



NEUROSURGERY NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

President's Message Patients: Our Greatest Priority

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



As your CNS President, I am keenly aware of the current myriad of obstructions and restrictions on our neurosurgical practices. We face additional

funding cuts that pose further threats to our research efforts, our training programs, our hospitals, and our income. We are experiencing unprecedented premium increases and reductions in providers of professional liability insurance. New governmental regulations threaten the ability of the CNS and other organizations to provide continuing medical education programs and services. As we tackle these and other serious issues, we must put forth well-defined responses and solutions, while maintaining our focus and commitment to our greatest professional priorities—our patients.

We live in a time when health care is felt by many to be “over-regulated” by state and federal statutes and regulations. The fixed pool of funding available to the Medicare system is a declining reimbursement dilemma that is all too familiar to participating neurosurgeons. From arbitrary reimbursement equations to the seemingly illogical reduction of critical equation components, to the diminution of relative value units for procedures performed, and to scheduled annual percentage reductions in provider reimbursement, neurosurgeons in particular are struggling to reorient their practices in an effort to maintain their viability. Why? Apparently, because the only obvious (translated—easy) mechanism to control accelerating health care costs (18% of gross domestic product, GDP) according to our national and state officials is to cap government support for government’s mandated programs.

Third party payors have “worked” to “gain control” of health care costs as well. In the process they often simply deny coverage for a variety of technologically innovative (translated—expensive) treatments and have likewise slashed reimbursement for services they choose to cover. Without apparent rhyme or reason, insurers have chipped away at reimbursements for all categories of health care services. While there may be no “rhyme” that is apparent, the “reason” behind these often drastic cuts in reimbursements is obvious: to shore up each insurer’s financial bottom line.

Malpractice expenses and accelerating premiums for medical liability insurance have handcuffed, and in some cases crippled, individual neurosurgeons and neurosurgical practice

groups. Medical liability insurance market trends clearly suggest that no health care provider is beyond reach if the current climate for punitive jury awards for bad outcomes as distinguished from

actual physician negligence is not brought into check with tort reform, including caps for noneconomic damages such as pain and suffering.

Recently, the Office of the Inspector General has decided to take action to regulate and restrict the interface of

Continued on page 2

Editor's Note: *During recent months many of our neurosurgical colleagues have honored us and their country by their dedicated service in the Military during the War on Terrorism. As new deployments loom during the coming months, many of these men and women may once again go into harm's way to serve our injured abroad. Since it has been my honor and good fortune to know Dr. William T. (Bill) Monacci over the last 10 years, I have asked him to provide an ongoing perspective on his work in several installments over the next several issues of the Neurosurgery News.*

Neurosurgery and the War on Terrorism

**William T. Monacci, M.D.,
LTC, MC, USA and
James M. Ecklund, M.D.,
LTC, MC, USA**

Military neurosurgery has a very long and proud tradition of service and innovation that comes to the forefront during times of war. September 11, 2001 was no exception. Since that date the United States has stepped up its War on Terrorism.

Terrorism threatens the security of the United States and the advancement of peace and prosperity throughout the world. Neurosurgery is termed a “go to war” specialty in the United States Army, as it is critical in providing care to our injured soldiers during combat in austere and remote environments. October 2001 saw the opening salvos of Operation Enduring Freedom with United States Forces engaged in combat in Afghanistan. Dr. Leon Moores

Continued on page 2



Lieutenant Colonel Leon E. Moores caring for Special Forces troops in Afghanistan.

INSIDE THIS ISSUE

Practice Guidelines	3
Recommended Bylaws Changes	7
CSNS News	11
Joint Section on Disorders of the Spine and Peripheral Nerves	17
Joint Section on Pediatric Neurosurgery	21
American College of Surgeons Report	21

CONGRESS OF NEUROLOGICAL SURGEONS®

10 N. Martingale Road
Suite 190
Schaumburg, IL 60173

NONPROFIT ORG.
U.S. POSTAGE
PAID
RICHMOND, VA
Permit No. 930

NEUROSURGERY NEWS

WINTER 2003
Volume 4—Number 1

Editor-In-Chief

B. Gregory Thompson, M.D.

Co-Editor

Karin Muraszko, M.D.

Editorial Board

P. David Adelson, M.D.

William Bingaman, M.D.

Rees Cosgrove, M.D.

J. Paul Elliott, M.D.

Martin C. Holland, M.D.

R. John Hurlbert, M.D.

Daniel F. Kelly, M.D.

Joel D. MacDonald, M.D.

Katie Orrico, J.D.

Congress of Neurological Surgeons® 2002–2003 Officers

President—Mark N. Hadley, M.D.

President-elect—Vincent Traynelis, M.D.

Vice-President—Nelson M. Oyesiku, M.D.

Secretary—Gerald E. Rodts, Jr., M.D.

Treasurer—Douglas S. Kondziolka, M.D.

Past President—Stephen M. Papadopoulos, M.D.

NEUROSURGERY NEWS is the official newsmagazine of The Congress of Neurological Surgeons®, located at 10 N. Martingale Road, Suite 190, Schaumburg, IL 60173. NEUROSURGERY NEWS is published bimonthly by Lippincott Williams & Wilkins, 351 W. Camden St., Baltimore, MD 21201-2436. Copyright © 2003 by The Congress of Neurological Surgeons®. No part of this publication may be reproduced in any form or language without written permission from the publisher. Published free of charge for the Congress membership with additional distribution. Annual subscription rates: Domestic institution \$86; International institution \$121; Single copy \$27. U.S. POSTMASTER: Send address changes to NEUROSURGERY NEWS, Lippincott Williams & Wilkins, 16522 Hunters Green Parkway, Hagerstown, MD 21740-2116. Library of Congress ISSN: 1525-819X.

All correspondence on editorial matters should be addressed to:

B. Gregory Thompson, M.D.
Editor-in-Chief
University of Michigan
1500 E. Medical Center Drive
Ann Arbor, MI 48109-0338
email: gregthom@umich.edu

President's Message

Continued from page 1

pharmaceutical companies and other corporate entities, including medical equipment and instrument manufacturers and suppliers with physicians and physician groups, including organized specialty societies like the CNS.

As neurosurgeons attempt to understand and address these complex issues, it is tempting to take a confrontational stand against these seemingly overwhelming developments. However, proposals or strategies in which patient access is restricted, such as neurosurgeons staging slow downs or participating in strikes, are simply not viable solutions. We, both as individuals and as a subspecialty organization, must maintain our stance on the higher ground and seek constructive and long-term solutions through forceful and well-developed responses. To that end, the CNS leadership, often in conjunction with the AANS, AANS/CNS Sections, the ABNS, and others, strive to generate a consensus neurosurgical position (when appropriate) and to identify multifaceted strategies for each new challenge, including the education of those who do not know, understand, or appreciate us and the complexities of the issues we face. We provide “neurosurgery-specific” accurate data to combat misconceptions or “imposed inaccuracies.” We highlight actual examples of difficulties and inequalities that neurosurgeons and our patients face. We present analysis and alternatives for proposed governmental action. Finally, we join with other physician groups with similar problems and similar commitments to finding solutions.

Whatever our approaches to these issues might be, our greatest priority must always be the patients we treat. We must stay focused on, committed to, and aligned with those we serve. Current market forces, faceless governmental agencies, and for-profit third-party insurers tend to create a “wholesale commodity” environment for medical care. Physicians and our services are being pushed to the margin and portrayed as “commodities,” rather than private, personal, and compassionate professionals. If we continue to treat patients as if they were family members rather than “another case” for the insurers; if we remain intimately concerned about our patients’ health, their welfare and their fears; if we truly provide top-quality individualized specialty care, nothing will ever divide our patients and us. Neurosurgeons are a small fraction of the physician providers in the United States; however, we are distinguished by the unique services that we provide and our unwavering commitment to those we serve. Our patients and our relationships with them are our greatest professional priorities, and that must never be allowed (or forced) to change.

We will continue to work diligently to

improve our collective circumstances in the present political, social, and economic environments. If, in the process, we continue to keep our patients, their needs, and their welfare as our top priority, we will be, as the saying goes, doing the right things for all the right reasons. □

Terrorism

Continued from page 1

LTC, USA, an Army neurosurgeon stationed at Walter Reed Medical Center, was deployed for a period during Operation Enduring Freedom in order to provide neurosurgical care and advise trauma teams deployed in the theatre.

As operations continue and the scope on the War of Terrorism broadens, it is likely that military neurosurgeons will be engaged throughout the theatre of operations. Many neurosurgeons across the Military have already been given notice of upcoming deployments. Neurosurgery in the Army is organized into specific teams, generally composed of two neurosurgeons, an anesthesiologist, and several technicians and support personnel. These neurosurgery “K” teams can be attached to larger facilities equipped with CT scanners as well as other modern equipment commonly found in the trauma rooms of most trauma centers. Each team deploys into the field with its own set of equipment. Typically, this would include a Mayfield headrest, bipolar electrocautery, a motor-driven perforator, an operating microscope, and the numerous disposables neurosurgeons require in their operating rooms.

Neurosurgeons in upcoming deployments will face challenges not previously shared by their predecessors. The practice of military neurosurgery must respond to meet these new demands. Bayonets and lower velocity slugs have been replaced by nuclear, biological and chemical weapons, and computerized ordinance delivery systems. Injuries have and will continue to become more complex. As we increasingly confront the threat of terrorism and urban conflict, the battlefield and enemy are often less well defined. We must anticipate less traditional threats. Terrorists may strike not only troops in the field but may engage support troops as well, such as large hospital facilities. Preparations must now be made to combat and respond to a wide variety of terrorist tools, including explosives and weapons of mass destruction. To meet this challenge, military neurosurgery has engaged not only the technological advances well known to the twenty-first century neurosurgeon, but has also continued to develop and hone methods to care for the soldier who may be injured in a fire fight and must be transported from a remote location. Military medical strategies to respond to such new battlefield threats have been in steady development and are ready for deployment.

One such example is a new neurological field assessment tool. The Glasgow Coma Scale is a useful assessment in a hospital environment, but it is unrealistic to expect a young 18-year-old medic to conduct this exam while under fire. The Marine Corp is currently investigating implementation of a more basic clinical evaluation tool that can be readily administered in the heat of battle and which would easily place the neurologically injured soldier into one of three categories: evacuate, return to battle, or expectant (not expected to survive). This tool relies on simple assessments of disorientation, weakness, seizure, pupillary abnormality, and the presence of a scalp laceration and/or skull fracture. Recent studies have shown a very high correlation with outcome. A continuing study will be performed in the upcoming deployments.

As operations continue and the scope on the War of Terrorism broadens, it is likely that military neurosurgeons will be engaged throughout the theatre of operations.

A Defense and Veterans Brain Injury registry form has also been developed and will be issued to all deploying neurosurgeons. The registry form is simple, readily accessible on CD ROM or hard copy, and will allow a rapid collection and appropriate dissemination of data that will be invaluable for improvement of neurosurgical care delivered to the injured soldier.

The Military traditionally has been and will continue to be a leader in research and technological innovation as it applies to the military mission. Today there are 38 neurosurgeons on active duty in the United States Armed Forces stationed at 15 different hospitals worldwide. There are approximately 60 neurosurgeons in the Armed Forces Reserves. Deployments for neurosurgeons vary from the previously discussed Army K teams (two neurosurgeons supporting a field hospital) to larger neurosurgical detachments supporting hospital ships and theatre hospitals.

As Consultant to the Surgeon General for Neurosurgery, I have been very happy to receive numerous calls from neurosurgeons across the United States volunteering their services should the need arise. All those who called expressed their desire to care for the brave young men and women who are serving our country and defending the United States in the name of peace and freedom. In fact, many men and women from the family of organized neurosurgery have previously experienced the honor of providing neurosurgical care to our military patients. With our continued collective support, the men and women who defend our shores will be well served far into the next century. I will keep the readers of this publication abreast of future developments in the upcoming months. □

Editor's Note: See the related article on *Practice Guidelines* on page 17.

Practice Guideline Development in Neurological Surgery

Beverly Walters, M.D.



The activities of Organized Neurosurgery in the realm of practice parameter development began in 1994 with the course given in Chicago to

representatives from several AANS/CNS Sections on the concepts of evidence-based medicine, including the practical aspects of making recommendations. Subsequently, the Joint Section on Neurotrauma and Critical Care undertook an organized effort to develop practice parameters around the treatment of traumatic brain injury, with funding from the Brain Trauma Foundation. Since publication, these practice recommendations have changed not only neurosurgical practice, but have improved outcome for patients with traumatic brain injury. Several other practice guidelines have subsequently been developed, including the comprehensive "Guidelines for the Treatment of Cervical Spine and Spinal Cord Injury" published as a supplement to *Neurosurgery* in March of 2002. These latter guidelines, developed under the auspices of the Joint Section on Spine and Peripheral Nerves, were cited in the Congressional Record for their importance by Congressman Jim Langevin of Rhode Island.

Under the strategic plan for the Congress of Neurological Surgeons, President Mark N. Hadley appointed several Joint Section representatives to help with the development of further practice recommendations. These include the Pain, Functional, Pediatric, and Spine Sections. The Sections have embraced the idea and are in the process of beginning these activities. This fits well within the efforts of organized neurosurgery and will further the cause of evidence-based practice.

About the Guidelines Committee

The organizational home of the guidelines movement within the neurosurgical organizations is the Guidelines Committee, a joint committee of the Congress of Neurological Surgeons and the American Association of Neurological Surgeons. It functions as a conduit for the production and approval of practice parameters, or guidelines, relevant to neurosurgical practice. The committee is made up of representatives from the Joint Sections designated to serve by the Executive Committee of that Section. Not every joint section

is engaged in the development of practice parameters, and therefore some sections do not have a representative to the Guidelines Committee.

Mission of the Guidelines Committee

The Guidelines Committee is committed to the development or facilitation of the development of scientifically sound and clinically relevant practice parameters for neurosurgery. These tools are to be used to apply medical effectiveness research, to assess the appropriateness of neurosurgical services, and to identify areas of service in

need of further investigation.

Practice parameters are defined as systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical conditions. They represent strategies for patient management, developed to assist physicians in clinical decision making. As components

Continued on page 4

Practice Guidelines

Continued from page 3

they may include the following, consistent with the recommendations of the American Medical Association:

Standards: authoritative statements of generally accepted principals for patient management, which reflect a high degree of clinical certainty.

Guidelines: recommendations for patient management which may identify a particular strategy or range of management strategies and which reflect moderate clinical certainty.

Practice Options: statements about strategies for patient management in which the outcomes are either unknown or the patient preferences are unknown or undecided and the clinical certainty is unclear.

Process of Guideline Development

Guideline development projects arise from a request as outlined below or from individuals or groups with a specific interest in such a project. All guideline projects originating within the AANS, the CNS or any of the Sections or Committees of the parent organizations should be developed and reviewed in conformity with the process outlined below.

Selection of a topic: Requests for development or help in developing a guideline or review criteria may be submitted to the Guidelines Committee by the Board of Directors of the AANS or CNS, the Chairpersons of the Joint Sections, the CSNS Executive Committee, the general membership, or other outside organizations. Such requests may also arise from within the Committee.

Requests should include: A statement of the general problem or topic and the specific questions to be addressed. Further there should be a justification for development of the guidelines based on the following criteria: frequency of the condition, procedure or intervention, controversy about the validity of the intervention, potential for improving health outcomes related to the topic, potential for reducing variations in practice, economic impact, needs of the membership, perceived urgency, government constraints or influence, required resources (financial, staff, member volunteers), adequacy of scientific evidence, statements of proposed frequency of review and updates to guidelines, and “key players,” i.e., organizations, individual experts, Joint committees that have a stake in the guideline.

