



# NEUROSURGERY

# NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

## President's Message: The Advantage of Perspective

**Mark N. Hadley, M.D.,  
F.A.C.S.**  
President, CNS



**T**he view from here is remarkable. As I examine the landscape of organized medicine and specifically organized neurosurgery I recognize extraordinary

challenges to our profession: declining reimbursements, medical liability insurance, increased government requirements and restrictions, contentious issues such as the SPORT study, surgery for lumbar spinal stenosis, the International Subarachnoid Aneurysm Trial (ISAT) and its implications for intracranial vascular neurosurgeons, and obstacles to reasonable and responsible solutions from HCFA, Congress, insurers, and special interest groups.

While that view is daunting, I am energized and optimistic. I have been elected to serve as the President of a large, mature, healthy, and respected neurosurgical member-service organization. My charge is to lead the Congress of Neurological Surgeons, and (with other leaders) organized neurosurgery, through this difficult terrain and to develop and implement reasonable and responsible solutions. We must pursue comprehensive strategies (independently as an organization and in partnership with others) to effect change on issues important to our specialty and our membership. In particular, we must provide our members with exceptional, contemporary educational products and mentor and train young neurosurgeons, including in public and organizational service.

I am fortunate to lead an efficient and effective 53-year-"young" organization. The CNS is responsive and extremely cost-effective. Incredibly innovative and industrious young men and women in volunteer roles lead the CNS as members of the CNS Executive Committee. Each gives inestimable time, energy, and intellect on behalf of the organization and our missions. Each is aware of their important responsibilities to the organization and to its membership. This group tackles the difficult issues facing our organization and specialty, generates cutting-edge educational products and publications of the CNS, and provides leadership and financial support to many initiatives and activities, including the Joint Sections of the AANS/CNS.

The CNS receives organizational support from a small but very effective professional staff, led by Laurie Behncke, the CNS's remarkable Executive Director. Ms. Behncke and her staff provide administrative and logistical support to the CNS and its Executive Committee,

direct implementation of Executive Committee actions and policies, coordinate membership data, manage the CNS Annual Meetings, and coordinate the countless activities and initiatives of the CNS. They do so at every step with fastidious attention to cost, quality, and efficiency.

The essential missions of the Congress of Neurological Surgeons as described in our mission statement and defined in our Strategic Plan are *education* in the science and medical care of neurosurgery, *leadership development*, and the *advancement of neurosurgery* and the special needs of our members. The primary educational tools of the CNS are its Annual Meeting and its publications, notably our journal, *NEUROSURGERY*. The CNS Executive Committee keeps these essential member educational products relevant and contemporary. The success of our recently completed 2002 Annual Meeting in Philadelphia

is a creative example of the interface between new technology (Palm™ handheld computers) and the science of our discipline. *NEUROSURGERY*, the official journal of our organization is celebrating its 25th anniversary. Under the leadership of Editor Michael L. J. Apuzzo, *NEUROSURGERY* has become the premier scientific journal of our profession and has achieved the highest citation index for any journal serving our discipline. *Clinical Neurosurgery*, the official text compilation of the science of our annual meetings remains a popular member benefit. *Neurosurgery News*, our official newsletter is an effective source of current information for our membership.

The Congress of Neurological Surgeons offers a variety of educational tools for our members and our profession. The *Medical Student Curriculum in Neurosurgery* is an outstanding outline of neurosurgery educational goals and course content for medical students in North America. It serves as an aid to deans, medical schools, and the faculty who

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## CNS Executive Director's Message

**Laurie L. Behncke**  
Executive Director, CNS



**S**erving as a steward for the Congress of Neurological Surgeons gives me a great sense of pride and confidence. As the CNS Executive Director, I feel fortunate to be leading an outstanding staff

that interacts daily with over 100 neurosurgical member volunteers servicing over 5,000 CNS members. Our aim is to support and advance the neurosurgical specialty and our neurosurgical community. At a time when all member service organizations face shrinking budgets and each CNS member faces falling reimbursements, it is imperative that each of us question the

value of membership in professional organizations, particularly the value of membership in the CNS. The CNS strives to provide top-flight educational products and a variety of member services at the lowest possible dues (only \$335 per year). We do not take our steady growth in active membership for granted.

Throughout this issue, you will see many examples of how membership in the CNS translates into daily value through CNS publications, educational products, advocacy, and scientific research and clinical practice endeavors. We at CNS Headquarters strive to enhance your membership value with an efficient infrastructure and skilled staff, committed leadership throughout the CNS Committee structure, and a stable, predictable operating budget.

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### President's Message

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plan third and fourth year curricula for medical students. The outline, in association with the Primer-Medical Student Curriculum, is a valuable education and reference resource.

The *Resident Curriculum Guidelines for Neurosurgery* provides a comprehensive guide to resident education in neurosurgery during each year of neurosurgical residency training. Well-defined goals and objectives allow program directors and instructors to prepare educational and teaching paradigms for the instruction of residents at every level of training within the residency program, and to establish guidelines and benchmarks for learning and performance. Program directors also use this CNS educational product to meet ACGME requirements for teaching and training.

*Self-Assessment in Neurological Surgery (SANS)* is a valuable self-study, self-assessment educational tool for neurosurgeons. Previously a joint initiative of the AANS and CNS, SANS is now produced solely by the CNS. The CNS is working closely with the American Board of Neurological Surgery to make SANS VII, due in October 2003, an even more effective educational tool for North American neurosurgeons as they prepare for recertification requirements recently imposed by the ABNS.

The Publications Committee of the CNS recently produced a remarkable new commemorative book entitled *Walter Dandy, The Personal Side of a Premier Surgeon*, edited by Issam Awad and Edward Laws, Jr. A new online text entitled *Geographical Neurosurgery* by Dr. Samuel Ohaegbulam has been developed and will be available in the spring of 2003, through [www.neurosurgery.org](http://www.neurosurgery.org). The directories of the CNS are among the most accurate and contemporary in organized medicine. They include the CNS Membership Directory, the World Directory of Neurological Surgeons, and the CNS Residents and Fellows Directory.

These are but a few of the educational services the CNS provides. A variety of educational fellowships are offered by the Congress of Neurological Surgeons to provide focused training and education to qualified members of the CNS. Fellowship opportunities range from International Fellowship training, Clinical Fellowships in a variety of subspecialty disciplines in neurosurgery, and Public Policy Fellowship training.

Mentoring and developing young leaders in neurosurgery is an essential mission of the Congress of Neurological Surgeons. The CNS is committed to assisting in the education and development of young neurosurgeons in the arenas of public service, organizational service and leadership, participation and leadership in state neurosurgical societies, and in political and socioeconomic advocacy. Public service may

be accomplished through public education and injury prevention programs, (specific for neurosurgeons, the Think First Foundation, for example). Organizational service may be accomplished via participation in volunteer committee work at a variety of levels within the CNS or at CNS Annual Meetings or through service to one of seven AANS/CNS Joint Sections. Advocacy participation is promoted through involvement with the AANS/CNS Council of State Neurosurgical Societies or with state societies, through interaction and liaison with other national medical organizations (AMA, ACS, etc.), or through service to the AANS/CNS Washington Committee.

The Leadership Development program of the CNS encourages and mentors young men and women to contribute for the entirety of their careers to the public and to organized neurosurgery beyond the contributions they might make in the practice of neurosurgery. It offers the opportunity to educate and train young neurosurgeons in issues important to their practices and that affect the profession of neurosurgery specifically and the practice of medicine in general. It also develops effective advocates who can represent neurosurgery in political and socioeconomic arenas and who can serve within the CNS and various other neurosurgical organizations. Most importantly, it trains young neurosurgeons to assist in the decision-making processes of organized neurosurgery.

The advancement of neurosurgery and the special needs of our profession are primary missions of the Congress of Neurological Surgeons. Beyond providing a myriad of educational services and the Leadership Development program, the CNS works closely with other neurosurgical organizations.

The Membership Committee provides a streamlined approach to membership in the CNS, processes applications, and upon approval by the Executive Committee of the CNS, confirms membership in one of eight membership categories: Active (practicing North American neurosurgeons), International Active (practicing international neurosurgeons), Associate (non-neurosurgeon physicians), Affiliate (non-physician allied health care clinicians/practitioners), Resident and Fellow (neurosurgical residents and fellows-in-training), Auxiliary (spouses of CNS members), Senior (retired member surgeons), and Honorary. Active, Associate, Affiliate, and Resident/Fellow members receive publications of the CNS (*NEUROSURGERY*, *Clinical Neurosurgery*, *Neurosurgery News*) and reduced registration fees at CNS Annual Meetings. Members who attend CNS Annual Meetings receive continuing medical education credits based on participation. The CNS provides verification of CME credits obtained at CNS meetings to its members. The CNS has an established Code of Ethics, CNS Guidelines on Physician Expert Witness Activity and Tes-

timony, and a Professional Conduct Committee to assist members in their practices and professional lives. The CNS provides service to its members by means of information transfer via personal, phone, Fax, mail, or e-mail communication, through NEUROSURGERY://ON-CALL® and by other media.

The Congress of Neurological Surgeons is actively involved with other neurosurgical and surgical/medical organizations. Our most important relationship is with the American Association of Neurological Surgeons (AANS). The CNS in conjunction with the AANS jointly governs and supports seven educational Joint Sections, several joint activities, and the joint Washington Committee. The leadership of the CNS actively participates on the Washington Committee, the most effective medical specialty advocacy group in Washington.

The volunteer spirit of the CNS, the insights of its young leaders, our commitment to our Mission Statement and Strategic Plan, and our efficient organizational structure allow us to have the lowest member dues of any comparable medical/surgical society in North America. Annual dues for CNS Active membership are \$335. Of each member's dues, \$120 per member goes toward joint Washington Committee expenses, \$140 goes to our publisher for *NEUROSURGERY* (\$120) and *Clinical Neurosurgery* (\$20), and \$20 is directed to the CSNS. Remarkably, the numerous other member services, publications, and educational products are accomplished on dues of \$55 per member.

That is efficiency and effectiveness to be proud of!

The leadership of the CNS will continue to work in a collegial, professional manner with our counterparts at the AANS. Issues of unification and merger have been raised previously. The CNS has developed and is prepared to implement a progressive unification structure for organized neurosurgery. We will continue to create efficiencies for organized neurosurgery, the CNS, and the AANS by improved interaction with the AANS. The CNS will vigorously support the relative educational autonomy of the AANS/CNS Section organizations and the Council of State Neurosurgical Societies (CSNS).

The CNS in particular and organized neurosurgery in general are in remarkably good shape. While there are difficult challenges ahead, the CNS is on the move to meet those challenges. We will act independently, and we will act collaboratively with the AANS (and other medical/surgical groups) for the greater good of our specialty and our missions. We will achieve the goals and missions of our organization in an efficient, cost-effective manner. These next years ahead will be great years for the Congress of Neurological Surgeons. Thank you for the opportunity and the honor to lead our organization. □

## Notes from the Editor

**B. Gregory Thompson, M.D.**  
Editor, *Neurosurgery News*



It is with great hope and perhaps a modicum of trepidation that I assume the role of Editor of *Neurosurgery News* from Michael Levy, M.D.

During the last 3 years Michael labored steadily to improve the quality of this bimonthly periodical, and beginning with this issue it will be my duty and honor to continue that effort. I am buoyed by the assistance of my intrepid colleague and co-editor Karin Muraszko, and our goal will be to provide highly relevant, accurate, and timely communications to the CNS membership on a variety of matters of importance to the family of Neurosurgery. To that end, we would greatly appreciate your thoughts and criticisms regarding *Neurosurgery News*.

### In the Current Issue

*May you live in interesting times* is an ancient Chinese proverb that is used often as a good luck toast, but just as often as a curse. Like it or not, we live in interesting times. The rate of change is dizzyingly fast. Ten years ago there were five functioning Web sites on the Internet. Today there are over 100 million. Spurred by exponentially expanding computing power and instantaneous electronic communication, technological development advances at a seemingly overwhelming rate, and the impact of such technological change will almost certainly be just as revolutionary for Neurosurgery as it has been on our society as a whole.

