



NEUROSURGERY NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

President's Message: The Power of Unity, the Value of Diversity

Stephen Papadopoulos, M.D.
President, CNS



Unity is a very powerful force in war, politics, and athletic competition. The power is derived from unification of vision, priority, and focus.

Diversity is an essential element of change, growth, and maturity. Diversity leads to strength in character and voice. In fact, unity without recognition, respect, and empowerment of diversity is doomed to failure.

We in the field of neurosurgery represent a phenomenal diversity in culture, background, interests, religion, and political beliefs. The vitality of organized neurosurgery is dependent on expression of our diversity. We need to continue to provide a forum for each and every one of us to express our unique points of view and talents. Our diversity is the source of strength that empowers unity.

Medical organizations succeed and fail based on this complex balance of diversity and unity. The American Medical Association has suffered substantial loss of membership over the last several years because of a perceived imbalance. Many neurosurgeons, in fact, voice a sentiment of disenfranchisement, feel poorly represented, and overtly disagree with many of the AMA's organizational policies. An organization that once sought to unify physicians with a singular voice and vision has perhaps not fully embraced the value and importance of diversity among its members; it is now weakening in membership and is perceived by many as a fractured organization.

Much has been said in recent months about unity in organized neurosurgery. There is a sense that our size, as a group of professionals, is small and unity of voice, vision, priority and focus is essential. The presidents of the CNS and the AANS have been charged by their respective Executive Committee and Board of Directors to explore potential models of unity between the two organizations. Stan Pelofsky and myself have begun a series of meetings with a goal of preparing a report of recommendations within 12 months.

Diversity of organized neurosurgery has brought all of us phenomenal successes over the years. Considering our size, as a group of professionals, we have achieved tremendous strength in unity. The Joint Washington Committee, equally supported, both financially and in volunteer member effort, by the CNS and AANS, represents the true strength of unity in organized neuro-

surgery. We stand with equal footing in Washington among medical organizations many times our size in membership. In fact, we have emerged as leaders in several key efforts over the years.

Diversity is the central element of the Washington Committee's strength and success. Key resources from the Joint Sections, CSNS, and other committees of the CNS and AANS represent the diverse workforce of the Washington Committee. We should all be justifiably proud of the Washington Committee's success; it respects the diversity of our

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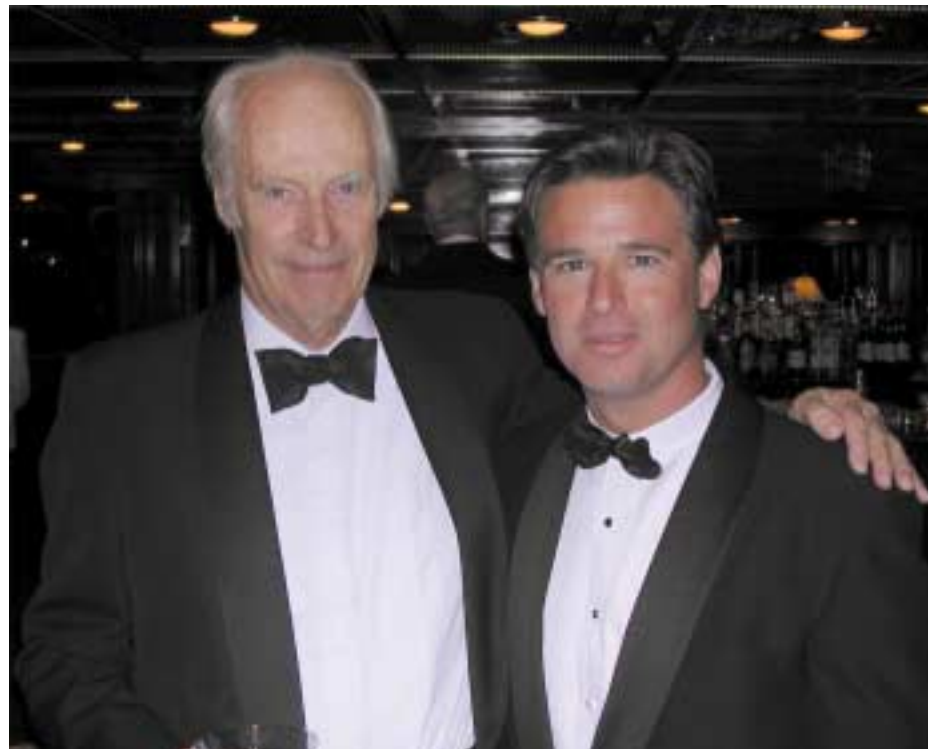
2001 CNS Annual Meeting: Reinventing Neurosurgery San Diego, California

Douglas Kondziolka, M.D.
2001 Annual Meeting Chairman

Much more than neurosurgery was "reinvented" at the San Diego CNS meeting this September. CNS members and exhibitors were challenged with reinventing their travel plans and arrangements, their willingness to attend a meeting given the recent terrorist attack, and their willingness to be away from family during

that terrible time. The CNS represented the first convention held in San Diego since the attack. The city had been virtually "shut down" for the 3 weeks prior to September 28. After 1 week following the attack had passed, the CNS officers made the decision to continue with the meeting, as long as no other terrorist activity occurred. This proved to be a wise decision on many fronts. Simply put, the decision to hold the meeting reflected the willingness of

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Sir George Martin (left) and Dr. Daniel L. Barrow.

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President's Message

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profession and the power of unified vision, priority, and focus.

Examples of the strength of diversity surround us. The Joint Sections were each formed recognizing that neurosurgeons of diverse background should have a forum of common interest with a goal of education, sharing of knowledge, and unification of vision, priority, and focus. The Spine Section has just completed a phenomenal compilation of work entitled, "Guidelines for the Management of Acute Cervical

Spine and Spinal Cord Injury." This effort, spearheaded by Mark Hadley and Beverly Walters, represents the hard work of a diverse group of contributors, each with their own perspective and opinions. The immense value of this document stems from Mark and Beverly's ability to harness diversity among the contributors and create unity in vision and voice.

The Joint Sections have lead the way as ambassadors for neurosurgery as well in bridging communication among colleagues in other disciplines. The Cerebrovascular Section shares a meeting with the American Association of Interventional and Therapeutic Neuroradiology, clearly establishing neurosurgery

as a vital participant in the evolving field of endovascular therapies. In 2003, the Spine Section will cosponsor a World Spine Meeting with the North American Spine Society. We only need to look around us to realize that our recognition and empowerment of diversity has resulted in great successes that other professional organizations simply do not enjoy.

Yes, the CNS and AANS should always seek improved avenues of unity. But let us not underestimate our phenomenal accomplishments. Let us understand and embrace the value of diversity. Diversity is the source of strength that empowers unity. □

EDITORIAL

Lessons from the Wall of Prayers

Rama Rao, M.D., and
Lewis R. Goldfrank, M.D.

A Wall of Prayers lines the entrance to Bellevue Hospital. On what was once a simple blue construction wall, pasted over "Post No Bills" stencils are hundreds of photos of men and women missing from the World Trade Center. They have a constant vigil: flowers, candles, and solemn observers stand. Fresh flowers are brought daily; candles are lit and relit. Solemn observers stand for minutes to read descriptions of myriad people.

Across the city their names and faces become unsettlingly familiar. They appear on phone booths, mailboxes, light poles, bus stops, and shop windows. Words like "Last seen 102nd floor WTC" reveal a paper trail of hope and despair stretching for blocks on end.

*It is the essence
of terrorism that lowers
us to our basest fear that our
seemingly safe environment is
not safe anymore*

On September 11, 2001, emergency medicine was thrust to the forefront of a horrible tragedy. Physicians and specialists in prehospital care and emergency nursing prepared makeshift triage areas amid chaotic conditions. At times, they followed the instructions designated by three blasts of the horn: "Run for your life."

At emergency departments within and around the city, medical staff swiftly deployed mechanisms to identify and

manage hundreds of critically ill and injured patients. Decontamination procedures were reviewed in case they were needed. Our preparedness, from housekeeping staff to critical care teams, was invaluable.

As we reflect on our crucial role in handling the disaster, some of us may focus on our ability to recognize and manage potential threats of biological, chemical, or radiation terrorism. Some will review the quality of our interactions with physicians from other specialties who so willingly came to assist us. Still others may consider how to deploy rescuers and physicians more safely to a disaster site. Perhaps some of us will develop a better mechanism to assist family members desperate to know if their loved ones can be counted among the missing and not the dead.

There are other critical aspects of this disaster that must be thoughtfully considered. On September 11, 2001, the sense of safety across the nation and indeed throughout the world was violently assaulted. In the wake of our staggering sorrow, we are left demoralized by the elusive motives of the attackers. No demands have been made, no conditions negotiated. There are no claims of responsibility enabling us to direct our anger.

We are experiencing the essence of terrorism. It has lowered us to our basest fear that our seemingly safe environment is not safe anymore. We find ourselves in an insidious atmosphere of imagined threats created by an unattended package, a sudden sound, or a readily identified race of people. It was in such similar circumstances that the rights of more than 100,000 Japanese Americans were violated. During World War II, persons of Japanese ancestry in the western United States, more than 60 percent of whom were born on American soil, were forcibly removed from their homes. They were placed in camps with tar paper barracks and barbed wire fences. Armed guards patrolled the perimeters. The personal effects of these "evacuees" were hastily sold or stored and often never recovered. These orders were sanctioned by the President of the United States in direct violation of the United States Constitution.

At that time a young man named Minoru Yamasaki, born in Seattle, WA, was working on the East Coast. Unlike his contemporaries he was spared the forced internment. Mr. Yamasaki ultimately became the chief architect of the World Trade Center. It is disquieting to consider that the towers may not have graced our skyline had his liberties been so violated.

Since World War II, our nation has made remarkable progress. We have moved

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The Wall of Prayers outside Bellevue Hospital in New York City.

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CNS Annual Meeting

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neurosurgeons not to abandon their practice and educational goals because of terrorism. The CNS notified all of our corporate exhibitors and sponsors, the vast majority of whom continued to attend the meeting. Little did we know that so many other people were relying on the Congress of Neurological Surgeons to hold their meeting at the San Diego Convention Center. From the hotel workers to the taxi drivers, the restaurant employees, and the convention center staff, neurosurgeons received thanks wherever they traveled in the city. The economic effects of travel have not only damaged the airline industry, but all of the businesses who rely upon planned convention center activities. The trickle-down economic effects to the people of the San Diego area were enormous.

Meeting attendance remained high. Registration projections before September 11 predicted the highest attendance figures ever at a CNS meeting. With some attrition due to the attacks, a record-setting number was not reached. However, over 5,500 people attended the meeting, equalling the

attendance at the 2000 CNS meeting in San Antonio.

All of the specially invited speakers attended the meeting except one. Admiral Albert Konetzni in his new position as head of the Atlantic Fleet sent his regrets. He was ably replaced by retired Marine Commandant Victor Kruluk, who spoke eloquently on the topic of leadership, with special mention of the military challenges currently faced. The scientific caliber could not have been higher. When Dr. Albert Rhoton walked onto the stage wearing 3D glasses on Monday morning and began his 3D presentation on neuroanatomy to a packed house, it was clear that neurosurgeons had come to learn. Dr. Robert Spetzler's spectacular 3D presentation on challenging neurosurgical approaches continued that tone. Special morning lectures by NASA origins committee director Alan Dressler and Nobel Laureate Francis Crick were special highlights. On Tuesday morning, Academy Award winning film editor and director Walter Murch spoke on creativity and reinvention, which led wonderfully into the superb presentation Wednesday on creativity by music producer Sir George Martin. Some called Martin's presentation "the best thing they've ever heard at a neuro-



CNS President Dr. Issam Awad and Distinguished Guest, Dr. Francis Crick.



Auxiliary President Catherina Awad and former United States Poet Laureate Robert Pinsky at the CNS Auxiliary Reception.



CNS President Dr. Issam Awad and Honored Guest Laureate, Dr. Michael L.J. Apuzzo.



CNS President Dr. Issam Awad and international members at the International Reception.



Implementation of 3D lectures during the Scientific Sessions.

surgical meeting." Dandy Orator Stephen Ambrose spoke on courage and perseverance and provided an eloquent narrative in the tradition of that lectureship. At a well-attended Thursday morning session on sports and spinal neurosurgery, former NFL quarterback Steve Young spoke passionately on his personal dealings with concussion and how patients and neurosurgeons should interact when it comes to issues of return to work, activities, and future risk exposure.

Honored guest Dr. Michael Apuzzo was

a true highlight of the meeting. His presentations took the form of slide images, sound, and film. The efforts of his filmmaker son Jason were evident and well appreciated.

Weekend practical courses were well attended. Several new courses were offered, including an endoscopic carpal tunnel course and a practice marketing course given by marketing professionals. Courses on vertebroplasty and kyphoplasty were the first to sell out. In the afternoon section symposia, a new format placing symposia topics at



Past and future CNS Presidents (left to right) Dr. Mark Hadley, Dr. Dan Barrow, and Dr. Hunt Batjer.



Members of the 2001 CNS Executive Committee.



The main exhibit floor at the 2001 CNS meeting in San Diego.

the end of the session allowed abstract speakers to present their information to a larger audience. This change in format was well received and should become standard at future meetings.

It has been a tremendous honor to serve the CNS as Annual Meeting Chairman and to work with a wonderful group of people who volunteered their time and efforts on behalf of the neurosurgical community. I would like to thank Scientific Program Chairman Richard Ellenbogen, Marketing Chairman Michael Levy, and Practical Course

Director Christopher Getch who were the key individuals working on your behalf. CNS Executive Director Laurie Behncke and her able staff handled tremendous meeting challenges in September that were unexpected and unprecedented. When neurosurgeons arrived at the meeting, everything appeared to be in order and running seamlessly. Ms. Behncke can singularly be congratulated for that achievement.

Work is already well under way for the 2002 CNS meeting in Philadelphia, and we look forward to seeing you there. □

Wall of Prayers

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past internment camps, McCarthyism, and the laws of Jim Crow. Discrimination in housing, education, and the workplace is illegal. These changes, however, are not accidents of history, but a direct result of our societal devotion to uphold the very U.S. principles targeted by our aggressors.

Our cooperative spirit, unified goals, and diverse origins gave us courage, as it does other nations struggling to achieve the same level of tolerance

Terrorism is powerful precisely because it threatens our faith in these values. Shaken by the attacks, we risk carrying out civil rights violations against our fellow citizens of Muslim, Islamic, and South Asian descent.

As physicians we are respected for our knowledge. We are not, however, immune from the pervasive xenophobia associated with these events. We must not only review our medical responses but also our psychological responses. We must recognize that what makes us strong as a nation is our diversity and the strength of democracy so easily seen in this city.