Approval of a request to develop selected topic: From within the AANS or CNS or the Joint Sections, submitted requests are reviewed by the Chairperson of the Committee and any members of the Committee who have an interest and expertise in the topic of

the proposed parameter. The Committee will review existing practice parameters and pertinent literature with the aid of the sponsor. Guidance may be solicited from recognized experts. The Committee may choose to endorse existing practice parameters, or to support development of a new guideline. If approved, such proposals will be assigned priority among all requests. The Joint Sections will be requested to participate in or assume responsibility for development of practice parameters and outcome measures on behalf of the parent organizations. When a request for review of a guideline product from a source outside of organized Neurosurgery is received, the document should be referred to the Chairperson of the Guidelines Committee for consideration by the Guidelines Committee

Preparation of draft of proposed parameter: The task of drafting a parameter is assigned to an expert or group of experts outside of the Committee, such as a Joint Section or an appropriate subspecialty organization or task force. Oversight of the development is maintained by assigning a member of the Committee as a coordinator and to maintain liaison with the Committee and assure that the parameter is developed in conformity with the process outlined by the Committee. The draft of the parameter is reviewed and edited by the Committee in view of the evidence presented. This may include review by other designated committees within organized neurosurgery as well as legal counsel. Other outside and interested organizations may be involved in the review process before final approval. The suggestions for changes are referred back to the development team for review and integration into the final draft.

Approval process: Approval of the final draft of the parameter is made by the project coordinator in conjunction with the development team. This should include review and approval from the Guidelines Committee that may exist within any of the Joint Sections involved in the project. This is followed by approval by the Chairperson and appropriate members of the Guidelines Committee, and then approval by the AANS Board of Directors and the CNS Executive Committee.

Dissemination: Practice Parameters approved as above will be submitted to the *Journal of Neurosurgery*, *NEUROSURGERY*, or other appropriate peer-reviewed journals and announced in the Bulletin. The AMA Practice Parameters Partnership and Forum will be advised of the document and a copy providing for listing in the compendium of such materials. A copy will be sent to the Agency for Health Care and Policy Research. Copies will be available at the Chicago offices of the AANS and CNS.

Guideline Development Checklist

This checklist is intended to provide a quick means of determining whether the specifics of the Guidelines Committee’s “Practice Parameters Development Process” and “Document Format” have been incorporated into draft parameters.

Overview (statement of problem and specific questions)

Justification

Description of literature review

Rationale for selection of expert testimony (if applicable)

Consensus process (where appropriate)

Clinical and therapeutic considerations, if appropriate

Recommendations stated as ‘standards,’ ‘guidelines,’ or ‘options’

Algorithm if appropriate

Reasoning process (with evidence table if appropriate)

Recommendations for future research

Summary of harms, benefits and costs for various interventions (“balance sheet” if appropriate)

Analysis of conflicting guidelines

Recommendations for next review

Reliability

Clinical adaptability

Flexibility

Disclaimer

References: footnoted in text in order of appearance; listed at end with quality of evidence rankings; include with the reference list a tab summarizing which references fall within each category (Class I, II, III)

Practice Guidelines

Continued from page 4

Format of Guidelines

The following shows, in a step-by-step fashion, how guidelines should be formatted.

I. Description of Process

An explanation of the exact review process used in the development of the guidelines will describe in detail the following:

A. Description of literature review

1. How the literature search was conducted (key words, which system, how many citations requested).
2. How articles were selected (e.g. all articles reviewed, only prospective studies selected, only outcomes-based studies selected, any other discriminating factors).
3. How articles were reviewed (e.g. articles reviewed in entirety, abstract review only).

B. Rationale for selection of expert testimony

C. Consensus process (e.g. Delphi method, group discussion, etc.).

II. Scientific Body

The scientific body of the parameters shall include a narrative and a detailed description of each element in the outline below if appropriate to the topic being reviewed. Recommendations should be incorporated into the discussion as appropriate.

A. Background

B. Scope of the problem (including epidemiology)

C. Clinical considerations (if appropriate)

1. Historical findings
2. Physical findings

3. Differential diagnosis
4. Confirmatory studies
 - a. Indications
 - b. Contraindications
 - c. Techniques
 - d. Complications
 - e. Evolving diagnostic studies
 - f. Tests of unproven value

D. Therapeutic considerations (if appropriate)

1. Indications
2. Contraindications
3. Technique
4. Documentation
5. Complications and treatment
6. Duration of care
7. Anticipated outcome, including available information on health outcomes experienced directly by patients (e.g. discomfort, assurance, seizure rate, as opposed to intermediate outcomes such as correct diagnosis or Dilantin level).
8. Available information on patient preferences
9. Recommended setting
10. Qualifications for performance
11. Role of consultants

E. Reasoning process

1. The **quality of evidence** selected should be indicated by ascribing to each citation in the reference list one of the following classifications:

Class I: Evidence provided by one or more well designed randomized controlled clinical trials, including overview (meta-analyses) of such trials.

Class II: Evidence provided by

well designed observational studies with concurrent controls (e.g. case control and cohort studies).

Class III: Evidence provided by expert opinion, case series, case reports and studies with historical controls.

2. The **reasoning and assumptions** upon which recommendations are based. Provide an explicit description of how evidence was abstracted from various sources, compared and combined. An "evidence table" should be considered when appropriate to the topic. If used, the evidence table should include the following elements for each study abstracted: study design, number of subjects, relevant study variable, and summary of results.

3. The **strength of recommendations or conclusions** is based on the quality and consistency of supporting evidence **as well as** the magnitudes of benefits, risks, and costs, and expressed as **standards, guidelines, or options**.

F. Recommendations for future research (if any; include recommendations for patient preference data)

G. Summary of harms, benefits and costs for interventions considered in the form of a graphic display or "balance sheet."

III. Additional Elements

A. An **analysis** of differences between these and **conflicting parameters** produced by other groups.

B. **Recommendations for next review.**

C. Documentation of how **reliability** was tested. Policies are reliable if, given the same clinical circumstances, they can be interpreted and applied consistently.

D. Description of population(s) to which statements apply. This is an indication of **clinical adaptability**.

E. An **indication** of the flexibility or recommendations. In which circumstances would exceptions be expected?

IV. Disclaimer

The following disclaimer statement, subject to approval by the AANS Board of Directors and CNS Executive Com-

mittee and offered by legal counsel, should be incorporated into the body of the document:

This [document title] is provided as an educational service of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS). It is based on an assessment of current scientific and clinical information, which we anticipate will be periodically reviewed and updated to include future developments in scientific information and technology. This information is designed to provide accurate and authoritative information in regard to the subject matter covered. It is not intended to include all possible proper methods of care for a particular neurological problem or all legitimate criteria for choosing to use a specific procedure. Neither is it intended to exclude any reasonable alternative methodologies. The AANS and CNS recognize that specific patient care decisions are the prerogative of the patient and the physician caring for the patient, based on all of the circumstances involved. The decision to adopt any particular recommendation contained in these Guidelines must be made by a treating physician in view of all the facts and circumstances in each particular case and on the basis of available resources. These Guidelines are distributed with the understanding that the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, and the other organizations that have collaborated in the development of these Guidelines are not engaged in rendering professional medical services.

The purpose of the disclaimer is to communicate the intended flexibility of the policies and to affirm the decision-making responsibilities of the physician and patient.

V. References

References will be footnoted and listed at the end of the document according to "Instructions to Authors" published in *NEUROSURGERY*. Each citation should include a quality of evidence ranking in an Evidentiary Table.

The foregoing outline should be observed when preparing the background paper for practice parameters and guidelines

Summary

The demand for practice recommendations comes from the public, from physicians, and from payors, including government. If organized neurosurgery is not proactive in developing these parameters, then other subspecialty organizations will take this on, or less appropriate, payor organizations, without benefit of neurosurgical expertise. The purpose of the Guideline Committee is to facilitate this process. □

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

ADVERTISING inquiries regarding advertising in *Neurosurgery News* should be directed to:

Kelly Adamitis

Lippincott Williams & Wilkins

530 Walnut Street, Philadelphia, PA 19106-3621

Tel: 215/521-8402 Fax: 215/521-8411

email: kadamiti@lww.com



Recommended Bylaws Changes

P. David Adelson, M.D.

Chairman, Bylaws Committee
Congress of Neurological Surgeons

The following Bylaws changes are being submitted by the Bylaws Committee for publication in *Neurosurgery News* in advance of the Annual Business Meeting.

1. Article VII, Section I, Committees K. Strategic Planning Committee

The Strategic Planning Committee shall consist of 7 members, the Past President, the President, the President-Elect, Secretary, Treasurer, Chairman of the CNS Education Committee, and the Chairman of the Joint Council of State Neurosurgical Societies. In the event that one of these individuals shall hold more than one of the above mentioned positions, the President shall appoint an alternate to the Committee. This Committee shall regularly meet to make recommendations relative to strategic planning of the Congress.

Recommended Change

The Strategic Planning Committee shall consist of 8 members, the Past President, the President, the President-Elect, Secretary, Treasurer, the Chairman of the CNS Education Committee, *the Annual Meeting Chairman, the Scientific Program Chairman*. The Chairman of the Strategic Planning Committee is the President-Elect. The President and President-Elect shall have the opportunity to appoint alternates to the Committee or members-at-large at their discretion. This Committee shall regularly meet to make recommendations relative to the strategic planning of the Congress of Neurological Surgeons.

Rationale

The change in the bylaw was indicated to more truly reflect the members most representative of the strategic planning process. The Strategic Planning Committee should and does consist of the elected representation and leadership of the Congress of Neurological Surgeons as well as those involved in the planning and future planning of the major educational product, the Annual Meeting. The officers and other members integral to the planning and future of the Congress need to be included with past, present, and future leadership participating in strategic planning. For that reason, the bylaws change has been requested.

2. Article VII, Section I, Subsection M. Newsletter

The Newsletter Editor shall be

appointed by the President, shall prepare editions of the Newsletter as directed by the Executive Committee.

Recommended Change

Article VII, Section I, Subsection M. *Neurosurgery News*

The Neurosurgery News Editor(s), who shall be appointed for a 3-year term renewable by the CNS President, shall appoint an editorial board and prepare editions of the Neurosurgery News as directed by the Executive Committee.

Rationale

Since the CNS Newsletter no longer exists, the change in the bylaw reflects the formation of *Neurosurgery News* as the regular periodical updating the membership of the CNS.

3. Article VII, Section I, Subsection L. Membership Committee

The Membership Committee shall consist of 7 members and shall review and vote on all the pre-applicants and applications for membership. Appointment to the Membership Committee shall be made by the President with the approval of the Executive Committee. Three members shall be appointed every other year, and 3 members plus the Chair shall be appointed on alternate years. The Chair shall be selected from among the members of the Executive Committee who are not officers, and shall serve a 2-year term, renewable by the CNS President.

Recommended Change

The Membership Committee shall consist of up to 7 members and shall review and vote on all the ~~pre-applicants and~~ applicants for membership. *The Chair shall be selected from among the members of the Executive Committee who are not officers, and shall serve a 2-year term, renewable by the CNS President. Appointment to the Membership Committee shall be made by the President in conjunction with the Chair of the Membership Committee with the approval of the Executive Committee. Members of the Committee shall be appointed for a 2-year term.*

Rationale

Change reflects clarification of the committee, its members, and their appointments.

4. Article VII, Section I, Subsection O. Publications Committee

The Publications Committee shall pro-

mote the educational goals of the Congress and provide educational information in written form for CNS members. The Committee shall provide direction and vision for new forms of educational communication.

Recommended Change

The Publications Committee shall promote the educational goals of the Congress and provide educational information in written *and/or electronic form* for CNS members. The Committee shall provide direction and vision for new forms of educational communication.

Rationale

Change reflects changes in transmission of both printed and electronic forms of publications by the CNS.

5. Article VII, Section IX, Publications

Publications and official information, proceedings, and papers presented at annual meeting and committee investigations must be approved by the Executive Committee before publication. The Congress Newsletter may be published after approval by the President and the Secretary.

Recommended Change

Publications and official information, proceedings, and papers presented at annual meeting and committee investigations must be approved by the Executive Committee before publication. *Neurosurgery News may be published after approval by the President and the Secretary.*

Rationale

Since the Congress Newsletter, no longer exists, having been replaced with *Neurosurgery News*, the change in the bylaw reflects the formation of *Neurosurgery News* as the regular periodical updating the membership of the CNS.

6. Article VIII, Representatives

Recommended addition to the bylaws

F. Think First/National Injury Prevention Foundation – 2 representatives with terms of 3 years renewable by the CNS President.

Rationale

Since the CNS has an ongoing representative liaison to the Think First/National Injury Prevention Foundation, the change reflects present practice.

7. Article VII, Section 1. Committees

In this section, the naming and organization of the listings are inconsistent. Changes in wording and naming of

committees are suggested to maintain consistency throughout this section.

A. The Annual Meeting Committee *changed to* The CNS Annual Meeting Committee

B. The Bylaws Committee *changed to* The CNS Bylaws Committee

F. The Distinguished Service Award Committee *changed to* The CNS Distinguished Service Award Committee.

H. The Finance Committee *changed to* The CNS Finance Committee.

I. The Historian and Archive Committee *changed to* The CNS Historian and Archive Committee.

K. The Strategic Planning Committee *changed to* The CNS Strategic Planning Committee

L. The Membership Committee *changed to* The CNS Membership Committee

N. The Nominations Committee *changed to* The CNS Nominations Committee

O. The Publications Committee *changed to* The CNS Publications Committee

P. The Professional Conduct Committee *changed to* The CNS Professional Conduct Committee

Q. The Resident Committee *changed to* The CNS Resident Committee

S. The Committee for Military Neurosurgeons *changed to* The CNS Committee for Military Neurosurgeons

Y. The International Committee *changed to* The CNS International Committee

W. The Committee for Neurosurgical Fellowships *changed to* The CNS Fellowships Committee

Y. The Public Relations Committee *changed to* The CNS Public Relations Committee

8. Article VII, Section 1. C. Certification Committee

Recommended Change

It is recommended that the Certification Committee, a standing committee, be eliminated from the Bylaws as a standing committee and moved such that in **Article VII, Section 1. G. The CNS Education Committee**, following the description and role of the Education Committee, a second

“...And this child was found dead on morning rounds...”

Carlo M. de Luna, M.D.

Foundation for International Education in Neurosurgery

Dr. David Sandberg is completing his chief residency year in neurosurgery at the Weill Medical College of Cornell University. He went to Tegucigalpa in Honduras under FIENS sponsorship during May of 2001 and 2002. The following is a compilation of his reports from those experiences. Dr. Sandberg is the first resident we have sponsored and his insight is particularly revealing.

This report is based on my rotation at Hospital Escuela in Tegucigalpa, Honduras. Because of my interest in pediatric neurosurgery, I concentrated my efforts on teaching the residents who were rotating through this service. Hospital Escuela is the major teaching hospital in the city and provides neurosurgical care to the majority of the population. The hospital is crowded, understaffed, and limited by its inadequate infrastructure and financial resources. Although the hospital serves over one million citizens, there are only four pediatric intensive care unit beds and four adult intensive care unit beds. Surgical cases in which patients require intensive care monitoring are routinely postponed or cancelled because there are no available beds. For example, during my second visit in 2002, we admitted a four year-old boy with frank lethargy. He was found to have hydrocephalus from a posterior fossa tumor. We were unable to perform surgery because there were no anesthesiologists available late in the afternoon. We placed a ventriculostomy, but the child remained lethargic. No ICU beds or mechanical ventilators were available, so he remained on the regular wards; this child was found dead on morning rounds the day after admission. Surgeons often choose between several cases that are true emergencies, knowing deferred cases may be cancelled for the day despite considerable risks to patients. Emergency surgeries, including traumatic epidural and subdural hematomas, are frequently postponed because of a lack of anesthesiologists, shortage of sterilized instruments, loss of running water, or in one case, a broken elevator preventing transport of patients to the operating room.

Many of the instruments in the operating room are broken. There was only one suction available, which offered no back up for emergencies. Ventriculostomy catheters and drainage bags are in short supply, so residents utilized pediatric feeding tubes connected to Foley drainage bags. Dr. Tatsumi, a visiting neurosurgeon from the United States donated a Camino monitoring system, but catheters are currently not available.

