



# NEUROSURGERY NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

## President's Message: CNS 2005 Annual Meeting

**Nelson M. Oyesiku, M.D.,  
Ph.D., F.A.C.S.**  
President, CNS

### Thanks for the Opportunity!



When the CNS Nominating Committee informed me that I had been selected to lead this wonderful organization, it took little time to understand that I had been offered a rare opportunity in organized neurosurgery. I am grateful to have served as the 55th President of the Congress of Neurological Surgeons. It has been a terrific year, and it is sadly coming to a close. The transition occurs at this year's Annual Meeting in Boston. It is fitting that I reflect on why the year has been so terrific.

Firstly, I have been privileged to work with an exceptionally committed group of CNS Officers, Executive Committee members, and CNS headquarters staff who gave freely of their time and talents in the service of the CNS membership. Thanks also to the collaborative Section, CSNS and AANS leadership. There are many others who have been immensely helpful, who freely gave their advice, lent a listening ear, and provided invisible (and invaluable) support—too many to mention and whose names do not appear because time and space will not allow.

Vincent C. Traynelis (Past-President) handling his role as senior statesman continued in his calm and effective manner. He chaired the Professional Conduct Committee, was an integral part of the Nominating and Award Committees, and provided sage advice during key deliberations. Richard G. Ellenbogen, President-Elect, chaired the Strategic Planning Committee. His efforts and those of others on the committee resulted in key initiatives. Dr. Ellenbogen will assume the CNS presidency in October. I am confident he will take the CNS to even higher levels of achievement. The CNS has never been in better shape financially, thanks to the foresight, policies, and legendary volunteerism of its EC members and headquarters staff, the leadership of our Treasurer, Douglas S. Kondziolka, and our financial advisers. The decisions made this year will continue to solidify the long-term financial health of the CNS. Anthony L. Asher, Vice President, has directed *SANS Wired* and has managed the interface of the CNS with the ABNS. He has also been the prime proponent of the new educational strategy for the CNS. In the year ahead, Gerald E. Rodts, Jr. will continue to expand *SANS Wired* into specialty modules. P. David Adelson, CNS Secretary, has diligently recorded our proceedings, managed correspondence and is

working with the IT committee and Gerald E. Rodts, Jr. in developing the CNS Document Archival and Retrieval System (CDARS), providing a searchable electronic repository which will serve the CNS far into the future. Dr. Adelson also led the Publications Committee, which oversees all CNS Publications, including our perennially incredibly successful journal *NEUROSURGERY*. It is impossible to overstate

the role Dr. Michael Apuzzo has played in the success of the CNS. His contributions to *NEUROSURGERY* are unparalleled. By any measurement—scientifically, financially, and editorially—he has exceeded even our most optimistic expectations. Thanks to him, his team and our publishers, *NEUROSURGERY* remains the leader. Guy M. McKhann, II, Ex-Officio, CNS EC, has done a yeoman's job as editor of *Clinical Neurosurgery* (CNS Annual Meeting Proceedings), editor of *Neurosurgery News*, and Vice-Chair of the Pub-

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2005 Officers and Executive Committee of the Congress of Neurological Surgeons.

## CSNS NEWS

### Pay-for-Performance

**Fernando Diaz**  
CSNS President

#### Background

The Centers for Medicare and Medicaid (CMS) adopted a system of reimbursement reduction to physician participants under the Sustainable Growth Methodology initially implemented but not activated until 2006. From that date forward, physician reimbursement for Medicare services will



be reduced at annual rate of 4 to 5%, until 2011. The Medicare Payment Advisory Commission (Med PAC) of

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## NEUROSURGERY NEWS

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All correspondence on editorial matters should be addressed to:

Guy M. McKhann  
Editor-in-Chief

Columbia Presbyterian Medical Center  
710 West 168th Street  
New York, NY 10032  
gm317@columbia.edu

### President's Message

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lications Committee. He takes over from David Adelson in the fall as Chair of the Publications Committee.

