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NEUROSURGERY NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

President's Message

Stephen Papadopoulos, M.D.
President, CNS



A few years ago I operated on a patient that died suddenly 2 days after surgery. The surgery was a complex spinal procedure, but not "life threatening." The patient was a husband and father, proud of his children and devoted to his wife. He was my father's age. We spend a far amount of time together preoperatively reviewing treatment options, complexities of the proposed operative procedure, and all the requisite potential complications. I was confident.

To this day I remember the phone call. I immediately went to the hospital to meet a family numb and in shock. At that moment, I was unable to give them an explanation as to what had "gone wrong," as if that would somehow provide some comfort. I didn't sleep well that night; I didn't sleep well for several nights to follow. I was sure I had done something wrong. I was sure I missed something. I played it over and over in mind trying to find the "mistake." The autopsy was not very helpful, perhaps an arrhythmia. I spoke to his wife and children a number of times.

The whole experience has given me much to reflect upon. We as neurosurgeons are blessed with a phenomenal gift. Others may not enjoy our technical talent and abilities. I personally believe this gift is God-given and with a purpose. Our desire to be healers with compassion is at the soul of our profession. I also know that we are not perfect. But it is simply naive to believe that every complication or untoward outcome is a result of that imperfection. There is and always will be an element of the unknown and unexplained that speaks to the essential complexity of life itself.

We reviewed the case at the M&M conference the following month. My colleagues didn't have anything to add that I hadn't thought of already, except for one thing. They were sure I would get sued. I was sure I wouldn't. Three months later the paperwork arrived in my office by certified mail.

Going through the motions of a medical malpractice lawsuit was emotionally exhausting. The deposition was humiliating. I remember sitting in that room realizing I was the only one there sworn and obligated to share the truth. The plaintiff's attorney was allowed to propose any theory or supposition without any basis in reality or truth. In fact, the issues had little to do with the truth. Rick Boothman, perhaps one of the finest lawyers I have ever met, told me "doctors let this get under their skin too much; it's all part of the theatrics, the

chess game." He goes on to say that this is one of the reasons that it continues, "Doctors are easy." Eventually I was dropped from the suit. The year-plus ordeal sucked energy away from my life and my practice. The cost was incalculable. The looming threat of another lawsuit lives with me even today.

We are in crisis. Medical malpractice insurance carriers are closing down in record numbers and those that remain are rapidly increasing the premiums, up to 200% last year in many states. The problem has reached critical proportions. A recent survey by the California Association of Neurological Surgeons reported that 62% of the prac-

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2002 CNS Annual Meeting: Freedom, Discovery, and Leadership Philadelphia, Pennsylvania

Richard G. Ellenbogen, M.D.
2002 Annual Meeting Chairman



The Congress of Neurological Surgeons invites you to join an extraordinary neurological surgery gathering featuring Honored Guest Dr. Volker K.H. Sonntag from the Barrow Neurological Institute. The CNS Annual Meeting will be held at the magnificent Pennsylva-

nia Convention Center from September 21 to 26th and promises to be an outstanding scientific gathering. The meeting theme is both appropriate for the city and in the light of current events: "Freedom, Discovery, Leadership." The theme represents the novel and bold directions neurosurgery is taking toward subjects such as technology, molecular biology, spinal surgery, and the full gamut of other subspecialty subjects. The CNS, with the help of nationally renowned leaders and young rising stars, will offer our membership a broad

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Jane Goodall, Ph.D. Visit Dr. Goodall's Web site at www.janegoodall.org.

Photo by Michael Neugebauer

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NEUROSURGERY NEWS

AANS ANNUAL MEETING ISSUE 2002
Volume 3—Number 2

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NEUROSURGERY NEWS is the official newsmagazine of The Congress of Neurological Surgeons®, located at 10 N. Martingale Road, Suite 190, Schaumburg, IL 60173. NEUROSURGERY NEWS is published bimonthly by Lippincott Williams & Wilkins, 351 W. Camden St., Baltimore, MD 21201-2436. Copyright © 2002 by The Congress of Neurological Surgeons®. No part of this publication may be reproduced in any form or language without written permission from the publisher. Published free of charge for the Congress membership with additional distribution. Annual subscription rates: Domestic institution \$85; International institution \$120; Single copy \$32. U.S. POSTMASTER: Send address changes to NEUROSURGERY NEWS, Lippincott Williams & Wilkins, 16522 Hunters Green Parkway, Hagerstown, MD 21740-2116. Library of Congress ISSN: 1525-819X.

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President's Message

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ting neurosurgeons that responded plan to retire, relocate, or change careers within the next 3 years. Current crisis spots include New York, Michigan, Pennsylvania, West Virginia, Florida, Ohio, Texas, Washington, and Mississippi, although in virtually every state, premiums for neurosurgeons and other high-risk specialties seem to be on the rise. The crisis is not only an issue of affordability, but also of the availability of professional liability insurance. For many, the recent announcement by St. Paul Insurance to drop its malpractice liability business is certainly adding to the availability problem. The median medical liability award is rising, with jury awards averaging near \$3.5 million!

A neurosurgeon from Texas wrote a let-

ter to me stating that his insurance premiums had doubled last year despite his "perfect" record. He had calculated that each case he treats cost him over \$700 in liability coverage, not even enough to cover reimbursement in some cases. "Is there anything organized neurosurgery can do to help?" he asked.

We will spend a full morning session at the CNS meeting in Philadelphia on this exact issue. The Council of State Neurosurgical Societies recently conducted a survey to collect data across the nation quantifying the financial magnitude of the problem. The Washington Committee has identified this issue as an immediate top priority. John Popp and Katie Orrico have developed a multipronged strategy. To help leverage our small size, we will participate in a number of coalitions, including the American Tort Reform Association (state initiatives), the Health Care Lia-

bility Alliance (federal initiatives), the National Coalition for Medical Liability Reform (federal initiatives), and the yet to be named new AMA/medical society coalition. We will pursue not only tort reforms, but also mechanisms to increase payments for liability insurance (e.g., increase the pool of dollars in the Medicare liability component). Neurosurgeons will have to participate in the advocacy process. We can't just sit idle and complain but need to be part of the solution. We need to work with our state neurosurgical societies and our state medical societies. We need to assist the Washington Committee when asked. We need to be proactive with the local press and write editorials and articles. "If you are not part of the solution, you are part of the problem," (Malcolm X). Stay involved; we need to work as a team. "Those who stay will be champions" (Bo Schembechler). □

2002 CNS Annual Meeting

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array of newly configured and timely practical courses and luncheons. Expanded discussions, member participation, and the presence of interna-

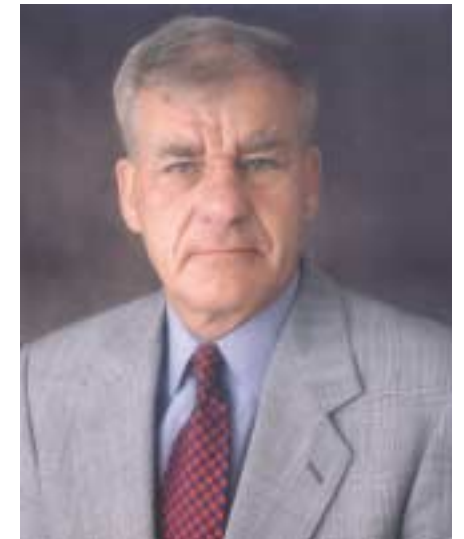
tional luminaries will spice up the offerings. The General Scientific Sessions promise to include cutting edge talks regarding our surgical field intermixed with invited lectures by scientists and leaders from other diverse and interesting fields. In addition, our 3rd Annual Dandy Orator promises to be



The Liberty Bell, Independence Hall.



Philadelphia skyline at night.



Volker K.H. Sonntag, M.D.

a showstopper. Jane Goodall, Ph.D., noted scientist and humanist, will deliver an address on "Reasons to Hope." Meg Whitman, CEO of eBay and Business Innovator, will talk about "Discoveries with the Internet." Greg Papadopoulos, computer visionary and CTO of Sun Microsystems will discuss "Future Directions of Our Technological Revolution." J. Craig Venter, noted scientific genius and DNA sequencing guru, will present his thoughts on "Mapping the Human Genome." These are only a few of the special invited lecturers that have agreed to speak at what promises to be the best-ever CNS annual meeting. Steve Papadopoulos, President of the CNS, Joel MacDonald, and Nelson Oyesiku, the Scientific Program Chairmen, the entire Executive Committee, and myself hope to see you there.

And now for the venue: Philadelphia, a city with a diverse blend of old and new, is a center of culture, music, sports and art. Save plenty of time and bring your family. Its central location makes it a short drive from half of the major cities on the East Coast. Make time to enjoy the fine arts at some of the country's best art museums, including the

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Integra Neurosciences
p/up NUN Winter

2002 CNS Annual Meeting

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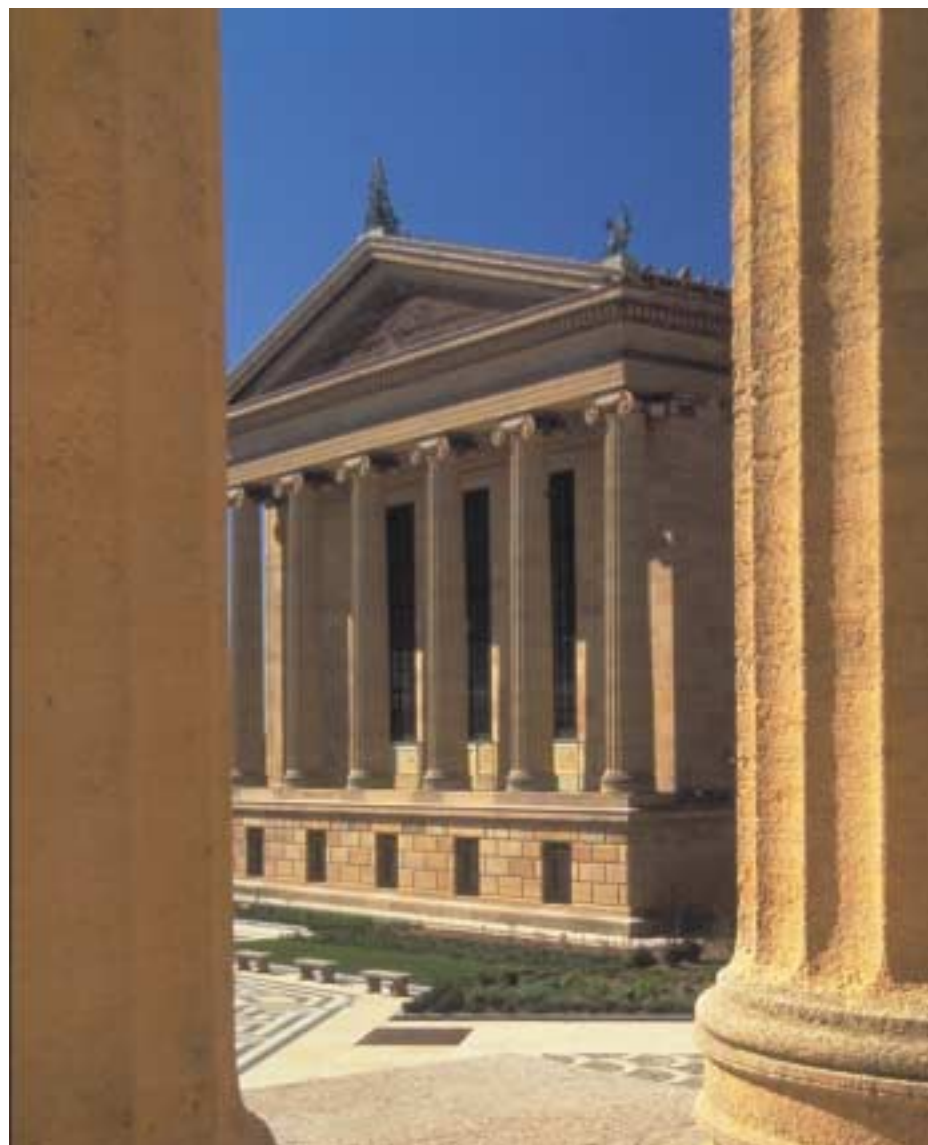
Philadelphia Museum of Art and the Rodin Museum. Take one of the city tours and listen to the tales of our nation's birth by visiting the Liberty Bell or Independence Hall. Or simply stroll through this rejuvenated historic city and visit the Italian Market, Boathouse Row along the river, or Fairmont Park, the largest landscaped city park in the world. The meeting hotels are state of the art and within short walking distance to the Convention Center.

The Scientific Program Committee of the CNS has opened the Scientific Abstract Center on *Neurosurgery*://On-Call at www.neurosurgery.org/cns/meetings/2002. We are hoping to attract residents from as many programs as possible to take advantage of the scientific offerings available to them at a markedly reduced rate. The neurosurgeons-in-training enrich our organization and represent the future of neurological surgery. Come give a talk or present a poster or simply enjoy the meeting. Established neurosurgeons, this is your organization. Come help shape it in Philadelphia! □



The Thinker, the Rodin Museum.

Photo courtesy of Philadelphia Convention and Visitors Bureau.



Philadelphia Museum of Art.

Photo courtesy of Philadelphia Convention and Visitors Bureau.

NEUROSURGERY

THE OFFICIAL JOURNAL OF THE CONGRESS OF NEUROLOGICAL SURGEONS



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Handle with Care: Avoiding Financial Conflicts of Interest in Clinical Research

By Scott Williams

Last year, Seattle's Fred Hutchinson Cancer Research Center entered into a legal and public relations imbroglio that all academic institutions hope to avoid. Fred Hutchinson faces a class-action lawsuit that alleges researchers did not offer adequate information to patients regarding the risks and benefits of certain experimental treatments, and that financial conflicts of interest involving researchers were not disclosed.

After a systematic review of the allegations, Fred Hutchinson's President and Director Lee Hartwell found "all these accusations to be blatantly false." Named in the suit are a number of individual investigators as well as a private company and its successor corporation. Allegedly, as a result of adverse events associated with use of the treatments – which involve trials conducted as far back as two decades ago – 20 people are said to have died.

Responding to negative local media publicity, Fred Hutchinson initiated a review of its practices in protecting human subjects in research, and its conflict of interest policy is currently under review by its Patient Protection Oversight Committee. With the considerable attention being paid to this delicate, complex topic by task forces and committees, regulatory bodies, and watchdog groups, financial conflicts of interest have become an "issue of the moment" on campuses nationwide. It has become abundantly clear that unless academic institutions have clearly stated policies and procedures in place to address such matters, they face a greater risk of major legal and public relations disasters that might have been otherwise averted.