The anesthesiologists at Hospital Escuela are understaffed. During my rotations, there were no attending anesthesiologists in the room. Residents performed cases without pulse-oximetry, and often needed multiple attempts at intubations. Patients who required prolonged intubation did not have access to ventilators because they were in short supply. Even simple precautions such as avoiding hypothermia in pediatric patients were not routinely administered.

The hospital floors are also understaffed, and I was told many of the nurses were hired with little more than a sixth grade education. Many did not have any neurological background. The majority of the wards lacked soap, a clean means of hand-drying, and even latex gloves. These conditions obviously increase the risk of spreading an infection from patient to patient.

Emergency surgeries, including traumatic epidural and subdural hematomas, are frequently postponed because of a lack of anesthesiologists, shortage of sterilized instruments, loss of running water, or in one case, a broken elevator preventing transport of patients to the operating room.

The neurosurgery residents at Hospital Escuela were hard-working and dedicated. As of 2002, there were eight residents training at the Hospital Escuela: one 5th-year, one 4th-year, three 2nd-years, and three 1st-years. A 5th year of residency training was recently added, in part based on my presentation in 2001 about residency education in the United States. However, resident education is still limited by several factors. Training in elective surgeries is overwhelmed by the amount of trauma. Since attending physicians are only available in the morning, the majority of afternoon and evening surgeries are unsupervised. Resident teaching conferences are held 3 days per week during the mornings and are excellent. However, I encouraged the faculty to hold a morbidity and mortality conference since many outcomes were never discussed in a formal setting. The neurosurgery library is small, and the department does not subscribe to journals. On my last visit, the residents received a computer with Internet access, allowing them to perform Medline searches.

Dr. Otto Spoerri, a visiting retired neurosurgeon from Germany, established a microsurgical training laboratory, which offered residents an opportunity to practice microsurgical skills. He arranged the donation of a Zeiss micro-

scope with two sets of oculars. This was a major contribution to teaching since it was also used in the adult operating room. Many neurosurgery residents, residents in other specialties, and medical students learned their microsurgical skills from Dr. Spoerri.

As a senior resident, I was able to contribute considerably more than I anticipated. I stayed with the on-call residents during many of the nights and weekends and assisted in operations and ward rounds. During many of these late operations, I was the most experienced surgeon in the room. I taught residents basic principles about procedure planning, patient positioning, proper suturing techniques, handling of brain tissue, and hemostasis. I encouraged residents to place ventriculostomies in patients with low Glasgow Coma Scale scores, particularly in trauma patients, and the number of patients with ventriculostomies increased by the time I left. I taught residents about ICP management, proper use of dexamethasone and mannitol, and other neurosurgical principles. Because of my interest in pediatric neurosurgery, I spent a majority of my time on the pediatric neurosurgical service. I taught proper techniques for ventriculoperitoneal shunting, management of patients with shunt infections, and repair of myelomeningoceles and lipomyelomeningoceles.

Currently, neurosurgical residency education in Hospital Escuela is still limited by factors intrinsic to the hospital and country, but some improvements have been made between my two visits. The neurosurgery residents have benefited from FIENS volunteers. Dr. Spoerri's continued presence has been particularly influential. I encourage FIENS to continue supporting this program, and I look forward to volunteering in the future at the Hospital Escuela.

There is probably no greater contrast in medicine than that between an academic residency program and a government hospital in a developing country. For the average FIENS volunteer, the transition between the two is mentally and physically difficult. For

those who have only known a university practice, the contrast is even more startling. Normally, when I review reports from recently arriving volunteers, it is a simple task to edit them for publication in this column. Dr. Sandberg's account however required more thought as to how much detail to include. In the end, I finally decided to let his description of the conditions in Hospital Escuela speak for itself.

As of this writing, there are currently no volunteers assigned to any of our sponsored locations. As Dr. Sandberg demonstrated, the impact of a volunteer is dramatic and measurable. Anyone wishing to volunteer for FIENS can contact Dr. Gail Rosseau at fiens@axionet.com. Anyone wishing to make a tax-deductible donation can contact Dr. Daniel F. Kelly, UCLA Medical Center, Box 957039, Ste. 18-218a NPI, Los Angeles, CA 90095-7039. □

Bylaws

Continued from page 7

paragraph shall read:

The CNS Certification Sub-Committee shall consist of a Chair and its members whose duties shall be to encourage completion of the certification process by all eligible neurosurgeons, to conduct programs to attain this goal, and to maintain a liaison with the uncertified neurosurgeon and the Congress.

Rationale

Previously as part of the Bylaws, the Certification Committee was a full standing committee of the CNS. The Certification Committee has always been intricately involved in the education of the board eligible neurosurgeon. In addition, since Neurosurgery is moving towards a re-certification process and the educational component of certification and the soon to be implemented re-certification are linked, the CNS Bylaws Committee, in conjunction with the CNS Executive Committee, have recommended that the Certification Committee become a subcommittee under the CNS Education Committee and its Chairman. □

NEUROSURGERY NEWS

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

Congress of Neurological Surgeons Treasurer's Report

Douglas Kondziolka, M.D., M.Sc., FRCS(C)
Treasurer, CNS



The Treasurer of the Congress of Neurological Surgeons functions in that role for a 3-year term. I am honored to serve as the new treasurer, and am indebted to

recent treasurers Dr. Paul Camarata (1999-2002) and Dr. Steve Papadopolous (1996-1999) for their guidance.

The following represent recent activities of the CNS:

- At the recent CNS Executive Committee Winter meeting, the committee voted to create a new **CNS Endowment Fund**, which will become part of the long-term investment portfolio of the Congress. The purpose of the fund is to endow, on an ongoing basis, educational and related initiatives of the Congress of Neurological Surgeons. The fund will support fellowship training in neurological surgery and other related educational programs. When the CNS reorganized its fellowship programs 5 years ago, it did so with plans to

eventually build an endowment that would foster these programs indefinitely.

- Dues statements were mailed in early December. A second mailing will go out in early March and a third at the end of April.
- The CNS will continue to use the "modified cash basis" of accounting. We reviewed the use of this method versus the accrual method with several independent accountants. Since member dues are collected in both 2002 and 2003, only half the dues would be reflected in the 2003 year. With the accrual method, we would need to change our fiscal year to the calendar year. This would create the need for budget approval at the time of the annual meeting. The 2004 budget will be created upon the predetermined schedule and submitted to the submitted to the Executive Committee in April. We will vote on the budget in June.
- The CNS Long-term Investment Portfolio is managed by Crawford Investment Counsel. The portfolio is balanced, using value-oriented investments. Over the last 6 months, the portfolio has declined by 2.75%. □

NEUROSURGERY://ON-CALL® Announces Contest Winner

Catherine L. Hamma
Manager, Web Site Services,
NEUROSURGERY://ON-CALL®

Bahaa E. Hafez, M.D., postdoctoral fellow at the University of Texas in Houston and instructor of Neurosurgery, Faculty of Medicine, Menofya University, Shebin, El-kom, Egypt, has been announced as the winner of the first Disorder of the Month contest by NEUROSURGERY://ON-CALL®. His article "Brain Metastasis" is the January 2003 Disorder of the Month, a *Health Resources* feature appearing in the public area of the N://OC® Web site (www.neurosurgery.org). In addition, his winning article provided Dr. Hafez with free registration to The Chicago Review Course in Neurological Surgery™.

Contest participants were asked to review the public area of the N://OC® Web site and select a neurosurgical disorder not currently covered or expand and update an existing subject. It was required that feature articles be between 5 and 10 pages long and cover symptoms, possible diagnostic tests, diagnosis, treatment options, prognosis, and

any other underlying information of benefit to the patient. A "Frequently Asked Questions" section was to be included as well as Web site references for other sources of information. In addition, articles had to be written in terms understandable to the general public. More information on the contest rules can be found on the Web site at www.neurosurgery.org/contest.html.

Response was tremendous and all of the articles submitted were excellent. Authors were advised that while they couldn't all be winners of the review course registration, their articles will be featured in future issues of Disorder of the Month. Watch the Web site in the coming months to review all participants' articles.

The Chicago Review Course in Neurosurgical Surgery™ (www.chicagoreviewcourse.com), offered by NSL Chicago Courses, is a rigorous 10-day course offering nearly 100 course topics with up to 12 hours of daily lectures. It is a comprehensive and intensive review for residents about to take their boards, newly established neurosurgeons, and practicing neurosurgeons who want to make sure that their diagnostic and surgical skills are current. □



Bahaa E. Hafez, M.D.'s article "Brain Metastasis" can be found on the in the public area of the N://OC® Web site (www.neurosurgery.org).

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.

Jeffrey E. Arle
Donald C. Austin
Basim M. Ayoub
Eric Busch
Bennie W. Chiles III
John J. Collins
Richard Day
Alessandro Ducati
Deborah L. Galante
Michelle M. Heidel
John L. Hudson
Takayuki Inagaki
Turker Kilic
John R. Macfarlane
Alvin Marcovici
Carolina Martins
Laura S. Pare

Joel T. Patterson
George T. Reiter
Curtis J. Rozzelle
Youssoupha Sakho
Abhan Sanan
Amit Schwartz
Khalid A. Sethi
Abbas Srour
Viviane Tabar
Kok-Kee Tang
Carl C. Troup
R. Shane Tubbs
Osly J. Vasquez
Todd Vitaz
Paul Waguespack
John E. Wanebo

CONGRESS OF
NEUROLOGICAL SURGEONS

CONTACT INFORMATION

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

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

Tel: 1-847-240-2500 / Fax: 1-847-240-0804
Email: info@1cns.org

The Think First/National Injury Prevention Foundation Urgently Needs Your Help!

P. David Adelson, M.D.

Chairman, Resource Development Committee
CNS Executive Committee, Think First Liaison
Think First/ National Injury Prevention Foundation



It's never too early in the year to plan how you'll direct your yearly charitable giving, so please consider how much more you can do to help those who are affected by traumatic injuries by sending a special, tax-deductible gift to the Think First/National Injury Prevention Foundation.

Whether for a child or an adult, as you know, it takes a lot of time, work and money to provide the many needed services and resources to those with disabilities secondary to traumatic injuries. The major impact that we can have is to prevent the injuries before they occur. We can only do it with the support of people like you, who truly care!

Your donation will allow us to continue to increase public awareness about traumatic injuries and its prevention, and ensure the highest quality of life for Americans affected by this challenging disease. With a presence in more than 250 communities throughout the United States, the Think First/ National Injury Prevention Foundation is the only national organization that provides education curricula specifically for school age children, and working to prevent the occurrence of half million American traumatic injuries each year. Your generous support will allow us to continue to:

- Develop education curricula for children to help prevent traumatic injuries and acquired disabilities across the United States.
- Promote an active advocacy agenda so our lawmakers hear the voice of the injury prevention community.
- Strengthen our capacity as a leader in promoting an education agenda for children to help prevent traumatic injuries and acquired disabilities across the United States.
- Conduct public awareness campaigns to educate the public about trauma and the message that trauma can happen to anyone and is preventable.

Please send your gift today—whatever amount you can afford to give. By taking a moment from your busy day to send your special year-end gift, you will have the satisfaction of knowing that the Think First/ National Injury Prevention Foundation will be able to create more programs to help us better

prevent traumatic injuries and ensure that these children have the opportunity to live their lives to the fullest.

Many other types of gifts allow you to fulfill your charitable intentions and may result in immediate and possible future benefits for you and your family. Please call, write or e-mail our office for details on wills, charitable giving and year-end gifts, including "life income gifts."

To help meet the most urgent needs, please send your special, tax-deductible gift by as soon as possible. Thank you in advance for your support of the Think First/ National Injury Prevention Foundation's work on behalf of the injury prevention community.

Think First Louisiana Meets the Neurosurgeons at the State Society Meeting

David A. Cavanaugh, M.D.

Medical Director
Think First/ National Injury Prevention Foundation

During the Council of State Neurosurgery Societies (CSNS) Meeting in 2001, a resolution was passed encouraging communication between Think First/National Injury Prevention Foundation through the Think First State Chapter Directors and State Neurosurgery Society officers to help Think First make a presence at state meetings. This allows a local Think First coordinator to update neurosurgeons on national events, as well as opportunities for meeting those involved with injury prevention and neurotrauma throughout their state. There is a national push to become more aware of injury prevention, and how this can happen in your community.

Just ask the Louisiana Neurosurgery Society members. President John Raggio asked Think First State Chapter Director Donna Cavanaugh to be on the program at their meeting in New Orleans January 17–18. She brought the attendees up to date on the Foundation as well as the recent revisions of the Think First for Teens, the Think First For Kids curriculum, and the Think First for Youth program now in development. Rolled out was the updated slide presentation for the Teens pro-

gram that is available for neurosurgeons to have for programs in their community. She also gave a brief history of how Think First was started by neurosurgeons Fletcher Eyster in Pensacola, Florida, and Clark Watts in Columbia, Missouri, and adopted by the AANS and CNS in 1990. And, those wanting to start a chapter in their own community in Louisiana or surrounding areas learned that Donna and her Shreveport team have trained chapters from Louisiana, Texas, and even Jamaica.

Neurosurgery's Think First programs have won multiple awards in the past, and now scientific studies recently published have shown efficacy. The April 2001 *Journal of Pediatric Nursing* reported a significant knowledge increase regarding the brain and spinal cord, and a significant decrease in self-reported high-risk behaviors among children who had participated in the Think First for Kids program. An article in *Injury Prevention* in August 2002 found that the "Think First For Kids curriculum leads to a significant change in knowledge about prevention of brain and spinal cord injuries among first through third grade students." An independent University of Toronto study of unintentional injury prevention efforts in North America identified Think First as "Best Practice in Comprehensive Community Based Prevention Strategies," for 2001 and for that reason, Think First programs are being moved toward a nationwide distribution. Neurosurgery, with its development and involvement with these programs, has clearly made an impact and will continue to do so going forward.

Unfortunately, the issues facing organized medicine and neurosurgery that have a high public profile, such as medicare cuts, reimbursement for taking call, and tort reform with caps on malpractice damages, often don't engender positive images. Therefore, another benefit of developing and distributing neurosurgery's own Brain and Spinal Cord Injury Prevention Program is the positive public impact for the profession as an organization performing public service within the community.

When is the next neurosurgery society meeting in your state? If you are an officer, or a member helping make the local arrangements, make sure that the Think First/ National Injury Prevention Foundation is on the agenda. If you are planning your state meeting, and have not heard from your State Chapter Director, or if you don't have a Think First chapter in your area, call 847-290-8600, or log on to www.thinkfirst.org and get the information you need. A Think First coordinator can present a very impressive media presentation from the national office tailored to the needs of your meeting. If you sponsor a Think First chapter, consider having one of your VIP (Voices of Injury Prevention) speakers participate.

If you are already involved in Think First, those you have helped to avoid devastating injury or death appreciate

your efforts and your financial donations. If you are not yet involved, please consider supporting your Think First/ National Injury Prevention Foundation and its work (www.thinkfirst.org). The lives of our children and youth are too important not to hear this important message.

Annual Think First Chapter Director's Workshop to Be Held in San Diego

Dorothy Zirkle, R.N., Ph.D., M.S.N.

Chairperson of the Think First State Chapter Director's Subcommittee
Member of Think First's Executive Committee and Board of Directors

The Annual Think First Chapter Director's Workshop will be held in San Diego, CA April 26–28, 2003, the weekend of the 2003 American Association of Neurological Surgeons Annual Meeting. Spending a weekend in sunny San Diego will be a valuable time investment, as this year's workshop promises to offer important training opportunities catering to those at every level of the injury prevention field including coordinators, speakers, and physicians. For the first time, participants will be afforded the opportunity to attend a Pre-Conference Seminar on Friday April 25, 2003 entitled "New Dimensions in Clinical Practice and Catastrophic Injury." The presentations are "Psychiatry of Brain Injury: Diagnosis and Management," given by Walter Strauser, M.D.; "Regulation and Function of Neurogenesis in the Adult Hippocampus," given by Henrietta Van Praag, Ph.D.; "Sexuality and Fertility in the Spinal Cord Injured Patient" given by Lynne Beresford, BSN, C.R.R.N.; and "Thoughts on Adjusting to Disability," given by Richard Green, LCSW. Particular to interested neurosurgeons who may be interested in developing their own international or national local chapters, training to become a new Think First Chapter will also be held on Friday April 25th.