C. Michael Cawley III, Member-at-Large, has managed the development of new leaders in the CNS through the CNS Leadership Development Committee (LDC). During the year, young, talented, and eager individuals have expressed a desire to join the CNS in its service to organized neurosurgery; we have met their enthusiasm with opportunities to serve. Our committees have been rejuvenated with new talent. Robert M. Friedlander, Member-at-Large, has served as Membership Chair. Membership now stands at 5466 and continues to grow, owing to the significant benefits offered by the CNS for relatively low membership dues, and the efforts of CNS staff and Dr. Friedlander's in serving member needs. Dr. Michael P. Steinmetz, Ex-Officio, CNS EC, Resident Committee and Dr. Kristen O. Riley, Ex-Officio, CNS EC Fellowships and Job Placement provide the vital link between residents and fellows and the CNS. Development of the next generation is a key element of the CNS mission of education. Members are the reason we exist, and their contributions and participation are the lifeblood of the organization. Member dues provide benefits such as education, meetings, publications, physician and patient resources, job placement service, advocacy, and practice management resources.

Linda M. Liau, Member-at-Large, was Assistant Editor of *Neurosurgery News*. The "News" disseminates newsworthy material to the membership. Karin M. Muraszko, Member-at-Large, worked on the Strategic Planning Committee, which sets future direction for the CNS. The triumvirate of Joel D. MacDonald, Ex-Officio, Ali R. Rezai, Member-at-Large, and Ashwini D. Sharan, Ex-Officio, marshaled their efforts on the Information Technology Committee to produce an imaginative, user-friendly CNS website featuring every aspect of the CNS at the click of a mouse. Newer initiatives on the IT Committee include the CNS Assistant, the CDARS and the Digital Posters at the Annual Meeting, which have replaced the old-fashioned "bill-boards." This initiative has already been enthusiastically embraced by poster authors for the 2005 meeting. Internet transmission of select presentations for digital audio players ("podcasting") will be provided for members after the meeting. The complete overhaul of the World Directory was completed in time for the WFNS meeting and was distributed without charge to all neurosurgeons worldwide. Dr. Sharan is to be credited with the difficult and time-consuming task of melding these various databases. Additional manpower for the CNS IT effort has been developed at CNS headquarters,

in further support of the critical role that it plays in our organization.

At the heart of the CNS Mission is education: Daniel K. Resnick, Ex-Officio, CNS EC has fulfilled this critical task effortlessly. Thanks to Dan and his group, many education initiatives were completed or are far into execution. These programs include resident curriculum, socioeconomic courses, a video library, University of Neurosurgery, and patient information brochures.

Mitesh V. Shah has kept the rules of corporate governance as By-Laws Chair. Recently, he has taken over direction of CNS Public Relations. In this new role, he will communicate the CNS Mission and accomplishments and interface with media.

True to its original charter as an international neurosurgical organization, the CNS has continued to expand internationally. Indeed, international active membership now stands at 22% of active membership. We are continuing our program of meeting partnerships this year with the European Association of Neurosurgical Societies. We have instituted an international speaker program to reciprocate with other international neurosurgical organizations. Recent CNS delegations have been sent to India, Scandinavia, WFNS in Marrakech, Asian Congress, and the Japanese Congress. Future delegations are planned for the Croatian Society, the Italian Society, and the Asian Congress. The CNS is committed to supporting the WFNS Foundation equipment donations to countries in need and also in the joint international initiatives for education and training. The CNS International Fellows Program remains exceedingly popular. Dr. Gail Rosseau and her International Committee are to be commended for their outstanding success in promoting and sustaining the CNS international mission.

On socioeconomic issues, the CNS has continued to maintain a strong voice of advocacy for neurosurgeons. The CNS, together with the AANS and the Washington Committee, has supported the medical liability reform effort, the deliberations with ASTRO over stereotactic radiosurgery, the outcomes and guidelines initiatives at the heart of the pay-for-performance program, coding and reimbursement issues, and regulatory issues. At the start of my term, I was fortunate to appoint two new CNS representatives to the Washington Committee, Mark E. Linskey, (also Ex-Officio CNS-EC) and Craig van der Veer. Both have demonstrated tremendous leadership on the Washington Committee. Mark Linksey also served as Guidelines Liaison.