### Executive Director

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Less known and less advertised, yet important, benefits of CNS membership are rarely showcased, such as our science-based CNS Annual Meeting or our journal, *NEUROSURGERY*, yet are vital and valued to all members. Examples can be found within a myriad of CNS volunteer efforts, such as CNS participation in and support of the AANS/CNS Washington Committee, Residency Review Committee for Neurosurgery, multiple delegates to the Council of State Neurosurgical Societies, CNS liaisons and delegates to the AMA, and our International Ambassadors program. All of this volunteer activity impacts favorably on each CNS member's personal and professional life. Daily, small battles are fought and won due to our ongoing support and efforts in education, advocacy, legal ini-

In his inaugural "President's Message" in this issue, Mark Hadley outlines how, through a wide variety of CNS services and educational initiatives, members can obtain assistance dealing with the myriad of nontechnological complexities while managing a modern neurosurgical practice, such as declining reimbursement, medical liability insurance, and increased governmental regulatory oversight, among others.

Perhaps the most "interesting" controversy at present, however, is that surrounding the recent publication of the ISAT (International Subarachnoid Aneurysm) Trial (see this page). Dr. Hadley collaborated with Robert Harbaugh, Chairman of the Cerebrovascular Joint Section of the CNS and AANS, and Roberto Heros, president of the AANS, to produce a timely and to-the-point response to ISAT, and one which is well worth reading. The appended "ISAT Talking Points" are a compendium of important caveats about the study, which will be important to emphasize should the media (and expensive industry ad campaigns) simplify, overstate, and prematurely generalize the study findings.

Readers are also encouraged to read the recently published letter to the Editor of *The Wall Street Journal* (page 6) regarding the Medical Liability Reform Legislation that was recently passed by the U.S. House of Representatives. Authored jointly by the executive officers of the three arms of organized neurosurgery (the CNS, AANS, and CSNS), this contribution represents a paragon of cooperation by organized neurosurgery.

We hope you'll find these articles... *interesting!* □

tiatives, and young member leadership development.

I recently spoke with one of our members who called to inquire whether the CNS could assist him regarding a professional conduct issue. This member inquired whether the CNS had written documents available to its members guiding professional conduct. I immediately directed this member to two member-service documents: the CNS Guidelines on Expert Witness Activity and Testimony and the CNS Code of Ethics. These two important member service documents are included in this issue for your review (pages 6 and 7). I felt a great deal of pride and satisfaction as our member sincerely thanked me (and his organization) for the assistance.

It is a pleasure to work for all of you. My staff and I appreciate your continued support. We will continue to serve and contribute to all of our members and their needs as we look forward to a great 2003. □



American  
Association of  
Neurological  
Surgeons

## AANS/CNS Section on Cerebrovascular Surgery: Position Statement on the International Subarachnoid Aneurysm Trial (ISAT)

*Tuesday, November 05, 2002*

The International Subarachnoid Aneurysm Trial (ISAT), a prospective, randomized trial comparing surgery (craniotomy for clipping) to endovascular therapy (coiling) in the treatment of ruptured intracra-

nial aneurysms, was recently published in *The Lancet* (1). The study results demonstrate that, for a particular subset of aneurysm patients cared for in designated study centers mostly outside of the United States, patients with ruptured aneurysms treated with coiling fared better at 1 year than patients with

## Talking Points on The International Subarachnoid Aneurysm Trial (ISAT)

1. The International Subarachnoid Aneurysm Trial (ISAT), a prospective randomized trial of craniotomy for aneurysm clipping versus endovascular coiling for ruptured intracranial aneurysms, was published Saturday, October 26, 2002 in *The Lancet*.
2. Most centers in the study were located in Europe (particularly England) and Canada. Only two patients were entered into the study from a single United States center. The results from ISAT may not be applicable to the United States, where practice patterns, particularly in reference to the degree of subspecialization of neurovascular surgeons in major centers, are different.
3. The study included 2,143 randomized patients with ruptured aneurysms. Patients were randomly assigned to be treated by aneurysm clipping or by endovascular coiling for their ruptured aneurysms. One year after randomization, ~24% of the coiled patients had died or were disabled, compared to ~31% of those who were treated with clipping.
4. The absolute risk reduction at 1 year for clipping versus coiling was 6.9%, not 22.6% (the relative risk reduction) as has been cited in the media. The figure of 22.6% makes it sound as though there is a dramatic difference in the number of poor outcomes with coiling versus clipping. This is not the case. It should also be noted that it is the absolute risk reduction that is of importance to the patients.
5. The results of the ISAT study are based on the functional outcomes of aneurysm patients with coiling or clipping after 1 year. The patients need to be followed for many years before legitimate conclusions can be drawn about which treatment is safer.
6. Although coiling is a suitable treatment option for some patients, the neurosurgeon must consider all factors to determine whether or not a patient is best treated by clipping or coiling. Nothing in the ISAT study indicates that coiling is the best treatment for most or all aneurysms.
7. Our interpretation of the ISAT results is as follows: "In a patient with a subarachnoid hemorrhage whose ruptured aneurysm is considered suitable for clipping or coiling, and for whom the neurovascular surgeon and the endovascular surgeon do not know, after considering all factors, which treatment option is better for a specific patient with a ruptured intracranial aneurysm, aneurysm coiling, at the centers involved in the ISAT study, yielded a 6.9% chance of a better functional outcome at 1-year follow-up compared to similar patients with ruptured aneurysms treated with craniotomy for clipping. Long-term follow-up of these patients will be essential to determine if aneurysm clipping or aneurysm coiling is the safer treatment for this subgroup of ruptured aneurysm patients over their lifetimes"
8. Patients with intracranial aneurysms should be referred to a vascular neurosurgeon to be evaluated for the most appropriate treatment.

ruptured aneurysms treated by clipping. We congratulate the organizers and participants of the ISAT for their critical thinking and dedicated clinical work. We believe, however, that the ISAT study results have been inaccurately reported in the media and that specific data from the trial have been and will be inappropriately applied and generalized to all patients with intracranial aneurysms. The purpose of this position paper is to identify points that we believe warrant emphasis and clarification. These points are meant to educate fellow neurosurgeons about the ISAT study, its results, and the concern many have about the potential misrepresentation of the ISAT results to the public and our patients.

The reported ISAT data demonstrate that patients with ruptured intracranial aneurysms treated with craniotomy for clipping had a 30.6% chance of a poor outcome at 1-year follow-up. Patients with ruptured aneurysms treated by endovascular coiling had a 23.7% chance of a poor outcome at 1-year follow-up. Therefore, the absolute risk reduction, at 1-year follow-up, when comparing aneurysm coiling to aneurysm clipping was 6.9%. Media reports have attributed a 22.6% risk reduction to endovascular coiling compared to craniotomy for aneurysm clipping. The figure of 22.6%, the overall study relative risk reduction, suggests there was a dramatic reduction in the number of poor outcomes among patients whose aneurysms were treated with coiling as compared to those patients whose aneurysms were surgically clipped. This is not the case. It is the absolute risk reduction that is of greatest importance to patients. Importantly, the absolute risk reduction of 6.9% reported by the ISAT authors should not be inappropriately generalized.

Most centers involved in ISAT were located in Europe (particularly England), Australia, and Canada. Only two patients were entered into the study from a single center in the United States. The results from ISAT may not be applicable to patients in the United States where practice patterns, particularly in reference to the degree of subspecialization of neurovascular surgeons in major centers, are different. It is essential to know how many practitioners in ISAT performed craniotomies for aneurysm clipping and how many practitioners performed endovascular procedures for aneurysm coiling. If the number of coiling cases per endovascular practitioner is significantly greater than the number of clipping cases per neurosurgical practitioner, the better outcome at 1-year follow-up for patients who were treated with aneurysm coiling (6.9% absolute risk reduction) could be completely explained by a difference in practitioner experience and expertise. The numbers of craniotomies per neurosurgeon and the number of coiling procedures per endovascular

specialist involved in the ISAT study have not been (but should be) published.

Most importantly, physicians and surgeons involved in ISAT felt that one form of treatment was preferred in almost 80% of patients considered for study. Of 9,278 patients with ruptured intracranial aneurysms assessed for ISAT eligibility, only 2,143 were ran-

domized. In those 7,135 patients not randomized, more patients underwent craniotomy for aneurysm clipping than endovascular aneurysm coiling. Over the course of the ISAT study, neurovascular teams in the participating centers felt that surgery was the best option for the majority of patients with ruptured aneurysms who were not randomized. Therefore, if an experienced vascular neurosurgeon thinks that cran-

iotomy for aneurysm clipping is the best option for a patient with a ruptured intracranial aneurysm, the patient should continue to be offered surgery as the treatment of choice. The results of ISAT do not apply to this larger group of patients, as they were excluded from the randomized trial. Disappointingly, outcomes and follow-up

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## LETTER TO THE EDITOR

*Editor's Note:* This titled letter was published in *The Wall Street Journal* and was composed jointly by the executive officers of the CNS, AANS, and CSNS to address the ongoing liability crisis in medicine and neurosurgery in particular.

### Liability Monster Inc. Disappears Surgeons

We agree with your October 1 editorial "Lawyers vs. Patients-II," which recognizes that the medical liability reform legislation recently passed by the House is "exactly the kind of common-sense reform" that could help get the medical liability crisis under control. Indeed, for neurosurgeons and our patients, the situation is even more grave than reported.

A recent nationwide survey of neurosurgeons conducted by the Council of State Neurosurgical Societies reveals that for the specialty of neurosurgery, 25 states are facing a "severe" liability crisis, with another 12 in a "potential" crisis. This crisis is not just about the availability and affordability of medical liability insurance for neurosurgeons, but most critically, it is about a looming problem of patient access to neurosurgical care. The most important findings of the survey showed that as a result of neurosurgeons' premium increases, 43% of neurosurgeons plan to, or are considering, restricting their practices; 29% plan to, or are considering, retiring from practice; and 19% plan to, or are considering, moving their practices.

What this means is that in many states without effective liability reform, patients can't get complex neurosurgical procedures, as neurosurgeons are no longer performing high-risk surgery. Many brain surgeons are no longer doing brain surgery. Patients can't get emergency medical treatment, as fewer neurosurgeons are covering hospital emergency rooms and trauma hospitals are shutting their doors and "divert-

ing" patients with serious head and spinal cord injuries to other locations. Critical life-saving time is lost while searching for an available emergency room. Patients can't find a neurosurgeon close to home, as neurosurgeons move to states where liability insurance costs are relatively stable, or they retire altogether. Patients must now travel great distances, often going out of state, to get neurosurgical care.

Rather than engaging in a finger-pointing debate among doctors, lawyers and insurance companies, we need to keep focused on the real issue: solving this problem to ensure patients' continued access to health care. The House and President Bush have recognized this and now the Senate must do likewise. Doing nothing is simply not an option for the citizens of this country who need consistent and quality neurosurgical care.

**Roberto C. Heros, M.D.**  
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Neurological Surgeons

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President,  
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## The Congress of Neurological Surgeons' Guidelines on Physician Expert Witness Activity and Testimony



Physicians have an obligation to review medical circumstances, medical records, and imaging studies and to testify in court (if necessary) as expert witnesses when appropriate. Neurosurgeon physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.

(This statement is an adaptation of guidelines developed by the Council of Medical Specialty Societies and the American College of Surgeons.)

### I. Qualifications for the Physician Expert Witness in Neurological Surgery

- The Neurosurgeon expert witness must have a current, valid, and unrestricted license to practice medicine in the state in which he or she practices.
- The Neurosurgeon expert witness should be a diplomate of the American Board of Neurological Surgery or have status with a specialty board recognized by the American Board of Medical Specialties.
- The specialty of the Neurosurgeon expert witness should be appropriate to the subject matter of the case. He or she should be qualified by experience and should have demonstrated competence in the subject of the case.
- The Neurosurgeon expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should be actively involved in the clinical practice of the specialty or the subject matter of the case during the time the testimony or opinion is provided.
- The Neurosurgeon expert witness should be able to demonstrate evidence of continuing medical education relevant to the specialty or the subject matter of the case.
- The Neurosurgeon expert should be prepared to document the percentage of time that is involved in serving as an expert witness. In addition, the Neurosurgeon expert should be willing to disclose the amount of fees or compensation obtained for such activities and the total number of times the Neurosurgeon expert has testified for the plaintiff or the defendant.