As any academician can attest, the devil is in the details. Negotiating with trial sponsors, IRBs, and other interested parties to define the terms of study protocols and related conflict of interest agreements can be a challenging task for even the most seasoned and diplomatic professional. In this environment, myriad critical factors must be considered before a study is even initiated. But negotiation may be greatly facilitated when a clearly stated policy on the topic is in place.

Laying the Groundwork

To encourage academic institutions to address these crucial issues, some committees and task forces have been formed to develop guidelines to aid researchers and administrators in formulating policies for their faculty. One such group is the Task Force on Financial Conflicts of Interest in Clinical

Research, established by the AAMC. The task force is a collective of leaders from academia, law, ethics, industry, media, and patient advocacy. Its mission is to revise the AAMC's guidelines on faculty conflict of interest and generate a similar document for institutions involved in human subjects research.

"Our objective in developing these guidelines was to provide leadership through a proactive response to concerns about financial conflicts of interest and protection of human subjects," says Jennifer Kulynych, JD, PhD, director in the AAMC Division of Biomedical and Health Sciences Research. "These AAMC recommendations go beyond current federal regulations addressing this issue, and our hope is that institutions will embark upon a systematic review of their policies with our guidelines in mind. We want to stress that it is important for institutions to be very conscious of the need for effective oversight of financial interests, but we also want to remind everyone that the pathway for biomedical advances involves partnerships



between academic institutions and industry." Four general elements are at the core of the guidelines. First, definitions of common policy terms, such as "significant financial interests in research," are provided with the recommendations. Second, the task force report recommends many substantive policy requirements, and proposes a model oversight mechanism. What committee or officer will oversee these efforts? What sanctions should be in place to protect the integrity of research at an institution? Next, how will faculty disclose finan-

works, and procedures that can be useful when developing a policy. Many of the guidelines – with the obvious objective of facilitating transparency – revolve around adequate disclosure to the institution, to publications, in oral presentations, to federal agencies, and in the human participant review process. Management examples are shared in the report to illuminate what has worked and not worked at different institutions. In general, the AAU suggests emphasizing principles rather than paperwork and developing all processes collaboratively to promote understanding and implementation of the policy. The full report may be accessed at www.aau.edu. For a print copy, write to the organization at 1200 New York Ave. NW, Suite 550, Washington, D.C., 20005.

Hopkins Bolsters Its Policy

Last year, the U.S. Office for Human Research Protections temporarily suspended federally funded clinical research projects at Johns Hopkins University in response to the death of a healthy 24-year-old woman who had participated in a trial of an experimental asthma drug. Hopkins has since bolstered a number of oversight mechanisms in their university's biomedical research review procedures. Revamping its financial conflict of interest policy is one such effort.

"We found there are a number of key considerations for a committee embarking on development or revision of a financial conflict of interest policy," says Julie Gottlieb, senior director of the Office of Policy Coordination at the Johns Hopkins University School of Medicine. Hopkins' Conflict of Interest Policy Review Committee consists of members of the university's standing committee on the topic as well as additional faculty, an ethicist, and Gottlieb.

The existing policy is just three paragraphs, but its implementation is critical. Hopkins' current process is modeled on the IRB system and

How does one define "individual financial conflicts of interest"?

It depends on whom you ask. The National Science Foundation (NSF), the U.S. Public Health Service (PHS), and the U.S. Food and Drug Administration (FDA) all have regulations in this arena. These institutions have specific procedures for addressing financial conflict of interest concerns among federally funded investigators (NSF and PHS) or researchers working with industry on new drug applications (FDA).

Ultimately, each institution must determine how to define "financial conflict of interest" in their policies. The Association of American Universities (AAU) has offered a definition (based on the AAMC's 1990 guidelines) in their task force's recent report on this topic:

"The term individual financial conflict of interest in science refers to situations in which financial considerations may compromise, or have the appearance of compromising, an investigator's professional judgment in conducting or reporting research. The bias such conflicts may conceivably impart not only affects collection, analysis, and interpretation of data, but also the hiring of staff, procurement of materials, sharing of results, choice of protocol, involvement of human participants, and the use of statistical methods."

between academic institutions and industry."

The AAMC task force report is entitled "Protecting Subjects, Preserving Trust, Promoting Progress: Guidelines for Developing and Implementing a Policy Concerning Individual Financial Interests in Human Subjects Research." It will provide academic leaders guidance on a host of issues to be considered when developing a financial conflict of interest policy for their institutions. Once approved by AAMC governance, the task force report will be available on the AAMC Web site (www.aamc.org).

cial interests, and how will that information be shared with institutional officers, IRBs, and research participants? Finally, what are the specific ways the institution will implement the policy and monitor compliance?

Last October, the AAU issued new guidelines on the development of both individual and institutional financial conflict of interest policies. In addition to defining individual financial conflicts of interest (see sidebar), the report gives an overview of this problem as it relates to academic professionals.

The AAU task force offers a number of specific guidelines, operational frame-

Handle With Care

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involves committee review of some 100 cases annually. A rich body of "case law," reflecting an active, detailed management process, helps guide decision-making. For example, when investigators are allowed to proceed with studies involving financial conflicts of interest, they are subject to several restrictions and a high degree of scrutiny. In order to provide more specific guidelines, procedures, and transparency, Gottlieb estimates the final revised policy will encompass several pages.

"During this revision process a great number of considerations come into play," she says. "But in general, committee members must decide on the breadth of the policy. How narrow or broad will it be? Will it encompass all research, just human research, or clinical practice? Institutions vary in their approach to a policy of this sort, but at Hopkins we try to capture a broad array of financial interests and review them

actively in regard to specific risks or biases they might raise."

An additional consideration for institutions is whether their policies will be prescriptive as to which arrangements are prohibited and which are allowed, or whether there will be room for review of specific cases. Gottlieb states that Hopkins' strong belief in faculty governance underlies the practice of faculty committee members reviewing conflict of interest issues case by case – with the parameters of the policy in mind – and making recommendations to the dean.

Whatever approach an institution takes seems secondary to the necessity that they carefully develop a financial conflict of interest policy for the protection of their faculty, the institution, and most of all, the patients for whom they care.

Reprinted with permission from *Academic Physician & Scientist* 2002; January February:1, 10–11. □

Gifts from Industry: Where to Draw the Line

Due to the changing landscape of biomedical research and its funding streams, gifts to physicians from industry representatives have become an increasingly common component of the interaction between the two groups. A number of these gifts are nominal in value and most likely do not cross the line of what would be considered appropriate. Furthermore, they may foster good will, interaction, and communication between the medical community and industry.

However, some gifts clearly do cross the line into an ethical gray zone and may potentially compromise the integrity of the doctor-patient relationship. The American Medical Association's Council on Ethical and Judicial Affairs has released guidelines for physicians in its current Code of Medical Ethics; these may be accessed at www.ama-assn.org/go/ethicalgifts. The AMA also has free pocket cards available for distribution. Call (312) 464-5101. The AMA's seven basic guidelines are summarized below:

❖ Gifts to individual physicians should primarily benefit the patient and should not be of substantial value. Textbooks and modest meals acquired via an educational function are appropriate; cash payments are inappropriate.

- ❖ Individual gifts to physicians may be appropriate as long as they are of minimal value (i.e., pens, notepads).
- ❖ Conferences sponsored by industry and attended by physicians should promote scientific and educational activities. The physician attending the meeting should make a financial conflict of interest disclosure.
- ❖ Subsidies to fund CME conferences or similar types of meetings are permitted. However, physicians should avoid direct travel-related compensation from the company; rather, subsidies should be paid directly to the conference sponsor to reduce registration fees for attendees.
- ❖ "Reasonable" honoraria for faculty at conferences are acceptable, as are "reasonable" travel-related expenses. "Genuine" consulting arrangements can be compensated, but "token" consulting or advisory arrangements that are attached to compensation should be avoided. Direct or indirect subsidies from industry to pay travel-related costs for attendance at meetings or to pay for a physician's time, however, should be avoided.
- ❖ Special funding for students, residents, or fellows to attend "carefully selected conferences" may be permissible, but the selection of these individuals should lie with the institution, not the sponsor. The AMA defines "carefully selected conferences" as the major scientific meetings affiliated with national or regional organizations or medical specialties.
- ❖ Finally, accept no gifts with strings attached. For example, gifts given as a result of physician prescribing practices are not acceptable. Similarly, responsibility for content and faculty for conferences underwritten by industry should lie solely in the hands of the conference organizers, not industry sponsors.

Beverly C. Walters, M.D. in Croatia

Of the diplomas, awards, and certificates decorating the walls of Dr. Beverly C. Walters' office, none have more value than those acknowledging her professional clinical work in Croatia. Dr. Walters' first contact with the country of Croatia came when she participated in a Central European neurosurgical educational program under the auspices of the Brain Trauma Foundation. The Foundation sponsored the creation of the *Guidelines for the Management of Severe Head Injury*, and the organization was awarded a grant from the George Soros Foundation to provide educational programs in Central Europe to help in improving outcomes of head-injured patients. As one of the lecturers in the program, Walters visited Budapest and then was assigned as a site visitor to Croatia. Dr. Miro Vukic was then the Brain Trauma Foundation clinical research fellow in the project and acted, with the Chairman of his Department, Professor Lucijan Negovetic, as host to Dr. Walters on her trip there.

Of the diplomas, awards, and certificates decorating the walls of Dr. Beverly C. Walters' office, none have more value than those acknowledging her professional clinical work in Croatia.

The three neurosurgeons struck up an acquaintance that rapidly turned to friendship. The Croatians became interested in the techniques Dr. Walters described to them for microsurgery of the cervical spine. She was then invited as a guest speaker and panel moderator for the Second Croatian Neurosurgical Society meeting in Opatija on the Adriatic Sea. She gave presentations, including videos, about her surgical results. The Croatians were intrigued and wanted to learn more. In the spring of 2000, Dr. Vukic came to Brown University to visit Dr. Walters and observe, with Dr. Negovetic, her surgical procedures. Satisfied that she had something valuable to teach, Dr. Negovetic left his (now junior attending) colleague in Dr. Walters' hands for a month.

After his month of observation in Providence, Dr. Vukic returned to Zagreb to expand his practice to include cervical disc microsurgery. The plan was that Dr. Walters would come once again to Zagreb to help Dr. Vukic in his fledgling undertaking. In November of 2000,



Dr. Beverly C. Walters

Dr. Walters went to Zagreb to operate on some of the first patients undergoing the procedure, and to help Dr. Vukic and Professor Negovetic in their work. The visit was featured in magazines, newspapers, and on television (Good Morning Croatia) and brought publicity to the Sisters of Mercy Hospital in Zagreb. The trip was very successful, although Dr. Walters was chagrined at the dearth of necessary instruments to perform the procedure. At that initial operative visit, she arranged with Codman to purchase \$12,000 (from her personal funds) in surgical equipment to facilitate the establishment of the practice of cervical spine surgery. Ultimately, Codman donated these instruments, and the money donated by Dr. Walters was used to help purchase a new high-speed drill. In December 2000, Walters returned once again to Zagreb to operate with Dr. Vukic, having been summoned to help with some more complicated forms of the procedure. She flew to Croatia one day, operated the next day, and then flew back to Rhode Island for Christmas with the family. At that visit, she was presented with the certificates of appreciation from Professor Negovetic and the General Manager of the hospital that now adorn her office walls and mean so much to her.

More recently, in November and December of 2001, Dr. Walters was called once again to Zagreb to help with more complicated cases, and brought more instruments donated by EBI, a Biomet Company. And again, she was featured in local magazines and newspapers and has been recognized on the street by some of the people in the country. She will be returning to Croatia in June of 2002 to speak at the Croatian Neurosurgical Congress in Zagreb and has persuaded Dr. Vukic to become an "Ambassador" in Croatia for the Congress of Neurological Surgeons. □

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The field of neurosurgery is changing rapidly. That's why now more than ever it's important to attend the CNS Annual Meeting. It's the best opportunity to discover the latest technologies, treatments, and techniques all in one convenient location. It's a small investment of time that just might lead to big rewards for you and your patients.



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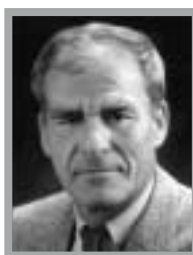
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Volker K. H. Sonntag
2002 Honored Guest

- Jane Goodall, PhD, Third Annual Walter J. Dandy Orator
- Bennett Stein, Special Emeritus Lecturer
- Greg Papadopoulos, SUN Microsystems
- Admiral Vern Clark, United States Navy
- J. Craig Venter, DNA Sequencing Pioneer
- Meg Whitman, eBay

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2003
Denver, CO
October 18-23

2004
San Francisco, CA
October 16-21

Washington Committee Update

Katie O. Orrico, J.D.

Director, AANS/CNS Washington Office



After the Washington Committee filed a lawsuit in November 1999, the wheels of justice have finally ground to a halt. The 7th Circuit Court of

Appeals (the circuit probably most favorably disposed politically to our suit) has just ruled against us and affirmed the District Court's decision dismissing our practice expense lawsuit on jurisdictional grounds. Recall that we had filed suit challenging the HHS Secretary's interpretation of Congress's statutory formula for calculating the so-called practice expense "down payment" that took money from those procedures that had practice expense relative values in excess of the work relative values and redistributed these excess RVUs to 10 primary care office visit codes. Rather than only applying the effects of this redistribution for 1 year (1998), HCFA (now CMS) continued to apply the effects of this throughout the transition from old PE

RVUs to new resource-based RVUs for practice expense, thus in effect creating the "gift that kept on giving" beyond 1998.

The substance of our argument was never really considered by the appeals court, as they found that they had no jurisdiction to even consider the matter because the Medicare statute essentially prohibits courts from hearing matters related to the fees that Medicare sets for its various providers (despite the fact that our real argument was the interpretation by HCFA of the statutory formula for setting those fees, not the methodology itself).

Anyway, the Washington Committee fought the fight. We did so at every level. We got at least a phase-in of the inevitable pain that would have otherwise been felt all at once (as opposed to over a 4-year period). We mitigated the losses by putting on pressure. The practice expense chapter is essentially closed.

All in all, when you consider that neurosurgery would have lost over \$100 million in 1998 alone without our successful legislative effort, our expenditures on this project were still well worth it. □

Transcript of Practice Expense Lawsuit

In the United States Court of Appeals For the Seventh Circuit

No. 00-2518

American Society of Cataract and Refractive Surgery; American Academy of Orthopedic Surgeons; American Academy of Ophthalmology, et al.,

Plaintiffs-Appellants,

v.

Tommy Thompson, Secretary of the United States Department of Health and Human Services and Thomas A. Scully, Administrator of the Centers for Medicare and Medicaid Services,¹

Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division. No. 98 C 7061—Ann Claire Williams, Judge.