It has indeed been a pleasure and a privilege to work with Robert Ratcheson (AANS Past-President), Phil Wirth (AANS President and fellow Georgian), Troy Tippet (Washington Committee Chair), and Rick Boop and Fernando Diaz (CSNS leadership) on the key issues affecting us all. William E. Binga-

man, Ex-Officio CNS EC, CNS CSNS Caucus Chair, also merits special mention for his excellent tenure for the CNS in the CSNS. In testimony to his skills, he moves on to become Treasurer of the CSNS.

The denouement to the year as president is the Annual Meeting. The responsibility for the year-long effort to stage this event falls squarely on the shoulders of the Scientific Program chairman, Christopher C. Getch, Ex-Officio, CNS EC, and the Annual Meeting chairman Christopher E. Wolfla, Ex-Officio, CNS EC. A brilliant Scientific Program and Annual Meeting agenda are the results of the creative efforts and all-out dedication of both these gentlemen and their committee members. Saleem I. Abdulrauf, Ex-Officio, CNS EC, has also played a significant role in the development of the Annual Meeting as Exhibits and Marketing Chairman. A review of the preliminary program is very revealing. I will not render a full account here, since it is available to all already. We are all looking forward to what promises to be an outstanding event—please join us for this wonderful celebration of our specialty.

For more than a decade, the CNS has been fortunate to have the guidance of an esteemed legal counsel and friend—Mr. Greg Willard—a talented attorney imbued with the volunteer spirit that permeates the CNS. Many of his valuable services and those of his global law firm, Bryan Cave, LLP, are provided gratis to the CNS because Greg and Bryan Cave believe in the CNS Mission. As in other years, this CNS president and EC have drawn heavily on his skills and goodwill. Greg, many thanks, again and again from me and on behalf of the membership!

A special commendation must be conveyed to our diligent, dedicated and talented CNS headquarters staff, Meetings—Andrea Caputo, Barb Gould, Lorena Fuentes, Maxine Prange, and Regina Shupak; Accounting and Membership—Kim Grube, Christine Kerwein, and Julie Wons; Web Support and Administration—Angela Pozzi and Rhoda Tran and, especially, Laurie Behncke (Executive Director) and her equally dedicated husband Ray. They have served us to their utmost, and we thank them for everything.

The CNS will continue to thrive and grow under vigorous and capable leadership in the years ahead. The talent pool is deep and committed. My only regret is not to be there "at the table" to see it first-hand, but I will join the many fans of the CNS to cheer it along as it continues its further ascendancy. In the short-term, I wish President-elect Richard Ellenbogen and his EC the very best for the year ahead.

Finally, and most of all, thank you to each of our members for a wonderful and unforgettable opportunity to serve as the 55th president of your Congress of Neurological Surgeons. ■

## CSNS News

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CMS, and the United States Congress have focused on the development of measures to provide payment incentives under the Medicare program to improve the overall quality of services provided to Medicare beneficiaries.

While these discussions have extended across the range of providers paid by Medicare, much of the more recent discussion surrounding pay-for-performance (P4P), or what is now being called value-based purchasing, has focused on the physician community. This is similar to what has been implemented on the inpatient side, with bonus payments paid to “high performers” and a “compare” website available for consumers. The purpose of P4P is to pay physicians based on quality and efficiency rather than a flat rate based on volume.

Most on Capitol Hill and at CMS view P4P as the great redeemer for the Medicare program. Although there is no proof that a P4P system would save any money, private insurers and corporations are pushing for P4P to have more accountability in the overall healthcare system. While P4P, outcomes, evidence-based medicine, etc. have the potential to improve patient care, there are great concerns regarding the proposals that are starting to surface.

The United States Congress and the CMS have been very clear that they think the physician community, particularly physician specialty organizations, should develop the quality measures for their specialty. Although both the Congress and the CMS have clearly stated that the physician community has been put on notice that quality measures are needed, a lack of measures will not stop this project from moving forward, i.e., if we do not develop quality measures, they will be developed for us!

The American College of Surgeons is attempting to develop quality measures that can be used across all of surgery. These will likely be “process measures” related to the prevention of certain complications, including infection, cardiac episode (MI), postoperative pneumonia, and thrombophlebitis.

### Legislation

The first pieces of P4P legislation were introduced over the past several weeks. Because of problems with prescription drug-related amendments in the Senate, it is unclear exactly how and when any P4P legislation is going to work its way on to the Senate floor for a vote.