### II. Guidelines for Behavior of the Physician Expert Witness in Neurological Surgery

- The Neurosurgeon expert witness should review the medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the Neurosurgeon expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the Neurosurgeon expert witness should apply the same standards of fairness and honesty.
- The Neurosurgeon expert witness should be prepared to distinguish between actual negligence (substandard medical care that results in harm) and an unfortunate medical outcome (recognized complication(s) occurring as a result of medical treatment).
- The Neurosurgeon expert witness should review the standards of practice prevailing at the time of the alleged occurrence.
- The Neurosurgeon expert witness should be prepared to state the basis of his or her testimony or opinion, and whether it is based on personal experience, specific clinical references, evidence-based guidelines, or a generally accepted opinion in the specialty field. The Neurosurgeon expert witness should be prepared to discuss important alternate methods and views.
- Compensation of the Neurosurgeon expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a Neurosurgeon expert witness to link compensation to the outcome of a case.
- The Neurosurgeon expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records, and subject to independent peer reviews. The Neurosurgeon expert witness should be aware that failure to provide truthful testimony exposes the Neurosurgeon expert to criminal prosecution for perjury, civil suits for negligence, revocation or suspension of his or her professional license, and/or disciplinary action including censure by the Congress of Neurological Surgeons.

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Prepared by Mark N. Hadley, M.D.  
President, Congress of Neurological  
Surgeons □



## Congress of Neurological Surgeons Code of Ethics

I. A Code of Ethics for professional conduct has been adopted by the Congress of Neurological Surgeons. The Code of Ethics shall serve as guidelines for neurological surgeons in their relationships with the patient, the patient's family, other health professionals, the legal system, government, and the community. The Code of Ethics shall serve as one method of assessing the standing of a physician in practice and may also serve as one method of evaluating prospective Members of the Congress of Neurological Surgeons.

II. The primary ethical consideration for neurological surgeons shall be commitment to providing optimal medical care for the patient as allowable by the resources and circumstances at hand. No activity shall be undertaken that does not serve the best interests of the patient. In doing so, neurological surgeons shall provide services in which they are competent as provided by training, experience and available resources. The ethical conduct of the neurological surgeon shall include involvement in continuing medical education and training in order to remain current on the latest in medical technology, information, and practice guidelines.

Patient privacy and confidentiality shall be respected and protected by the neurological surgeon unless otherwise required by the law. The neurological surgeon shall communicate effectively with the patient and family during the decision-making process. The surgeon shall act as the patient's advocate in circumstances where the patient is unable to do so (due to illness) to provide relief of pain and suffering or to allow for dignity in dying. The lawful wishes of the competent patient or family or those wishes previously declared legally shall be respected. When human research or experimentation is considered, the surgeon shall provide accurate and honest information to the patient and family to obtain informed consent.

III. The ethical conduct of the neurological surgeon in dealing with the legal system shall include protection of patient-physician confidentiality and cooperation with members of the legal profession in order that justice shall prevail. When serving as an expert witness, the neurological surgeon shall present reasonable opinions as supported by acceptable practice standards

and current scientific knowledge and shall not misrepresent science for legal or financial gain.

IV. The ethical conduct of the neurological surgeon shall include sup-

porting the patient's rights and privileges as well as those of the physician when health care-related legislation is under consideration by our government. When called upon, the neurological surgeon shall provide accurate and honest information to government agencies involved with health care financing or legislation or reform. With regard to the relationship with insurance, compensation or reimbursement

agencies, the neurological surgeon shall provide prompt, accurate and complete medical records and information to those agencies. The neurological surgeon shall receive patient care compensation for services he/she actually delivers or supervises. The division of income among members of an organized group may be based upon the value

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## 3rd Annual CNS/Think First Golf Outing Is Big Success

**David Cavanaugh, M.D., and David Adelson, M.D.**

The 3rd Annual Congress of Neurological Surgeons/Think First National Injury Prevention Foundation Golf Outing took place on September 22, 2002 during the CNS meeting in Philadelphia and was considered a rousing success. A beautiful, sunny Sunday greeted the close to 60 golfers who came out to support the Foundation, and they proceeded to enjoy a great round of golf before the activities of the CNS Scientific Sessions began. The outing was held at the Rancocas Golf Club, a Robert Trent Jones designed, over 6600 yard, par 71, 75 rated course that provided both low and high handicappers a real challenge with lots of trees, water, and sand.

Medtronic, Inc. was the major event sponsor, and the rest of the outing was generously underwritten by numerous other sponsors for individual holes and the providing of prizes. Playing a best

ball, scramble format, everybody had the opportunity to help out the team. With a breakfast kickoff, lunch, and the awards ceremony, there was to plenty to eat and drink throughout the round and at the 19th hole. For the awards, the first place prize was won by Luis Cervantes, M.D. and his foursome (at 9 under par), with second place going to Team Synthes. Dr. Cervantes and crew received Morton's Gift Certificates and Philadelphia Phillies game tickets donated by Lippincott Williams & Wilkins. Team Synthes also collected Phillies game tickets and a Rancocas Pro Shop Gift Certificate. The last place, or worst prize, at 4 over par, (mind you, they only lost/won on handicap holes) was grabbed by Team KLS Martin. They could be seen weaving through the course in their golf carts, spraying shots onto neighboring fairways and the like. At the other extreme, the winner for the Closest to the Pin and Longest Drive was won by the same ringer, we mean golfer from LWW, Bill Walker, who walked away with gift certificates and other assorted golf col-



Off to the links...



Think First Board members (left to right): David Cavanaugh, Medical Director; Donna Cavanaugh, LA State Chapter Director and Board Member; Dorothy Zirkle, Executive Committee Member; Michael Turner, Chairman; and David (Tiger Woods) Adelson, Resource and Development Committee, Chairman Think First National Injury Prevention Foundation Board of Directors.



The winning team (left to right): Whitney Carlton III, Brian Dorey, Luis Cervantes, M.D., and William Menges, Esq.



Left to right: Michael Phillips, Michael Caron, M.D., Andy Bala, and Kevin Murray.

lectibles. Three others won gift certificates through the random drawing. All of the prizewinners also came away with Think First hats and shirts, and all the golfers received a golfer's kit (donated in part by Cyberonics) and a beautiful golf towel (donated by Codman/Johnson & Johnson) to remember their day on the links. The big success though was the \$15,000 that was raised to help charitably fund the Think First Foundation and continue its award winning injury prevention programs for children and teenagers.

The Think First/National Injury Prevention Foundation wants to personally thank all the participants and sponsors who were instrumental in making the day a success and the CNS for its support. We are looking forward to seeing all the participants back to make next year's outing even that much more a success. Now is the time to make plans to participate in the 4th Annual CNS/Think First Golf Outing on Sunday, October 19th, 2003 at the CNS meeting in Denver. Mark your calendar, or put the date into your new Palm™ Pilot. Playing on Sunday morning gives you plenty of time eat, drink, and play golf, and still be ready for the

Opening Reception kicking off the CNS Annual Meeting. Plan to bring yourself or a foursome, or sponsor a tee or hole. Whatever you do, it is a great way to help neurosurgery's National Injury Prevention Foundation and enjoy a round of golf during the meeting.

Special appreciation to the following individuals and corporations for their sponsorship and support of the 3rd Annual CNS/Think First Golf Outing 2002-Philadelphia:

ABS Medical Inc.

Ad Tech, Inc.

Dr. and Mrs. David Adelson

Axon Medical Inc.

Carl Zeiss, Inc.

Drs. Michael and Theresa Caron

Codman/Johnson & Johnson, Inc.

Cyberonics

Indianapolis Neurosurgical Group

Integra Life Sciences

KLS Martin, Inc.

Lippincott Williams & Wilkins



The second place team from Lippincott Williams & Wilkins with Michael Turner, M.D., Chairman of Think First (left to right): Michael Turner, Bob Williams, Kelly Adamitis, Michael Guire, and Wayne Wojcik.



AANS Think First liason Ted Jacobs, M.D., and brain ball.

Medtronic, Inc.  
Morton's of Chicago  
Shube Family  
Surgical One Supply

Synthes Spine  
Think First State Chapter Directors  
Think First Chapters/Satellites  
Wolf Instruments

## Code of Ethics

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of services performed by each member as determined by group members.

- V. The ethical conduct of the neurological surgeon shall include avoidance of the abuse of alcohol and drugs or other self-abusive behavior. Should the physician become physically and/or mentally impaired due to medical infirmity, substance abuse or mental illness, the neurological surgeon should submit voluntarily for professional evaluation and treatment. In these circumstances, the practice of the neurological surgeon shall be limited appropriately. It is the ethical obligation of the neurological surgeon to approach any colleague who appears to be impaired and rec-

ommend treatment and/or referral to the appropriate hospital or regional professional committee.

- VI. The neurological surgeon has an ethical and social obligation to be aware of local, regional, national and international matters that may affect health care or the individual rights of physicians and patients and to take action when deemed necessary.

The Code of Ethics of the Congress of Neurological Surgeons shall be revised periodically based on need and the recommendations of the Membership.

*Approved by the CNS Executive Committee 4/7/00.*

*Approved by CNS Membership at Annual Business Meeting, September 26, 2000.*

# Project Shunt: The University of Michigan Goes to Guatemala

**Karin Muraszko, M.D.**  
Editor, *Neurosurgery News*



For the past 5 years members of the University of Michigan Departments of Neurosurgery, Anesthesia, and Operating rooms have organized a trip to Guatemala to perform neurosurgical procedures for indigent children. Working with Healing the Children and The Pediatric Foundation of Guatemala, the purpose of the project is to provide much needed neurosurgical care to children in Guatemala. The project began 5 years ago with an outreach from the Michigan/Ohio branch of the international foundation Healing the Children. They already had placed volunteers from the University of Michigan in various projects and were seeking to organize a neurosurgical mission. Several members of the Neurosurgery Department began working on the project and after an initial evaluation of the feasibility of such a mission, the first Project Shunt was organized in 1998. This was only 2 years after civil unrest had abated in Guatemala and government stability was, and is, still in question. The mission was done in conjunction with the Pediatric Foundation of Guatemala, a nonprofit organization dedicated to providing care for the poor and underserved children of Guatemala.



Spinal dysraphism is unfortunately frequent due to malnutrition. However, "Project Shunt" has been able to treat children with increasingly complex cases, such as in this child with a cranial meningocele and a lumbar meningocele.

Guatemala is a country of extraordinary beauty and extreme poverty. It has some of the worst statistics regarding health care of any Latin American country. Years of civil war have taken their toll and there is little infrastructure to provide care for its children. Prenatal care is almost unheard of and

though there is an emerging middle class, there is great disparity between the classes. The majority (51.6%) of the population is between 0 and 18. Of Guatemala's 5.4 million children, 83% live in severe poverty. Dietary issues, likely genetic predispositions, and poor prenatal care make Guatemala one of the leaders in children with spina bifida. It was with this background that we attempted to organize a neurosurgical medical mission to Guatemala.

Important to our initial goals was a desire to provide quality, safe health care for these children. As with any project, no one individual can take complete responsibility. In the first years, Dr. Nicholas Boulis, winner of the Young Neurosurgeons Humanitarian Award, took on the important role of organizer of the trip. Since those first 2 years, there have been other residents who have taken on this roll. It has now become a tradition at Michigan that a senior resident takes on the role of lead organizer for the mission. Each resident participates 1 year as a member of the team to gain experience and insight as to the needs of the project and to help understand the extensive planning necessary to have a successful mission. The next year that resident will organize the mission and is the team leader regarding logistics, organization of supplies and personnel. The next year they will act as an advisor and, if possible, a participant in the mission. Thus each participating resident will be part of three missions. Among the residents who have participated in the mission, Miroslav Bobek, Andrew Youkilis, Luis Rodriguez, and Vishal Gala, all have learned a great deal about spina bifida and tethered cord, as well as about what it really takes to create an operating room and a successful operation. As the Chief Medical Director, my job is to help supervise the mission, to fund raise for the mission and to act as the surgical director in Guatemala. I am aided in this by Suresh Ramnath, a colleague at the University of Michigan. At present three neurosurgical staff, three neurosurgical residents, three anesthesia staff, two anesthesia residents, and five nurses represent the operating room team. In addition, this year we will be joined by a pediatrician (Matthew Boulis, M.D., Nick Boulis' dad), a pediatric intensivist (Susan Bratton, M.D.) and three additional support persons.

Anesthesiology was perhaps the most challenging aspect of the organizational part of the mission. Safe surgical procedures, particularly in children, require expert anesthesia and we were anxious to provide quality care. We started with the premise that the operation these children would receive would be of equal quality to that received by our children at Michigan's Mott Children's Hospital.

