



NEUROSURGERY

NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

President's Message: It's Been an Honor

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

President, CNS



How quickly a year flies by! It is hard to believe that my tenure as CNS President will come to an end during our 2003 Annual Meeting in Denver

in October. It has been an honor to serve you as the 53rd President of the Congress of Neurological Surgeons.

My involvement with the CNS began as a resident in 1983. Over the years, I have been fortunate to serve with some of the very best in our field as we tackled Congress initiatives, including Dick Roski, Art Day, Ralph Dacey, Stephen Haines, Marc Mayberg, and Bill Friedman, among many others. Now, 20 years later as I prepare to pass the reins of the CNS, I am indebted to the many men and women who allowed me the opportunity to learn from and work with them. To those that I mentioned by name—and the many more who I didn't—I thank you.

As my term comes to an end, I'd like to reflect briefly upon what we have accomplished together this year and what we have to look forward to in the future. The role of the CNS as an international member-service educational organization has never been greater; our organization has never been stronger or as large; and our commitment to our educational mission has never been more focused. Our relationships with our sister organization, the AANS, and with the American Board of Neurological Surgery, the AMA, the ACS, the NIH, and our multiple coalition partners have never been better. The following are examples of CNS' accomplishments this year, with the names of the principal individual, or chairperson, of the initiative:

- Development of a rational, finite plan for unification of essential services, overlapping activities, and a joint organization with the AANS (Steve Papadopoulos)
- Strategic initiatives in CNS leadership development to encourage, identify, and promote future young men and women leaders and contributors in neurosurgery (Rich Ellenbogen)
- Expansion of the Council of State Neurosurgical Societies (CSNS) role in organized neurosurgery in an advocacy role and as the working group (workforce) for the AANS/CNS Washington Committee (Rick Boop and James Bean)
- Expansion of the CNS commitment to and member involvement in the CSNS (William Bingaman and Rick Boop)
- Expansion of the CNS Executive

Committee to increase talented, broad-spectrum representation (Resident member representation, additional CSNS representation, WINS representation, expanded International Committee representation) (Kristen Riley, Cheryl Muszynski, and Gail Rousseau)

- Dedication to CNS International membership and expansion of the CNS International Committee (Nelson Oyesiku and Gail Rousseau)

- Creation of the CNS Medical Evidence Based Guidelines Development Program and (joint) AANS/CNS Guidelines Committee (Beverly Walters)
- Promotion of four new, essential, medical evidence-based guidelines initiatives in collaboration with AANS/CNS Sections: Lumbar Spinal Fusion—Spine Section (Daniel Resnick); Pediatric Brain Tumors—Peds Section/Tumor Section (Karin Muraszko); Neurostimulation for Functional Disease—Functional & Stereotactic

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Executive Director's Message: The Value of Volunteering

Laurie L. Behncke
Executive Director, CNS



Even though the neurosurgery specialty is facing far greater external challenges than ever before, the Congress of Neurological Surgeons volunteer spirit has never been

stronger or more energized. I am in awe, and always have been, of the hundreds of CNS volunteers who contribute to and develop programs, initiatives, and educational products that strengthen and bolster the entire neurosurgical community. Here is just a brief mention of some of the most recent and paramount efforts directed by various volunteers and supported by our dynamic staff.

Because the CNS membership renewals are up over last year and new members are on the rise, we are more than ever encouraged about our future. Our top-rated Membership Committee, lead by Dr. Christopher Getch, now boasts over 5200 members in over 70 countries. Please call 847-240-2500, toll-free 877-517-1CNS (1267), or e-mail info@1cns.org regarding any membership inquiries.

Our new Online Membership Appli-

cation program allows for the most efficient processing system ever. Also, available this year at the Annual Meeting for download to your PDA is our updated member directory, the 2004 CNS Contact Guide. Visit a "beaming" station at convenient locations throughout the Colorado Convention Center. Have a data update? Changes and e-mail address updates can be made in seconds on our Web site at www.neurosurgeon.org.

Our International Membership recruitment efforts have never been stronger. Earlier this year, the CNS exhibited at the World Spine II meeting in Chicago, Illinois. The CNS volunteers and staff had a great opportunity to recruit and interact with international members from across the globe.

Excitement is everywhere about the release of SANS (Self Assessment in Neurological Surgery) Wired 2004, thanks to the outstanding efforts of Dr. Anthony Asher and the SANS Wired Committee. We have SANS Wired 2004 on exhibit in the CNS Member Services, Booth #834, here at the Annual Meeting. Stop by for a demonstration. Go to www.neurosurgeon.org to purchase your copy today.

SANS Wired 2004 is the widely antic-

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WASHINGTON COMMITTEE NEWS

CMS Publishes Proposed Medicare Physician Fee Schedule for 2004

Katie O. Orrico, Director
AANS/CNS Washington Office



On August 15, 2003, the Centers for Medicare and Medicaid Services (CMS) published the proposed 2004 Medicare Physician Fee Schedule regulation. While this regulation contains several policy changes that will have no perceptible impact on neurosurgeons' reimbursement rates, tucked away in the 271-page proposal, however, is a single paragraph noting that CMS confirms its earlier estimates that there will likely be an across-the-board 4.2% reduction in payments to all physicians. This reduction is due to the arcane formula that CMS is required to use to calculate reimbursement rates. CMS estimates that the combination of all these factors may amount to an overall 4% reduction in neurosurgeons' reimbursement.

Flawed Formula Contributes to Projected Fee Cuts

This 4.2% reduction is expected even though earlier this year Congress restored over \$54 billion (over the next 10 years) to the Medicare Physician Fee Schedule. This is because Congress only gave CMS the authority to correct certain errors it had made in previous years, but the legislation passed in February did nothing to change the basic formula for calculating physician payments. Thus, each year, CMS must continue to update the fee schedule according to the Sustainable Growth Rate (SGR) system, which is designed to rein in the growth of physician services. By law, the formula requires CMS to adjust the annual update up or down depending on how actual expenditures compare to an expenditure target rate, or SGR. The SGR is calculated based on a number of factors, including medical inflation, the projected Gross Domestic Product (GDP), and the projected growth in the number of beneficiaries in fee-for-service Medicare. The 4.2% reduction is largely due to slow growth in the economy and to a significant growth in the volume of physician services in 2002.

This projection will be updated before the final rule, however, and as CMS Administrator, Tom Scully, observed, "Physicians should note that while CMS is required to publish a proposed physician fee schedule rule at this time, both the House and Senate versions of Medicare legislation contain provisions

that address the proposed fee schedule cuts." As reported in the Summer 2003 issue of *Neurosurgery News*, the Medicare reform bill passed by the House of Representatives (H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003) contains a provision that would prevent any cuts in Medicare physician reimbursement for 2004 and 2005, requiring physician payment updates of at least 1.5% for these 2 years. The Senate bill (S. 1, the Prescription Drug and Medicare Improvement Act of 2003) urges the enactment of legislation to fix the Medicare payment formula. We are cautiously optimistic that Congress will address this before January 2004. Even if a law is enacted after CMS publishes a final physician fee schedule rule, the law will supercede the final rule, and payments will be adjusted accordingly.

...tucked away in the 271-page proposal...is a single paragraph noting that...there will likely be an across-the-board 4.2% reduction in payments to all physicians.

Neurosurgeons should be aware, however, that if enacted, the House-passed provision would only delay the pain caused by the 4.2% reductions because the bill does not include any additional money to fund this provision. Rather, it would require CMS to only push these reductions out to future years, which will compound the problem and result in steep reductions of nearly 6% for 2006 and several years beyond. Because of this, the CNS and AANS, through the Alliance of Specialty Medicine, are working with Congress to develop an alternative proposal that would minimize the "roller coaster" effects that the current payment formula has on reimbursement rates. The "take-the-money-and-run" approach may look attractive for 2004 and 2005, but given the huge projected Federal budget deficits, it will be extremely difficult to enact legislation in the future to prevent the reimbursement "cliff" that will be caused if the House bill becomes law.

Minimal Adjustments to Reflect Higher Malpractice Insurance Costs Proposed

Despite organized neurosurgery's continued pressure on CMS to make significant changes in the malpractice relative value units to reflect the recent steep increases in professional liability

insurance (PLI) premiums, CMS only proposed minor modifications. Furthermore, the changes that they do propose are essentially budget neutral, so neurosurgeons will hardly notice them.

Medicare physician payments for PLI are determined partly by relative value units and partly by other elements of the fee schedule. Recall that payments for each service are based upon three factors:

- Relative value units (RVUs) for each service, reflecting the relative amount of physician work effort, practice expenses, and PLI expenses involved with furnishing each service (under the current fee schedule, the PLI component represents 3.2% of total fee schedule dollars and work and practice expense account for 52.6% and 44.2%, respectively);
- A dollar conversion factor that translates these RVUs into monetary payment amounts; and
- Geographic practice cost indexes (GPCIs) for physician work, practice expenses, and malpractice insurance expenses to reflect differences in physician practice costs among geographic areas.

All three of these factors affect the total payment amount for a service, and there is a PLI element in each of these factors.

With respect to the RVU factor, CMS has proposed increasing the amount of money allocated to the PLI dollar pool to a whopping 3.8%. To do this, however, it must rob Peter to pay Paul, and therefore has proposed reducing the work pool to 52.5% and the practice expense pool to 43.7%. Based on CNS and AANS data, PLI costs represent from between 7% to 15% of total physician practice income, so these changes will not even come close to representing neurosurgeons' real PLI costs. Furthermore, CMS has also not updated the PLI RVUs themselves, so this proposed change will do nothing to account for the increases that neurosurgeons are seeing in their PLI costs. CMS last revised the PLI RVUs in 2001 and by law they do not have to be updated again until 2006.

CMS has also proposed modest changes to conversion factor formula to reflect changes in the Medicare Economic Index (MEI). The MEI, which measure medical inflation, is a key element of the SGR system. This element of the regulation is highly technical and complex, but essentially according to the proposal, CMS will use more current pricing and cost data (2000 data versus the current 1996 data) to more accurately measure the costs associated with physician earnings, practice expenses, and PLI expenses. The same ratio as stated above will be employed, and PLI costs will account for a higher percentage (3.8% versus 3.2%) of costs associated with the medical inflation index. Given the fact that this percent-

President's Message

Continued from page 1

- Section (Ali Rezai); and Neurostimulation for Pain—Pain Section (Jamie Henderson)
- Membership and active role in the NIH Brain Attack Coalition, a multidisciplinary specialty group addressing critical issues of stroke and cerebrovascular disease at the national/NIH level (Michael Cawley)
 - Development of support for the Lumbar Spinal Stenosis Study, the Spine Section, AANS/CNS response to the threat of the SPORT study (Paul McCormick)
 - Collaborative development and commitment to a multiorganizational coalition to bring reform to the Professional Liability Insurance crisis (Vincent Traynelis and the AANS/CNS Washington Committee)
 - Development of SANS-Wired, a self-assessment examination for neurosurgeons to be used as a component of American Board of Neurological Surgery recertification examination and maintenance of competence (MOC) (Tony Asher, Editor and Chairman)
 - Further artistic and scientific growth and acclaim for our official journal, *NEUROSURGERY*, including the number one citation index within our specialty (Michael L. J. Apuzzo, Editor)
 - Refinement and expanded services, and efficiency of our central office and staff (eight FTEs for over 5200 members!) (Laurie Behncke, Executive Director)
 - Redevelopment, remodeling, multiple upgrades to the official CNS Web site (Ali Rezai and Joel MacDonald)
 - Expansion, updates to the CNS World Directory of Neurological Surgeons (Paul Grabb, Joel MacDonald, and Richard Perrin)
 - Development of the CNS Educational and Fellowship Endowment Fund (Douglas Kondziolka)
 - Recertification of our organization by the ACCME (Chris Wolfla and Greg Thompson)
 - Restructuring of *Neurosurgery News*, the official newsletter of the CNS (Greg Thompson and Karin Muraszko)
 - Creation and promotion of an outstanding CNS 2003 Annual Meeting in Denver (Nelson Oyesiku, Joel MacDonald, and Laurie Behncke)

We have much for which to be proud. Many thanks to the remarkably talented and vigorous men and women elected and appointed to the CNS Executive Committee for your incredible energy, commitment, creativity, and voluntary contributions.

I leave the leadership position of the CNS in the very good hands of Presi-

dent-Elect, Vincent C. Traynelis, M.D., and I look forward to seeing the organization continue to thrive under his very capable leadership.

To the many colleagues and friends (domestic and international) that I have been fortunate to have made over the years, it indeed has been a pleasure and an honor to have been invited to serve with you and for you.

Executive Director

Continued from page 1

ipated online educational tool with multimedia-rich questions covering the full spectrum of neurosurgical practice. For the first time ever, SANS Wired users are able to test their knowledge and prepare for the written boards, while receiving CME credit online.

(Please refer to our SANS Wired 2004 advertisement in this issue for more information.)

Each year, the CNS places primary emphasis on the production of its Annual Meeting—making it the premiere educational and scientific event that you cannot afford to miss! The 2003 Annual Meeting is better than

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Integra Neurosciences p/up September 2003 Neurosurgery 4/c

Executive Director

Continued from page 1

ever—an educational and scientific experience not to be beat. Dr. Joel MacDonald and Dr. Nelson Oyesiku worked nonstop along with members of the Annual Meeting and Scientific Program Committees to bring you and your spouse and guests the most exciting scientific, exhibition, and social program ever here in Denver.

Dr. MacDonald and Dr. Oyesiku directed a Scientific Program that encompasses over 635 experts in the field of neurosurgery, including over 80 international faculty participating in sessions, courses, seminars, and our new video symposia. Onsite registration for the meeting and all events is available at the Colorado Convention Center beginning at 7:00 a.m., October 18. This meeting offers 25 CME hours, the most ever at an Annual Meeting, and the opportunity to earn 15 additional CME hours through optional educational programs.