### Frist/Clinton Bill

The first piece of legislation discussing P4P was introduced by Senators Frist (R-TN) and Clinton (D-NY). The P4P language was included in legislation addressing electronic medical records. The legislation calls on HHS to adopt uniform healthcare quality measures to

assess the effectiveness, timeliness, patient self-management, patient-centeredness, and the efficiency and safety of care delivered by healthcare providers across all federal healthcare programs, including Medicare. In addition, the legislation directs HHS to establish a value-based purchasing pilot project using the measures developed and electronic medical records. There is no money allocated to this pilot proj-

ect and the legislation directs CMS to use existing Medicare funds as necessary.

Finally, the legislation states that modifications should be made to the physician fee schedule to include payment for reporting on quality measures and overall improvement of healthcare quality. Payments will be made by taking a cut from all providers and reallocating

the funds to those participating. Despite its prominent sponsors, this bill is considered symbolic “place-holder” legislation meant to get the ball rolling, bring attention to the issues, and send a message to the healthcare community that the process has begun.

### Grassley/Baucus Bill

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CNS ad #1  
4/c

## CSNS News

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Senators Grassley (R-IA) and Baucus (D-MT), chair and ranking member of the Senate Finance Committee, introduced S. 1356, the Medicare Value-Purchasing Act of 2005 in July. This bipartisan bill, which has three cosponsors, provides for comprehensive P4P across all of Medicare, including physician services.

The essentials of this bill are as follows:

Participation will not be mandatory. If a physician does not participate s/he will be cut 2% on January 1, 2007. If s/he chooses to participate, s/he will be cut 1 to 2% beginning on January 1, 2008, s/he will be required to submit quality and efficiency data to CMS in the manner determined by CMS, and s/he will be responsible for any administrative costs. On December 31, 2009 s/he may or may not receive a bonus payment of some yet-to-be-determined amount if s/he meets the criteria set forth by CMS after the fact. The physician will know the measures used to determine payment in 2008, but s/he will not know the thresholds and the payment levels. Sustainable Growth Rate (SGR) cuts (5% per year) will continue under this bill as now determined by CMS.

The AANS, CNS and most other organizations have yet to officially respond to this bill. The Society of Thoracic Surgeons has officially endorsed the bill.

### Nancy Johnson Bill

The "Medicare Value-Based Purchasing for Physicians' Services Act of 2005" (H.R. 3617), legislation was recently introduced by Rep. Nancy Johnson, chair of the House Ways and Means Health Subcommittee. Specifically, H.R. 3617 would restructure the Medicare physician reimbursement formula to link payment to quality incentives. But, in so doing, it would also enact much needed reforms to preserve the financial viability of physician practices and preserve patient access to surgical care. The essential provisions

of the bill include the following:

It repeals the SGR methodology used to determine the annual update for Medicare physician payments and bases future payments on the Medicare Economic Index, which measures annual practice inflation costs for physicians. It also enacts a phased-in, value-based purchasing program over several years by starting with voluntary, initial reporting measures beginning in 2007. And, it bases quality measures for a value-based purchasing program on the efforts of physician specialty organizations, such as the American College of Surgeons work with the Surgical Care Improvement Project (SCIP) and in the National Surgical Quality Improvement Program (NSQIP).

In response to discussions about P4P, the American College of Surgeons has been collaborating with other surgical specialty societies to draft a proposal for P4P that is based on recognized best practices and that avoids imposing an undue burden on surgeons. In a recent communication from the American College of Surgeons Thomas Russell, M.D., F.A.C.S. stated

...a P4P program must replace the SGR with a reimbursement formula that better accounts for rising practice costs, must be phased-in over several years, and must be based on the physician community's proven quality improvement efforts. An incentive-based payment system simply cannot function in a "zero budget" environment under which increased spending on one set of services produces unsustainable payment cuts in another, and payment updates consistently fail to keep pace with the cost of providing care. The "Medicare Value-Based Purchasing for Physicians' Services Act of 2005" is only the proposal in Congress that takes these concerns into account.

It is time for physicians to take a proactive stance in the determination of our reimbursement and the measures used to establish that reimbursement, rather than letting the system dictate how we will be paid for what we do. ■

## Emphasis of CNS Website is on Education

Michael P. Steinmetz, M.D.