The full conference agenda begins on Saturday April 26, 2003 and will offer learning opportunities for program coordinators, speakers, and neurosurgeons who have been in the field for years as well as those who may be interested in creating or building up a new Think First Chapter. Attendees will hear from nationally recognized keynote speakers including Azim Khamisa, a man who lost his son to gang violence

CSNS NEWS

Chairman's Corner

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



Neurology and its practitioners currently face difficult and challenging times. Many of those challenges come from federal oversight agencies, state and local regulators, insurance industry, health care plans, the legal system, and many others. The CSNS, along with the AANS and CNS, deals directly with many issues affecting the practice of neurosurgery. This article will present a summarized description of the Council's history, its current structure and function, and how its proceedings impact the practice of neurosurgery. Lastly, I will discuss how to become a productive participant in the Council's infrastructure.

As described in a previous *Neurosurgery News* issue by Dr. Robert Schwetschenau, the roots of the CSNS began with the establishment of the Socioeconomic Committee in 1963 by the CNS. Subsequently it became the National Advisory Group on socioeconomic of the AANS and CNS in 1976 and was later reorganized into the Joint Socioeconomic Committee (JSEC) in 1978, with representation from each state (1 per 50 neurosurgeons in the state). Eventually it evolved into the Council of State Neurosurgical Societies, with direct and equal funding from both parent organizations. The Council was established with the purpose of providing a forum for state neurosurgical society delegates to discuss, consider, propose, and debate on many socioeconomic issues affecting the practice of neurosurgery.

Evolution in the Council's rules, regulations, and logistical proceedings, has taken place over the years. Currently, the membership of the Council is derived from three primary sources: 1) delegates elected from each neurosurgical state society with a ratio of 1 delegate per 50 member neurosurgeons, 2) appointed delegates with special talents and expertise or knowledge by the presidents of the AANS and CNS, and 3) residents in neurological surgery who are selected from each of the four quadrants and serve as full voting members for a period of 1 year. The CSNS functions under an Executive Board made up of the officers (David Jimenez, M.D., Chairman; Frederick



A. Boop, M.D., Vice Chairman; Gary M. Bloomgarden, M.D., Recording Secretary; Edie E. Zusman, M.D., Corresponding Secretary; Randall W. Smith, M.D., Treasurer; and Robert Schwetschenau, M.D., Historian) and four quadrant chair persons (Steven Onesti, M.D., Northeast Quadrant; Fernando G. Diaz, M.D., Northwest Quadrant; Patrick Jacob, M.D., Southeast Quadrant; and Phil Willman, M.D., Southwest Quadrant). Meetings of the Council take place 2 days prior to each annual meeting of the AANS and CNS. Executive Committee meetings take place 6 weeks prior to each of the annual meetings. All meetings take place under the rules of "Parliamentary Procedure."

The CSNS has eight standing committees through which all the members of the Council participate. The **Communication and Education Committee** develops and coordinates CSNS programs, presentations and publications on socioeconomic materials and information through annual or special meeting programs. The **Workforce Committee** researches, analyzes and reports and recommends action or policy on neurosurgery workforce needs. The **Coding and Reimbursement Committee** coordinates CSNS participation with the **AANS and CNS Coding and Reimbursement Committee** and such activities as CPT coding and reimbursement activities. The **Neuro-Trauma Committee** researches, reports, and recommends actual policy on socioeconomic activities affecting the delivery of neurosurgical trauma care. The **Medical Practices Committee** recommends action, policy, or information dissemination on factors affecting neurosurgical practice including practice management, clinical privileges, technological issues, ethical controversies, etc. The **Medico-Legal Committee** researches, reports and educates the CSNS and AANS on medico-legal issues affecting neurosurgical practice, including professional liability, informed consent, Medicare fraud and abuse, regulation enforcement of CPT coding, E&M documentation rules, antitrust laws, and other pertinent laws and regulations. The **Young Physicians Committee** undertakes research report on the projects and issues affecting young neurosurgeons including job search, practice

initiation, board certification, etc. And lastly, the **Health Systems Cost Control Committee** researches and reports on social, political, and economic factors affecting the cost of medical care and management cost of neurosurgical practice. All the committees actually become involved in the projects of the CSNS as well as review of resolutions and recommendations to the General Assembly during the resolution debate and vote.

Through the resolution process, members of the CSNS work through the many issues affecting the practice of neurosurgery. Resolutions are submitted 6 weeks in advance and are debated and voted upon by the General Assembly. Adopted resolutions are then sent to the Board of Directors of the American Association of Neurological Surgeons and the Executive Committee of the Congress of Neurological Surgeons for review and implementation if accepted. Any neurosurgeon, through a delegate or an appointed member, can submit a resolution for discussion and vote. During our last meeting in Philadelphia, eight resolutions were submitted and discussed. The following is a summary of these resolutions.

Resolution I: CMS and Medicare Attitudinal Survey

Adopted Substitute Resolution I

Be it resolved, that the attached survey, or future modifications thereof, be approved by the general CSNS body for use in periodic attitudinal surveying of the CSNS Membership and this survey be administered during CSNS registration by the CSNS Meeting Coordinator as part of the registration process at each subsequent CSNS meeting beginning in 2003, or by other means deemed appropriate by the committee with the completed forms turned over to the Medical Practice Committee for formal collection, analysis, and generation of a survey report for timely transmission to the Washington Committee, and the biannual survey reports be safely and faithfully kept in a database or spreadsheet by the Chairman of the Medical Practices Committee for ongoing use in longitudinal result trends analysis.

Resolution II: Neurosurgery Resident Work Hour Regulations

Adopted Following Substitute Resolution II

Be it resolved, that the Young Physicians Committee of the CSNS be directed to determine a master plan to obtain useful data, potentially with the aid of the Senior Society, that could result in amelioration of the potential neurosurgery problem with resident work hour restrictions. Be it further resolved, that the gathered data from such master plan be reported back at the next CSNS meeting and to the Washington Committee and that a budget of \$3,000 be provided from the CSNS State Society Voluntary Contribution plan.

Resolution III: Restricted Physician Workforce

Adopted Substitute Resolution II

Resolution IV: Pay Shortfall for Neurosurgeons in the United States Military

Adopted Substitute Resolution IV

Be it resolved, that the CSNS petition the AANS/CNS through the Washington Committee, with input from the Military Neurosurgeons' Committee, to send a letter to the Surgeon General of the Military Services supporting the increase in compensation to active duty neurosurgeons to make it feasible for long-term retention of qualified neurosurgeons.

Resolution V: Reserve Medical Officer Civilian Practice Insurance

Adopted Amended Substitute Resolution V

Be it resolved, that organized neurosurgery work through its representation to broad national organizations such as the American Medical Association to decrease the disincentive to participate in reserve duty in the Armed Forces.

Resolution VI: Neurological Surgery Resident Hour Survey

Adopted Substitute Resolution II

Resolution VII: Creation of a New 501(c)(6) Tax Exempt Organization for Neurosurgery

Adopted Substitute Resolution VII

Be it resolved, that the AANS and CNS create a 501(c)(6) organization for all of neurosurgery, not only to support the Washington Committee and the Neurosurgical PAC, but also as an integral part of a true merger of the two organizations to meet the critical needs of our profession.

Resolution VIII: Merger of AANS and CNS

Not Adopted

Be it resolved, that the leadership of the AANS and CNS be asked to form a committee which will act directly or through the CSNS to contact the leadership of the ACP/ASIM for the purpose of our benefitting from their experiences.

Heretofore, administrators and office managers of neurosurgical practices have had no formal organization or venue to communicate, organize, collect data, and share ideas. As a result of a resolution, the Medical Practices and Reimbursement Committee have diligently worked with the leadership of the respective chairmen (Drs. Linskey and Przybylski) to help organize and create such an organization. The Council has committed over \$30,000 to help fund the early phases of this project. That organization will be of significant value to all practicing neurosurgeons and their office staff.

I encourage your participation in the Council, which can be done by becoming

CSNS News

Continued from page 11

ing involved with your state neurosurgical society and becoming a delegate member. If you think you have expertise that may be of benefit to the Council and neurosurgery, please contact me or the AANS or CNS presidents for a special appointment. If you are a resident, have your program director nominate you to your quadrant chairman. Involvement in organized neurosurgery and particularly on the Council can be a very satisfying and productive experience.

Exploring and Tapping Undiscovered Resources Within Our Specialty



Mark Linskey



Greg Przybylski

Mark Linskey and Greg Przybylski

Co-Chairmen, CSNS Ad Hoc Neurosurgery Practice Manager & Administrator Organization Committee

Practice management has always been of primary concern to individual neurosurgeons, and is increasingly looming larger and larger on the political, legal, and economic radar screens of our national neurosurgery organizations and our Washington Committee. How we do business, our ability to remain economically solvent (let alone thrive), and our ability to continue to survive in a future of ever increasing regulatory obligations, shrinking reimbursements, and rising medical liability and regulatory compliance overhead costs are all critical practice management issues. Until recently, our two main national organizations (AANS and CNS) have primarily focused on educational and scientific missions to the benefit of us all. Efforts to champion and study practice management issues and promote an agenda to improve the practice management environment for us all were initially limited to Herculean volunteer efforts of a few seminal individual neurosurgeons. Some of the many noteworthy examples included Byron C.

Pevehouse, Ben W. Blackett, John A. Kusske, and Robert E. Florin. More recently these issues have been championed in a more organized fashion by the AANS/CNS Joint Committee on Coding & Reimbursement, the Council of State Neurosurgical Societies (CSNS), the AANS Education & Practice Management Department, and the AANS/CNS Washington Committee and Washington Office.

Yet, even with these more organized tools wielded in a more concerted and strategic fashion, the individuals providing the motive force, as well as the data input for strategic decisions remain neurosurgeons. In order for the Coding & Reimbursement Committee, the Washington Committee, and individual neurosurgeons struggling to manage their own practices to make informed decisions, and make intelligent future plans regarding a host of practice management issues, they all need current and accurate practice management data, as well as a knowledge of accurate data trends over time. In this regard, it is important to recognize that while socioeconomic and practice management issues are of obvious importance and concern to every neurosurgeon, they are the actual "bread and butter," day-to-day fare of our own practice managers and administrators. Indeed, it is not unusual for our practice managers and administrators to know more about staffing needs, customary salary ranges, overhead costs, productivity ranges, coding details, third-party and governmental agency regulatory constraints and processes, and fee and reimbursement rates than we do. This information and subject matter expertise is a critical, and a currently untapped and unorganized resource for neurosurgery.

The CSNS is the socioeconomic arm of both the AANS and the CNS, and the avenue for grass roots representation and input for all neurosurgeons within both parent organizations. Beginning with a feasibility study to explore different strategies for investigating reimbursement methodologies performed between September 2001 and April 2002, the CSNS recognized that the key first step to obtaining reliable and relevant practice management data over time for individual neurosurgeons, the Coding & Reimbursement Committee, and the Washington Committee to make sound data-driven decisions, would be the organization of our own neurosurgery practice managers and administrators into their own society. The new society would provide needed services for its members, but would also serve as a critical practice management research "data mine" for the neurosurgery specialty as a whole.

Two different strategies were carefully explored. The first involved strengthening neurosurgery participation in the preexisting Medical Group Managers Association (MGMA) through encouraging neurosurgeons to enroll their practice managers and administrators

in the Neuroscience Assembly of the MGMA. It was quickly recognized that this approach would be suboptimal for our purposes. First of all, the Neuroscience Practices Assembly of the MGMA is very poorly penetrated by neurosurgery practice manager and administrators at the present time. While the MGMA has approximately 19,000 members, only 300 are members of the Neuroscience Practices Assembly, which is dominated by neurology and other neuroscience medical practices. Only 13 neurosurgery practice managers or administrators answered at least one question on the 2001 MGMA practice management survey, and only 9 to 10 completed the whole survey. Second, the MGMA survey only provides data for physician compensation, administrator and employee compensation, practice costs, productivity, and staffing. No coding, billing, third-party billing process, or actual reimbursement data is collected. The collected data is very generic, since it must apply equally well to all types of medical practice, and year-to-year longitudinal trends in data results are not analyzed.

The CSNS decided instead to support and mentor the establishment of a brand new, independent, but closely affiliated, neurosurgery practice manager and administrator society. This approach provides greater flexibility and autonomy for potential members, allows for more concentrated focus on issues of greatest importance to neurosurgery, and allows for stronger and more effective affiliation and cooperation between the new society and the CSNS. The idea was not new. Many medical subspecialty societies have recognized the value in organizing an affiliated practice manager and administrator society. Examples include the American Academy of Orthopedic Surgeons (Bones Society, Inc.—A National Society of Orthopaedic Administrators), the American Academy of Otolaryngology—Head & Neck Surgeons (Association of Otolaryngology Administrators), and the American Academy of Dermatology (Association of Dermatology Administrators & Managers—ADAM). Some of the obvious potential benefits of such a society for neurosurgery practice managers and administrators, their affiliated individual neurosurgeons, and neurosurgery in general are enumerated and outlined in Table 1.

To accomplish this goal, an Ad Hoc Neurosurgery Practice Manager & Administrator Organization Committee (PMAOC) was established at the April 2002 CSNS meeting in Toronto. The members of this new Ad Hoc Committee are listed in Table 2. The charge given to this committee included the following: 1) initiate, guide, advise and mentor the establishment of the envisioned new society; 2) supervise the funding of the new organization for 3 years, or until it was financially solvent for routine non-research-related operations based on its own dues and

meeting fees; and 3) disappear once the new organization is firmly established and self sustaining. In order to accomplish the first goal, the PMAOC realized that it needed to identify a core nucleus of motivated and enthusiastic neurosurgery practice managers and administrators to serve as an initial "critical mass" for the society's organizational efforts. They had to bring these people together in an organizational meeting that could be facilitated by members of the PMAOC, and they needed to prepare a rough draft of potential new society bylaws consistent with planning goals that could be fine-tuned and embellished at the organizational meeting into preliminary society bylaws.

A master list of more than 1,200 potential neurosurgery practice managers and administrators was created by combining the database from the AANS Education & Practice Management Section, the contributors to the AANS 1995 Practice Management Survey Project submitted by Robert Florin, and a select neurosurgery client list by K. Zupko and Associates[®]. This master list will serve as resource for sending out a general call for membership for the new society. After cross referencing these lists with one another, a "select list" of 91 practice managers and administrators with proven interest in practice management research and/or benchmarking were identified for invitation to an organizational meeting to be held 07:30–12:00, September 20, 2002 in Philadelphia. Both Mr. Bruce Saunders (Executive Director, Association of Dermatology Administrators & Managers [ADAM]) and Ms. Julie Kahlfeldt (Society Director, Bones Society, Inc.—A National Society of Orthopaedic Administrators) were contacted by the PMAOC. Both agreed to serve as honored guest speakers at the planned organizational meeting to describe the potential benefits of forming the new society, and to present the "lessons learned" from their own society's organizational experiences. A mass mailing to all 91 contacts went out July 1, 2002. Announcements were also published in CNS-sponsored *Neurosurgery News* and the AANS *E-Blast*. This was followed up by personal phone calls from the Co-Chairmen of the Ad Hoc Committee on August 1 and 2. NeuroSource, Inc.[®] participated by independently contacting select members of their own client list. By September 15, 2002, 35 practice managers or administrators had committed to come (39% of those contacted). During the period of May 1–September 1, 2002, a rough draft of preliminary society bylaws was written, circulated to all Ad Hoc Committee members and consultants, and revised according to solicited suggestions. The bylaws draft was then reviewed by AANS and CNS legal counsel.