Chairman Paul Grabb, Information and Technology Committee, has supported the ongoing efforts of Dr. Ali Rezai, Web Editor, and former Web Editor, Dr. Joel MacDonald as our Web site, www.neurosurgeon.org, is reengineered. New design features are being introduced to make our site even more efficient and resourceful for you in the future. If you are interested in a sneak preview of what's in store, go to www.neurosurgeon.org. Be sure to visit www.neurosurgeon.org often, because new exciting and inventive features are being added through the fall.

We couldn't be more proud of the ongoing efforts of the multitude of CNS volunteers who make meaningful contributions to the future of neurosurgical practice. As all CNS members experience the benefits of the value of volunteerism, we encourage you to continue to support the CNS by participating in its new programs. We hope each of you enjoy Denver and the CNS Annual Meeting.

If you would like more information on how to become a CNS volunteer, please contact the CNS Secretary, Dr. Gerald Rodts at gerald_rodts@emoryhealthcare.org or the CNS Headquarters at 847-240-2500, toll-free 877-517-1CNS (1267), or info@1cns.org. □

Washington Committee

Continued from page 2

age is still a small factor in the overall inflation formula, the impact of this proposed change will have little or no real effect on neurosurgeons' reimbursement.

Finally, CMS is proposing to update the current geographic practice costs indices (GPCIs) to better reflect regional PLI cost changes. Unfortunately, the proposed regulation did not provide any details because CMS is still in the

process of collecting PLI premium data. Hopefully, these changes will account for the steep PLI premium increases that neurosurgeons have experienced in the various "crisis" states, such as Pennsylvania, Florida, Illinois, Mississippi, Nevada, North Carolina, Missouri, Texas, and others. Once again, however, these revisions are made in a budget neutral manner, so increases to one geographic location, mean decreases in another. CMS has pledged to use the most recent PLI cost data available for making these changes, proposing to use premium information for 2001–2002, and if possible it will include some trend data for 2003.

CMS Approves Neurosurgery's Recommendations for Practice Expenses

Thanks to the hard work of Jaimie Metcalf, M.D. (member of the AANS/CNS Coding and Reimbursement Committee), neurosurgery scored a victory in negotiations related to

changes in the practice expense component of the fee schedule. Over the past several years, neurosurgery has been working to refine the practice expense RVUs to better reflect the actual costs of neurosurgical practice. One element of this involves determining the values of clinical staff. Through his efforts on the AMA's Practice Expense Advisory Committee (PEAC), Dr. Metcalf was able to obtain additional money to be allocated to this category of expense. In the proposed rule, CMS has indicated that it will accept the changes recommended by the PEAC. While this will not dramatically increase neurosurgeons' practice expense values, every little bit counts!

Proposed Reimbursement Rates Similar to 1992

It comes as no surprise to neurosurgeons that reimbursement rates have been steadily declining over the past years. What is startling, however, is how similar the proposed 2004 rates are to

those in 1992 when the Medicare adopted the Resource Based Relative Value System (RBRVS). Clearly, the biggest losses occurred when Congress eliminated the separate surgical conversion factor in 1998 and new practice expense values were established. Clearly payments are not keeping pace with medical inflation, and if Congress fails to change the manner in which Medicare reimburses physicians, these negative trends will continue into the future. The following chart highlights payment rates for many common neurosurgical services since the inception of the RBRVS.

Getting More Information

The proposed regulation can be found at: <http://www.cms.hhs.gov/providerupdate/newregs.asp>. Once here, scroll down to "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004." The rule is available in PDF format in six parts (due to its size). □

National Medicare Payment Rates¹

CPT Code	Procedure Description	1992	1997	1998	1999	2000	2001	2002	2003	CMS Estimate 2004 ²	House Bill 2004 ³
22554	Ant cerv fusion	\$1,354	\$1,662	\$1,539	\$1,416	\$1,450	\$1,443	\$1,306	\$1,352	\$1,223	\$1,296
22612	Lumbar post-lat fusion	1,255	1,801	1,648	1,533	1,549	1,582	1,449	1,421	1,362	1,443
22630	PLIF	1,389	1,705	1,557	1,464	1,526	1,579	1,471	1,421	1,355	1,436
22842	Lumbar pedicle screws	1,414	842	754	724	779	825	776	784	750	795
22845	Ant cerv instrumentation	1,138	761	682	668	766	828	744	751	719	762
22851	Intervert biomech device	N/A	580	520	484	499	511	411	415	363	420
35301	Carotid endarterectomy	1,093	1,436	1,320	1,220	1,236	1,228	1,061	1,074	1,037	1,099
61107	Twist drill- ventric	540	485	431	391	383	377	331	346	332	323
61154	Burr hole for SDH	1,087	1,411	1,275	1,160	1,159	1,132	994	1,020	977	1,035
61312	Crani for subdural	1,605	2,065	1,950	1,787	1,820	1,792	1,598	1,654	1,584	1,678
61313	Crani for ICH	1,600	2,086	1,957	1,800	1,836	1,815	1,620	1,662	1,591	1,686
61510	Craniotomy for tumor	1,807	2,405	2,216	2,040	2,085	2,058	1,840	1,892	1,813	1,921
61512	Crani for meningioma	1,913	2,778	2,546	2,369	2,480	2,486	2,259	2,315	2,206	2,337
61700	Craniotomy for aneurysm	2,358	3,509	3,224	3,059	3,359	3,448	3,226	3,287	3,148	3,336
61751	Stereotactic biopsy	1,311	1,660	1,520	1,376	1,354	1,320	1,162	1,175	1,142	1,210
61793	Radiosurgery	1,307	1,639	1,400	1,290	1,326	1,303	1,152	1,165	1,103	1,169
61795	Intraop frameless stereotaxis	246	444	368	331	305	292	253	255	244	259
62223	VP shunt	1,044	1,285	1,103	1,004	997	981	868	881	846	896
62230	Shunt revision	698	875	814	754	778	775	690	731	683	724
62362	Programmable pump implant	N/A	443	425	408	430	456	433	440	436	425
63030	Lumbar discectomy	966	1,205	1,028	946	950	957	874	844	802	850
63042	Recurrent lumbar disc	1,461	1,763	1,507	1,376	1,348	1,349	1,214	1,188	1,132	1,199
63047	Lumbar laminectomy	1,408	1,408	1,290	1,177	1,136	1,143	1,037	1,010	961	1,018
63075	Ant cerv discectomy	1,126	1,609	1,475	1,373	1,431	1,455	1,338	1,312	1,250	1,324
63081	Ant cerv corpectomy	1,685	2,164	1,993	1,824	1,833	1,818	1,624	1,581	1,508	1,597
63650	Perc epidural dorsal column stim	596	647	597	524	463	439	369	374	371	393
64718	Ulnar nerve transposition	435	546	503	469	464	475	440	447	461	488
64721	Carpal tunnel	317	398	361	349	361	397	399	387	357	378
99243	Office Consultation	81	94	102	103	117	118	116	117	114	121
	National Conversion Factor	\$31.00	\$40.96(s)	\$36.69	\$34.73	\$36.61	\$38.26	\$36.20	\$36.78	\$35.24	\$37.34
			\$33.85 (ns)								

¹ All figures are based on the total relative value units (RVUs) for each service multiplied by the national conversion factor. National rates are modified by geographic practice cost indices (GPCIs), which take into account geographic cost differences in providing physician services. Thus, neurosurgeons' reimbursement rates will differ depending on where they live.

² CMS estimated reimbursement rates for 2004 may change when the final fee schedule regulation is published in November 2003.

³ Estimates based on a 1.5% increase in the 2004 conversion factor should the provisions contained in H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003, become law.

The 2003 CNS Annual Meeting Committee Report

Joel D. MacDonald, M.D.
2003 CNS Annual Meeting Chairman



The primary mission of the Congress of Neurological Surgeons is to promote the advancement of neurosurgery through education.

Nothing our organization does supports this aspect of the mission as significantly or in as grand a scope as the Annual Meeting. This year's meeting, our 53rd in succession, to be held in Denver, October 18-23, 2003, promises to be a spectacular educational opportunity with unparalleled scientific content and innovation.

Dr. Nelson Oyesiku, the 2003 Scientific Program Chairman, has carefully woven a program that will take participants on a journey beginning with the fundamentals of neurosurgical practice and the scientific foundations of our clinical work through technological innovations and contemporary clinical controversies in neurosurgery. The competition this year for scientific abstracts to be presented in the Open Program was quite stiff and the quality shows. Over 600 abstracts were selected either for oral presentations, oral poster presentations, or posters. The total available Category I CME credits (25 hours) will be greater this year than any prior CNS Annual Meeting.

Each day of the meeting promises a unique experience, but I am personally most excited about Wednesday, October 22. This is the "Innovations in Technique and Technology" day. General Scientific Session III is linked to an expanded Exhibit Hall lunch/technology experience and is further linked to Special Course III on Wednesday afternoon. This entire day is devoted to innovations in technique and technology and their relationship to contemporary neurosurgical practice. An entirely new paradigm for neurosurgeon/exhibitor interface and marketing will be unveiled called the "OR/ICU/Office of the Future." This interactive session will take place in the Exhibit Hall and will enlist our corporate exhibitors and vendors. The idea is to educate and market their state of the art neurosurgical products in the familiar (to the neurosurgeon) environment in which they will be utilized (i.e., the OR, the ICU, or in the office). Two hours of unopposed time will be devoted to this activity, so that meeting participants may focus their attention on this unique marketing strategy without missing out on other valuable educational experiences. Finally, Wednesday will also host an entire afternoon symposium devoted to a new, contemporary form of adult learning: "The Digital Masters Series Sympo-

sium." These contemporary video presentations will feature noted neuro-surgical experts from around the world. Each "Master" presenter will emphasize a particular operative procedure or technique in a brief 10-minute digital movie. Each will be present to narrate

their digital video presentation. Participants will not only see these great surgeons in action, but will also have an opportunity for discussion.

The Congress of Neurological Surgeons will honor a distinguished leader within modern neurological surgery as the 2003 CNS Honored Guest. Dr. Julian T. Hoff, the Richard C. Schneider Professor and Chairman of the Department of Neurosurgery at the University of

Michigan, has shaped the course of modern neurosurgery as an academic physician for over 30 years. He will deliver three featured lectures throughout the course of the meeting.

A series of featured speakers will both enlighten and entertain. Roberta L. Bondar, M.D., Ph.D. will deliver the Fourth Annual Walter Dandy Distin-

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Meet the Officers: President Mark Hadley

Dan Barrow, M.D.

Mark Norman Hadley, the 53rd President of the Congress of Neurological Surgeons, was born and raised in Napa, California, one of three children of Jack and Marie Hadley. Mark was active in sports, scholastics, and student government through high school. He served as Student Body President his senior year, was class Salutatorian, and was nationally ranked in the boy's mile and half-mile runs. He was a National Merit Scholar and accepted a 4-year academic and track scholarship to Stanford University in 1974. Mark graduated from Stanford in 1978 with a B.A. in Economics and was a 4-year varsity letterman. He began his medical education at Albany Medical College in upstate New York in the summer of 1978, where he was profoundly influenced by John Popp, M.D., Professor of Surgery and Neurosurgery. Mark received his M.D. degree in 1982.

Dr. Hadley completed his general surgery internship at the University of California under F. William Blaisdale, M.D., and began his postgraduate neurosurgical training in 1983 at the Barrow Neurological Institute in Phoenix, Arizona, under mentors Robert F. Spetzler, M.D., Volker K. H. Sonntag, M.D., Andrew E. Shetter, M.D., John R.

Green, M.D., and others. Mark was one of the most prolific residents of his era, obtaining \$1.3 million in research grants, publishing 52 scientific articles, and winning four major resident awards, including the inaugural Mayfield Award. Upon graduation in 1988, Dr. Hadley served 3 years as a neurosurgeon in the United States Air Force. In 1991, Dr. Hadley accepted the position of Assistant Professor of Neurological Surgery under Richard B. Morawetz, M.D., at the University of Alabama at Birmingham. His main areas of clinical and scientific interest are disorders of the spine and spinal cord. He was promoted to Associate Professor in 1993 and Professor in 1997. He has been actively involved in medical student, resident, and fellow education at UAB and has served as the Director of Resident and Medical Student Education, and continues in his roles as the Director of the Neurological Surgery Residency Training program and Director of the Neurological Surgery Spine Fellowship program. He is the Medical Director of an active regional Think First injury prevention program and has served as Team Physician to the University of Alabama and the University of Alabama at Birmingham athletic programs.

Dr. Hadley has authored over 150 scientific articles and chapters in medical textbooks. He has authored or edited



The Hadleys (left to right): Mollie, Mark, Jack, Lori, and Christopher (back).

several neurosurgical compilations, including *Self Assessment for Neurological Surgeons (SANS) VI* for the AANS and CNS in 1997, multiple educational videotapes, Video Perspectives in Neurological Surgery, and most recently, the comprehensive *Guidelines for the Management of Acute Cervical Spine and Spinal Cord Injuries* published as a supplement to *NEUROSURGERY* (1999–present). He has been a visiting professor at major universities throughout the United States and has received a variety of honors, including selection by his peers among America's Top Doctors, 2001 and 2002.

Dr. Hadley has been active in organized neurosurgery since his residency training. He has served on the Executive Committee of the Congress of Neurological Surgeons (1994–present) and of the AANCS/CNS Section on Disorders of the Spine and Peripheral Nerves (1992–1999). He has served as the Secretary of the CNS (1997–2000), as CNS Vice President (2001), President-Elect (2002), and is currently the President. He has also served as a

member of the AANS/CNS Washington Committee (2001–present).