Ali R. Rezai

The Congress of Neurological Surgeons (CNS) is dedicated to the education of neurosurgeons in-training and continuing medical education for neurosurgeons.

The CNS website ([www.neurosurgon.org](http://www.neurosurgon.org)) has a strong emphasis towards bringing education to the CNS membership. There are various educational tools and resources available for medical students, residents, and practicing

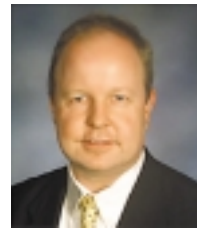
neurosurgeons. These include CME web-based courses, links to pertinent CME opportunities, a professional meeting calendar, links to guidelines, books, and other publications. Additional features include CNS abstract archives, image database, PDA resources, and an expanding video library.

There are a number of links provided to residents, fellows, and program directors. There is a list of CNS-sponsored fellowships. There is also a general fellowship directory with contact infor-

## Re-engineering the Neurosurgery Guidelines Effort: A Critical Need in Preparation for Pay-for-Performance

Mark E. Linskey, M.D.

CNS Liaison to the AANS/CNS Guidelines Committee



Pay for Performance (P4P) is clearly a tactic intended to affect a strategy of both optimizing quality and limiting cost for healthcare in the United States. As

such, it requires the ability to measure both endpoints for its implementation. The cost side of the equation is far more advanced and accessible at the present time than the quality side of the equation, and we anticipate that the major new efforts in the P4P initiative will be focused on attempts to measure quality in a way that can be matched with pre-existing cost accounting. Given that P4P is an unfunded mandate, and that no funds are likely to be made available to develop quality measures. It therefore seems likely that regulatory bodies and third party payers will adopt measures, measurement systems, and schemas already developed by other entities and apply them to their constituents rather than develop their own. They will likely continue to obtain directional and strategic guidance from the Institute of Medicine (IOM) of the National Academy of Science (NAS), and independent services such as the RAND Corporation.

Donabedian formulated the quality paradigm for healthcare delivery where measures of quality are divided into 1) Structure, 2) Process, and 3) Outcome. The structural aspect is most easily and cheapest measured and neurosurgery correlates include training credentials, maintenance of board certification and proof of patient access. Unfortunately, structural measures of quality have never been convincingly linked to improved quality of care nor reduction in healthcare costs for a given modicum of healthcare provided. On the other extreme of the spectrum, clinical outcomes are the most expensive and difficult to measure, and must be individually developed and validated for each surgical procedure assessed. As a result clinical outcomes for specific procedures are least likely to be adopted by the P4P program nationally, and adopted outcomes measures are likely to remain focused on more generic measures such as patient satisfaction and functional outcome measures.

Analysis of current healthcare trends suggests that process measures are far more likely to account for the lion's share of P4P quality measurement. This

is likely because surrogate process measures are more cheaply acquired and tracked, apply generically to the majority of surgical procedures and pathologies, and can link more directly to analysis of cost savings for a given modicum of healthcare provided. Surrogate quality indicators for neurosurgical procedures will likely follow the lead of the already developed and validated AHRQ quality indicators (prevention, inpatient, and patient safety), the already developed and validated VA-NSQUIP system (currently under study for confirmation in the private setting by the ACS - ACS-NQIP), and the developing CMS quality indicator project. Each of these systems are already in place or development, apply to all surgical procedures, and are far more easily measured and tracked than individual surgeons clinical outcomes for specific surgical procedures. However, each of these systems assumes that the decision to operate was correct, and that the choice of operation was appropriate.