The Wall of Prayers is a testament to our diversity. The missing and the dead, who worked among each other, origi-

nated from seventy-nine different nations. We also see the diversity in our communities. On the Queens bound F train in New York, it is common to see a Tibetan monk in a saffron robe sitting next to a white man reading the *Wall Street Journal*. People reading Hebrew prayer books, Polish crossword puzzles, and newspapers in Russian, Spanish, and Korean all reveal the spectacular freedom our nation supports to embrace our origins and beliefs without fear. Surely those who come to stand before the Wall of Prayers recognize our multiethnic community.

Reflecting on September 11, it is clear that the thousands of hours of collective training for such a mass disaster could not have prepared us for the devastating realization that our stretchers would remain empty. Many of us stared down onto crisp clean sheets feeling powerless. But around the world, people were watching closely. Our cooperative spirit, unified goals, and diverse origins gave us courage as it did and does strangers in other nations struggling to achieve the same level of tolerance. As emergency physicians we must find a meaningful way to continue to improve the quality of life of people, the quality of our health care for all humans, and the quality of our interpersonal relationships. So much healing remains to be done.

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The RUNN Course: Interview with Dr. Issam Awad

Rudolph J. Schrot, M.D.
University of California-Davis

Equally at home discussing the molecular genetics of cavernous malformations or the history of philosophy and science, Issam Awad spearheads the Review and Update in Neuroscience for Neurosurgeons (RUNN) as Course Director, a position he has held since 1999. Under his leadership, the Course enrollment doubled. Dr. Awad is an inspiring lecturer and gifted moderator. Moreover, his charisma and down-to-earth interaction with the RUNN participants breathed life into the Course throughout the week. Dr. Awad was always to be found dining with RUNN students in the cafeteria or chatting after hours during the social gatherings. In this interview over lunch on the last day of the RUNN Course 2001 at Woods Hole, Dr. Awad elaborates on the history and philosophy of the Course.

When was the first RUNN Course?

The Course was started in 1982 by Dr. Henry Schmidek who was a professor of neurosurgery at Harvard at that time. Dr. Schmidek had long been associated with neuroscientists at Woods Hole. He was very concerned that neurobiology was exploding in the 1980s way beyond the ability of neurosurgeons to keep up with it. He felt that in the 1960s and 1970s neurosurgeons still kept up with developments in neurobiology, but things were now getting out of hand. He thought there should be an opportunity for neurosurgeons to be immersed in a review of what had happened in the past year, hence the word research "update."

Wasn't that in keeping with the tradition of early neurosurgeons such as Cushing who were neuroscientists?

Yes! The neurosurgeons were the neuroscientists; the neuroscientists were usually either neurologists or neurosurgeons. But that tradition started to fade away with the increased complexity of clinical care and with the explosion of science and neurobiology, especially genomics, in the 1960s and 1970s. It became clear that neurosurgeons could not possibly keep up with everything that was developing in science. Dr. Schmidek felt that an update would be important, a research update in neuroscience for neurosurgeons (RUNN). He conceived of a 2-week course with 2-hour talks to provide depth rather than shallowness. He also came up with late evening social gatherings to discuss the activities of the day, as well as blocked time for library reading. (Those were the days before Medline and PubMed, so that the library was an indispensable physical resource of information.)

So that's how the Course started. Initially the RUNN Course was supported by the NIH and by registration fees. Soon the AANS started to work with Dr. Schmidek in sponsoring the Course and in arranging its administration and management. Among the people who were involved early on was Dr. Charles Hodge, who had been a RUNN Course faculty member for many years and who became the next leader of the Course. Dr. Hodge's wife Cathy was the RUNN Course co-coordinator. (She started the tradition that the wife of the Course director was the one who handles the administrative work.)

Originally, a joint committee of the AANS and the CNS called the "Joint Committee on Education" oversaw the Course. Under Dr. Hodge, the Course remained at 2 weeks, but the lectures were shortened to 90 minutes. Very heavy lobbying to program directors took place at that time. It soon became common knowledge among residency programs that the RUNN Course was a great resource for residents.

The next director was Dr. Cordell Gross, who had been a faculty member and a co-director with Dr. Hodge. He and his wife Linda were the director and coordinator until 1998, when Dr. Gross developed metastatic cancer. I had been on the faculty since 1992 and was a co-director helping Dr. Hodge and Dr. Gross since 1996. The first Course that I was asked to direct was in 1999, and we put together the group of co-directors who have remained: Ed Oldfield, Robert Dempsey, Charles Hodge Allan Friedman, and Bruce Anderson. I asked my wife Cathy to coordinate it.

I made several major changes in 1999. First, we asked the Society of Neurological Surgeons to assume the sponsorship of the Course instead of the AANS or CNS. That was very important, since the Society of Neurological Surgeons, known as the "senior society," is the society of program directors. Hence, we put the Course directly under the auspices of the program directors themselves, instead of having to lobby to them from an outside organization. Second, I shortened the program to 1 week. Attendees and program directors alike had always been in favor of this change, but I had met with resistance from the co-directors in the past. Being in charge gives one the chance to make changes! We made it 1 week, and ever since that time the attendance has increased. We preserved the 90-minute lecture format because we didn't want the lectures to get short and shallow. In the 1-week format we also added the evening lectures, and we added emphasis on career development. We started to bring more speakers from the NIH to explain career opportunities at the NIH. The atten-



dance had actually been going down in the 1990s, which was a very serious concern. That was one of the reasons we changed the sponsorship and length of the program.

We preserved the contribution of many of the senior faculty who had been around almost as early as the Course inception. You saw many of them here: Daniel Alkon ["Memory"] was one of them. They were in love with the Course and believed in its principles. The rule I adopted for renewing faculty members was that as long as a faculty member received attendee evaluations of "excellent" or "very good," we would invite that individual to return. If an evaluation drops, it opens up an opportunity for us to bring in a new person. We've started to bring in neurosurgeons to act as role models—people who are very successful in academic neurosurgery like Robert Friedlander and others—to show you how they did it.

So originally RUNN faculty were mostly basic scientists?

Yes, and mostly only very senior people at that. I was already a full professor before I was invited to come to give my first talk. But now we've changed all that and welcome people who only 5 or 6 years ago were sitting in those same chairs in the audience.

And how does one decide as director what topics are appropriate?

The co-directors and I have a review session where we look at topics that you, the residents, generate on past evaluations, but quite frankly the residents don't really know that much about what's going on out there, so we also talk among each other about what may be the important issues, such as signaling, stem cells, apoptosis, etc. Some things are standard each year; other things go out of fashion. For example, we used to have talks on chaos theory and the EEG; now instead we have talks on functional MRI and

cortical reorganization. When we think of a topic, we ask who would be the very best person to talk about it. We then toss around the names of both neurosurgeons and non-neurosurgeons.

Some residents might read the RUNN Course description and think that it might make for a good Board review.

It is not a Board review. I tell people that it is could be a good chance to study for the Boards if you want to use some of the reading time for that purpose, but this is not what the RUNN Course is all about. First, it is about updating you on what is going on in neuroscience and on developments in neurobiology that can affect neurosurgical diseases. That way, you can understand what's going on in science. Second, the Course develops scientific literacy. You may choose at some point in your life to delve more into topics that are presented and apply them within your career. If not, then at least you can better understand the scientific underpinnings of an article as you read it. The third real objective is to help you explore your own research involvement; if you have already done research, you can ask yourself the question, "Did I do it well, did I not do it well, and how can I do it better next time?" If you haven't done research, this gives you a good chance to start planning it.

Do you think there is a best time for a resident in his residency training to participate in the Course?

We would like the residents to come here before they take their long block of research time, but as you know, this is highly variable among programs. It is probably best that residents attend the RUNN Course before they waste a lot of time on research that's not focused. A lot of people think they know what they want to do, but then they go into it in a very shallow way and they lose a lot of time.

Most residency programs have some research going on at their respective institutions. What advantage comes with participation in the RUNN Course?

This course is all about breaking down insularity; it's about opening things up. Every time I come here I learn five or six new things that I had no clue about. When I go back to my practice and to my teaching, my mind is more open about things. I can evoke analogies and connections that I didn't know existed before.

Looking toward the future, what is the ideal size for the Course?

I think that as long as we have more than 50 residents, the Course is very healthy; there is a critical mass of people to ask questions (or if a few decide to take the afternoon off, then we don't have the situation where someone comes to talk and no one attends the lecture!) The numbers from the mid-1980s fluctuated around 40 residents. Toward the mid-1990s the numbers were going down. We had a year with only 34 people. We were very concerned that the Course would not survive under those conditions. Since we've restructured it in the past 3 years we've been increasing. This year we had 64 registrants. Now, if we had one registrant from each program, that would put us at about 112 and I don't think we can accommodate that; I think around 80 would be ideal.

The interview ended as the cafeteria closed and attendees made their way back to the lecture hall to hear the penultimate lecture, "Signaling Pathways and Neural Cell Fate," by Murat Gunel of Yale (and a recent RUNN graduate). As the Course drew to a close, Dr. Awad's charge to the participants rang clear: "Do science. Do good science. Be a multidimensional person. Go for it. Do not make excuses." □

RUNN Course Report

Rudolph J. Schrot, M.D.
University of California-Davis

Sixty-four neurosurgery residents lived in Woods Hole, Massachusetts for 1 week. Trainees from throughout North America traded their familiar hospital or laboratory surroundings for the lecture hall, their comfortable accommodations for a college-style dormitory, and their bustling urban confines for a quaint New England fishing village. Woods Hole, a tiny, otherwise unassuming Cape Cod village, is haunted by the ghosts of Nobel laureates. It is home to the famous Marine Biological Laboratory (MBL), the Woods Hole Oceanographic Institution, the National Marine

Fisheries Service, the Woods Hole Research Center, and the Sea Education Association. Woods Hole is also home to the annual Review and Update in Neuroscience for Neurosurgeons (RUNN), celebrating its 20th annual session at the MBL from October 20th through 27th.

Participants of the 2001 RUNN course feasted on a smorgasbord of topics that ran the gamut of neuroscience. In a score or more of 90-minute lectures, top neuroscientists passionately shared their investigative fields: angiogenesis, apoptosis, signaling pathways and cell fate, cortical plasticity, convection delivery, evidence-based medicine, glial barriers and scarring, the history of science, hypothermia, memory, model neural systems, molecular biology of pituitary adenomas, microprocessor design, molecular genetics, neuroregeneration, neurotransplantation, repetitive patterned exercise therapy, stem cells, synapse formation, and viral infections of the central nervous system. Attendees especially enjoyed practical aspects of the Course, such as the lecture "Project Design and Grantsmanship" by Dr. Michael Walker, recently retired director of the NIH NINDS Division of Stroke, Trauma, and Neurodegenerative Disorders. Freed from mundane distractions, participants reflected not only on the course material presented, but also on their own career development as well.

Even amid the grueling lecture schedule, attendees found a free afternoon for excursion to Martha's Vineyard or Boston. And thanks to an ingenious cadre of neurosurgery residents, the PowerPoint projector and PA system by day became a full screen movie theater with booming sound by night.

Dr. Issam Awad, Ogsbury-Kindt Professor and Chairman of Neurosurgery at the University of Colorado and RUNN Course Director, orchestrates the Course together with his wife Cathy and a team of co-directors. Setting a pace of informality and congeniality, Dr. Awad explains the philosophy of the Course: "It is not a Board review. The real objective is to help you explore your own research involvement." The RUNN Course is administered under the auspices of the Society of Neurological Surgeons. For further information, go to the Web site at <http://www.societyns.org>. □

CNS International Committee

Nelson M. Oyesiku, M.D., Ph.D., F.A.C.S

Chairman, CNS International Committee

The mission of the International Committee (IC) of the Congress of Neurological Surgeons is to enhance the education of international neurosurgeons in the service of humanity through of a model of volunteerism, and to facilitate the contribution of international neurosurgeons to the core mission of the CNS.

The IC operationally addresses its mission through a number of subcommittees, including the Annual Meeting, Membership and Publications, International Development, and Professional Assistance Committees.

At the CNS Annual Meeting, the IC organizes the International Luncheon and the International Reception. The luncheon program includes a scientific presentation along an international theme. The reception provides a forum for social exchange with fellow CNS members and spouses. This year's meeting agenda will as always include both these events. Please mark your calendars accordingly; all are welcome.

The CNS-IC works closely with other neurosurgical organizations involved in the international development of neurosurgery, particularly the World Federation of Neurosurgical Societies (WFNS) and Foundation for International Education in Neurosurgery (FIENS). The IC-CNS and FIENS have established a collaborative program known as VINE (Volunteers for International Neurosurgical Education).

CNS-IC Activities

- CNS Annual Meeting San Diego: International Luncheon and International Reception
- International membership
- CNS International Fellowship
- World Directory
- Book distribution
- VINE: professional assistance/education
- FIND : technical support
- CNS Ambassador program

International Active Membership

Benefits of Membership

- Subscription to *NEUROSURGERY* (including *Neurosurgery://On-Call*), Concepts in Neurosurgery series, Clinical Neurosurgery series, subscription to *Neurosurgery News*, *World Directory of Neurological Surgeons*
- Reduced registration fees for the CNS Annual Meeting
- Right to be elected to office and the opportunity to participate in the organization and functioning of the CNS through membership on the various committees of the Congress
- Representation on public policy
- Networking opportunities with over 4,600 fellow members from around the world
- Right to sponsor abstracts at the annual meeting

Application Requirements

- Board-certified neurosurgeon or international neurosurgeon requirements
- Copy of Board certificates or equivalents
- CV
- Two- sponsor endorsement signatures from active CNS members

Annual Dues

- \$265, plus one-time \$20 processing fee

International Membership

The international membership of the Congress of Neurological Surgeons is almost 600 strong and growing.

Dr. Ab Guha (Toronto, Canada) of the CNS International Committee is our CNS Membership Committee liaison working on IC memberships with Dr. Getch, Chair of the CNS Membership Committee. Recently, new members of

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THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

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CNS International

Continued from page 7

the CNS International Committee as of April '01 are:

- Deepak Awasthi, Associate Professor, LSU
- Renee Osterdock, Assistant Professor, Tulane University
- Murat Gunel, Assistant Professor, Yale University
- Greg Foltz, Neurosurgery Resident, University of Washington

International Luncheon and Reception, San Diego 2001

The International Luncheon at the CNS San Diego Annual Meeting featured Moderator Michael Carey (Louisiana) and panelists Professor Ramamurthi, who delivered the keynote address, and Professors Abdeslam El-Khamlichi and Perrin, who also made excellent presentations.

International Reception: This year's International Reception was much larger than in previous years. The honored guest, Professor Michael Apuzzo, has a longstanding commitment to international neurosurgery. The editorial board of the CNS journal *NEUROSURGERY*, which has a very broad international membership, was well represented. Current CNS Ambassadors were acknowledged at a special presentation during the reception.

