



# NEUROSURGERY

## NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

## President's Message

### Vincent C. Traynelis, M.D.

President, CNS



The intense desire to improve the outcome of the patients we treat is a common bond among all neurosurgeons. These improvements are

achieved through basic and clinical research, enhanced diagnostic techniques, and the development of new treatment strategies. Today, advances in transportation, digital communication, data transfer, and ever-changing technologies encourage all neurosurgeons to transcend political and geographic borders and interact in a true global community. There has never been a more ideal time to expand and communicate the educational mission of the Congress of Neurological Surgeons into the international community.

Currently, there are over 550 CNS active international members representing 73 countries and every continent except Antarctica. International members have an honorable tradition of actively contributing to the CNS. Our international colleagues have served on the CNS Executive Committee, the International Liaison and Advisory Panel of *NEUROSURGERY* (the outstanding CNS scientific journal), taught at the Annual Meeting in Practical Courses and Lunch Seminars, and shared their experience and knowledge in our General Sessions and Special Courses. Active International CNS membership is a great value; some of the major benefits include an annual subscription to *NEUROSURGERY*, reduced registration fee for the CNS Annual Meeting, a complimentary copy of *Clinical Neurosurgery*, and access to all CNS educational products.

The CNS has a long history of partnering with non-North American neurosurgical societies to exchange scientific and educational knowledge at meetings. The sharing of information between the Japanese Congress of Neurological Surgeons and the CNS at each organization's annual meeting is an excellent example of such a relationship. Many other societies have interacted with the CNS in this manner and more will continue to do so in the future. I am pleased to announce that the 2004 CNS Annual Meeting in San Francisco, October 16–21, is a joint meeting with the Società Italiana di Neurochirurgia. The CNS has cosponsored similar meetings abroad for many years. Looking to the future, several such meetings have already been confirmed: Joint CNS-Croatia Society of Neurosurgery (2005), Joint CNS-Asian Conference of Neurosurgery (2006), and Joint CNS-Italian Society of Neurosurgery (2007). A most spectacular gathering that occurs at the CNS

Annual Meetings is the International Reception. The International Committee serves as the host of this reception, which will take place at the 2004 CNS Annual Meeting in San Francisco on Wednesday, October 20. Supported by *NEUROSURGERY* in conjunction with the CNS, this gala event is a special celebration for the CNS Active International members and allows many to renew acquaintances or make new friendships.

The CNS International Committee is active in a number of other international pursuits. Our former Chair, Nelson Oyesiku, has turned over the leadership of this important committee to Gail Rosseau. Dr. Rosseau has been active in international neurosurgical endeavors for many years and she brings fresh ideas and enthusiastic leadership to the CNS International Committee. The CNS International Fellowship is a unique effort to extend educational opportunities to neurosurgeons from developing countries. Fellowships are awarded based on a competitive merit selection process, as decided by the International Fellowship Committee of the CNS International Committee. CNS International Fellowships are offered with the hope that the participating fellow will acquire training that will enhance the quality of care provided in his or her home country. Each 3- to 6-month fellowship consists of primarily a clinical experience, including observation of office, hospital and operating room activities. However, some research experience may also be included in the Fellowship. Applicants must have completed their formal neurosurgical training and have been in practice for 5 years or less. A North American sponsor (who must also be a CNS active member) named by the prospective fellow serves to mentor the educational activities during the fellowship. Preference is usually given to individuals who would not otherwise have had an opportunity to come for additional training in North America. Applications for the CNS International Fellowship may be found on the CNS Web site or by contacting the Chairman of the CNS Fellowships Program,

Paul J. Camarata, at CNS Headquarters at 847-240-2500 or e-mail at [info@1cns.org](mailto:info@1cns.org).

The CNS International Committee is an important partner of the Foundation for International Education in Neurological Surgery (FIENS), which is currently chaired by Russell Hardy. Education is a cornerstone of the FIENS' mission. This organization is primarily interested in educational activity and the development of educational programs in cooperation with areas of neurosurgical development throughout the world. A number of years ago, FIENS and the CNS International Committee developed a joint program, Volunteers for International Neurosurgical Education (VINE). Over the last several years, neurosurgical expertise has been made available in Ghana, Honduras, India, Indonesia, Kenya, Nepal, Peru, Philippines, Taiwan, Thailand, and Zimbabwe through this program. A number of years ago, the Federation for Neurosurgical Development (FIND) was established. The mission of this group was to collect and send donated surgical equipment to third world countries. FIND has now become part of FIENS, and contributions of equipment are still needed and welcome. FIENS and the CNS International Committee have many other ongoing projects and are always striving to expand their pool of volunteers. Interested individuals may contact Dr. Gail Rosseau at CNS Headquarters at 847-240-2500 or e-mail to [info@1cns.org](mailto:info@1cns.org).

The CNS recognizes and appreciates the perspective, expertise, commitment, and fine work that defines every neurosurgeon throughout the world. The CNS plans to continue to partner with other neurosurgical societies and, when appropriate, work in communities outside of North America. The technology that has improved communication and travel presents an unprecedented opportunity to advance the care of neurosurgical patients. Working together, we can enrich each other's lives and improve the outcome of our patients. I thank all of our active international members for their contributions to the CNS and invite neurosurgeons worldwide to join our organization and help the CNS expand the scope of its educational mission. □

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## NEUROSURGERY NEWS

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## MEET THE OFFICERS

### Nelson Oyesiku, President-Elect

**D**r. Nelson Oyesiku was born in Nigeria where he graduated from St. Gregory's College and received his medical degree from the University of Ibadan. He then attended the University of London, as a Commonwealth Scholar where he obtained a Masters of Science degree. He obtained his neurosurgical training at Emory University, Atlanta. During his residency, he also completed a Ph.D. degree in the neuroscience graduate program at Emory studying the role of neurotrophic factors in neuronal survival and regeneration.

Dr. Oyesiku was appointed to the neurosurgical faculty at Emory upon completion of his training. He is currently Associate Professor of Neurological Surgery and Director of the Laboratory of Molecular Neurosurgery & Biotechnology. His clinical and research focus is the surgical treatment and molecular biology of pituitary tumors. He has received an NIH CIDA Award and Medical Faculty Development Award from the Robert Wood Johnson Foundation. He has authored several manuscripts, book chapters and a book in the field of neurosurgery and basic science. Dr. Oyesiku's laboratory has identified unique aspects of pituitary adenoma gene expression and is developing a new modality for imaging and targeted therapy of pituitary tumors.

Dr. Oyesiku has served Emory University, Emory Clinic, and the Emory Hospital on various committees and he has also served on several state and regional committees.

Dr. Oyesiku has been Vice-President of the Congress of Neurological Surgeons and serves on the Executive Committee of the CNS and the Executive Committee of the Joint Section of

Neurotrauma/Critical Care. He has been Chair of the CNS International Committee and served on the CNS Publications Committee. He is on the editorial board of *NEUROSURGERY*, the official journal of the CNS. He is also on the Board of Directors, Federation for International Education in Neurosurgery and the Volunteers for International Education in Neurosurgery. He is a CNS Delegate to the World Federation of Neurosurgical Societies. He was Scientific Program Chairman for the CNS 2003 meeting and is the Annual Meeting Chairman of the CNS 2004 Meeting. He is Secretary/Treasurer of the Georgia Neurosurgical Society.

He has been selected by his peers as one of "The Best Doctors in America" and was selected by the Consumer Research Council of America as one of "America's Top Surgeons." He is a Fellow of the American College of Surgeons. He is named in Marquis Who's Who in America.

Nelson and Lola have been married for 21 years. Lola is an R.N. with specialty training in Obstetrical Nursing, and is a certified midwife. She works part-time for Grady Hospital, Atlanta. They have three children: Angela (20) is a sophomore at University of Georgia at Athens, and Linda (16) and Nelson III (13) both attend Pace Academy in Atlanta. Linda plays the piano and Nelson III plays the trumpet. Angela enjoys volleyball and singing. Linda and Nelson III play soccer and basketball for their school teams. Lola enjoys gardening and cooking, while Nelson enjoys golf, football, cricket, and reading. Lola, Nelson, and the kids have enjoyed seeing a great deal of the world together and have made the quadrennial pilgrimage to the World Cup finals a regular feature of their travels. □



The Oyesikus (left to right): Nelson, Lola, Nelson III, Angela, and Linda.

## CNS Publications Committee

**P. David Adelson, M.D.**  
Chairman



**Members:** Joel MacDonald, Gregory Thompson, Karin Muraszko, Michael Apuzzo, Jim Mulligan, Guy McKhann, Anthony Asher, Christopher Wolfla, Ali Rezai,

The current status of some of the projects from the Publications Committee of the CNS:

### **Clinical Neurosurgery**

Under the Editorial leadership of Guy McKhann and Associate Editorial assistance of Charles Cobbs, Sander Connolly, and Murat Gunel, Volume 51 has been submitted to Lippincott Williams & Wilkins for publication in May 2004. Volume 50 was mailed to members just before the last CNS meeting and was well received. For this upcoming volume, in addition to the General Scientific Session manuscripts, Resident Award and Section Award manuscripts were included for publication.