Argued November 2, 2000—Decided January 28, 2002

Before Manion, Kanne, and Evans, Circuit Judges.

Kanne, Circuit Judge. Eleven national medical societies and associations representing physicians of different specialties (collectively "petitioners") appeal the district court's dismissal of their statutory and constitutional challenge to a regulation promulgated by the Secretary of the Department of Health and Human Services ("Secretary") implementing a new system for calculating a component of the Medicare physician fee schedule for lack of subject matter jurisdiction. Petitioners contend that their claim is not precluded from judicial review, and that the Secretary's regulation is directly contrary to the transition formula Congress established for calculating the relevant component. Because 42 U.S.C. sec. 1395w-4(i)(1)(B) bars judicial review of petitioners' claim, we affirm the district court.

I. History

Medicare, the federal health insurance program for the aged and disabled has three parts: Part A—Hospital Insurance Benefits; Part B—Supplemental Medical Insurance Benefits; and, Part C—Miscellaneous Provisions. See 42 U.S.C. sec. 1395 et seq. This case deals with Part B, which is a voluntary supplemental insurance program that covers payment for physicians' services and

other healthcare services to aged and disabled individuals who enroll in the program. See 42 U.S.C. sec. 1395j-1395w-4. Physicians who participate in the Medicare program are reimbursed at a rate outlined in a physicians' fee schedule. Payment amounts under the fee schedule are calculated by multiplying (1) the relative value of a service; (2) the conversion factor for the particular year; and (3) the geographic adjustment factor applicable to the locality in which the service was provided. See 42 U.S.C. sec. 1395w-4(b)(1). The first component, the relative value of a service, is calculated by combining three subcomponents each of which is measured in terms of relative value units ("RVUs"). The three subcomponents are (1) the work component ("Work RVUs"); (2) the practice expense component ("PE-RVUs"); and (3) the malpractice component ("Malpractice RVUs"). See 42 U.S.C. sec. 1395w-4(c)(2)(A)(i) & (c)(2)(C)(i)-(iii).

This case focuses specifically on the determination of PE-RVUs. In 1994, Congress directed the Secretary to develop a resource-based system for calculating PE-RVUs. See Social Security Act Amendments of 1994, Pub. L. No. 103-432, sec. 121(a)(1), 108 Stat. 4398, 4408 (1994) (codified at 42 U.S.C. sec. 1395w-4(c)(2)). Historically, PE-RVUs were "charged-based," meaning that they were predominately based upon "historical pattern[s] of charges billed by [physicians]." H. R. Rep. No. 101-247, at 338 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2064. A "resource-based" system would be based on "the relative practice expense resources involved in furnishing the service." See 42 U.S.C. sec. 1395w-4(c)(2)(C)(ii).

In 1997, the Secretary proposed a new system for determining PE-RVUs. She qualified her proposal, however, by acknowledging that the new system warranted a transition period that should be gradually implemented. See 62 Fed. Reg. 33158, 33194 (June 18, 1997) (to be codified at 42 C.F.R. pts. 400, 405, 410, 414). Shortly thereafter, Congress passed the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997) (codified at 42 U.S.C. sec. 1395w-4). In this legislation, Congress provided that the new system for calculating PE-RVUs would be phased in over a four-year period beginning in 1999:

The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service For 1999, such num-

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¹ Tommy G. Thompson is substituted as defendant in place of the former Secretary, Donna E. Shalala and Thomas A. Scully is substituted as defendant in place of the former administrator, Nancy Min De Parle. See Fed. R. Civ. P. 25(d)(1). The Health Care Financing Administration is now the Centers for Medicare and Medicaid Services.

ber of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.

42 U.S.C. sec. 1395w-4(c)(2)(C)(ii). The above-cited language is the formula prescribed by Congress to be used during the four-year transition period to resource-based PE-RVUs. In June 1998, the Secretary published her proposed rule for implementing the new resource-based system pursuant to Congress's directive in the Balanced Budget Act of 1997. See 63 Fed. Reg. 30818 (June 5, 1998). The Secretary indicated that she would use the 1998 PE-RVUs, as adjusted, in implementing Congress's four-year transition. See *id.* at 30839. Thus, "the final rule" published in November 1998 explained:

For services furnished beginning January 1, 1999, the practice expense RVUs are based on 75 percent of the practice expense RVUs applicable to services furnished in 1998 and 25 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2000, the practice expense RVUs are based on 50 percent of the practice expense RVUs applicable to services furnished in 1998 and 50 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2001, the practice expense RVUs are based on 25 percent of the practice expense RVUs applicable to services furnished in 1998 and 75 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2002 and subsequent years, the practice expense RVUs are based entirely on relative practice expense resources.

63 Fed. Reg. 58814, 58910-11 (Nov. 2, 1998) (codified at 42 C.F.R. sec. 414.22(b)(5)) (emphasis added). In implementing the transition formula, the Secretary determined that the language "such product" in sec. 1395w-4(c)(2)(C)(ii) referred to the PE-RVUs for 1998. See 42 sec. C.F.R. 414.22(b)(5).

Two days after the final rule was promulgated, the petitioners filed a complaint in the United States District Court for the Northern District of Illinois, alleging that the final rule was arbitrary, capricious, and contrary to law in violation of the Medicare Act, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment. Petitioners sought expedited relief that included: a declaratory judgment finding that the Secretary's transition formula as described in the final rule

was improper; an injunction enjoining respondents from implementing the transition formula as described in the final rule; and an order requiring the implementation of the transition formula as petitioners contend Congress mandated by statute.² The respondents moved to dismiss petitioners' complaint, contending that 42 U.S.C. sec. 1395w-4(i)(1) barred petitioners' claim.

Title 42 of the United States Code section 1395w-4(i)(1) provides that:

There shall be no administrative or judicial review under section 1395ff of this title or otherwise of—

- (A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i) of this section),
- (B) the determination of relative values and relative value units under subsection (c) of this section, including adjustments under subsection (c)(2)(F) of this section and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993,
- (C) the determination of conversion factors under subsection (d) of this section,
- (D) the establishment of geographic adjustment factors under subsection (e) of this section, and
- (E) the establishment of the system for the coding of physicians' services under this section.

(Emphasis added). The district court referred the case to a magistrate judge to conduct necessary proceedings and enter a Report and Recommendation on respondents' motion to dismiss and petitioners' motion for expedited declaratory judgment. The magistrate judge first considered whether 42 U.S.C. sec. 1395w-4(i)(1)(B) precluded judicial review of the petitioners' challenge. The magistrate judge found that although this subsection "clearly bars administrative and judicial review of the determination of relative value units . . . this type of bar on judicial and administrative review does not preclude a collateral challenge on statutory or constitutional grounds." Thus, the magistrate reasoned that because "[w]hat petitioners [were] really seeking [was] a ruling on whether the Secretary violated the Constitution or federal statutes while interpreting the statutory requirements for the transition to resource-based PE-RVUs," they were not precluded from seeking judicial review.

The magistrate judge then considered the merits of petitioners' claims. In light of the "unclear text of sec. 1395w-4(c)(2)(C)(ii), the context of the statute, the related sections of the Medicare Act, the history of PE-RVUs, and the real-world situation to which the statute pertains," the magistrate found that the language of sec. 1395w-4(c)(2)(C)(ii) was not plain and unambiguous. Fur-

² Essentially, petitioners contend that the "such product" language in Congress's transition formula refers to the PE-RVUs for 1991 and not for 1998, as the Secretary's regulation provides.

thermore, for many of the reasons articulated as to why the statute was ambiguous, as well as the deference due to the Secretary's interpretation, the magistrate judge determined that the Secretary's integration of the 1998 adjusted PE-RVUs into the such product language of the transition formula was a reasonable interpretation of the statute. Thus, the magistrate concluded that the respondents did not violate the Medicare Act, the APA, or petitioners' due process rights.

Both parties filed objections to the magistrate judge's Report and Recommendation with the district court. The district court considered the magistrate judge's Report and Recommendation; however, the court decided to grant the respondents' motion to dismiss petitioners' complaint for lack of jurisdiction pursuant to sec. 1395w-4(i)(1)(B). The court explained that "[b]ecause the express language of the statute bars judicial review, and the overall structure of the Medicare Part B payment scheme supports this conclusion," it found sufficient "congressional intent to foreclose judicial review of the Secretary's instructions and regulations." Additionally, the district court found that petitioners' "challenge to the process used to determine relative values and relative value units [was] not procedural or collateral but [was] in fact substantive," and therefore subject to preclusion by sec. 1395w-4(i)(1)(B). Furthermore, with respect to the merits of petitioners' complaint, the court noted that even if the Medicare Act permitted judicial review of petitioners' challenge, it would still have found in favor of respondents, the court then adopted the magistrate judge's report with respect to this issue. Petitioners now appeal.

II. Analysis

On appeal, this court first must determine whether 42 U.S.C. sec. 1395w-4(i)(1)(B) precludes judicial review of petitioners' claim. If review is precluded, we must consider whether this bar violates petitioners' constitutional rights and the doctrine of separation of powers. However, if this court does have jurisdiction to review petitioners' claim, the issue becomes whether the Secretary's regulation violated the Medicare Act, the APA, or the petitioners' due process rights.

We review a district court's dismissal for lack of subject matter jurisdiction *de novo*. See *Neuma, Inc. v. AMP, Inc.*, 259 F.3d 864, 871 (7th Cir. 2001). We conduct this review mindful of the strong presumption that Congress intends judicial review of administrative action. See *Bowen v. Mich. Acad. of Family Physicians*, 476 U.S. 667, 672, 106 S. Ct. 2133, 90 L. Ed. 2d 623 (1986). "[O]nly upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review." *Abbott Labs. v. Gardner*, 387 U.S. 136, 141, 87 S. Ct.

1507, 18 L. Ed. 2d 681 (1967). While we acknowledge that respondents bear a heavy burden to overcome "the strong presumption that Congress did not mean to prohibit all judicial review of" administrative action, *Bowen*, 476 U.S. at 672 (quotation omitted), we also recognize that "all presumptions used in interpreting statutes, may be overcome by, *inter alia*, specific language or specific legislative history that is a reliable indicator of congressional intent, or a specific congressional intent to preclude judicial review that is fairly discernible in the detail of the legislative scheme." *Bowen*, 476 U.S. at 673 (quotations omitted).

We agree with the district court's determination that the Medicare Act, by its express terms, precludes judicial review of the determination of relative values and relative value units, including review of the regulation promulgated by the Secretary implementing a statutory transition formula for the determination of PE-RVUs. Title 42 of the United States Code section 1395w-4(i)(1) expressly provides that: "there shall be no administrative or judicial review under section 1395ff of this title or otherwise of— . . . (B) the determination of relative values and relative value units under subsection (c) of this section . . ." (emphasis added) ("paragraph (B)"). We find this provision to be a clear and explicit indication of Congress's intent to prohibit administrative and judicial review of the Secretary's decision now challenged by petitioners. While petitioners acknowledge that paragraph (B) precludes administrative and judicial review of the Secretary's determination of specific RVUs assigned to specific services (e.g., the Secretary's decision to assign a specific number of RVUs for gallbladder surgery), they assert that this provision does not foreclose review of a systemic challenge to the Secretary's interpretation of Congress's nondiscretionary instructions for establishing components of the physician fee schedule.

In support of their argument, petitioners rely on language from *Furlong v. Shalala*, 1996 WL 393526, at *8 (S.D.N.Y. July 12, 1996), *aff'd in part and rev'd in part on other grounds*, 156 F.3d 384 (2d Cir. 1998). In *Furlong*, the district court found that paragraph (B) did not bar judicial review of a challenge to the application of the "one-and-one-half rule"³ to reimbursement payments under the physician fee

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³ The "one-and-one-half rule" was a multiple procedure reimbursement rule. Under this rule, the total Medicare-approved charges were determined by adding the Medicare-approved charges for one of the procedures to one-half of the Medicare-approved charges for the other procedure. The "one-and-one-half rule" was being applied to invasive monitoring procedures. The *Furlong* plaintiffs asserted that their reimbursements were insufficient because their monitoring procedures were medical, not surgical procedures and therefore should not be subject to the "one and one half rule." See *id.*

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schedule. *Id.* In so finding, the Furlong court explained that paragraph (B) “does not foreclose judicial review of all issues which may implicate subsection (c).” *Id.* In the case at bar, petitioners assert that, similar to Furlong, their challenge involves an issue that implicates subsection (c) and to which judicial review is not foreclosed. However, petitioners ignore the balance of the Furlong court’s reasoning. The rule challenged in Furlong was an ancillary policy applied only after relative values had been determined. See *id.* The Furlong court explicitly recognized that “relative values first must be determined and that only after this determination does a value exist which the [ancillary policy] may reduce by one-half.” *Id.* Far from being ancillary to the determination of relative values, the regulation challenged by petitioners in this case is an integral part of the relative value determination.

Petitioners also seek support for their position from the Supreme Court’s decision in *McNary v. Haitian Refugee Center*, 498 U.S. 479, 111 S. Ct. 888, 112 L. Ed. 2d 1005 (1991). In *McNary*, the Court held that sec. 210(e) of the Immigration and Nationality Act (INA), which barred judicial review “of a determination respecting an application” for special agricultural worker (“SAW”) status, did not bar judicial review of collateral challenges to unconstitutional practices and policies used in processing the application. 498 U.S. at 492 (quotation omitted). Petitioners rely on the similar use of the word “determination” in paragraph (B) to support their claim that the scope of that prohibition should be interpreted so as to permit their challenge. We do not agree.

The fact that the regulation in *McNary* and the regulation at issue in the case at bar both contain the word “determination” does not further petitioners’ argument. Petitioners’ mechanical comparison fails to acknowledge important differences between the claims asserted in *McNary* and the claim in the case at bar, and how these claims relate to the respective regulations being challenged. In *McNary*, the Court found that the language of sec. 210(e) prohibited the judicial review of an individual’s challenge to the determination of his or her application for SAW status. See *id.* at 492. Thus, the Court concluded that the plaintiff’s claim was outside the scope of sec. 210(e)’s prohibition because it merely challenged the policies and practices employed by the INS in processing applications. See *id.* Conversely, in this case, the language in paragraph (B) explicitly includes petitioners’ challenge. Petitioners’ claim consists of a challenge to a regulation implementing a formula for determining PE-RVUs. It would be difficult for Congress to have written paragraph (B) in clearer terms prohibiting such a challenge. See *Painter v. Shalala*, 97 F.3d

1351, 1356 (10th Cir. 1996) (finding that “the ‘no review’ provision clearly indicates Congress’ intent to preclude administrative and judicial review of the manner in which the conversion factor is calculated by the Secretary”); *Am. Soc’y of Dermatology v. Shalala*, 962 F. Supp. 141, 146 (D.D.C. 1996) (finding that “Congress plainly intended to give the Secretary the authority to develop and implement the [resource-based relative value scale] system without being subjected to judicial scrutiny), *aff’d*, 116 F.3d 941 (D.C. Cir. 1997).

