematoma. What do you do?

A. Get out of bed, dress, and drive to the hospital to admit the patient.

B. Refuse to go to the emergency room because you are not on call.

C. Tell the emergency room you will be happy to see the patient, provided a check for $1000 is stapled to the patient's gown.

D. Tell the emergency room that they have mistaken you for your twin brother, and, in fact, he's really the one they should be calling.

E. Suggest that Neurology admit the patient.

Do you want to go 50/50 on this one?

Case Number Eight

You have been on call for the emergency room by yourself for the entire weekend. You have been extremely busy. There have been five neurosurgical admissions to the ICU–three with intracranial pressure monitors–and all five cases are on ventilators. Saturday night you never went to bed because you were doing emergency surgery all night. It is now 10:00 am Sunday morning, and you are dragging yourself through ICU rounds. Marginal Memorial Emergency Room calls, wanting to transfer to you an 80-year-old female patient with a large hypertensive hemorrhage. She is already intubated and is receiving labetalol to control her hypertension. What do you do?

A. Accept the patient in transfer.

B. Refuse to accept the patient because you are not on staff at Marginal Memorial Hospital.

C. Refuse the patient, stating you are overworked with your present patient load. Make the point that all the patients will suffer, including the transfer, if you accept it.

D. Call your brother-in-law to come in from home to help you manage these patients (although he sells swimming pools for a living, he is a quick learner).

Is that your final answer?

Change papers with your neighbor and compare his or her responses to the correct answers below.

Answers:

1–A	4–C	7–A
2–C	5–D	8–C
3–B	6–B	

Each case illustrates a number of important points that are emphasized below.

Case Number One: You are obligated to accept in transfer patients from other emergency rooms when you are on call. However, HCFA requires 24/7 emergency room coverage only when four or more members of a specialty are on staff at a given hospital. If three or fewer neurosurgeons are on staff at a hospital, HCFA allows for gaps in the call schedule. It is allowable, therefore, that no neurosurgeon was on call at Elsewhere Community Hospital the night in question.

Case Number Two: Your obligation to accept patients in transfer extends to all patients regardless of managed care affiliations and of ability to pay. If you believe that an EMTALA violation has occurred, you are obligated to report the incident. However, because the best interests of the patient come first, you must accept the transfer.

Case Number Three: A screening examination of the patient must take place at the sending facility, and the patient must be safe enough to transport. It is not required that the patient be stable enough for surgery prior to transfer.

Case Number Four: You probably have had to deal with inexperienced, emotionally charged emergency room physicians in the past. The patients are

usually better off in your care. The problem here is that the patient might die en route. Aside from being unstable and in shock, the required screening examination was incomplete. Prior to transfer, the patient needs to be stabilized, with the chest and abdomen fully evaluated.

Case Number Five: Provided the surgeon is reliable and not interested in filing a complaint, answers A and C would also be correct. However, an audit by a HCFA surveyor was conducted of this case years later. He determined this to be an EMTALA violation despite the fact that no complaints were filed by anyone involved. Remember that when a HCFA surveyor conducts an investigation, he is empowered to research past cases to look for additional violations.

Case Number Six: Considering the best interests of the patient, she should be managed elsewhere. You could be hours in the operating room while the patient herniates in your emergency room. Keep in mind, however, that you will probably be reported to HCFA. The HCFA surveyor will probably examine the hospital operating room log to verify your alibi.

Case Number Seven: This one is a bit tricky. According to EMTALA rules, if you go to the emergency room to see a patient, you have de facto placed yourself on call for the remaining call period. From that point on, you must respond to the emergency room and accept transfers as if your name was on the call roster. Perhaps you should reconsider the way in which you help your golf partners. It might work better if you convince the primary physician to admit the patient, and you consult later. Seeing one of your own patients in the emergency room is an exception to this rule.

Case Number Eight: HCFA will frequently accept physician fatigue as a legitimate reason for refusing a transfer. It is acknowledged that overloading a neurosurgeon with sick patients can adversely affect patient care. To remain consistent, you must cease admitting patients from your own hospital emergency room as well as others. Be prepared to justify your action in the event of an investigation.

When dealing with EMTALA issues, it is largely a "rule of men" rather than the "rule of law." The HCFA surveyors and OIG investigators have tremendous latitude when judging whether or not a complaint has merit. As such, please consider this article to be a helpful guide, not a detailed review of law and statute.

I apologize to the reader, as well as to ABC, for my poor imitation of a prime time TV game show. Last month, I contacted the AANS and CNS, asking them to set aside a million dollars in prize money to be awarded to those of you with perfect scores. For some unexplained reason, my letter was not answered.

Those of you with perfect scores are more than qualified to be EMTALA investigators. A job with HCFA is not such a bad consolation prize.

Did Troy Aikman and Steve Young Retire Too Soon?

Julian E. Bailes, M.D.

The recent retirement of two of the National Football League's greatest quarterbacks has served to keep the problem of cerebral concussion in the spotlight. Troy Aikman, the six-time Pro Bowler who led the Dallas Cowboys to three Super Bowl victories and holds most of the Cowboys passing records, announced in April that he will retire from football. After 12 seasons and 10 concussions, including two during an 11-game 2000 season, he decided to end his Cowboy, and presumably professional, career. As a Pittsburgh Steeler team physician, I, along with Joe Maroon, watched from the sideline as Troy's exceptional intelligence and passing talents methodically dismantled the Steelers to win Super Bowl XXX in 1995. In the 1999 season, Steve Young played in only three games after suffering his fourth concussion in 3 years. He subsequently retired from the San Francisco 49ers, ending a 13-year career during which he had won numerous awards and accolades, including seven consecutive Pro Bowl appearances, Player of the Year, Most Valuable Player in Super Bowl XXIX, and the highest single-season rating for NFL quarterbacks. Because of his series of concussions and their aftermath, it is assumed that the risk of cumulative effects of head injuries was the biggest factor in his decision to retire.