Evidence-based medicine clinical practice parameters (guidelines) are another form of process quality measure that is more likely to have a central role in the P4P program than specific clinical outcomes measurements. Some have argued that, just like structural measures of quality, guidelines implementation and compliance so far has little evidence to clearly demonstrate improvement in the quality of healthcare. On the other hand, the first guidelines published under the auspices of the AANS, the Traumatic Brain Injury Guidelines, when used, have been shown in two separate studies to decrease mortality, improve functional outcomes, and decrease costs of care, both short and long term. Furthermore, unexplainable variation in healthcare delivery was centrally and specifically recognized by the IOM in their seminal 2001 report "Crossing the quality chasm: A new health system for the twenty-first century" as a major symptom of the poor quality of healthcare in the United States, and reducing this variation was listed as a major priority in beginning to improve healthcare quality nationally. Indeed, stabilizing processes through reduction in variation is a central tenet, and initial starting point of most quality and quality improvement movements and philosophies. Finally, clinical practice guidelines provide the only handle that regulatory agencies will have in not just measuring how a procedure was performed, but whether it should have been performed at all. When these realizations are added to the potential cost-

**Porex Surgical 4/c**

## Practice Guidelines

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savings benefit of reducing the number of unnecessary or questionable surgical procedures performed in the United States, the attraction and inevitability of adherence to practice parameter guidelines as a prominent quality measure in the P4P program should be obvious.

Currently reams of "guidelines" are being collected nationally through the National Guidelines Clearing House (NGC) supported by the federal government. Unfortunately, unlike the National Health Service in Great Britain that requires strict procedural criteria for including guidelines in their listings, the NGC has no established quality criteria for their guidelines. The NGC contains consensus as well as EBM structured guidelines. It contains guidelines produced by patient advocacy groups (often corporate funded and influenced), private corporations and non-profit groups, and many professional societies (e.g., neurology, orthopedics, vascular surgery, plastic surgery, cardiology, ENT, etc) that are promulgating guidelines of questionable quality that include neurosurgical procedures and pathologies. If we do not establish our own high-quality, defensible, EBM-based practice parameter guidelines that we can promote as superior and preferred to CMS and other agencies, we will likely be held to guideline standards foisted upon us by external agencies, groups, and societies. The good news is that the IOM specifically recommended that CMS and Congress look to professional societies to make the relevant scientific evidence available to regulators and the public (recommendation 8 in *Crossing the Quality Chasm 2001*). The bad news is that as described in the last article in this three-part series, our progress to date has been woefully insufficient and our efforts, as structured, are likely unsustainable.

Becoming serious about developing neurosurgery guidelines on a national level means becoming professional. Neurosurgeons need to remain in control of topic choice, representative physician panel selection, evidence table judgment calls, and judgments regarding strength of recommendation based on levels of evidence available. However, the literature searching, other research, classification table development, photocopying, copy editing, organization and timeline prompting, statistical analysis, and methodology advise can all be performed by infrastructure support staff and epidemiology consultants. Establishing this type of infrastructure support will significantly reduce the time required to produce each clinical guideline (currently 1-3 years each), increase the number of guidelines produced in a given year, and significantly reduce the "burn out" effect on our volunteer neurosurgery

members with guidelines expertise and interest.

Establishing this type of infrastructure support will certainly cost money and the form that the re-engineering effort should take is by no means obvious. One option would involve developing an in-house infrastructure support staff consisting of Ph.D. epidemiology support, research assistants, copy editors, and other support personnel within either the CNS or the AANS in a manner similar to that adopted by the North American Spine Society (NASS) and the American Heart Association (AHA). A second option would be to empower each neurosurgery volunteer leader of the specific guidelines production effort to contract with a support and expertise infrastructure at their institution, or at an institution of their choice, on a one-time basis for the duration of the specific project. A third option would be to contract as a national organization(s) with an Agency for Healthcare Research and Quality (AHRQ) - funded evidence based practice center (EPC) for these services as either a long term contract with volume limits, or an annual retainer fee plus a set fee per individual guidelines project (there are currently 13 EPCs in the US and Canada). A fourth option would be to contract as a national organization(s) with an individual institutional academic department for these services as the BTF has done with the Department of Medical Informatics and Clinical Epidemiology (DMICE) at the Oregon Health and Science University.