Paragraph (B) bars the review of the “determination of relative values and relative value units.” 42 U.S.C. sec. 1395w-4(i)(1). The regulation at issue sets out the formula for calculating PE-RVUs, practice expense relative value units. Petitioners’ challenge is precisely what Congress sought to prohibit.

We find *Heckler v. Ringer*, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984), a case which involved the Medicare Act, to be more analogous than *McNary*. In *Heckler*, the Court addressed a challenge to the Secretary’s

policy of refusing reimbursement for a particular type of surgery. See *id.* at 605. Without exhausting the administrative remedies, the plaintiffs sought relief in district court. See *id.* They attempted to distinguish their claim on the ground that it was procedural and not substantive, and therefore, not within the scope of the administrative review channeling provision. See *id.* at 614. However, the Court concluded that “the claims of . . . respondents [were nothing] more than, at bottom, a claim that they should be paid for their [particu-

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lar] surgery.” Id. The Court explained that the procedural claim was inextricably intertwined with the plaintiffs’ claim for benefits, and therefore, must be channeled through the administrative review that was provided for in the statute. Id. Unlike McNary, but similar to the plaintiffs in Heckler, the “relief that [petitioners] seek to redress their supposed ‘procedural’ objections is the invalidation of the Secretary’s current policy” for determining PE-RVUs. Id. We agree with the district court and conclude that such a challenge is not a

procedural challenge, but rather a substantive challenge. We find that such a challenge falls within the scope of paragraph (B)’s clear bar on administrative and judicial review.

Additionally, the payment scheme in Part B of the Medicare Act supports our determination that Congress intended to bar judicial review of petitioners’ challenge. RVUs are used to calculate the physician’s fee schedule. The fee schedule is updated yearly and each year’s schedule is established by November 1 of the preceding year. See

42 U.S.C. sec. 1395w-4(b)(1). As respondents highlight, this tight time frame demands that the Secretary’s decisions regarding the RVUs be made quickly and efficiently. Further, Congress directed that adjustments in the RVU component of the fee schedule be made in a budget neutral fashion, see 42 U.S.C. sec. sec. 1395w- 4(c)(2)(B)(ii), (c)(2)(F), 1395w-4 note, requiring increases for some services to be offset by decreases in others. While petitioners acknowledge that a favorable decision would be disruptive, we believe,

as respondents persuade us to, that to ensure finality so that the Secretary can make any necessary budget neutrality adjustments, claims such as petitioners’ claim must be precluded from judicial review.

Petitioners argue that preclusion of their claim would be unconstitutional. Petitioners contend that without an opportunity for judicial review both their due process rights and the doctrine of separation of powers are violated. We do not find petitioners’ arguments persuasive.

Petitioners assert that they “clearly have a property interest in reimbursement for their Medicare services in the amounts mandated by Congress through the transition formula set out in BBA’97.” By enacting a regulation that they claim is contrary to Congress’s transition formula, petitioners claim that the Secretary violated their due process rights. In order to trigger the procedural protections available under the Due Process Clause of the Constitution, petitioners must have a “legitimate claim of entitlement.” *Bd. of Regents of State Colls. v. Roth*, 408 U.S. 564, 577, 92 S. Ct. 2701, 33 L. Ed. 2d 548 (1972). In *Roth*, the Court explained that “[t]o have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it Property interests . . . are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law” Id. Petitioners rely on *Furlong v. Shalala*, 156 F.3d 384, 393 (2d Cir. 1998) (“*Furlong II*”) for their proposition that physicians have a property interest in reimbursement for their Medicare services in the amounts mandated by Congress through the transition formula. We find that petitioners’ reliance is misplaced. In *Furlong II*, the issue addressed was whether non-assigned physicians’ due process rights were violated by the Secretary’s decision to deny them appeals rights. See *id.* The petitioner-physicians argued that they had a protected property interest in having the Medicare-approved charge for their services be based upon a rate equal to the amount promulgated in the statutory fee schedule, without being subject to reduction by the operation of the “one-and-one-half rule.” Id. The court explained that “professionals who provide services under a federal program such as . . . Medicare have a property interest in reimbursement for their services at that the ‘duly promulgated reimbursement rate.’” Id. at 393 (quotation omitted). Further, the court explained that “[t]he fee schedule provides the Medicare-approved rates for services and thus would typically constitute the duly promulgated reimbursement rate.” Id. The petitioner-physicians argued that the application of the rule deprived them of this interest without due process of law because they have no recourse under the Act

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and its implementing regulations to appeal the allegedly improper determinations. See *id.* The court determined that a series of ALJ decisions that reversed the application of the rule to assigned-physicians, who had appeals rights, established a cognizable property interest in the reimbursement rate set out in the fee schedule, without a subsequent reduction, for non-assigned physicians, who did not have appeals rights. See *id.* at 395.

We agree with petitioners' assertion to the extent that they claim that they have a property interest in being reimbursed at the duly promulgated reimbursement rate as set out in the fee schedule. Petitioners, however, have not established that they have a property interest in the transition formula used to determine PE-RVUs. Petitioners argue that their property interest is greater than the property interest established by the ALJ decisions in *Furlong II* because their interest is found in a statutory mandate. We do not agree. Title 42 of the United States Code section 1395w-4(c)(2)(C)(ii) provides, in pertinent part: "The Secretary shall determine a number of practice expense relative value units for the service . . ." (emphasis added). The language of the statute plainly authorizes the Secretary to determine PE-RVUs.

In *Painter*, the Tenth Circuit found that there was no legitimate property interest in having reimbursements calculated in a particular manner. See 97 F.3d at 1357-58. Petitioners highlight that court's statement that there is "nothing in the Medicare Act that would lead a reasonable physician to believe he might be entitled to a greater payment amount for a particular service than was outlined in the Secretary's fee schedule." *Id.* at 1358. Petitioners contend that, unlike in *Painter*, in this case there is something in the Medicare Act that leads a reasonable physician to believe he is entitled to a greater payment. We find petitioners' reliance on this single sentence in the *Painter* court's analysis to be unpersuasive. The *Painter* court emphasized the structure of the Part B payment scheme in reaching its conclusion. See *id.* at 1357. That court stressed that the Secretary was charged with establishing the conversion factor, the component at issue in *Painter*. See *id.* Similarly, in this case, the Secretary was charged with establishing PE-RVUs. Additionally, the *Painter* court stressed that physicians knew prior to providing services the amount according to the fee schedule that they would be reimbursed during a particular year. See *id.* Similar to the conclusion reached by the Tenth Circuit, we find that petitioners are not "entitled to a greater payment amount for a particular service than was outlined in the Sec-

retary's fee schedule." *Id.* at 1358.

Petitioners assert that by foreclosing judicial review, "the Secretary—rather than the courts—would effectively be the final arbiter of the meaning of an act of Congress." In regard to this alleged violation of the doctrine of separation of powers, we remind petitioners that:

[O]ur conclusion that judicial review is not available for [petitioners'] claim follows from our interpretation of an act of Congress, by which we and all federal courts are bound. The judicial power of the United States conferred by Article III of the Constitution is upheld just as surely by withholding judicial relief where Congress has permissibly foreclosed it, as it is by granting such relief where authorized by the Constitution or by statute.

Dalton v. Specter, 511 U.S. 462, 477, 114 S. Ct. 1719, 128 L. Ed. 2d 497 (1994). Thus, we find no separation of powers violation where we are merely adhering to an explicit congressional prohibition of judicial review. The *Painter* court found that "[i]n enacting the 'no review' provision and prohibiting review of the Secretary's calculation of the conversion factor, we find no indication that Congress intended to infringe upon the powers of the judiciary and prohibit review of substantial constitutional issues." 97 F.3d at 1359. Likewise, we find no such indication here. While we recognize that in regard to the conversion factor at issue in *Painter*, Congress did not provide instructions for calculating the conversion factor, we do not believe that the guidance provided with respect to the transition formula for PE-RVUs alters the analysis.

Finally, petitioners argue even if paragraph (B) bars judicial review of their claim, this court should find jurisdiction because in enacting the final rule, the Secretary violated a clear statutory mandate and exceeded the scope of her delegated authority. See *Leedom v. Kyne*, 358 U.S. 184, 188, 79 S. Ct. 180, 3 L. Ed. 2d 210 (1958); see also *Hanauer v. Reich*, 82 F.3d 1304, 1307 (4th Cir. 1996). This argument requires us to take a cursory look at the merits of petitioners' claim to determine whether the Secretary exceeded her authority. See *Hanauer*, 82 F.3d at 1309. Because, on the merits, we would find the Secretary's regulation to be a reasonable interpretation of an unclear statutory mandate, we do not find petitioners' argument to be meritorious.

III. Conclusion

For the foregoing reasons, we AFFIRM the district court's decision granting respondent's motion to dismiss. □

Joint Steering Committee for Public Policy Legislative Update

If you are not already a member of the Congressional Liaison Committee (CLC) of the Federation of American Societies for Experimental Biology (FASEB), please join at <http://www.jscpp.org/clc.htm>. This organization does a great job of keeping one up to date with important doings in Washington that determine research budgets.

I. Political Landscape

The start of the Second Session of the 107th Congress shows little sign that partisan divisions will be easily bridged. The year 2002 is an election year, and the balance of power is at stake. All of the seats in the House of Representatives and one third of the seats in the Senate are up for reelection. Republicans in the House currently hold a slim six-vote margin. Democrats in the Senate hold the majority in an unusual 50/49/1 split. Democrats look to the history of midterm elections, in which the President's party traditionally loses seats, to bolster their hope of taking back the House and maintaining control of the Senate. Republicans look to President Bush's astronomically high approval ratings and an edge in Congressional redistricting to shore up their plans to hold on to the House and to retake the Senate. All that will be settled in November. In the meantime, maneuvering for position in the elections will dictate the politics of each body.

II. Administration's FY 2003 Budget Proposal

On February 4th, President Bush released his budget for FY 2003. The \$2.13 trillion budget contains a 3.7% total increase in funding over last year and an 8.5% discretionary funding increase. This will allow for a 14% increase in defense spending, a 200% increase in homeland security spending and an average of a 2% increase for domestic discretionary spending. It is important to note that the 10-year surplus of \$5.5 trillion has now declined to less than \$2 trillion. The President's FY 2003 Budget contains \$80 billion in deficit spending.

NIH and NSF Funding

Within the tight FY 2003 budget, funding for science did extremely well. The President's request included a budget for the NIH of \$27.3 billion, a 15.8%, \$3.7 billion increase to complete the 5-year doubling effort. In addition, the budget proposal included a 5%, \$240 million increase for the NSF, bringing the agency's total budget request to \$5.036 billion in FY 2003. In an effort to improve NSF-sponsored research, the President's budget increases the size

of the average NSF award, from \$90,000 to \$120,000. The proposed NSF increase, while larger than the increase proposed by the Bush Administration last year, is still short of the level necessary to complete the NSF doubling by FY2006.

The JSC is very pleased with the Administration's proposed largest-ever increase for biomedical research.

III. On the Hill

Currently, cloning is the lead biomedical research issue in the Senate. Senator Sam Brownback (R-KS) has introduced legislation that would ban all cloning, including nuclear transplantation—criminalizing researchers and denying patients the benefit of any treatments or cures developed from research outside the United States. Hearings are underway, and the Senate will take up this legislation in March. Please contact your Senators to urge them to oppose Senator Brownback's Human Cloning Prohibition Act. Due to labored mail processing procedures, phone and fax is the preferred method of contact.

Nuclear Transplantation (Therapeutic Cloning) Talking Points

The nation's leading scientists, including two committees of the National Academy of Sciences, agree that cloning to reproduce humans should be illegal, but that therapeutic cloning, or somatic cell nuclear transfer technology (SCNT), should be permitted.

By moving stem cell research forward, SCNT could bring new hope to the nearly 100 million Americans who suffer from cancer, Alzheimer's, diabetes, hepatitis, Parkinson's disease, and other devastating conditions for which treatments must still be found.

SCNT allows a patient's own genetic material to be used to develop advanced stem cell therapies. These therapies—including transplants and transfusions—would be tailored to match each patient's specific medical condition without causing the patient's immune system to attack and reject the therapy.

For information on how to contact your Senator, see <http://www.senate.gov/> or call the Capitol Switchboard (202-224-3121) and ask to be transferred to your Senator(s).

IV. Help Spread the Message

This year, Congress will face many complex biomedical research policy issues including stem cells, cloning, and bioterrorism prevention. It is more important now than ever before that

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Job Placement Service

Joel D. MacDonald, M.D.

Editor, *Neurosurgery://On-Call*



Since the earliest days of *Neurosurgery://On-Call*, the Congress of Neurological Surgeons has endeavored to provide those seeking employment, or those

with positions to fill, a mechanism for identifying such opportunities. The Online Job Placement Service began quite humbly as an electronic bulletin board. Users could post their application or job descriptions in an open forum. The functionality of the initial version of the Job Placement Service was quite limited, as there was no way to screen each of the postings for particular characteristics such as practice type or area of specialty.

About 5 years ago, the system was redesigned to incorporate contemporary database technology. Users were able to fill out an online form describing their qualifications or the particulars of a job opportunity and then use a simplified search engine to review only the listings of interest. The Job Placement Service has recently undergone another complete overhaul that has preserved much of the original functionality but has also extended the features, so that it is now much more useful and up-to-date.

Like the previous version of the Job Placement Service, users can choose at the welcome to either post or edit an application or job opportunity or review existing listings. To file a listing with the service, the user is prompted with a basic form that collects demographic information, including e-mail address, as well as specific characteristics such as practice specification, practice size, location, population base, subspecialty interest, and any other additional comments. Each listing is then submitted but is not made public until it has been reviewed manually for completeness. Dr. P. David Adelson has recently been the director of the Job Placement Service. He has spearheaded the efforts to revise the site and its functionality and currently reviews each listing individually before it can be made public.

The Job Placement Service receives approximately 15 to 30 new postings for positions each month and about 10 to 15 new applications. Listings are now automatically deleted from the list once they have aged more than 6 months. The site has become an important focal point for commercial job locator services. A number of listings on the site are actually listings through these independent contractors.

When an individual creates a new listing, a unique user-name and password is assigned. This user-name and pass-

word combination can be used to return to the site and make corrections or changes to the listing. Each change is also reviewed manually before being made public. This prevents any unscrupulous use of the service.