It has been estimated that approximately 120 concussions occur annually in NFL games, a number that is likely to underestimate the additional head injuries that occur during preseason training camp and during practice sessions during the season. The number of major or catastrophic head injuries has remained relatively small, with an average of 4 (range, 0–7) deaths each year in organized football in the United States. However, the more prevalent brain insult is the minor head injury or concussion, which has been variously estimated to occur in 4% to 19% of football players, with a current projection of approximately 5% of football players annually sustaining a cerebral concussion (Bailes JE, Cantu RC: Head injuries in athletes. *Neurosurgery* 48:26-46, 2001).

There are three primary issues involved with head injuries in football players or, for that matter, in any athletes. First, there is always the potential for a life-threatening hematoma causing brain herniation. Though uncommon, this possibility must be considered in every downed athlete.

Second, if return to the game occurs prematurely, there may be significant impact upon the athlete's playing ability, school performance (in the case of a scholar-athlete), and his or her very life. The return to contact sports must occur only after the athlete has become asymptomatic, with a normal neurological examination and normal level of functioning. Numerous ancillary tests are currently at our disposal to assist in making such a return-to-play decision, including MRI scanning, neuropsychological testing, postural assessment, and studies of brain metabolism. The second-impact syndrome is a rare but usually fatal phenomenon in which a second, often relatively minor, head impact occurs in a player who has not totally recovered from the effects of an earlier minor head injury, leading to irreversible brain engorgement and edema. This unusual condition must always be kept in mind by those physicians and athletic trainers who attend to athletes participating in contact sports.

The last major issue regarding head injuries in athletes, and perhaps the most difficult one to discern, is the long-term effect on brain functioning and future well-being of the athlete after retirement. Relatively little has been known until recent years. The plights of several professional athletes have shed light upon life after football, including the potential for multiple concussions to have severely deleterious effects. This phenomenon was the subject of a cover story in a recent issue of *Sports Illustrated* (Nack W: The Wrecking Yard. *Sports Illustrated*, May 7, 2001, pp. 61–75). In this report, postconcussion syndrome was cited as one of the most common and troublesome maladies among former players, many of whom suffered from headaches, forgetfulness, blurred vision, and difficulty with mental tracking.

Few studies have attempted to assess the chronic effects of repetitive minor head injuries on long-term cerebral function. Our study of 1,200 retired professional football players, performed in conjunction with the NFL Players Association, showed that, in comparison to age-matched controls, a higher percentage of former players are living with ongoing problems affecting memory, personality, intellectual performance, and chronic headaches (Jordan BD, Bailes JE: Concussion history and current neurological symptoms among retired professional football players. Presented at the 52nd Annual Meeting of the American Academy of Neurology, San Diego, CA, May 2000).

Did Troy Aikman and Steve Young retire too soon? From my perspective as a distant but educated observer, the answer is no. Current data, although limited and experiential, seem to indicate that today's players, as the cliché goes, are certainly bigger, stronger, and faster, and they inflict ever-increasing impact loads during the course of hitting and tackling. Playing quarterback in the NFL is among the most dangerous positions in all of sports because of the need to constantly and repetitively sustain jarring blows and absorb the kinetic energy of numerous pursuers. If it came down to betting our brains, most of us would probably err on the side of leaving the game perhaps a bit too early, for as we know, you can ice the ankle, but not the brain. I think they made the right decision. □

WFNS NEWS

From the Editor

Dr. Eduardo A. Karol
http://www.wfns.org

It has been a great honor, pleasure and responsibility to serve you as Editor of the World Federation Neurosurgical Societies (WFNS) for this 4-year period (1997–2001).

I am grateful to both Dr. Patrick Kelly who initially hosted the Web site of the WFNS and Dr. Alon Mogilner who acted as our Webmaster. Shortly thereafter, with the cooperation of Mundo21 we were fortunate enough to be able to professionally redesign the Web pages and develop multiple sections in the hope of being useful to our members as well as attempting to extend to the Web site the educational and communicational objectives of the WFNS.

Throughout this period, I counted on the permanent help of Dr. Manuel Dujovny, who provided his generous advice. We were able to develop and update specific sections listing the objectives of the WFNS, member societies and delegates, and reports from the President and Chairman of the Education Committee. A new Registration Page increased the newly created E-mail Directory to about 6,000 addresses

The Web pages also list details on a most impressive project "The Basic Set of Neurosurgical Instruments" initiated by Dr. Madjid Samii, the President of WFNS, with the invaluable cooperation of Aesculap in an attempt to improve and make neurosurgery avail-

Continued on page 18

WFNS News

Continued from page 17

able in some of the most remote corners of the world. Another important initiative of Dr. Samii was the creation of the WFNS certificate available to all members of the WFNS for the cost of $100 (U.S.). Details about on how to obtain the certificate are now available in the same section.

A section on training programs in the United States and Canada as well as in other parts of the world is being constructed.