With Joel McDonald, we continue to explore the idea of incorporating a DVD-based video capture of plenary sessions as a future companion to *Clinical Neurosurgery*. Presentations are becoming increasingly visual: often, significant information and appeal is lost from the presentation to text transformation. In further discussion at the Publications Committee meeting in Denver, the issue of how best to approach this problem and cost was discussed. The cost for finalized video capture, editing, and distribution have been sent out for a quote. Once a budget has been determined, it will be submitted to the CNS Executive Committee for consideration.

Planning for Volume 52 is underway. General Scientific Session speakers and Section Award winners for the Denver CNS meeting have been contacted by e-mail and mail with author instructions and timing of submission requests. Suggestions for increasing the response rate, narrowing the window between the meeting and the manuscript submissions, and/or otherwise improving *Clinical Neurosurgery*, were also discussed.

### **CNS Web Site**

The CNS Web site is now up and running and is located at [www.neurosurgon.org](http://www.neurosurgon.org). The initial framework structure and the physician and patient resources have been installed and an

## CNS Publications Committee

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editorial board put in place. Rhoda Tran, based at the CNS office has been hired as the Webmaster to work along with Dr. Ali Rezai, the CNS Web site Editor. The approach to the present Web site is to develop it from scratch allowing us an opportunity to re-examine a new look, navigation, etc. Obviously, the feeling was that publications would be a major subheading on the Web site. Consideration was made to further develop the potential for online CME and books or other types of novel, innovative content. The CNS Web site will serve as a first available site for such things as news, links, and first publications such as *Geographic Neurosurgery*, have already been published, and are accessible online at the site. Other possible content ideas for online books include *The Epidemiology of Neurosurgical Disease*, which will likely be the next product for online publication. Further ideas and potential products will be discussed among the Editorial Board members.

It was also discussed whether the Web site could serve as an educational resource for CSNS. Content such as "What Is a Neurosurgeon" and other socioeconomic potential topics were provided for Dr. Rezai to consider. In addition, it was felt that the Web site should consider other types of links and resources or generic content for the lay public. Developing a committee of volunteers at the CSNS and CNS to develop this area has potential and was recommended as part of the CNS Web site committee. Dr. Rezai and Dr. Perez-Cruet of the CSNS will identify interested individuals to potentially develop these lay public content links.

### **NEUROSURGERY**

Our Journal, *NEUROSURGERY*, remains our major instrument of communication and for scientific literature under the innovative and capable leadership of Dr. Michael Apuzzo. Highlights from his recent report to the Publications Committee noted that there were increased submissions to the journal this past year, now averaging approximately 2,000 submitted manuscripts annually. In addition, the leadership and involvement by the Editorial Board has increased, and Dr. Apuzzo commented that each manuscript is reviewed by 4 to 6 reviewers, who provide multifaceted and multispecialty reviews. Though there was some concern that this may slow down the process of review, through the use of the new electronic review system, Pegasus, which came online in the past few months, the process of submission, review and revision has been further streamlined and made more efficient to speed the overall process. In addition, the Rhoton compilation volume on Neurosurgical Anatomy was published and has been a big success. This visually beautiful and a classic volume

was supported through a grant by Zeiss Inc., in support of the CNS, Dr. Rhoton and the field of neurosurgery.

Dr. Apuzzo recognized the contributions of Dr. Robert Cantu for his role in the issue of *NEUROSURGERY* dealing with sports concussion in the NFL this past fall. In addition, the recent journal dedicated to forensic neurosurgery including an article by Dr. Robert Grossman regarding the JFK assassi-

nation and its effect on present trauma care. Another potential future supplement is a historical vignette of stereotactic neurosurgery to be developed by Blaine Nashold.

Lastly, Dr. Apuzzo noted that the impact factor/citation index for *NEUROSURGERY* was 2.896, making our journal the highest rated neurosurgery journal concerning its impact factor. *NEUROSURGERY* is also in the top 6% of

all surgical journals. The hope was that this high rating will continue to increase with the addition of OVID as a platform for the distribution of *NEUROSURGERY* through LWW.

### **Translation of the Walter Dandy Biography**

Recently, Dr. Adelson was contacted regarding the possibility of translating

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## Report from the International Committee

**Gail Rosseau, M.D.**



It is with great pleasure that I assumed the Chairmanship of the CNS International Committee. I follow a superb leader in that role, Nelson

Oyesiku, and I am very grateful for his help and guidance during the transition.

The CNS International Committee remains an extremely robust program of the Congress of Neurological Surgeons. CNS Ambassadors have been appointed from a number of foreign countries and this program is expected to continue to grow significantly in the coming years.

An Italian American friendship meeting will be one of the highlights of the 54th Annual CNS Meeting in San Francisco in October. During that meeting, there will also be a special outreach program to involve our international

members in Think First activities, including establishment of international chapters of Think First and participation in the Think First golf outing. The CNS Annual Meeting will also feature an international luncheon, as well as an international reception on Wednesday evening. Finally, international members are welcome at the CNS International Committee Meeting, which will be held on Sunday afternoon. All are welcome.

The CNS International Fellowships continue to be considered one of the best opportunities available for international neurosurgeons to spend time with an American neurosurgical service. The fellowship remains extremely competitive and is generally awarded to three to four deserving neurosurgeons per year, in a fashion that respects the geographic diversity of both fellows and their North American sponsors.

I remain available to assist any member with concerns of an international nature. I hope you do not hesitate to contact me at [grosseau@cinn.org](mailto:grosseau@cinn.org) if I may be of assistance. □

### CNS Publications Committee

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the 1984 CNS publication of the biography of Walter Dandy by Dr. John Fox into Chinese for distribution to Chinese neurosurgeons. Approval for this translation and distribution was given with the proviso that the CNS be recognized

for its original development and publication of the book. While it was suggested that this volume would probably not generate a significant amount of revenue from China, the CNS Executive Committee has decided that any potential revenue to the CNS be set aside for a scholarship or sponsorship for Chinese neurosurgeons to travel to the CNS Annual Meetings. □

## CNS Membership: Applications in Progress

The following individuals have applied for Membership to the Congress of Neurological Surgeons. Commentary or questions should be directed to Robert M. Friedlander, M.D., Chairman Membership Committee, phone: 847-240-2500; e-mail: [info@1cns.org](mailto:info@1cns.org).

Maxwell Boakye

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Giancarlo Hernandez

Jefrey Johnson

Florence LeFranc

Gerald Lemole Jr.

Demetrius Lopes

Christiano Lumenta

Reza Malek

David Rothbart

Paul Santiago

Nicholas Voss

Louis Whitworth

## JOINT SECTION ON NEUROTRAUMA AND CRITICAL CARE

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### Chairman's Message

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



Clinical research is vital for understanding the anatomic, physiologic, and molecular bases of the diseases we treat and for discovering better treatments. Studies

involving rodents can suggest specific avenues for investigation, but there are many interspecies differences that limit valid comparisons. With few exceptions, the most relevant clinical research programs in neurotrauma are directed by neurosurgeons. Through our daily clinical experience, we see which problems most directly cause adverse outcomes for our patients and glean practical potential solutions to those problems. Numerous members of the Joint Section have succeeded in balancing busy neurosurgical practices with incredible research productivity. We have helped to define the numerous molecular and physiologic mechanisms of secondary brain injury in humans through microdialysis and CSF studies and systematic imaging studies of cerebral blood flow and metabolism. We have critically assessed the use of more than a dozen novel pharmacologic agents intended to limit secondary brain injury and improve outcomes after TBI. While none of these studies has found improved outcomes as a result of a particular drug, they have clarified the appropriate design of future studies. For example, we now know that TBI trials must account for the influence of gender and that a new treatment may benefit patients with focal contusions but not those with diffuse injuries. Advances in neurotrauma research could be greatly accelerated if more neurosurgeons were involved, particularly in multicenter trials. However, many neurosurgeons do not consider conducting research because of increasing pressures to expand their clinical volume as reimbursement continues to fall.

In this issue of the newsletter, we invited two senior colleagues to relate their experience with balancing active clinical research programs and clinical practice. Despite very different backgrounds, both exemplify the true academic neurosurgeon. Bill Welch trained for a career in academic neurosurgery, and completed fellowships in both neurooncology and spine surgery before joining the faculty at the University of Pittsburgh and developing a successful academic spine program. He directs clinical research projects funded both

by the NIH and private industry. Dom Esposito began his career in private practice. He came to academics only after he could no longer resist direct involvement in developing better treatments for patients with TBI. After years of private practice, he joined the faculty at the University of Mississippi and quickly developed a well-funded and productive TBI research program.