The real power of the system is the ability to screen the listings for opportunities with desired individual specifications. From the main entry page, one can use the search button to review either posted positions or applications.

The search engine provides checkboxes to locate listings based on practice specifications, practice size, location, area of population, or subspecialties. Search results can also be sorted according to user specifications. When the search results are returned, each listing can be reviewed individually or rapid communication can be initiated via e-mail hyperlink.

The Job Placement Service is easy to access through the Young Neurosurgeon section of *Neurosurgery://On-Call* or directly at <http://www.neurosurgery.org/jobs>. The service may be used free

of charge by all members of the AANS and CNS. If you are looking for a job or you have a position to fill, visit the Job Placement Service. It is a terrific free member service provided by the Congress of Neurological Surgeons. Who knows, maybe your dream job or dream partner is already listed!



Carl Zeiss
New 4/c

LETTER TO THE EDITOR

In the fall issue of *Neurosurgery News*, there appeared a front page article entitled, "Cameras in the ED: Fame or Invasion of Privacy?" I have been interested in this question for decades, and it shows no sign of an easy resolution. But it's a hopeful sign that Ruth SoRelle and Ann Scheck have at least raised the issue for consideration.

For years physicians have had this awful love-in with the television industry and it began shortly after the event that has come to be known as The Sexual Revolution. Suddenly, the human body was the focus of attention that it had never before gotten. But it wasn't as though TV moguls suddenly began to care about medical breakthroughs, etc.. What happened was that they discovered that they could deliver pornography to a hungry audience and at the same time do it, presumably, under respectable circumstances. Women, of course, were the first easy victims, but they weren't called that of course. They were led to believe that they were performing some valuable public service by allowing their bodies to be filmed while undergoing all sorts of medical procedures: abortions, childbirth, pelvic exams, breast examinations, etc. There was even a "contest" on a Boston TV station that would allow the "winner" to give birth publicly on the particular show involved. It was a grotesque violation of privacy and decency, and when I protested I was informed that I had a "dirty" mind! So much for any opposition. This may have little relevance to the current question of cameras in the emergency department, but it is still part of a larger problem. And the larger problem is the decline of our culture.

Of course cameras in the emergency department are an invasion of privacy. Anyone with an ounce of common sense can determine that. Put a camera anywhere and you charge the atmosphere with abnormal elements. People start behaving differently; they can't help playing to the camera. It's one thing when it is a teaching film and all participants know what they are doing,



It's quite another when these shows are accessible to ordinary viewers. And ordinary viewers can be voyeuristic and just plain curious. But that in no way justifies the medical profession's pandering to their tastes.

We all know that one can justify just about anything one has a mind to do and couch it in the most high sounding rhetoric. But it's all garbage. In fact, the medical profession has surrendered its leadership role and has, for personal and perhaps monetary reasons, sold out. Its schizophrenic approach to women has actually contributed to the breakdown of public decency and normal values. There is a chain reaction, too complex to develop here, but the huge incidence of wife beating, date rape, incest, etc. can be traced to the way women have come to be viewed, and thanks to the medical profession's role, women are generally viewed as though their brains were between their legs.

Does the question change if we violate the rights of privacy for men as well? Of course not. Cameras have absolutely no place in the emergency room or any other place dealing with the ordinary practice of medicine. Sure, we can get used to them; sure there are some people who would do anything to get themselves on camera, but it's all ego driven, or ratings driven, and it's another bit of "plaque" hardening society's spiritual arteries.

Alexandra Mark, Ph.D.
Newport, Rhode Island



Friend or Foe? Managing the Media to Your Advantage

In our highly connected society with print publications of every stripe, Internet sites catering to every conceivable human interest niche, and dozens of broadcast news media available at the click of a button, the occasional unfavorable press account is a reality for most organizations. This may be especially true for academic medical institutions, which are tethered to some of the most vexing challenges that face America's health care system. On one hand, because academic institutions stand at the nation's forefront of scientific inquiry, the research community's quest for solutions to medical problems can present great rewards for patients, scientists, and institutions. However, public relations problems may follow such instances as revelations of poor budgeting leading to a red bottom line, or any number of other issues.

"A principal rule of thumb in public relations: when a problem arises, deal with it."

In today's media-rich environment, institutions must clearly address community concerns about specific issues in a responsible, honest fashion. What steps might academic institutions take to respond to specific negative press, while simultaneously working to bolster an overall favorable image?

"Ideally it is important for physicians, scientists, and administrators to understand the value of the public relations office, and for that office to build relationships with key researchers and administrators before any difficult situation arises," said Kara Gavin, who manages media and public relations for the University of Michigan Health System. "When something negative becomes public knowledge—and invariably it will happen—it greatly facilitates matters if these relationships are already strong, and if the spokespeople have been thoroughly briefed regarding the situation and how to handle the media."

This points to a principal rule of thumb in public relations: when a problem arises, deal with it. Few things create more distrust and ill will in the community than covering up or brushing off potentially controversial events, and the best way to attract media attention is to deny or obfuscate details around an emerging story.

In order to respond appropriately to a controversial situation, facts must first be collected. Pertinent documents, firsthand accounts from involved parties, and consultation with administrative and legal staff are critical, but also consider how the press have conveyed this information, as well as any public reac-

tion occurring as a consequence.

Once the background work is rounded off, the right spokesperson should be chosen to present the case to the press and public. Briefing documents that provide details on the issue at hand, as well as a pre-prepared, sample question-and-answer interview document, might assist in organizing the spokesperson's thoughts and responses prior to interaction with the media. This preparation could prove invaluable, because—in p.r. speak—it is crucial to remain "on message" when addressing concerns about the specific situation arousing controversy.

A secondary goal of many crisis intervention strategies is to highlight the institutional accomplishments to provide "balance" in the coverage. What new scientific advances have been discovered at the facility? What programs have been initiated to serve the interests of the community? Has the organization consistently remained in the black in this era of health care cost containment?

"When something negative becomes public knowledge—and invariably it will happen—it greatly facilitates matters if the spokespeople have been thoroughly briefed regarding the situation and how to handle the media."

A major challenge for academic medical institutions in this regard is language. Translating complex medical or financial information to the layperson involves a certain skill, and sometimes physicians and administrators need guidance in crafting statements readily understandable to the general public.

"Working with scientists to convey their findings to media can be challenging, because the average person doesn't have the background to understand the terminology used by scientists or clinical researchers," said Sally Pobojewski, a senior science writer at the University of Michigan Health System. "One of the recommendations I make to scientists is to try and explain their work in a way that creates a visual image in the mind of the reader or television viewer. Metaphors can work wonders in helping to explain complex processes."

Furthermore, it is important that messages conveyed are succinct and repeated often. Use of jargon during interviews with reporters from mainstream media outlets is a sure-fire way to get your interview reduced to a sound bite crafted by the reporter or the university media office. Media relations experts can attest that repetition

Joint Steering Committee

Continued from page 12

scientists and physicians make their voices heard. Scientists are the most eloquent advocates for biomedical research. You can help strengthen our advocacy efforts by asking your colleagues to join the CLC. Open to scientists and students at all career levels, the CLC puts scientists in contact with their Members of Congress.

Online registration is available at <http://www.jscpp.org/clc.htm>. For further information or assistance, contact Matt Zonarich at mzonarich@jscpp.org.



NEUROSURGERY
NEWS

*E-mail letters to the editor,
article ideas, meeting
notices, and press releases
to: mlevy@hsc.usc.edu*

provides a tactic for delivering a consistent statement to a larger audience, as well as driving home crucial points that an institution must convey in order to solidify its image within the community.

And beyond specific tactics, turn on the charm for added effect. "I'd say one of the more important factors I look for when selecting appropriate candidates to speak to the press is their enthusiasm," said Pobojewski. "Clearly when they love their work and express excitement about an advance, that will shine through in the interview and enhance

the coverage it receives."

Reprinted with permission from *Academic Physician & Scientist* 2002; January February:1, 12. □

An excellent resource on this topic is the National Association of Science Writers' "Communicating Science News: A Guide for Public Information Officers, Scientists, and Physicians." Check <http://nasw.org/csn> for further information or to order a print version of the document.

CNS Membership: Applications in Progress

The following individuals have applied for Membership to the Congress of Neurological Surgeons. Commentary or questions should be directed to Christopher Getch, M.D., Chairman Membership Committee, phone: 312-695-6279; e-mail: cgetch@nmff.nwu.edu.

Daniel D. Balasa
Ronaldo Bartels
Ricardo Boccaletti
George K. Bovis
William E. Butler
Richard Byrne
Richard Byrne
Anthony L. Capocelli, Jr.
Paola Cappabianca
Andrew S. Chiou
Maeng-Ki Cho
Bohdan W. Chopko
Stephane Clemenceau
Douglas Cohen
Moise Danielpour
Krushna B. Das
Carlos David
Wolfgang Deinsberger
Carlo DeLuna
Michael J. Drewek
Christopher Duma
Saad Dusari
Yasser F. El Sawaf
Mohamed El-Fiki
Matt El-Kadi
Ashraf Elkerdany
Thomas Ellis
Hossam El-Noamany
Alain Fabi
Mohamed Fahmy
Frank Fichtel
Paul M. Francis
Marc H. Friedberg
Mark A. Fulton
Michael Groff
David P. Gruber
Jorge Guridi
Ricardo Hanel
David J. Harter
Peter O. Holliday, III
William D. Hunter
Toru Iwama
Toshifumi Kamiryo
Tetsuo Kanno
Charles Kanos
Krissanee Karnchanapan
Bum-Tae Kim
Dong H. Kim

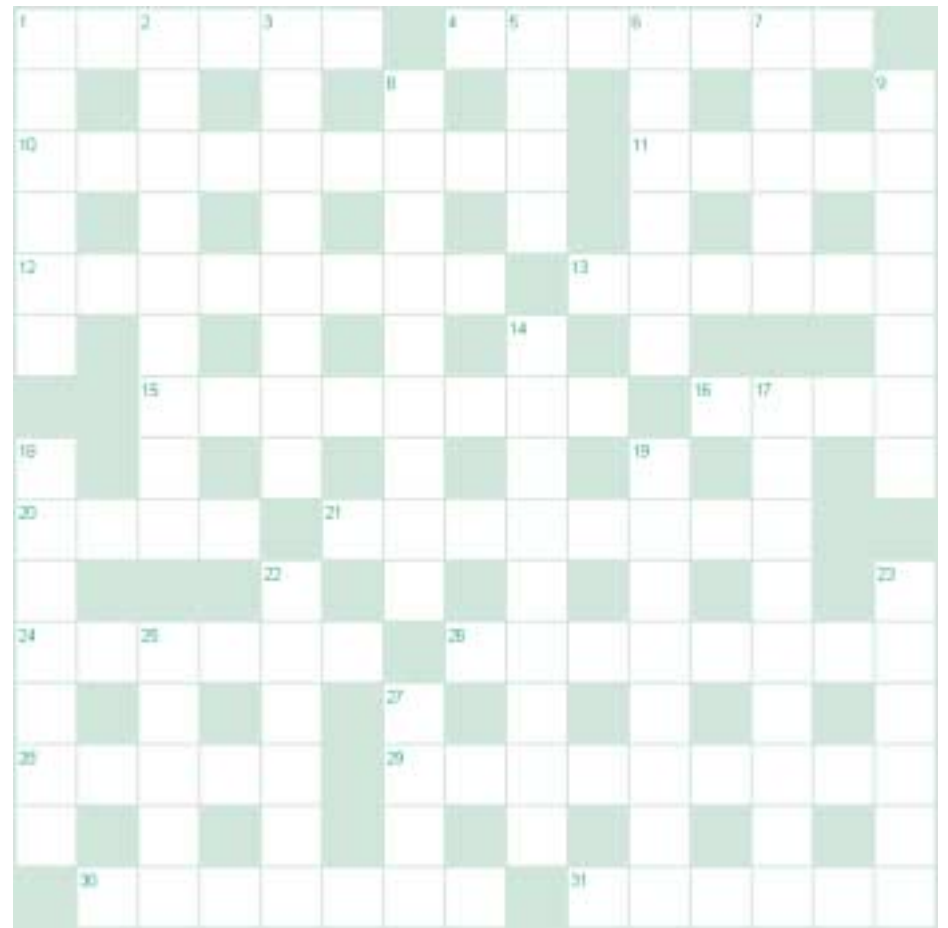
Hyun-Jib Kim
Miriam Y. Kim
Ali Krisht
John J. Kruse
Sanjay Kumar
Zachary T. Levine
Jodie K. Levitt
George Mandybur
John McMahon
Sanford Lee Meeks
Vivek Mehta
Luis R. Mello
Robert A. Mericle
Arlan Mintz
Bharat Mittal
Leo Moores
Pietro Mortini
John Norris
Jeffrey G. Ojemann
Mehmet Ozgur
Charles Park
Jung Y. (Jon) Park
Aman B. Patel
Rajaram N. Patil
Michael Paul
Ronald Pokrupa
Attique UR Rehman
John A. Sandin III
Theodore H. Schwartz
David J. Sedor
D. Krupa Shankar
Nagasawa Shiro
Nathan E. Simmons
Teck-Mun Soo
Mahadev K. Souris
Milan Spaic
Thomas G. Spurlock
John Steck
Zhu Tao
Mahendran Venugopal
Juan Alberto Vigo
Felipe Wainer
Jeffrey Weinberg
Eric Wolfson
Samuel Wong
Zhang Xiaoning
Cannon Zhu

CRYPTIC CROSSWORD PUZZLE

Loki

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. Extravagant washing-like? (6)
4. Gamma Knife brand heard to excell after 50 (7)
10. Coach Lombardi will get to reign in contagion (9)
11. Faint soon, falling around west (5)
12. Reaction of disgust in later amusement (8)
13. Stick on Pixie drink (6)
15. Shimmery surface seen on unwinding silk coil (3,5)
16. Back right musical sensitivity (4)
20. Borsch effluvium overcomes cook (4)
21. Plan for the clue she'd worked on (8)
24. Top spur used for spreading (6)
26. Would item found back in mesa be Mohave plate? (4,4)
28. Sea nearly engulfed flat digger (5)
29. I've passed edge in pit of cavemen (9)
30. Penny, taking usury without us, gains 100 (7)
31. Spirited meeting of Mediterranean and Eastern France (6)

DOWN

1. Pretty wild volley (6)
2. Disfigured user cover! (9)
3. No outside assistance used by female record-holding elf (4-4)
5. Vessel made by sheep-right (4)
6. Chases a merchant holding seeds (6)
7. Amino acid found by Dept. of Police in Los Angeles (1-4)
8. "The Brain's" interest surrounded Swiss William's Euro Community (9)
9. Surgical supplier to anger it badly (7)
14. Love god is after muscled heart thickening (9)
17. High point of first two on Everest in great joy (9)
18. Easy to cross Illinois in winter time delight (7)
19. Certain of Dad holding Univ. sports official (4-4)
22. He got in best request (6)
23. Tranquil in laser energy (6)
25. Talk for a teenager's outing (5)
27. Boom box (4)

THE ART AND BUSINESS OF MEDICINE

Visioning

Douglas V. Johnson

Executive Director
Surgical Management Professionals



Visioning, according to Webster, is, "to see in or as if in a vision: Imagine." I remember hearing the story of a POW who during the time of his captivity

taught himself to play golf. As a psychological diversion during his captivity he would wake up each morning and mentally go through every single detail associated with playing a round of golf. He would start by picking out his clothes, to driving to the course to actually playing each hole on his imaginary course. The complexity of this exercise was made even more difficult because he had never played golf. His visioning was so good, however, that when he returned home, he shot an 80 on his first round of golf. Athletes have been visioning as a part of their training for quite a few years. Other professionals are just now beginning this technique. The technique is basically to see yourself as successful in something you want passionately to achieve.