A major development, the Young Neurosurgeons Forum, was created by Dr. Edward Laws, with a special Section on the Web site as well as in the new interactive Neurosurgical Forum. We have been fortunate enough to count on the excellent CPCs provided by Dr. Peter Black and original articles on neuroscience for neurosurgeons from Dr. Dubrovsky in an attempt to stimulate the academic interest of our young neurosurgeons.

Subspecialty sections in the Forum are being developed by dynamic young neurosurgeons such as Dr. Goel, who is developing the section on skull base, and Dr. Sekhon, who is handling the Forum on spine as well as the section on congresses, which is becoming comprehensive. We are grateful to the many different authorities, members of our societies, and personal friends who have provided detailed information on the neurosurgical activities in their own areas. All Young Neurosurgeons handling specific sections in the Forum will act as associate editors, counting on the supervision and advice of the most renowned experts in each area.

Dr. Federico Viñas handled the Book Reviews section, which was recently modified to include multiple subspecialties. Dr. Fabian Cremaschi gathered data to make information available to more than 2,000 journals on neurosurgery, neurology, basic neuroscience, and allied disciplines, most of which have appropriate links.

Last, but not least, we are proud to announce that through the efforts of Dr. Armando Basso, the first issue of the electronic version of *Critical Reviews in Neurosurgery*, the official journal of the WFNS, can be already accessed by clicking on the homepage.

We are grateful to the designers, programmers, and other technical personnel who are working on technical developments, skillfully guided by Tanya Alvarez.

I wish to thank the members of the WFNS for their confidence, Mrs. Jan Joseph for her patience and expertise, all the members and friends who helped me, and particularly my wife, Dr. Alicia Karol, who devoted much of her time and energy to push forward this project.

From the Chairman of the Young Neurosurgeons Forum

Edward R. Laws, Jr., M.D.

The first meeting of The Young Neurosurgeons Forum occurred Monday afternoon during the Sydney World Congress in September 2001. We had an extraordinary group of vigorous young neurosurgeons who moved forward with the various projects that had been recommended. The discussions fell into the following important categories:

1. Mentoring young neurosurgeons in developing areas
2. Web site activities for young neurosurgeons, including networking, case consultation, and subspecialty interest
3. Young neurosurgeon editors for Web site material pertinent to each of the subspecialty areas for which the World Federation has an acting committee. Currently these consist of the following: neurotraumatology, neuro-oncology, cerebrovascular surgery, skull base surgery, radiosurgery, pediatric neurosurgery, and stereotactic and functional neurosurgery
4. Assistance with maintenance and updating of the World Directory of Neurological Surgeons

A number of additional projects that the Young Neurosurgeons would like to initiate, were discussed at the time of the meeting. Those who wish to get started with Internet activities should feel free to contact Dr. Eduardo A. Karol, either through the WFNS Web site or with his direct e-mail address, which is *drkarol@cvtci.com.ar.*

From the Chairman of the Editorial Board of *Critical Reviews in Neurosurgery*

Armando Basso, M.D., Ph.D.

When Anthony Raimondi founded *Critical Reviews in Neurosurgery (CR)*, he aimed at distributing up-to-date information on neurosurgery as interpreted and commented by the most important experts worldwide. The goal was to rapidly get in touch with as many neurosurgeons around the world as possible.

In 1995, due to its special format, the WFNS decided to adopt *CR* as its official publication, with the objective of broadcasting actualized data at a lower cost throughout the world.

And now the WFNS has decided to advance a little further in this direction and facilitate *CR* in its original format to the international neurosurgical family, with the continuity of its Editorial Committee and without any extra cost, by taking advantage of this wonderful opportunity the World Wide Web is giving us.

Beginning in September 2001, you will find *Critical Reviews in Neurosurgery*'s site on the Internet as a quarterly publication.

We hope to be useful to everyone, and to honor Tony Raimondi, the founder of this publication, in the way he deserved.

Report of the Education Committee Chairman

July 1997–September 2001

Jacques Brotchi, M.D., Ph.D.

Neurosurgical education has always been one of the main goals of the WFNS, as shown in the past by my predecessors at the chairmanship of the education committee, Dr. A. Basso and Dr. J. I. Ausman, who both did an excellent job. When I took the position in Amsterdam, on the decision of the President of the WFNS, Dr. M. Samii, I was very enthusiastic with the challenge, and I did my best during the past 4 years to visit as many countries as possible and to make contacts for the future. I have introduced the concept "how I do it" in our first courses, with immediate success and requests for more from the attendees.

Education is dependent on the content of the scientific program, but also on the quality of the speakers. I must say that I have been delighted to welcome a constellation of highly distinguished neurosurgeons who delivered superb lectures. They should be commended for their excellent job and for their time and generosity to the WFNS program. I would like to remind everyone that all WFNS faculty members pay their own travel expenses when participating in courses.

I am deeply grateful to Drs. A. Atos de Souza, A. Antunes, M. Apuzzo, J. Ausman, A. Basso, P. Black, D. Bruce, A. Cheesman, M. Choux, E. de Oliveira, F. Diaz, C. Di Rocco, G. Dohrmann, N. Dorsch, W. Draf, F. Epstein, R. Fahlbusch, E. Fernandez, A. El-Gindy, A. El-Khamlichi, T. Hori, K. Kalangu, E. Karol, T. Kawase, Y. Keravel, S. Kobayashi, A. Konovalov, Ed. Laws, C. Liu, D. McLone, N. Martin, I. Nyary, R. Perrin, A. Potapov, P. Rabischong, I. Raja, H. Rekate, D. Rosenthal, G. Rosseau, M. Samii, C. Sainte-Rose, V. Sonntag, K. Takakura, R. Tasker, D. Thomas, F. Umansky, A. Valavanis, M. Walker, G. Walter, V. Zelman, M. Zerah.