FIENS/VINE

- The VINE committee has been established. Members include David Fairholm (Chair), Nelson Oyesiku, Richard Perrin, Dan Kelly, Roy Tyrer, Frank Culicchia, and Gail Rosseau.
- A VINE exhibit was on display at CNS 2001 San Diego that highlighted current VINE activities.

CNS International Fellowship

The CNS International Fellowship Awards extend educational opportunities to neurosurgeons from developing countries. CNS International Fellowships are offered with the hope that the participating fellow will acquire training that will enhance the quality of care provided in his or her home country. The fellowship consists of a primarily clinical experience, including observation of office, hospital, and operating room activities

This year's awardees are as follows:

- The CNS Elekta Lars Leksell International Fellowship
Dr. Narendra Nathoo (South Africa)

- The CNS George Ablin International Fellowship
Dr. Nimrod Mwang-ombe (Kenya)
Dr. Xi-Feng You (China)

- The CNS Kenichiro Sugita International Fellowship

Dr. Ricardo Hanel (Brazil)

CNS Ambassador Program

The CNS Ambassador program, is a unique opportunity for CNS international members to become further involved in CNS activities.

A CNS ambassador serves as the CNS liaison in his or her country and is the nucleus for developing and executing professional assistance/educational programs run by the CNS or FIENS. The CNS has a long tradition of these ventures and seeks new opportunities to extend its educational mission. CNS Ambassadors develop joint ventures with the CNS and the local neurosurgical society and participate at CNS annual meeting. Ambassadors help promote CNS membership and programs in their countries.

CNS Ambassador benefits includes reduced meeting registration, reduced course registration, badge, and certificate. Ambassadors are CNS International Active Status Members in good standing in their national neurosurgical society.

Current CNS Ambassadors

- Dr. Anjun Habid Vohra—Pakistan
- Dr. Basant K. Misra—India
- Dr. Yoko Kato—Japan
- Dr. Abdel H. Zidan—Egypt
- Dr. I.H. Aydin—Turkey
- Dr. Nasri J Sami Khoury—Jordan
- Dr. Luciano Mastronardi—Italy
- Dr. Giuseppe Mariniello—Italy

New CNS Ambassadors

- Dr. Henry W. S. Schroeder—Germany
- Dr. Aaron Mohanty—Bangalore, India
- Antoine Nachanakian—Lebanon, President of PANS
- Dr. Kiril Lozance—Macedonia
- Prof. A. V. Ciurea—President of the Romanian Society of Neurosurgery

New CNS-International Joint Meetings

The CNS International Committee and three other national/regional neurosurgical societies are currently in the planning stage of joint meetings.

The CNS and the **Francophone**

Neurosurgical Society are planning a joint meeting for November 2002 in Paris, France. Professor Yves Keravel and Dr. Nelson Oyesiku are currently in the planning stages of the program. Neurosurgeons from both societies will discuss topical neurosurgical issues from their respective vantage points.

Pan-Arab Neurosurgical Society: A proposal has been made by Professor Antoine Nachanakian, President of PANS for a biannual teaching course, with the first to be held in Saudi Arabia in January 2003. A planning dialogue between Antoine Nachanakian,

President of PANS, and Dr. Nelson Oyesiku is underway to ensure the success of the program.

Neurosurgical Society of India-CNS Joint Meeting: Professor Misra (Mumbai, India), Secretary, Indian Society of Cerebrovascular Surgery and Vice President, Asian Congress of Neurosurgery, has developed a proposal for a joint CNS India-CNS USA meeting. The objectives, agenda, and logistics for the meeting are being jointly developed. Stay tuned for further information on this and other planned joint meetings. □

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.

- | | |
|-----------------------------------|------------------------|
| Steven Agata | Deven Khosla |
| Brent Alford | John W. Kim |
| Nizar Al-Amiri | David J. Langer |
| Jaime Baisden | Iver Langmoen |
| Hans E. Bakken | Michael A. Leonard |
| Carlos Eduardo Barbosa-Cavalcanti | Jae Y. Lim |
| Meinhard Bienst | Russell R. Lonser |
| Nicholas M. Boulis | Adel M. Malek |
| J. Travis Burt | Amir S. Malik |
| Tanvir F. Choudhri | Geoffrey T. Manley |
| Sharon Clark | Christopher B. Michael |
| Brent Clyde | Thomas Moore |
| Shekhar Dragam | Narenora Nathoo |
| Steven A. Dutcher | Carolyn Scott Neltner |
| Muftah Eljamel | Michael Nido |
| Robert P. Feldman | Serge Obukhov |
| Andrew D. Fine | Nareh P. Patel |
| Jeffrey Florman | Nicholas Poulos |
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| Saadi Ghatan | Alejandra Rabadan |
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| Jordi X. Kellogg | John P. Wadley |
| Ahmed Khan | Timothy F. Witham |



Washington Committee Update

Katie O. Orrico, J.D.
Director, AANS/CNS Washington Office

I. CODING AND REIMBURSEMENT

A. Medicare Fee Schedule

- CMS 2002 Fee Schedule Rule.** On November 1, 2001, CMS published the final 2002 Medicare Fee Schedule. Included in this regulation is a 5.4% across-the-board reduction in Medicare reimbursement, as the Medicare conversion factor will go from \$38.26 in 2001 to \$36.20 in 2002. This decrease is attributed to a -4.8% update and budget neutrality adjustments for increases to the work relative values associated with the 5-year review and anticipated volume increases associated with the practice expense reductions. Additional reductions for most neurosurgical procedures are included in the fee schedule as well, as resource-based practice expenses will be fully implemented in 2002.

The following chart illustrates payment levels for commonly performed neurosurgical services since the inception of the resource-based relative value scale (RBRVS) in 1992, focusing primarily on 1997-2002. As you can see, payment levels have fluctuated a great deal over the past decade. This is due to a number of factors including, but not limited to, the 5-year review of work values (1992 and 2002), implementation of resource-based practice expenses (1998-2002), implementation of resource based malpractice expenses (2000), elimination of the separate conversion factor for surgery (1998), and other changes to the update/ conversion factor formula.

CPT Code	Procedure	National Medicare Payment Rate						% Change	% Change	
		1992	1997	1998	1999	2000	2001	2002	1992-02	1997-02
22554	Ant cerv fusion	\$1,354	\$1,662	\$1,539	\$1,416	\$1,450	\$1,443	\$1,306	-4%	-21%
22612	Lumbar post-lat fusion	1,255	1,801	1,648	1,533	1,549	1,582	1,449	15	-20
22630	PLIF	1,389	1,705	1,557	1,464	1,526	1,579	1,471	6	-14
22842	Lumbar pedicle screws	1,414	842	754	724	779	825	776	-45	-8
22845	Ant cerv instrumentation	1,138	761	682	668	766	828	744	-35	2
22851	Intervert biomech device	N/A	580	520	484	499	511	411	N/A	-29
35301	Carotid endarterectomy	1,093	1,436	1,320	1,220	1,236	1,228	1,061	-3	-26
61107	Twist drill- ventric	540	485	431	391	383	377	331	-39	-32
61154	Burr hole for SDH	1,087	1,411	1,275	1,160	1,159	1,132	994	-9	-30
61312	Crani for subdural	1,605	2,065	1,950	1,787	1,820	1,792	1,598	0	-23
61313	Crani for ICH	1,600	2,086	1,957	1,800	1,836	1,815	1,620	1	-22
61510	Craniotomy for tumor	1,807	2,405	2,216	2,040	2,085	2,058	1,840	2	-23
61512	Crani for meningioma	1,913	2,778	2,546	2,369	2,480	2,486	2,259	18	-19
61700	Craniotomy for aneurysm	2,358	3,509	3,224	3,059	3,359	3,448	3,226	37	-8
61751	Stereotactic biopsy	1,311	1,660	1,520	1,376	1,354	1,320	1,162	-11	-30
61793	Radiosurgery	1,307	1,639	1,400	1,290	1,326	1,303	1,152	-12	-30
61795	Intraop frameless stereotaxis	246	444	368	331	305	292	253	3	-43
62223	VP shunt	1,044	1,285	1,103	1,004	997	981	868	-17	-32
62230	Shunt revision	698	875	814	754	778	775	690	-1	-21
62362	Programmable pump implant	N/A	443	425	408	430	456	433	N/A	-2
63030	Lumbar discectomy	966	1,205	1,028	946	950	957	874	-10	-27
63042	Recurrent lumbar disc	1,461	1,763	1,507	1,376	1,348	1,349	1,214	-17	-31
63047	Lumbar laminectomy	1,408	1,408	1,290	1,177	1,136	1,143	1,037	-26	-26
63075	Ant cerv discectomy	1,126	1,609	1,475	1,373	1,431	1,455	1,338	19	-17
63081	Ant cerv corpectomy	1,685	2,164	1,993	1,824	1,833	1,818	1,624	-4	-25
63650	Perc epidural dorsal column stim	596	647	597	524	463	439	369	-38	-43
64718	Ulnar nerve transposition	435	546	503	469	464	475	440	1	-19
64721	Carpal tunnel	317	398	361	349	361	397	399	26	0
99243	Office Consultation	81	94	102	103	117	118	116	43	23
Conversion Factor		\$31.00	\$40.96 (s) \$33.85 (ns)	\$36.69	\$34.73	\$36.61	\$38.26	\$36.20		

We are working closely with the AMA, ACS and other specialty societies to aggressively lobby key Members of Congress to fix the update formula problems through legislation that we hope will be included in the end of the year spending package. To provide short-term relief from this problem, Senator James Jeffords (I-VT) and Senator John Breaux (D-LA) have introduced a bill in the U.S. Senate to dramatically improve the physician Medicare payment update for 2002. The bill is S. 1660, the "Medicare Physician Payment Fairness Act of 2001."

- Practice Expenses.** Changes to practice expense RVUs in the rule did change, going up an average of 2.1% across the 485 neurosurgical codes. These changes reflect the inputs from the Practice Expense Advisory Committee (PEAC).

B. CPT/Coding Issues.

1. **EMTALA Tracking Code.** The AANS and CNS have submitted a resolution to the AMA House of Delegates requesting that the CPT Editorial Panel create a tracking code for accounting for EMTALA mandated services.
2. **Gliadel.** Guilford Pharmaceuticals has requested that the Committee consider supporting a new code to account for additional work for inserting "interstitial chemotherapy device". After a presentation from Keith Black, MD and company representatives, the Committee agreed to submit a proposal to CPT, which will be considered in February.
3. **Complex Aneurysm.** The Committee is considering the need to create a new CPT code to account for additional work of exposing the carotid for proximal control.
4. **New Endovascular Codes.** John Wilson and Bob Harbaugh have developed proposed new endovascular codes, which have been approved by the CV section. We are working to reach consensus with several other societies, before proceeding with a final proposal to be submitted to CPT. After discussion, we decided to test the waters by proposing only two new CPT codes to describe temporary endovascular extracranial balloon occlusion and its radiological supervision and interpretation component.
5. **New Endoscopic Codes.** Jeff Cozzens presented new neuroendoscopic codes at the recent CPT Editorial Panel meeting. The panel voted to add with modifications a new Neuroendoscopy sub-section, heading, cross-reference and six new neuroendoscopy codes. The Panel also voted to add two new cross references to the Twist, Burr Hole, or Trephine sub-section, and five new cross-references and revision of code 62201 in the Cerebrospinal Fluid (CSF) Shunt subsection.
6. **Pain Pump Refill Code.** Sam Hassenbusch has worked with several societies to finalize a new code proposal for a dedicated spinal infusion pump refill code. This will be discussed at the November CPT meeting.
7. **Trauma Codes.** We have proposed creating several new trauma codes and have submitted the following proposal to CPT for consideration at its February meeting.

613X1 Craniotomy, decompressive, with duroplasty for treatment of intracranial hypertension

613X2 Craniotomy / craniectomy for decompressive lobectomy for intracranial hypertension (e.g., trauma, stroke) without associated intraparenchymal hematoma

+ 613X3 Incision and subcutaneous placement of cranial bone flap

+ 62148 Incision and retrieval of subcutaneous cranial bone flap for cranioplasty

8. **Modifier -62.** The AANS and CNS submitted comments to CMS related to the agency's proposed changes to its payment policy for co-surgery (modifier -62). CMS is proposing to develop a list of procedures where -62 is allowed and to eliminate the current payment policy, which pays each co-surgeon 62.5% of the total fee. We strongly objected to making any changes to this policy. There was no decision made for implementation in 2002.

C. AMA RUC/PEAC Issues:

1. **Implantation of Sacral Nerve Neuro-Stimulators.** The RUC will survey code changes related to the implantation of sacral nerve stimulators. Once the survey work is complete, the AANS and CNS will review the results and provide comments to the RUC on the appropriate values for these codes.
2. **PEAC Pre-Service Clinical Staff Proposal.** The AMA Specialty Society RVS Update Committee (AMA RUC) approved a recommendation from its Practice Expense Advisory Committee (PEAC) during its recent February meeting to accept standard Pre-Service Clinical Staff time packages for all procedure codes with 90-Day global periods. There will be exceptions for those specialties that demonstrate that the time packages are substantially less than the time necessary for their pre-clinical staff activities. Neurosurgery is one specialty that the RUC agreed would likely have pre-service activity times that are higher than the recommended package time of 60 minutes. The Coding & Reimbursement Committee of the AANS-CNS contends that there are several groupings of procedures that do require additional pre-service clinical staff labor. Dr. Jamie Metcalf our representative to the PEAC made our presentation at the August PEAC meeting. He was able to get our complex cranial and spinal codes 75 minutes of pre-service time. The Committee conducted a survey at the CNS Annual Meeting to determine what kind of staff neurosurgeons use for a variety of clinical tasks. The results will be tabulated and presented to PEAC.
3. **Vertebroplasty RVU Refinement.** Dr. Richard D. Fessler participated in a CMS sponsored refinement panel to argue for an increase in the RVUs for 22522, percutaneous vertebroplasty add-on code. In our comments to CMS last year, we had recommended a value of 4.31 work RVUs, while CMS assigned only 3.00 RVUs. As a result of our presentation, CMS has agreed to increase the values to 4.31 work RVUs effective on January 2, 2002.
4. **Endoscopic Codes.** The Committee will conduct a survey on the new endoscopic codes and present recommended RVUs to the RUC at an upcoming meeting.

D. Medicare Reform. The Washington Committee continues to track various legislative proposal to reform Medicare. At the AANS/CNS request, the American College of Surgeons recently convened a symposium on this topic. John Kusske attended this. It is unlikely that the 107th Congress will pass any comprehensive reform proposal, although it is possible that a small prescription drug package will be enacted next year depending on election year pressures.