The ultimate strategy needed and chosen is due be discussed as part of the planned agenda for this fall's Joint Officer Meeting of the CNS and AANS. Whichever decision is reached will certainly be an improvement over the status quo. Limping along purely based on ad hoc "volunteerism," at our current pace, and with our current initiative structure and rate of personnel burn out, will certainly not position our specialty to be ready to protect our interests in a looming P4P environment. ■

## Editor's Note

**Guy M. McKhann II, M.D.**

Editor, *Neurosurgery News*



As I prepare for the 55th Annual CNS meeting in Boston, I can't help but think back to where most of us were this past April, enjoying the AANS Annual Meeting in New Orleans. The Scientific Program organized by Dr. James Rutka and Dr. Richard Fessler, combined with the

## Richard G. Ellenbogen: President-Elect

Richard G. Ellenbogen is Professor and Chairman of Neurological Surgery at the University of Washington School of Medicine. He holds the Theodore S. Roberts Endowed Chair in Neurological Surgery, is the Chief of Neurological Surgery at Harborview Medical Center, and Chief of Pediatric Neurological Surgery at Children's Hospital and Regional Medical Center in Seattle, Washington. He is currently the President-Elect of the Congress of Neurological Surgeons. Since 1989, Rich has enjoyed nearly every job on the Scientific Committee and Annual Meeting Committee for the CNS.

Dr. Ellenbogen was born and raised in New York, where he attended public school. He received his college degree in biochemistry at Brown University in 1980 and his medical degree from Brown in 1983. After completing a residency in 1989 at Children's Hospital, Brigham & Women's Hospital in Boston, Harvard Medical School, Dr. Ellenbogen became a staff neurosurgeon at Walter Reed Army Medical Center in Washington, D.C. He was deployed in support of Operation Desert Storm as Commander of the 252nd Medical Detachment with the XVIII Airborne Corp, and he was awarded a Bronze Star during that deployment. After he returned to Walter Reed, he became the Neurosurgical Director of the DOD/VA Head Injury Project. Subsequently, he became the Chief of Neurosurgery and Residency Program Director at Walter Reed Army Medical Center, and Chairman of the National Capital Area Neurosurgery Residency Consortium, prior to joining the UW Department of Neurological Surgery in November of 1997.

Dr. Ellenbogen's clinical practice focuses on pediatric and adult brain tumors, craniofacial and congenital anomalies, trauma, and neuroendoscopy. Dr. Ellenbogen's current extramural funded research (NIH and



NCI) is in the field of hindbrain abnormalities and cerebrospinal fluid physiology, and brain tumors. He is using magnetic resonance to study the anatomic and physiological (CSF) properties of patients with Chiari malformations. In addition, his UW Nanotechnology research group (MINDD) is studying techniques to improve molecular imaging of brain tumors in situ, and in the operating room.

Rich and his wife, Sandy, have been together for 23 years, and have been married for 19 years. Sandy, who was raised in South Dakota, is an intensive care unit nurse and works at the University of Washington Medical Center. They have three children: Rachel (16) who goes to high school and rows for the Pocock Crew Team in Seattle, Paul (14) who is a self-acclaimed computer addict and fraconophile who loves fencing, and the high spirited Zach (12) who plays every sport imaginable from football to baseball. Rich's hobbies include fly-fishing, hunting, skiing, and cooking. The Ellenbogens enjoy swimming together, watching movies, and traveling as a family. ■

always entertaining New Orleans food and festivities to produce a memorable occasion. It is almost unfathomable to think that that much of the "Big Easy" has been destroyed by Hurricane Katrina. It is similarly hard to believe that the Convention Center disaster that unfolded after the storm occurred at the exact site where we celebrated the latest in neurosurgery just 5 months ago.

I found myself riveted by the coverage of this disaster, as I was 4 years ago after 9/11. I do not have family in New Orleans, and my family and close friends were all fortunately safe on 9/11. However, I have been one step removed from many family and friendship trees directly impacted by both of these tragedies. Times like this are

always ripe for reflection. Many of us turn away from the coverage after becoming saturated by the 24/7 media world in which we live. I am unfortunately unable to do this, and end up analyzing the events, editorials, and human reactions ad infinitum.

In thinking recently about Hurricane Katrina, there are several aspects I find striking, which are of direct relevance to us as members of our neurosurgical and local communities:

- 1) The resiliency of the human spirit in the face of overwhelming adversity is amazing. The strength and resolve is remarkable.
- 2) The power of the individual cannot

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ESP Pharma  
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## RUNN Course Readies for 21st Year

The 21st Research Update in Neuroscience for Neurosurgeons (RUNN), sponsored by the Society of Neurological Surgeons, will be held October 23–30 at its customary location, the Marine Biological Laboratory in Woods Hole Massachusetts. The mission of the course is to provide an introduction to and an update of the

latest concepts, hypotheses, and methods of neurobiology and neuroscience relevant to neurological surgery. These are presented by accomplished neuroscientists in an atmosphere emphasizing scientific rigor, highlighting models of career development for neurosurgeon-scientists, and illustrating potential future neurosurgical applications.