I thank all for their support and participation in WFNS courses. A great part of the success of our courses should be credited to them.

Since the WFNS congress in Amsterdam, 12 courses have been organized with the help of local committees to whom I also express my most sincere thanks:

Santiago de Chile (Chile), Rasht (Iran), Tegucigalpa (Honduras), Harare (Zimbabwe), Istanbul (Turkey), Moscow (Russia), Gramado (Brazil), Blantyre (Malawi), Amman (Jordan), Singapore, San Jose (Costa Rica), Cordoba (Argentina).

The future, after Sydney, is already on the way with planned courses in:

- Belem (Brazil), October 2001
- Chennai (India), November 2001
- Bucharest (Romania), May 2002
- Abidjan (Ivory Cost), November 2002
- El Salvador, 2003

Last but not least, contacts are well engaged for future WFNS courses in Uruguay (2003), Saudi Arabia, China, Bangladesh, Hong Kong, Ecuador, Russia, and Kazakhstan.

My successor is inheriting an exciting program, but I am sure he will add new and superb courses around the world.

Education is one of the best investments for helping colleagues in developing countries, who face daily difficulties in performing quality neurosurgery, and who work very hard, sometimes in very bad conditions.

By leaving the chairmanship of the education committee, I would like to express my most sincere thanks to all the members of the WFNS Administrative Council for their confidence and support. I also want to thank everybody who helped me during these fantastic and unforgettable 4 years of my life.

Editor's Note: We welcome your comments and suggestions to Dr. Eduardo A. Karol. Please let us know your society's URL, if not previously provided. We welcome any information on journals and other pertinent information from your area to be included as a link within the WFNS Web site.

If you know of a colleague who didn't receive these two newsletters, please ask them to send their e-mails to Dr Eduardo A. Karol (drkarol@cvtci.com.ar) or to register on the Web site (www.wfns.org).

Dr. Eduardo A. Karol, Editor ☐

NEUROSURGERY Introduces

OPERATIVE Nuances

- A new and practical scholarly innovation -

- A concise guide for detailed refinements of operative technique -

Recognized experts and "experts in their own right" will share their signature techniques on a tightly focused operative event in this new section. The multiple perspectives on the same operative procedure will expose the reader to the complex and diverse spectrum of individuals' surgical techniques.

Submissions, solicited and unsolicited, will be peer-reviewed by the Operative Nuances panel headed by Robert Spetzler with J. Diaz Day.

Coupled with the print edition, NEUROSURGERY ***Online will include a special version of Operative Nuances. The internet edition will incorporate extensive use of Quicktime™ videos and a separate collective archive.***

OPERATIVE Nuances

Robert F. Spetzler, M.D., *Associate Editor*
J. Diaz Day, M.D., *Principal*

Operative Nuances Panel

Edward C. Benzel, M.D. Takanori Fukushima, M.D. Nobuo Hashimoto, M.D. Andres M. Lozano, M.D., Ph.D.
Albert L. Rhoton, Jr., M.D. Madjid Samii, M.D., Ph.D. M. Gazi Yaşargil, M.D.

For further information on article guidelines and submissions contact the NEUROSURGERY ***editorial office, Phone (323) 442-3001, FAX (323) 442-3002.***

OFFICIAL JOURNAL OF THE CONGRESS OF NEUROLOGICAL SURGEONS
NEUROSURGERY

PRESS RELEASE

Codman and Shurtleff, Inc. Announces the Formation of Codman Neuro Sciences Sàrl

Joint venture with Germany-based Tricumed Medizintechnik GmbH to focus on the development of implantable drug delivery systems for the neurological marketplace

Codman and Shurtleff, Inc., a Johnson & Johnson company, have announced that it has entered into a joint venture with Tricumed Medizintechnik GmbH of Kiel, Germany to form Codman Neuro Sciences Sàrl. Under the agreement, Codman Neuro Sciences Sàrl will acquire all intellectual property related to the design and manufacturing of Tricumed Medizintechnik GmbH implantable drug pumps. Codman Neuro Sciences Sàrl will be located in the Canton of Neuchatel, Switzerland.