II. ACADEMIC CENTERS/TRAINING

A. Biomedical Research

1. **NIH Funding.** Both the House and Senate have passed the Labor, HHS appropriations bills. The following chart highlights the monies allocated for FY 2002.

Agency	House	Senate	% Change
NIH	\$22.8 billion	\$22.9 billion	13%
NCI	4.1 billion	4.1 billion	11%
NINDS	1.3 billion	1.3 billion	11%
NIAMS	440 million	441 million	11%

The differences between the bills are not significant, other than some provisions related to bioterrorism. These must now be worked out in a conference committee.

2. **SPORT Study.** In July, the SPORT study PI, Dr. James Weinstein, met with AANS/CNS leaders to discuss our concerns. At that meeting, we outlined our concerns and requested that (1) we have access to the raw data; and (2) that neurosurgery be part of the study writing group and that the AANS and CNS get to identify the individual participating. Dr. Weinstein essentially rejected our requests. The AANS and CNS sent Dr. Weinstein a follow-up letter reiterating our concerns. We will widely publicize our criticisms and seek NASS support of our position. The Washington Committee also discussed the possibility of conducting our own study using our on-line outcomes project.
3. **Stem Cell Research.** The AANS and CNS have joined the Coalition for the Advancement of Medical Research (CAMR). In June, the AANS, CNS and Senior Society each sent letters to President Bush urging him to permit federal funding of stem cell research. In August, the president announced his decision to allow very limited funding of stem cell research utilizing currently existing stem cell lines. Many in Congress are not satisfied that this goes far enough and next year will press for legislation expanding the authority of NIH to fund this research.
4. **NINDS Director.** The AANS and CNS are supporting the appointment of Robert Grossman, MD to be the next director of the NINDS. The search process has stalled pending the appointment of the NIH director.
5. **Stroke Research.** Senator Kennedy introduced the "STOP Stroke Act of 2001." The AANS and CNS actively participated in the drafting of this legislation. The bill would create a specific appropriation, in the form of matching grants to the states, in order for the states to create comprehensive stroke treatment systems to utilize the most advanced stroke treatment protocols. Monies would be used for public service announcements and developing other advertising methods to promote stroke prevention practices. Also very positive are the numerous references in the bill requiring states to consult with surgical groups when implementing their systems and the reference to using standards of the Brain Attack Coalition. The bill passed out of committee and is anticipated to come to the Senate floor for a vote soon. The House Energy and Commerce Committee has indicated its support for the measure and may try to push it through before the end of the year.

III. NEUROSURGICAL PRACTICE

A. E&M Documentation Guidelines. In June, the AANS and CNS submitted a comment letter to ASPEN Systems (HCFA's contractor) outlining our many concerns with the E&M project. In addition, we signed-on to an AMA/specialty society coalition letter to HCFA Administrator, Tom Scully, requesting a one-year moratorium on the entire E&M project. Following these letters, HHS Secretary Tommy Thompson canceled the ASPEN contract and put the entire E&M project on hold pending a comprehensive review. He also announced that he would be establishing an E&M Task Force. The AANS and CNS formally nominated Dr. Tippet for this task force, which will now be conducted under the auspices of the CPT Editorial Panel. AMA staff has informally informed us that Dr. Tippet will be appointed to this task force.

B. **Fraud and Abuse/Regulatory Burdens**

1. **Congressional Activities.** Legislative and regulatory activities seeking to minimize the regulatory burden for physicians is a "hot topic" this year and there is a lot of

activity currently ongoing on this issue. The House Ways and Means and Energy and Commerce Committees have passed bills and are now reconciling the differences before the final package goes to the House floor for a vote. The Senate Finance Committee is continuing to draft similar legislation. The bills include: Medicare contractor reforms, changes to the audit process, changes to the regulation process, requirements for educating physicians on billing and coding rules, and specifications for E&M documentation guidelines.

2. **Administrative Action.** In keeping with his promise to reform HCFA, on Thursday, June 14, the Department of Health and Human Services Secretary, Tommy Thompson, announced the first component of his plan to reform the Health Care Financing Administration (HCFA). The new agency, the Centers for Medicare & Medicaid Services (CMS), will consist of three distinct centers. The Center for Medicare Management will be responsible for the traditional fee-for-service program (overseeing most physician payment policies and programs). The Center for Beneficiary Choices will focus on Medigap and Medicare+Choice programs. The Center for Medicaid and State Operations will have jurisdiction over Medicaid and the children's health insurance programs. In making this announcement, Secretary Thompson and CMS Administrator Tom Scully pledged that the new agency will be significantly more responsive to the concerns of physicians. Over the course of the next several months, there will be a series of administrative reforms aimed at reducing the regulatory hassles that physicians now face in treating Medicare patients.
3. **Neurosurgeon Audited by Medicare.** A neurosurgeon was recently audited by his Medicare carrier for his coding practices related to treatment for trigeminal neuralgia. He appealed the decision and is awaiting a final ruling by the hearing officer. To assist this neurosurgeon, the AANS and CNS, working through the Coding and Reimbursement Committee, developed an official position for coding these services and send it to the carrier and the hearing officer for consideration.

C. **Managed Care/Insurance**

1. **Patients Bill of Rights.** Until September 11th, this was one of the hottest legislative topics in the Congress. The AANS and CNS have been involved in crafting various versions of this legislation and have worked particularly closely with the Senate and House Republicans and the White House. On June 29, 2001, the Senate passed an amended version of the McCain, Kennedy Edwards bill by a margin of 59-36. The final compromise package includes provisions giving patients the ability to see the physician of their choice, access to specialists, coverage of emergency services, and an internal and independent external appeals process. Patients will be able to sue HMOs in state court (for harm arising from medical decision making) and in federal court (for coverage/contract disputes). All insured patients will be covered by the protections of the bill. The House of Representatives passed its version of the bill in late July, after Charlie Norwood (R- GA) reached a compromise with President Bush. A House/Senate conference committee will need to be appointed to reconcile the two versions of the bill. The major differences are in the liability section of the bills. No action will happen on this legislation until next year.
2. **Collective Negotiations/Antitrust Reform.** The Congress failed to pass the Campbell bill last year and Tom Campbell lost his bid for the US Senate, meaning that

there is no obvious champion for a similar bill in the 107th Congress. We are currently working with the AMA to identify new sponsors and make changes to the bill to increase its chances of successful passage. Rep. Bob Barr (R-GA) and John Conyers (D-MI) will be the likely sponsors in the House. This legislation has been placed on the back burner due to September 11th events.

D. Trauma/EMTALA. The Washington Committee is the Trauma Section on a number of issues related to EMTALA. There are a multitude of activities on this issue currently underway.

1. **Position Statement on On-Call Stipends.** The AANS and CNS revised the position statement on emergency services to make it more forceful. The position that was adopted is: "Hospitals should provide neurosurgeons with reasonable compensation for serving on the on-call panel. This compensation should supplement any reimbursement the neurosurgeon receives for services rendered while serving on-call."
2. **Education Packet.** The Washington Committee recommended that as documents are developed they should be placed on the web site. The Trauma Section recently mailed out a packet of materials, and these will be updated for the web. We are seeking the assistance of an attorney to develop a simplified contract for on-call stipend reimbursement.
3. **GAO Report to Congress.** In June, the GAO published its final report to congress on EMTALA. Unfortunately, the report failed to conclude as we hoped, that EMTALA is causing a great deal of problems regarding availability of on-call physicians, and increased burdens on emergency departments and hospitals. We are evaluating what our next steps regarding this report. The GAO is also preparing an additional report on the costs of uncompensated care and other costs of the EMTALA mandate. We are working with Rep. John Shadegg (R-AZ) and Senator Jon Kyl (R-AZ) on this report.
4. **Congressional Briefing.** We are working with Rep. Shadegg and Sen. Kyl, the AMA, and others to organize a House/Senate briefing on all elements of EMTALA to educate Congressional staff and others on this issue. Because of September 11th events, it will now likely occur early next year. Following the briefing, we will circulate a letter to all Congressional offices. This letter will be sent to HHS Secretary Tommy Thompson from Senators and Representatives urging that he make changes to EMTALA regulations (see below).
5. **Regulatory Relief.** We are working with the AMA, hospital groups and other specialty societies to develop a list of regulatory changes that CMS can make to limit the scope of EMTALA regulations to the original intent and language of the statute. We will also be seeking clarification of existing EMTALA requirements and limited safe harbors/exceptions for on-call physicians. In addition, we are recommending that CMS establish a special EMTALA Advisory Group that includes representatives from medical specialty societies and others. The OIG and GAO recommended the creation of the advisory group. Rep. Shadegg was able to get several EMTALA related provisions into the House Energy and Commerce regulatory reform bill. One provision would mandate the establishment of the task force. A neurosurgeon will be a required task force member.
6. **Legislation.** Rep. Shadegg and Sen. Kyl are interested in developing an EMTALA bill that would limit the scope of the law, provide for reimbursement for EMTALA mandated

services and limit the liability that physicians may have when treating patients pursuant to EMTALA.

7. **OIG Reports.** The HHS Office of Inspector General issued two EMTALA related reports in January. While we were initially worried that these reports would be negative, particularly on the problems related to on-call physicians, they actually should help support our efforts for legislative and regulatory relief on this issue. The reports noted that the neurosurgery is the most difficult specialty to provide on-call services and that this is related to payment problems. While not making any recommendations along these lines, the report intimates that improved payment would improve on-call availability.
8. **Trauma Systems Funding.** Last year, the Appropriations bill allocated \$3 million for the Trauma Care Systems Planning and Development Act that the AANS and CNS had actively lobbied for along with the American College of Surgeons (ACS). We are working to increase this amount for FY 2002.
9. **Hand Gun Violence.** The AANS and CNS have been invited to be members of the group Doctors Against Hand Gun Injury. In addition, the Brady Center to Prevent Gun Violence has requested that the AANS and CNS become more active in their legislative efforts on gun injury prevention. The Trauma Section, in conjunction with the Washington Committee, will develop a recommended position statement.

E. Medical Malpractice Reform. Representative Jim Greenwood (R-PA) has introduced HR 2103, the Medical Malpractice Rx Act of 2001." This bill contains the standard reforms including a \$500,000 cap on non-economic damages, 2-year statute of limitations, proportionate liability, etc. The AANS and CNS sent a letter to the entire House of Representatives urging members to co-sponsor the bill. It is highly unlikely that this bill be pass the Congress.

IV. MISCELLANEOUS

- A. **Decade of the Spine.** Edward Benzel, through COSS, will oversee the project. As part of this effort, the AANS/CNS and NASS will likely convene a "World Spine II" meeting in 2003 in Chicago. NASS is taking the lead on this effort.
- B. **Neurosurgical Leadership Development Conference (NLDC).** Working with the CSNS, the Washington Committee assisted in launching the inaugural Neurosurgical Leadership Development Conference (NLDC) in July. This program was a huge success, with over 80 neurosurgeons attending a 3-day program that included practice management and coding education, grassroots training, issue briefs and visits to Congressional offices. Because of its success, we will convene the program again in July 2002.
- C. **American Medical Association.**
 1. **Peter Carmel for AMA Board.** Peter Carmel, MD, CNS Delegate to the AMA, ran for a position on the AMA Board. The elections were held in June 2001, but unfortunately he was not elected. He made a strong showing, however, and plans to run again next year.
 2. **Reorganizing AANS and CNS Delegates.** The Washington Committee has recommended that we reorganize our AMA delegate structure. To that end, we will appoint delegates and alternates to fill all available slots and appoint a liaison to the Washington Committee to ensure a closer working relationship between the Committee and our AMA delegates.

THE ART AND BUSINESS OF MEDICINE

Please Don't Sell the Farm

Douglas V. Johnson

Executive Director
Surgical Management Professionals



In the nursery rhyme, "Old McDonald Had a Farm," Mr. McDonald brags about all of the animals he has on the farm. He sings with real gusto

about, "a cluck cluck here and a moo moo there." But nowhere does he mention any interest in, "sell sell here and sell sell there." As a kid I loved that song. It seemed to cover all the values I cherished about growing up on a farm. Values such as hard work, an honest day's work for an honest day's pay, self-reliance, and control over my own destiny. It seems that today more and more physicians feel that they have lost control. Many see the only way to control their destiny is to put it in the hands of others...to sell the farm. There is an alternative. We hear these discussions when physicians discuss their interest and possible participation in the development of an Ambulatory Surgical Center or Surgical Specialty Hospital (ASC/SSH). They talk about improving the surgical experience for their patients. They share the desire to be more actively involved in the management and governance of a center. They certainly voice the commitment that in "their center," staff will be appreciated and rewarded for excellence. They are convinced that physicians will take pride in the operational efficiencies. They know that their colleagues will secure an additional revenue source that will keep their incomes competitive while at the same time offering attractive incentives for the recruitment of new partners.

Golly gee then (I bet you have not heard that since Andy Griffith reruns), if this truly is a way to create the environment in which physicians want to practice and care for their patients, why isn't everyone working in an ASC/SSH, invested in one, or in the process of building one? The answers we hear fall into three categories:

1. You will hurt the local hospital.

This category of justification generally evolves in three phases. Phase 1 begins at the first mention of interest in an ASC/SSH. The comment generally takes the form of, "If the physicians pursue this venture, it will bankrupt this hospital. We will be forced to close the

ER, shut down OB, and discontinue other essential community services." Phase II begins when the consultant shows up to assist the physicians develop the project. The comments then generally happen in the doctor's lounge from a few well-paid in-house physicians or employed primary care practitioners asking, "Why are you doing this to our community hospital?" Phase III finally originates in the CEO's office or the Hospital Board Room with the challenge, "We will recruit your competition."

2. CON/Competition/Managed Care/Referral Base

Let me address each one of these separately:

- CON or Certificate of Need—This program was originally designed to effectively assure, on a statewide basis, the equitable and efficient allocation of scarce health care capital resources, but which has degenerated into a system of legalizing monopolies. This can be, from a time, money, and aggravation perspective, a genuine deterrent. There are 18 states with active CON laws. Some of these are being thrown out and/or drastically declared.
- Competition—Competition is a very real threat. If a genuine business opportunity is not available and you have researched it thoroughly, this could be the red flag.
- Managed care—Managed care is usually not a deterrent since most insurance companies are looking for patient-supported, less costly, high-quality alternatives. Only in the case where the insurance company is owned by a hospital, which specifically will not contract with you, should this be a real concern. Even then, with sufficient physician leverage, this can be overcome.
- Referral base—Referral base is usually not an issue unless the referring physicians are from a primary care network owned and controlled by the hospital.

3. Leadership

Leadership obviously is an essential part of 1 and 2, but it is also a category of its own. Often, no apparent threats exist to physicians organizing their future other than that there simply is no one capable or willing to lead the charge, organize the efforts, or manage the outcomes.