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## Project Shunt

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Working with staff anesthesiologists Judy Negele and Brian Woodcock and more recently John Stork from Case Western Reserve's Rainbow Babies Hospital, we have had to limit and define reasonable and feasible surgical procedures. Because the need is so great, it is crucial that careful consideration be given to feasibility. At our initial missions, equipment was limited. Our ORs were essential rooms with electrical outlets, ability to provide some inhalation anesthesia and oxygen and little else. Slowly we began to collect equipment. Because we did not have ventilators, procedures were done using narcotics and spontaneous ventilation. A blood bank was not available and there is no ICU. All of this has led us to carefully consider the types of procedures we were willing to or could perform.

We are guests in a country that has some fears about foreign, particularly American, aid. Particularly with our initial missions, we wanted to demonstrate not only our commitment, but also our competency in safely performing a variety of procedures. Each year we have expanded our repertoire of procedures by increasing our equipment inventory and by making appropriate contingency plans available. We now take three sterilizer units with us, surgical equipment enough to run three operating rooms simultaneously and adequate supplies (medical and surgical) to provide pre-operative and post operative care for all of the children we operate on. At the end of each mission, we do a QA to assess what we need and more importantly how we might do it better next time.

Industry support for this mission has been extraordinary. We have received funding, equipment, and supplies from Amsco, Baxter, Codman, Ethicon, Johnson & Johnson, Medtronic, NMT, Shelhigh, and Stryker. Shunts have been supplied from almost every manufacturer, and companies have graciously agreed to allow us to borrow equipment for the trip. We send thousands of pounds of supplies and equipment to Guatemala in the weeks before a mission. Each participant is allowed on suitcase and will bring along an additional footlocker of equipment and supplies. We have begun leaving more equipment in Guatemala as the Pediatric Foundation has now acquired a more permanent residence and is no longer merely renting space for the mission. We have also begun to purchase equipment to supply the operating rooms. Funding will always remain a challenge and we have an established a nonprofit fund within the Department of Neurosurgery to allow for tax-deductible contributions. I find that in lieu of payment, legal firms and organizations are very willing to contribute. Particularly in the legal arena, I am happy to see such payments made to Project Shunt rather than to me.

Personally, I have learned how better to manage a team of diverse personalities. Idealistically the first year, we took on too many cases. We operated 20 to 21 hours a day and tried to run the ORs continuously. After 3 days we had worn out our nurses and our anesthesiologists. Discontentment with the ranks grew and the esprit de corps began to flag. I began to understand that we needed some downtime to regroup and rest. We planned more carefully with subsequent missions and expanded the number of people we brought with us to allow us to work more efficiently. This year we will take 25 people with us, including six anesthesiology members. We have also expanded our Post-Operative Care group. Many of these children are poorly nourished and require careful monitoring postoperatively. Additional personal allows us to do this, as well as to teach families about various aspects of disease and health maintenance. We work hard to create a pleasant environment for these children and this includes not just quality health care, but also a cheerful environment including balloons and toys. All of these supplies must be shipped down either ahead of time or with us. We can only buy limited amounts of supplies in Guatemala. For example, we do purchase narcotics, oxygen, and some anesthetic agents in Guatemala. Other drugs we bring with us. The cost of manufactured goods is quite high in Guatemala. An amazing dichotomy exists between handmade and manufactured goods. A hand-embroidered towel may only cost \$1, while a roll of paper towels can be \$2 to \$3.

As with most physicians, I became a doctor because I was fascinated by the human condition and I wanted very much to help people. Somewhere along the line, it has become very complicated to accomplish that goal. There are more forms and less patient contact time. Guatemala presents many challenges but also helps each of the team members reaffirm why they became health care professionals. I am always amazed by the generosity and hospitality of our Guatemalan colleagues and the warmth of the patients. Last year we went to Guatemala 2 weeks after 9/11. Team members felt anxious and very vulnerable. We arrived to find that numerous of our patients and their families had contacted the Foundation to find out if their "American doctors" were okay. Some had traveled miles through jungles to reach a telephone just to check on us. We had a very successful mission, and one teenage girl thanked us for coming and told us "we were the best army against terrorism" the United States had. It was an emotional and particularly meaningful trip. We performed 35 operations in 5 short days.

We have become more adept with each mission. We still scrounge for equipment but have learned to plan far in advance and now know what resources are available. We are in a continuous fund-raising mode and begin planning



Drs. Karin Muraszko and Andrew Youkilis begin surgical repair on a Guatemalan child with a tethered cord.



A Guatemalan infant with severe, untreated hydrocephalus is prepared for surgery.

the next mission within days of arrival home from the previous mission. In a typical mission, we arrive on a Saturday and spend a little time allowing ourselves to acclimate. It gives members of the team a chance to do a little shopping at local markets. Sunday we divide into two groups. One group helps set up the OR and the other group evaluates patients and decides which operations will be done that mission. The schedule is established and as in any OR, remains fluid until the very end.

The hardest part of the job is deciding who will receive an operation. Often there are cases that are just too big or too complicated for us to do. We find ourselves making a decision about whether doing three or four shorter cases is better than doing one very long case. Preference is clearly given to procedures that will, in and of themselves, be the only treatment necessary for the child. Because there is a high incidence of spina bifida, we do many complex tethered spinal cords along with repair of myelomeningocele and placements of shunts. We have done a variety of encephalocele repairs and some limited intracranial work. It is perhaps the hardest part of the mission to tell a family that we don't think we can help their child. Many of these families have trav-

eled days to reach the Foundation. All are full of hope that we will be the cure for their child.

We have a wonderful relationship with the Pediatric Foundation of Guatemala, who will follow these children postoperatively after we are gone. In addition, there is a cadre of Guatemalan surgeons who have spent time with us to learn pediatric neurosurgical techniques and follow these children as well. Unfortunately, there are not enough neurosurgeons and insufficient funds to provide consistent care. They are simply overwhelmed. Finally, we are not the only U.S. neurosurgical group that does such a mission to Guatemala, and each group tries to stagger their arrival time in Guatemala to spread out the various missions throughout a given year. We recognize that we are having only a small impact on neurosurgical disease in Guatemala but at least for some children, we do make a difference and have a significant impact on their lives. We try to leave equipment behind with each trip. We also leave behind supplies, particularly for children in whom we have placed a shunt. Many would argue that resources spent in this fashion would be better placed in broader preventative health projects or immunizations.

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## Publications of the CNS

### Douglas Kondziolka, M.D.

Past Chairman, CNS Publications Committee



CNS publications are stronger, more vibrant and innovative as ever! Led by our flagship publication, *NEUROSURGERY*, CNS members receive

the best in scientific communication, educational initiatives, unique publications, Internet-based information, and news announcements. The new chair of the CNS Publication Committee, Dr. David Adelson, will shepherd our publications products for the next 3 years. The CNS is always looking for volunteers! For anyone wishing to participate in CNS publication projects, please contact Dr. Adelson.



*NEUROSURGERY*: Led by innovative editor, Michael Apuzzo, our journal now holds the highest impact factor of all neurosurgical publications. This year, the journal celebrates its 25 years of publication. The submission rate continues to escalate. Earlier this year, Dr. Apuzzo and staff redesigned the journal to make it even more forward moving. New inserts include: "Neurosurgery Science Times" which will be formulated by Associate Editor, Issam Awad and principal, Richard Ellenbogen. Dr. Jim Rutka is the new Associate Editor for Features. "In Press" articles now appear on our Web site 2 to 4 months before print publication. The much-heralded supplements were released this October at the Philadelphia meeting. Dr. Rhoton's supplement "Surgery and Anatomy of the Supratentorial Space" and Dr. Richard Fessler's "Minimally Invasive Spinal Surgery" have been enthusiastically received. The recent publication of the cervical spine and spinal cord injury guidelines was a remarkable success.

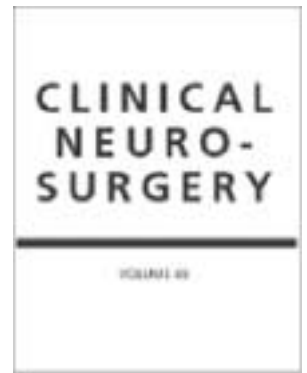
Because the CNS mission includes international education, the October issue featured a Japanese cover as well as a significant number of Japanese publications. I recently attended the Annual Meeting of the Japan Neurosurgical Society where the Lippincott Williams & Wilkins and CNS booth was well attended. Over 400 copies of Dr. Rhoton's supplement sold at that meeting.

It is our hope that international readers will become members of the CNS so that such educational products will come to them as part of their membership dues. In a word, our journal is known for its "freshness." Constantly improving, striving for new educational initiatives, and remaining an exciting place for a neurosurgeon to spend valu-

able time, *NEUROSURGERY* continues to be the benchmark of our specialty. The CNS Publication Committee wishes to congratulate Dr. Apuzzo and his staff as well as the Editorial Board for their hard work and loyalty to the CNS.

*Clinical Neurosurgery*: A CNS tradition, *Clinical Neurosurgery* represents the annual status of neurosurgical science, presented at the Congress of Neuro-

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## JOINT SECTION ON CEREBROVASCULAR SURGERY

# Sixth Annual Meeting of the CV/ASITN in Phoenix Promises Controversial Scientific Sessions and Outstanding Practical Courses

The AANS/CNS Section on Cerebrovascular Surgery and the American Society of Interventional & Therapeutic Neuroradiology have completed planning for their Sixth Annual Joint Meeting, which will be held in Phoenix, Arizona at the Phoenix Civic Plaza Convention Center on February 16– 9, 2003. Annual Meeting Co-Chairs Greg Thompson, from the CV Section, and Buddy Connor, from the ASITN, have assembled an outstanding scientific program that will feature, among other highlights, four state-of-the-art Practical Courses and five Scientific Plenary Sessions that will emphasize current controversies in the management of patients with cerebrovascular disease.

This year's meeting will also mark the first time that the Society of Neurological Anesthesia and Critical Care (SNACC) has participated as a sponsor for the meeting. The Annual Meeting Committee has worked closely with leadership from SNACC during formation of the scientific program to bring the neuroanesthesia/critical care perspective into many of the Scientific Symposia and Luncheon Seminars.

Five Scientific Symposia and 19 Luncheon Seminars are scheduled, featuring renowned experts in the field of neurosurgery, interventional neuroradiology, neuroanesthesiology, and neurological intensive care. The plenary Scientific Symposia promise to be particularly memorable, as leading experts will critically review and debate areas of current controversy, such as the appropriate treatment of unruptured

aneurysms, and the "clip vs. coil" controversy in the light of the recently published ISUIA and ISAT studies. Dr. Robert Spetzler, always a provocative speaker, will give the sixth annual Luessenhop Lecture (accompanied by 3D video): "Surgical Management of the Perforators: The Real Key to Operative Success."

On Saturday, February 15th, an afternoon session has been developed in conjunction with the AHA International Stroke Conference. This will be a very informative program, with emphasis on the evaluation of vertebrobasilar insufficiency and the treatment of cerebral aneurysms. Registrants for the CV/ASITN meeting are encouraged to register at the AHA Stroke meeting. CV/ASITN meeting attendees also will be offered additional CME credits and a special reduced 1-day registration fee for registration on Saturday at the Stroke meeting, if they wish to attend.

Four special courses will take place on Sunday and offer additional educational opportunities for CME credit. They include:

**Special Course 1**, "Special Techniques in Microsurgical Aneurysm Surgery," is a limited-enrollment, full-day course that will be composed of two spectacular half-day Practical courses. The course will feature workshop lectures and 3D demonstrations in the state-of-the-art surgical laboratories of the Barrow Neurological Institute. The morning course, "Skull Base Approaches: What Every Neurovascular Surgeon Should Know," will be directed by Jacques Morcos and Joseph Zabramski, and will feature a star-studded lineup of surgical expertise, with, among others, experts such as Drs. Steven Giannotta,



Hunt Batjer, Robert Spetzler, Chandra Sen, Tom Kopitnik, and J.D. Day. Following lunch, the topic will be "Microvascular Bypass and Reconstruction for Unclippable/Uncoilable Aneurysms." David Newell and Greg Thompson will direct this course with an all-star faculty, including among others Drs. Laligam Sekhar, Neil Martin, Michael Lawton, and Wink Fisher. The afternoon course will conclude with a 3D video demonstration by Dr. Spetzler, and a limited number of participants may elect to do a special additional 2-hour microsurgical anastomosis practical lab with rats.