Dr. Hadley is a dedicated, and fortunate, husband and father. He and his lovely wife, Lori Frances Hadley, live in Birmingham with sons Christopher (14), Jack (7), and daughter Mollie (4), and dog Bucky. Mark and Lori run a busy but haphazard “multiple children to different activities” shuttle service and are band, ballet, math team, track, soccer, basketball, baseball, tennis, and golf enthusiasts. In their spare time they enjoy the beaches of the Destin-Seaside area of Florida (Lori's birthplace and site of Mark and Lori's marriage) and are active in the Birmingham community and in the Episcopal Church.

Mark will be joined at this year's Annual Meeting by his many neurosurgeon and scientist friends and colleagues, former residents and fellows, and his partners in practice at UAB. His older sister, Karen, younger brother Paul, his immediate family (Lori, Christopher, Jack, and Mollie), and Lori's parents will also be there. □



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in
Neuroscience for Neurosurgeons

RUNN 2003 November 9–16th

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Co-directors
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Catherine Awad
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Cherry Hills Village, CO 80110
Phone: (303) 806-0777
Fax: (303) 806-0712
Email: caawad@mac.com

Visit the RUNN web site at <http://www.societyns.org>

CNS Annual Meeting

Continued from page 5

guished Oration. Dr. Bondar is a noted neurologist, NASA scientist, astronaut, environmentalist, and photographer. 2003 CNS President Mark N. Hadley, M.D., will culminate his outstanding year of leadership at this year's meeting. His Presidential Address, “The Value of Neurosurgery” will be delivered on Monday morning, October 20, at 11:30 am. John W. McDonald III, M.D., Ph.D., who is the Director of the Spinal Cord Injury Program at the Washington University School of Medicine in St. Louis, Missouri, will review various strategies for repair of the damaged spinal cord. Dr. Andres Lozano will present a timely lecture discussing the role of nervous system stimulation for restoring and optimizing function. President-Elect of the Congress, Dr. Vincent Traynelis, will review the current status of the professional liability crisis and update the membership on

the efforts on the Congress of Neurological Surgeons, in conjunction with coalition members, to address these issues.

The Mile High City of Denver, Colorado offers a wide spectrum of recreational and cultural activities. The nearby Rocky Mountains provide world-class mountain biking, hiking, fishing, and golf for those who are outdoor enthusiasts. The city itself offers a rich diversity of cultural venues ranging from the Performing Arts Complex, art and history museums, to the Colorado Ocean Journal Aquarium. There are numerous world-class restaurants and, of course, major professional sports arenas.

The 2003 Annual Meeting of the Congress of Neurological Surgeons will be a unique and memorable educational experience. I appreciate the opportunity and honor to have been allowed to lead the team that put it together. I look forward to seeing you in Denver! □

CNS OR/ICU of the Future

new 4/c

Introducing Denver...

Michael H. Handler M.D., F.A.C.S., F.A.A.P.

Associate Professor, Department of Neurosurgery
University of Colorado Health Sciences Center, and The Children's Hospital
Denver, Colorado



As Local Arrangements Chairman, I would like to introduce all of you to Denver, the site of our annual meeting this year, and to share my enthusiasm for this wonderful city.

Contrary to popular belief, Denver is not in the mountains; it sits at the high, rolling western edge of the Great Plains. The "Foothills" (a gentle series of peaks ranging from 7,000 to 11,000 feet high) start to rise 15 miles west of the city, and slightly beyond that is the Continental Divide and a series of peaks soaring to heights of 14,000 feet, the "Front Range." Although considered "Western" in character (though I can assure you it's not a cow-town anymore!), Denver is actually located in the middle of the country, 346 miles west of the exact center of the continental United States. Our nickname is the "Mile High City," as the altitude of much of the city is 5,280 feet above sea level, marked at any number of spots around town. The City and County of Denver has a population of 510,000 and the six-county metro area has a population of 2.3 million; our population has increased by 23% since 1990. Denver is the 20th largest metro area in America, and has the 10th largest downtown area.

Denver is a clean, young, and green city with over 200 parks and dozens of tree-lined boulevards. The architecture reflects the city's three boom periods: Victorian, when silver was discovered in Leadville; turn-of-the-century, when gold was discovered in Cripple Creek; and contemporary, when the energy boom added 16 skyscrapers to the downtown skyline in a 3-year period, 1980-1983.

Unlike some Western cities, Denver has a pedestrian-friendly central downtown area. Here, within easy walking distance, are the city's convention complex and hotels, performing arts complex, and a wide variety of shops, department stores, restaurants, and nightspots. A mile-long pedestrian mall cuts through the heart of downtown Denver and is surrounded by a series of parks and plazas that soften the towering skyscrapers and provide viewpoints from which to see and appreciate the modern architecture.

Lower Downtown (called "LoDo" by locals) is on the northern edge of downtown, an easy walk from the hotels, and offers one of the nation's greatest con-

centrations of Victorian buildings and warehouses, many of which have been refurbished to house restaurants, art galleries, offices, and shops. This is the center of the city's brew pubs, with six large brew pubs and micro breweries, each brewing six to eight exclusive beers, all within easy walking distance of each other.

Located just east of a high mountain barrier and a long distance from any moisture source, Denver has a mild, dry, and arid climate. It records 300 days of sunshine a year—more annual hours of sun than San Diego or Miami Beach. In October, the weather on a given day can be variable. We can expect cool nights and generally warm, mild, pleasant days. It will still be early to expect snow. Fall is a particularly delightful time to visit the city and make day excursions to the mountains to view the colorful changing of the aspen trees, which usually takes place from mid-September until mid-October.

Denver has some of the finest museums in the West, with a wide variety of historical, western, artistic, and horticultural themes. The Denver Art Museum, the Colorado History Museum, the State Capitol, and the Denver Mint are easy walks from the downtown hotels, and the Museum of Nature and Science and the Denver Zoo (consistently rated one of the top 10 in the country) are a short cab ride away.

With nine theaters offering 10,800 seats, the Denver Performing Arts Complex is the second largest performing arts center in the nation (after Lincoln Center in New York) in seating capacity and the largest in the world under one roof. The center is entered under a block-long glass arch and is noted for its unusual and striking architecture. The Denver Center Theater Company won a Tony Award in 1998 for best regional theatre acting company.

Denver, with 300 days of sunshine a year, is a sports capital. The city offers over 450 miles of paved, designated bike paths, including two beautiful stretches through downtown along Cherry Creek and along the South Platte River. There are over 70 golf courses in the area, which stay open year-round, and more than 143 free tennis courts. The course for our Think First Golf outing, on Sunday October 19th, will be the Ridge at Castle Pines, the #1 upscale public facility in Colorado. It is consistently rated one of the "must-play" courses by golf magazines.

Sadly, it appears that Denver will not be hosting the World Series, so Coors field—home of the Colorado Rockies—will be closed during our meeting, though it is an easy walk from the hotels. The Pepsi Center, home of the Avalanche and Nuggets, is also close by. Invesco Field at Mile High, home of the Broncos, is a short ride from downtown as well.



Downtown Denver and the Rockies' "Front Ranges."



Denver has the 10th largest downtown in the country.

Within an hour and a half drive from Denver, there are opportunities for skiing, river running, hiking, fishing, camping, horseback riding, sailing, or mountain biking. Half of Colorado is public land open to all forms of recreation, with two national parks, six national monuments, 11 national forests, three national recreation areas, and 30 state parks.

There are any number of easy excursions into the mountains from Denver. Golden Gate State Park offers wonderful hiking only a half-hour out of town. Central City and Black Hawk, located 34 miles west of Denver, are two historic old mining towns from the 1870s that have come alive with limited

Continued on page 12



Colorado State Capitol.

2003–2004 CNS Fellowship Award Winners

Paul Camarata, M.D.

In keeping with the CNS's mission of education, the CNS funds over \$150,000 of fellowships annually, helping young neurosurgeons to enhance their skills through additional training in a particular field. In addition to our four CNS International Fellows, there are seven other new CNS fellows whose proposals were selected from a stellar group of applicants. Together with our corporate sponsors Depuy/Acromed and Elekta, the CNS



Deepa Soni



Josh Medow



Samir Lapsiwala

is proud to announce the winners of the 2003–2004 CNS fellowships (see sidebar on page 10).

Beginning with this issue, we will profile several of the fellowship recipients, beginning with the winners of the CNS

Cushing and Dandy Clinical Fellowships. The CNS Cushing and Dandy Fellowships are meant to help facilitate the acquisition of clinical skills and knowledge at an institution outside of the primary training program and may be used to provide in-depth clinical and surgical experience in a subspecialty area.

It is written by that "A journey of a thousand miles must begin with a single

step," (Lau-Tzu). And it is with the aid of the CNS Dandy Fellowship that Boston resident **Dr. Deepa Soni** will begin her in-depth study of tumor biology and epidemiology by traveling some 10,000 miles and studying with Professor Andrew Kaye at the Royal Melbourne Hospital in Melbourne, Australia. Dr. Soni obtained her Bachelors degree at the University of Michi-

Continued on page 10

J&J Advanced Wound Care 4/c New

Fellowships

Continued from page 9

gan in Cellular and Molecular Biology, but not without a generous exposure to the liberal arts, with a minor in French. After completing her M.D. at Howard University College of Medicine, she entered an Internship in General Surgery at the Brigham and Women's Hospital/The Children's Hospital in

Boston, followed by entry into the neurosurgical training program there. She has also completed the Program in Clinical Effectiveness at the Harvard School of Public Health, and a Postdoctoral fellowship at the Children's Hospital/Harvard Medical School.

In addition to several publications, Dr. Soni has won numerous awards in neurosurgery, including the World Federation of Neurosurgeons Young Neuro-

surgeon's Award, the Women In Neurosurgery Award for best manuscript, and the American College of Surgeons Trauma Section national award for best manuscript/presentation. Her research experience has taken her to the Centre Hospitalier St. Anne in Paris to study the neuropathological features of a proposed new class of brain tumors, in addition to studying with a number of other mentors dating back to her undergraduate days.



Elizabeth Tyler-Kabara



Vishal Gala

J&J Advanced Wound Care K New

2003–2004 CNS Fellowship Award Winners

CNS Cushing Fellowship:
Dr. Aurangzeb Nagy

CNS Dandy Fellowship :
Dr. Deepa Soni

CNS Margot Anderson
Foundation Fellowship in Brain
Restoration Research:
Dr. Elizabeth Tyler-Kabara

CNS Wilder Penfield Clinical
Investigation Fellowship:
Dr. Vishal Gala

CNS/DePuy AcroMed Fellowship
in Spinal Neurosurgery:
Dr. Samir Lapsiwala

CNS Clinical Fellowship in
Syringomyelia
and Chiari Malformation
Dr. Joshua Medow

CNS Elekta Clinical Fellow in
Radiosurgery:
Dr. Gyorgy Szeifert

CNS Lars Leksell International Fellow:
Dr. Khaled Mohamed El-Sayed

CNS George Ablin International Fellow:
Dr. Foad Elahi

CNS George Ablin International Fellow:
Dr. Rezeki Sembiring

CNS Kenichiro Sugita International
Fellow:
Dr. Raul Falero

CNS Meeting ad
new
4/c

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.

Robert Adams
David Adler
Ayman AL-Shayji
Gregory Balturshot
Robert Bohinski
John Campbell
John Cifelli
Arlindo D'Avilia
Bret A. Dirks
John Dorman
Bernardete Ethan
Gregory Foltz
James Forage
Benjamin Fulmer
Bassam Hadi
Odette Harris
Frank Hsu
Mazhar Husain
Robert Ingraham

Omar Jimenez
Jonathan Friedman
Wayel Kaakaji
Maciej Lesniak
Lawrence Liu
Samuel Macomson
Edison McDaniels
Carter E. Morris
Graham Mouw
Peter Nakaji
Raza Nasir
Greg Olavarria
Joel T. Patterson
Brian Payne
Kresimir Rotim
Kevin Stevenson
Richard Stovall
Najeeb Thomas
Junichi Yamamoto

Introducing Denver

Continued from page 8

stakes casino gambling. Georgetown is a delightful Victorian village with 200 restored buildings from the 1870s set in a spectacular mountain valley. Pikes Peak, 14,000 feet high, is located 60 miles south of Denver and features more than 40 attractions centered around it. Things to see there include the Air Force Academy, the famous Broadmoor Resort with its lake and three golf courses, the Pro Rodeo Hall of Fame with its exhibits, and Garden of the Gods, which has gigantic 500-foot high red sandstone rock monuments in a spectacular setting at the base of Pikes Peak. Rocky Mountain National Park is located 71 miles northwest of Denver and features 400 square miles of scenic beauty, including Trail Ridge Road, the highest continuous highway in the world crossing the Continental Divide at over 2 miles above sea level. The park has two information centers, hundreds of miles of hiking trails, tranquil lakes, waterfalls, wildlife, and horseback riding.

Of course, you are coming here for the spectacular scientific presentation our committee has organized, but Denver will provide any number of exciting ways to spend time when you need to get away from the meeting for a while. My wife Wendy and I look forward to welcoming you all to town. □

Fellowships

Continued from page 10

Although her residency keeps her quite busy, her plate is full of a number of extracurricular activities, including volunteering as an Adult Literacy Teacher in Boston. She enjoys chess, traveling, and dancing, and in the little time remaining in her busy schedule, she satisfies her musical interests in singing and playing the clarinet.

Dr. Soni's interest in brain tumor biology has been nurtured throughout her undergraduate and graduate medical career. Before applying for the CNS Dandy Clinical Fellowship, she contacted many former fellows to learn of their experiences. Because of Dr. Kaye's renowned expertise in the field of neurooncology and his broad clinical experience, she opted to pursue training opportunities with him in Melbourne. "Although great scientist and clinicians can be found all over the world, a person who sincerely believes in all aspects of studying a disease and has actually implemented that practice is the type of mentor who could really shape my future career," she remarks.