The National Neurotrauma Society provides an excellent forum for collaboration between neurosurgeons and basic neuroscientists interested in neurotrauma research. Virtually all clinical and basic science investigators currently conducting brain and spinal cord injury research are members and regularly attend the annual meeting. Ross Bullock, the past chair of the Joint Section, also was a recent president of the Neurotrauma Society. The Joint Section strongly supports this organization, and we encourage you to attend their 2003 annual meeting in Biloxi, Mississippi, on November 6 and 7.

## Academic Research in the HIPPA Era

**William C. Welch, M.D., F.A.C.S., F.I.N.S.**  
**Patricia Karausky, R.N.**

Physicians clearly are living in interesting times, especially those active in academic pursuits. In the past, physicians could pose a question, perform a limited retrospective study and derive an answer with the expectation of peer-review publication. Scientific expectations are much higher today. Current study proposals require considerations of funding (costs can not be off-loaded to insurance companies), Institutional Review Board approval, patient counseling and consent, extensive data collection, interpretation and generation of a work documenting the methods of study and conclusions. Should the study involve the investigation of a new device or drug, a Food and Drug Administration (FDA) audit can reasonably be expected. Studies funded by the National Institutes of Health require safety review committee meetings in addition to the above requirements. Most journals expect that studies will be randomized and have an adequate follow-up period.

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## Joint Section on Neurotrauma and Critical Care

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With the advent of the Health Information Portability and Privacy Act (HIPPA) rules, yet another layer of difficulty has been applied to research endeavors. Under the guise of protecting human subjects' rights, two of the

most important pieces of research have been negatively affected. Research regarding the collection and analysis of medical record information will be required to undergo a process of de-identification of data by an "Honest Broker" before it can ever reach the office of the clinical investigator. This process can often result in data that is not useful due to the vigorous cleansing process of the eighteen items that

will assure complete de-identification of the subject. These identifiers include dates directly related to an individual including discharge date and date of birth, device identifiers, any number, characteristic or code or other unique identifier. Another option to fulfill this regulation would be to request that the IRB grant a waiver of consent. To satisfy the regulatory criteria, the requirements for a waiver include proof that

the research could not be practicably conducted without a waiver and without access to the PHI (Personal Health Information) Additional assurances include: protection of improper use of identifiers, plans to destroy the information at the earliest opportunity and written assurance that PHI will not be reused or disclosed improperly. A waiver of authorization will not be easily obtained. Lastly, each department can develop a research registry to preemptively get permission from potential subjects, who come to the clinic, to allow their PHI to be used for research. While this may be an answer for future research, not only is it bulky and slow to develop, but also what are we to do about the vast pool of retrospective data that could be accessed for research purposes?

The second area of research adversely affected by the HIPAA privacy rules comes with the identification and recruitment of subjects. It is no longer permissible to be recommended to a study by the physician and to consequently be seen by the co-coordinator. Now, potential subjects must sign an authorization for the sharing of personal health information with the study team. While this is a reasonably benign process it involves one more barrier to recruitment. The study team can no longer perform routine recruitment activities such as accessing patient visit lists, review a chart or call a potential subject at the direction of the physician, without violating the HIPAA laws.

And so it comes to this for the potential subject. At the front desk of a clinic he/she is asked to go through the registration process, to read and sign as guarantors. They are given a research registry consent to read and sign for future studies. After being seen by the physician and determined to be a potential candidate for a study, they are asked to sign an authorization for the sharing of their PHI and, lastly, they are asked to sign a 10 to 20 page consent to enroll in the study. One of the hallmark attributes of informed consent is that the manner and the context in which the information is presented are as important as the information itself. Have we not done a great disservice to the consent process by reducing the comprehension level of the subject through the plethora of documents requiring signatures? Does our fervor for privatizing research subjects PHI, ultimately result in harm to the very people we are protecting? As the Belmont Report so succinctly states: Respect for Persons, Justice and Beneficence. Can't that be enough guidance for the ethical practitioner?

Despite these difficulties, researchers have, and will, continue to perform research. A significant effect of these daunting regulations is that it forces the researcher to ask a well defined question, develop a plan of execution, and see the process through to the end. One may require financial support from a

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granting source to obtain the resources to perform the study. Thus, the proposal is scrutinized by the granting source(s), the IRB(s), and potentially the FDA. Each of these institutions may positively contribute to the development of the project. As the difficulty and cost of research continues to escalate, one hopes that the quality of the finished product will as well.

William C. Welch, M.D., F.A.C.S., F.I.N.S. is an Associate Professor of Neurological Surgery, Orthopaedic Surgery and Rehabilitation Science and Technology and the Director of Neurosurgical Spine Services and the Spine Specialty Center at the University of Pittsburgh Medical Center.

Patricia Karausky, R.N. is a Clinical Research Coordinator for the Department of Neurosurgery at the University of Pittsburgh Medical Center.

## Clinical Research in Private Practice

**Domenic P. Esposito, M.D., F.A.C.S.**

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

Despite the tremendous volume of clinical material, which is handled by private practice neurosurgeons in this country, very little clinical research is actually performed in this setting. This is particularly true for neurosurgical practices serving community hospitals. This article will attempt to analyze some of the reasons for this phenomenon and propose some potential solutions. The reasons why clinical research is seldom performed in the private practice setting are fairly self-evident. Obviously the priorities for the maintenance of a private practice are different than those found in a university environment. There is no such thing as "protected time" in private practice, which would allow the clinician to dedicate a portion of his/her week to activities such as grant writing, data collection and data analysis. Most neurosurgeons work well over 40 hours per week and the time that they have at their disposal after their hours of work are seldom dedicated to research activities. In addition, there are some significant medical-legal issues to be considered as well as the new HIPPA regulations and governmental constraints that would make even the interested practitioner somewhat leery to embark on these endeavors, particularly without very competent research personnel to help get the research structured for compliance. Lastly and probably most importantly, in a private practice setting there is a lack of the support personnel, such as

clinical research coordinators and technical assistants, to assist with the performance of clinical research activities. In many cases, the individuals who do spend time in the clinical research arena have to bear a substantial portion of the cost of these studies from their office overhead.

Given the above issues, why do the authors feel that clinical research should be performed in the private practice

environment? First and most importantly, there is a wealth of clinical material that is handled in the private practice environment. In fact, in the arenas of certain issues such as simple and complex spine surgery, carotid endarterectomy, peripheral nerve surgery and critical care neurosurgery, the number of cases performed in the private practice setting often far exceeds the same number of similar cases performed in the university environment.

Secondly, particularly in light of the new requirements for residency training, many individuals who are coming out of neurosurgical programs have had anywhere between six and nine years of surgical and neurosurgical training, and often during their training they have been exposed to both basic science and clinical research projects. The era of the neurosurgeons that trained

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# CNS Annual Meeting ad new 4/c

## Joint Section on Neurotrauma and Critical Care

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in three or four years and perhaps had little exposure to a research environment is quickly drawing to a close as these individuals no longer practice. It seems to the authors somewhat of a waste of hard work and time on the part of the young neurosurgeons and their teachers that following the completion of their residency these skills are never used again. Those individuals slated for careers in private practice do not or seldom become involved in research activity and academic activity in general. Many individuals feel that once they have chosen a private practice environment that they will likely continue to do this for the rest of their professional careers. By abandoning all connection with academic medicine and any form of clinical research these individuals may be closing some doors that they may find appealing during the latter portion of their clinical careers. It seems somewhat ironic that this shift towards better trained scientist-neurosurgeons has occurred over the same time period that research in many settings, both academic and private, has become technically and economically more difficult.

Are there solutions to this problem? The authors feel that the one solution lies with our academic institutions. We think that the academic institutions should reach out to private practitioners and try to keep them involved in academic endeavors. Often the academic institution will be able to provide some of the support materials necessary to allow the private practitioner to participate in clinical research projects. In addition, from the standpoint of the private practitioner, particularly the young private practitioner, there needs to be a spirit of volunteerism on their part to pursue these endeavors. Perhaps in medium and large size private practice groups, one individual could be given the resources and time to coordinate the academic activities for the group.