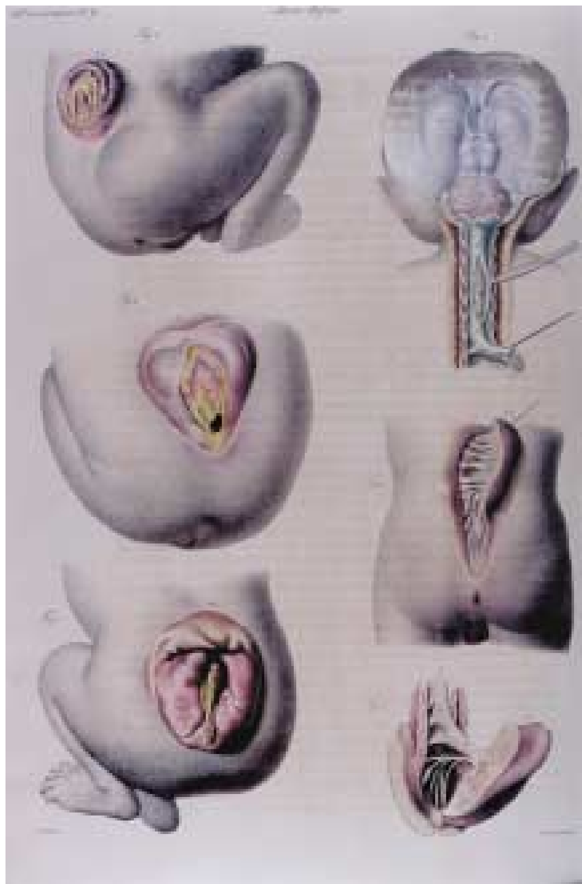
According to the manufacturer, the joint venture will be a platform for growth in one of the most rapidly expanding segments of the neurological market, implantable pumps for delivery of medication directly into the cerebrospinal fluid, which then routes drugs to the spinal cord and brain. Current indications for these systems include treatment of intractable pain and spasticity related to central nervous system injury or disease. The benefits include smaller dose requirements than for oral or systemic regimens, higher efficacy, fewer side effects, and enhanced compliance.

A board of directors has been appointed to lead the organization which will market and distribute the existing implantable infusion drug pumps as well as the future pump generations jointly developed by Codman Neuro Sciences Sàrl and Tricumed Medizintechnik GmbH.

Tricumed Medizintechnik GmbH is a limited liability company medical device company with expertise in the design and development of implantable constant flow and programmable pumps for intrathecal delivery of drugs.

Codman and Shurtleff, Inc, a Johnson & Johnson company, is based in Raynham, Massachusetts, and is a world leader in neurosurgical implants and surgical products.

For more information, please contact Leslee McGovern, Devine & Pearson, phone: 617-472-2700, email: *lmcgovern@devine-pearson.com*, or Debbie Williams, Director, Marketing Services, Codman & Shurtleff, Inc., phone: 508-828-3140, email: *dwillia2@dpyus.jnj. com.* □

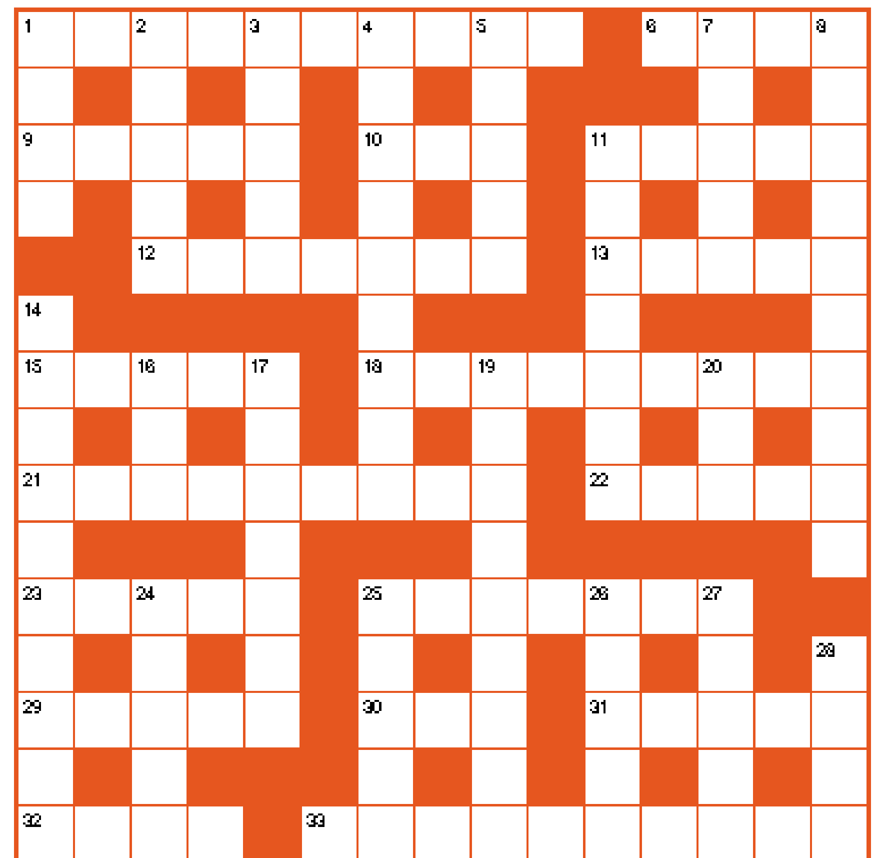


19th century illustration of spina bifida by Jean Cruveilhier, *Anatomie pathologique du corps humain, ou Descriptions, avec figures lithographiées et coloriées, des diverses altérations morbides dont le corps humain est susceptible.* Paris, Baillière, 1829-1842, vol. 1. (Courtesy, Rare Book Room, Norris Medical Library, Keck School of Medicine, University of Southern California, Los Angeles, California.)

CRYPTIC CROSSWORD PUZZLE

Cryptic Crossword Puzzle clues are composed of two parts: a straight definition, as a regular crossword would have, and a cryptic clue based on some sort of word-play (anagrams, charades, homophones, hidden words, etc.) leading to the same answer. Keys to solving them are to ignore punctuation, and to find the dividing point between the two parts of the clue.