The organizational meeting of the new neurosurgery practice managers occurred as planned on September 20, 2002 in Philadelphia. The meeting was attended by 28 practice managers and

TABLE 1

POTENTIAL BENEFITS OF MEMBERSHIP IN A NEUROSURGICAL SUBSPECIALTY PRACTICE MANAGEMENT SOCIETY

- Continuing education specifically tailored for relevance to your professional practice
- A mechanism for service & professional recognition within your specialty profession
- An up-to-date and accurate directory of point of contact information for professional colleagues across the country
- Annual meetings designed to provide collegial social interaction and networking & benchmarking opportunities, as well as updates on coding and reimbursement issues & regulatory changes specific for your specialty, the latest advances in business management strategies and tools, and the latest data regarding current management practices, structures & models
- Networking infrastructure continuously available for immediate advice on specific practice management issues
- Newsletters designed to present practical solutions to common business problems and alerts regarding changes in relevant coding and reimbursement rules as well as regulatory policies
- Web sites designed to access useful information as well as obtain answers to immediate member questions and concerns
- Accurate, relevant, & current benchmark practice data for making data-based business decisions updated annually via society research through member surveys

TABLE 2

CSNS AD HOC NEUROSURGERY PRACTICE MANAGER & ADMINISTRATOR ORGANIZATION COMMITTEE

COMMITTEE MEMBERS:

Jim Bean
 Sam Hassenbusch
 Mark Linskey, Co-Chairman
 Cheryl Muszynski
 Greg Przybylski, Co-Chairman
 John Wilson

COMMITTEE CONSULTANTS:

R. Florin	AANS 1995 Practice Management Survey project
C. Hill	Washington Office
J. Ries	AANS Office, Education & Practice Management Section
C. Gallagher	Karen Zupko & Associates, Inc.®
R. Mayo	NeuroSource, Inc.®

administrators (31% of those contacted), as well as all members of the CSNS Ad Hoc PMAOC. Preliminary bylaws were approved and the organization decided to call itself "Neurosurgery Executive's Resource, Value, & Education Society" (NERVES). The 28 neurosurgery practice managers and administrators came from 16 different states and represented a cross section of types of neurosurgery practice, including private practice, academics, small groups, large groups, and multispecialty groups. The only type of group not yet represented was solo practice.

The neurosurgery groups who supported and sponsored their practice

manager/administrator to attend the organizational meeting are listed in Table 3. A preliminary Executive Committee was nominated and voted upon. The results of the election are listed in Table 4. A preliminary timeline for further society development and evolution was established. The first annual meeting of NERVES along with the first business meeting of the new society (where new officers and the bylaws will be ratified) is scheduled for April 2003 in San Diego during the next CSNS meeting. The hope is to have research efforts legally reviewed and fully organized in order to hold the first

Continued on page 15

TABLE 3

NEUROSURGEONS & NEUROSURGERY PRACTICES THAT SUPPORTED THE FORMATION OF "NERVES" BY SPONSORING THEIR PRACTICE MANAGERS/ADMINISTRATORS TO ATTEND THE ORGANIZATIONAL MEETING 9/20/02 IN PHILADELPHIA

AR

Neurosurgical Associates of NE Arkansas, Jonesboro, AR
 Kenneth Tonymon, M.D.
 Rebecca Barrett-Tuck, M.D.
 Gregory Ricca, M.D.
 Jeffery Kornblum, M.D.

CO

University of Colorado Department of Neurosurgery, Denver, CO
 Issam A. Awad, M.D.
 Robert E. Breeze, M.D.
 William Choi, M.D.
 J. Paul Elliott, M.D.
 Michael H. Handler, M.D.
 Glenn W. Kindt, M.D.
 Kevin O. Lillehei, M.D.
 Lori McBride, M.D.
 Steven Ojemann, M.D.
 Ken R. Winston, M.D.
 Peter Witt, M.D.

CT

Connecticut Neurosurgery, PC, New Haven, CT
 Gary M. Bloomgarden, M.D.
 Thomas J. Arkins, M.D.
 Isaac Goodrich, M.D.
 James Sabshin, M.D.

FL

Neurospinal Associates, Bradenton, FL
 Michael King, M.D.
 Philip Tally, M.D.
 James Tiesi, M.D.

University of Florida Health Science Center, Gainesville, FL
 William Friedman, M.D.
 Kelly Foote, M.D.
 Jeffrey Henn, M.D.
 James Gainer, Jr., M.D.
 Patrick Jacob, M.D.
 Stephen Lewis, M.D.
 Robert Mericle, M.D.
 David Pincus, M.D.
 Glenn Rehtine, M.D.
 Albert Rhoton, Jr., M.D.
 Steven Roper, M.D.
 Frank Bova, M.D.

Lyerly Neurosurgical Associates, Jacksonville, FL
 Javier GarciaBengochea, M.D.
 John C. Hawkins, III M.D.
 Paulo Monteiro, M.D.

Tallahassee Neurological Clinic, Tallahassee, FL
 Mark J. Cuffe, M.D.
 Christopher S. Rumana, M.D.
 Todd S. Crawford, M.D.

GA

Athens Spine & Neurological Surgery, Athens, GA
 Timothy Phillips, M.D.
 Geoffrey Cole, M.D.

Georgia Neurological Surgery, Athens, GA
 Robert E. Dicks, M.D.
 John V. Cuff, M.D.
 Kimberly P. Walpert, M.D.

Columbus Neurologic & Spinal Surgical Center, Columbus, GA
 Mark Goldman, M.D.
 Michael Gorum, M.D.
 Benjamin Auerbach, M.D.

Neurological Institute Of Savannah, Savannah, GA
 Roy Baker, M.D.
 Randolph Bishop, M.D.
 Cliff Cannon, Jr, M.D.

Edward F. Downing, M.D.
 Louis G. Horn, IV, M.D.
 James G. Lindley, Jr, M.D.
 Fremont P. Wirth, M.D.

IL

Associated University Neurosurgeons, S.C., Peoria, IL

Patrick Elwood, M.D.
 Patrick Tracy, M.D.
 John Henderson, M.D.
 William Hanigan, M.D.
 William Olivero, M.D.
 Dzung Dinh, M.D.
 Giuseppe Lanzino, M.D.

MD

Washington Brain and Spine, Bethesda, MD

John Barrett, M.D.
 Donald Cocney, M.D.
 Jeff Jacobson, M.D.
 Alexandros Powers, M.D.
 Edward Aulisi, M.D.
 Zachary Levine, M.D.
 Donald Wright, M.D.

MI

University Neurosurgical Associates, PC, Southfield, MI

Jeffery Brown, M.D.
 Fernando Dias, M.D., Ph.D.
 Richard Fessler, M.D.
 Charles Frederick Harvey, M.D.
 Robert R. Johnson II, M.D.
 Paul King, M.D.
 Miguel Lis-Planells, M.D.
 Daniel Michael, M.D., Ph.D.
 Seth Rengachary, M.D.
 Andrew Sloan, M.D.
 Lucia Zamorano, M.D., Dr.Med.

NE

Midwest Neurosurgery, Omaha, NE

Leslie C. Hellbusch, M.D.
 Douglas J. Long, M.D.
 Stephen E. Doran, M.D.
 John S. Treves, M.D.
 Mark J. Puccioni, M.D.

NY

Upstate Medical University, Syracuse, NY

David Carter, M.D. Ph.D.
 Charles J. Hodge, Jr., M.D.
 David Eng, M.D.
 James W. Holsapple, M.D.
 Gregory Canute, M.D.
 Satish Krishnamurthy, M.D.
 Craig T. Montgomery, M.D.
 Gerard S. Rodziewicz, M.D.
 Kenneth Yonemura, M.D.
 Robert Kang, M.D.
 Michael Shende, M.D.
 William Stewart, M.D.

NC

Carolina Neurosurgery & Spine Associates, Charlotte, NC

Jerry M. Petty, M.D.
 C. Scott McLanahan, M.D.
 Craig A. VanDerVeer, M.D.
 Frederick E. Finger III, M.D.
 Michael D. Heafner, M.D.
 Tim E. Adamson, M.D.
 E. Hunter Dyer, M.D.
 Anthony L. Asher, M.D.
 Mark P. Redding, M.D.
 Martin M. Henegar, M.D.
 Domagoj Coric, M.D.
 Michael A. Cowan, M.D.
 Joe D. Bernard, M.D.
 David S. Jones, M.D.

OK

Neuroscience Specialists, Oklahoma City, OK

B J Rutledge, M.D.
 Don Rhinehart, M.D.
 Stan Pelofsky, M.D.
 Glenn Schoenhals, M.D.
 Stephen Cagle, M.D.
 Robert Remondino, M.D.
 Eric Friedman, M.D.
 Lonnie Lamprich, M.D.
 Michael Hahn, M.D.
 Robert Tibbs, M.D.

PA

Lancaster Neuroscience and Spine Associates, Lancaster, PA

James Argires, M.D.
 Perry Argires, M.D.
 Daniel Good, M.D.
 V. Ward Barr, M.D.
 Eddy Garrido, M.D.
 John Gastaldo, M.D.
 Keith Kuhlengel, M.D.
 Christopher Kager

TN

Highlands Neurosurgery, PC, Bristol, TN

Matthew Wood, Jr., M.D.
 James Travis Burt, M.D.

The Neurosurgical Group of Chattanooga, PC, Chattanooga, TN

W. Charles A. Sternbergh, Jr., M.D.
 Walter M. Boehm, M.D.
 Peter E. Boehm, M.D.
 Timothy A. Strait, M.D.
 D. Philip Megison, M.D.
 Michael R. Gallagher, M.D.
 Thomas D. Fulbright, M.D.
 R. Lee Kern, Jr., M.D.

Neurosurgical Associates, PC, Knoxville, TN

William Reid, M.D.
 William Tyler, M.D.
 William Synder, M.D.
 Louis W. Harris, M.D.

Semmes Murphey Clinic, Memphis, TN

Morris W. Ray, M.D.
 Allen S. Boyd, M.D.
 Joseph S. Hudson, M.D.
 Jerry Engelberg, M.D.
 Clarence B. Watridge, M.D.
 Robert A. Sanford, M.D.
 Michael S. Muhlbauer, M.D.
 Rodney G. Olinger, M.D.
 Maurice M. Smith, M.D.
 James C. Metcalf, Jr., M.D.
 Glenn A. Crosby, II, M.D.
 Shelly D. Timmons, M.D., Ph.D
 Jon H. Robertson, M.D.
 Claudio A. Feler, M.D.
 Kevin T. Foley, M.D.
 David L. Cunningham, M.D.
 Stephanie L. Einhaus, M.D.
 Allen K. Sills, Jr., M.D.
 Frederick A. Boop, M.D.
 Bruce M. Frankel, M.D.
 Jeffrey M. Sorenson, M.D.
 Robert A. Sanford, M.D.
 Michael S. Muhlbauer, M.D.
 Stephanie L. Einhaus, M.D.

Neurological Surgeons, PC, Nashville, TN

Everette Howell, Jr., M.D.
 Vaughan Allen, M.D.
 Timothy Schoettle, M.D.
 Gregory Lanford, M.D.
 Steven Abram, M.D.
 Scott Standard, M.D.
 Carl Hampf, M.D.
 Jason Hubbard, M.D.

Semmes Murphey Clinic, Jackson, TN

H. Glenn Barnett, M.D.

Joseph Rowland, M.D.
John Campbell, M.D.

TX

Arlington Neurosurgical and Spine Associates, Arlington, TX

Frederick Todd II, M.D.
Kevin Teal, M.D. VA

Neurosurgical Associates, P.C., Richmond, VA

William R. White, M.D.
Claude W. Wilson, M.D.
K. Singh Sahni, M.D.
Jackson B. Salvant, Jr., M.D.
David S. Geckle, M.D.
Peter A. Alexander, M.D.

WY

Central Wyoming Neurosurgery, Casper, WY

Robert Narotzky, M.D.
Joseph Sramek, M.D.

STATES/DISTRICTS NOT YET REPRESENTED (N = 35):

AL, AK, AZ, CA, DE, DC, HI, ID, IN, IA, KS, KY, LA, ME, MA, MN, MS, MO, MT, NV, NH, NJ, NM, ND, OH, OR, PR, RI, SC, SD, UT, VT, WA, WV, WI

CSNS News

Continued from page 13

neurosurgery practice management survey in 2004.

The progress to date in launching this important and historical venture has been both exciting and gratifying. All neurosurgeons are asked to consider the importance of this project to neurosurgery as a whole as well as the potential benefit to your own practices. The participation of 28 people in the initial organizational meeting was very encouraging. It is a larger number than ADAM enjoyed at its organizational meeting. It is already larger than the neurosurgery participation in the last MGMA practice management survey. However, in looking at the state and neurosurgical groups represented in

Table 3, it is important to note that many states are not yet represented (17/50 represented – 34%) and that many of our practices have yet to participate. Indeed, large and/or populous states such as California, Massachusetts, New Jersey, and Ohio were not represented at all. Large U.S. urban centers such as New York City, Chicago, Los Angeles, the San Francisco Bay area, Boston, Baltimore, Cleveland, Philadelphia, Pittsburgh, St. Louis, and Washington DC were glaringly absent. Indeed, only 5 of the 92 (5.4%) of the academic training programs were represented, and only 7.2% of the estimated 2,600 practicing neurosurgeons in the United States were represented.

The active support of all U.S. neurosurgeons will be absolutely critical in the success of this endeavor as well as the quality of the data that can be

obtained through practice management research. It is very important that the society represent all geographical regions, as well as all practice types. The practices themselves will be the beneficiaries as their practice managers/administrators are better able to do their job due to benefits outlined in Table 1, and as accurate, current, and relevant practice management benchmark data starts to become available to help them make data-based business decisions. Support can take the form of encouraging your practice manager or administrator to join the new society, agreeing to pay their membership dues and/or meeting travel and fees as a practice expense, or even just granting them the time away from the practice for organization-related activities. We are asking everyone to actively support and encourage membership and participation of your own practice managers and administrators in the new organization. Ultimately, we need to see every neurosurgery practice in the United States on the list in future tables of participants.

State Society Corner

Ann Warbel, R.N.

Tara Morrison, Executive Director, provides the following update: **“The Georgia Neurosurgical Society** will hold its Annual Fall Meeting on November 22–24, 2002 at the Sheraton Buckhead Hotel in Atlanta, Georgia. The meeting will begin on Friday, November 22 with a Coding & Reimbursement Seminar put on by Karen Zupko & Associates. Saturday and Sunday will be our Scientific Programs. Our Honored Guest Speaker this fall is Dr. J. Paul Muizelaar, Chairman, Department of Neurosurgery at the University of California-Davis.”

Dr. Robert Harbaugh, President of the NENS, submits the following report: **“The New England Neurosurgical Society** had a very successful meeting at the Newport Marriott in Newport, Rhode Island September 13, 2002. During the Board of Trustees meeting a proposal was brought forth by Dr. Dempsey to add a position of Treasurer for the organization. During the last year the activities of the New England Neurosurgical Society have increased substantially. We now routinely invite guest dinner speakers and have been successful in obtaining funding from industry for our meetings. Because of this, the job of the Secretary/Treasurer has grown considerably. After extensive discussion at the Board of Trustees meeting we are going to recommend that the job of Secretary/Treasurer be divided into two positions. This will require a vote of the membership at the annual meeting in June.

“The Board of Trustees also discussed nominees for officers to be elected at the June meeting. The Board of Trustees has nominated Peter Dempsey for President, Gary Bloomgarden for Secretary, and Chris Ogilvy for Treasurer. Additional nominations can be made from the floor at the June meeting.