But to flesh out the town-gown alliance

we need to go beyond the spirit of volunteerism and collegiality. There is great practical benefit for both a private practice and an academic institution to develop research partnerships with private practices. The wealth of clinical material alluded to above is unavailable to the academic institution doing research unless such a partnership is present. Data collection can be undertaken by university personnel working in or with the private practice as long as the duties are clearly outlined and do not violate FTC regulations. This type of affiliation is the only practical way for otherwise unaffiliated individuals in private practice to undertake clinical research unless they are independently wealthy or have extraordinarily understanding partners. Another option, given the right environment and a critical mass of like-minded physicians within a supportive community, a non-profit institute can be built that supports the personnel required to write grants, develop funding, collect and analyze data and recruit or accrue patients under the direction of the physicians. Such institutes typically function in other ways as well, such as educating the community about neurologic disease, holding outreach clinics, applying careful outcomes measures, and providing inter-disciplinary clinical care coordination and administrative support in addition to organizing the research activities. As such an institute takes root, it attracts bright and energetic young physicians with an inclination towards research who for whatever reason are not interested in pursuing a purely academic career. Although very difficult to build, this may be an ideal way to bring research to the community.

In addition, much research is supported in "the private sector" by pharmaceutical or device companies. Although this is seldom as satisfying as basic "bench work" or clinical research that springs from your own grant writing efforts, it clearly allows the private practice surgeon to participate at some level in research in such a way as the fiscal burden for doing it is relieved. The authors realize that there are a number of private practice neurosurgeons who

participate in academic activities and certainly these individuals are to be commended for wearing more than one hat. We do feel very strongly, however, that there is a wealth of clinical material, which is not being collected and documented for research studies.

Domenic P. Esposito, M.D., F.A.C.S., is Associate Professor and Director of Neurotrauma at the University of Mississippi Medical Center.

John McVicker, M.D., F.A.C.S. is the Past Chair of the Neurotrauma Committee of the CSNS and presently the JSNTCC Executive Committee, Member-at-Large.

## Joint Section of Neurotrauma/Critical Care Position Statement on Reconciling On-Call Responsibilities with EMTALA Requirements

### Background

For over 1 year, the Joint Section of Neurotrauma/Critical Care has been grappling with the complex issue of on-call physicians' responsibilities for delivering neurotrauma services. After much discussion, the Section's Executive Committee has identified the following issues, among others, that represent the crux of the dilemma facing each neurotrauma service that aims to implement reasonable on-call physician policies:

Ensuring the greatest degree of safety for the patient suffering traumatic injury to the brain or spinal cord;

Endorsing the caveat that the neurosurgical specialist provides the best care needed by the neurotrauma patient;

Reconciling the inherent conflict of EMTALA's policy that physicians are not required to be on-call at all times with the law's requirement that hospitals must maintain the on-call list in a manner that "best meets the needs of the hospital's patients;" and

Matching the limited number of neurosurgeons with the total number of hospitals requiring on-call coverage, while at the same time acknowledging that there are simply more hospitals than neurosurgeons available to provide continuous neurotrauma services.

### Consensus Opinion

Multiple factors within various geographic regions (including location, available neurosurgical work force versus nonparticipatory work force, proximity to other neurosurgical centers,

and typical elective and neurotrauma workload) inevitably conflict with the EMTALA guidelines established to protect the patient, the neurosurgeon and the institution. Each institution and its neurosurgeons should therefore specify these provisions contractually when they address the unique requirements of the area to ensure compliance with EMTALA. Ultimately, only the individual neurosurgeon can determine the limits of his or her ability to provide continued coverage. Hospitals should not force or coerce neurosurgeons to provide continuous on-call coverage when it is impossible or unreasonable for neurosurgeons to do so.

To best meet the needs of patients, in advance and prior to crisis, the neurosurgeons and the institutions must negotiate contingency plans and inter-hospital transfer agreements for periods of non-coverage (whether due to fatigue, simultaneous coverage, vacation, or limited number of neurosurgeons in the area or available to the institution).

### Rationale

Recognizing that it is unavoidable that an individual neurosurgeon might be required to be on-call simultaneously at more than one institution because of the lopsided ratio of individual neurosurgeons relative to institutions requiring neurosurgical coverage, recent EMTALA guidelines now permit simultaneous on-call coverage. These guidelines further acknowledge that EMTALA does not require institutions to have continuous neurotrauma availability. However, the guidelines require, among other things, that hospitals have "policies and procedures to follow when an on-call physician is simultaneously on-call at another hospital and is not available to respond. Hospital policies may include, but are not limited to procedures for back-up on-call physicians or the implementation of an appropriate EMTALA transfer..." EMTALA guidelines further permit on-call physicians to schedule elective surgery while on-call, although these same guidelines also state that hospitals may prohibit this practice. It is therefore incumbent on the neurosurgeon and the institution(s) to address all of these issues in writing to avoid any uncertainties with their respective EMTALA obligations.

## Acknowledgments

The Joint Section wishes to thank Sam Hassenbusch and the other members of the Coding and Reimbursement Committee for their work in pushing through the new CPT codes for TBI. In the 2003 CPT Manual, you will find new codes for decompressive craniectomy (61322) and decompressive lobectomy (61323) for intractable intracranial hypertension. We encourage you and your billing staff to review these codes and use them as appropriate. □

## Did you know?

Potentially useful codes from the 2003 CPT Manual including new additions (\*\*)

99050	Services requested after office hours in addition to basic service
99052	Services requested between 10:00 pm and 8:00 am in addition to basic service
99054	Services requested on Sundays and holidays in addition to basic service
99056	Services provided at request of patient in a location other than physician's office that are normally provided in the office
99058	Office services provided on an emergency basis
**61322	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy
**61323	With lobectomy
**61316	Incision and subcutaneous placement of cranial bone graft

## JOINT SECTION OF THE SPINE AND PERIPHERAL NERVES

### Highlights of the 2004 Spine Section Meeting

Daniel Resnick, M.D.

The 2004 meeting of the Joint Section on Disorders of the Spine and Peripheral Nerves was held on March 17–20. The scientific program committee put together a faculty made up of international superstars of spinal surgery. Cooperation with the Scoliosis Research Society and the Cervical Spine Research Society enabled the section to attract some of the most talented orthopedic and neurosurgical spine surgeons to serve as faculty for a number of special courses and to speak on their areas of expertise in the general sessions. Topics covered in this year's program included disc arthroplasty, clinical experience with bone morphogenetic proteins, new craniocervical fixation techniques, and advances in the treatment of spinal deformity.

Featured orthopedic surgeon speakers this year included Juergen Harms, Ken Burkus, Robert Frazer, Kieth Bridwell, and Rick Delamarter. John Jane and Martin Weiss were also featured and presented their perspectives on several aspects of spinal surgery. Volker Sonntag, Ed Benzel, Dennis Maiman, Nancy Epstein, Alan Crockard, Arnold

Menezes, David Kline, and many others helped round out the faculty and provide a depth and breadth of experience not before seen at any Spine Section meeting.

There were five special courses, a nurse and physician's assistant course, and a practice management seminar offered in conjunction with the meeting. Those wishing to brush up on the basics of spinal surgery or peripheral nerve surgery before the board examinations were encouraged to attend the "fundamentals" courses. There were two "Master Surgeon" courses as well, with panels of senior faculty discussing the management of difficult cases. There were over 50 platform presentations and 70 posters describing the cutting edge of spine surgery research.

The Section offered a number of research and clinical training awards this year, including the Ron Apfelbaum research grant, the David Kline research grant, the Sanford Larson Award, Cloward Fellowship, and the Mayfield Award. This year, a David Cahill Fellowship was awarded in honor of Dr. Cahill. Past award winners presented the results of their work funded by the Section during the general session. □

## JOINT SECTION ON STEREOTACTIC AND FUNCTIONAL NEUROSURGERY

### The 2003 ASSFN Quadrennial Meeting

Rees Cosgrove, M.D.

Stereotactic and functional neurosurgery has enjoyed an exciting renaissance over the past few years with advances in technology, imaging, deep brain stimulation, and neuromodulation. For both the American Society for Stereotactic and Functional Neurosurgery and the Joint Section, the year ahead promises to be equally exciting!

The 2003 ASSFN Quadrennial Meeting was held this past May in New York City at the Plaza Hotel and was simply outstanding. Over 300 participants enjoyed a superb scientific program organized by Dr. Andres Lozano and the sophisticated New York scene and social events arranged by Dr. Patrick Kelly. The success of this meeting along with the rapidly accelerating pace of

new knowledge in the field has encouraged us to finally hold meetings every 2 years rather than every 4 years.

Our next meeting will be held in Cleveland, OH, October 1–3, 2004 and is being organized by Phil Starr as Scientific Program Director by Dr. Ali Rezai who is in charge of local arrangements. This meeting will focus on the role of neuromodulation in the areas of movement disorders, epilepsy, pain, and psychiatry. See page 18 for announcement.

For complete details, visit the course Web site at:

<https://www.clevelandclinicmeded.com/courses/assfn-neuromodulation2004.htm> or contact Martha Tobin at 800-223-2273, ext 53449; e-mail: [tobinm@ccf.org](mailto:tobinm@ccf.org).

The next biennial meeting of the ASSFN will be held in Boston at the Copley Plaza on June 1-4, 2006. □

## Women In Neurosurgery Update

Cheryl A. Muszynski, M.D., F.A.C.S., F.A.A.P.