Solution on page 22



ACROSS

1. Stereotactic radiosurgery is making fame in operation (5,5)
6. Indonesian island coffee (4)
9. Surprise in a labyrinth (5)
10. Certified physical therapist starts AMA reference book (3)
11. Low-grade Communist has one preserved (5)
12. Braised wild gull (3,4)
13. Limit of incoherent anger (5)
15. Prone to be dishonest (5)
18. Angel flies into Asia to fight pain (9)
21. Prisoner, not too bright, went to otolaryngologist for seasoning (9)
22. It's nice to have miserly-at-heart relative (5)
23. Jaded means to drill a hole down (5)
25. Galileo pardoned some big cat (7)
29. Wile E. Coyote's heavy-weight chorus (5)
30. Intravenous solution sounds fine for wall-climber (3)
31. Motto for commercial era (5)
32. Oral surgeon lost 1st to Depression (4)
33. Masculine rodent took New Testament to be evil (10)

DOWN

1. What a rodent does into foreign, awful meat (4)
2. Me and Sharpton's dinners (5)
3. An era rising to where the action was (5)
4. Can't tie it loosely in a blink (9)
5. Nauseating and sounded like someone had a party (5)
7. A legal claim against immigrant (5)
8. Confused twaddle Pat edited in part (10)
11. Horseshoe dust cloth in lair or patch (7)
14. Shortage of wild pig replaces little bit of everything in bed slate (10)
16. It's been charged to keep an eye on broadcast (3)
17. Wafer implanted with spatter from G.I. ladle (7)
19. Star cell disturbs Castro yet (9)
20. View electrical engineers south and north (3)
24. Poe protagonist in 30 across (5)
25. People I can see through optical instrument (5)
26. In the style of Missouri mission (5)
27. Doctor to copy curtain (5)
28. Fluorides first applied to skinless teeth are concern for podiatrists (4)

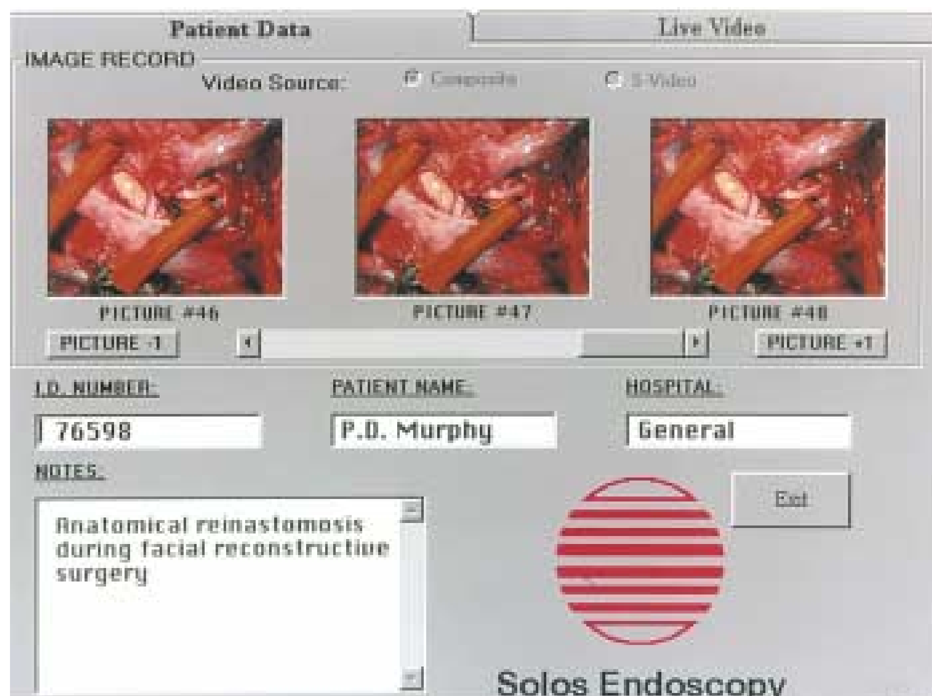
NEW PRODUCTS

Solos Endoscopy Introduces Advanced Digital Integration System

Solos Endoscopy has introduced an advanced system to provide high-resolution digital pictures of laparoscopic procedures, MRIs, x-rays, and other medical, dental, and microscopic images obtained from any standard one- or three-chip surgical camera.

According to the manufacturer, with the Digital Integration System 2000, images can be captured during surgery by pressing a foot pedal or by using the remote camera button on a video probe.

DIS2000 signal processing software converts both black and white, and color video signals obtained from any source into high-resolution digital bitmaps so anatomical structures can be viewed in detail. Up to 600 images can be permanently archived on a single CD where they won't fade.



Once captured on a CD by the DIS2000, these pictures can be viewed, annotated, printed, e-mailed, made into slides or incorporated into PowerPoint presentations at the doctor's convenience on a PC or laptop using the familiar Windows interface.

According to Solos President and CEO, Bob Segersten, "The DIS2000 is designed to make it easy for doctors and other medical professionals to write reports and document procedures and diagnosis with permanent high-definition computer images for future reference, insurance purposes, referrals, teaching and training."

Solos Endoscopy is a leading supplier of surgical cameras, light sources, and handheld instruments.