“The Board of Trustees next discussed the winter and spring meeting of the New England Neurosurgical Society. The winter meeting will be held February 28th in Lebanon, NH at the Dartmouth Hitchcock Medical Center. Our dinner will be held at the Hanover Inn. The spring meeting will occur June 6th at the MIT Endicott House. The winter meeting will feature a forum in the morning from 9:30 to 11:30 on medical liability and liability reform. We will have a panel discussion with neurosurgical representatives from each of the New England states. In addition Katie Orrico, the Director of the AANS/CNS Washington office, will be here to discuss national efforts at liability reform and a New England medical malpractice defense attorney will also be available for the discussion. We are planning a noon controversy on clipping versus coiling for intracranial aneurysms. A scientific session with formal presentations and interesting case presentations will occur from 1 to 5 pm. We will gather at the Hanover Inn for cocktails at 6 pm and dinner at 7 pm. A dinner speaker is being arranged. The June 6th meeting at the Endicott House will feature a free coding course from 9 to 11 in the morning, a noon controversy topic on spinal instrumentation, and a scientific program from 1 to 5 pm. Further details regarding these meetings will be forthcoming.

“At the Newport, Medtronic presented a free coding course for neurosurgeons, neurosurgical office managers, or other interested parties. This was well attended and proved to be very successful. Our noon controversy session focused on whether or not neurosurgical subspecialty certification was a good idea. Dr. Michael Scott spoke for such certification and Dr. Art Day spoke against. Both Mike and Art presented very thoughtful arguments for their positions and a vigorous discussion ensued. The scientific session featured formal presentations from the Massachusetts General Hospital, The Lahey Clinic, Tufts New England Medical Center, and the Dartmouth Hitchcock Medical Center. In addition to these formal presentations Dr. Gerard Mohr, Dr. Peter Dempsey, and Dr. Carlos David presented interesting and challenging cases for discussion. As is usually the case at the New England Neurosurgical Society meetings, the discussion following these presentations was vigorous and enlightening.

“After the scientific session we gathered for cocktails and dinner at the Newport Marriott. Our guest and Ben Whitcomb Lecturer was Roberto Heros. Dr. Heros presented his reflections on Cuba and

TABLE 4

NEWLY ELECTED INTERIM EXECUTIVE COMMITTEE OF “NERVES”

INTERIM PRESIDENT	Mark Mason	Nashville, TN
INTERIM VICE PRESIDENT	Cheryl Harris	Arlington, TX
INTERIM SECRETARY	Barbara Hurlbert	Jacksonville, FL
INTERIM TREASURER	Johanna Hartigan	New Haven, CT
INTERIM “PRESIDENT EMERITUS”	Robert Rosso	Columbus, GA
INTERIM WESTERN REGIONAL DIRECTOR	Tammy Marr	Omaha, NE
INTERIM NE REGIONAL DIRECTOR	Nicholas Green	Southfield, MI
INTERIM SE REGIONAL DIRECTOR	Mary Cloninger	Charlotte, NC

State Neurosurgery Society Meeting Information

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

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

STATE	PRESIDENT	PHONE	E-MAIL /Website	MEETING DATE	PLACE
Alabama	Winfield Fisher	(205) 934-1430	wfisher@uabmc.edu		
Arizona	Stephen Rittland	(928) 779-7880			
Arkansas	Kenneth Tonymon	(870) 972-1112	KTonymon@aol.com		
California	Lawrence M. Shuer	(650) 723-6093	Ishuer@stanford.edu www.cans1.org	January 17-19, 2003	The Sutton Place Newport Beach, CA
Colorado	John McVicker	(303) 788-4000	johnmcvicker@rmna.net		
Connecticut	Isaac Goodrich	(203) 781-3400	None		
Delaware	J. Rafael Yanez	(302) 674-9100	None		
District of Columbia	Gary Dennis	(202) 865-6682	gcdennis@pol.net		
Florida	R. Patrick Jacob	(352) 392-4331	jacob@neurosurgery.ufl.edu		
Georgia	Gerald Kadis	(912) 226-8880	gkadis@rose.net Tara Morrison: taramorr@bellsouth.net	November 22-24, 2002	Sheraton Buckhead Hotel Atlanta, GA
Hawaii	Jon Graham	(808) 550-4939	jgraham@my.teampraxis.com		
Idaho	Christian Zimmerman	(208) 367-3500	None		
Illinois	Stephen Ondra	(312) 695-6282	sondra@nmff.edu		
Indiana	Jeffrey Crecellius	(765) 448-8000	crecelij@arnett.com		
Iowa-Midwest	John Treves	(402) 559-9605	kbard@unmc.edu		
Kentucky	John J. Guarnaschelli	(502) 584-4121	ngglsiwb@thepoint.net		
Louisiana	C. Babson Fresh	(318) 443-4576	None		
Maine	Thomas Doolittle	(207) 873-6615	None		
Maryland	Thomas Ducker	(410) 224-0545	None		
Michigan	Mark Krinock	(606) 343-1264	mkrinock@borgess.com		
Minnesota	Mahmoud Nagib	(612) 871-7278			
Mississippi	Philip Azordegan	(601) 354-8895	zsozso@bellsouth.net		
Missouri	David F. Jimenez	(573) 882-4908	jimenezd@health.missouri.edu		
New England Neurosurgical Society	Robert Harbaugh	(603) 650-8732	robert.e.harbaugh@hitchcock.org	February 28, 2003	Dartmouth Hitchcock Medical Center Lebanon, NH
New Jersey	Edward Von der Schmidt	(609) 924-3614			
New Mexico	Erich Marchand	(505) 988-3233	emarchand@neurosurgerynm.com		
New York	Paul Spurgas	(518) 377-2642			
North Carolina	C Scott McLanahan	(704) 376-1605	scottmclanahan@cnsa.com		
Ohio	William Bingaman	(216) 444-9058	bingamb@ccf.org		
Oklahoma	Robert Remordino	(405) 748-3300	stanp@neurosurg.org		
Oregon	Edmund Frank	(503) 494-4314	franke@ohsu.edu		
Pennsylvania	Robert Rosenwasser	(215) 928-7004	robert.h.rosenwasser@mail.tju.edu		
Rhode Island	Beverly Walters	(401) 421-4703	Beverly_Walters@brown.edu	www.rinsonline.com	
South Carolina	Mike Tyler	(803) 553-7615	None		
Tennessee	Clarence Watridge	(901) 260-0712	cwatridge@semmes-murphey.com		
Texas	Haring Nauta	(409) 772-1500	hjnauta@utmb.edu	www.texmed.org	
Utah	Bryson Smith	(801) 479-9119	brysonsmithmd@earthlink.net		
Virginia	Anthony Caputy	(202) 994-2210	neuase@gwumc.edu		
West Virginia	David L. Weinsweig	(304) 525-6825	weinsweigd@tsnci.com		
Washington	Timothy Steege	(206) 623-0922	tsteege@aol.com		
Wisconsin	Spencer Block	(414) 438-6500	mniinfo@execpc.com		

CSNS News

Continued from page 15

Latin America past, present, and future. This proved to be a very interesting lecture that was greatly enjoyed by all. It was great to see Roberto back in New England.

"The Newport meeting was very well attended and the quality of the presentations was superb. I hope that you will be able to attend the winter meeting in New Hampshire and the spring meeting in Massachusetts. We are doing our best to make this a high value meeting for all who attend. Any suggestions you might have to improve the meetings are welcomed. Best of luck in all of your endeavors and I hope to see you soon.

Dr. Alan Cohen, President of the OSNS, summarizes the following: "The annual meeting of the **Ohio State Neurosurgical Society** was held on September 14, 2002 at the Glenmoor resort in Canton, Ohio, with Dr. Al Cohen presiding. Tim Maglione of the Ohio State Medical Association provided an update on the current medical liability crisis. Dr. Tina Rodriguez of CWRU won the award for the best resident presentation for her talk, 'Prediction of functional outcome following spontaneous intracerebral hemorrhage in adults: a proposed grading system.' The honored guest was Dr. Tom Luerssen, Chief of Pediatric Neurosurgery at the Riley Children's Hospital in Indianapolis, who spoke about 'Pitfalls in the management of cranial trauma.' Dr. Bob Ratcheson was named Neurosurgeon of the Year.

The following new officers were elected: President, Dr. Bill Bingaman; President-Elect, Dr. John McGregor; Treasurer, Dr. James Anderson; and Secretary, Dr. Dody Robinson."

Upcoming Meetings

November 2002

22-24

Georgia Neurosurgical Society

Sheraton Buckhead Hotel
Atlanta, GA

Guest Speaker: Dr. J. Paul Mulzelaar

Contact: Tara Morrison

E-mail: taramorr@bellsouth.net

Phone: (404) 881-5090

January 2003

17-19

California Association of Neurological Surgeons

The Sutton Place
Newport Beach, CA

Contact: Janine Tash

E-mail: jt4ns@aol.com

Phone: (916) 457-2267

February 2003

28

New England Neurosurgical Society

Dartmouth-Hitchcock Medical Center
The Hanover Inn

Lebanon, NH

Guest Speaker: Katie Orrico,
Director AANS/CNS Washington
Office

Contact: Dr. Robert Harbaugh

E-mail: robert.e.harbaugh@hitchcock.org

Phone: (603) 650-8732

June 2003

6

New England Neurosurgical Society

The Endicott House at MIT
Dedham, MA

Contact: Dr. Robert Harbaugh

E-mail: robert.e.harbaugh@hitchcock.org

Phone: (603) 650-8732

Think First

Continued from page 10

and in the wake of this tragedy has worked with the father of his son's killer to try to stem the tide of gang violence in our communities. Breakout sessions will allow participants to choose topics relevant to individual chapter needs, including research, grant writing, recruiting, and marketing. Results of a 3-year longitudinal study of the Think First for Kids curriculum will be presented, and updates on Think First National activities will be shared. Conference organizers have sought to ensure that the workshop will be practical, interesting, and relevant to participants from a wide range of backgrounds and needs. Whether it is time to sharpen your skills in injury prevention program management, or time to get your feet wet as you become or think about becoming a new Think First chapter, the 2003 Workshop will help you achieve those goals!

See you in San Diego!

SPECIAL ANNOUNCEMENT!

Neurosurgery News is now accepting Classified Line Advertisements! Line ads are the perfect low-cost solution for meeting your advertising needs. Display advertising is still available for those times when greater visibility is desired.

- ✓ Positions Available
- ✓ Fellowships
- ✓ Seminars
- ✓ Research Grants

See page 23 for rates and contact information.

JOINT SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

Practice Guidelines

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

The end result, **Practice Guidelines in the Treatment of Cervical Spine and Spinal Cord Injury**, was published under separate cover as a supplement to the March 2002 issue of the journal *NEUROSURGERY*. This publication is destined to become the reference manual for all clinicians involved in treating cervical spine injuries from the paramedics in the field, to the rehabilitation specialists involved in long-term follow-up.

We are continuing to publish a synopsis of each of the recommendations in this and subsequent editions of *Neurosurgery News*. The following is an excerpt from Chapter 3 of 22.

CLINICAL ASSESSMENT FOLLOWING ACUTE CERVICAL SPINAL CORD INJURY

Recommendations

Neurological Examination

Standards: There is insufficient evidence to support neurological examination standards.

Guidelines: There is insufficient evidence to support neurological examination guidelines.

Options: The ASIA international standards for neurological and functional classification of spinal cord injury is recommended as the preferred neurological examination tool for clinicians involved in the assessment and care of acute spinal cord injury patients.

Functional Outcome Assessment

Standards: There is insufficient evidence to support functional outcome assessment standards.

Guidelines: The Functional Indepen-

dence Measure (FIM) is recommended as the functional outcome assessment tool for clinicians involved in the assessment and care of acute spinal cord injury patients.

Options: The modified Barthel Index (MBI) is recommended as a functional outcome assessment tool for clinicians involved in the assessment and care of acute spinal cord injury patients.

Rationale

Acute traumatic spinal cord injury affects 12,000 to 14,000 people in North America each year. The functional consequences of an acute spinal cord injury (ASCI) are variable, therefore the initial clinical presentation of patients with ASCI is a key factor in determining triage and therapy and predicting prognosis. Consistent and reproducible neurological assessment scales are necessary to define the acute injury patient's neurological deficits and to facilitate communication about patient status to caregivers. Prognostic information provided by comparing injury victims to the outcomes of historical patients with similar injuries is of value to patients and families. The evaluation of new therapies proposed for the treatment of ASCI require the use of accurate, reproducible neurological assessment scales and reliable functional outcome measurement tools, not only to measure potential improvement following therapy, but to determine its functional significance. For these reasons, the clinical neurological assessment and the determination of functional abilities are important aspects of the care of patients with ASCI. The purpose of this review of the medical literature is to determine which neurological assessment scales and which functional impairment tools have the greatest utility in the care of patients with acute spinal cord injuries.

Summary

A variety of injury classification schemes have been utilized to describe patients who have sustained spinal cord injuries. There are two general types of assessment scales, neurological examination scales and functional outcome scales. The most accurate and meaningful description of spinal cord injury patients, in the acute setting and in follow-up, appears to be that accomplished by using a neurological scale in conjunction with a functional outcome scale. At present, the most utilized and studied neurological assessment scales are the ASIA scores including the motor index scores, sensory scores and the ASIA Impairment scale. After multiple revisions and several refinements these scales are easy to apply, and are reliable.