The WINS highlight of the recent Congress of Neurological Surgeons (CNS) 2003 meeting in Denver was the lecture "How to Create More Balance and Peace at Work: Connect," by the dynamic and well-respected author and motivator Vickie Falcone. During her one-hour interactive presentation, Ms. Falcone demonstrated techniques for living and functioning with more ease and less conflict in relationship—both on and off the job. She also outlined eight steps for "high-level connecting" and explained how one's upbringing and subsequent environmental influences, in conjunction with today's high-technology culture, have often decreased the authenticity and quality of our communication skills. Ms. Falcone shared refreshing perspectives on techniques that may be incorporated into one's approach to optimize the quality of doctor/patient relationships. Although her outlook is based on principles initially directed toward improved parenting skills, she demonstrated the applicability of these principles to neurosurgeons' professional relationships. As the Alexa Canaday Lecturer at the WINS reception at the CNS 2003 meeting in Denver, Ms. Falcone shared her passionate motivation for transformation and left her audience geared for positive change.

WINS continues to offer an annual Sherry Apple Travel Scholarship, awarded to the resident judged to have authored the most outstanding abstract for the CNS Annual Meeting. This Travel Scholarship is an award of \$1,000 and is intended to defray the travel and housing costs incurred by the resident in attending this particular meeting. The Sherry Apple Resident Travel Scholarship is named in honor of our Past President, who was tragically killed in a boating accident in 2001, but who embodied the courageous, academic, and uplifting spirit of WINS.

WINS is in the process of revising our informational pamphlet, "So You Want to Become a Neurosurgeon," which provides input from the presidents of both the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. This pamphlet is used by medical students across the country to help them understand the application process in neurosurgery. It is available on the CNS Web page for easy downloading.

Finally, new statistics document that the number of board-certified women neurosurgeons in the United States continues to escalate. Although the face of "the best and the brightest" in neurosurgery may look different today than in the past, it will most surely look dramatically different in our future. WINS continues to function as an agent for change and the provider of a forum for issues not addressed elsewhere in organized neurosurgery. □

**PHOENIX 2005**

**SAVE THE DATE!**

2005 Annual Meeting of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves

March 9-12, 2005

JW Marriott Desert Ridge Resort & Spa  
Phoenix, Arizona

American Association of Neurological Surgeons  
Jointly Sponsored by the American Association of Neurological Surgeons

## CSNS NEWS

### Chairman's Corner

**Frederick A. Boop, M.D.**  
Chairman, CSNS



As we head into the spring of 2004, the CSNS finds itself confronted with election year politics, the professional liability campaign being at

the forefront. Senator Edwards, a plaintiff's attorney who has won over \$100 million in awards in suits against physicians, remains a democratic contender for the presidential race. At the same time, the Senate democrats have prevented debate on the first of several incremental bills designed to propose medical liability reform for specific subgroups of practitioners. The bill, The Access to Health Care for Mothers and Well Babies, proposed medical liability protection for obstetricians in order to maintain access for pregnant mothers. This was voted down at the end of February. Other incremental bills being put forth over the next year include a similar bill supporting protection for rural physicians and another offering protection for "good Samaritans" who offer help in emergency situations. There is no question that the medical liability crisis will be one of the major topics of the upcoming presidential election campaign.

Four years ago, Lyal Leibrock, then chairman of the CSNS, proposed the first Neurosurgical Leadership Development Conference. Designed to offer a lecture series on how to influence political process, this 2-day meeting was an unqualified success. After hearing lobbyists speak on how to address political issues before congresspersons, participants reviewed pertinent bills pending before Congress and were then accompanied by members of the Washington office on visits to the Hill to discuss neurosurgery's position on the various issues before congressmen and congressional health aides.

This summer we are planning the third "Leibrock Leadership Development Conference for Neurosurgery." Strategically scheduled to take place in Washington, DC, 2 weeks before the National Democratic Convention, the conference this year will focus on the issue of medical liability reform. Katie Orrico and her office have put together an all-star cast of speakers to address attendees and educate them on the issues before Congress. This will be followed by visits to the Hill to meet with our respective congresspersons. The meeting will be held at the Washington Court Hotel, a beautiful venue two



blocks from the Capitol. We are asking that at least three representatives from each state society attend. In addition, any neurosurgeon who has contributed to a congressional campaign or has a personal relationship with a member of congress is asked to attend. If we can amass enough neurosurgeons, we hope to hold a photo op with several key politicians to make the point that the liability crisis is of sufficient magnitude that neurosurgeons across the country are willing to leave their practices to come to Washington and make a statement. I hope that you can make the time to participate.

This is a critical year for neurosurgeons across the country to become involved in neurosurgical leadership. This election cycle brings physicians closer than we have ever been in the history of medicine to bringing forward federal legislation to limit the awards in medical liability suits. There are a number of key seats up for reelection this fall, with only a dozen or so votes needing to change for us to have a chance at passing a reform bill. Your participation is key to our success. Please plan to be there.

## Neurosurgical Leadership Development Conference

**July 18-20, 2004, Washington, D.C.**

**Karin M. Muraszko, M.D., F.A.C.S.**  
**William Bingaman, M.D.**  
**Lyal G. Leibrock, M.D., F.A.C.S.**

The Council of State Neurosurgical Societies (CSNS) will offer its third Neurosurgical Leadership Development Conference (NLDC) in Washington, D.C. this summer. With the able assistance of Katie Orrico and

## NEUROSURGICAL LEADERSHIP DEVELOPMENT CONFERENCE

WASHINGTON COURT HOTEL - WASHINGTON, DC  
JULY 18-20, 2004

<b>Saturday, July 17</b> 6:00 – 7:30 pm	Welcome Reception with Exhibitors
<b>Sunday, July 18</b> 7:30 – 8:00 am	Continental Breakfast with Exhibitors
7:30 am – 4:00 pm	Exhibits Open
8:00 am – 5:30 pm	Practice Management Seminar Topic Highlights Coding and Reimbursement New CPT Codes Medicare Overview Physician Ownership of Specialty Hospitals Medical Legal Strategies
10:40 – 11:00 am	Beverage Break with Exhibitors
12:05 – 1:15 pm	Lunch with Exhibitors
2:45 – 3:15 pm	Beverage Break with Exhibitors
6:00 – 7:30 pm	Reception with Exhibitors
<b>Monday, July 19</b> 7:30 – 8:00 am	Continental Breakfast with Exhibitors
7:30 am – 4:00 pm	Exhibits Open
8:00 am – 5:30 pm	NLDC Conference Topic Highlights Medical Liability Campaign Update (Bean/Orrico) Issue and Political Advocacy and/or November Elections Predictions (Political Consultant) Congressional Staff Panel – Differing Views on How to Solve the Medical Liability Crisis (Key Republican and Democratic staff) Prospects for Federal Medical Liability Reform Legislation (Several Members of Congress and White House) Hill Visits Preparation – SINGLE ISSUE FOCUS THIS TIME: Medical Liability Reform
10:30 – 11:00 am	Beverage Break with Exhibitors
12:00 – 1:15 pm	Lunch with Exhibitors
2:45 – 3:15 pm	Beverage Break with Exhibitors
	Open Evening
<b>Tuesday, July 20</b> 8:00 – 9:00 am	Hill Visit Rally Breakfast
9:00 am 12:00 pm	Congressional Visits
12:00 – 2:00 pm	Hill Visit Wrap-Up

the Washington Committee, this conference has been instrumental in preparing neurosurgeons to meet the demands of a changing and challenging socioeconomic front. The conference will help prepare neurosurgeons to become advocates in their local communities and will help them to understand the complex political and economic environment that they now face. It will also help them understand how advocacy can occur at a variety of levels.

The continuing medical education component of the meeting will focus on asset protection for individual neurosurgeons. This will provide particular insight as to asset protection with

respect to malpractice litigation, particularly in an environment of shrinking malpractice insurance protection. This course should not only help the individual neurosurgeon, but also act as a template for group practices in developing strategies to assist in asset protection. A second important aspect of this continuing education course will be a discussion of medical liability. It will not only provide insight as to the national scene with respect to liability reform but also prepare the individual neurosurgeon to develop strategies to protect him or herself from exposure and thereby limit their liability. There

# Integra Neurosciences

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## CSNS News

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will be a specific discussion of physician ownership of specialty hospitals, clinics, and health care facilities. In addition, there will be a review of coding and reimbursement, highlighting new CPT codes, and a Medicare overview.