The pressures and time constraints of the average physician day pushes aside activities not normally or routinely required. At the same time, the anxiety of not addressing the future continues to destine practitioners to a future that does little more than imitate the past. The clinical side of medicine is usually managed quite well through journals, CMEs, and collegial discussions. The business side, however, is often left to a practice manager who is for the most part tending to the physicians' directions, when they have time to give them. Managing the business of medicine should not be left to the varying abilities and skills of practice managers and certainly not just to the physicians' "When I have time," motivation.

Let's discuss, for a minute, taking the time to do some visioning. Consider the following perspectives:

Medical Practitioners: Start your visioning from 20 years out. That seems a bit far into the future, but think back 20 years and consider how fast that has gone. As you think about the next 20 years, imagine the changes in technology, procedure, and pharmacology. Also, think about the changing demands of patients, availability of information, and life style differences. Ask yourself then how these changes will affect the demands on your practice; the many locations your practice

will continue to support the requirements on your time, and maybe even the different kinds of professionals that will be available.

Health Care Reimbursement:

Reflecting back again to the 80s, we saw the beginning of the acronym parade, the introduction of risk to providers, and the notion that there are a finite amount of resources to apply to health. We have begun to at least entertain rationing, more patient choice, and the looming baby boomer aging challenges. Principally, we have been paid for what we do. The more we do, the more we make. Imagine a health care culture that requires guarantees, tracks and publishes all outcome data, and rewards wellness. In addition, as we become more and more accustomed to alternative therapies, reimbursement will be spread over a larger number of providers that will constantly and often times politically be more or less appreciated.

Ownership and Location of Practice Sites:

In not too many years we have come full circle on who owns health care facilities and where we practice. Doctors used to own almost all the hospitals. With the advent of spiraling costs, sophistication of technology and facilities, and demands increasing dramatically, the federal government, local communities, and the investor community began and now own the bulk of the facilities. As this evolution continued, physicians, after having brought their practices into the hospital's four walls, then began to venture their practices out again. Medical oncologists, ophthalmologists, and many others began setting up independent facilities. Today we are seeing the further expansion of where physicians practice, with ambulatory surgical centers and surgical specialty hospitals becoming more and more prevalent. We are also seeing the reintegration of practitioners and health systems as the concept of medical malls and campuses begin to appear.

Patients: Patients have also come full circle from health care delivered principally in the home, to hospitals, to doctor's offices, to surgical centers and specialty hospitals, and now back to the home.

There will always be a multiplicity of locations where health will be delivered. Whatever the location you can be assured that it will be largely determined by preference, cost, and technology.

My introduction of the concept of visioning is not meant to be exhaustive. It is meant to suggest that you set time aside in your practice life to think about the future. Not just ponder what the future might bring and wonder how you will adjust, survive, or even want to continue. But to actually make some

concrete assessments of your future and how you will position yourself. No one with any certainty can predict the future. However, you can begin with visioning that you and your practice "will be the provider of choice in a diversified, dynamic health care mar-

ket." Now you just need to figure out what that will take. Seeing yourself as the captain of your destiny instead of the victim is a great first step if you have never done that before. Just that as a first step is to begin your visioning. Congratulations and good luck. □

Neurosurgery:// On-Call Update

Joel D. MacDonald, M.D.

Editor, *Neurosurgery://On-Call*



Recently, a regulatory issue recently arose with regard to *Neurosurgery://On-Call*. The Federal Government has mandated that Web sites such as ours

that are vulnerable to Internet vandalism install a firewall to prevent demand-of-service attacks. These are a specific type of server attack that can use an Internet server to widely distribute computer viruses without the knowledge or control of the owner. A firewall is essentially an electronic drawbridge and moat that protects the Web site server from intrusion by all but authorized users. This does not in any way effect

the public access to the content on the Web site but it does prevent manipulation of the files and use of the server behind the Web site as a relay point. The firewall software for servers such as the one used by *Neurosurgery://On-Call* is expensive and complex and requires special expertise for installation. We recently completed installation of this layer of protection and are now in compliance.

Membership Application

The CNS electronic membership application is nearly ready to activate on *Neurosurgery://On-Call*. This project was coordinated by Dr. Chris Getch and will serve as a more efficient conduit for processing new membership applications for the CNS.

Meeting Support

Neurosurgery://On-Call is entering a phase of meeting support for the CNS 2002 Annual Meeting in Philadelphia. The abstract site now permits graphic submission. □

Think First Report

P. David Adelson, M.D.

Chairman/Liaison to the Think First/National Injury Prevention Foundation



The following is a progress report for the Think First Committee for the Winter CNS EC meeting that was held in Chicago. This is an informa-

tional progress report only. There are no action items

Relationship to Organized Neurosurgery

The relationship between the Think First Foundation and the CNS remains on a stable, positive note. Since last reported, the goals of the CNS-Think First Liaison Committee continue to be met with regard to the overall assistance of the Think First Foundation in meeting its mission and goals.

Name Change

The Board of Directors of the Think First Foundation, in order to better transmit their message, has changed the name of the foundation to the Think First/National Injury Prevention

Foundation. It is felt that this name change will increase the understanding and awareness of potential sponsors and donors without losing the identity with the Think First name.

Think First Issues Regarding CNS Relationship

Regarding CNS assistance for manpower need, these needs have been met and will continually be updated with members for each of the Think First standing committees through individual contacts and the Leadership Development Committee.

Financially, the Think First Foundation continues to control expenses, generating adequate revenues to stay positive financially. The CNS continues to facilitate those efforts through helping in reducing their expenses and assisting Think First to facilitate their fundraising efforts. The Foundation has now been balance sheet positive for 2 years in a row. With additional funding they will continue to push forward with revisions, updates, and extension of the current programs. Further fundraising and grant making opportunities are being pursued.

Think First Web Site

With consultation/oversight from

Continued on page 17

CNS/AANS Letter to James N. Weinstein, D.O., M.S., Regarding the NIAMS Spine Patient Outcome Research Trial (SPORT)

Thank you for meeting with representatives from the American Neurosurgical Community regarding the SPORT study earlier this year. The candor of the discussion was helpful. We particularly appreciate that you and your staff took the time from your busy schedule to join us.

All of us understand the devotion you have shown in developing studies and trying to further an understanding of spine related diseases. In a previous letter to you, the Presidents of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons stated their concerns regarding the SPORT study. Even after our friendly and informative discussion in Washington, D.C. on July 20, 2001, the neurosurgical community consisting of representatives of the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, and the AANS/CNS Section of Spinal Disorders continue to have reservations about the effectiveness of the study. We believe that the study will make it very difficult to demonstrate a benefit for surgery and which group of patients would benefit from surgery. Although we do appreciate the opportunity you offered for additional neurosurgeons to join the study, we have great reservations about the design of the study itself and therefore are reluctant to promote this.

We continue to have significant concerns regarding certain specific areas, including:

The study was designed to address the broad hypothesis "Is surgery a more effective treatment for lumbar disc herniation, lumbar stenosis and/or degenerative spondylolisthesis than non-operative treatment?" However, the study assumes homogeneity of the patient population, when in fact there is significant heterogeneity with respect to clinical presentation (duration, distribution, severity of symptoms), natural history, radiographic abnormality and others. The impact of these variables can only be addressed through stratified analyses and we are worried that the numbers will be inadequate to allow significant stratification.

There is a question that may not be answered: Do the patients who agree to randomization differ from those who do not in ways that are associated with treatment outcomes? It is not clear that the needed sample size of the population to be studied is adequate for the 25% cross over from non-surgery to

surgery, because that group, unfortunately, will be kept in the non-surgical category.

There is lenient selection of patients for the study in which only one neurologic deficit must be present, such as a numb toe. Those patients almost invariably do well with non-operative therapy.

The study does not look at patients who have acutely herniated lumbar discs and who therefore require urgent surgery.

In the non-operative treatment of patients, it allows almost every form of treatment, including acupuncture, but only a few special forms of surgery are permitted within the guidelines of the study. Moreover, it does not allow a surgeon to prescribe a specific surgical treatment for a specific disease. As an example, if a patient required decompression at L3-L4 and L4-L5 with a spondylolisthesis at L4-L5, only the latter level could be fused electively. We know of no surgeons who would decompress two levels and fuse only one level.

The study is concentrated at Spine Centers and academic centers, which excludes the largest number of patients who are seen and treated in the United States: those seeing private practitioners who are not in spine centers. We feel that these populations are substantially different and that a significant selection bias will exist.

In estimating the cost of the treatment, we believe it is inappropriate to exclude the costs on non-operative therapy that may go on for months before a patient is rendered cured or is sent to a surgeon. The study only recognizes payment for 30 days of treatment and ignores the high cost of prolonged non-operative therapy.

Overall, we believe the study is irresponsibly scientifically flawed and will yield interpretative results that will undoubtedly result in limitations in patients' access to quality care. This is simply an untenable result for neurosurgeons and our patients and we sincerely hope that you will follow through on at least two commitments that we believe you made to us at our July meeting:

- That you are willing to start a new study with neurosurgeons and others to see if we can answer some of these questions that may not be answered by the current SPORT study; and
- That if the study outline is accepted by Spine we could state our reservations in an editorial commentary.

Again we thank you on behalf of the

neurosurgical groups present for taking time from your busy schedule to meet with us in Washington, D.C.

Stan Pelofsky, M.D.
President
American Association of
Neurological Surgeons

Stephen M. Papadopoulos, M.D.

President
Congress of Neurological Surgeons

Think First Report

Continued from page 16

Neurosurgery On-Call, the current plan is to improve the Think First Web site. Presently a basic overhaul is in progress to improve the look, utility, the educational content, the dissemination of research/efficacy of the program, links to other injury prevention sites, and further solicitation in fundraising. This is presently being revised with CNS and Board members of Think First. In the future, with access to more funding and/or expertise, we would hope for a more advanced revision.

Marketing and Public Relations

The golf outing in San Diego was held at the Riverwalk Golf Club and was enjoyable and profitable. The outing for Philadelphia is being planned and will be scaled back and less geared toward celebrity participation. Instead, it will be just an outing day to help raise money for the foundation with dona-

tion opportunities for individuals, foursomes, and companies.

Checkbox

The checkbox was again available on the CNS dues statement to raise further awareness and increased participation by the neurosurgical community in Think First. Last year it helped raise approximately \$5500 for the Foundation.

Chapter Director's Meeting

The annual Think First Chapter Director's Meetings/Symposium is held annually at the AANS meeting. The meeting may be moved to the CNS annual meeting venue to help defray expenses, and this idea is now seriously being considered.

In summary, the CNS and Think First committee continues to assist Think First through new ideas, reduction of expenses, co-promotion, facilitation of fundraising, and, most importantly, the supply of manpower for the development of a self-sufficient organization.

AASFN REPORT

Flora Maragoulas

The American Society of Stereotactic and Functional Neurosurgery welcomes its new Officers: president, Doug Kondziolka; vice president, G. Rees Cosgrove; secretary/treasurer, Andres Lozano. Board members include Antonio A.F. DeSalles, Allan J. Hamilton, John R. Adler, Alain C.J. deLotbiniere Richard D. Bucholz, Ali Rezai, Philip Starr, Robert Gross, Robert Maciunas, and Michael Schulder.

The organization is currently going through a process of self-review with an analysis of all of its key programs. The board is working to address the issues of membership, publications, meetings, and scientific programs. We hope to begin the new journal format in 2003. Past president Dr. David Roberts has accepted the position of chief editor of Stereotactic and Functional Neurosurgery.

Dr. Michael Schulder, our membership committee chair, together with Dr. Andres Lozano, has managed the Web site. The site features information on the societies leaders, bylaws, educational initiatives, future meetings, and links to many related societies.

Andres Lozano, the current secre-

tary/treasurer of the society, has chaired our initiative to review the society bylaws.

The ASSFN is proud to announce the **Philip L. Gildenberg Award in Stereotactic and Functional Neurosurgery**, given to the best resident paper presented under the Joint Section symposium at the annual meeting of the American Association of Neurological Surgeons. This year's winning paper was "Developing Hybrid Brain-Machine Interfaces: Chronic, Multisite, Microwire Electrode Recordings in Primates" by Dragan Dimitrov, M.D., Jerald Kralik, Ph.D., and Miguel Nicolesis, M.D., Ph.D.

The 2003 ASSFN meeting, hosted by Dr. Patrick Kelly, will be held in New York City on May 14-16, 2003 and, at present, the plan is to hold it at the Plaza Hotel, adjacent to Central Park. Scientific Meeting Chairman Andres Lozano has been working to put together the preliminary program.

Also, the Third Arctic Stereotactic Conference will take place in Svalbard, Spitsbergen, Norway from June 16-20, 2002. Forms are available for download on our Web site.

For more information on these and other topics regarding the ASSFN visit our site at www.assfn.org!

CSNS NEWS

Chairman's Corner

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



Several pressing issues are coming together to cause significant problems for practicing neurosurgeons in the United States at the present time.