Having now described what I believe are the general reasons physicians believe is a good reason not to own their own farm, let me tell you why I do not believe these reasons should in all cases be necessarily a deterrent:

1. **I don't want to hurt the local hospital.** To my knowledge there has never been a hospital or ER closed, OB unit shut down, or a significant community interest compromised because a surgical center or surgical specialty hospital was opened. What I have seen are lots of hospitals making incredibly stupid decisions. Some of these decisions involve choosing to compete with physician interests that end up costing considerably more than any physician partnership. What also invariably happens is the development of hard feelings created in the process. These resentments are so entrenched that they often will only be overcome by a "few high priced funerals." Fortunately, and I think I can say in most cases, after all of the ego levels settle back to normal, the opportunity for compromises, accommodations, and an entirely new relationship appears. This relationship often creates a new physician-hospital partnership concept or at least a "Let's continue to work together even as competitors" type perspective.

2. **CON/Competition/Managed Care/Referral Base.** All of these areas are either fact (CON regulations), perception (competition), negotiated (managed care), or behavioral (relationship with existing referral bases). Expert insight, past relationships, or guidance can avoid the immovable, soften the intransigent, and manipulate the affable.

3. **Leadership.** The most difficult hurdle to overcome is if there honestly is not a leader in the group. Leaders can be nonexistent in a practice or even in a medical community. You can always hire leadership. However, be very sure that if you do not have committed leadership, and agree to hire it, you at least then have committed followership.

I guess I will close with a few other barnyard rules for you to consider:

1. Even with all of his pride, Old McDonald never turned the farm completely over to the animals.
2. Standing at the barn door can signal everyone is free to leave, or the recognition that everyone is already gone.
3. Not everything on the ground is a bird's nest, should be stepped in, or can be found by smell.

One rule I am absolutely sure of is that, for all that physicians hold dear and wish to create as their legacy to the communities they so faithfully serve, we are all better for physicians who are listening to the marketplace and the pleas of their colleagues to "Please don't sell the farm." □

WFNS NEWS



Dr. William B. Scoville

William Beecher Scoville Prize

The Secretariat of the World Federation of Neurosurgical Societies (WFNS) in Geneva, Switzerland announced that Michael L. J. Apuzzo, M.D., was awarded the William Beecher Scoville Prize at the Opening Ceremonies of the September 2001 World Congress in Sydney, Australia.

The WFNS is the world's largest neurosurgical society, composed of more than 90 societies representing all continents and countries of the globe. General scientific meetings for the organization are held every 4 years in continental rotation.

The William Beecher Scoville Prize is awarded at the World Congress to the neurosurgeon who has been considered to have made the principal contribution to the "art and science of neurosurgery on an international scale." In determining the recipient, each continent is allowed to present eight nominees to an international panel of academic and political luminaries.

Dr. William Scoville was a creative and energetic Yale neurological surgeon

Continued on page 14



Dr. Michael L.J. Apuzzo

Medicare Action Alert

*Medicare Physician Fee Schedule for 2002
Published Changes in Conversion Factor
Cause Across-the-Board Reductions in Reimbursement*

**CONTACT YOUR
SENATORS AND
REPRESENTATIVES NOW
AND URGE THEM TO
FIX THE PROBLEM
BEFORE YEAR'S END**

On November 1, 2001, the Centers for Medicare and Medicaid Services (CMS—formerly HCFA) published the 2002 Medicare physician fee schedule. Included in this regulation is a 5.4% across-the-board reduction in Medicare reimbursement, as the Medicare conversion factor will go from \$38.26 in 2001 to \$36.20 in 2002. This decrease is attributed to a -4.8% update and budget neutrality adjustments for increases to the work relative values associated with the 5-year review and anticipated volume increases associated with the practice expense reductions. Additional reductions for most neurosurgical procedures are included in the fee schedule as well, as resource-based practice expenses will be fully implemented in 2002.

Payment Updated Flawed

The principle reason for the reduction in the 2002 conversion factor is a flawed formula for determining the annual update. Medicare physician payment updates are based on a system called the "sustainable growth rate," or SGR. The SGR is a target rate of growth in Medicare spending for physician services. Annual updates in Medicare payments for physician services depend on whether actual spending growth exceeds or falls short of this target. If actual spending is below the target, conversion factor updates can be as high as 3% above inflation. But if actual spending exceeds the target, it can lead to cuts of as much as 7% below inflation. The U.S. Gross Domestic Product (GDP) is a major factor in calculating the SGR target. When GDP growth is strong, payment updates are more likely to keep up with inflation in practice costs, but declining GDP growth will generally lead to physician payment cuts. Even though GDP has no impact on health care needs, therefore, an economic downturn can lead to steep Medicare payment cuts. The problems of declining target spending and potentially accelerating actual spending are compounded by problems in the way CMS calculates inflation in practice costs using the Medicare Economic Index (MEI), because it fails to account for important components of the rising costs of practice.

CMS and Other Government Officials Acknowledge Flaws Need Correction

Key policy makers, including the Medicare Payment Advisory Commission (MedPAC), CMS Administrator Tom Scully, HHS Secretary Tommy Thompson, and Members of Congress all acknowledge that the current formula is flawed. The AANS and CNS, working together with the American Medical Association, the American College of Surgeons, and other medical specialty societies, are working closely with these policy makers to modify the formula. Despite our hope that we could achieve these changes without legislation, it is now clear that Congress must pass legislation to fix the problem before January 1, 2002. If Congress fails to act, these reductions will take place. Fortunately, key Members of Congress have pledged to fix this problem, and they are currently considering several options. Several obstacles nevertheless exist, including a fairly high price tag to fix the formula and competing national interests for additional spending as a result of the September 11th events. Fixing this problem is currently the number one priority of the AANS/CNS, and we are working aggressively to make it happen.

Impact of Fee Schedule Changes

The chart on page 9 (see Washington Committee Report) illustrates payment levels for commonly performed neurosurgical services since the inception of the resource-based relative value scale (RBRVS) in 1992, focusing primarily on 1997–2002. As you can see, payment levels have fluctuated a great deal over the past decade. This is due to a number of factors including, but not limited to, the 5-year review of work values (1992 and 2002), implementation of resource-based practice expenses (1998–2002), implementation of resource-based malpractice expenses (2000), elimination of the separate conversion factor for surgery (1998), and other changes to the update/conversion factor formula.

What You Can Do

The AANS and CNS are urging all neurosurgeons to IMMEDIATELY contact (either by phone or by faxing a letter to their office) their senators and representatives to make them aware of this problem and request that they fix the Medicare update problem before the end of the year. You should stress the following points in your communications:

1. Key policy makers agree that the current formula is flawed. For example, the Medicare Payment Advisory Commission (MedPAC) has called for the elimination of the current update formula and

warned that cuts of the magnitude expected under this formula next year could "raise concerns about the adequacy of payments and beneficiary access to care." Experience has already shown the danger of unrealistic payment rates in Medicaid, where 20 years of studies have consistently concluded that fee levels affect both access and outcomes. Medicare is not immune from similar problems.

2. For specialties like neurosurgery, the current payment reductions come on the heels of significant cuts in the practice expense component of the Medicare fee schedule. Neurosurgeons provide critical services to our nation's elderly, and reimbursement for treatments for stroke, degenerative spine disease, and brain tumors has been reduced by 30% since 1997.
3. The current payment formula continues to apply faulty 1998 and 1999 data that has unfairly removed billions of dollars from the permitted spending target. It is unfair to continue to penalize physicians and our patients for these errors.
4. Medicare cuts could lead to even bigger problems next year—especially in states where many other public and private payers tie their payment rates to Medicare's. At the same time, premiums for professional liability insurance and other practice costs are skyrocketing, making it extremely difficult for neurosurgeons to meet these fixed expenses.

To contact your Members of Congress call the Capitol Switchboard at 202-224-3121. When writing a letter, please address it as follows:

The Honorable John Doe
United States Senate
Washington, DC 20510

Dear Senator Doe:

The Honorable Jane Doe
United States House of
Representatives
Washington, DC 20515

Dear Representative Doe:

If you have any questions related to this or other health policy issues, please contact Katie O. Orrico, Director, AANS/CNS Washington Office at 202-628-2072 or via e-mail at korrico@neurosurgery.org. As always, we would be grateful to receive copies of your correspondence and any feedback you can provide us related to your contacts with your Members of Congress. These can be faxed to us at 202-628-5264.

Thank you for your assistance!

WFNS News

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who made numerous contributions to the practical and intellectual content of the field of neurosurgery while being highly active in globally organized medicine. The ebullient Scoville was primarily involved during the period of the 1940s through 1970s. He continues to be remembered for his important innovations in operative instrumentation and his novel ideas regarding intracranial and spinal neurosurgery.

Dr. Apuzzo, who is coincidentally a former Scoville pupil, is the Edwin M. Todd/Trent H. Wells, Jr. Professor of Neurological Surgery and Radiation Oncology, Biology, and Physics at the Keck School of Medicine of the University of Southern California in Los Angeles. He is recognized for numerous seminal contributions to the field of neurosurgery, particularly for pioneering efforts in areas of cerebral microsurgery, stereotactic surgery, radiosurgery, neuro-oncology, and minimally invasive techniques. His work to introduce modern aspects of cellular and molecular biology to the operative armamentarium has been particularly noteworthy. He has more than 500 publications in the scientific literature, including 36 individual volumes.

Dr. Apuzzo has been especially active as an ardent advocate of the international exchange of ideas and the concept of unified global education. He is editor of the principal international journal *NEUROSURGERY*, which was the initiator of electronic and digital informational exchange on a global scale within the neurosurgical field.

In October 2001, he was the Honored Guest Laureate of the Congress of Neurological Surgeons at their 51st Annual Meeting in San Diego, a distinction that is generally considered the field's highest academic honor.

**NEUROSURGERY
NEWS**

E-mail

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

CSNS NEWS

Chairman's Corner

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



The most recent meeting of the assembly of the Council State Neurosurgical Societies took place on September 28 and 29, 2001 in San

Diego, immediately preceding the CNS Annual Meeting. Even though the meeting took place only 17 days after the tragic events of September 11, delegate attendance to the meeting was near normal levels. Overall, the meeting was excellent, and several important actions were accomplished. Dr. Gary Bloomgarden was elected to the office of Recording Secretary of the Council, and Dr. Mark Linskey was appointed Chairman of the Medical Practices Committee. As described in the previous *Neurosurgery News* issue, a number of important issues and topics were discussed, debated and voted upon via the resolution process. A total of seven resolutions were submitted to the Assembly by the delegate members. The following is a summary of the resolutions and their disposition.

RESOLUTION I

Title: "Role of Mid-level Practitioners in the CSNS"

Dr. Leibrock, immediate past Chairman, appointed an ad-hoc committee to study and report on the feasibility of incorporating mid-level practitioners (advanced practice neurosurgery nurses and neurosurgical physician assistants) into the CSNS. The following substitute resolution was approved by the Assembly.

"Be it resolved, that Mid-level Neurosurgical Practitioners (PA-C and APRN) be invited as guests of the CSNS to attend committee meetings, quadrant meetings, luncheons, and plenary sessions. The Association of Neurosurgical Physician Assistants (ANSPA) and the American Associate of Neuroscience Nurses (AANN) may each appoint two representatives to attend the CSNS at their own expense. These representatives must be associate members of the AANS or CNS. The attendance will be limited for 2 years, after which the Executive Committee will provide recommendations for future attendance."

Therefore, with acceptance of this Resolution, the assembly is formally inviting our professional colleagues to

participate in the deliberative process of the Council. Their input will be most welcomed.

RESOLUTION II

Title: "Facilitation of Think First"

The Council continues to recognize the importance of the educational and prevention functions of the Think First Foundation. We strongly believe neurosurgery should fully support this important effort that so greatly impacts our general population. As such, the following amended resolution was passed.

"Be it resolved, that the CSNS will help facilitate communication between the State Neurosurgical Societies and the Think First State Chapter Directors by:

1. Writing a letter to the State Neurosurgical Societies asking that they include a representative of Think First at their annual meetings.
2. That the state societies designate a liaison to the state/regional Think First Program.
3. Encouraging members to participate in active Think First programs in their area.
4. Encouraging members to help establish new programs in their state with the assistance of the State Chapter Director."

Letters have been sent to the State Neurosurgical Societies and their presidents in compliance with the resolution.

RESOLUTION III

Title: "Disciplinary Actions for CNS and AANS Members"

This resolution was submitted to address concerns regarding censure of neurosurgeons by one or two of the parent organizations. It recommended and resolved that:

"The CSNS recommend that the AANS and CNS act jointly in the censure of physicians, ideally through the formation of a single committee and

Be it further resolved, that if a single professional conduct committee cannot be formed, that the procedures and time sequence followed for the evaluation of a physician under review be essentially the same for the two organizations."

Following significant testimony and debate, this resolution was voted down. Currently, the AANS and the CNS have separate Professional Conduct Committees that review cases and censure members and are deemed appropriate by each organization. Testimony was given that it would not be legally feasible to have a single committee censure individuals for two separate organizations.

RESOLUTION IV

Title: "Reimbursement Methodologies"

This Resolution resolved

"That the CSNS task the CSNS Medical Practice Committee and Reimbursement Committee to work jointly with the AANS-CNS Coding and Reimbursement Committee to study the feasibility and details for:

- Organizing representative practice managers
- Defining their status with our parent organizations
- Allowing for collection of practice costs and reimbursement information across geographic regions on a regular and ongoing basis

Be it further resolved, that the CSNS Medical Practice Committee and CSNS Reimbursement Committee should report back to the CSNS on this feasibility and details at the next CSNS meeting."

This is an extremely important resolution that both committees will be exploring and reporting to the CSNS Executive Committee. Organizing neurosurgery practice managers so that important practice data can be adequately collected and studied should prove invaluable to neurosurgery.

RESOLUTION V

This Resolution was referred to Communication and Education Committee for further study. It resolved that

"The AANS and CNS actively recruit and promote membership from the Neurosurgical National Association of Cuba, in an appropriate category, and

Be it further resolved, that the AANS and CNS do so gratis for a period of 5 years, including Journal subscriptions to be renewed at their discretion."

RESOLUTION VI

Title: "Joint Lobbying for Injury Prevention"

"Be it resolved, that organized neurosurgery, through its representative leadership of the AANS and CNS, approach Think First to establish a state legislative lobbying package promulgating the reduction of traumatic injuries through state-supported, school-run educational programs."

Following testimony and debate, the Assembly voted down this resolution.