A description of the fellowships offered by the CNS can be found at the CNS Web site at <http://www.neurosurgon.org>.

In the next *Neurosurgery News*, we will profile the CNS Cushing Clinical Fellowship winner, Dr. Aury Nagy, as well as the International Fellows. □

RESIDENT CORNER

Resident Membership in the CNS

Kristen Riley, M.D.

As Resident Members of the Congress of Neurological Surgeons, neurosurgical residents enjoy a variety of professional, academic, and personal benefits. Resident members receive a free annual subscription to the official journal of the CNS, *NEUROSURGERY*. This outstanding value is provided through generous corporate support from Johnson & Johnson Codman, DePuy, Inc. CNS Resident Members also receive the bimonthly newsletter, *Neurosurgery News*, and the annual meeting summary book, *Clinical Neurosurgery*. Additional educational materials created by the CNS include the *Medical Student Curriculum for Neurosurgery* and the *Resident Curriculum Guidelines for Neurosurgery*, both of which provide didactic strategies for learning and training in neurosurgery. These sets of guidelines can be found on line at the CNS Web site. The soon to be released Self Assessment for Neurological Surgery (SANS), will offer the most comprehensive, up-to-date, and pertinent collection of review questions applicable not only to the written board examination, but also for recertification by the American Board of Neurological Surgery. These educational tools represent but a few of the outstanding

educational products the CNS has developed.

In addition to discounted registration fees, *free* housing is offered at the annual meeting, and Resident Members receive complimentary tickets to the opening reception and to the Resident Honored Guest Luncheon. This year's 53rd Annual Meeting in Denver promises to showcase the most current and contemporary science of our discipline and the newest and most exciting technological advances in our field. Don't miss the opportunity to visit the Exhibitors' Hall. You will have an opportunity to participate in a hands-on demonstration within the Operating Room/ICU of the Future, a new marketing and exhibiting paradigm that allows neurosurgeons to use instruments and technology in their true-to-form, lifelike setting.

The new CNS Web site offers links to all CNS activities and programs, including a newly developed extensive image library and other resource materials. The Web site also houses the CNS Job Placement Center. This professional service provides links to neurosurgeons throughout the United States who are looking for colleagues to join their practices. In conjunction with Job Placement Services Committee, the CNS will be hosting a cocktail party at the Denver Annual Meeting to facilitate resident job search endeavors. We anticipate bringing together practicing neurosurgeons who are looking to add partners to their practices with senior level residents beginning their job

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Attention Neurosurgery Residents and Recruiters

If you are within 2-3 years of completing your residency, we would like to invite you to a Resident Recruitment Social at the Congress of Neurological Surgeons Annual Meeting in Denver. This first-time event aims to bring together practicing physicians who are looking to add partners/colleagues to their practice with newly trained Neurosurgeons.

If you are a recruiter or are looking to fill positions in your practice, please join us for an opportunity to meet young neurosurgeons who may fit your requirements.

We anticipate an informal gathering with the opportunity to become acquainted with Neurosurgeons across the country. Hopefully, this event will lead to future business partnerships for many of you. The Resident Recruitment Social is being coordinated in close conjunction with the CNS's Job Placement Service.

Please mark the date on your calendar and plan to attend in Denver!

Kristen Riley, M.D.

Chief Resident, Neurosurgery, University of AL-Birmingham
CNS Executive Committee, Chairman, Resident Committee

Michael Cawley, M.D.

Emory University
CNS Executive Committee, Chairman, Job Placement Service

The Resident Recruitment Social
Colorado Convention Center
Room A101

Tuesday, October 21, 2003; 5:30 pm-7:00 pm

RSVP by October 1 to info@1CNS.org or call 1-877-517-1CNS

A Year on the Board of American Medical Association

Peter Carmel, M.D.

Last year, I was elected to the AMA Board of Trustees. This election would not have been possible without the support of organized neurosurgery. The CNS, the AANS, and the CSNS all provided valuable financial support and important help from their staffs. Members of the Joint Officers, the CSNS, and the Society of Neurological Surgeons made direct phone calls to the AMA delegates, which was an unusual event in AMA elections. Many thanks to you all.

Work on the Board of Trustees has involved more time and much greater learning than I had imagined. The AMA is a \$260 million a year business, and in this age of Sarbanes/Oxley, even not-for-profit companies need to carefully monitor their employees, their finances, and their business conduct.

The AMA has committed \$3.1 million to the medical liability reform effort.

I have been appointed to the Audit and the Operations Committees of the Board. It has been necessary to read a great deal to acquire a grasp of the financial oversight responsibilities of a Trustee. Both the external auditors and the Chief Financial Officer of the AMA have been patient in trying to give us nonbusiness types the financial principles needed to objectively look at the operations of the organization. Because of a number of highly publicized AMA incidents over the last 10 years, the Trustees are deeply aware of the need to adequately supervise the operations of the organization without micro-managing.

Medical liability reform has been designated by the House of Delegates as the number one legislative priority of the AMA. The Board Chairman asked me to head a Task Force on Medical Liability Reform and assigned four members of the House of Delegates to the Task Force. I received permission to enlarge the Task Force and added three neurosurgeons, Roy Vandever, Stu Dunsker, and Ed Laws. Each of these individuals have strong experience with this issue, and liability reform is an important neurosurgical priority.

The AMA has committed \$3.1 million to the medical liability reform effort. The liability bill was introduced in the House of Representative by Jim Greenwood of Pennsylvania and was titled HR#5. (The single digit designation indicates that this is one of the Bush administrations highest priorities.) This bill passed the House of Representa-

tives by an even wider margin than a similar bill had in the 107th Congress.

The companion bill was introduced into the Senate by Senator Ensign of Nevada. Dr. Frist brought the bill to the Senate floor in early July on a proce-

dural vote for cloture. There were 49 votes for and 48 votes against this cloture motion. The bill will now be heard in committee and many discussions will go forward trying to develop a useful Senate version. Some senators still feel that the problem is not with sky-rocketing liability payments, but with the insurance industry. (This has been a major reeducation effort.) Some senators are concerned about the amount of the "cap" while others, on both sides

of the aisle, are talking about some exemption from the cap. Most exemptions would have the effect of removing the cap completely, and should be opposed. In visiting with a number of Senators, it is refreshing to know that they are both smart and well informed, even those who oppose us. There is an earnest effort taking place to create a bipartisan bill that would allow a win

Continued on page 17

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The Role of Self Assessment in an Evolving Health Care Environment: The Significance of the SANS Wired Project

**Anthony L. Asher, M.D.,
F.A.C.S.**

Editor, SANS Wired



Perpetual change, most notably the constant evolution of treatment paradigms, is an inherent quality of the practice of medicine. In light of this reality, physicians' organizations have long

recognized that on-going physician education is essential to in maintaining currency in medical knowledge and skills. Medical organizations have attempted to address the need for the development of quality instruction and periodic skills assessment following the completion of residency training in a variety of ways. First, multispecialty organizations such as the American Medical Association (AMA), with the assistance of groups providing independent oversight, such as the Accreditation Council for Continuing Medical Education (ACCME), have defined standards for the development of educational programs. The AMA Physician's Recognition Award program, introduced in 1968, provided the basis for the current continuing medical education (CME) credit system and is an excellent example of organized medicine's attempts to identify, develop, and promote standards for quality CME. Second, specialty organizations, such as the Congress of Neurological Surgeons and the American Association of Neurological Surgeons, have endeavored over the years to create a wide range of educational offerings that address multiple issues of importance related to patient care and general practice. Finally, specialty boards have attempted to measure physicians' assimilation of new knowledge and certify core competencies through periodic recertification examinations.

Despite the efforts of medical organizations to develop, as the AMA definition of CME states, "educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession," recent developments have given rise to expectations of greater physician accountability and optimization of care among the American public. In particular, two influential reports issued by the Quality of Health Care in America Committee of the Institute of Medicine (IOM) have dramatically changed the way health

care organizations are likely to assess the performance of individual providers and will unquestionably lead to a restructuring of educational programs in medicine.

The Institute of Medicine is a nonprofit organization and a component of the National Academies that was created to provide science-based advice on matters of medicine and health. The Quality of Health Care in America Committee's first report, issued in 1999, called attention to the prevalence of preventable medical errors in the United States and provided a comprehensive strategy for reducing such errors. Among the committee's recommendations was a call to raise performance standards and expectations for improvements in safety through the actions of oversight organizations and professional groups. The committee's second report, issued in 2001, recommends a sweeping redesign of the American health care system and provides overarching principles and specific directions for policy makers, health care leaders, clinicians, regulators, and purchasers of health care. In this report, all health care constituencies are challenged to improve the quality and accessibility of care. Of particular relevance to clinicians is the committee's recommendation that physicians demonstrate skill maintenance and verify performance on an ongoing basis through a process of "lifelong learning" and evaluation of competence. In the report, the definition of competence is expanded to include areas outside of traditional medical knowledge, including an understanding of health care systems and the optimization of communication skills. Throughout this document, an emphasis is made on the need for performance and outcome measurements focusing on improvement of care and accountability.

Certifying boards, which were created to provide assurance to the public that physicians with board certification have successfully completed educational programs and evaluation processes designed to assess the knowledge, skills, and experience required to provide quality patient care in specific specialties, took particular note of the IOM reports. In response to the increasing interest on the part of the public and governmental agencies in the requirement of greater oversight for physicians, The American Board of Medical Specialties (ABMS), an organization that oversees of 24 medical specialty boards, recently decided that all medical specialties should develop "Maintenance of Certification" programs to replace the current recertification initiatives. The Maintenance of Certification

(MOC) Program is to be broader in scope than previous recertification programs, because it will involve an assessment of a wide variety of parameters, not just cognitive knowledge and clinical skills. Specialty boards will have some freedom in terms of how MOC programs are developed. All MOC programs, however, must possess the following components: Evidence of Professional Standing (likely to include documentation of a full and unrestricted license to practice medicine), Evidence of Commitment to Lifelong Learning and Periodic Self-Assessment (i.e., specialty-specific CME programs and self-assessment devices), Evidence of Cognitive Expertise (passing secure examinations at standard time intervals), and Evidence of Evaluation of Practice Performance. The ABMS has determined that the lifelong learning and physician self-assessment will be integral parts of its Maintenance of Certification Program.

In 1999, the American Board of Neurological Surgery (ABNS) embarked on its own recertification program, awarding time-limited certificates that must be renewed every 10 years, conditional on passing a written examination of neurosurgical knowledge. Recently, the ABNS has begun to develop its own MOC program, based on guidelines developed by the ABMS. Unlike recertification, the MOC Program is an ongoing process in which a diplomate's credentials, licensures, and professional standing are verified, and practice-related knowledge and performance are evaluated. As in other specialty boards, the ABNS MOC program will be much more comprehensive than previous recertification efforts, and will involve maintenance and assessments of basic competencies throughout a 10-year cycle. The ABMS and the Accreditation Council for Graduate Medical Education have formulated and adopted the following six essential competencies for the practicing physician: 1) medical knowledge, 2) patient care, 3) interpersonal and communication skills, 4) professionalism, 5) practice-based learning and improvement, and 6) systems-based practice. All physician specialists will be required to develop these competencies during their medical education and residency training, to confirm them as part of initial certification, and to maintain them throughout their professional careers in practice. These core competencies will be assessed by the ABNS through the four required components of MOC, as defined by the ABMS and outlined above.

Part of the challenge of medical education systems will be the development of programs to help address the new requirements for MOC. In that regard, self-assessment devices are likely to be particularly valuable educational tools. Self-assessment devices have been used in a variety of disciplines as professional development aids. Formative uses of self-assessment focus on individual learning, particularly to reinforce behav-

ior change. These tools are typically designed to accomplish the following aims:

- Allow individuals to reflect on their own performance strengths and weaknesses in order to identify learning needs.
- Reinforce new skills or behaviors in order to improve performance.

Self-assessment is closely tied to the separate concept of self-learning, which is particularly important in medicine because clinicians must continually update their clinical knowledge base. Well-constructed self-assessment tools can accomplish the dual goal of self-assessment and self-learning, by allowing users to perform specific tasks and conduct a review of their performance, and then provide education in the areas where individual performance was weak.

Perhaps the best known example of self-assessment in medicine has been the very successful Surgical Education Self Assessment Program (SESAP) of the American College of Surgeons (ACS). Originally devised in 1972, SESAP consists of a series of questions on multiple surgical topics. Questions in SESAP are designed to reproduce the diagnostic and treatment challenges faced in the practice of surgery, thereby providing practicing surgeons an opportunity to stay abreast of current standards in surgical practice. The program is based on the opinions of expert surgeons and the published literature. The SESAP was designed with the belief that surgeons could educate themselves by reviewing the questions they answered incorrectly. By reviewing questions in multiple subspecialty areas, surgeons are also provided the opportunity to assess their understanding of various topics and clarify areas for improvement.

Organized neurosurgery also has a long history of developing successful self-assessment devices. The first attempt to have a self-assessment examination in neurosurgery was a joint effort with the ACS, and was modeled on the successful SESAP product. This effort, termed the Self Assessment in Neurological Surgery (SANS) proved to be well received, and the second version of SANS (SANS II) was developed entirely by the Joint Commission of Education of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. The SANS program was conceived through the energy and imagination of Drs. Robert King, John Tew, Stephen Mahaley, and Robert Ratcheson.

Planning for SANS II began in 1980 and was an overwhelming success when published after 3 years of preparation in 1983. Dr. Ratcheson was the Program Coordinator for SANS II, and the first SANS committee was comprised of Drs. Martin Camins, Paul Chapman, Robert Crowell, Grant Gauger, Julius Goodman, Alan Hudson, Joseph McFadden, Morris Ray, Hugo Rizzoli,

CNS ad
SANS
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new

B. J. MacPherson Becomes a Voice of Injury Prevention for ThinkFirst

P. David Adelson, M.D.

CNS Executive Committee, ThinkFirst Liaison



Christian Zimmerman, M.D., F.A.C.S., neurosurgeon and Chairman of the Board for the Idaho Neurological Institute, recently presented a significant

case study to an audience of ThinkFirst coordinators at the AANS national meeting held in San Diego in April 2003. The case study involved B.J.