Solos is located at 14 Norfolk Avenue, South Easton, Massachusetts 02375. For more information, please telephone 508-230-5550; toll free 800-388-6445; fax: 508-230-5381; online at *www.solosendoscopy.com.*

Low Back Pain Patients Report Real Relief after Treatment with Compact Homestretch® Pneumatic Traction

Designed to provide lumbar patients with immediate access to relief when back pain strikes, the compact Homestretch traction bed is economical, pneumatically powered, and readily accessible. According to the manufacturer, an increasing number of physicians are prescribing this non-threatening pain management therapy device for use at home as well as in the clinical setting.

The portable unit weighs only 13 pounds yet provides lumbar patients traction control with minimal slippage, plus consistent pull up to 180 pounds (60 psi). A small and ergonomically designed hand pump, complete with pressure gauge and release valve, puts patients in control of their own traction.

This easy-to-operate unit simplifies the traction process and encourages regular use. With a few strokes on the compact hand pump, the patient supplies air pressure to an extender bar under the traction bed. A comfortable chest wrap keeps the patient securely in place while the extender slowly emerges from the foot of the bed and pulls on a wide strap that envelops the user's hips, creating traction on the lower back. The pump's release valve makes it easy for the patient to switch from controlled to intermittent traction.

The traction bed is 43″ x 16″ x 4″ and made of high impact FDA-approved ABS material. No assembly is needed. Stores easily under a bed or in a closet. Priced at half the cost of comparable lumbar traction devices, Homestretch comes complete with chest and pelvic straps, plus an air-pressure pump, gauge and release valve. The unit is shipped in a carrying/storage carton and comes with a 48-page manual of back-care guidelines and illustrated strengthening exercises for the lower back.

Registered with the FDA as a Class 1 device, Homestretch is a prescription product sold with an unconditional 30-day money back guarantee. Costs are covered by most major insurance companies, including Workers' Comp when used in the clinic as a modality. It may be billed under CPT code 97012 (manual traction) or 97140 (manual therapy techniques). Homestretch dealers deliver the unit to the physician's office or to the patient and process all related billing.

With products sold throughout the United States and Canada, Glacier Cross has been providing soft-as-air traction products to sufferers of low back and neck pain for more than twelve years.

For more information call 800/388-4828 or visit our Web site at *www.glaciercross.com.* ☐

CRYPTIC CROSSWORD PUZZLE IS ON PAGE 20

Solution key: 👂 homophone, * anagram, < inside of, > wrapped around

ACROSS

1. GAMMA KNIFE: MAKING+FAME *
6. JAVA: double definition
9. AMAZE: A+MAZE
10. CPT: double definition
11. DRIED: D+RED > I
12. SEA BIRD: BRAISED *
13. RANGE: ANGER *
15. LYING: double definition
18. ANALGESIA: ANGEL* < ASIA
21. CONDIMENT: CON+DIM+E.N.T.
22. NIECE: NICE > (mis)E(rly)
23. BORED: BORE+D(own)
25. LEOPARD: hidden
29. ANVIL: double definition
30. IVY: 👂 of I.V.
31. ADAGE: AD+AGE
32. DENT: DENT(ist) - (1st)
33. MALEVOLENT: MALE+VOLE+N.T.

DOWN

1. GNAW: hidden
2. MEALS: ME+AL'S
3. ARENA: AN+ERA reversed
4. NICTITATE: CAN'T+TIE+IT *
5. FETID: 👂 of FETED
7. ALIEN: A+LIEN
8. ADDLEPATED: hidden
11. DURAGEN: U+RAG < DEN
14. BLACKBOARD: LACK+BOAR < B(e)D
16. ION: 👂 of EYE ON
17. GLIADEL: G.I.+LADLE *
19. ASTROCYTE: CASTRO+YET *
20. SEE: E.E.+S reversed
24. RAVEN: hidden in (int)RAVEN(ous)
25. LEICA: hidden
26. ALAMO: A LA+MO
27. DRAPE: DR.+APE
28. FEET: F(luorides)+(t)EET(h)

CNS Internet Usage Policy

Christopher Wolfla, M.D.

The Congress of Neurological Surgeons (CNS) acknowledges that the Internet is a powerful tool for the worldwide collection and dissemination of information. As such, the CNS recognizes the importance of aggressive use of this medium to fulfill its educational, scientific, and humanitarian missions.

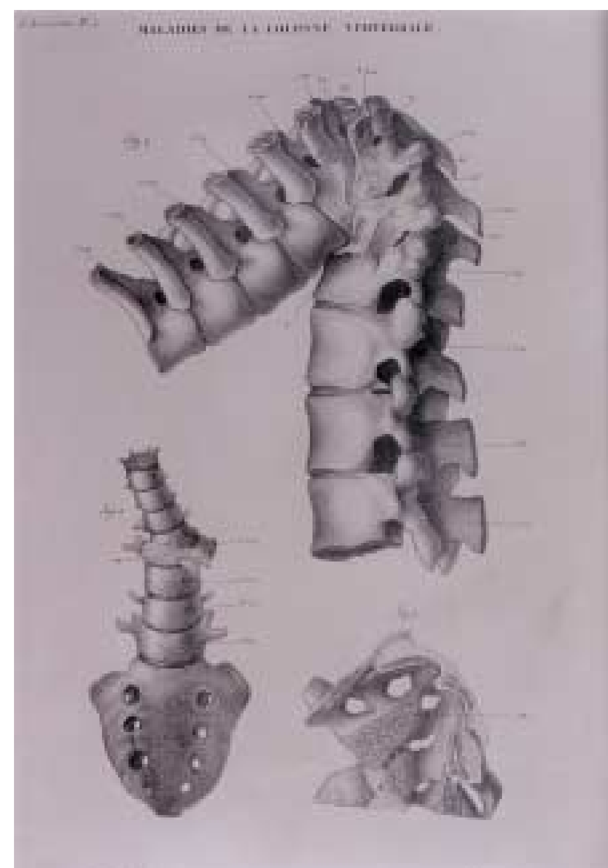
Because of the numerous opportunities for use and misuse of the Internet, the CNS also recognizes the importance of developing guidelines for its use of the Internet. These guidelines have been developed in ensure that the CNS uses the Internet only for the purpose of fulfilling its educational, scientific, and humanitarian missions.