**Special Course 2**, "Acute Stroke: Interventional Management," is a half-day morning course that will be directed by Drs. Buddy Connors and Lee Guterman. This course will emphasize the practical aspects of endovascular management of acute stroke. Speakers such as Stanley Barnwell and Thomas Tomsick will report on recent interventional trials (e.g., ReoPro), novel neuroprotectants, and new mechanical interventional devices for stroke.

**Special Course 3**, "Endovascular Management of Aneurysms" is a half-day afternoon course directed by Drs. Alejandro Berenstein and Robert Rosenwasser. This extremely popular course will rapidly review a series of key practical issues, including a review of currently available coils, research on liquid embolics, flow dynamics, pre- and postembolization anticoagulation management, and techniques (such as stenting and balloon protection) for giant aneurysm treatment. The course will feature national and international luminaries such as Drs. Michael Mawad, Jacques Moret, Charles Kerber, and Gary Duckwiler.

**Special Course 4**, "Critical Care Management in the Neurological ICU," will be directed by Dr. Josh Bederson and will feature contributions from several outstanding faculty from both the CV Section and SNACC. This course has been highly in demand in past years, so registrants should sign up early.

On Monday morning, the Scientific Program will get a jump-start in Scientific Symposium I with what promises to be a spirited discussion of the recently published ISAT and ISUIA studies. Dr. Andy Molyneux and Richard Kerr, principal investigators of the ISAT trial, will describe the initial results of that study, and then Dr. Clairborne Johnston and CV Section Past President Issam Awad will debate whether the

study should now resolve the "clip vs. coil" question. CV Section Chairman Robert Harbaugh will then follow with further critical analysis of the ISUIA and ISAT studies.

Subsequent Scientific Symposia during the next 2 days will

address other controversies in the treatment of midgrade cerebral AVMs, acute stroke, and intracranial atherosclerotic disease. Defining the standard of care for intraprocedural cerebral monitoring and cerebral protection will also be discussed, with contributions from some outstanding SNACC fac-



ulty. The final plenary Scientific Session on Wednesday morning will conclude with a Special Seminar on the "Prevention and Treatment of Complications in the Management of Cerebral Aneurysms," which will include the Luessenhop Lecture by Dr. Spetzler.

There will be over 225 oral and poster abstract presentations at the meeting this year. In addition, over 40 exhibitors are expected to display their wares and the latest advances in technology.

The social program for this meeting includes all the advantages of a mid-winter visit to the sunny desert of the Southwest. The meeting's opening reception on Sunday evening on the terrace at the Crowne Plaza Hotel will celebrate a midwinter respite in balmy Phoenix with Southwestern cuisine, a steel drum band, and flamenco dancers. Another first this year will occur on Tuesday evening February 18th, when Dr. Robert Harbaugh, chair of the CV Section, will host a cocktail reception for all CV members who are also interventionalists. For meeting attendees who are able to stay after the final morning session on Wednesday, February 19th, golf tee times will be made available on request.

Advance Registration and Housing materials are available now, and don't forget about the Early Bird Discount—register by the advance registration deadline of Monday, January 20, 2003 and save \$100. Submit your housing form without delay. Reservations will be confirmed directly by the Crowne Plaza Phoenix Downtown Hotel. □



## JOINT SECTION ON NEUROTRAUMA AND CRITICAL CARE

### Chairman's Message

Donald Marion, M.D.,  
F.A.C.S.



With this issue of *Neurotrauma and Critical Care News*, I provide my inaugural Chairman's Message. I first want to thank Ross Bullock, M.D., for his

remarkable achievements as our past chair. Highlights of Dr. Bullock's tenure include shepherding through a position statement on reimbursement for on-call coverage for trauma, which has been endorsed not only by the Neurotrauma Section's Executive Committee but also by the executive committees of the American Association of Neurological Surgeons and Congress of Neurological Surgeons. In addition, we now have current procedural technology codes for decompressive craniectomy, and lobectomy for contusions or intractable intracranial hypertension. Perhaps, more importantly, Dr. Bullock continues to lead the way toward a better understanding of the mechanisms of secondary brain injury through his pioneering research, and the Neurotrauma Section's membership is indebted to him.

The section's leadership also is grateful to the Washington Committee and particularly, Katie Orrico, J.D., director of the AANS/CNS Washington Office, for their flurry of recent activity regarding clarification of Emergency Medical Treatment and Labor Act regulations. For the past several years, Neurotrauma Section members, including John McVicker, M.D., and Alex Valadka, M.D., have done an excellent job of presenting informative lectures at our national meetings to try to educate our membership about these regulations. As these individuals and others more carefully researched the issues, however, it became increasingly clear that the EMTALA guidelines were confusing. In an attempt to clarify several issues, Trent Haywood, chief medical officer of Centers for Medicare and Medicaid Services Region V, was invited to address attendees at the recent AANS annual meeting in Chicago. Unfortunately, his remarks raised even more concern. Specifically, he suggested that while neurosurgeons were not required to take call every day of the year, hospitals could require this and CMS did not prohibit it. He stated that simultaneous call at several hospitals was prohibited unless backup coverage had been arranged in advance by the neurosurgeons. Finally, he strongly suggested that elective surgery could only be allowed when the neurosurgeon was on call if backup coverage

was arranged in advance by that neurosurgeon.

The AANS and the CNS quickly responded. On May 30, the presidents of the AANS and CNS sent a letter to Thomas Scully, administrator of CMS, strongly urging that:

- neurosurgeons be permitted to take simultaneous call at more than one hospital, particularly in view of the fact that there are almost twice as many hospitals as there are practicing neurosurgeons;
- treating or on-call physicians be permitted to request transfer of patients to hospitals where the on-call neurosurgeon is physically located;
- CMS provide explicit language that prohibits hospitals from requiring constant call coverage;
- neurosurgeons be permitted to perform elective surgery when they are on call; and
- neurosurgeons should only be required to be on call for emergency services within the scope of their usual practice.

This letter led to a very positive early June meeting between Katie Orrico and CMS staffers, and a June 13 CMS reversal of its position on simultaneous call. The Neurotrauma Section very strongly supports these efforts on the part of the AANS and CNS.

In an effort to make the Neurotrauma Section as efficient as possible and responsive to the needs of the membership, I have reorganized the subcommittee structure. In so doing, I have placed particular emphases on the liaisons to related and I think very important organizations such as the Council of State Neurosurgical Societies, Think First, and the Society of Critical Care Medicine. Thomas Hoyt, M.D., Dan Michael, M.D., and William Coplin, M.D., are the respective liaisons from these organizations. I also have created the Special Initiative Committee, headed by Jamie Ullman, M.D.. Over the years, it has become clear to me that a number of very important issues related to neurotrauma do not necessarily fall under any of the previous committee designations and yet are relevant to contemporary practice. For example, issues related to EMTALA, on-call reimbursement, and non-neurosurgeons placing ICP monitors are all currently being debated and deserve focused attention. I have charged this committee, which is composed of some of our more senior members, with drafting responses to these and other current issues. I encourage the Neurotrauma Section membership to contact my office at any time regarding your concerns with neurotrauma or critical

care, either locally or in a general way, and I will either address the issues personally or triage them to our appropriate new subcommittees.

Finally, I have asked David Adelson, M.D., the new editor of *Neurotrauma and Critical Care News*, to focus on a major controversial clinical or preclinical issue related to neurotrauma or critical care in each issue of the newsletter. For this issue of the newsletter, we have elected to focus on the controversies surrounding stipends for on-call coverage. Neurosurgeon availability is a prerequisite for any Level I or Level II trauma center. Unfortunately, designated trauma centers outnumber the number of practicing neurosurgeons in this country. In order to help neurosurgeons, and especially those in private practice, provide neurotrauma coverage, the Neurotrauma Section together with our parent organizations endorsed the AANS/CNS Position Statement on Improving Access to Emergency Neurosurgical Services, indicating that it is appropriate for hospitals to provide a reasonable stipend for being on the on-call panel at their hospital. As might be expected, many hospitals are resisting this suggestion, and in some locations neurosurgeons have found that they can no longer participate in trauma call, leading to the inability of their particular hospital to continue as a trauma center.

As someone who was involved in the early stages of development of the position statement, which addresses reimbursement for trauma call coverage, I would remind readers that the impetus for the development of the statement was to help private practice neurosurgeons in rural communities where, because of the limited number of people in their practice group, they were finding that they were being asked to take call coverage as often as every other night. Our hope was that if a hospital provided a stipend equal to a neurosurgeon's annual salary, then a small-group practice would be able to hire an extra partner who could significantly relieve the group's on-call burden. It has never been our intention that this position statement be used for anything other than to restore some normalcy to the lives of hardworking neurosurgeons. I agree, however, that with acceptance of a trauma stipend comes certain obligations and responsibilities. Among these include the responsibility for attending medical audit committee meetings of the trauma program at one's hospital and other administrative duties as required for Level I or Level II trauma center. In this issue of the newsletter, we have invited John McVicker, M.D., and Jack Wilberger, M.D., to discuss these issues more thoroughly, and I hope the readership will find their comments informative.

I look forward to the next 2 years as your Neurotrauma Section chair and encourage you to contact me at any point with your concerns or problems related to neurotrauma and critical care.

## Trauma Contracts Improve Trauma Care: Trauma Stipends May Not

John McVicker, M.D.,  
F.A.C.S.

Why can't we be reliably available for neurotrauma?

Op-ed columns in major newspapers opine that as a specialty neurosurgery can't, or won't, cover trauma in our nation's emergency departments. I do not accept the thesis that the problem is neurosurgery's collective bad attitude. In 1992, an often-quoted report from the Office of the Inspector General (OIG) of the Department of Health and Human Services addressed the problem of specialty trauma call coverage in the nation's emergency departments and found neurosurgery to be the worst. Sixty-six percent of specialty physicians surveyed stated that fear of increased malpractice liability had persuaded them not to participate in on-call activities. Forty-seven percent of the physicians considered Emergency Medical Treatment and Labor Act anti-dumping laws a serious drawback to participation in emergency care, and 44% reported that reimbursement for emergency services was inadequate. Nearly half of the hospitals claiming to have neurosurgical services in their emergency departments had difficulty ensuring coverage. The OIG concluded that many specialists don't participate in trauma care because they are engaged in more reliably compensated activities.

If a hospital has made a commitment to neurotrauma care, it is responsible for ensuring neurosurgical availability. As hospital systems expand, market trauma care and often profit from it, the neurosurgeon's time for reliably compensated elective cases shrinks. The situation is made worse by comparatively fewer neurosurgeons relative to other high-demand trauma specialists. Even though neurosurgery is a small specialty, 57% of all high acuity trauma patients have some neurologic injury, and half of the 150,000 injury-related deaths that occur annually in the United States involve a serious brain injury that is primarily responsible for the patient's demise. Yet as of 1995 there were over three times as many emergency room physicians, four and one-half times as many orthopedists, and over six times as many general surgeons to cover the needs of the emergency room.

Is there a simple answer to this complex problem? Is reimbursement for on-call availability (call stipends) the gold at rainbow's end?

Data recently collected suggests that a cohort of surgeons, unreimbursed for

## Joint Neurotrauma

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trauma availability, performed significantly better at trauma program requirements such as QA meeting attendance, trauma continuing medical education and emergency department response times than their reimbursed colleagues (J. Wilberger, personal communication). These two groups may not be comparable for critical variables such as academic versus private practice, the presence of resident staff, and other coexisting means of reimbursement for trauma participation, but the answer may be obvious: stipends alone don't guarantee quality neurotrauma care.

We need a solution that addresses the complexities of the problem. Careful contracting with a hospital or system to provide tailored services with specific safeguards and responsibilities for both parties may be the answer.

Every community possesses unique demographics, differences in neurosurgical workforce, strengths and weaknesses of the regional trauma system. Funding sources, managed care prevalence and aggressiveness, competing hospitals and systems alter the landscape. Regardless, neurosurgical availability is key to the success of any major trauma program. Contracts between trauma hospitals and neurosurgeons can ensure neurosurgical availability, mandate neurosurgical participation in quality assurance, education, protocol and program development, and promote trauma program outreach. Contracts could improve the institution's ability to meet EMTALA obligations, help assure that the institution meets standards required for trauma center verification, and improve coordination among trauma specialists. Contracts may provide the funds necessary to bring needed neurosurgical workforce to a community with limited elective cases, and may be the only way some neurosurgeons can afford to remain on a medical staff that requires participation in trauma.