RESOLUTION VII

Title: "Weapons of Mass Destruction"

Resolved that

"The CSNS, CNS, and AANS support all urgent efforts aimed at domestic preparedness for attack by Weapons of Mass Destruction (WMD), and



Be it further resolved, that the CSNS, CNS, and AANS urgently call on all neurosurgeons to educate themselves regarding the management of victims of WMD and educate themselves regarding the domestic preparedness system for WMD, and

Be it further resolved, that the CSNS, CNS, and AANS urgently call on neurosurgeons to assist in and support the education of all physicians and health care professionals in their community regarding domestic preparedness for attack by WMD, and

Be it further resolved, that all American neurosurgeons, the CSNS, CNS, and AANS insist that their local hospitals fully implement all federal programs for domestic preparedness for attack by WMD, and

Be it further resolved, that the CSNS, CNS, and AANS consider participating in state and federal lobbying efforts to fully fund such efforts for domestic preparedness for attack by WMD."

In light of current events, it was deemed to be an important resolution that requires further and more careful study and, therefore, was referred to The Joint Committee of Military Neurosurgeons for further development.

The next Executive Committee meeting will take place in Chicago on March 2, 2002. Any questions regarding the Council or its activities, please feel free to contact me at: jimenezd@health.missouri.edu.

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

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



I have been asked to communicate to the members of our neurosurgical community my thoughts and ideas since stepping down as Chairman of the Council of State

Neurosurgical Societies (CSNS). I have traveled to some practices around the country as a senior member of the Council and found these experiences

CNS News

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to be very enlightening and useful. I enjoy these opportunities and hope those I visit do as well.

I recently traveled to Tallahassee, Florida, to give a talk on head injury and was able to meet with members of a young, motivated, aggressive neurosurgery staff at the Tallahassee Memorial Hospital. These neurosurgeons, Drs. Romano, Crawford, and Cuffe, allowed me the opportunity to ascertain what issues were important to them and what they were trying to accomplish in neurosurgery throughout the panhandle of Florida compared to issues we face in my state, Nebraska. Interestingly, I found that, while there are local interests specific to a geographic area, there are many collective areas of interest that involve neurosurgery as an entire community.

One of the topics we discussed was what to do when making a decision about the productivity and usefulness of Gamma Knife versus Linac radiosurgery considering the cost of the two and how the hospitals and physicians can afford to use it. We had an interesting discussion about this, with no conclusion being reached other than the fact that one is certainly much more expensive than the other. In addition, hospitals can use the Linac in so many other ways if they are not using it specifically for stereotactic radiosurgery.

We also addressed an issue that is currently common among neurosurgeons and the medical community as a whole: elevated malpractice premiums. This issue, at crisis point 30 years ago, has simmered over the years, and now its specter has risen again in many states, including Florida and Nebraska. I also have friends in Philadelphia telling me that their malpractice premiums are approaching \$125,000 to \$150,000 a year, onerous sums for anyone in any profession. The national organizations for neurosurgery and the AANS/CNS Washington Committee are going to have to take a very aggressive posture in bringing the issue to the attention of U.S. and state legislators. A multifaceted approach is required to resolve this issue. Neurosurgeons need to be involved in their local state societies, state neurosurgical organizations, and the CSNS because resolution of these issues is best handled at the local level. Nationally, issues in relationship to tort reform need to be worked on again and again until some sense is brought to the area of malpractice. Educating neurosurgeons in the methods of influencing state and national legislators is vital to prevailing in the malpractice battle. The organizing committee of next year's National Leadership Development Conference in Washington, DC, is investigating ways to accomplish this.

Neurosurgeons also are aware that the government is going to lower reimbursement to physicians, particularly

in the area of Medicare, at a time when malpractice premiums are rapidly increasing. How Congress could possibly think this is a good idea in relation to access to medical care for patients is beyond my comprehension. I have written and communicated with my local congressmen and senators to convey to them my angst at how these changes could be considered at this particular moment in time. I welcome any feedback anyone has regarding this issue and how we can address it. Certainly it needs to be aggressively addressed through the American College of Surgeons, the American Medical Association, and individual physicians, or there are going to be some dramatic changes to health care access for people who need it the most—those in their senior years of life and the uninsured population—if the reimbursement reductions are carried forward by CMS. I reiterate the sentiments of the AANS/CNS Washington Committee and call neurosurgeons to action: Every neurosurgeon needs to support the Physician Payment Fairness Act of 2001, introduced November 8, 2001, by Senators James Jeffords (R-VT) and John Breaux (D-LA).

I continue to plan trips to other areas around the country and will provide thoughts in the future regarding these visits.

Editorial note: For more information on the Physician Payment Fairness Act of 2001 and tips on contacting your senator, go to the AANS Web site at www.neurosurgery.org/socioeconomic/2002feeschedulealert-2.pdf.

Think First State Chapter Directors Subcommittee and the CSNS: Communication Enhances Injury Prevention Education

Bill Biebuyck

Chief Executive Officer
Think First National Injury Prevention Foundation

Be it resolved, that the CSNS will help facilitate communication between the State Neurosurgical Societies and the Think First State Chapter Directors ...

With that recently adopted resolution, the membership of the Council of State Neurosurgical Societies formally reaffirmed neurosurgery's commitment to the injury prevention education efforts of Think First.

The resolution encouraged various methods of facilitating this communication to include:

1. An invitation for a Think First representative to attend the CSNS Annual Meetings
2. Designation of a liaison to the state/regional Think First program
3. Encouraging members to help establish new programs in their state with the assistance of the Think First State Chapter Director

The Think First State Chapter Directors Subcommittee was established in April 2001 as both ambassadors of the Think First National Office and mentors to existing and proposed local chapters. There are currently 23 State Chapter Directors. To aid the Subcommittee in their efforts, the Think First Board of Directors recently established a Board position to accommodate the membership of the Subcommittee's Chairperson.

The ultimate goals of the Subcommittee are to insure that all states identify a State Chapter Director (currently there are 23) and that Think First programs are available in all schools. The CSNS can play a prominent role in the accomplishment of these goals.

Under the leadership of Chairperson, Dorothy Zirkle, RN, MSN, the Subcommittee is ready, willing, and able to keep you informed and involved via presentation at one of your meetings. If you are in a position of leadership with CSNS, you will be hearing from a representative of the State Chapter Directors Subcommittee in the near future, or you may wish to initiate contact. Dorothy Zirkle can be contacted at Sharp Healthcare, Grossmont Hospital, 5555 Grossmont Center Drive, La Mesa, CA 91942. Phone: 619-644-4661, e-mail: dorothy.zirkle@sharp.com.

Organized neurosurgery has been and continues to be a major reason for the success of the injury prevention education programs of Think First. We are grateful. Communication between State Chapter Directors and neurosurgery can enhance what is most important—affecting the unacceptable number of tragedies that are inflicted on our nation's young people.

State Society Corner

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

The Arizona Neurosurgical Society met in Tucson October 13, 2001. Dr. William L. White submits the following report:

"Our fall meeting included an academic component. Residents were invited to present papers and submit the abstracts in advance to compete for the John Green Award Resident Paper. The first place paper received \$500, and the second place paper \$250. The first place

paper was presented by Jeffrey Henn, M.D., entitled "Interactive Stereoscopic Virtual Reality: A New Technique for Neurosurgical Education." There was a tie for second place, with both presenters receiving the cash award. The first was won by Gregory Lekovic, M.D. for his paper titled "Anterior Lumbar Interbody Fusion (ALIF): 110 Consecutive Cases." The second winner was L. Fernando Gonzales, M.D., for his submission of "Cranial Vertebral Junction Fixation with Transarticular Screws: Biomechanical Analysis of a Novel Technique." There were five papers presented in all.

"The business meeting included reports from representatives attending the CSNS, AMA, and the National Leadership Conference. The officers elected to take office in 2002 were announced. They are:

President: Stephen Ritland, M.D.
President-elect: Philip Carter, M.D.
Treasurer: Joseph M. Zabramski, M.D.
Secretary: Hillel Baldwin, M.D.
CSNS delegate: Cameron G. McDougall, M.D.
CSNS alternate: Marc Letellier, M.D.
CSNS alternate: Randall W. Porter, M.D.
ArMA delegate: Eric Sipos, M.D.
ArMA alternate: Bradley Noblett, M.D.
ArMA alternate: Arash G. Vishteh, M.D."

The **Arkansas Neurosurgical Society**, also known as The Robert Watson Society, held its reorganizational meeting August 24, 2001. Dr. Mark Linskey provides the following update:

"Preliminary by-laws for reorganization were worked out and approved. An interim slate of officers were elected and the results are as follows:

President: Kenneth Tonymon, Jonesboro, AR
Vice President: Ali Krisht, Little Rock, AR
Secretary: Mark Linskey, Little Rock, AR
Treasurer: Kelly Danks, Fayetteville, AR
South Regional Director: Freddie Contreras, Texarkana, AR
Central Regional Director: Tim Burson, Little Rock, AR
North Regional Director: Tony Capocelli, Fort Smith, AR
Acting Immediate: Tom Fletcher, Little Rock, AR

The first executive committee meeting of the reorganized society is scheduled November 3, 2001 in Little Rock.

Dr. Robert E. Harbaugh provides this report from the **New England Neurosurgical Society**:

"The New England Neurosurgical Society held its autumn meeting on September 21, 2001 at the Norman Rockwell Museum in Stockbridge, MA. At the Business Meeting, the dates and sites for future meetings were discussed. Our winter meeting will be held March 1, 2002 at the Killington Grand Hotel in Killington, VT. Tom Marshall, the Executive Director of the AANS, has agreed to make a presentation at noon on March 1 regarding the activities of the AANS. The summer meeting will be held on June 7, 2002 at the Colonial Inn in Concord, MA. We are going to be asking John Popp to give a special noon presentation on the activities of the Washington Committee. Following the presentation, he will be available to answer any questions about this very important committee of the AANS and CNS. Our Autumn 2002 meeting will be held September 13th in Newport, RI, at the Newport Marriott.

A discussion was conducted regarding the potential merger of New England state neurosurgical societies into the New England Neurosurgical Society. The New Hampshire Neurosurgical Association has merged all of its activities with the New England Neurosurgical Society. New Hampshire continues to send a representative and alternate to the Council of State of Neurosurgical Societies, but has merged all of meeting activities with the New England Neurosurgical Society. Vermont and Massachusetts have taken a similar approach and do not hold independent state meetings. We have written to the presidents of the Maine, Rhode Island, and Connecticut neurosurgical societies to see if they would be interested in this type of arrangement as well.

We also had a discussion regarding the Society's Annual Resident Award. A decision was made to name this award in memory of the first President of our Society, Dr. William B. Scoville. The noon lectures will also be named for neurosurgeons who have been active in our Society in the past. The noon lecture at the Spring meeting, which is always held in the Boston area, will be the William H. Sweet lecture. The winter meeting noon lecture will be the Donaghy Lecture, and the noon lecture at the autumn meeting will be designated as the Whitcomb Lecture. I should also note that Professor Yasargil, the keynote speaker for our 50th Anniversary meeting in Boston, was kind enough to write and say that the New England Neurosurgical Society did not need to reimburse him for his air fare. A letter of thanks is being sent.

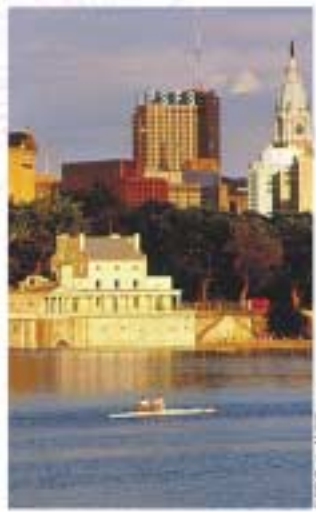
The scientific session started at noon, with a special lecture by Dr. Lycurgus Davey on the research he has done regarding the Hippocratic Oath. It was greatly appreciated. The open scientific session began with a moment of silence for victims of the September 11 terror-

ist attacks and for our own deceased members. Dr. Steven Kalkanis presented his work on umbilical cord blood stem cell transplantation in a mouse model of ALS. Dr. Peng Chen presented his work on the effects of inosine on CNS regenerative reorganization and functional recovery after cerebral infarction. Dr. Vasillious Zaras presented a paper on nasofrontal dermoid sinus cysts, and Dr. Peter Catalano discussed a combined

transtemporal-C1 transverse process vertebrectomy approach for large paragangliomas of the jugular bulb region. Dr. Edward R. Smith presented another surgical technique paper, evaluating a far posterior subtemporal approach to the dorsolateral brain stem. Dr. James Kryzanski reviewed the experience with 41 cases of acromegaly, and Dr. Henry Pallatoni reviewed a large series of children with lipomatous malformations associated with closed neural tube

defects. Dr. Hulda Magnadottir presented two papers: one evaluating patient-reported functional health status preoperatively and at 6 months following carotid endarterectomy, and a second paper in which she discussed a decision analysis approach to determine the value of carotid endarterectomy for symptomatic patients with 30%–50% carotid stenosis. Robert E. Harbaugh

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2002 Congress of Neurological Surgeons Annual Meeting September 21 - 26, 2002

PHILADELPHIA

Call for Abstracts

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CNS News

Continued from page 17

presented a short historical vignette on Harvey Cushing's influence on Dr. E. A. Codman, the founder of surgical outcomes studies.

Following the scientific session, we had time to tour the Norman Rockwell Museum. After the tour we gathered at the Red Lion Inn in Stockbridge for cocktails, dinner, and conversation with our colleagues."

The **Illinois State Neurosurgical Society** meeting has been rescheduled for December 1, 2001.

The **Ohio State Neurosurgical Society** meeting scheduled for September 15, 2001 was canceled. A rescheduled date is to be determined.

The **Tennessee Neurosurgery Society** Meeting scheduled for September 2001 was canceled. It has been rescheduled for August 17-18, 2001.