MacPherson, former San Diego Gulls hockey player, who suffered a spinal cord injury during a playoff game in Boise on May 4, 2001, striking his head and neck on the ice. He was evaluated at the scene and found to be completely anesthetic, had flaccid paralysis of all four extremities, pinprick sensation at C4 level, no motor function distal to C4, and with significant neck pain. He was transported to Saint Alphonsus Hospital in Boise, where a CT scan and lateral C-spine films demonstrated C4-5 dislocation, bilateral jumped facets, and canal compromise. Dr. Zimmerman took B.J. immediately to the operating room in hopes of restor-

ing some neurological function. Intraoperatively, his spinal canal was decompressed and post-op, B.J. had return of sensation and some movement in his left foot. In the 2 years since his injury, B.J. has regained almost full sensation, movement and strength in his entire body. On March 9, 2003, B.J. skated in public at a San Diego Gulls home game. He circled the ice, stick in hand, for the first time since his injury. "I said that I would be back on this ice someday," said the former team captain, drawing a standing ovation from fans at the pre-game activities. "This is a goal that I'm finally reaching."

As a thank you to Dr. Zimmerman, and in the hopes of preventing children from suffering paralyzing injuries, B.J. will serve as a national VIP (Voice of Injury Prevention) spokesman for ThinkFirst. Dr. Zimmerman, who will serve as co-spokesman, will join him in his efforts to help outlying ThinkFirst

chapters form and garner support in the neurosurgery community for injury prevention education.

Every year more than 2.2 million people in North America suffer a traumatic brain injury. In addition, nearly 20,000 people suffer permanent paralysis as a result of injury to the spinal cord each year. Tragically, more than 100,000 people die each year as a result of brain and spinal cord injuries. The only cure? Education and prevention.

ThinkFirst is a nonprofit injury prevention education organization, founded in 1986 by the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS). There are 266 active ThinkFirst chapters in North America that educate more than 4.1 million students annually. The school-based curriculum focuses on five specific injury categories. They include cars and seat belts, bikes and helmets, water and diving, sports and recreation, and violence prevention.

For more information and news about the ThinkFirst/National Injury Prevention Foundation, visit the Web site at www.thinkfirst.org or contact CEO Dorothy Zirkle at 619-644-4661.

(As seen in the *Neurotransmitter*, Volume 1 Issue 2, Idaho Neurological Institute.) □

Resident Corner

Continued from page 12

searches. See the announcement on this page for the time and place of the Resident Recruitment Social.

One of the ways the CNS serves its primary mission of education is through numerous fellowships. Open to all residents, these competitive fellowships support diverse educational experiences for up to 1 year of specialized training. From pediatrics, spinal instrumentation, public policy in health care administration, and clinical trial administration to basic neuroscience research, the CNS offers a host of fellowship opportunities applicable to all neurosurgery residents.

Finally, the Congress is interested in issues facing neurosurgery residents. Medical malpractice insurance, coding dilemmas, and recertification are all topics we will encounter as we complete our residency programs. As current residents, work hour regulations are changing the way our training programs function and are organized. In order to assess the effect of work hour restrictions on neurosurgery residents, we are conducting a brief survey of active neurosurgical residents. If you are a resident, please take a few minutes to complete the survey found at <http://www.cans.hs.uab/survey.htm>.

Become a Resident Member of the Congress of Neurological Surgeons. It is a great value and a great opportunity. □

About Your Impact

Participating in this first-class event means you are directly contributing to:

- Development and distribution of education curricula for children and public awareness campaigns for adults to help prevent trauma injuries and acquired disabilities across the U.S.
- Promotion of an active advocacy agenda so our lawmakers hear the voice of the injury prevention community

You can register online @www.thinkfirst.org/golf. Or, you can mail this form with your check (payable to ThinkFirst) or charge information to: Radionics/Valleylab/CNS Golf Outing for ThinkFirst, 5550 Meadowbrook Drive, Suite 110, Rolling Meadows, IL 60008.

Name: _____
 Address: _____
 City: _____ State: _____ ZIP/Postal: _____
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Event Sign-Up	
Sign up for:	Price
<input type="checkbox"/> 1 Golfer	\$250
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<input type="checkbox"/> Continental Breakfast Sponsor (2 Foursomes & breakfast recognition)	\$5,000
<input type="checkbox"/> 19th Hole Sponsor (2 Foursomes & recognition at post golf reception)	\$5,000
<input type="checkbox"/> Other - provide a prize or a golfer gift package item, sponsor a contest - be creative! Or, you don't golf but wish to provide a gift to ThinkFirst. Support of any kind welcome. Description: _____	\$ _____
Total: _____	

My Foursomes (please provide additional names on another sheet of paper)

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 Please type your name to serve as a signature.
 Today's Date (mo/day/yr): _____ / _____ / _____

4th Annual Radionics/Valleylab/CNS Golf Outing for ThinkFirst

Sunday, October 19, 2003
 8:30 a.m. - 4 p.m.
 The Ridge at Castle Pines North Golf Club
 Denver, Colorado

AMA

Continued from page 13

on liability reform later this fall.

AMA lobbying efforts in the 108th Congress started with a need to correct the Medicare reimbursement formula. Using this formula, CMS had announced that there would be a further 4.4% cut in Medicare reimbursement. Lobbying efforts were directed at pointing out the flaws in the Medicare formula and the resultant increasing lack of access to medical care for seniors as doctors pulled out of the system.

I was impressed with the clout that the AMA name still has among the public and particularly the Congress. While physicians find the AMA a good target for criticism, the public and the Congress still perceive it as the voice of organized medicine.

In talking to representatives, it was apparent that many were anxious for more information on the flawed formula and the threat posed to access to medical care for seniors. Everywhere we went we were received with both courtesy and great interest, with the possible exception of the Office of my representative, Charles Rangel. The Congress did vote to rescind the proposed cut, and instead gave a 1.4% increase in reimbursement. This change in reimbursement has been calculated by the Congressional Budget Office to result in \$54 billion in additional revenues to physicians over the next decade. While many organizations worked hard to achieve this success, the leadership role of the AMA has been noted by many in the media, including *Time* magazine and CNN.

The change in this year's reimbursement is a temporary fix. What is really needed is to correct the flawed formula which mandates decreased medical payments in a recession. The Senate now seems willing to review the formula. The administration is proposing an interim solution that would increase Medicare payments 1.5% in each of the next 2 years, but insists that Congress fix the formula. No one wants to add to Medicare spending when a high drug Medicare subsidy is likely.

Neurosurgery has influence in Washington far out of proportion to either our numbers or the Washington budget. Neurosurgery has taken the leadership of a coalition of high-risk specialties. Both our Washington Committee and our Washington Office have been very effective in advancing our advocacy agenda. □

SANS

Continued from page 14

Kenneth Smith, Richard Smith, Michael Scott, George Sybert, Philip Weinstein, Phillip Williams, and Fremont Wirth. Richard Carter, an educational psychologist with the American Academy of Neurology, was a consultant. SANS

II was distinguished by the incorporation of case scenarios and the increased use of questions accompanied by radiological studies.

Further editions of SANS continued to expand the use of diagnostic illustrations and case presentations. SANS IV was the first edition available on computer disc. The last version of SANS, SANS VI, utilized CD-ROM technology in order to provide users with a multimedia educational experience. Editors of previous SANS exams have included Drs. Peter Black, George Sybert, and Mark Hadley.

Since its initial development 25 years ago, SANS has become a popular teaching device that has been routinely utilized by thousands of neurosurgeons as a key element of their continuing medical education. SANS employs a self-instructional and self-evaluation format consisting of questions and answers, each with a critique and pertinent references. SANS has been designed to help neurosurgeons do the following:

- Maintain and improve proficiency in surgical decision making.
- Stay abreast of the latest advances in the field.
- Prepare for certification/recertification.

The SANS project is now exclusively sponsored by the Congress of Neurological Surgeons. In 2001, an extensive review of the SANS effort was conducted by the Education Committee of the CNS and proposals were made to enhance the educational value of this product. The end result of that analysis, SANS Wired, has been 2 years in the making and is an entirely digital and online version of this unique teaching tool. We believe this digital format will provide users with a number of new benefits including:

- The ability to utilize SANS from any computer with on-line access.
- Enhanced feedback on individual performance.
- Links to relevant sites on the Internet.
- Ongoing feature and content updates.

Previous SANS issues have been released approximately every 4 years. The SANS Wired committee intends to release new issues of SANS every 12–18 months. SANS issues will now be designated by “model years.” The first issue of SANS Wired, SANS 2004, will be released in September 2003 and will contain approximately 220 questions. For the first time in many years, the content of SANS 2004 will be entirely novel. Over 50 individuals have contributed to the development of SANS 2004. Several new categories have been added to SANS, including neurosurgical anatomy, functional neurosurgery, stereotactic technique, and associated specialties (neuroradiology, neurootology, neuropathology, neuroanesthesia, and neuroophthalmology). Multiple new features, made possible by the digital format, are now available and include the ability to

instantly review lists of incorrectly answered questions by category, book-marking capabilities, and note-taking functions. Numerous links to relevant Internet sites have been incorporated. Users will have the option of taking the exam by category or with questions arranged in a random fashion. Additionally, SANS users will now be able to apply for up to 22 hours of category one AMA-PRA credit, which will be awarded online. Smaller SANS “sub-specialty modules” are now in development and will be offered separately from the parent product. These modules will provide surgeons with expanded opportunities to assess their knowledge base in specific clinical areas.

SANS has been used in the past to help neurosurgeons prepare for board examinations and is now being more significantly integrated into the expanded process of MOC. SANS has recently been endorsed by the American Board of Neurological Surgery (ABNS; www.abns.org) as a valuable tool to help fulfill the Self-Assessment portion of “Life-Long Learning” for MOC. Additionally, a substantial portion of the content of the planned ABNS Recertification/Maintenance of Certification cognitive examinations will be derived directly from SANS questions. Participation in the SANS program, therefore, will be of substantial benefit to individual neurosurgeons in their preparations for Recertification/MOC examinations.

Because of SANS' association with the recertification/MOC process, this product will undergo extensive reviews to ensure the accuracy and relevance of its content. In addition to editorial reviews, all SANS issues will now be analyzed by an independent SANS review board composed of leaders in multiple neurosurgical subspecialties and ABNS representatives. In addition, SANS users will also have the oppor-

tunity to provide feedback to the SANS editorial board by way of online evaluations.

In summary, forces within and without of the medical profession are now radically reshaping traditional systems of health care education. In particular, oversight organizations are now insisting on the development of new programs to evaluate the practice-related knowledge and performance of individual clinicians. The MOC programs now being developed by all specialty boards, including the ABNS, will allow for the maintenance and comprehensive assessment of multiple clinical competencies over time. Self-assessment devices such as SANS are uniquely suited to addressing two of the four required components of MOC (Evidence of Commitment to Lifelong Learning and Periodic Self-Assessment, Evidence of Cognitive Expertise), and are therefore likely to play a major role in the ongoing efforts to maintain and improve the quality of health care.

Institute of Medicine Web site:
<http://www.iom.edu/>

Congress of Neurological Surgeons Web site:
<http://www.neurosurgeon.org>

ACCME Web site:
<http://www.accme.org/>

AMA Web site:
<http://www.ama-assn.org/>

ACS Web site:
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Chairman's Report: FIENS Activities 2003

Russell W. Hardy, Jr., M.D.
Chairman, FIENS

The Foundation for International Education in Neurological Surgery (FIENS) held its Annual Board Meeting on March 8, 2003.

The following officers were named for the coming year: Chair, Russell W. Hardy, Jr., M.D.; Vice Chair, Daniel Kelly, M.D.; Secretary, Robert Dempsey, M.D.; and Treasurer, Frank Culicchia, M.D.

The following members were renominated for 3-year terms on the Board: Hunt Batjer, Carlo DeLuna, Patrick Johnson, Edward Laws, Jr. and Roy Tyrer. In addition, Dr. Ted Tatsumi was nominated for a Board position, as was Dr. Beverly Walters, a nominee of the Congress of Neurological Surgeons.

It is also noted that Dr. Lee Finney resigned from the Board. Dr. Finney served a number of terms as a FIENS Board member and Vice President. Most particularly, however, he devoted an extensive amount of personal time to volunteering in Central America, especially Honduras. His contributions to FIENS activities will certainly be missed.

There was ongoing turmoil in the world during the year 2002, and consequently we have been careful as to where we have sent our volunteers. Nevertheless, we have sent nine neurosurgeons to countries on three continents. We have had three spend a month each in Khon Kaen, Thailand, two have gone to Indonesia, two to Central America, and two to Ghana. I would like particularly to mention Dr. Ted Tatsumi who has spent an extensive amount of time in both Honduras and Guatemala and plans to return there in the future. We have also continued to provide financial support to Dr. Otto Spoerri who is working full-time with the Residency Program in Tegucigalpa, Honduras. We

expect to have an increased presence in Central America in the next few years, both in Guatemala and also in Belize, a country currently without a neurosurgeon.

We also have received requests for assistance from Kenya and Uganda. We hope to send volunteers to Kenya in the near future in order to strengthen neurosurgical training and care in that country and also to Uganda, where we have received a request from Dr. Ben Warf, an American neurosurgeon who is practicing pediatric neurosurgery on a full-time basis in Mbale.

As in the past, we are continuing to collect equipment and distribute it to many of the countries where we send volunteers. I would like to mention in particular a large donation of equipment, which we recently have received from the Integra Life Sciences Corporation.