Despite anti-kickback "payment for referral" issues, legal analysis suggests that physicians can expect fair market compensation for services that go beyond usual medical staff obligations. When limited workforce and high demand are considered, it is apparent that neurotrauma coverage demands more from the neurosurgeon than general emergency coverage does of the average medical staff member, and is

worthy of additional compensation at fair market value.

Neurosurgeons engaged in a trauma program should be able to require the hospital to provide adequate equipment for neurosurgical procedures, maintain nursing and ancillary staffing at appropriate levels, and enter into defined transfer agreements when the on-call doctor unavoidably becomes unavailable. The contract can define fair com-

ensation or the provision of other methods of compensation such as billing services, trauma data management, neurosurgical recruitment, etc. With or without a stipend, contracting for ED coverage is an appropriate and necessary step to protect yourself and your patients. As a member of the Neurotrauma Section's Executive Committee has phrased it, "No neurosurgeon should be expected to cover a trauma service beyond the limits of a safe and

reasonable workload...."

But we must not hold our hospitals hostage. An institution should be able to expect a participating neurosurgeon to agree to reasonable and specific frequency and duration of call periods, response times, and if necessary, back up call schedules. It could reasonably expect trauma QA committee involvement, neurotrauma protocol development and maintenance, trauma-specific

## NEUROSURGERY NEWS

*E-mail letters to the editor,  
article ideas, meeting notices,  
and press releases to:  
[gregthom@umich.edu](mailto:gregthom@umich.edu)*

CME, and participation in nursing education and trauma outreach programs.

If this give-and-take-relationship is honored, neurotrauma contracts can be a win-win situation. The hospital reduces its EMTALA exposure, improves its performance in the trauma center verification process, and ensures neurosurgical participation in quality assurance and program development by supporting voluntary trauma con-

tracts. For the neurosurgeon, these contracts help alleviate the double burden of providing mandatory uncompensated care even as their reliably compensated elective practice is impacted. Everyone negotiates for and knows what their responsibilities in the provision of trauma care will be. Excessive and unsafe workload on the neurosurgeon can be avoided. These contractual relationships are increasingly prevalent nationwide. Although it will

not be easy to reliably confirm, I believe these legal agreements between neurotrauma centers and trauma neurosurgeons will greatly facilitate neurosurgical participation in trauma care, as they become common practice.

*John McVicker, M.D., F.A.C.S., is a member-at-large of the AANS/CNS Section on Neurotrauma and Critical Care Executive Committee and past chair of the CSNS Neurotrauma Committee.*

## Neurosurgeons and Their Responsibilities to Trauma Centers

**Jack Wilberger, M.D., F.A.C.S.**

It is unlikely that anyone would disagree with the fact that neurosurgeons are the best trained and qualified to manage neurotrauma. Arguably, we as members of society at large and our particular communities of practice have a moral and ethical obligation to make our talents and services available to deal with emergency neurosurgical problems—especially neurotrauma. Trauma centers evolved and are now accredited by many states primarily because it has been shown in many studies that they save lives—especially of the more seriously injured. Unquestionably, trauma centers need neurosurgeons as a part of the team to accomplish this worthy goal. Unfortunately there are not enough neurosurgeons either available or who are willing to commit their time and energy to support this critical need.

A number of years ago, a true shortage of neurosurgeons in the Western parts of the United States gave rise to payment of stipends to neurosurgeons for trauma call. This practice was rapidly embraced by a number of neurosurgeons around the country. Several years ago the AANS/CNS Section on Neurotrauma and Critical Care officially sanctioned this practice by providing advice on stipend negotiations and even providing “sample” contracts to all neurosurgeons. Has this practice relieved the manpower shortage? Has it made neurosurgeons more responsive to providing neurotrauma care? In my opinion the answer is a resounding no.

In a recent survey I conducted of 150 Level I and Level II trauma centers, 101 were providing reimbursement for neurotrauma call. The average reimbursement was \$1,175 per day with the maximum being \$2,054 per day. In those centers providing reimbursement, neurosurgical commitment was substantially less compared to those centers not providing reimbursement as measured by a neurosurgeon’s specific obligations to not only care for patients, but also ensure that the trauma center continues to meet all of the oftentimes rigorous requirements for maintaining accreditation or verification. Thus, the Neurotrauma Section’s support of stipends for neurotrauma call has been, in my opinion, a step in the wrong direction.

In addition, most trauma centers operate on a limited margin and many are unprofitable, drawing resources from

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## Joint Neurotrauma

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other hospital operations. Many cannot sustain what will certainly be not only an escalating demand for stipends (with the imprimatur of the Neurotrauma Section), but also increasing levels of payment. Even in the busiest of Level I trauma centers it is very unusual for more than 50 emergency neurotrauma surgeries to be done in 1 year. Assuming four neurosurgeons taking call (at most Level II centers there are only two), receiving the average daily stipend, each would receive over \$8000 per case; obviously this is an oversimplification as it does not take into account other neurotrauma consultations requiring the neurosurgeon's time and effort.

Therefore, I feel the Neurotrauma Section has unintentionally done an injustice to the necessary and appropriate delivery of neurotrauma care by sanctioning open-ended stipend negotiations without appropriate checks and balances. There are certainly true manpower shortages where the burden of taking neurotrauma call justifies special reimbursement arrangements. However there are many more instances where I am concerned that such stipends perhaps are being used to cover other practice losses, without a true commitment to neurotrauma coverage. I urge the Neurotrauma Section to take a strong stance on this issue. Interestingly, I have yet to hear of anyone asking for stipends to take emergency cerebrovascular call. Is neurotrauma call any less of a responsibility to the patients of our communities who depend on us?

*Jack Wilberger, M.D., F.A.C.S., is past chair of the AANS/CNS Section on Neurotrauma and Critical Care and a member of the American College of Surgeons' Committee on Trauma Ex-Officio Executive Committee.*

## Committee Updates

### Coding and Reimbursement Committee

#### John Wilson, M.D.

AANS Relative Value Update Committee (RUC) Adviser

It was announced at the Neurotrauma Section Executive Committee meeting in April 2002 that four new current procedural technology codes had been approved: decompressive craniectomy with duraplasty; trauma lobectomy without evacuation of hematoma or contusion; implantation of craniotomy flap in the abdominal wall; and retrieval of bone flap from the abdominal wall with reimplantation into the skull. These

codes will appear in the 2003 CPT book. These codes were valued through the American Medical Association RUC process through a survey that had been sent to 130 randomly selected members of the Neurotrauma Section, a sample size that represented approximately 10% of the section's membership. Though the response to the Coding and Reimbursement Committee was poor, it at least met the required number of 30 evaluations. Through this process, the CRC learned that future projects of this type would be more likely to succeed if they worked with section liaisons to identify individuals who would complete and return the surveys promptly.

In terms of evaluation of the new codes, responses were very consistent. Respondents agreed that decompressive craniectomy was most comparable to a craniotomy for acute subdural hematoma, but the decompressive craniectomy was valued a bit higher. The RUC also looked at the intensity of the work and though the valuation was low, it was consistent. The concern expressed was that the RUC usually gives very short notice about these surveys, so it would be difficult to take the time to better educate respondents of future surveys and details to be taken into account. Despite these difficulties and inherent problems, the system worked well and four new codes will be available that more closely match the work being done.

### Spinal Cord Injury Committee

#### Michael Fehlings, M.D., Ph.D.

The December 15 issue of Spine dealt with spinal cord injury, including the GM1 ganglioside data. Additionally, members of the Neurotrauma Section Spinal Cord Injury Committee organized a practical clinic on spinal cord injury and its treatment over the weekend prior to the AANS meeting that attracted approximately 40 attendees. Finally, it was noted that the Surgical Treatment for Acute Spinal Cord Injury Study was still viable and plans were being made to further develop the study for a clinical trial. Michael Fehlings, M.D., distributed an executive summary of the trial and noted that all the STASCIS centers can begin entering patients as soon as patients arrive at the hospital. A pilot study involving several of the centers is currently underway. The hope in the near future is that the STASCIS investigators will reapply to National Institutes of Health for funding.

The question arose as to whether reapplication for NIH funding was worth the time and effort, given that a previous funding application had been rejected.

In reality, only the NIH could contribute enough funding to make such a large trial feasible. The general feeling was funding could be more likely obtained as compared to several years ago. Specifically, it was felt that the NIH was more interested in trials of this type at this time and the biological rationale of the grant has been further supported with the appearance of two peer-reviewed articles: one in the Guidelines and the other an evidence-based review. Interest in such a trial has also increased within the National Neurotrauma Society and in the Christopher Reeve Paralysis Foundation. Other additions to the proposal that have likely strengthened the application include: improved imaging analysis, more American involvement in addition to Canadian involvement in the organization, administration, and data analysis, more multidisciplinary in its approach, Web-based data entry, decreased cost of the trial, as well as evaluating the window of opportunity for treatment with surgical intervention. Seed money from the Neurotrauma Section was sought to establish and maintain a database and \$10,000 was approved to support this venture.

Recognition at the Neurotrauma Section Executive Committee meeting was made of Dr. Fehlings' contributions to the section in that he has been instrumental in raising over \$150,000 for Neurotrauma Section grants and awards over the last few years.

### Pediatric Neurotrauma Committee

#### P. David Adelson, M.D.

Members of the Pediatric Neurotrauma Committee remain active in multiple areas making excellent progress on a number of projects. They will be highlighted in this committee update.

**The Pediatric Severe TBI Guidelines.** Excellent progress continues on the Pediatric Severe Traumatic Brain Injury (TBI) Guidelines. Drafts of each of the chapters are being completed and compiled by this summer. The Guidelines draft will be distributed on compact disc to all of the national societies for initial review and comments. A September 2002 meeting is planned to finalize the different revisions and complete the final product. The Guidelines will then be published simultaneously in the Journal of Trauma and Pediatric Critical Care Medicine. Randy Chestnut, M.D., has lead the group which has included a cross section of pediatric specialists in neurosurgery, critical care, emergency medicine, trauma, and epidemiology. Neurosurgical involvement included David Adelson, M.D., Nathan Selden,

M.D., and Michael Partington, M.D..

**Multicenter Trial: Phase II Study of Hypothermia for Severe TBI in Children and Evaluation of Initial and Outcome Assessments in Children Following Severe TBI.** The Phase II Multicenter Trial for Hypothermia following Severe TBI in children continues and will likely finish up accrual by December 2002. Most of the aims and goals of the study are being met which includes not only the safety and performance study, but studies of the optimal initial assessment in young children and infants and improved outcome assessments in children. The study is likely to be completed as originally projected. Once the data is analyzed, abstracts will be submitted to the different national meetings in order to disseminate the information. The principal investigator was Dr. David Adelson and co-investigators included John Ragheb, M.D., Douglas Brockmeyer, M.D., Jan Paul Muizelaar, M.D., Harvey Levin, Ph.D., Ann-Christine Duhaime, M.D., and Paul Kanev, M.D..

**Neurosurgery Clinics of North America: Non-Accidental Neurotrauma in Children.** This publication was completed and distributed in July 2002. Chapters included identification, evaluation and treatment of these children as well as some interesting chapters on the unique pathophysiology of this injured age group, outcomes, and future issues, hopefully in the area of prevention and education. Also importantly, there is chapter on the medical/legal aspects particularly as it relates to the treating physician. Drs. Adelson and Partington were the editors for this edition.

**Cervical Spine Clearance Recommendations for Young Children.** A new working group of pediatric neurosurgeons and members of the Pediatric Neurotrauma Committee met at the CNS Meeting in San Diego and in December 2001 at the AANS/CNS Section on Pediatric Neurosurgery meeting in New York to discuss the issues surrounding clearance of the comatose or young child where there is the question of radiologic versus clinical clearance. This group is planning, potentially, a multicenter prospective study to look at best practice management in these situations. Members involved include Drs. Adelson, Brockmeyer, and Partington, and Mark Dias, M.D., Dachlang Pang, M.D., Paul Grabb, M.D., as well as others.

### Fellowships/Awards Committee

#### Michael Fehlings, M.D., Ph.D.

The Neurotrauma Section presently gives out four awards.