Upcoming Meetings**January 2002**

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

- 1) The New Regulatory Paradigm for Health Care
The Criminalization of Health Care presented by Dr. John Kusske
EMTALA: Still a Problem after 14 Years—The COBRA Still Bites

- 2) Creating a 7-Step Compliance Plan
- 3) New and Emerging Therapies for ALS, MS, Alzheimer's, Epilepsy and Polyneuropathy (4 CME credits)
- 4) Qualified Medical Evaluator course for California Workers Compensation

19-20

Arkansas State Neurosurgical Society
(The Robert Watson Society)
Little Rock, AK
Program Chairman: Ali Krisht
E-mail: krishtali@exchange.uams.edu
Local Arrangement Chair: David Reding
E-mail: dreding@worldnet.att.net

26-27

Louisiana Neurosurgical Society
Radisson Hotel Bentley
Alexandria, LA
Guest Speaker: Kevin Foley
Contact: C. Babson Fresh
Phone: 318-443-4576

April 2002

18-20

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

August 2002

17-18

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

AANS/CNS JOINT SECTION ON TUMORS**Update from the Executive Council****Isabelle M. Germano, M.D.**

Under the leadership of Dr. Rutka, AANS/CNS Joint Section on Tumors Chairman, the section is planning a very active and exciting series of events. Plans for the next 6 months

include the presentation of a new award, efforts targeted to increase the membership and membership services, exciting scientific programs at the upcoming AANS and CNS meetings, the Fifth Biennial Tumor Satellite Symposium, and several publications on areas of interest by the Education Committee

The section is currently giving four annual awards. Dr. McDermott, Award Committee Chairman, prepared a useful table summarizing all winners of the four awards given by the Joint Section on Tumors for the past 4 years (see below). In addition, the Farber Award will be given at the 2002 AANS meeting in Chicago and will thereafter alternate years with the Society for Neuro-Oncology (SNO). Nominations for the Farber were received and currently being selected by Dr. Rutka in consultation with, Dr. Ed Shaw, President of SNO, Dr. Berger, and Jim Farber. The National Brain Tumor Foundation (NBTF) has again offered to fund a \$15,000 translational research grant in 2002. This information is being disseminated to the entire membership, and the selected winner will be presented the award in April in Chicago.

The section membership has been steadily growing over the past year, with a current number of members of over 700. Dr. Warnick, Membership Committee Chair, plans to boost the membership by e-blast mailing and targeting of international candidates. Additionally, in the near future, the Section will recognize several outstanding individuals with honorary memberships.

Membership services will continue to grow in the next 6 months under the leadership of Dr. Lang, Membership Services Chair. The existing Web site is undergoing additional construction and will include additional information, such as fellowships and awards. Additionally, links to various support organizations will be installed. Our newsletter, prepared by Dr. Barnett, continues to highlight the activities of the Section in a highly informative way.

Under the leadership of Dr. Liao, Research Committee Chair, a list of funding opportunities from governmental as well as private organizations is available to the members. Additionally, information on the Tumor Progress Review Group report can be found at the following site: <http://planning.cancer.gov/>.

Dr. Jeff Olson, Guidelines Committee Chair, is in the process of updating the guidelines for management of a newly diagnosed/discovered lesion consistent with the glioblastoma multiforme project. The subcommittee members have been assembled, including representation from related disciplines such as neuro-oncology, radiation oncology, ASTRO, etc. Over 10,000 abstracts and summaries have been acquired, screened, and sorted by specialty area. Teleconferences and face-to-face meetings are being planned.

The Scientific Program of the CNS 2001 Annual Meeting prepared by Dr. Coldwell was a great success. Dr.

Continued on page 19

CONTACT INFORMATION

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

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CONGRESS OF NEUROLOGICAL SURGEONS
10 N. Martingale Road, Suite 190
Schaumburg, Illinois 60173

Tel: 1-847-240-2500 / Fax: 1-847-240-0804

Email: info@1cns.org

CONGRESS OF NEUROLOGICAL SURGEONS

AANS/CNS Joint Section on Tumors Award Winners

Year	Mahaley Award	Preuss Award	Young Investigator	Farber Award
2001	Yutaka Sawamura Hae-Dong Jho	Jeffrey R. Leonard Andrew T. Parsa	Turker Kilic Randy L. Jensen	Robert L. Martuza
2000	Robert J. Weil Ronald E. Warnick	Amy B. Heimberger Michael D. Taylor	Karen S. Aboody John S. Yu	Stuart A. Grossman
1999	Doug Kondziolka Bruce Pollock	Sandeep Kunwar Terrance Julien	S. Walter Stummer Quentin Malone	Ed Oldfield
1998	Prem Pilay Byron Young	Matthias M. Feldkamp Bob S. Carter	Michael Hsiao Eric H. Elowitz	

Joint Section on Tumors

Continued from page 18

Broaddus is preparing the 2002 AANS meeting program. The program will begin with a 1-hour special symposium on central nervous system tumor invasion. The three speakers are currently being selected. The award presentations and the oral papers will follow the symposium. Future program leaders are Dr. Bruce (CNS 2002) and Dr. Guha (AANS 2003).

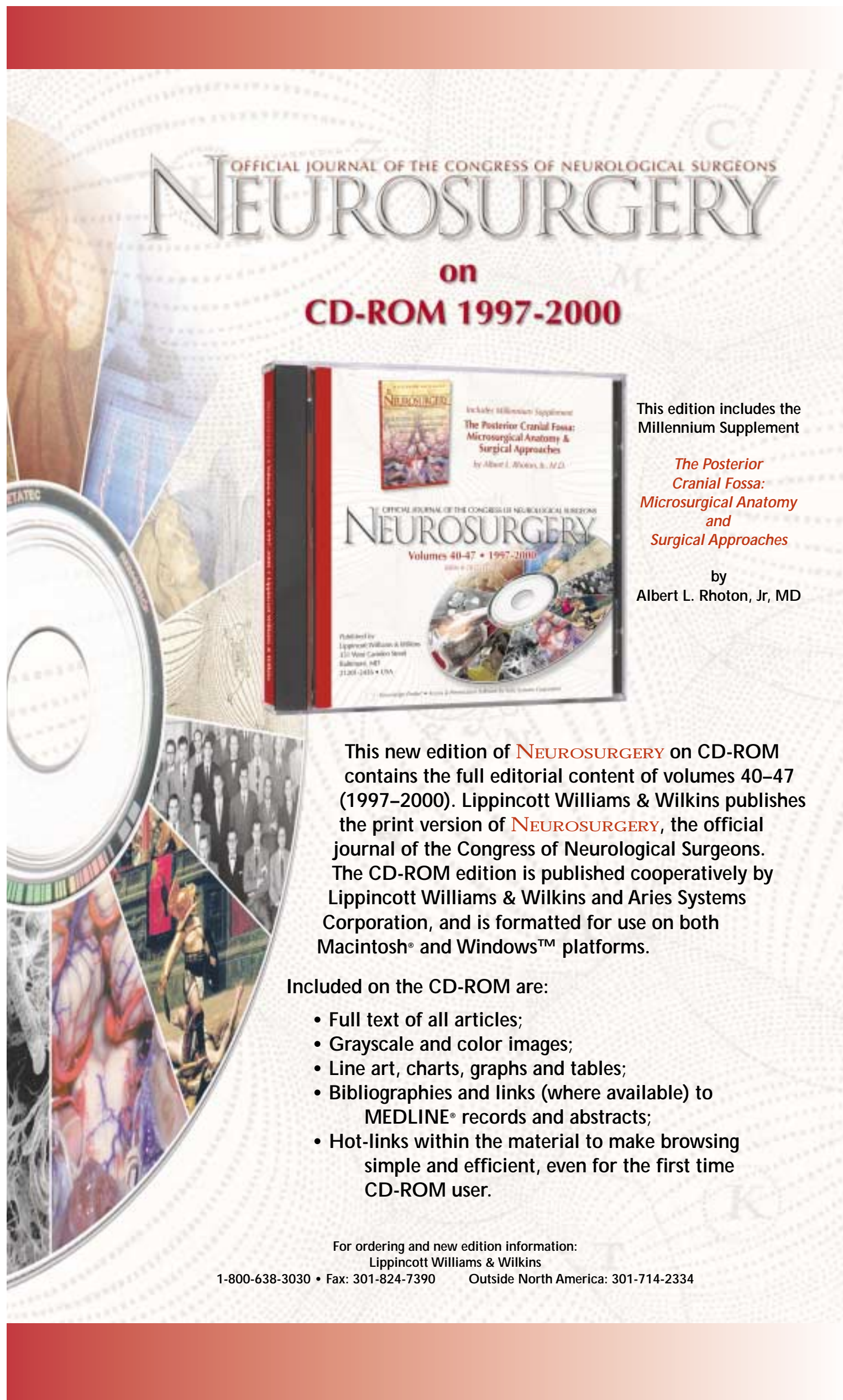
The Education Committee's plans for the next year are numerous. Dr. Gupta is organizing the Fifth Biennial Satellite Symposium in Chicago following the AANS meeting. This will start on Thursday, April 11, 2002 at 1:00 p.m. and ending Friday, April 12, at 4:00 a.m.. All meeting events will be held at the Sheraton Hotel and Towers. The symposium will consist of three discussion sessions focused on scientific and clinical topics alternating with free paper sessions. The three sessions will be skull base chondrosarcomas and chordomas, viral gene therapy for brain tumors, and management of low-grade gliomas. The keynote speaker will be Dr. Arturo Alvarez-Buylla, and the luncheon seminar on Friday will be titled, "A primer in current molecular biology techniques." Dr. Isabelle Germano is planning a special issue of *Neurosurgical Focus* on "Malignant Gliomas: Present and Future." The topics that will be covered include clinical as well as laboratory discoveries that are pertinent to future clinical trials. Dr. O'Rourke is preparing a special issue of the *Journal of Neuro-Oncology* focusing on the topic of "emerging biologic therapeutic approaches." The *Selected Review in Neuro-Oncology* guided by Dr. Asher has recently released Volume 2, Issue 2 of the Journal and continues to make improvements to the product. Dr. Asher is also working with the CNS Education Committee to develop an online CME component for the review.

Dr. Chin, Section representative at the Washington Committee and Coding and Reimbursement Committee, is working closely with our parent organizations and their dealings with the various governmental branches.

Looking forward to a very productive next 6 months, the AANS/CNS Joint Section on Tumors wants to remind you that our goal is to best serve all of you. Thus, do not hesitate to contact us if you have additional suggestions.

For AANS/CNS Joint Section on Tumors membership applications, contact:

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PO Box 670515/Neurosurgery
Cincinnati, OH 45267-0515
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Hospital Avoidant: The On-Call Crisis

The problems are so many – from lack of payment to a higher chance of being sued – that most specialists just won't answer on-call pages



Illustration by Vincent Giarrano

Anne Scheck

To explain the current on-call crisis, one example is worth a thousand PowerPoints

At least that's the way Todd Taylor, M.D., sees it. In Phoenix, where he practices, the case of the vanishing surgical specialist for hand injuries is the best way he has for illustrating why there's an on-call crisis.

When it seemed no such surgeon could be found during weekends and at night, Dr. Taylor asked a local hand surgeon to explain the reasons behind the disappearance.

These surgeons still practice in the thriving desert metropolis, he was told, but they have set up shop in surgical centers, outside the traditional medical setting. They have become – as Dr. Taylor terms it – hospital avoidant.

Lack of Resources

Why? Forget the nice, pat, lifestyle-related explanations, Dr. Taylor said. It's too simple to say the lack of a hand surgeon to care for the victim of a Friday night fight is because these specialists don't want to deal with the lower socioeconomic rungs of society or that they lack the energy or motivation to scramble out of bed at 2 a.m. "Most [surgeons] do want to volunteer," noted Dr. Taylor, recounting how the hand surgeon explained the dilemma to him. "But then they get stuck caring for patients in a situation in which society

has failed to give them the needed resources."

Compare the sparsely staffed operating room in the wee hours of the morning to "the usual OR, where the surgeon is king and has handmaidens," he said. But even that doesn't reveal the entire story. The surgical procedure, in the case of a serious hand injury, is only "10 percent of what needs to be done," Dr. Taylor stressed.

"Let's say this patient comes back [to the surgeon], the way he's supposed to – and that doesn't always happen – but in this case it does. The doctor tells him he needs rehab. Then the guy says: 'What? I don't even have the money for antibiotics.'"

"You hear the drumbeats (of public sentiment) getting louder and louder."

Dr. Todd Taylor

The next chapter in this saga is the sound of a patient falling through the cracks because perhaps the visits are financially or physically difficult to make or maybe English isn't his native tongue and he doesn't understand the necessity of rehabilitation. "So there he is, a year down the road or so, with a

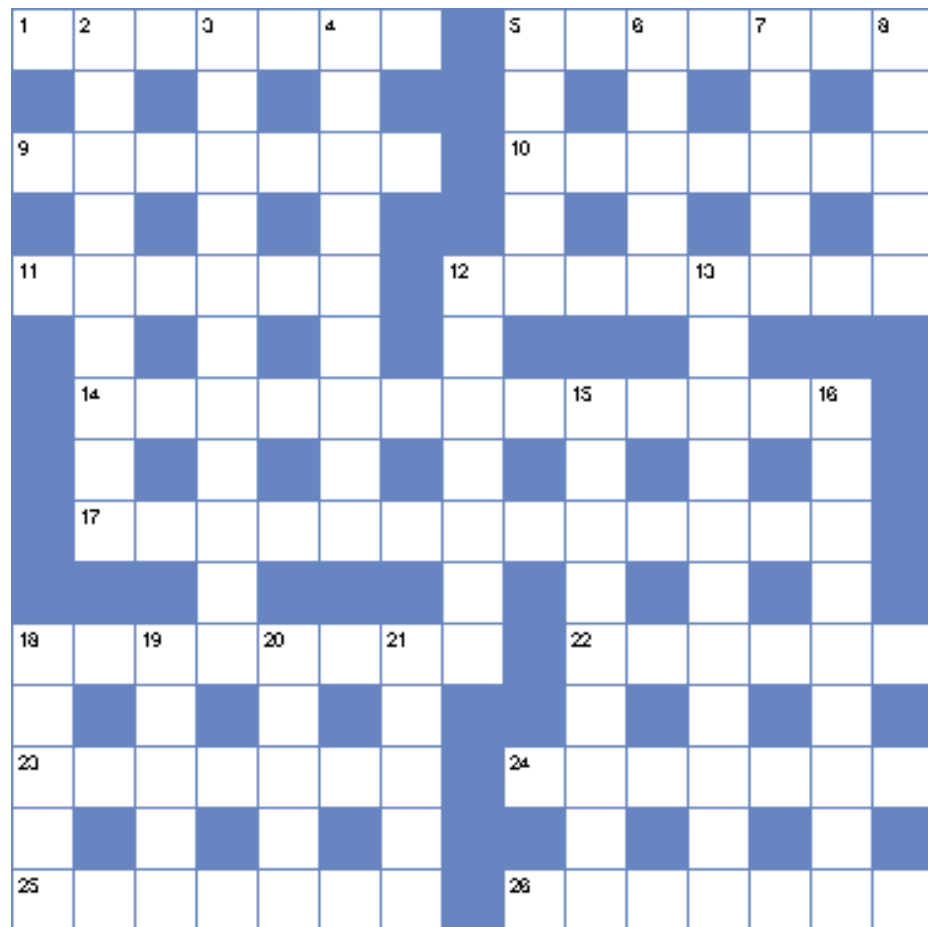
Continued on page 22

CRYPTIC CROSSWORD PUZZLE

Owen K. "Loki" Lorion

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

Solution on page 22



ACROSS

1. Pair of ovaries in egg-producing hen between flights (7)
5. Dessert sounds like a sure bet (7)
9. Fiberoptic monitoring system for 5&10 mixed right before nine (7)
10. Ivy fish makes bitter flavoring (7)
11. Junior Achievement gets no employment from oil producer (6)
12. Let cat out of bag about storm at equipment maker (8)
14. Befuddled simian ate thin cold reliever (13)
17. Gold table of contents has height of shortstop Wagner: around zero where indigenous (13)
18. Drill brand into dislocated scapulae (8)
22. Well-muscled for part in the wedding (6)
23. Defective lung or a listlessness (7)
24. Newspaper elicits small stare? (7)
25. They help adjust pressure so measure of acidity, say, is disrupted (7)
26. Spotty infection identified in home as lesions (7)

DOWN

2. A study o' Hari's skin tumor (9)
3. From resort host, a ticket holds standing (11)
4. Hawaii, after spigot was put into saga as written on marker stone (9)
5. Taste of South American victory or nothing (5)
6. "On," we cried without enthusiasm (5)
7. Roll up in a little gaberdine (5)
8. Both robbers' hearts beat rapidly (5)
12. Coaches place kiss on pate (3,4)
13. Nothing is prophetic sign in monster's Loch which arouse disgust (11)
15. A match on a map turned 180 degrees (5-4)
16. Ethane she treated like what dura does to the spine (9)
18. Fat lassie gives birth to Titan (5)
19. Un-pus sore to brighten day (5)
20. High interest paid to American urinary walls (5)
21. Beginning associate or teaching aide comes right from the heart (5)

Correction:

Owen K. "Loki" Lorion was left off as author of the Cryptic Crossword Puzzle in issues 4, 5, and 6 of Volume 2/2001.