A major concern in the past several years has been the gradual erosion of our small endowment fund. This is mainly due to supporting our volunteer program. As many of you know, our volunteers receive no salary, but we do pay for transportation and certain educational expenses. Another problem is that in the past we have not been particularly aggressive in raising funds. For this reason, we have begun a more vigorous fund raising and marketing program, an effort significantly helped by pro bono contributions from Hooek Advertising Agency. I am pleased to say that this program has led to a modest increase in donations this year and, hopefully, a larger increase in years to come. As a result of our marketing efforts, we also have had a number of inquiries by potential volunteers whom we hope to send abroad in the next few years.

In short, FIENS continues to carry out our mission of providing neurosurgical education and care in developing countries, an effort that continues to flourish in spite of adverse world conditions. □

CEREBROVASCULAR SECTION

Chairman's Message: What's in a Name?

Warren R. Selman, M.D.

What's in a name? That which we call a rose

By any other name would smell as sweet.

—*Romeo and Juliet. Act ii. Sc. 2.*

I am honored to serve as Chair of the Cerebrovascular Section, and fortunate to follow the outstanding leadership of our previous Chair, Dr. Robert Harbaugh. The past year witnessed the release of the results of the first randomized multicenter trial of clip and coil treatment for ruptured intracranial aneurysms. The thoughtful analysis of this study from the leaders of the Cerebrovascular Section, the American Association of Neurological Surgeons, and the Congress of Neurological Surgeons continues to be a model for debate regarding the applicability of this study to cerebrovascular practices in North America, and the need for and relative merits of designing and implementing another trial. The relationship with our endovascular colleagues has been strengthened by open and frank discussion between the leadership and members of both organizations about these topics and other important issues facing our society. The Joint Leadership Council of the Cerebrovascular Section and the American Society of Interventional and Therapeutic Neuroradiology, which was formed last year, continues to examine and respond to issues that affect endovascular and microsurgical treatment of cerebrovascular disorders. We are working closely to formulate paradigms that will allow both groups to work together in a mutually beneficial way and allow us to ensure that it is the neuroscience community that establishes best practice patterns for the care of patients with cerebrovascular disease.

Given this background, it is time to look forward to the challenges and opportunities of the coming year. With all else that occupied our thoughts last year, little notice may have been given to a small but significant change in our name. The AANS/CNS Section on Cerebrovascular Surgery quietly became the AANS/CNS Cerebrovascular Section. I believe this name more accurately reflects the breadth and depth of our organization with respect to patient care, research, and education. While I have no intention of overlooking the advancements that our rich heritage of outstanding, innovative, and masterful surgeons have made to

improve the outcomes of patients with cerebrovascular disorders, we have always been about much more than surgical treatment alone.

We do not need to look far in the past for evidence of this commitment to the care of patients with all etiologies of stroke when, in 1994, Drs. Julian Hoff and Roberto Heros, with the support of the AANS, forged the Brain Attack Coalition, an alliance of every major stroke care organization that continues to shape stroke prevention, care, and policy to this day. Under the passionate and influential leadership of Drs. Heros and Hoff, the Coalition engaged in the solicitation of additional medical and health care organizations to support the Brain Attack effort. Neurosurgery remains actively engaged in the Brain Attack Coalition on projects such as the development of recommendations for Stroke Centers. Neurosurgery, which now has representatives from both the AANS and the CNS, has the opportunity to work closely with all the organizations of the Coalition that now includes The American Academy of Neurology, The American Association of Neurological Surgeons, The American Association of Neuroscience Nurses, The American College of Emergency Physicians, The American Society of Neuroradiology, The American Stroke Association, The Centers for Disease Control and Prevention, The Congress of Neurological Surgeons, The National Association of EMS Physicians, The National Institute of Neurological Disorders and Stroke, The National Stroke Association, The Stroke Belt Consortium, and the Veterans Administration.

The American Stroke Association, another organization with a recent name change as it was previously known as the Stroke Council of the American Heart Association, is the largest organization in North America devoted to the prevention and treatment of all forms of cerebrovascular disorders. Neurosurgery's representation and leadership in these organizations underscores our commitment to lessen the burden of all forms of stroke. The Cerebrovascular Section Vice Chairman, Dr. Marc Mayberg, is President of the American Stroke Association, and Dr. Richard Hodosh, a longstanding member of our Section, serves as a member of the National Stroke Advisory Council as well as the Chairman of the Stroke Task Force Affiliates in New York, New Jersey, and Connecticut. Neurosurgeons have always been, and will continue to be, involved in the prevention and treatment of the full spectrum of cere-

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Email: info@1cns.org

brovascular disorders.

Education remains a primary goal of the Cerebrovascular Section. We will begin our educational year with two scientific sessions that will take place on, Monday, October 20th and Wednesday, October 22nd, at the Congress of Neurological Surgeons Annual Meeting in Denver, Colorado. Dr. Murat Gunel, Assistant Professor of Neurosurgery at Yale School of Medicine, has organized an outstanding cerebrovascular program for this meeting. The first session will include a symposium entitled, "Surgical Anatomy of Intracranial Circulation," and will feature this year's Drake Lecturer, Dr. Arthur Day, who will be speaking on "The Surgical Anatomy of the MCA." Additional lectures will be delivered by Drs. Issam Awad and Hunt Batjer, who will be speaking on the surgical anatomies of the paraclinoid region and basilar tip region respectively. Our second symposium, scheduled for Wednesday, October 22nd, is entitled "The Essence of Cerebrovascular Surgery: Incorporating Today's Technology and the Comprehensive Stroke Center Into Practice," and will feature lectures on ischemic disease by Dr. Neil Martin, arteriovenous malformations by Dr. Robert Spetzler, anterior circulation aneurysms by Dr. Robert Solomon, and posterior circulation aneurysms by Dr. Jacques Morcos.

The vitality and growth of our Section is dependent on the enthusiasm and participation of our membership. As Chair of the Cerebrovascular Section, I welcome and encourage you to contact me directly (warrenselman@uhhs.com) to become actively involved in our organization. I look forward to working with you this year.

Editor's Corner: Do We Need Any More Trials to Compare Clipping and Coiling of Aneurysms?

Robert M. Friedlander,
M.D., M.A.

Over the past several years, there has been significant controversy pertaining to the strategy regarding clinical trials for the comparison of open surgical approaches versus endovascular therapy for the treatment of intracranial aneurysms. Opinions regarding these two approaches come from a variety of medical subspecialists including neurosurgeons, interventional neuroradiologists, and neurologists. Input from industry is also biasing the matter, in particular as it pertains to public opinion. Fundamental questions regarding trials for the treatment of intracranial aneurysms include:

- Should there be further trials evaluating these technologies?
- What kind of aneurysm should be evaluated: ruptured or unruptured?
- How long should the follow-up be?
- How should the patients be followed?

In addition, since results of two major clinical trials have been published, it is unclear how they have impacted the actual clinical practice of neurosurgeons as well as the desire or need to perform further trials.

To address some of these important issues, a questionnaire was designed to survey the opinion of practicing neurosurgeons. The questionnaire was distributed during the special cerebrovascular symposium at the 2003 annual meeting of the AANS. The symposium titled "How and when to organize a clinical trial for comparing surgical vs. endovascular treatment of aneurysms" had two speakers. Dr. Robert Harbaugh from the Department of Neurosurgery at the Pennsylvania State University and Dr. Alexander Norbash from the Department of Neuroradiology and Neurosurgery at the Brigham and Women's Hospital, respectively, provided a surgical and an endovascular perspective on these issues. As the moderator, I presented the questions on a screen, and the audience was able to provide answers via a hand held cordless device. The questions were presented both before and after the presentations. As there were more people present at the end of the session rather than at the beginning, more responses were recorded after the presentations.

Given the nature of the questionnaire and the format of data acquisition, I have not analyzed the responses using scientific statistical methods. I rather wish to present the raw data, since I believe that important information can be extracted. Given the composition of the audience, the responses represent for the most part, the opinions of neurosurgeons in practice or in training, with interests in cerebrovascular surgery.

The first set of questions pertained to opinions regarding the need for new clinical trials for the comparison of surgical and endovascular approaches for the treatment of ruptured (Fig. 1) and unruptured (Fig. 2) aneurysms. The majority of respondents believed that new clinical trials were needed to com-

pare the two technologies for both ruptured and unruptured aneurysms. Following the talks, there was a slight increase in the proportion of respondents believing that new trials are required. Essentially, the same proportion of respondents thought that clinical trials were required for both ruptured (88%) and unruptured (91%) aneurysms.

The next set of questions pertained to the length of follow-up that should elapse after treatment; the questions did not address the mode of follow-up. A significant component of the presentations made by Drs. Harbaugh and Norbash dealt with this issue. The presenters stressed the importance of an objective long-term angiographic evaluation of the treatment results. The audience was given a choice of length of follow-up of 6 months, 1, 5, 10, or more years. After the presentations, the opinion of the audience was altered as reflected in an increase in the follow-up period. To provide an average follow-up period of time, respondents in the longer than 10 years category were arbitrarily assigned to 15 years. The average follow-up for patients with ruptured aneurysms was 7.3 and 8.5 years, respectively, before and after the presentations (Fig. 3). The average for follow-up for patients with unruptured aneurysms was 8.0 and 8.9 years, respectively, before and after the presentations (Fig. 4). Although the answers were somewhat different, with the recommended follow-up for unruptured aneurysms being slightly longer, a clear consensus appears to be that the follow-up should be in the range 7 to 9 years. Stressing the unscientific nature of this analysis, I do note, however, that important trends can be identified from these responses.

For the success of a multicenter clinical trial it is critical that the involved

Continued on page 20

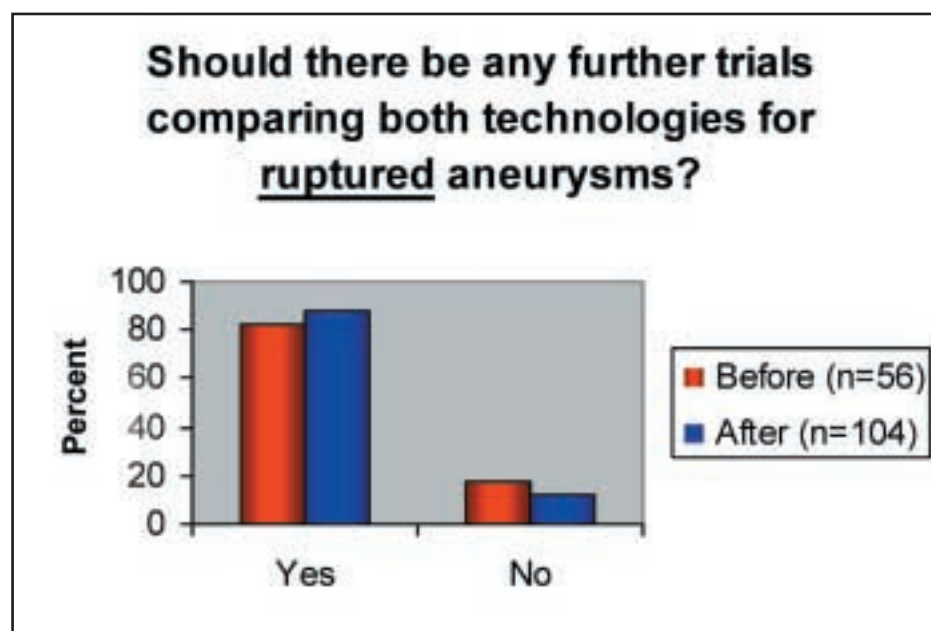


Figure 1

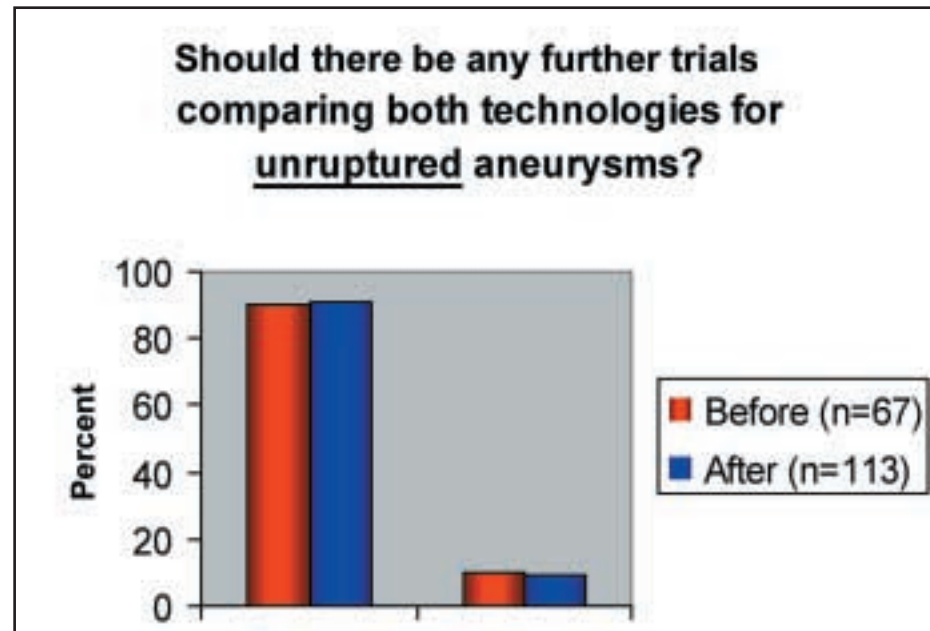


Figure 2

Cerebrovascular Section

Continued from page 19

investigators enter all the eligible patients into randomization. It is imperative to objectively remove the biases of the individual investigator to ensure a trial's success. As such, the next set of questions enquired as to the willingness of the respondents to include all their eligible patients into the study. After the presentations, 79% (ruptured, Fig. 5) and 86% (unruptured, Fig. 6) of respon-

dents answered that they were willing to randomize all their eligible patients into a trial. These are remarkable numbers and provide evidence as to the willingness of neurosurgeons to participate and enroll patients into such studies.