The 1996 ASIA recommendations for

EVIDENTIARY TABLE: Neurological Examination Scales

First Author Reference	Description of Study	Data Class	Conclusions
Jonsson, 2000 <i>Spinal Cord</i>	A study of the inter-rater reliability of the ASIA ISCSCI-92. Physicians and physiotherapists classified 23 patients according to the ISCSCI-92 and calculated Kappa values.	Class III	This study indicates a weak inter-rater reliability for scoring incomplete SCI lesions using the 1992 ASIA standards.
Cohen, 1998 <i>Spinal Cord</i>	This study was a test of the ASIA ISCSCI-92. Participants completed a pretest and posttest in which they classified two patients who had a SCI.	Class III	Further revision of the ASIA 1992 standards and more training was needed to ensure accurate classification of spinal cord injury.
El Masry, 1996 <i>Spine</i>	A study to assess the reliability of the ASIA and NASCIS motor scores. The motor scores of 62 consecutive acute SCI patients were retrospectively reviewed.	Class III	The differences in correlation coefficients between the ASIA motor score and the NASCIS motor score were not statistically significant. The ASIA and NASCIS motor scores can both be used for the neurological quantification of motor deficit and motor recovery.
Wells, 1995 <i>J Spinal Cord Med</i>	A comparison of the Frankel Scale, Yale Scale, Motor Index Score, MBI, Functional Independence Measurement (FIM) in 35 consecutive acute SCI patients.	Class III	The best assessment tool is a combination of two scales, one based on neurological impairment and the other on functional disability.
Waters, 1994 <i>Arch Phys Med Rehab</i>	An assessment of strength using motor scores derived from ASIA compared with motor scores based on biomechanical aspects of walking in predicting ambulatory performance in 36 SCI patients.	Class III	The ASIA scoring system compared favorably with the biomechanical scoring system. ASIA motor score strongly correlates with walking ability.
Davis, 1993 <i>Spine</i>	A prospective study of 665 acute SCI patients to determine the reliability of the Frankel and Sunnybrook scales.	Class III	Demonstrated high inter-rater reliability of Frankel and Sunnybrook scales. Both scales correspond to total sensory and motor function but are insensitive to walking and bladder function.
Bednarczyk, 1993 <i>J Rehab Research & Dev</i>	A study comparing ASIA scale, NASCIS scale and wheelchair basketball (BB) Sports Test in 30 SCI patients classified by the same examiner.	Class III	ASIA Scale showed the greatest discrimination in grouping subjects with ASCI. NASCIS scale had negative correlation with ASIA scale and BB sports test.
Botsford, 1992 <i>Orthopedics</i>	Description of a new functionally oriented scale with assessment of motor and sensory function, rectal tone and bladder function.	Class III	Botsford scale was sensitive for the detection of improvement in function over time following SCI.
Priebe, 1991 <i>Am J Phys Med & Rehab</i>	A study of the interobserver reliability of the 1989 revised ASIA standards assessed by quiz given to 15 physicians.	Class III	The interobserver reliability for the revised ASIA (1989) standards were improved compared to previous versions, but less than optimal. Changes were recommended.
Bracken, 1990 <i>New England Journal of Med</i>	Multi-center North American trial examining effects of methylprednisolone or naloxone in ASCI. (NASCIS II)	Class III for neurological assessment	Motor scores of 14 muscles on 0-5 point scale, right side of body only. Sensory scores of pin prick and light touch, 1-3 point scale, bilateral. No inter-rater reliability comparison.
Lazar, 1989 <i>Arch Phys Med & Rehab</i>	A prospective study of the relationship between early motor status and functional outcome after SCI in 78 patients. Motor status was measured by the ASIA Motor Index Score and functional status was evaluated with the Modified Barthel Index.	Class III	The MIS correlated well with functional status for quadriplegic patients, poorly for paraplegic patients. Individual differences in ambulation limit its predictive utility.
Bracken, 1985 <i>J Neurosurg</i>	Multi-center North American trial examining effects of methylprednisolone in ASCI. (NASCIS I)	Class III for neurological assessment	Motor scores of 14 muscles on 1-6 point scale. Right side of body only. Sensory scores of pinprick and light touch, 1-3 point scale, bilateral. No inter-rater reliability comparison.
Tator, 1982 <i>Early Management of Spinal Cord Injury</i>	Initial description of the Sunnybrook Scale, a 10 grade numerical neurological assessment scale.	Class III	Improvement from the Frankel scale. Motor grading subdivided but not very sensitive.
Cherazi, 1981 <i>J Neurosurg</i>	Initial description of the Yale scale and its use in a group of 37 patients with SCI.	Class III	Provides assessment of the severity of SCI.
Lucas, 1979 <i>American Surgeon</i>	Initial description of a motor classification of patients with SCI and its use in 800 patients.	Class III	Allows the clinical researcher to evaluate current treatments and assess the potential of new treatment regimes.
Bracken, 1977 <i>Paraplegia</i>	Description of 133 ASCI patients classified using motor and sensory scales developed by Yale Spinal Cord Injury Study Group.	Class III	Considerable discrepancy between motor and sensory impairment scales among patients with greater motor than sensory loss.
Frankel, 1969 <i>Paraplegia</i>	The first clinical study of the Frankel scale to assess neurologic recovery in 682 patients treated with postural reduction of spinal fractures.	Class III	First neurological examination scale for ASCI.

EVIDENTIARY TABLE: Functional Outcome Scales

First Author Reference	Description of Study	Data Class	Conclusions
Field-Fote, 2001 <i>J Rehabil Med</i>	SCI-FAI offered as functional assessment scale for gait assessment.	Class III	Reliable and relatively sensitive measure of walking ability in patients with SCI. Interrater reliability good. No kappa values offered.
Kucukdeveci, 2000 <i>Scan J of Rehab Med</i>	To determine the reliability and validity of the MBI in Turkey.	Class III	Adaptation of the modified Barthel Index successful in Turkey as long as its limitations are recognized. Kappa values > 0.5.
Ditunno, 2000 <i>Spinal Cord</i>	WISCI offered as index for ambulation skills following SCI in pilot study.	Class III	Good reliability, excellent interrater reliability but needs assessment in clinical settings.
Yavuz, 1998 <i>Spinal Cord</i>	Assessment of the relationship of two functional tests, FIM and QIF, to ASIA scores.	Class III	Strong correlation between FIM and QIF to ASIA scores.
Catz, 1997 <i>Spinal Cord</i>	SCIM offered as new disability scale for spinal cord lesions. Thirty patients assessed with SCIM and FIM.	Class III	SCIM more sensitive than FIM.
Hamilton, 1994 <i>Scan J of Rehab Med</i>	Assessment of interrater agreement of FIM in 1018 patients in 89 UDS hospitals.	Class II	Kappa values for 7 level FIM ranged from 0.53 to 0.66. Kappa values higher in subset of UDS hospitals with experienced rehab clinicians, 0.69 to 0.84.
Dodds, 1993 <i>Arch Phys Med Rehabil</i>	Assessment of reliability of FIM in characterizing 11,102 UDS rehab patients.	Class III	FIM has high internal consistency, adequate discriminative capabilities, and was good indicator of burden of care.
Hamilton, 1991 <i>Arch Phys Med Rehabil</i>	Interrater agreement assessment of FIM in 263 patients in 21 UDS hospitals.	Class II	Kappa values for 7 level FIM ranged from 0.61 to 0.76, mean 0.71.
Shah, 1989 <i>Journal of Clin Epidemiology</i>	Description of Modified Barthel Index (MBI).	Class III	The MBI has greater sensitivity and improved reliability than the original version, without additional difficulty or implementation time.
Gresham, 1986 <i>Paraplegia</i>	Assessment of QIF as functional scale, compared to Barthel Index.	Class III	The QIF was more sensitive and reliable than the Barthel Index.
Tator et al, 1993 <i>Surg Neurology</i>	A study of 201 ASCI patients, ICU care, hemodynamic support compared to 351 prior patients	Class III	Less severe cord injuries due to immobilization, resuscitation and early transfer to ICU setting.
Armitage et al, 1990 <i>BMJ</i>	Case reports of four patients who developed respiratory problems during airplane transport.	Class III	Airplane air is less humid and measures to optimize humidity and pulmonary function travel in high cervical injury patients may be required
Boyd et al, 1989 <i>J Trauma-Injury Infection & Crit Care</i>	A prospective cohort study to determine the effectiveness of air transport for major trauma patients when transferred to a trauma center from a rural emergency room.	Class III	Patients with severe multiple injury from rural areas fare better with helicopter EMS than ground EMS
Burney et al, 1989 <i>J Trauma-Injury Infection & Crit Care</i>	Retrospective review of the means of transport and type of stabilization used for all patients with ASCI.	Class III	Acute SCI patients can be safely transported by air or ground using standard precautions. Distance and extent of associated injury are the best determinants of mode of transport.
Tator et al, 1984 <i>Can J of Surg</i>	A retrospective review of results of innovations between 1974 to 1979 at Sunnybrook Medical Centre in Toronto.	Class III	Patients transferred to the SCI unit earlier, with consequent marked reduction in complications and cost of care.
Hachen, 1977 <i>J Trauma</i>	A study of 188 ASCI managed in centre ICU, aggressive treatment of hypotension, respiratory insufficiency	Class III	Reduced morbidity and mortality with early transfer, attentive ICU care and monitoring, and aggressive treatment of hypotension and respiratory failure.
Zach, et al, 1976 <i>Paraplegia</i>	A study of 117 ASCI at Swiss Center, ICU setting aggressive BP, volume therapy. Rheomacrodex x 5d Dexamethasone x 10d	Class III	Improved neurological outcome with aggressive medical treatment. Better outcome for early referrals.
Hachen, 1974 <i>Paraplegia</i>	Retrospective review of effectiveness of emergency transportation of spinal injury patients in Switzerland. Between 1965-1974 all SCI patients were immediately transported by air to SCI center. Mortality reduced to zero, during transport. Average time for the rescue operation reduced from 4.5 hours to 50 minutes. Significant reduction in cardiovascular and respiratory morbidity.	Class III	Mortality and morbidity of patients with acute spinal injury is reduced by a well-organized medical response with smooth and rapid transfer by helicopter to a specialized SCI center.

Joint Spine

Continued from page 17

international standards of neurological and functional classification of spinal cord injury include the ASIA scales, as noted, and the Functional Independence Measure (FIM). FIM as a functional outcome tool has been studied extensively. It appears to be the best functional outcome scale used to describe disability among SCI patients, both early and late after injury. It is easy to administer and is valid and reliable.

Inter-rater agreement with FIM has been high in several studies with reported Kappa values of 0.53 to 0.76.

Key Issues for Future Investigation

Any future investigation of or clinical trial involving spinal cord injury patients must include both a neurological examination scale and a functional outcome assessment. Therapeutic trials of spinal cord injury patients should include reli-

Continued on page 20

Joint Spine

Continued from page 19

able neurological and functional scoring systems and should verify the validity and inter-rater reliability of those scoring scales as part of the investigational paradigm.

Annual Meeting – Tampa Bay, Florida

The AANS/CNS Section on Disorders of the Spine and Peripheral Nerves will hold its 19th annual meeting in Orlando, Florida at the beautiful Saddlebrook Resort from March 5–8. Make your reservations now!



Awards

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

of disorders of the spine and peripheral nerves.

The awards range from \$15,000–\$30,000 and are intended for primary investigators of planned clinical studies requiring national level funding to support the preparation of grant proposals and external consultations and to assist in the development of the proposal, planning meetings, and the collection of pilot data. Work that can be completed without such support (such as literature review and preliminary protocol design) should be completed before applying for the Larson or the Sonntag Awards.

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

Application details for research grants are available from James D. Guest, M.D., Ph.D., c/o Neurological Institute of New York, 710 W. 168th Street, New York, NY 10032, (212) 305-7976, or check out our Web site at www.neurosurgery.org. The application deadline for grants to be awarded for 2003 is Dec. 1, 2002.

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

Application information for the Cloward Fellowship Award can be acquired from Timothy C. Ryken, M.D., The University of Iowa Hospitals & Clinics, Division of Neurosurgery, 200 Hawkins Drive, Iowa City, IA 52242. E-mail: Christopher G. Paramore, M.D., Lake Norman Neurological and Spine Surgery, 156 Centre Church Road, Suite 204, Mooresville, NC 28117, c.paramore@lnrnc.hma-corp.com, or check out our Web site at www.neurosurgery.org

The application deadline for the 2004 Cloward Fellowship Award is September 15, 2003.

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

basic science research. Each award is valued at \$500.

For further information and submission forms, please contact: Christopher G. Paramore, M.D., Lake Norman Neurological and Spine Surgery, 156 Centre Church Road, Suite 204, Mooresville, NC 28117, c.paramore@lnrnc.hma-corp.com, or check out our website at www.neurosurgery.org.

Deadlines

- December 1, 2002: Sonntag and Larson Clinical Research Grants
- September 15, 2003: Cloward Fellowship Award
- September 15, 2003: Mayfield Awards

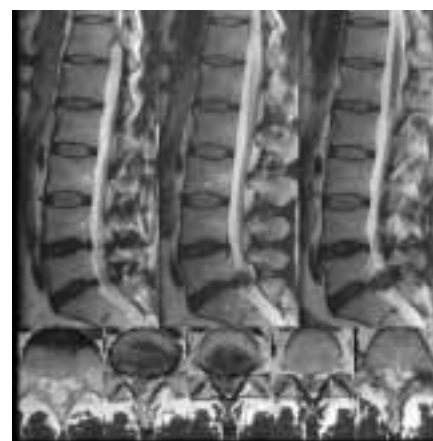
Coding Corner

Gregory J. Przybylski, M.D.

Minimally-Invasive Spine Surgery Coding

We have seen substantial attention at our annual and regional meetings given toward minimally-invasive spinal surgery techniques. While the potential benefits of reduced perioperative morbidity are commonly accepted, a frequent question arises concerning the physician coding of these new procedures. This coding corner addresses the current concepts and future options regarding codes for minimally-invasive spinal surgery.

Although the use of CPT (current procedural terminology) codes for describ-



ing physician services has been a part of practice for several decades, the codes are revised annually as new technology evolves. However, some common procedures are incompletely described by current codes. Whereas a physician may choose the code best describing the service provided, there has been an increasing effort at the American Medical Association (AMA) to make the descriptions more specific as part of the CPT-5 project. Moreover, the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) are demanding use of existing codes only is the procedure performed is

exactly the same as the service descriptor in the code.

Consequently, nearly all of the current codes for decompression as well as arthrodesis and instrumentation describe open rather than endoscopic or minimally-invasive techniques. The only recent exception was the revision of 63030 (lumbar hemilaminotomy for discectomy), which was revised at CPT to include an open or endoscopic technique. Otherwise, other percutaneous procedures that only currently have open procedure counterparts must be coded with an unlisted code such as 22899 or 64999. The reimbursement implications of using unlisted codes include manual review, requirement of documentation, and a likelihood of payment denial.

The AANS/CNS Coding and Reimbursement Committee, the Joint Section Coding Committee, and the North American Spine Society Operative Coding Committee are all currently discussing this issue to reevaluate various options. Given the recommendation of the AMA and the insistence of CMS that open codes should not be used for percutaneous or endoscopic procedures, alternatives to unlisted codes need to be explored. However, the issue is much more complicated than simply creating a new series of codes for these techniques.

One option would involve the development of an endoscopic-assistance add-on code similar to the microdissection code 69990 that would be used in conjunction with the open code. The AANS/CNS recently had such an add-on code approved by CPT for 2003 and valued by the Relative-value Update Committee (RUC) of the AMA for endoscopically assisted placement of a ventricular catheter. A similar add-on code previously existed for endoscopic biliary surgery. However, this method only addresses the issue of endoscopic assistance for open, or perhaps minimally open, procedures, but not percutaneous procedures.

Alternatively, new codes can be developed for these techniques and valued on their own merit. However, CMS has held the position that minimally-invasive procedures require less physician work and therefore will be paid less by CMS in comparison to the open procedures. Likewise, the RUC desires a "significant burden of proof" to value a minimally-invasive procedure higher than an open procedure. The predominant driving force of valuing physician work is the time required to provide the service. This includes both surgical intraoperative time as well as postoperative follow-up care for the 90-day global period. Since a significant advantage of minimally-invasive procedures includes shorter hospital stays and diminished postoperative care, the estimated physician work is less than that of an open procedure.

Consequently, the coding committees

JOINT SECTION ON PEDIATRIC NEUROSURGERY

Chairman's Message

Thomas G. Luerksen, M.D., F.A.C.S., F.A.A.P.

Chairman, Joint Section on Pediatric Neurosurgery



As I near the completion of my term as Chair of the Section on Pediatric Neurosurgery of the AANS and CNS, I am happy to report that the Section is thriving and has continued to expand its long tradition of promoting education in the pediatric neurosciences. We have also expanded our relationships with certain societies so that our membership can fully interact with organizations that contain our referring physicians and pediatric subspecialty colleagues.

Annual Meeting News

Like many of the other Sections, the Pediatric Section accomplishes greatest part of its educational mission through its meetings. The Annual Winter Meeting of the Section on Pediatric Neurosurgery was held from December 4 through 7, 2002 at the Hyatt Regency Gainey Ranch in Scottsdale, Arizona. This was one of the most successful meetings ever held by the Section. Program Chair Harold L. Rekate, M.D. organized a wonderful scientific and social program. A large number of the 85 papers and 45 posters were presented by residents and fellows. Honored guest Volker K. H. Sonntag, M.D. gave the Raimondi Lecture and presented the complex issues surrounding recertification in neurosurgery.

Several awards were given out at this year's meeting. David Anderson, M.D., a resident at the Duke University program, won the Kenneth Shulman award for the best paper given by a resident-in-training for his paper entitled "Mechanisms of reclosure in the surgical model of myelomeningocele: implications for fetal surgery." Dr. Anderson will represent this paper and formally receive his award during the Pediatric Section's Scientific Session at the upcoming AANS meeting in San Diego.

The Hydrocephalus Association, an organization with a long history of supporting the scientific activities of the Pediatric Section, gave out two awards for the best papers about hydrocephalus. Dr. Joshua Medow, a resident in the University of Wisconsin program won a Hydrocephalus Association

Award for his paper entitled "Quick brain MRI vs. CT scan for evaluating shunted hydrocephalus." Dr. Jonathan Miller, a resident in Case Western Reserve program also won a Hydrocephalus Association Award for his paper entitled "Aberrant neuronal development in hydrocephalus."