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## CNS Membership Update 2002

**Christopher C. Getch, M.D.**  
Chair, CNS Membership Committee

The Congress of Neurological Surgeons continues to grow, expand member services, and flourish. The current CNS membership as of July 2002 stands at 5,074 members. Membership in the Congress of Neurological Surgeons remains one of the best values in organized medicine for practicing neurosurgeons and neurosurgical residents. CNS Resident Members, for a one-time \$25 fee, receive a wide range of benefits:

- One-time membership fee of \$25
- Reduced registration fee for Annual Meeting and Meeting Luncheon Seminars
- Complimentary housing at the Annual Meeting on a first come, first serve basis
- Free annual subscription to *NEUROSURGERY*, official journal of the CNS (sponsored by Codman, Inc.)
- CNS-funded Resident Awards
- Variety of funded educational CNS Fellowship opportunities
- *Neurosurgery News*, official bimonthly news magazine of the CNS
- *Clinical Neurosurgery*
- *Young Neurosurgeons' Directory*
- CNS Member Directory
- Online access to NEUROSURGERY://ON-CALL®
- Job Placement Service facilitating linkage between members and career opportunities.

Active CNS members (North American and International) pay dues of only \$335 per year, the lowest dues structure for a similar-sized membership service organization in organized medicine.

- Annual dues of \$335
- Reduced registration fee for Annual Meeting
- Opportunity to participate in the Annual Meeting and/or the subspecialty meeting of the CNS
- Opportunity to participate in the organization and function of the CNS through membership on various committees of the CNS
- Subscription to *NEUROSURGERY*, official journal of the CNS
- *Neurosurgery News*, official bimonthly news magazine of the CNS
- *Clinical Neurosurgery*
- Reduced prices on other CNS publications, educational products, and courses.
- CNS Member Contact Guide
- Online access to NEUROSURGERY://ON-CALL®
- Job Placement Service facilitating linkage between members and career opportunities

- Variety of funded educational CNS Fellowship opportunities

Over the past several years, a considerable amount of thought and effort has been put into maximizing CNS member benefits, including those of CNS International Members. Recently, the benefits available to CNS International members were expanded to include all those available to active North American members, without the dues of one membership group underwriting those of another.

Becoming a member in the Congress of Neurological Surgeons has become faster, easier, and more convenient. Implementation of several improvements in the membership process and the transition of membership application processing to the CNS headquarters' office in Schaumburg, Illinois has resulted in efficiency and cost savings. Centralization of application processing has made it easier to track and process applications in less time. It has allowed for a more rapid response to inquiries about a member's application status. Simplification of the transition process from Resident membership to Active membership in the Congress has also been a benefit. Residents at the end of their training may simply fill out a short form with their program director's verification, which can then be submitted in application for consideration by the CNS Executive Committee for conversion to Active membership.

An online CNS membership application service will be available in the near future to potential CNS members through NEUROSURGERY://ON-CALL®. This system has been developed by Dr. Joel MacDonald, Chairman of the Information/Technology Committee, Cathy Hamma at NEUROSURGERY://ON-CALL®, and the CNS Membership Committee. The ability to apply online will significantly decrease the amount of time it takes to process a membership application, particularly for potential International CNS members. Until this new system is up and running, traditional CNS membership application forms are available through NEUROSURGERY://ON-CALL® at [www.neurosurgery.org](http://www.neurosurgery.org).

During the 2002 CNS Annual Meeting in Philadelphia, every effort was made to facilitate membership applications and member service inquiries. A large number of membership inquiries were made, questions were answered, and completed applications were submitted at the CNS Membership booth located centrally in the Exhibit Hall.

One of the most difficult tasks facing the Membership Committee of the CNS is keeping track of CNS members as they transition from Resident Members to Fellows to Active Members of the CNS, or a CNS member's transition from one practice to another. We

request that all CNS members, whether completing training or changing practices, please keep our office informed of any change in address and/or location. Please contact Member Services at 847-240-2500 or by e-mail at [info@1cns.org](mailto:info@1cns.org).

Join us as we continue to grow and continue to provide exceptional member service and educational benefits of the greatest value and lowest possible cost. □

## 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](mailto:cgetch@nmff.nwu.edu).

M. Samy Abdou  
Aviva Abosch  
Philipp Aldana  
Ayman F. Al-Shayji  
Lars Anker  
Paul J. Apostolides  
Jose Arias  
Muhammad Arif  
Bradley J. Bartholomew  
Tjemme Beems  
David Black  
Miroslav Bobek  
Adam J. Brandt  
W. EK Braunsdorf  
Joao G. Carvalho  
Jeffrey E. Catrambone MD  
Jin Woo Chang  
Tae-Hyun Cho  
Julius E. Ciembroniewicz  
Frederic Collingnon  
Jean-Valery Coumans  
Kemal Dizdarevic  
Jill W. Donaldson  
Susan R. Durham  
W. Jeffrey Elias  
Daryl R. Fourney  
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Abdi S. Ghodsi  
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Devon A. Hoover MD  
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Brian Iuliano  
Gustavo A. Izaguirre  
Joseph A. Jestus  
Terrance Julien  
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Stuart Kaplan  
Marcus F. Keep  
Hansung Kim  
Kenneth E. Korber  
Charles Kuntz IV  
Sagi Kuznits  
Giuseppe Lanzino

Paul S. Larson  
Albert S. Lee  
Kenneth M. Liebman  
Caleb R. Lippman  
Erwin Lo  
Hulda B. Magnadottir  
Paul G. Matz  
Richard Meagher  
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Praveen Mummaneni  
Ilyas Munshi  
Eric W. Nottmeier  
Matthias F. Oertel  
Michael Y. Oh  
Matthew F. Philips  
Richard S. Polin  
Guillermo C. Ribas  
Howard Riina  
Sean A. Salehi  
John H. Sampson  
Roberto M. Sanchez  
Ahmet M. Sanli  
John Sarzier  
Lauren F. Schwartz  
Nathan R.W. Selden  
Keiji Shimizu  
Yong Sam Shin  
Ran Vijai P. Singh  
Santiago V. Sosa  
David Steven  
Jeffrey A. Stone  
Mark A. Testaiuti  
Neil A. Troffkin  
Hari Tumi  
Osly Vasquez  
Philip A. Villanueva  
Miroslav Vukic  
John Wahlig  
Tadeusz Wellisz  
Jonathan A. White  
Gregory C. Wiggins  
Eric H. Wolfson  
Ofer M. Zikel  
Martin Zonenshayn

## ISAT Report

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were not provided for the non-randomized patients.

Neurosurgeons await with interest the long-term follow-up data on the 2143 ISAT patients. It is crucial to determine whether or not aneurysm coiling will be as effective as craniotomy for aneurysm clipping after subarachnoid hemorrhage in preventing re-bleeding over the lifetime of the patient. During the short follow-up period of the interim report, 2.6% of patients whose aneurysms were treated with coiling suffered a hemorrhage after treatment as opposed to 0.9% of patients treated with craniotomy for aneurysm clipping. Although re-bleeding more than 1 year after treatment was low in both ISAT treatment groups, if the early differential rate of hemorrhage were to persist, the 6.9% absolute risk reduction attributed to endovascular aneurysm coiling at 1-year follow-up in the ISAT study would soon disappear. In addition, more than four times more patients treated with aneurysm coiling required additional treatment for their ruptured aneurysm than did patients treated with craniotomy for aneurysm clipping. The 2,143 randomized patients in the ISAT study will need to be followed for many years before legitimate conclusions can be drawn about whether aneurysm clipping or aneurysm coiling is the preferred form of treatment for ruptured intracranial aneurysms in patients suitable for either form of therapy.

*The ISAT report is an important step in defining the roles of endovascular and microsurgical treatment of patients with ruptured intracranial aneurysms.*

We believe that an accurate interpretation of the ISAT study would be: "In a patient whose ruptured aneurysm is considered suitable for clipping or coiling, and for whom the neurovascular surgeon and the endovascular surgeon do not know, after considering all factors, which treatment option is better for a specific patient with a ruptured aneurysm, aneurysm coiling, at the centers involved in the ISAT study, yielded a 6.9% chance of a better functional outcome at 1-year follow-up compared to similar patients with ruptured aneurysms treated with craniotomy for clipping. Long-term follow-up of these patients will be essential to determine which of these two forms of treatment is safer and more effective for this subgroup of patients over their lifetimes". The ISAT report is an important step in defining the roles of endovascular and microsurgical treatment of patients with ruptured intracranial aneurysms. The points noted above are raised to

remind all of us that much more study is needed to develop definitive medical evidence on this issue. To extrapolate the early results of this study to all patients with intracranial aneurysms (ruptured or not) would be a misinterpretation of the ISAT data and a serious disservice to our patients and our profession.

### Robert E. Harbaugh, M.D., F.A.C.S

Chairman, AANS/CNS Section on Cerebrovascular Surgery

### Roberto C. Heros, M.D., F.A.C.S.

President, American Association of Neurological Surgeons

### Mark N. Hadley, M.D., F.A.C.S.

President, Congress of Neurological Surgeons

1. International Subarachnoid Aneurysm Collaborative Group. International subarachnoid aneurysm trial (ISAT) of neurosurgical clipping versus endovascular coiling in 2143 patients with ruptured intracranial aneurysms: A randomized trial. *Lancet* 360:1267-1274, 2002. □

## Project Shunt

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We have tried to address this issue by working with the March of Dimes in Michigan to provide vitamins, educational materials, and Internet resources for the Pediatric Foundation.

We have each been blessed with careers in health care. We live in the United States and have been provided a quality of life that is envied throughout the world. The ability to reach out and provide medical care to Guatemala has been a wonderful learning experience for me and for my team. Particularly for my residents, it has taught them much not only about spina bifida, but also about why they chose to be physicians. They have learned how to do complex cases with less equipment but with equal quality and care. Each one of the team comes back from the mission enriched and understanding how privileged we are for so many things. It is hard work, and it requires lots of preparation, but it is rewarding in ways that are immeasurable. □

## Publications

Continued from page 11

logical Surgeons Meeting each year. Under the current directorship of Dr. Guy McKhann, *Clinical Neurosurgery* includes the published works of the CNS honored guests and the invited plenary session speakers. The book is mailed to all CNS members within 1 year of the meeting. It remains a valuable educational product with its origins almost over five decades ago.

*CNS-Online Publications:* Our first Internet-based publication, "Geographical

Neurosurgery" is now available for worldwide access. Written by Professor Samuel Ohaegbulam, Chief of Neurosurgery at Memfys Hospital for Neurosurgery in Enugu, Nigeria, this landmark publication reviews the incidence of neurosurgical disorders across the country as well as manpower issues, trends in management, and the variability in patient care across different countries. To my knowledge, such a work has never before been published. When Professor Ohaegbulam brought this project to the CNS Publication Committee, we believed that a book alone would not do this project justice. By placing this on the CNS Web site, neurosurgeons across the world will be able to access this information easily. It will also be easier to update. Please take a look at this monumental work!

*Neurosurgery News:* CNS would like to formally thank Dr. Michael Levy, who has edited both the CNS Newsletter and the initial years of *Neurosurgery News* with enthusiasm and professionalism. Two new editors, Dr. Gregory Thomp-



son and Dr. Karin Muraszko, will work to ensure timeliness of publication, informative content, and product advertising for this important CNS liaison with its members.



*Self Assessment in Neurological Surgery:* Dr. Tony Asher is nearing completion of the new SANS project. The CNS initiative may be adopted by the American Board of Neurological Surgery as they work towards creating study materials and examinations for credentialing renewal. The previous edition, SANS VI, was a big success. We fully anticipate that SANS VII will reach an even wider audience. □

## Joint Neurotrauma

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The Synthes Corporation supports two awards for resident research, one in brain and craniofacial injury and one in spinal cord and spinal column injury. At the AANS meeting in Chicago, the cranial award was given to Joseph Neimat and the spine award was presented to Edward Smith. Coincidentally, both awardees are from Massachusetts General Hospital.

The third award administered by the Neurotrauma Section is the Codman Fellowship in Neurotrauma and Critical Care. The 2002-2003 fellowship was awarded to Bradley Jacobs of the University of Toronto. The initial commitment from Codman is an annual award for three years. The Neurotrauma Section is hopeful that this commitment will be extended by three more years.

The fourth award is the J. Douglas Miller Traveling Fellowship, which was awarded to Ivan Ng, who will be using the award funds to visit the University of Pittsburgh and the Medical College of Virginia.

## AANS/CNS Section on Neurotrauma and Critical Care Officers and Committee Chairs

Chair: Donald W. Marion, M.D.

Chair-Elect: Alex B. Valadka, M.D.