The next set of questions was only presented after the talks. The questions evaluated whether the results of the International Study of Unruptured Intracranial Aneurysms (ISUIA) and the International Subarachnoid Aneurysm Trial (ISAT) trials had changed their particular practice pat-

terns. There were 115 respondents for these questions. The data from the ISUIA trial resulted in an alteration of practice pattern in 41% of respondents (Fig. 7). The data from the ISAT trial resulted in an alteration of practice pattern in 30% of respondents (Fig. 8). The questions were not designed to address how the practice patterns were changed. However, broadly one may assume that the ISUIA trial might have influenced neurosurgeons to be more conservative in the management of unruptured aneurysms. Similarly, one may assume

that the results of the ISAT trial might bias neurosurgeons more towards recommending endovascular therapy for the treatment of ruptured aneurysms.

Given that this is not a scientific evaluation of the data generated by this questionnaire, I have taken the liberty of making certain assumptions in the interpretation of the data. I conclude that the information obtained from the above-described questionnaire supports the following generalizations:

- a) Clinical trials for the comparison

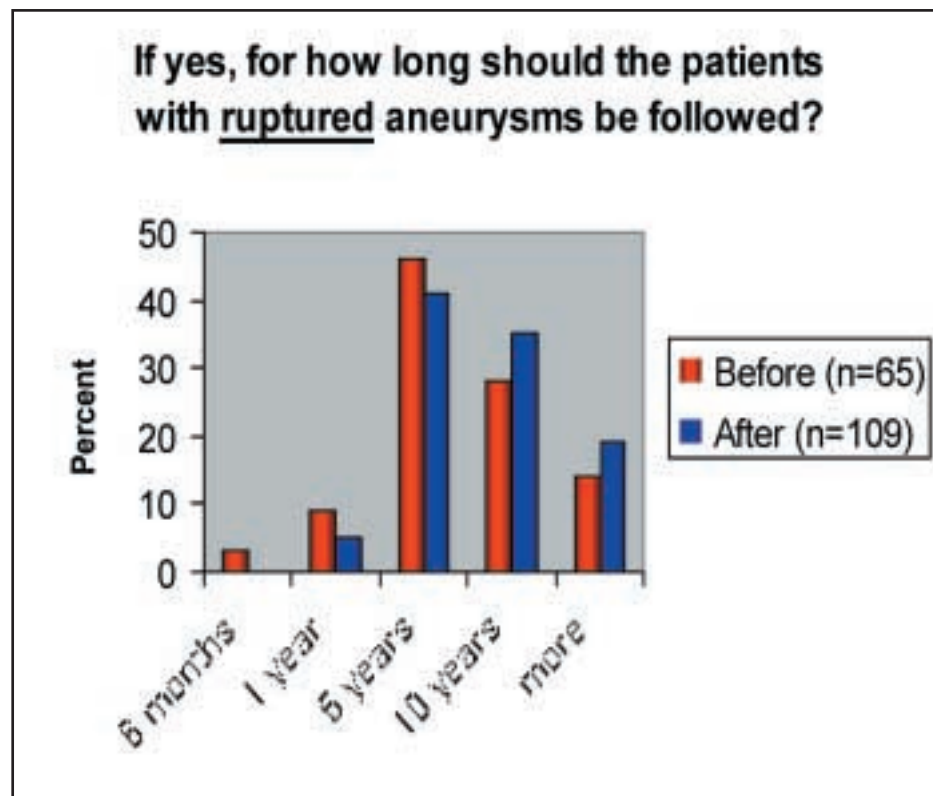


Figure 3

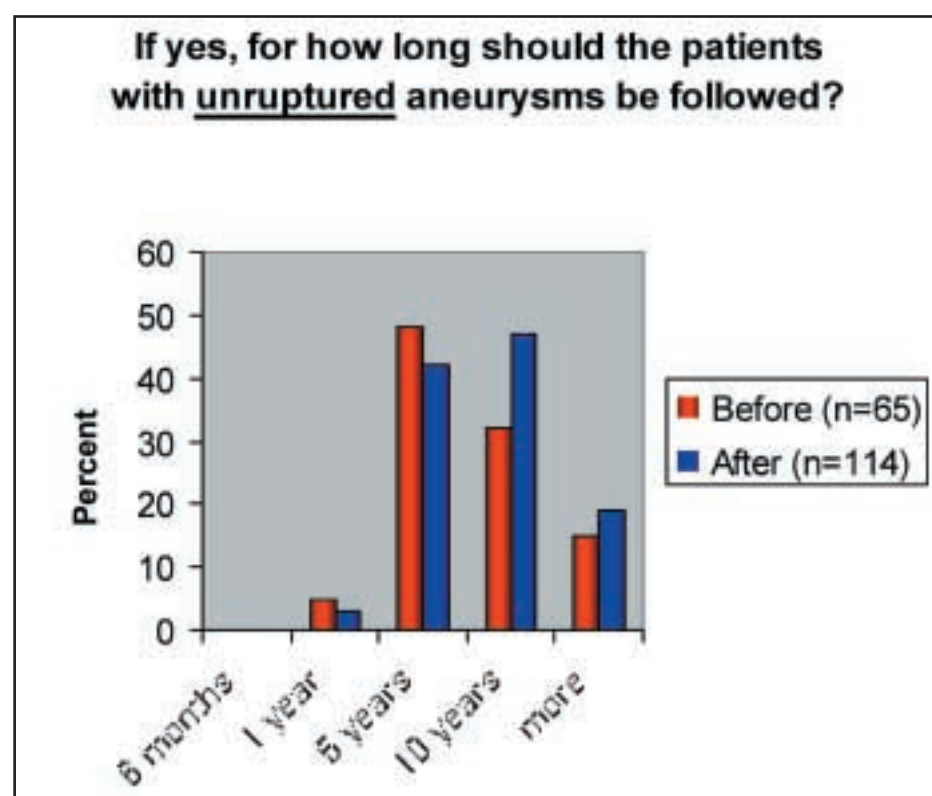


Figure 4

	Ruptured	Unruptured
Before	7.3	8.0
After	8.5	8.9



Figure 5

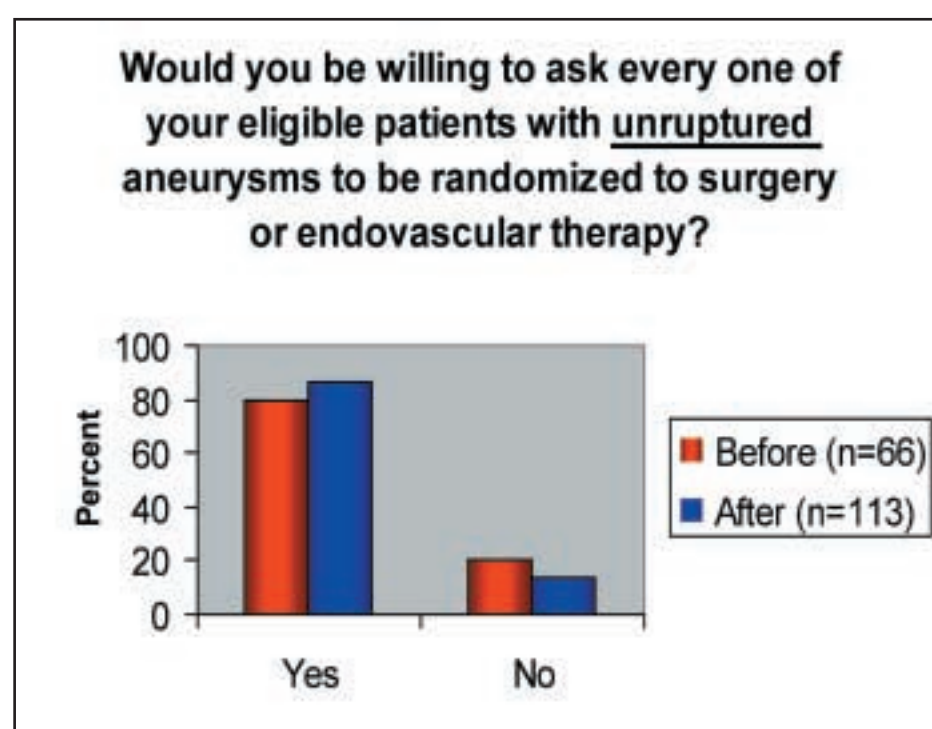


Figure 6

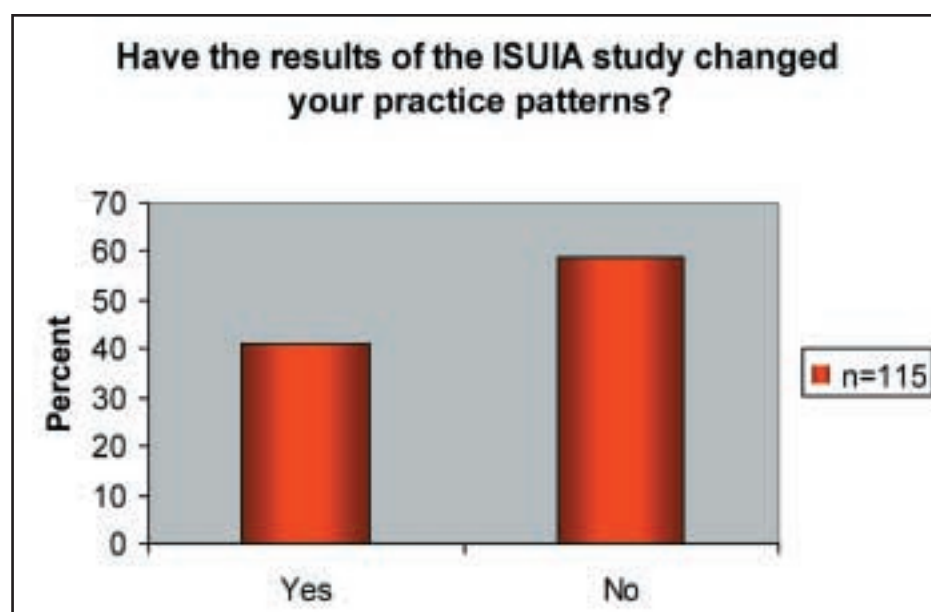


Figure 7

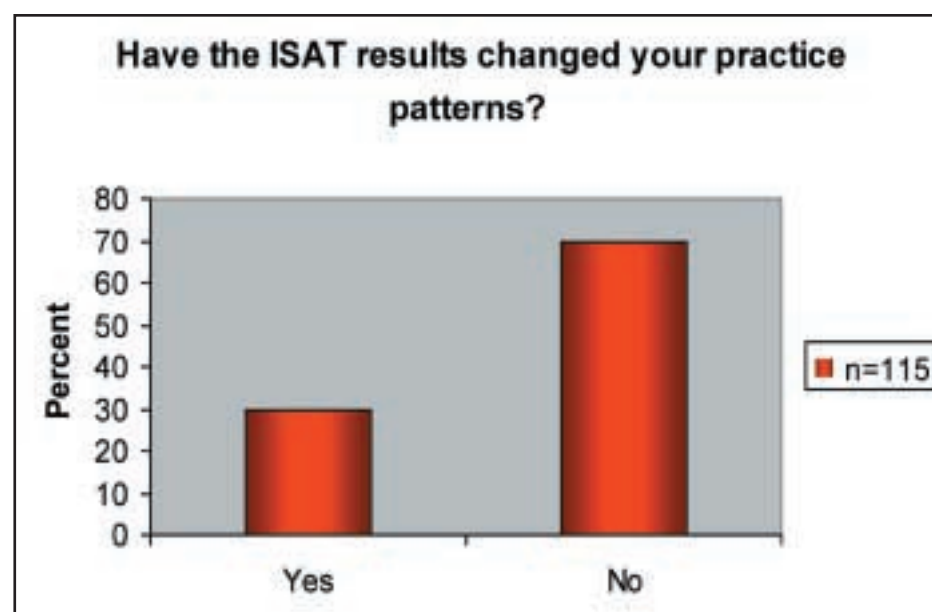


Figure 8

of surgical clipping and endovascular therapy for ruptured and unruptured aneurysms are indicated and supported by the majority of neurosurgeons.

- Follow-up after treatment should be at least in the order of 7 to 9 years.
- Most neurosurgeons would be willing to randomize appropriate patients into an appropriate study.
- The ISUIA and ISAT trials have both had some degree of impact on the management of patients with intracranial aneurysms.

Technology Report

Drug Eluting Stents to Prevent Restenosis

**Ricardo J. Komotar, M.D.,
and E. Sander Connolly, Jr.,
M.D.,**

Department of Neurosurgery
Columbia University
New York, NY

Atherosclerosis is the leading cause of death in the United States. Angioplasty is com-

monly used to reduce vessel stenosis and revascularize ischemic tissue. While the introduction of angioplasty nearly 25 years ago has revolutionized the treatment of vascular disease, restenosis frequently occurs as an arterial injury response. Presently, the deployment of intra-arterial stents is used to maintain vessel patency in such circumstances. Clinical restenosis continues to occur, however, with stent placement and rep-

resents one of the major limitations involving the treatment of atherosclerosis both extra-cranially as well as intracranially.

In an attempt to improve the efficacy of stenting and reduce the rate of restenosis, emphasis has been placed on the development of drug-eluting stents. This new technology allows

Continued on page 22

Dr. Robert Ray Smith

Robert Ray Smith died on the tennis court at the age of 70, this past May 8th. Characteristically, he went out winning... ahead 4-2 in the first set of a tournament match. An early death, and shock for those who knew him ... but not a bad way to go, I thought.