With regard to Internet sites owned or operated by the CNS:

1. All material posted on the Internet by the CNS will be in accordance with the Code of Ethics of the CNS.
2. All material posted on the Internet will be in accordance with the educational, scientific, and humanitarian missions of the CNS.
3. The CNS will protect the privacy of individuals viewing material which has been posted for public viewing on the Internet on CNS sites, except where this policy would conflict with local, state, or federal law.
4. Advertising material will be allowed on CNS Internet sites, so long as this material does not conflict with the missions of the CNS or its Code of Ethics,
5. Advertising material will be clearly identified as such within Internet sites operated by the CNS.
6. Internet sites operated by the CNS will clearly post the following disclaimer: "The inclusion of a paid advertisement within an Internet site operated by the Congress of Neurological Surgeons does not constitute an endorsement by the Congress of Neurological Surgeons or its members."
7. Material posted on the Internet on sites owned or operated by the CNS, unless clearly identified as advertising material, will not result in, or be construed to result in, financial gain for any individual or group of individuals.
8. All materials posted on Internet sites owned or operated by the CNS are copyrighted property of the CNS and are not to be reproduced in any fashion without the expressed, written permission of the CNS.

With regard to Internet sites not operated by the CNS:

1. The CNS may contribute listings, content, and other material deemed appropriated by the Executive Committee to Internet sites not owned or operated by the CNS, so long as this action does not conflict with the educational, scientific, and humanitarian missions of the CNS.
2. The CNS may contribute listings, content, and other material deemed appropriated by the Executive Committee to Internet sites not owned or operated by the CNS, so long as this action does not conflict with the Code of Ethics of the CNS.
3. The CNS will protect the privacy of its members when contributing material to Internet sites not owned or operated by the CNS, except where this policy would conflict with local, state, or federal law.
4. Material posted on Internet sites not owned or operated by the CNS will clearly post the following disclaimer: "The inclusion of this material does not constitute an endorsement by the Congress of Neurological Surgeons or its members."
5. All material posted on Internet sites not owned or operated by the CNS is copyrighted property of the CNS is not to be reproduced in any fashion without the expressed, written permission of the CNS. □



Examples of bony destruction of the vertebral column. From, Jean Cruveilhier, *Anatomie pathologique du corps humain, ou Descriptions, avec figures lithographiées et coloriées, des diverses altérations morbides dont le corps humain est susceptible.* Paris, Baillière, 1829-1842, vol. 1. (Courtesy, Rare Book Room, Norris Medical Library, Keck School of Medicine, University of Southern California, Los Angeles, California.)

CLASSIFIED ADVERTISING

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Phone: 800-528-1843
Fax: 410-528-4452
E-mail: *jwilliam@lww.com*

MADISON, WISCONSIN

Dean Medical Center, a 400+ physician multispecialty group, is actively seeking a BE/BC Neurosurgeon with fellowship training in pediatric neurosurgery or a strong interest in pediatric neurosurgery to join their four member team. Approximately 30% of the patient population would be pediatric with 70% being general adult neurosurgery patients. Madison, population 200,000+, is the state capitol of Wisconsin, and the home of the University of Wisconsin (a Big 10 School). Madison consistently ranks as one of the best places to live in the U.S. due to its great lifestyle, strong economy, excellent educational and recreational opportunities. Excellent compensation and benefits are provided with employment leading to shareholder status.

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E-mail: slindblom@ssmhc.com

THE MONTANA NEUROSURGERY CENTER

Neurosurgery Position

If you enjoy the outdoors, respect a balanced lifestyle, and want to practice state-of-the-art **neurosurgery** in the **Rocky Mountains**, join us in our practice. We are actively seeking a board eligible or certified neurosurgeon who is as much a **partner** as a **friend**. Our new office is designed with a sophisticated atmosphere and services two local hospitals. Case distribution is broad, encompassing **cranial, vascular, complex spine, pediatric**, and **stereotactive** procedures including **radiosurgery**.

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Tel. 406-327-4290
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INSTRUCTOR

The Department of Neurological Surgery, College of Medicine, University of Florida is seeking a board certified/board eligible academic neurosurgeon for a position at the Instructor level. This position will offer a wide variety of opportunities for clinical care, teaching and research. Salary will be commensurate with experience, academic qualifications and publication record. Anticipated start date: January 1, 2002

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Department of Neurological Surgery
P.O. Box 100265
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Gainesville, FL 32610

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Editorial Profile

Neurosurgery News, a topical reader-friendly compendium of timely information, is designed to keep readers abreast of all the new and significant events in the field of Neurosurgery. *Neurosurgery News* offers the latest in research and clinical advances, socioeconomic issues, CNS membership information, CME credits and where to earn them, fellowship information, meeting and symposia dates, and more!

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