The second day's program will provide training as to how to approach local and national legislators with respect to neurosurgical issues and concerns. Understanding the role of the various health policy staff personnel will be a key feature of this session. Often it is these congressional and senatorial staff personnel that can help effect change and promote understanding of these important issues. Attendees will hear an update of neurosurgery's effort with respect to medical liability and there will be a congressional staff panel to examine "Differing Views on How to Solve the Medical Liability Crisis," which will include key Republican and Democratic staffers. These sessions will help participants navigate the alphabet soup of agencies, regulators, and policy makers that are shareholders in health care policy. Individual state initiatives will be highlighted with respect to liability reform and the need for grassroots action.

Every neurosurgeon's voice is important and must be heard regarding these issues. Often we possess the passion but lack the experience or skills to effectively express our concerns and needs. The NLDC is an outstanding opportunity to sharpen one's skills and learn the delicate art of persuasion of state and federal legislators. Understanding these important socioeconomic issues is important for every neurosurgeon. It is important that neurosurgeons from every state attend the NLDC, because no matter how insignificant a Congressman from an individual state may be, in the right position or on the right committee he or she may be an important ally to neurosurgery. NLDC-2004 needs people from every state and especially larger states; we need multiple representatives to be able to communicate the important concerns of the practicing neurosurgeon. This conference will help train the individual neurosurgeon how to interact effectively with elected representative and regulators in a positive and professional fashion to achieve not only expression of their own concerns, but also the larger concerns of organized neurosurgery.

NLDC 2004 is a very exciting program and the CSNS hopes that now, more than ever, there will be an outstanding turnout. The meeting headquarters at the Washington Court Hotel are in the heart of the Capitol area, conveniently located to Senators and Congressmen. Extraordinary efforts have been made to bring participants into significant contact with their legislative representatives and their staffers. Armed with the knowledge provided by this course, par-

ticipants will be able to be advocates for themselves and for neurosurgery. This is not the time to sit back and complain. It is the time to participate and become a clear voice for the needs of the practicing neurosurgeon. Do not miss this opportunity to be your own best advocate!

## Curmudgeon: Reflections of a Lifetime in Neurosurgery

**Robert Schwetschenau, M.D.**

Cur-mud-jun (definition)—an irascible, churlish person.

You'll note that I didn't use the adjective that invariably accompanies the term "old," as in "old curmudgeon." It's bad enough to be asked for some reflections on past events in neurosurgery, without having to simultaneously accept the sobriquet of "old."

It is amazing, however, to look at the past and realize that there's not much new under the sun. I left the Army in 1975 and began practicing in Cincinnati. My home had been there, and both my wife's and my families were there. I really hadn't considered any other geographic options. I arrived to find myself in the middle of a liability insurance crisis—new, and sometimes, renewed malpractice insurance was simply unattainable. Finally the State of Ohio had to step in and the Legislature formed the Joint Underwriting Assurance, or JUA. The state, in essence, became the insurer for hundreds of physicians in Ohio, but it was several years before the private market once again began to write coverage policies and the JUA dissolved.

You might remember The Physician's Insurance Exchange (P.I.E.) as a fiasco, but actually it was a very successful endeavor, started by two of our own members—Ed Bishop and Herb Bell—and provided affordable premiums, but most importantly, aggressive, competent defense against abusive suits. Local review boards of selected shareholders reviewed all suits and decided which had merit and settlement options should be pursued, and which should be defended. These suits were never settled. Word soon got out among trial lawyers that P.I.E. was not the place to look for a fast buck settlement for a nuisance lawsuit. The company flourished and malpractice lawsuits seemed to diminish, until non-physician executives of the company began using it and its reserves as their own funds. The subsequent dissolution of the company has chilled the development of any other physician's mutual insurance companies.

Of course, the OSNS cooperated with the OSMA in persuading legislators to consider tort reform in Ohio. After a long, politically difficult campaign caps on noneconomic damages, modification of joint-and-several liability, rational limits on the statute of limitations, and other potential curbs on the profusion of legal muggings that had been taking place were signed into law in the State of Ohio. The Plaintiffs Bar wasted no time in bringing this to a Supreme Court made up generally of former trial attorneys who quickly found the new legislation enacted by the people's representatives in the legislature to be unconstitutional. This time around the voters were a little smarter, electing new judges, THEN getting legislation passed.

On the economic front, I regret to say that I practiced in what has come to be called the "Golden Age of Medicine" without recognizing it or, sadly, without capitalizing upon it. Since I didn't profit from it, I choose to look upon this appellation as a misnomer. Surely, the discovery of penicillin and subsequent development of successive families of antibiotics, or the eradication of plagues such as polio, or smallpox, or the promise of the application of genetic technology to the treatment or prevention of disease merit this designation.

Now if the title was changed to the "Gold-Laden Age" we're on to something I can agree with. When physicians embraced Medicare in 1965—after all we were treating many of these patients at reduced rates or for free anyway—there was much more of a feeling of societal obligation and, I dare say, more of a feeling of satisfaction in our professional lives. There were no debates about treating those with no ability pay. There was no consideration of not covering the Emergency Room. There was no need for EMTALA or HIPPA or even CMS. For the most part, we were adequately compensated by the society we served and generally enjoyed wide esteem and appreciation. Then an obscure economist, Professor Hsaio of Harvard University, under contract from the government developed the Resource-based Relative Value Scale—the RBRVS—which was supposed to determine the cost and complexity of each and every described example of medical work, how much it cost to produce that unit of medical work, and also a component that took into account the cost for malpractice insurance associated with that particular work. No matter that only eight specialties were actually surveyed. Chairman Hsaio had the omniscience to be able to determine linkages or equivalencies between, say, lumbar laminectomies by neurosurgeons (not surveyed) and, say, cholecystectomies by general surgeons (surveyed). Then, with everything categorized, like the old joke, it remained only to argue about the price.

Some of the more naive or less far-sighted of us (myself included) believed that this was a system only to be applied

to Medicare patients and the amount the government decided to pay for each relative value unit would apply only to those patients. The schedule quickly became the MSRP for medical reimbursement as applied by the managed care companies or other third-party payors. Because of our fears of "being left out" and waking one January 1st with no patients to see, we flocked to sign contracts that in some cases provided below Medicare reimbursements. (We will bring you so many patients you can make it up in volume.) Since most if not all of the practitioners in a given area signed up with all the third-party payors, there was no increase in volume, just a decrease in reimbursement. Truly, as a neurosurgeon from California remarked to me, there is no floor on what a neurosurgeon can make as the insurance companies chased the lowest bidder.

What's a poor neurosurgeon to do? The answer most chose to maintain our income, cover the increasing costs of running a modern practice, and fend off the ever-increasing insurance premiums for another year was simply to run harder—see more patients, perform more (relatively) better recompensed procedures, and seek ways to supplement income.

I don't know about you, but everything I ever did to supplement my income within a short time was made illegal or unprofitable. In Cincinnati, only one hospital could have a CAT scanner thanks to a government agency that didn't believe this new technology was necessary and would simply add to the community's health care expense. My group purchased the second CAT scanner in town. One and a half years later, the government body was disbanded, and within 6 months, every hospital with more than 100 beds had a CAT scanner.

We built a Medical Building. Because over a third of the partners were oncologists, we put a linear accelerator in the building. The oncology partnership exploded into subatomic pieces, and we now have a very expensive lead-lined storage area in the basement.

We formed an MRI partnership but were politely, then less politely, asked to leave when it became apparent that relatively ethical neurosurgeons couldn't order the sheer volume of scans that an orthopedic surgeon could.

Saddest to see are the neurosurgeons who have given up their practice or large portions thereof to the practice of "medicolegal neurosurgery." I'm not speaking of the practitioners who perform the necessary task of providing appropriate (and the AANS has published guidelines on providing appropriate medical testimony—chief among them to only testify to facts, and not to champion one side or another without pointing out alternate opinions if there are such) testimony, for we alone are the best witnesses for appropriate med-

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## CSNS News

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ical care and treatment of our own patients or care rendered by other neurosurgeons. I'm speaking of neurosurgeons who repeatedly stretch testimony to trivialize a patient's legitimate complaints or, conversely, aid in making unwarranted and unsustainable statements to argue for a desired outcome. I might add that the AANS Professional Conduct Committee reviews such cases and has sanctioned members who egregiously stray from the guidelines. Our efforts have been upheld at the Supreme Court level and are being examined or copied by other professional organizations.

Speaking of the AANS, and not forgetting the CNS, our professional organizations have labored mightily in defending our specialty and striven to advance our cause in the legislative arena, the forum of public opinion, and the battlefields of managed care and Medicare reimbursement. I am grateful to the Ohio State Neurosurgical Society for affording me the opportunity to participate in these activities as your representative for these exciting 28 years. You have heard what our Washington representative is doing on our behalf. You will be asked to contribute to support our PAC. You have heard what a former president of the AANS—and a former recipient of this same award—is doing to try reverse the trend of increasing liability litigation that is crippling our ability to practice and forcing some of us to consider leaving the practice of neurosurgery. You will be asked to contribute significantly to this effort.