Dr. Smith retired from academic practice in 1995 but continued to provide neurosurgical care in Jackson, Mississippi up to the time of his death. Tennis and private practice were not, however, where he shone. It was his contributions to neurosurgical research and teaching, especially regarding the treatment of cerebrovascular disease, which separated Dr. Smith from the pack. He served as Chairman of the Department of Neurosurgery at the University of Mississippi Medical Center from 1977 until 1995.

I admired his vision, especially when it came to seeing the potential of endovascular treatment. Selected by the Stroke Council of the American Heart Association to visit neurosurgical centers in Russia during the 1980s, he was exposed early to balloon tech-

nology for the treatment of cerebral aneurysms and vasospasm. He rapidly jumped on the bandwagon, bucking the trend.

These were the glory years for vascular neurosurgery. Cranial surgeons were getting bolder with their techniques and the microsurgical treatment of aneurysms had become a standard part of the neurosurgical armamentarium. I remember the first reports coming out of Russia, some communicated through Dr. Smith's group, on endovascular treatment. Not many within the neurosurgical community saw the potential, and fewer still tried to adopt it. Charles Drake, the then doyen of our subspecialty, appreciated the intuitive beauty of endovascular treatment. In a speech at the 1988 AANS meeting in Toronto, Drake suggested that young neurosurgeons should become involved in this emerging field. His speech had a profound impact on me. Smith's work did, too.

He did not reach the ethereal professional summits achieved by Dr. Drake, but Smith's work positively impacted patient care, both at home and abroad. His publication list suggests that he only settled on cerebrovascular disease in mid-career, and vasospasm became his major research interest. While not trained in endovascular technique, he encouraged his radiology colleagues,



and collaborated with Yuri Zubkov from St. Petersburg, the innovator of cerebral balloon angioplasty.

Smith saw a comprehensive role for himself as a cerebrovascular surgeon. He eagerly embraced new techniques, especially if they were less invasive. He was an early and major enthusiast for radiosurgery. He was a member of his hospital's stroke committee. He became trained in transcranial Doppler sonography and rose to leadership positions in this field. He was Chairman of the AANS CV Section and a member of the Executive Committee of the Stroke Council of the American Heart Association, as well as numer-

ous editorial boards. Scores of journal articles and book chapters, and several books emanated from Smith's pen.

The venue of his professional career, Mississippi, also speaks of the man. A modest childhood in the smaller city of Vicksburg; loss of an older brother during the Second World War; the development of a deep appreciation for nature and the outdoors, these were formative events. "Bobby Ray," more southern country boy than patrician gentleman by background, never forgot where he came from. With a deep sense of duty and humanity, he devoted most of his professional life to advancing and sharing medical knowledge and providing sophisticated care to all comers at what was, for the most part, a charity hospital. He was loyal not only to his profession but also to his state. Jackson, Mississippi was a difficult place to live during the turbulence of the 1960s and 70s. His innovative, forward thinking mind, I am sure, kept him in good stead during those times. He was no reactionary.

His wife, Helen, a daughter and three grandchildren, one of whom is an excellent tennis player, having achieved top ranking in the state, survive Dr. Smith.

—Robert Friedlander, M.D.

CSNS NEWS

Chairman's Corner

Frederick A. Boop, M.D.

Chairman, CSNS



The CSNS leadership has had a busy summer. Working in conjunction with the Washington Committee, the CSNS has been developing an e-mail list of all

the state neurosurgical societies, their new officers, and the dates of the various state meetings. Katie Orrico and Jim Bean are attempting to attend many of the state society meetings in order to discuss the professional liability initiative. In these rapidly shifting times, the CSNS is developing an e-mail rapid communication line, such that information sent from the Washington Committee leadership can be forwarded to the CSNS quadrant chairmen, who in turn can forward that information to the state neurosurgical society leadership, who can in turn forward it to their respective members. Member queries then can flow in the opposite direction, facilitating an exchange of information.

The CSNS has also formed a new ad hoc committee chaired by ex-chairman Lyal Leibrock and current CSNS treasurer Gary Bloomgarden. The committee has been working diligently to develop funding for the next Neurosurgical Leadership Development Conference (NLDC) to be held in Washington, DC next July. Being an election cycle, these conferences hope to involve neurosurgeons who aspire to become politically active. Typically, the conference will open with a coding and reimbursement course on Sunday. On Monday, a series of lectures will be offered on how to effectively speak to your congressperson, what to say and what not to say. Other lectures will cover the latest political issues before Congress that impact neurosurgeons. On Tuesday morning, Ms. Orrico's office will have organized meetings between the attendees and their respective congresspersons to discuss these issues. The two prior NLDC meetings have been very successful in gaining access for our Washington Committee members with various members of congress. I would encourage anyone who is discouraged by their current liability climate, disheartened by the progressive decline in reimbursement, or upset by the growing number of unfunded congressional mandates to seriously consider attending this next NLDC meeting and learning how to effectively participate in the political process.

The CSNS is preparing for their next plenary session, to be held in Denver the Friday and Saturday prior to the CNS meeting. Thus far we have six resolutions to be debated at the meeting. Issues range from continued debate over the format of the Maintenance of Certification process for neurosurgery to oversight for physician extenders. Anyone interested in attending these sessions should contact his or her state CSNS delegate. If you have a burning issue affecting your practice, which you wish to bring to our attention, contact your state delegate for advice on how to formulate a resolution. Remember, recognizing and discussing a practice-related problem over the luncheon table in your OR lounge will never bring about change. If you wish to precipitate change, becoming involved at the national level gives you the chance. The CSNS can be your foot in the door.

Finally, Dr. Hadley and the leadership of the CNS have been working closely with the CSNS this year in putting together this year's annual meeting. A number of seminars and an afternoon session devoted to socioeconomic issues will be on the agenda in Denver. We hope to see you there.

"Our Society's next meeting has been scheduled for January 2004. Dr. Hiram Mercado accepted his position until January 2004, when we will decide if he should continue to serve as our president until January 2005. As part of our appointments it was decided that the secretary would act as treasurer.

"In that meeting, our chapter will attempt to elect the President-elect for 2005 so that person can immediately begin getting acquainted with the position's duties and responsibilities."

Upcoming Meetings

October 2003

TBD

Connecticut State Neurosurgical Society

Q-Club

New Haven, CT

November 2003

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Maryland Neurosurgical Society

Maryland Club
Baltimore, MD

Contact: Henry M. Shuey, Jr., M.D.

E-mail: sushu98@comcast.net

Phone: 410-646-0220

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Ohio State Neurosurgical Society

Sheraton Suites Hotel
Columbus, OH

Contact: John McGregor, M.D. or William Bingaman, M.D.

E-mail: mgregor.1@medctr.osu.edu or bingamb@ccf.org

Phone: 614-283-5440 or 216-444-9058

January 2004

17-18

California Association of Neurological Surgeons

Sutton Place Hotel
Newport Beach, CA

Topics: Socioeconomics (January 17, 2004)

Pain Management Course Part II (January 18, 2004)

Contact: Janine Tash

E-mail: jt4ns@aol.com

Phone: 916-457-2267

23-24

Louisiana State Neurosurgical Society

Lake Charles, LA

Contact: Deepak Awasthi, M.D.

E-mail: dawast@lsuic.edu

Phone: 504-568-6125

Cerebrovascular Section

Continued from page 21

delivery of active drug at the precise site and time of vessel injury, thereby achieving higher local concentrations and minimizing potential systemic toxicity. The critical mechanism of restenosis initially involves the release of growth factors as a response to arterial injury after high-pressure stent deployment. This change in the extracellular milieu triggers vascular smooth muscle cells (VSMCs) to undergo phenotypic change, proliferate, migrate, and form the neo-intima. Thus, potential candidate drugs must target the inhibition of VSMC hyperproliferation.

Since neointimal tissue accumulation closely parallels benign tumor growth, the use of antineoplastic pharmacologic agents to reduce the rate of post-stent restenosis holds considerable promise. Rapamycin (Sirolimus) has been shown to reduce VSMC proliferation by preventing growth factor dependent cellular activation. Clinical trials with Sirolimus have demonstrated excellent results. A 238-patient, double-blind, randomized trial showed a restenosis rate of 0% in patients receiving

Sirolimus-eluting stents, compared to 26% in patients with placebo (3). Of note, a patient in this trial retained 100% vessel patency at 16-month follow-up. Another study demonstrated a 9.2% restenosis rate in patients treated with Sirolimus-eluting stents, compared with 32.3% in control patients (2).

Paclitaxel is another antineoplastic agent that has been shown to reduce VSMC proliferation by disrupting intracellular microtubule formation. As with Sirolimus, clinical trials involving paclitaxel have shown remarkable efficacy. In one trial, no patients receiving a paclitaxel-coated stent had restenosis at 6-months follow-up, compared to 10% restenosis rate in the control group (1).

While stents coated with Sirolimus and Paclitaxel have been effective in clinical trials, several concerns exist regarding this new technology. Long-term follow-up is lacking, as a result, safety issues regarding chronic drug-elution must be addressed. Such agents may delay intimal maturation and normal endothelial function, thus raising the potential for late thrombotic events. Other issues include malapposition, aneurysm formation, edge effects, overlapped segments, and polymer-induced inflammation. Furthermore, the safety and efficacy of drug eluting stents for the treatment of carotid artery disease, intracranial atherosclerosis and lower extremity claudication remains, as yet, unknown.

In conclusion, drug-eluting stents offer considerable promise. By addressing what is presently a common and significant complication following stent placement, these devices have the potential to significantly impact the current standard of care for vascular disease.

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NEUROSURGERY NEWS

E-mail letters to the editor, article ideas, meeting notices, and press releases to: gregthom@umich.edu

NEW PRODUCTS/PRESS RELEASES

Integra NeuroSciences™ Study of OSVII® Smart Valveä Reports Positive Results for Treatment of Hydrocephalus

Results Indicate an Unsurpassed Long-Term Survival Rate in Hydrocephalus Patients

Plainsboro, New Jersey—Integra LifeSciences Holdings Corporation (Nasdaq: IART) today announced the results of a 5-year prospective, multicenter study of the OSVII® Smart Valve™, a flow-regulating shunt used for the treatment of hydrocephalus. The study was conducted by Dr. Patrick W. Hanlo of the Department of Neurosurgery, Utrecht University Medical Center, and Center for Biostatistics, Utrecht University, Utrecht, The Netherlands. The results of the study, which were published in the July 2003 edition of the *Journal of Neurosurgery*, reveal an exceptionally low rate of valve-related complications with fewer incidents of mechanical dysfunction than other valves previously studied. The investigators in this study found that the OSV II Smart Valve survival rate was 62% at 5 years, whereas previous independent studies have shown a 60% survival rate at 1 year with other valves tested.

The Hanlo study illustrates that the OSV II Smart Valve can reduce the incidence of overdrainage and shunt obstruction,

which resulted in a better long-term survival rate in this study. Dr. Hanlo stated, "The valve's long-term stability, a 62% overall shunt survival rate at 5 years follow-up, and low incidences of chronic overdrainage, led us to conclude that flow-regulating shunts can offer numerous clinical advantages over other valve technologies."

According to the manufacturer, the OSV II Smart Valve is a self-adjusting valve that automatically adjusts to the patient's changing needs. The OSV II Smart Valve represents a revolutionary advancement in the treatment of hydrocephalus, as it functions physiologically at varying pressures and does not require any programming or reprogramming. While other valves may require manual reprogramming and surgeon revisits, the OSV II Smart Valve automatically adjusts to conditions present, eliminating the need for pressure range changes or programming. For more information on the OSV II Smart Valve technology, please visit www.integra-neurosciences.com/smartvalve.

Integra currently offers a diverse line of hydrocephalus management products, including the OSVII Smart Valve, Inte-

gra Hakim®, Equiflow®, Novus®, LPV® and Pudenz™ shunts, ventricular, peritoneal and cardiac catheters.

Integra LifeSciences Holdings Corporation is a diversified medical technology company that develops, manufactures, and markets medical devices for use in a variety of applications. The primary applications for our products are neuro-trauma and neurosurgery, plastic and reconstructive surgery, and soft tissue repair.

For more information, contact: Integra LifeSciences Holdings Corporation, John B. Henneman III, Executive Vice President, 609-936-2481, jhenneman@Integra-LS.com, or John Bostjancic, Senior Director of Finance, 609-936-2239, jbostjancic@Integra-LS.com.

New Corporate Identity Joins Two Brands

Cincinnati/Münsingen/Nidau—It has formally been announced that Ohio Medical Instrument Company, Inc. (OMI®), and Schaerer Mayfield Schweiz, AG (formerly Schaerer Medical), two well-established companies that have operated as a business alliance in recent years, are being brought together by Schaerer Mayfield Holding, AG, under the joint name of Schaerer Mayfield. The change signifies the new ownership of OMI by Schaerer Mayfield Holding, AG, headquartered in Nidau, Switzerland.

Schaerer Mayfield Schweiz, AG, Münsingen, Switzerland, was founded in Bern, the capital of Switzerland, in 1892. The Company's core businesses include the manufacturing and worldwide marketing of the Schaerer surgical tables and sterilizer product lines. The Company boasts a significant global presence through the Schaerer brand name.

Schaerer Mayfield, USA, Inc., formerly OMI, located in Cincinnati, Ohio, was founded in 1968 by Dr. Frank Mayfield, an internationally known neurosurgeon. The Company is widely recognized for its Mayfield® line of cranial stabilization products, which are extensively utilized by neurosurgeons throughout the world.

The new corporate identity joins together the Schaerer and Mayfield® brands. At a recent Board of Directors meeting, it was noted, "This name change will better reflect the Companies' relationship, and capitalize on the long history of Schaerer and the solid Mayfield® brand preference in the neurosurgical market. It shows the broader line of synergistic operating room products available to our collective customers all over the globe." □

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