Next year, the Section moves from the Valley of the Sun to the (hopefully) snowy Wasatch Mountains as it meets in Salt Lake City, Utah, December 2 through 5, 2003. John Kestle, M.D. and Douglas Brockmeyer, M.D. will be the meeting chairs.

Traveling Fellowships

The Pediatric Section has sponsored traveling fellowships for many years. These fellowships allow a resident interested in pediatric neurosurgery to spend up to 3 months at a major pediatric neurosurgical center. This has been a very popular program and the Traveling Fellowship Committee receives numerous applications for the one or two fellowships offered every year. This year, the Pediatric Section awarded two traveling fellowships, one for a U.S. resident and one for an international trainee. Dr. Robert Owen, a resident in the University of Kentucky program and Dr. Adrian Careras from Costa Rica were this year's traveling fellows, and both will spend their fellowship time at the Children's Hospital, Boston.

Interactions with Other Societies and Organizations

During the past 2 years, the Section on Pediatric Neurosurgery has expanded its relationships with several societies and organizations that are in the forefront of pediatric specialty and pediatric neurosurgical care. In addition to our long standing working relationship with the American Society of Pediatric Neurosurgeons, we have recently formed a liaison and have encouraged our memberships' involvement in the newly created Section on Neurosurgery within the American Academy of Pediatrics. While this certainly adds another meeting to the travel schedule, it is well worth it.

Recently, we also began to undertake the development of a liaison with the American Academy of Family Physicians and with the International Society for Pediatric Neurosurgery.

New Officers

It has been a wonderful experience for me to serve as the Section's chair. I have been blessed with an energetic and productive Executive Committee and with a large number of Section members who have volunteered their time and talents for countless special projects. I

Continued on page 22

Report from the American College of Surgeons

Edward R. Laws, M.D., F.A.C.S.

Regent for Neurosurgery
Chairman, Board of Regents
American College of Surgeons

It is my privilege now to have this opportunity and to assure you that the American College of Surgeons is thriving in every way, and is becoming more and more pertinent to the needs of all surgeons including those of us in specialty areas like neurosurgery. The American College of Surgeons is able to represent nearly 60,000 surgeons and has developed a strong network of cooperation with the entire house of surgery. The educational efforts of the American College of Surgeons range from ACLS courses to specific teaching modules regarding surgical simulation and methods of evaluating the introduction of new surgical techniques and concepts.

Although education remains the major goal of the American College of Surgeons, it is important to recognize that the College represents surgeons in a number of different national and international organizations. These include the ACGME where the American College of Surgeons makes up a significant component of the RRC, the JCAHO, which accredits hospitals and has major representation on its Board by surgeons appointed by the American College of Surgeons, the CMSS, the American Medical Association, which through its RUC sets and evaluates the new codes for surgical procedures, the American Hospital Association, The American Association of Medical Colleges, and internationally the International Surgical Society (SIC). In Washington, the American College of Surgeons supplies representatives to CMS (formerly HCFA), FDA, AHCPR, the Veteran's Administration, NIH, and the Department of Health and Human Services. The American College of Surgeons also supports national level pathology review, the American Joint Committee on Cancer, which publishes recommendations for staging cancer, and the various cancer and trauma registries.

Trauma systems throughout the country are administered under the umbrella of the American College of Surgeons and the recent problems that neurosurgeons have had providing a surgical coverage have been well handled and well supported by the centralized efforts of the College.

Recent initiatives by the ACS have included the development of a malpractice coverage plan that is nationwide and is of significant assistance to neurosurgeons in certain states that have had major problems with malpractice coverage. There is a major effort underway to develop a "branding" program to let everyone know that the initials

"FACS" after a surgeon's name indicate that he or she has met standards of expertise of ethics and dedication to the patient that truly enhance our level of practice and standing in the medical community at large.

At the present time there are neurosurgeons active in all of the major committee work within the American College of Surgeons and at every level of the leadership, from the Board of Regents to the Board of Governors to the commissions and committee activities. Neurosurgery is perceived as one of the strongest links in the surgical community and it is in the best interest of every neurosurgeon to become an active member of the American College of Surgeons. □

The American College of Surgeons Oncology Group

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

Chair, Brain/CNS Organ Site Committee
American College of Surgeons Oncology Group, Charlotte, NC



A growing discipline, termed evidence-based medicine, seeks to make health care decision making reflect more closely the results of scientific research. In an era when evidence-

based medicine is becoming increasingly prevalent in medical school curricula and clinical practice, the significance of multi-institutional clinical trials, which have been long recognized as the gold standard for resolving important therapeutic issues, has never been greater.

One of the most successful clinical research efforts over the last several decades has been the Clinical Trial Cooperative Groups Program, sponsored by the Cancer Therapy Evaluation Program (CTEP) of the National Cancer Institute (NCI). The Cooperative Group Program was established in 1955 with an initial appropriation of \$5,000,000 from Congress. Continued growth of the cooperative groups has led to a steady increase in funding, with an NCI appropriation of \$154,000,000 for the Cooperative Group Program in 2001.

Continued on page 22

Joint Spine

Continued from page 20

of the various societies are carefully examining the available options as well as the future reimbursement implications of these approaches. In the interim, the recommendation for minimally-invasive procedures that do not already have a specific "non-open" code should be billed using an unlisted code, with the exception of endoscopically assisted lumbar discectomy, which can be coded 63030.

Consultants Corner

Last month we presented incidental imaging studies from a 36-year-old asymptomatic patient.

We asked our panel of experts their opinion on management. Here's what they said:

- "If he were asymptomatic I would not have gotten the MRI and would not be in this quandary. If he were truly asymptomatic, I would warn him to look out for radicular or bowel and bladder symptoms and follow him. If he had any symptoms, I would offer him a microdiscectomy."
- "If he's asymptomatic why did he have this scan? If indeed he is asymptomatic, ie no post void residual, etc., etc., I would leave it alone."
- "I would recommend elective surgery. The risk of neurological demise is great. I have followed several patients nonoperatively with very large free fragment disc herniations at L4-5 or L5-S1, but in those patients the fragment migrated to below the level of the subjacent pedicle (to behind the lower vertebral body). In those patients, their radicular pain subsided. They were followed closely for signs and symptoms of perineal numbness or worse. In this case, however, the fragment is larger than any that I have followed nonoperatively. I would also request that flexion and extension x-rays be obtained to rule out an occult instability. If none is present, then I would recommend laminectomy (right-sided, but extending past midline) and discectomy."
- "Given the history of back and leg pain, now asymptomatic; I am assuming that there is no neurological deficit on exam. If that is the case, I would treat this with observation only. Despite the very impressive findings (I read this as a large central L5S1 disc herniation), I could not bring myself to operate on an asymptomatic patient. There is evidence in the literature of this type of herniation

"disappearing" (likely just being auto-digested). I could certainly make someone worse than normal with an operation."

- "I understand that he was completely asymptomatic by the time you saw him and his neurological exam was normal. I am assuming that he has no bowel/bladder or sexual dysfunction. The MRI demonstrates degenerative changes in the L4-5 and L5-S1 discs. There is a very large HNP at L5-S1 that causes severe canal compromise. In addition, there appears to be mild retrolisthesis at L5-S1. In this asymptomatic patient, there is no need for further workup or interventions. There is no indication for surgery here. I would recommend exercises for low back strengthening/stretching exercises. Because the herniation is large, I would see him back in clinic in several months to make sure he remains asymptomatic."

Final Score: Observation 4-Surgery 1. This is a tough scenario and certainly tests the nerves of anyone who has been involved in a case like it. Clearly there is no right or wrong answer. In this instance management was observational. The patient continues to do well 1 year later and has no neurological complaints (including bowel or bladder). He has not been re-imaged.

Many thanks to our expert panel consisting of, in alphabetical order:

- Dr. Carl Laurysen, Washington University School of Medicine, St. Louis, MO
- Dr. Christopher Paramore, Lake Norman Neurological Surgery, Mooresville, NC
- Dr. Daniel Resnick, University of Wisconsin, Madison, WI
- Dr. Gerald E. Rodts Jr., Emory University, Atlanta, GA
- Dr. Julie York, Loyola Medical Center, Maywood, IL

AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves – Executive Committee Elections

In accordance with Joint Section Bylaws, the Nominating Committee has forwarded the names of the following individuals for positions on the executive committee:

President Elect: Gerald E. Rodts, Jr.

Secretary Treasurer: Timothy Ryken

Member at Large: Joseph Alexander

Comments, Submissions, or Suggestions for the Spine Section?

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

Joint Pediatric

Continued from page 21

am especially grateful for the efforts of Dr. Rick Abbott, who is not only the Secretary of the Pediatric Section, but also was the Annual Meeting Chair for 2001. Less than 3 months after September 11 attacks, the Pediatric Section met in New York City. We were one of the first returning conventions and the first major neurosurgical organization to meet in New York after the destruction of the World Trade Center. Rick worked tirelessly with the hotel, the exhibitors, and with the meetings staff to make this a success, which it clearly was.

New officers were elected in December and they will start their terms at the end of April. The new Chair of the Pediatric Section is Andrew Parent, M.D. Dr. Abbott is the new Chair-Elect. Dr. Jeffrey Wisoff will become Secretary, and Dr. Ann-Christine Duhaim will be the new Treasurer. With this kind of leadership, I am absolutely confident that the Pediatric Section will meet all of the upcoming challenges and continue to serve its membership at a high level. □

American College of Surgeons

Continued from page 21

The American College of Surgeons Oncology Group (ACOSOG) is the newest of 10 cooperative groups funded by CTEP. It is the only cooperative group whose primary focus is the surgical management of patients with malignant solid tumors. The American College of Surgeons Board of Regents approved the concept for a surgical clinical trials cooperative group in 1993. After the establishment of a working

committee, an initial set of protocols covering a broad range of surgical specialties was developed and a grant was submitted to the National Cancer Institute. A site visit was held at Washington University in St. Louis in June 1997. Upon recommendation of the NCI study section, the grant was funded with an initial start date of May 15, 1998. The group was initially based at the American College of Surgeons office in Chicago. In January 2001, the group moved its operations to the Duke University Medical Center, and since then, ACOSOG has developed a strong working relationship with the Duke Clinical Research Institute.

As a clinical trials group, the ACOSOG possesses a number of unique characteristics that deserve emphasis: First, unlike other cooperative groups, the primary leadership of ACOSOG derives from surgical specialties. Second, ACOSOG seeks to be inclusive and surgeons are encouraged to participate in surgical trials regardless of their practice setting or geographic location. Finally, ACOSOG is committed to educating surgeons about the correct conduct of clinical research and the importance of adhering to the principles of good clinical practice as they relate to human subjects.

The Clinical Trial Development Center for ACOSOG is represented in the aggregate by 10 Organ Site Committees (OSC). These committees are composed of surgeons, medical oncologists, diagnostic radiologists, radiation oncologists, nurses, patient advocates, biostatisticians, and ethicists. The individual organ site committees are led by smaller working groups, which set policy for and direct the activities of each OSC. Suggestions for a clinical trial usually come from a member of an OSC. Both academic and community-based surgeons may propose trials to an OSC. Once an idea comes forth, a Study Review Committee determines if the concept merits further development. If the Review Committee recommends that a study go forward, the organ site chair points a study committee, which is responsible for protocol development. The protocol development proceeds with the involvement of members of the study committee, the Statistics and Data Coordinating Center of ACOSOG and CTEP. Once the protocol is approved by the NCI, the study is open for patient accrual.

Neurosurgery's role within ACOSOG has expanded rapidly over the last few years. The Brain/CNS Organ Site Committee of ACOSOG was formed in 1999 by the ACOSOG group chair, Dr. Sam Wells. The Brain/CNS OSC is charged with developing and implementing cooperative, multi-institutional trials for the treatment of brain tumors. From 1999 to 2002, Dr. Ed Laws chaired this committee. Under Dr. Laws' leadership, a working group was created that included specialists from neurosurgery, medical oncology, radi-

CLASSIFIED ADVERTISING

POSITIONS AVAILABLE

CLINICAL PRACTICE, TEACHING

International Research in a four person private practice working in a 500-bed university-affiliated Medical Center. Five Star Neurosurgery rating. Level One Trauma Center. Call is 1:6. Compensation is above the 80th percentile. No buy-in. General Surgery & Neurosurgery residents in house. \$1 million NIH grant. Congenial, personable partners. NICU with Neuro-Hospitalist-Intensivist. 90 miles from Atlanta, 2 hours from the beach.

Teresa Unser, Resource Consulting Group, Inc. 4284 Grand Oaks Drive, Kennesaw, GA 30144. (770) 975-7399 or (877) 975-7399. Fax: (770) 975-8838. teresa.unser@mindspring.com

SOUTH CAROLINA

Beautiful upstate South Carolina provides an excellent opportunity for a young BE/BC Neurosurgeon to join a hard-working, family oriented group of four well-trained Neurosurgeons in a diverse and challenging practice. Excellent progressive hospitals with pleasant staff and patients. Close to mountains and beaches. Compensation is excellent. For confidential inquiries, please contact:

Robbie Williams, Practice Adm.
(864) 224-5700
E-mail: robbie@piedneuro.com

SPECIAL ANNOUNCEMENT! NEUROSURGERY NEWS

is now accepting Classified Line Advertisements! Line ads are the perfect low-cost solution for meeting your advertising needs. Display advertising is still available for those times when greater visibility is desired.

POSITIONS AVAILABLE FELLOWSHIPS SEMINARS RESEARCH GRANTS

In-Column Line Rates:

\$250.00 for 100 words/\$3.00 per additional word.

Display Space:	1x	3x
1/4 page	\$400	\$390
1/2 page	\$660	\$635
1 page	\$1,040	\$990

Frequency Discounts are available. The full text of all classifieds is posted on www.Neurosurgery-Online.com

For more information on placing your classified advertisement in *NEUROSURGERY NEWS*, contact:

Jennifer Williams

Phone: 800-528-1843; Fax: 410-528-4452

E-mail: jwilliam@lww.com

Editorial Profile

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

American College of Surgeons

Continued from page 21

ation oncology, radiology, neuropsychology, and nursing. A mechanism for developing brain tumor-related clinical trials was also put into place, and the brain group's first clinical protocol was submitted to CTEP. Since February 2002, Dr. Anthony Asher has chaired the Brain Organ Site Committee. The Brain/CNS group has just opened its first protocol, Z0300 (SRS vs. SRS + WBRT for patients with 1-3 brain metastases). This protocol is presently being activated at more than 30 institutions nationally. The Brain/CNS Organ Site Committee is actively developing other concepts for CTEP submission.

The Joint Section on Tumors is well represented in the leadership structure of the ACOSOG Brain/CNS Organ Site Committee. Neurosurgeons from multiple institutions, both academic and community, in the United States and Canada have positions on the working group. In addition to protocol development and expanding the slate of open brain tumor trials, major objectives of the Brain/CNS working group include educating neurosurgeons about ACOSOG and developing a network of member physicians across North America and Europe.

In summary, ACOSOG represents an unprecedented opportunity for neurosurgeons and other physicians to investigate important clinical questions related to brain cancer in the setting of cooperative, multi-institutional trials. Additionally, because of the inclusive mission of ACOSOG, a unique opportunity exists to foster interaction between individuals in a variety of practice settings. Finally, it is hoped that ACOSOG will ultimately evolve into a funding mechanism for a broad variety of surgically based cooperative group protocols. In our situation, this could ultimately translate into an enhanced ability to access NIH funding for multi-institutional studies in spine, cerebrovascular disease, and other disease entities.

Interested neurosurgeons are encouraged to learn more about ACOSOG and consider participation with this group. For general information on ACOSOG, individuals can access the group's Web site at www.ACOSOG.org. You may also feel free to contact the Brain/CNS Organ Site Committee Chair, Dr. Anthony Asher at asher@CNSA.com. For specific information regarding the group's open NCI protocol, you may contact Ms. Tracy Kerby at kerby001@surgerytrials.Duke.edu or call 919-668-8588. □