The Emergency Medical Treatment and Labor Act (EMTALA) enacted by Congress in 1986 was originally passed to give patients a right to emergency health care and to prevent "patient dumping" by hospitals on economic grounds. That piece of legislation and several amendments made to it in subsequent years have turned it into a cumbersome, unfunded government mandate that is placing significant burden on neurosurgeons taking emergency call throughout the country. This law is forcing neurosurgeons to take excessive trauma call and to provide disproportionate amount of patient services without compensation. A number of neurosurgeons across the country are considering (and some have done so) not providing neurosurgical care at hospitals that demand impractical on call schedules. Under EMTALA, neurosurgeons who do not respond to an emergency call can face federal fines of up to \$50,000, exclusion from participation in the Medicare and Medicaid programs, and even criminal sanctions. Needless to say, this places a significant burden on neurosurgeons covering several hospitals at the same time. Similarly, professional liability insurance premiums have soared to unaffordable levels in many regions throughout the country. High-risk specialties like neurosurgery, have been the hardest hit in 2001 and 2002. Many neurosurgeons have seen increases of up to 200% in their premiums in a single year. States such as Arkansas, Connecticut, Illinois, Nevada, Washington, North Carolina,

Pennsylvania, Ohio, and Texas have seen increases of at least 30%. The St. Paul Companies, insurers of doctors in 45 states, announced they will no longer underwrite medical liability policies. Thus, another liability crisis looms upon us.

The Council of State Neurosurgical Societies, recognizes these critical issues to be important and in need of action. The Council is currently working with the Washington Committee, the AANS, and the CNS in developing strategies and ways to address these issues. The Medicolegal and Neurotrauma Committees of the CSNS have been tasked appropriately. A survey has been sent to all practicing neurosurgeons in an attempt to learn the scope and severity of this problem. Results of this survey will be published in future *Neurosurgery News* issues. At the next CNS meeting in Philadelphia, the CSNS plans to host a plenary session on Thursday, September 26, dedicated to the malpractice insurance problem. An educational program, with federal, state, and industry perspectives will be presented. However, the most important part of the program will deal with instructing neurosurgeons how to become involved and what they can do to help counteract this crisis.

At the upcoming AANS meeting in Chicago, a special symposium on EMTALA will be held on Wednesday, April 10th from 11:45 am to 1:00 pm. Trent J. Haywood, M.D., J.D., the Region V Chief Medical Officer for the Center of Medicare and Medicaid Services, will be featured along with John Kusske, M.D., Katy Orrico, J.D., and John McVicker, M.D.(invited). A frank and open discussion will be presented with plenty of time for a question-and-answer period.

Plans are also being made to hold a second National Leadership Development Conference (NLDC) in Washington from July 20-23, 2002. Last year's NLDC program was extremely successful and productive. This year's themes will concentrate on the effects of EMTALA and professional liability on the practice of neurosurgery. Our goals will be to take our message to all of our senators and state representatives

on the Hill. Only legislative advocacy and individual involvement by all neurosurgeons will bring resolution to these problems. Please plan to attend all of the aforementioned programs. If you have any questions please contact me at jimenezd@health.missouri.edu.

Thoughts and Travels of the Immediate Past-Chairman of the CSNS

Lyal G. Leibrock, M.D., F.A.C.S.



Since the last issue, I have not traveled as far abroad as I did with the very pleasant journey to Tallahassee. I did visit the Rose Bowl as a good University of Nebraska indi-

vidual and will not comment further regarding that event.

I did travel locally inside Nebraska and wish to reflect on some critical issues that have come to my attention regarding the delivery of trauma care in this state, which is more rural than many other states. One of the issues in the state that I was able to bring to the attention to one of our senators at the NLDC, I think with some success, was the request by a hospital, in one of our modest-sized cities, to go from a Level III to a Level II trauma center. The only neurosurgeon in the town would then be required to be on-call 24 hours a day, 7 days a week, 365 days a year, because he is the only neurosurgeon. The neurosurgeon, along with my help as the Chairman of Neurosurgery at the state university, tried to explain to the hospital that this was an impossible task. The hospital administration intended to require this effort without any monetary reimbursement or annual sporadic coverage for the neurosurgeon to be on-call all of these hours, putting an arduous burden on his family and practice. In fact, after failed negotiations that went on for a considerable period of time, the neurosurgeon decided to leave. He moved to another community because he did not think he could provide the service the hospital was requiring him to provide without getting into legal jeopardy. This is another regulation that needs to be looked at, particularly in the more rural areas. Dr. Kusske and others in California have told me that this has placed a burden on neurosurgeons even in big cities. If neurosurgeons are going to be required to provide these services, then we need to aggressively convince the regulators and CMS, as well as the individual



trauma systems and health departments in the state, that neurosurgeons need to be reimbursed for this coverage. This is an issue that should not be dropped. It should continue to be on the forefront of the Washington Committee's agenda and be foremost of the concerns of politically active neurosurgeons. I try to be as politically active as I can without being an annoyance to elected public officials, but I think this is a critical issue that all neurosurgeons are going to have to get involved with and address at local, state, and national levels.

Recently, I had to review a lawsuit brought by a family because of the lack of neurosurgery coverage. An individual was injured and one of the two neurosurgeons at the Level II trauma center in a rural part of the state where he was to be treated was away on vacation. Because the hospital and ICU were full, the patient was diverted by aircraft to a town almost three times as far from the eastern part of the state where he had been injured. The neurosurgeons there were able to save the patient, but in a compromised state. The question came up whether there was a problem with the trauma system or was it neglect in the treatment of the head-injured patient by the physicians in this small rural community of less than 10,000. A family practitioner and a CRNA did the intubation. I was able to review the case and found that there were no problems. Certainly, if they had gotten the patient to the nearest hospital, which unfortunately had no beds and no neurosurgeon available to take care of him immediately on arrival, there is the question whether things could have been done more expediently. After a thorough review, I do not think it would have made any difference in this particular case. Nevertheless, this case again points out that there is not an adequate number of neurosurgeons in these less densely populated areas to provide services. As it was, the patient was transported from the site of injury to a rural hospital and then by aircraft to a definitive care site in Lincoln in less than 8 hours. If you drove that distance by car it would have taken about as long just to get from the hospital to the facility where the patient was admitted. Problems with the delivery of neurosurgery trauma care need be well planned for; we cannot have regulations driving neurosurgeons out of medium-sized communities. There must be a way to



The Executive Committee of the CSNS, pictured here at the last NLDC, is made up of the officers, Committee chairmen, Quadrant chairmen, and various representatives from the AANS and CNS.

reimburse these people for all the time they are spending taking care of these complex and time-consuming trauma cases. I would also point out that the patient in this case was self-pay. Most neurosurgeons would understand what the reimbursement level for that effort will turn out to be for the neurosurgeons who provided this central care.

In the last issue, I discussed reimbursement and how that needed to be addressed with the CMS. I have received information from the senator of my state that, early in this session of Congress in 2002, some rectification may be made regarding reimbursement.

A malpractice crisis is again arising, much as it did in the 1960s. In Nebraska, we have been protected by a cap law that has remained in existence for several decades. The State Supreme Court of Nebraska may overturn this law in a signal case of parents who claim their child suffered malpractice during delivery. The judge awarded the family between \$5 and \$6 million, while the cap law only allows the distribution of \$1.25 million. Every year, trial lawyers have brought bills before the state legislature to raise or overturn the cap. When I first moved to Nebraska in 1978, the cap was \$1 million, and a few years ago it was raised to \$1.25 million to account for inflation. There may be a move to make it \$1.5 million, also based on inflation. The individual physician only has to pay the first \$200,000, and the state superfund that we pay into, which is run by the insurance commissioner's office, pays the remainder. However, the resolution of the case mentioned above, which will be heard in the summer of 2002, may throw out the cap law, thereby placing us in the same jeopardy as physicians in many other states, for example in Pennsylvania. I know in many other states there is an aggressive push by trial lawyers and insurance companies to raise these premiums to an onerous amount, making it difficult to continue in the practice of neurosurgery. The neurosurgical community must be aggressively vigilant about these issues so that they can be resolved before they harm the delivery of neurosurgical care. Similar to the problem of Medicare not keeping up with medical costs, reimbursement denies access to a growing elderly population who require neurosurgical care, particularly, in relationship to spinal column issues.

I hope these thoughts will bring out issues that, though local, I have also found when I travel to other places. These concerns tend to be quite general in scope and on the plate of every neurosurgical community in every state. Good attendance at the upcoming NLDC in July in Washington, DC, is greatly needed, so that we can develop advocates for neurosurgery who will be active in every state, since many of these issues are decided state by state and not by national fiat.

2002 CPT Update

Rhonda Petruziello

Coding and Reimbursement Specialist
Cleveland Clinic Foundation

The year 2002 for physicians across all specialties brings a reduction in Medicare reimbursement of about 5.4% or a decrease of \$2.06 per relative value unit (RVU), which is a little more than the raise given the year before (approximately \$2.00 per RVU).

Relative value units (RVU) are the measurement multiplied by the conversion factor (\$36.20) to establish the value and reimbursement for all CPT codes by the Center for Medicare/Medicaid Services (CMS) formerly known as HCFA. There are three components to the total RVUs allowed for each CPT code. They are work, practice expense, and malpractice, and each has its own value or RVU. This year the final phase for the practice expense computation was fully implemented and was higher than originally predicted for most CPT codes, but this unfortunately does not help any of the specialties recover from the reduced conversion factor for 2002 of \$36.20 from \$38.26 in 2001.

Now more than ever, physicians should review the impact this will have on their practices by identifying the RVUs for certain case types and how this impacts reimbursement for those case types. This can help physicians learn how to enhance their coding skills and where to concentrate efforts for policy changes needed to help improve reimbursement. Listed below you will find some comparisons by case type of 2001 to 2002 by RVU and Medicare allowable in Ohio for the neurosurgeon.

CPT 2002 has five new CPT codes for the neurosurgeon and 14 revisions to existing CPT codes. The AMA focused heavily on revising or clarifying descriptions of all CPT codes in 2002 so that they would be better understood. For neurosurgery, that meant a revision as simple as eliminating the abbreviation of CSF and replacing it with cerebrospinal fluid or replacing the word drug with medication. CPT modifiers are now accepted as the standard for all insurance payors in 2002. This should help physicians optimize reimbursement for complex services, co-surgeries, and multiple surgeries, when in the past insurance carriers had the option to ignore modifiers used to help further describe the procedure performed. This in some cases may have contributed to inadequate reimbursement. CPT 2002 has also defined co-surgery in certain subsections (i.e., musculoskeletal and nervous systems) and provided the appropriate coding scenarios for services performed. Surgeons should understand the intent of this modifier and should always discuss the usage of "62" before the procedure is performed.

Physicians need to start becoming familiar with the new changes to CPT 2002 and make sure that their charge records have been appropriately updated to ensure proper coding is assigned to every procedure. It is also a good idea to monitor reimbursement closely in an effort to identify whether insurance carriers have accepted the 2002 CPT changes and are appropriately reimbursing. As always, physician practices should exercise their right to appeal all those underpaid and denied claims not only to improve reimbursement but also to educate insurance carriers.

Case Examples	2001 CPT	2001 RVU's	2001 Med Allow	2002 RVU's	2002 Med Allow
Brain Tumor	61510	53.80	\$ 2,005.65	50.82	\$ 1,784.65
	61795	7.62	\$ 284.07	6.99	\$ 245.68
	69990	5.89	\$ 220.02	5.90	\$ 207.41
		67.31	\$ 2,509.74	63.71	\$ 2,237.74 (-11%)
Epilepsy	61538	52.08	\$ 1,939.60	48.49	\$ 1,702.24
	69990	5.89	\$ 220.02	5.90	\$ 207.41
		57.97	\$ 2,159.62	54.39	\$ 1,909.65 (-12%)
Vascular	61700	90.12	\$ 3,366.38	89.12	\$ 3,130.67
	62140	26.16	\$ 974.05	24.83	\$ 871.23
	69990	5.89	\$ 220.02	5.90	\$ 207.41
	62272	2.21	\$ 147.22	2.10	\$ 168.29
	34.26	\$ 4,707.67	32.83	\$ 4,377.60 (-7%)	
Spine	63075	38.03	\$ 1,415.46	36.97	\$ 1,296.01
	22554.51	37.71	\$ 700.93	36.07	\$ 631.95
	22845	21.65	\$ 807.75	20.56	\$ 722.67
	20931	3.34	\$ 124.54	3.13	\$ 110.00
		62.70	\$ 3,048.68	59.76	\$ 2,760.63 (-9%)
	63030	25.01	\$ 928.76	24.13	\$ 844.72
	63035	5.89	\$ 219.47	5.39	\$ 189.47
	30.90	\$ 1,148.23	29.52	\$ 1,034.19 (-10%)	
63047	29.87	\$ 1,109.66	28.64	\$ 1,003.19	
63048	6.11	\$ 227.62	5.59	\$ 196.49	
	35.98	\$ 1,337.28	34.23	\$ 1,199.68 (-10%)	

State Society Corner

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

The California Association of Neurological Surgeons held their meeting January 18-20, 2002 at the Renaissance Parc 55 Hotel in San Francisco. Socioeconomic topics covered included coding issues, EMTALA, and Medicare compliance issues. The scientific component included new therapies for ALS, polyneuropathy, epilepsy, Alzheimer's, and MS. Dr. Lawrence M. Shuer of Stanford University Medical center is the new president. For further information, visit their Web site at www.cans1.org.

The Connecticut State Neurosurgical Society held its annual meeting November 21, 2001. Dr. Isaac Goodrich submits the following information:

"The annual meeting of the Connecticut State Neurosurgical Society was held on New Haven on November 21, 2001. Dr. Michael Apuzzo was the Honored Guest of the Society. His presentation was on the 'Neurosurgical Operating Room in the 21st Century' and was well received by the attendees. Over half of the Society attended the meeting. Dinner then followed with lively collegial discourse."

The Hawaii Neurosurgical Society held its first quarterly meeting January 24, 2002. Dr. Jon Graham has posted the following summary:

"Our guest speaker was Dr. John Rausch, an anesthesiologist who has organized the largest single anesthesia group in Hawaii that recently went non-par with HMSA, the largest insurance carrier in Hawaii. He spoke about the advantages and disadvantages of incorporation. Our next meeting is scheduled for May 2, 2002 and the tentatively scheduled speaker is Dr. Michael Apuzzo on a topic of his choosing. Elections will be held at that meeting for officers per our by-laws."

The Illinois Neurosurgical Society held its fall meeting December 1, 2001. Dr. Thomas Hurley reports the following:

New officers for 2002: President, Stephen Ondra; Vice President, Ann Stroink; Secretary, Thomas Hurley; Treasurer, Stan Fronczak; Membership, Christopher Getch.

Changing the by-laws to let the officers hold their position for 2 years instead of 1 year was discussed. The plan is to bring this suggestion to the Society for a vote at the annual spring meeting. As usual, the meeting will be held immediately following the Annual Scientific

CSNS News

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Meeting of the Interurban Neurosurgical Society Friday, March 8, 2002 in Chicago."

The **Minnesota Neurosurgical Society** met in November 2001. Dr. Mahmoud Nagib was elected president. A statewide meeting is planned inclusive of all practicing and retired neurosurgeons in Minnesota for May (2002). Dr. Walter Hall will represent the State of Minnesota at the Joint Council of State Neurosurgical Societies.