It's true that we live in an era of the supremacy of the individual. Individual entitlement and absence of individual responsibility characterize the populace and, by extension, our patients. Not only is authority questioned, it is generally denied. We no longer treat "our" patients—we are now involved in providing them education to make choices about directing their care. Occasionally we are even called on to render technical assistance. Woe to us, however, if things don't turn out to their complete satisfaction. I do miss the respect, the financial rewards, and

the deference we once enjoyed. But this is akin to missing the comfort of the extended family, or the security of small towns or neighborhoods with unlocked doors and children released to "outside" with no concerns that they would misbehave or be the victim of misbehavior.

The World changes. Life changes. Get over it! Some of this is a good thing.

Neurosurgery in the 21st century is dif-

ferent from the specialty that Harvey Cushing founded. We have evolved and will continue to do so. The exciting advances afforded by superior neuroimaging, computer-assisted stereotaxy, genetic manipulation and neuromodulation, and minimally invasive surgical techniques guarantee that the specialty of neurosurgery will continue to afford significant intellectual and personal satisfaction as well as improve the lives of our patients. We

will continue to attract "the best and the brightest" and, nearing the end of our careers, be able to look back with pride at our accomplishments and a degree of wistfulness in not being a part of what is to come.

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### The 50th Annual Meeting of the Western Neurosurgical Society

Rancho Bernardo Inn,  
San Diego, California,

September 11-14, 2004

For more information, registration, and  
abstract submission, please go to  
Web site: <http://www.westnsurg.org/>

or contact Austin Colohan, M.D. at  
(909) 558-4952, e-mail:  
[acolohan@ahs.llumc.edu](mailto:acolohan@ahs.llumc.edu)

## CSNS News

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## State Society Corner

Ann Warbel, R.N.

Dr. Peter Dempsey provides the following update from **The New England Neurosurgical Society**: "The NENS held a joint meeting with the New England Spine Study Group on February 27, 2004 in Bedford, New Hampshire. The meeting was devoted to discussing spine-related topics and featured Dr. Rusty Rodts speaking on 'Surgical Treatment Paradigms for Lumbar Discogenic Syndrome.' The next NENS meeting will take place on June 4, 2004 at the MIT Endicott House in Dedham, Massachusetts."

**The Tennessee Neurosurgical Society** meeting will be held August 21-22, 2004 at the Hilton Suites Downtown, Nashville, TN. All Tennessee neurosurgeons, residents, nurses, and office administrators/managers are urged to make plans to attend this very informative and helpful meeting. Please con-

tact Mistina Pannell at [mpannell@semmes-murphey.com](mailto:mpannell@semmes-murphey.com) for further information.

## Upcoming Meetings

May 2004

14-15

Texas Association of Neurological Surgeons  
Austin, TX  
Contact: Richard C. Naftalis, M.D.  
E-mail: [Richard\\_Naftalis@msn.com](mailto:Richard_Naftalis@msn.com) or [www.texmed.org](http://www.texmed.org)  
Phone: (972) 566-6444

14-16

Neurosurgical Society of Alabama  
Hilton San Destin Resort  
Destin, FL  
Contact: Thomas Francavilla, M.D.  
E-mail: [tlfrancavi@hotmail.com](mailto:tlfrancavi@hotmail.com)  
Phone: (205) 991-4400

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Hawaii Association of Neurological Surgeons

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## NEUROSURGERY AND THE MIDDLE EAST WAR

### The 207th Neuro Team in Iraq Revisited

MAJ Richard Teff, M.D.

A lot has changed since Rocco described the situation at Dogwood. The Skullcrackers are still here, but we've got a new address. In August we packed up our gear, struck our tents, and convoyed to Ibn Sina Hospital, formerly Saddam's private hospital for the Republican Guard. This location in the heart of Baghdad is the center of Coalition medical care these days. We're sporting a state-of-the-art CT scanner and the hottest care this side of the Euphrates. The place was in shambles when we arrived, but the 28th Combat Support Hospital cleaned up and reconstituted the joint. We're moving on to bigger and better things now.

We haven't forgotten our primary mis-

sion. Our Coalition fighters are still getting shot up. They come by helicopter, ambulance, and private vehicle. They come by day and by night. They never stop coming. The fighting's not over by any means. We're ready for it, though. After 6 months of nonstop trauma, the 207th Neuro Team is a well-oiled machine. John Canady is probably the most talented nurse anesthetist in the theatre of operations. Victor Settles has kept us organized from the very start. Paul Messier and Felecia McCray scrub cases day and night. Steffi Humphrey circulates with the best of them. And our new neurologist, Kurt Washburn, picked up the reigns when Cannard fell out.

With our new location come a number of new missions. First and foremost is

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## J&J Advanced Wound Care New K



Al Jumla Al Asabia—Baghdad's only neurosurgery hospital.



Ibn Al Kef Hospital—partially destroyed in the UN blast.

## Iraq

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the nation-building mission. Our Iraqi neurosurgery colleagues need our help. There are more than 20 governmental hospitals in Baghdad. Of these, only one is designated for neurosurgery alone. This location, Al Jumla Al Asabia, is the workplace for 15 staff neurosurgeons, an equal number of “permanent” neurosurgery residents, and countless “rotator” interns. They have the goods, but none of the training. I was fortunate to visit and see this place with my own eyes recently. They showed me a brand spanking new Carl Storz neuroendoscopy system that had never been used. I also saw an Elekta operating microscope and a Brain Lab navigational system. The guys are itching to use their new toys, but they can’t afford the trip to Germany for the training. Alternately, the companies are hesitant to send their technical representatives into a war zone. The solution: Rocco and I are teaching them everything we know.

Our work has already been aided by friends from the United States. David Jimenez (University of Missouri) sent PowerPoint presentations and signed copies of his textbook on neuroendoscopy. These books, donated by Thieme Medical Publishers, are the first step in teaching our Iraqi friends about their new technology. Brian Scanlan, president of Thieme Publishing, is working on a library donation worth \$150,000. AANS/CNS Publishing has offered titles as well. In future months we will present educational seminars and coordinate skills labs. Eventually we will operate together, employing old and new technologies for the people of Iraq. Now is an exciting time to be a neurosurgeon in Baghdad.

It’s not easy to make things happen here, though. One must always remember that there are people who want to kill you around every corner. A typical day goes like this: Wake up 0600. It would be nice to shower, but the water tanks are empty. I’ll have to settle for a tooth brushing and a head wash with bottled drinking water. Rounds at 0630. There are no residents or Dictaphones at Ibn Sina. We do things the old fashioned way. Two Americans from yesterday are going to Germany this afternoon. Gotta get the paperwork done. Five enemy prisoners are paraplegics and therefore not candidates for the prison camps. Check for bedsores. I wish we had real hospital beds instead of cots here. Three civilians are awaiting placement. One is a VIP whose boss was assassinated. He’s paraplegic after taking a bullet in the spine. Dressings are changed. Orders and notes are written. The ER is quiet. Time for breakfast. Powdered eggs and shelf stable milk never tasted so good. Wish I had a fly swatter: our outdoor dining facility is too close to the garbage bins.

Back to the hooch to don my travel

gear: Kevlar helmet, flack jacket, 9-mm pistol, and M-16 rifle. My friends with the Special Forces Civil Affairs have arranged a mission. We have two tactical vehicles with SAWs (Squad Automatic Weapons) today. Everyone pulls security when we roll out into Bagdad. Around us it’s business as usual in Iraq. People stop and watch us as we rumble by. A few wave, others scowl. Many are tired of the Americans. We all watch closely for signs of ambush—piles of

rocks or other objects on the side of the road, watchers with radios, silhouettes in windows, fast approaching vehicles. We drive through “Ambush Alley,” where Coalition fighters weathered a shower of small arms fire just a few months ago. Traffic is chaotic as usual. We drive over medians and around stopped vehicles. Nobody pays attention to traffic lights or the new police. We honk our horns and cut other drivers off. Was that guy driving a horse-

drawn buggy? Eventually we reach the gates of our destination: Al Jumla Al Asabia. I am greeted by Dr. Ayad Al Dahwi, hospital director. We have tea and discuss recent events. He is excited about our new friendship. I am escorted to their operating theatre to view the endoscopy system. It’s awesome! We assemble and familiarize ourselves with the tower and its components. Every-

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# Carl Zeiss Surgical New 4/c

## Iraq

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thing works perfectly. Next we go to a lecture hall. I have a little something prepared to introduce neuroendoscopy. They receive it well. They want to schedule a case. We need practice first.

The ride home is equally unnerving but also uneventful. My Special Forces friends are practiced and capable escorts. I am clumsy with my weapons. They try not to laugh. We all share a

Pepsi when we return. Same time, same place next week.