Secretary/Treasurer: P. David Adelson, M.D. F.A.C.S. □

### The 2003 meeting of the Joint Section on Stereotactic and Functional Neurosurgery

will be held May 18-21, 2003 at the Plaza Hotel in New York City. Come immerse yourself in the latest science on movement disorder surgery, radiosurgery, epilepsy, robotics and technology, pain surgery, and image-guided neurooncology.

Come enjoy New York at its finest hotel location!

For further information, visit the Web site of the American Society for Stereotactic and Functional Neurosurgery at [www.assfn.org](http://www.assfn.org).

Douglas S. Kondziolka, M.D., F.R.C.S.  
President, American Society for Stereotactic and Functional Neurosurgery

## NEW PRODUCTS

# Möller-Wedel Introduces the Perfect Balance Surgical Microscope

Mason, OH—Möller-Wedel has introduced the Möller 20-1000 operating system at the Congress of Neurological Surgeons in Philadelphia in September 2002. The system contains the new FS 4-20 floor stand, the Möller Hi-R 1000 microscope, and the LR 1000 light router.

According to the manufacturer, the Möller 20-1000 is designed to stay in perfect balance even after reconfiguration. The key to the balance is in the unique design of the overhead arm with a storage compartment for the microscope accessories. The microscope contains new technology for precise and effortless movements without the need to shift weights. Not only will the operating room staff save time in balancing, but it will also save time in carrying the parts to a separate storage place.

The Möller Hi-R 1000 microscope features apochromatic optics to provide high resolution and crystal clear images.

The microscope contains a 6X zoom and variable objective with an exceptional working range. Fine XY corrections can be made via the joy pad on the 14-function handle, foot switch, or with the navigation system.

As a replacement for the double eyepiece and beam splitter, the light router LR 1000 is equipped with new eyepiece heads that are inclinable by  $\pm 100$  degrees. The light path can be switched between an observer scope and a facing eyepiece.

Möller-Wedel, a Haag-Streit company, specializes in operating microscopes. A manufacturer of precision optics since 1864, Möller-Wedel is based in Wedel, Germany, with an additional sales, service, and distribution center at Haag-Streit USA, in Mason, Ohio.

For more information, contact Ed Rae, 1-800-440-9105. □



## 2003 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](http://www.aans.org).

### American Association of Neurological Surgeons **Basic Principles of Anatomy and Terminology for Neurosurgery Office Staff**

Tampa, Florida  
January 30, 2003  
Hotel: Marriott Tampa Westshore  
Primary Meeting Contact: Vanessa Garlisch

E-mail: [epm@aans.org](mailto:epm@aans.org)  
Web site: [www.aans.org](http://www.aans.org)

Description: This overview of anatomical terminology and neurosurgical procedures aids office staff in understanding operative reports and assists them in the appropriate coding of procedures. This program will ensure familiarity with the clinical aspects of CPT coding and comprehension of the coding concepts that will be presented.

### American Association of Neurological Surgeons **Managing Coding and Reimbursement Challenges in Neurosurgery: 2003**

Tampa, Florida  
January 31–February 1, 2003  
Hotel: Marriott Tampa Westshore  
Primary Meeting Contact: Vanessa Garlisch

E-mail: [epm@aans.org](mailto:epm@aans.org)  
Web site: [www.aans.org](http://www.aans.org)

Description: The course begins by providing an overview of Evaluation and Management (E&M) Coding and Documentation. If you think that E&M coding and documentation guidelines do not matter anymore because there are potentially new guidelines "around the corner," you are mistaken. Your documentation will be reviewed on guidelines as they existed on the date of service...which is today. The course progresses into some of today's most important practice management issues: the latest about HIPAA requirements as well as billing and reimbursement issues for the use of non-physician providers in neurosurgical practices. Discussions on modifiers and the 2003 updates for Medicare, CPT, and ICD-9 close out the session.

### American Association of Neurological Surgeons **Basic Principles of Anatomy and Terminology for Neuro-**

### **surgery Office Staff**

San Antonio, Texas  
February 20, 2003  
Hotel: San Antonio Marriott Riverwalk  
Primary Meeting Contact: Vanessa Garlisch

E-mail: [epm@aans.org](mailto:epm@aans.org)  
Web site: [www.aans.org](http://www.aans.org)

Description: This overview of anatomical terminology and neurosurgical procedures aids office staff in understanding operative reports and assists them in the appropriate coding of procedures. This program will ensure familiarity with the clinical aspects of CPT coding and comprehension of the coding concepts that will be presented.

### American Association of Neurological Surgeons **Managing Coding and Reimbursement Challenges in Neurosurgery: 2003**

San Antonio, Texas  
February 21–22, 2003  
Hotel: San Antonio Marriott Riverwalk  
Primary Meeting Contact: Vanessa Garlisch

E-mail: [epm@aans.org](mailto:epm@aans.org)  
Web site: [www.aans.org](http://www.aans.org)

Description: The course begins by providing an overview of Evaluation and Management (E&M) Coding and Documentation. If you think that E&M coding and documentation guidelines do not matter anymore because there are potentially new guidelines "around the corner," you are mistaken. Your documentation will be reviewed on guidelines as they existed on the date of service...which is today. The course progresses into some of today's most important practice management issues: the latest about HIPAA requirements as well as billing and reimbursement issues for the use of non-physician providers in neurosurgical practices. Discussions on modifiers and the 2003 updates for Medicare, CPT, and ICD-9 close out the session.

### American Association of Neurological Surgeons **Managing Coding and Reimbursement Challenges in Neurosurgery: 2003**

Seattle, Washington  
March 14–15, 2003  
Hotel: W Seattle  
Primary Meeting Contact: Vanessa Garlisch

E-mail: [epm@aans.org](mailto:epm@aans.org)  
Web site: [www.aans.org](http://www.aans.org)

Description: The course begins by providing an overview of Evaluation and Management (E&M) Coding and Documentation. If you think that E&M coding and documentation guidelines do not matter anymore because there are potentially new guidelines "around the corner," you are mistaken. Your documentation will be reviewed on guidelines as they

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American Association of  
Neurological Surgeons  
**Managing Coding and  
Reimbursement Challenges  
in Neurosurgery: 2003**

Chicago, Illinois  
May 16-17, 2003  
Hotel: The Palmer House Hilton  
Primary Meeting Contact: Vanessa  
Garlisch

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

Web site: [www.aans.org](http://www.aans.org)

Description: The course begins by providing an overview of Evaluation and Management (E&M) Coding and Documentation. If you think that E&M coding and documentation guidelines do not matter anymore because there are potentially new guidelines "around the corner," you are mistaken. Your documentation will be reviewed on guidelines as they existed on the date of service...which is today. The course progresses into some of today's most important practice management issues: the latest about HIPAA requirements as well as billing and reimbursement issues for the use of non-physician providers in neurosurgical practices. Discussions on modifiers and the 2003 updates for Medicare, CPT, and ICD-9 close out the session.

American Association of  
Neurological Surgeons  
**Neurosurgical Practice  
Management: Managing Your  
Practice by the Numbers**

Chicago, Illinois  
May 18, 2003  
Hotel: The Palmer House Hilton  
Primary Meeting Contact: Vanessa  
Garlisch

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

Web site: [www.aans.org](http://www.aans.org)

Description: This course is designed to help neurosurgeons and practice managers get a complete grasp on the practice financials. This course is clear, actionable and will increase your sense of competence in diagnosing the health of your practice.

American Association of  
Neurological Surgeons  
**Managing Coding and  
Reimbursement Challenges  
in Neurosurgery: 2003**

Charlotte, North Carolina  
August 22-23, 2003  
Hotel: The Westin Charlotte  
Primary Meeting Contact: Vanessa  
Garlisch

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

Web site: [www.aans.org](http://www.aans.org)

Description: The course begins by providing an overview of Evaluation and Management (E&M) Coding and Documentation. If you think that E&M coding and documentation guidelines do not matter anymore because there are potentially new guidelines "around the corner," you are mistaken. Your documentation will be reviewed on guidelines as they

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American Association of  
Neurological Surgeons  
**Managing Coding and  
Reimbursement Challenges  
in Neurosurgery: 2003**

San Francisco, California  
September 26-27, 2003  
Hotel: Grand Hyatt San Francisco on  
Union Square  
Primary Meeting Contact: Vanessa

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# CLASSIFIED ADVERTISING

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**Jennifer Williams**

**Phone: 800-528-1843; Fax: 410-528-4452 E-mail: [jwilliam@lww.com](mailto:jwilliam@lww.com)**

## Editorial Profile

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

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## Issuance and Deadlines

AANS Issue .....	3/13
Spring 2003 .....	5/12
Summer 2003 .....	7/11
CNS Issue .....	9/05
Fall 2003 .....	10/15

## Materials

Display ads may be supplied in the form of offset negatives, mechanicals or camera-ready copy.

## CLASSIFIED ADVERTISING



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- Virginia (3)

\*This list represents 19 private practice openings. A site visit was made to each practice. Read about these opportunities@ [www.ns-inc.com](http://www.ns-inc.com)

**Joyce A. Campbell, BSN MBA**  
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### CONTACT INFORMATION

To become a member, renew your membership, update your address, or for CNS inquiries, contact:

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Schaumburg, Illinois 60173

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Email: [info@1cns.org](mailto:info@1cns.org)

### Meeting Listings

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Garlisch

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

Web site: [www.aans.org](http://www.aans.org)

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American Association of  
Neurological Surgeons

#### Neurosurgical Practice

##### Management: Managing Your Practice by the Numbers

San Francisco, California

September 28, 2003

Hotel: Grand Hyatt San Francisco on Union Square

Primary Meeting Contact: Vanessa Garlisch

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

Web site: [www.aans.org](http://www.aans.org)

Description: This course is designed to help neurosurgeons and practice managers get a complete grasp on the practice financials. This course is clear, actionable and will increase your sense of competence in diagnosing the health of your practice.

American Association of  
Neurological Surgeons

#### Beyond Residency: The Real World

Los Angeles, California

October 4, 2003

Location: UCLA Medical Center

Primary Meeting Contact: Vanessa Garlisch

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

Web site: [www.aans.org](http://www.aans.org)

Description: Residents will prepare for the "Real World" at this educational program and meet fellow residents from around the US and Canada who will become colleagues and friends throughout their neurosurgery career! This course has been designed specifically for residents. Topics will include: basic coding; how to evaluate a job and establish a practice; practice management; academic vs. private practice paradigms. Residents will have a question and answer session with some of the leading surgeons in neurosurgery.

American Association of  
Neurological Surgeons

#### Managing Coding and Reimbursement Challenges in Neurosurgery: 2003

Baltimore, Maryland

November 21-22, 2003

Hotel: Baltimore Marriott Inner Harbor

Primary Meeting Contact: Vanessa Garlisch

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

Web site: [www.aans.org](http://www.aans.org)

Description: The course begins by providing an overview of Evaluation and Management (E&M) Coding and Documentation. If you think that E&M coding and documentation guidelines do not matter anymore because there are potentially new guidelines "around the corner," you are mistaken. Your documentation will be reviewed on guidelines as they existed on the date of service...which is today. The course progresses into some of today's most important practice management issues: the latest about HIPAA requirements as well as billing and reimbursement issues for the use of non-physician providers in neurosurgical practices. Discussions on modifiers and the 2003 updates for Medicare, CPT, and ICD-9 close out the session.

American Association of  
Neurological Surgeons and

#### Congress of Neurological Surgeons Section on Pediatric Neurological Surgery Annual Meeting

December 3-6, 2003

Miami, Florida

Location: TBD

Primary Meeting Contact: Lisa Sykes

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

Web site: [www.neurosurgery.org/pediatric](http://www.neurosurgery.org/pediatric)

American Association of  
Neurological Surgeons and

#### Congress of Neurological Surgeons Section on Cerebrovascular Surgery Annual Meeting

February 1-4, 2004

San Diego, California

Location: Sheraton

Primary Meeting Contact: Lisa Sykes

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

Web site: [www.neurosurgery.org/cv](http://www.neurosurgery.org/cv)

American Association of  
Neurological Surgeons and

#### Congress of Neurological Surgeons Section on Disorders of the Spine and Peripheral Nerves Annual Meeting

March 17-20, 2004

San Diego, California

Location: San Diego Marriott Hotel & Marina

Primary Meeting Contact: Lisa Sykes

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

Web site: [www.neurosurgery.org/spine](http://www.neurosurgery.org/spine) □