Upcoming Meetings

March 2002

New England Neurosurgical Society
The Killington Grand Hotel & Conference Center
Killington, VT
Guest Speaker: Thomas Marshall,
Executive Director of AANS
Contact: Peter K. Dempsey, MD
E-mail: peter.k.dempsey@lahey.org

Illinois Neurosurgical Society
Chicago, IL
Contact: Thomas R. Hurley, MD
E-mail: thurley@silvercross.org

Maine Neurosurgical Society
Grand Summit Hotel at Sugarloaf

Contact: Thomas Doolittle
Phone: 207-873-6615

April 2002

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

May 2002

Hawaii Neurosurgical Society
Honolulu, HI
Guest Speaker: Michael Apuzzo, MD
Contact: Jon F. Graham, MD
Phone: 808-550-4939

June 2002

Iowa-Midwest Neurosurgical Society
Iowa City, IA

Contact: Kellie Bard
Phone: 402-559-9605
E-mail: kbard@unmc.edu

August 2002

Tennessee Neurosurgery Society
Opryland Hotel
Nashville, TN
Contact: Clarence B. Watridge
Phone: 901-522-7700
E-mail: _mpannell@semmes-murphey.com

January 2003

California Association of Neurosurgeons
The Sutton Place
Newport Beach, CA
Contact: Janine Tash
Phone: (916) 457-2267
E-mail: Jt4ns@aol.com

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 DATE	PLACE	SPEAKERS
Alabama	John C. Fraser	(256) 386-7499	None			
Arizona	William L. White	(602) 406-3466	William.White@BNAneuro.net			
Arkansas	Kenneth Tonymon	(870) 972-1112	KTonymon@aol.com		Little Rock, AK	
California	Lawrence M. Shuer	(650) 723-6093	lshuer@stanford.edu	January 17-19, 2003	The Sutton Place, Newport Beach, CA	
Colorado	John McVicker	(303) 788-4000	johnmcvicker@rmna.net			
Connecticut	Isaac Goodrich	(203) 781-3400	None			
Delaware	J. Rafael Yanez	(302) 674-9100	None			
Florida	Philip Tally	(941) 794-3118	ptally@aol.com			
Georgia	Gerald Kadis	(912) 226-8880	gkadis@rose.net			
Hawaii	Jon Graham	(808) 550-4939	jgraham@my.teampraxis.com	May 2, 2002	Honolulu, HI	
Idaho	Christian Zimmerman	(208) 367-3500	None			
Illinois	Stephen Ondra	(312) 695-6282	sondra@mff.nwu.edu	March 8, 2002	Chicago, IL	
Indiana	Jeffrey Crecellius	(765) 448-8000	crecelij@arnett.com			
Iowa-Midwest	John Treves	(402) 559-9605	kbard@unmc.edu	June 1, 2002	Iowa City, IA	
Kentucky	John J. Guarnaschelli	(502) 584-4121	ngglsiw@thepoint.net			
Louisiana	C. Babson Fresh	(318) 443-4576	None			
Maine	Thomas Doolittle	(207) 873-6615	None	March 16-17, 2002	Grand Summit Hotel at Sugarloaf	
Maryland	Thomas Ducker	(410) 224-0545	None			
Michigan	Murali Guthikonda	(248) 569-9467	MGuthikonda@neurosurgery.wayne.edu			
Minnesota	Mahmoud Nagib	(612) 871-7278		May 2002		
Mississippi	Philip Azordegan	(601) 354-8895	zsozso@bellsouth.net			
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	March 1, 2002	Killington Grand Hotel, Killington, VT	
New Jersey	Edward Von der Schmidt		(609) 924-3614			
New Mexico	Erich Marchand	(505) 988-3233	emarchand@neurosurgerynm.com			
New York	Paul Spurgas	(518) 377-2642	SpurgasP@shine.org			
North Carolina	C Scott McLanahan	(704) 376-1605	scottmclanahan@cnsa.com			
Ohio	Alan Cohen	(216) 844-5741	alan.cohen@uhhs.com			
Oklahoma	Robert Remordino	(405) 748-3300	stanp@neurosurg.org			
Oregon	Edmund Frank	(503) 494-4314	franke@ohsu.edu			
Pennsylvania	Robert Rosenwasser	(215) 928-7004	robert.h.rosenwasser@mail.tju.edu			
Rhode Island	Beverly Walters	(401) 421-4703	Beverly_Walters@brown.edu			
Tennessee	Clarence Watridge	(901) 260-0712	cwatridge@semmes-murphey.com	August 17-18, 2002	Opryland Hotel, Nashville, TN	
Texas	Haring Nauta	(409) 772-1500	hjnauta@utmb.edu	April 18-20, 2002	Adam's Mark Hotel, Dallas, TX	
Utah	Bryson Smith	(801) 479-9119	brysonsmithmd@earthlink.net			
Virginia	Anthony Caputy	(202) 994-2210	neuase@gwumc.edu			
West Virginia	David L. Weinsweig	(304) 525-6825	weinsweigd@tsnci.com			
Washington	Timothy Steege	(206) 623-0922	tsteege@aol.com			
Wisconsin	Spencer Block	(414) 438-6500	mniinfo@execpc.com			

JOINT SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

Practice Guidelines

The AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves, under the direction of Dr. Mark Hadley and Dr. Beverly Walters, has completed an evidence-based review of literature pertaining to the treatment of cervical spine trauma and spinal cord injury. This work represents a monumental effort of many prominent experts in spinal surgery and embraces 22 clinical questions ranging from immobilization in the field to the role of Methylprednisolone after acute spinal cord injury. The evidence has taken 2 years to compile and analyze.

The end result, *Practice Guidelines in the Treatment of Cervical Spine and Spinal Cord Injury*, has been published under separate cover as a supplement to the March 2002 issue of the journal *NEUROSURGERY*. This publication is destined to become the reference manual for all clinicians involved in treating cervical spine injuries from the paramedics in the field to the rehabilitation specialists involved in long-term follow-up. The special issue has been circulated free of charge to all current subscribers of *NEUROSURGERY*. Congratulations to Drs. Hadley and Walters along with the rest of their team for a job well done!

Awards

Research Funding: The AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves has established two Research Grants: the *Larson Award* and the *Sonntag Award*. They are intended to establish funding for clinical projects related to the spine and peripheral nerves and to provide a means of peer review for clinical research projects to help improve the quality of the proposal and, therefore, enhance competitiveness for National Institutes of Health (NIH) funding. The awards are also meant to provide continued funding on an annual basis to establish the AANS/CNS Spine Section as a known source for quality clinical research aimed at answering questions pertaining to the treatment of disorders of the spine and peripheral nerves.

The awards range from \$15,000 to \$30,000 and are intended for primary investigators of planned clinical studies requiring national level funding to support the preparation of grant proposals and external consultations and to assist in the development of the proposal, planning meetings, and the col-

lection of pilot data. Work that can be completed without such support (such as literature review and preliminary protocol design) should be completed before applying for the Larson or the Sonntag Awards.

The format of the proposal should follow that of the NIH grant package. Specifically, applications should not exceed five single-spaced pages. The applicants should address their specific aims, pertinent literature review and previous studies review, include a brief summary of the proposed study, and a plan for utilization of the funds, as well as a detailed budget and budget justification. The budget should not include salary support for the primary investigator or co-investigators.

Application details for research grants are available from Michael G. Fehlings, M.D., Ph.D., The Toronto Hospital, 399 Bathurst St., Suite 2-417, Toronto, Ontario M5T 2S8, Canada (tel. 416-603-5627), or check out our Web site at www.neurosurgery.org. The application deadline for grants to be awarded for 2002 is December 1, 2001.

Fellowship Funding: The *Cloward Fellowship Award* is sponsored by Medtronic/Sofamore Danek and is awarded annually to one or two U.S. or Canadian trained neurosurgical residents to provide supplemental funds for advanced education and research in disorders of the spine or peripheral nerves in the form of fellowship training. The amount of the award is \$30,000.

Application information for the Cloward Fellowship Award can be acquired from Timothy C. Ryken, M.D., The University of Iowa Hospitals & Clinics, Division of Neurosurgery, 200 Hawkins Drive, Iowa City, IA 52242. E-mail: timothy-ryken@uiowa.edu. The application deadline for the 2002 Cloward Fellowship Award is September 15, 2001.

Resident Awards: The *Mayfield Award* is presented annually by the Joint Section on Disorders of the Spine and Peripheral Nerves to the neurosurgical resident who authors an outstanding research manuscript detailing a laboratory or clinical investigation in the area of spinal or peripheral nerve disorders. Two awards are available, one for clinical research and one for basic science research. Each award is valued at \$500.00.

For further information and submission forms, please contact: Timothy C. Ryken, MD, The University of Iowa Hospitals & Clinics, Division of Neurosurgery, 200 Hawkins Drive, Iowa City, IA 52242. E-mail: timothy-ryken@uiowa.edu, or check out our Web site at www.neurosurgery.org.

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2002 Meeting Listings

General information for all listings: American Association of Neurological Surgeons, 5550 Meadowbrook Drive, Rolling Meadows, IL 60008. Toll free: 888-566-AANS; Phone: 847-378-0500; Fax: 847-378-0600; Web site: www.aans.org.

American Association of Neurological Surgeons
Managing Coding and Reimbursement Challenges in Neurosurgery: 2002

New Orleans, Louisiana
March 1-2, 2002
Hotel: The Maison Dupuy
Primary Meeting Contact: Vanessa Garlisch
E-mail: epm@aans.org
Web site: www.aans.org

American Association of Neurological Surgeons and Congress of Neurological Surgeons
Section on Pain Annual Meeting

Chicago, Illinois
April 4-5, 2002
Primary Meeting Contact: Lisa Sykes, Director of Meetings
E-mail address: aansam@aans.org
Web site: www.neurosurgery.org/pain

American Association of Neurological Surgeons and Congress of Neurological Surgeons
Section on Tumors Annual Meeting

Chicago, Illinois
April 11-12, 2002
Primary Meeting Contact: Lisa Sykes, Director of Meetings
E-mail address: aansam@aans.org
Web site: www.neurosurgery.org/tumors

American Association of Neurological Surgeons
Managing Coding and Reimbursement Challenges in Neurosurgery: 2002

Anaheim, California
May 10-11, 2002
Hotel: Anaheim Marriott Suites
Primary Meeting Contact: Vanessa Garlisch
E-mail: epm@aans.org
Web site: www.aans.org

American Association of Neurological Surgeons
Neurosurgery Review by Case Management: Oral Board Preparation

Hartford, Connecticut
May 26-28, 2002
Hotel: Dolce Hastings Conference Hotel
Primary Meeting Contact: Vanessa Garlisch
E-mail: epm@aans.org
Web site: www.aans.org

American Association of Neurological Surgeons
Managing Coding and Reimbursement Challenges in Neurosurgery: 2002

Boston, Massachusetts
August 23-24, 2002
Hotel: Omni Parker House
Primary Meeting Contact: Vanessa Garlisch
E-mail: epm@aans.org
Web site: www.aans.org

American Association of Neurological Surgeons
Managing Coding and Reimbursement Challenges in Neurosurgery: 2002

Chicago, Illinois
September 6-7, 2002
Hotel: The Palmer House Hilton
Primary Meeting Contact: Vanessa Garlisch
E-mail: epm@aans.org
Web site: www.aans.org

American Association of Neurological Surgeons
Neurosurgery Review by Case Management: Oral Board Preparation

Houston, Texas
November 10-12, 2002
Hotel: Doubletree Hotel - Houston
Primary Meeting Contact: Vanessa Garlisch
E-mail: epm@aans.org
Web site: www.aans.org

American Association of Neurological Surgeons
Managing Coding and Reimbursement Challenges in Neurosurgery: 2002

Washington, DC
November 15-16, 2002
Hotel: Marriott at Metro Center
Primary Meeting Contact: Vanessa Garlisch
E-mail: epm@aans.org
Web site: www.aans.org

American Association of Neurological Surgeons and Congress of Neurological Surgeons
Section on Pediatric Neurological Surgery Annual Meeting

December 4 - 7, 2002
Phoenix, Arizona
Primary Meeting Contact: Lisa Sykes
E-mail: aansam@aans.org
Web site: www.neurosurgery.org/pediatric

CRYPTIC CROSSWORD PUZZLE IS ON PAGE 15



Solution key: ⑨ homophone, * anagram, < inside of, > wrapped around

ACROSS

1. double definition pun
4. L+EKSELL ⑨
10. VINCE>RULE
11. SOON>W
12. UGH<LATER
13. IMP+ALE
15. SILK+COIL *
16. R+EAR
20. hidden
21. CLUE+SHE+D *
24. T+ROWEL
26. hidden and reversed in mESA BE MOHave
28. SE(a)>PAD
29. RIM<PIT + I+VE
30. CENT+(us)URY
31. SEA+(fra)NCE

DOWN

1. VOLLEY*
2. USER+COVER * &Lit!
3. SHE+LP > ELF
5. EWE+R
6. hidden
7. D.O.P.<L.A.
8. INT. > TELL+E.C.
9. ANGER+IT *
14. (mu)SCL(ed)+EROS+IS
17. EV(crest)<ELATION
18. EASY>C(entral)S(tandard)T(ime)
19. SIRE > U.+REF
22. HE<BEST
23. hidden
25. hidden
27. double definition

PRESS RELEASE

Elekta's Leksell Gamma Knife® Expands into New Health Care Market in Canada

Stockholm, Sweden, March 8, 2002—Elekta announced today the first acquisition of Leksell Gamma Knife® in Canada by the Winnipeg Regional Health Authority (WRHA). Contrary to past perceptions that only large markets can support a Leksell Gamma Knife® sys-

tem, Health Sciences Center has found it to be cost-effective and is looking to establish this site as a center of excellence for neurosurgery and neurosciences in the province.

"I've seen first-hand the types of patients that can be treated. Typically with tra-

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For further information, please contact: Lars Jonsteg, VP Corporate Relations, Elekta AB (publ), tel. +46 8 587 254 82 or Michelle Lee, Public Relations Manager, Elekta North and South America, tel. +1 770 300 9725, ext.145. □

Joint Section

Continued from page 21

Deadlines

September 15, 2002: Cloward Fellowship Award

September 15, 2002: Mayfield Awards

December 1, 2002: Sonntag and Larson Clinical Research Grants

Comments, Submissions, or Suggestions for the Spine Section?

Please e-mail John Hurlbert at jhurlber@ucalgary.ca or contact through surface mail: Dr. R.J. Hurlbert, University of Calgary Spine Program, Foothills Hospital and Medical Centre, 1403-29th St. N.W., Calgary, AB Canada T2N 2T9. □

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