Back at the hospital, Rocco has admitted two new patients. One is an American with a zone II neck injury. They explored him and the vital structures were uninjured. The guy is recovering in the ICU. The other patient didn't fare as well. She was 60 and in the wrong place at the wrong time. A bullet gave her an explosive left hemispheric brain lesion. She isn't going to do well. I slip away for a run. A few miles through the "Green Zone" is

always eerie. We're supposed to be safe from bullets and mortars. I don't see anyone suspicious. It's strange running with a weapon. After a shower and evening rounds, we gather to talk about the day. I am excited about my progress. Rocco will go next week to talk about penetrating brain injuries. Settles and the guys have a movie to play. We open mail from home and munch on snacks people have sent. I call my son and my girl on the sat phone. Life is pretty good. Lights out by 10.

It's amazing the odyssey of events that has brought our team from Fort Bragg through Kuwait and Dogwood to Baghdad. But here we are, right in the middle of it all. I look around me and all I see is chaos and suffering. There are no easy solutions here. Rocco and I will do what we can to make things better for neurosurgery in this corner of the world. We hope our colleagues will do the same for their specialties. We thank all who have guided and assisted us along the way. Ours is a small contribution, but it seems to make all the difference.

## Neurosurgery and the War on Terror: Update

**William Monacci, M.D., and James Ecklund, M.D.**

In the aftermath of the large-scale combat phase of Operation Iraqi Freedom (OIF), military neurosurgery has scaled down its presence in theater as wartime operations continue. Although our military had ousted and eventually captured deposed Iraqi dictator Sadaam Hussein, resistance continues in the form of daily attacks on coalition troops and the burgeoning Iraqi security force. This resistance takes the form of IEDs or Improvised Explosive Devices, which are planted along roadways, and are triggered with wireless devices or trip wires, and can cause tremendous damage to vehicles and personnel passing in convoys.

Ambushes carried out with small arms fire, mortars, and rocket-propelled grenades continue to cause significant injuries on a daily basis. For every soldier or civilian killed, several are severely injured, requiring aggressive trauma management to save their lives. As in other parts of the Middle East, suicide bombings have caused massive devastation to buildings and clusters of people nearby. These attacks, in the presence of an Iraqi health system striving to get established, have produced significant challenges to the American and Coalition Military Combat Casualty Care system.

In early May 2003, LTC Rocco Armonda and MAJ Rich Teff and their team, moved from Kuwait to locate with the 28th Combat Support Hospital in the Baghdad area where they served as the sole neurosurgical referral for Northern Iraq. After enduring particularly harsh conditions in the tent hospital located in the desert outside Baghdad with temperatures reaching 130 to 140 degrees Fahrenheit, and mortar attacks on a frequent basis, they relocated to a fixed facility in the Green Zone in Baghdad, which improved the situation. CT scanners could not be kept running in the unyielding desert heat. The 28th's new home in a more climate-controlled setting allowed better functioning of the scanners, with an exception made for frequent power outages and the occasional mortar attack. The team was kept busy as the insurgent attacks continued, which required them to perform numerous interventions for shrapnel and gunshot wounds to the head and spine. They also took care of a number of Iraqi civilians injured in the attacks, as well as those having a myriad of neurosurgical problems. Iraqi neurosurgery, while improving, lacks significant capability. The team returned home this month after a very grueling year. They were replaced by a neurosurgery team led by LTC Jeff Poffenbarger and MAJ Tom Rapacki. As the attacks have not substantially abated, they will likely be busy and contribute to saving many brave American, Coalition and Iraqi lives.

In Kuwait, neurosurgeons MAJ Dan Donovan and MAJ John Iskander provided support to southern Iraq and

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Ibn Sina Hospital—center of Coalition medicine in Iraq.



Teff and Baghdad neurosurgeons.



Teff teaching neuroendoscopy hands on.



The original Skullcrackers June 2003.



Teff in the green zone among signs of prior conflict.

## Iraq

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Kuwait where attacks, although not as numerous as in the Northern Sunni Triangle, continued as they cared for a number of neurosurgical casualties. As the southern sector was pacified, their team redeployed home in October. LTC Bill Monacci is presently in Kuwait to augment medical services during the largest troop movement since WWII, which includes approximately 250,000 military personnel.

Our Coalition partners in Kuwait and Germany have played an invaluable role in providing Neurosurgical support to our military services. Dr. Abbas Ramadan the Chief of Neurosurgery at Ibn Sina Hospital in Kuwait City and his team have served as a referral center for neurosurgical problems occurring in military personnel since 1991 as there is not typically a military neurosurgeon stationed in Kuwait. They have a busy well-equipped center that provides neurosurgical services to the two million people of Kuwait. Dr. Monacci has spent time attending their rounds and conferences; he has enjoyed their hospitality. We extend to them our thanks for aiding our military personnel. The Neurosurgery Hospital at Homburg Germany, near our main military medical center at Landstuhl, has state of the art neurosurgical capabilities that have benefited our troops who require immediate neurosurgical interventions in that part of the world for a number of years. Telemedicine and video-teleconferencing facilities are being installed at both centers to allow closer real-time collaboration and interaction with their military counterparts at Walter Reed Army Medical Center in Washington.

In Operation Enduring Freedom in Afghanistan, LTC(P) Leon Moores was first deployed in March 2002 to provide neurosurgical care, and to evaluate the need for neurosurgeons in theater. His evaluation confirmed that the first 6 months of active combat brought no operative head or spinal pathology in American or coalition forces. During periods of expected increased operations and potential casualties, neurosurgeons will be deployed to augment an existing Combat Support Hospital in Afghanistan. In November LTC(P) Jim Ecklund and LTC Geoff Ling (Neuro-intensivist) deployed within 30 hours notice to provide on-site neurosurgical coverage. They carried all the required equipment to augment the existing field hospital in two-foot lockers, and within 36 hours of arrival were in the OR, operating on a coalition soldier with a GSW to the head. During this 3-week mission, they operated on several of US and coalition casualties, and provided additional humanitarian care to local Afghan nationals. In order to facilitate consultation in the event of an unexpected neurosurgical casualty in this theater, telemedicine link-ups to Walter Reed

have been placed in the operating room. This provides outstanding audio and video real-time capability to help guide the on-site general surgeon before evacuation.

Several reserve neurosurgical personnel have also played key roles in supporting neurosurgical missions. They have augmented our stateside medical centers where deployments depleted active duty neurosurgeons, and have

served overseas in Landstuhl, Germany, the principle first-line evacuation site from theater. Without their valuable contribution, it would have been difficult to successfully carry out the mission.

A multi-disciplinary meeting was held at Walter Reed in early December to review vulnerabilities of present protective devices for the head and neck. Clinical specialists who had reviewed

the injury patterns and mechanisms injuring our troops during the Iraqi and Afghan campaigns met with a host of Army representatives, including those from the research and development departments to modify existing protective measures and to fast track improvements and get them into the field. Further, after-action reviews will

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# SANS Wired new 4/c

## Iraq

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be held this spring in order to optimize battlefield care and protection.

In summary, the mission continues as brave Americans together with their Coalition partners, work at establishing Democracy in Iraq and Afghanistan.

While they continue to put themselves in harm's way on behalf of the American people, the military medical system is there to support them. All neurosurgeons can be proud of the neurosurgical care we provide our men and women in uniform far from our borders. The deployed military neurosurgeons have worked arduously under difficult circumstances to carry out their mission, and have done well. □



Telemedicine connection from Walter Reed Army Medical Center into the operating room of the 352nd Combat Support Hospital, Bagram Afghanistan provides real-time consultation and guidance.



Drs. Leon Moores and Dave Floyd operate on casualty at Camp Doha, Kuwait. Leon and Dave were later replaced by Drs. Dan Donovan and John Iskander during the sustainment phase of OIF.



Dr. Rocco Armonda providing humanitarian care in Baghdad during OIF.



Dr. James Ecklund examining post-op patient with interpreter in ICU, at 352nd Combat Support Hospital, Bagram, Afghanistan.

## CSNS News

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Location TBD

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**June 2004**

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New England Neurosurgical Society

MIT Endicott House

Dedham, MA

Contact: Peter K. Dempsey, M.D.

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Tennessee Neurosurgical Society

Hilton Suites Downtown

Nashville, TN

Contact: Mistina Pannell

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Hawaii Association of Neurological Surgeons

Location TBD

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**November 2004**

**18**


Hawaii Association Of Neurological Surgeons

Location TBD

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**Kathleen Egan, DSc.**  
Vanderbilt University

**Patrick Kelly, M.D.**  
New York University

**John Latterra, M.D.**  
Johns Hopkins University  
School of Medicine

**Glenn Lesser, M.D.**  
Wake Forest University

**Roy Patchell, M.D.**  
University of Kentucky

**Michael Prados, M.D.**  
University of California  
at San Francisco

**James Rutka, M.D.**  
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