NEW PRODUCTS

Odin Medical Technologies Receives CE Mark for Its PoleStar™ N-10 Intraoperative MR Imaging Device

Yokneam, Israel—Odin Medical Technologies, Ltd. has announced that the PoleStar MR imaging guidance system was certified in accordance with the European Community Medical Device Directive (MDD) 93/42/EEC and can be marked with the CE Mark. According to the manufacturer, this makes the PoleStar N-10 the first and only compact intraoperative magnetic resonance (MR) imaging guidance system available in the European Community countries for use in a standard operating room.

Images from the PoleStar N-10 provide neurosurgeons with a real-time view of the patient's brain throughout a surgical procedure by using a confined magnetic field, enabling instruments and life support equipment to rest undisturbed only a few feet away from the device. Surgeons can evaluate progress at any point during the procedure and can remove lesions with exquisite precision.

Earlier this year at the annual meeting of the American Association of Neurological Surgeons (AANS) in Toronto, Canada, leading neurosurgeon Dr. Rene Bernays, Zurich, Switzerland, presented a comparative study of intraoperative MR systems. He reported that the PoleStar's dedicated neurosurgical system offers the power of real-time MR imaging guidance at less cost, better ergonomics, and greater acceptance than its competition.

Odin Medical Technologies, Ltd. develops and manufactures intraoperative MR imaging systems designed to improve neurosurgical interventions, with a special focus on minimally invasive procedures. Odin Medical Technologies Europe bvba was established in Belgium as the sales, marketing, and customer support office for Europe.

For more information, log on to www.odinmed.com. □

NuVasive™ Will Market Two Key Elements of Its Minimally Invasive Spine Surgery System

San Diego, CA—NuVasive™ has announced that the company has received Food and Drug Administration (FDA) 510(k) clearance to market two new proprietary components of its minimally invasive spine surgery system. According to the manufacturer, the NeuroVision™ Intraoperative Nerve Guidance System incorporates sophisticated software and graphical user interface to enable the surgeon to navigate past nerves while advancing cannula to access the spine in a minimally invasive fashion. The Hemi-Arc™ Surgical Navigator enables the surgeon to accurately guide cannulae and surgical instruments to targeted areas of the spine through alignment with radiographic imaging.

The NeuroVision™ System provides intraoperative electromyographic (EMG) nerve surveillance to assist in the location and evaluation of spinal nerves during percutaneous surgery of the spine, by administering low amperage electrical energy to tissues and nerves at the operative site, and EMG monitoring of muscle groups associated with those nerves. The system has two modes of operation utilizing surgical

cannulae. The detection mode is used to advance the cannula to the operative site and provides levels of stimulation to support nerve detection. The direction mode is used after the system has detected a nerve and provides the surgeon with information on the directional location of the detected nerve.

"The 510(k) clearance of these two products further expands NuVasive™'s product offering to conduct spine fusion surgery through a far lateral minimally invasive approach to the spine," said Alex Lukianov, NuVasive™'s president and chief executive officer.

The Hemi-Arc™ Surgical Navigator serves as a trajectory guide instrument holder that is aligned with the operative site using real time, or near real-time image intensified C-arm fluoroscopy. The Hemi-Arc™ guide frame is adjustable in several planes of motion to provide a precisely controlled path of entry for cannulae and instruments. The enhanced design of the system allows for easier and faster alignment of the device for lateral/posterolateral access to the spine in a uniportal unilateral procedure.

The minimally invasive XLIF™ (eXtreme Lateral Interbody Fusion) approach to the spine developed by NuVasive™ is made possible through active nerve monitoring offered by the NeuroVision™ System. The surgeon can determine a nerve's proximity to the cannula and receive guidance as to what direction should be taken to avoid contact, thus safe and reproducible access to the spine. Once the spine is accessed, the surgeon may use NuVasive™'s Triad™ precision machined allograft, or any interbody fusion device currently available in the marketplace.

NuVasive™ is a privately held medical device company headquartered in San Diego with European offices in Munich that designs, manufactures and markets minimally invasive spine surgery systems. The Company's expertise is in minimal access for surgery of the spine, neurophysiologic devices, unique implants, and alternative treatments for degenerative disc disease.

For more information, contact Steven J. McGowan, Chief Financial Officer, NuVasive, Inc., 10065 Old Grove Road, San Diego, CA 92131; phone: 858-271-7070. □

INNERCOOL Receives Regulatory Approvals

San Diego, CA—INNERCOOL therapies, Inc. has received the CE Mark approval for its Celsius Control™ System, a proprietary endovascular catheter technology that exchanges heat directly with blood in the circulatory system to induce and/or reverse hypothermia (mild cooling). The CE Mark allows the company to market the Celsius Control System throughout the European Union. The company has also received marketing approval from the Australian Therapeutic Goods Administration (TGA).

"We are very pleased to receive regulatory approvals in both Europe and Australia for the Celsius Control System," said John Dobak, M.D., President and CEO of INNERCOOL. "These approvals continue to provide validation regarding the safety and quality of our technology. We look forward to introducing the Celsius Control System into these markets."

INNERCOOL is currently conducting multicenter, clinical trials with the Celsius Control System in the treatment of acute ischemic stroke and during surgical repair of unruptured brain aneurysms (TCAS). The company is also planning to begin a multicenter, clinical trial in acute myocardial infarction by the second quarter of 2002.

INNERCOOL recently announced positive interim data from the TCAS trial, which showed that time to achieve mild hypothermia (33°C) and restore normal body temperature with its Celsius Control System is superior to traditional surface cooling methods. In addition, the safety profile was positive and showed no difference between the Celsius Control System and the control method. The data was presented in October at the Congress of Neurological Surgeons 51st Annual Meeting in San Diego by Gary Steinberg, M.D., Professor and Chairman, Department of Neurosurgery at Stanford University School of Medicine and Principal Investigator of the TCAS trial.

Mild hypothermia has the potential to prevent tissue or organ damage during periods of ischemia that occur during stroke and heart attack or for temperature control in surgical and critical care applications. Physicians currently induce and reverse hypothermia with cooling blankets and other body surface cooling devices, which are difficult to control and have limited efficacy.

INNERCOOL's Celsius Control System consists of an endovascular catheter, circulating set and console. The tip of the catheter incorporates a proprietary, alloy-based Temperature Control Element (TCE) that is cooled or warmed with saline solution circulated from the console. When placed in the inferior vena cava, the TCE exchanges heat directly with the blood flowing in the vessels of the body, resulting in cooling or rewarming of the downstream organs and body. The System does not require fluids to be perfused into the patient, nor does it require blood to be circulated outside the body.

INNERCOOL therapies, Inc., is a San Diego-based medical device company pioneering the field of hypothermic therapy with its proprietary Celsius Control System. This state-of-the-art, endovascular technology platform is designed to precisely induce, maintain and/or reverse hypothermia (mild cooling) to prevent tissue damage during periods of ischemia. Potential applications include acute ischemic stroke (brain attack), acute myocardial infarction (heart attack) and temperature control in surgical or critical care procedures. For additional company background, please visit the INNERCOOL therapies' Web site at: www.INNERCOOL.com.

For more information, contact INNERCOOL therapies, Inc., Brad Klos, 858-677-6390, bradk@innercool.com or Mentus, Inc., Kathy Witz Sweeney, 858-455-5500, ext. 140, kwitz@mentusonline.com. □

CRYPTIC CROSSWORD PUZZLE IS ON PAGE 20



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

ACROSS

- LAYOVER: OV(aries) > LAYER
- SHERBET: ⑨ SURE BET
- VENTRIX: V + TEN* + R + IX
- VINEGAR: VINE + GAR
- JOJOBA: J.A. < O + JOB
- BRAINLAB: BLAB < RAIN
- ANTIHISTAMINE: SIMIAN+ATE+THIN *
- AUTOCHTHONOUS: AU + T.O.C. + HT. + HONUS > O
- AESCULAP: SCAPULAE*
- THEWED: hidden
- LANGUOR: LUNG+OR+A *
- GAZETTE: pun
- SOPHYSA: SO + PH + SAY*
- MEASLES: hidden

DOWN

- ADENOMATA: A + DEN + O(f) + MATA
- ORTHOSTATIC: hidden
- EPITAPHIC: HI + TAP < EPIC
- SAVOR: S.A. + V(ictory) + OR + (nothing!)
- ENNUI: ⑨ ON+WE
- BAGEL: hidden and reversed
- THROB: hidden
- BUS STOP: BUSS + TOP
- NOISOMENESS: O + IS + OMEN < NESS
- ABOUT FACE: A + BOUT + FACE
- ENSHEATHE: ETHANE+SHE *
- ATLAS: hidden
- SUNUP: UN+PUS *
- USURY: U.S. + UR(inar)Y [or + U(rina)RY]
- AORTA: A(ssociate) + OR + T.A.

Hospital Avoidant

Continued from page 20

clawed hand," Dr. Taylor said. And then the man, partially disabled, sees lawyers' advertisements around town or on television "telling him how much money" he may be owed for a bad medical outcome.

The next thing the hand surgeon knows, he's being sued. He looks at the man's hand, and realizes he isn't proud of the surgical result, but was powerless to do much about it. The end result: The surgeon no longer takes call from the local emergency department. "This is how it happens," said Dr. Taylor.

EMTALA assumes that physician participation in emergency medicine was a given, "part of the ethical duty of the healing professions."

—
Dr. Loren Johnson

Documenting the Problem

A few rays of light, however, may be making their way toward illuminating the dark end of that tunnel, thanks to a new study. In a blow-by-blow description of the depth of the on-call crisis, California emergency physician Loren Johnson, M.D., along with Dr. Taylor, has documented the problem and its national proportions in a recent study (*Ann Emerg Med* 2001;37:495).

The article arrives amid reports of countless violations of the Emergency Medical Treatment and Active Labor

Act (EMTALA), the law mandating that "a hospital that offers services for emergency medical conditions (and) agrees to maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition." Under the law, on-call physicians must respond to a request from the ED within a reasonable period of time, regardless of the patient's insurance coverage or ability to pay. In states such as New Jersey, for example, maximum response time to an urgent request is 30 minutes.

But, in what some emergency physicians liken to fairy-tale status, EMTALA currently is discussed more as a great and honorable medical quest than as a workable solution to health care delivery. For instance, it has no provisions to finance on-call specialty services. Why? Because when it was enacted, legislators assumed that physician participation in emergency medicine was a given, "part of the ethical duty of the healing professions," as Dr. Johnson put it.

And for any cynic who believes some physicians simply lost their moral fiber, some research shows that they may have lost the taste for legal fights. When a Texas lawyer looked at the ramifications of EMTALA, she found that the law itself is landing more physicians than ever in court, and the statute "clearly puts the responsibility on the hospital's on-call physicians" (*BUMC Proceedings* 1999;12:135).

National Dilemma

Further, as the *Annals* article indicates, though on-call problems are severe at most community hospitals, they constitute a nationwide problem that now extends to academic medical centers. In addition, the issue is deeply affected overall by the encroachment of man-

aged care, said Dr. Johnson, the chief medical officer of Sutter Emergency Medical Associates in Davis, CA.

In fact, he found that low fees or complete lack of payment by public payors and managed care organizations is the most common grievance of on-call physicians. Conversely, staff-model health maintenance organizations, such as Kaiser, a huge California provider, appear to be unaffected, he pointed out.

As a result, a state-level, on-call task force in California has been formed. It is comprised of members from the California chapter of the American College of Emergency Physicians (CalACEP) as well as others, including the California Medical Association and the California Healthcare Association, said Dr. Johnson who is president of CalACEP. A report on the task force recommendations is expected in January.

Many on-call specialists have set up shop outside traditional medical settings and become hospital avoidant

Although Dr. Johnson said he believes it's too soon to say with certainty what the recommendations of the task force will be, California's governor, Gray Davis, has a track record of funding advocacy for social causes, a history that Dr. Johnson said he finds encouraging. Patching up the gaps in funding, however, is only part of the answer, he said. Enforcement of the provisions of EMTALA will mean closing interpretative loopholes, improving the coordination of care, and setting priorities for services, all of which mean a

renewed declaration of emergency medicine as a public service, he said.

So will California unveil a workable solution for EMTALA around the time of its next Rose Parade? It's a tall order, acknowledged Dr. Johnson, particularly in a state still reeling from rolling blackouts and an energy crisis. Dr. Taylor, in neighboring Arizona, is more optimistic. "You hear the drumbeats (of public sentiment) getting louder and louder," he observed. "This is an issue everyone's getting to be concerned about."

And in fact, in August, the Arizona College of Emergency Physicians approved a policy statement that addressed funding for "episodic coverage" of the health care population that is unable to pay, a target group of about 26 million Americans, about 9.5 percent of the population. These emergency physicians endorsed a plan for eligibility screening, based on a sliding scale, to provide single-event coverage when indicated.

The plan also has provisions for low-cost government loans, which could be put in place to cover more extensive care. They also call for another mechanism to help finance episodic health care coverage: tax relief. Through a means test or by establishing certain income thresholds, someone experiencing significant health care costs during a given year would be able to take a tax credit or tax deduction depending on the situation.

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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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