A milieu of total immersion in scientific discourse is designed to foster creative discussions among neurosurgical trainees and faculty. Participants are instructed on how to select a research topic and mentor, as well as how to design hypothesis-driven experiments and grant writing. The course is designed to stimulate neurosurgical trainees to participate in basic, translational, and clinical research relevant to the practice of neurological surgery.

The RUNN course was the brainchild

of Henry Schmidek, formerly of Harvard University and the University of Vermont. The course was conceived in response to the anticipated expansion of neurosciences, which he predicted in the early 1980s. The course was designed to combat what he perceived as potential illiteracy in basic neurobiology that he feared would weaken the specialty of neurosurgery. Dr. Schmidek's RUNN Course has been instrumental in setting the course of the last generation of academic neurosurgeons. In 1999, the leadership of the RUNN Course was entrusted to Issam A. Awad. Dr. Awad broadened the goals of the RUNN Course to educate neurosurgical residents in formulating hypothesis-driven experiments, establishing laboratories, and writing grants. To this end, several neurosurgeons who headed successful basic science laboratories were added to the faculty.

In 2004, Dr. Awad passed the baton of leadership to Allan H. Friedman (Duke University) and Robert M. Friedlander (Harvard) as the new Directors of the course. The Co-Directors of the course are Issam A. Awad (Northwestern), Bruce Andersen (Idaho Neurological Institute), Henry Brem (Johns Hopkins), Robert J. Dempsey (University of Wisconsin), and Charles Hodge, Jr. (SUNY at Syracuse). Dr. Andersen works closely with Jim Gailbraith and Paul Gallant (both of the National Institutes of Health) on the squid lab and microscopy workshop. Course Coordinator, Karen Koenig, works throughout the year to ensure that RUNN is executed flawlessly, and manages the organization, administration, and accounting of the course.

### The 2004 RUNN Course Report

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**Peter Grossi, M.D.**

Resident Attendee  
Neurosurgical Resident, Duke University Hospital

I believe I speak for the group of faculty and resident attendees in declaring the 2004 RUNN course a tremendous success. This year was the 20th year of the RUNN Course. The course, set on the historic campus of the Marine Biological Laboratory in Woods Hole Massachusetts, brought 70 attendees from a variety of programs together for a week of inspiring lectures on various topics in neuroscience and neurosurgery.

The course directors, Dr. Allan Friedman from Duke and Dr. Robert Friedlander from Harvard, organized a wonderfully diverse group of enthusiastic lecturers from all over the country to discuss research topics shaping clinical neurosurgery. Talks ranged from basic science lectures on the neuronal cell signaling to discussions of clinical research design and the history of the

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Figure 1. RUNN course directors Robert Friedlander (l) and Allan Friedman at the 2004 course.



Figure 2. Wood's Hole Harbor outside of the MBL, location of the RUNN course.

## RUNN

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scientific method. We were also fortunate to have Dr. Henry Schmidek, the founder of the RUNN Course, in attendance. Dr. Schmidek's interest and insightful comments clearly demonstrated his passion for the course and the topics presented and his enthusiasm was infectious.

All lectures were held in the conference center of the Woods Hole Marine Biological Laboratory. We attended lectures during the day and ate and slept within the confines of the "MBL" immersed in the history of Hodgkin and Huxley and other pioneers of neurobiological research. During the week, we were also able to explore the resources of the MBL and even demonstrate our own surgical prowess by dissecting a squid giant axon.

The daily lectures included fascinating lectures on brain tumor therapy by Dr. Henry Brem and convection-enhanced delivery by Dr. Edward Oldfield, as well as Dr. Friedlander discussing his cutting-edge research on apoptosis. The evening sessions, including lectures on axonal regeneration and computer neural networks, were some of the most enlightening and entertaining talks. The

course concluded with a special lecture by Dr. Peter Black on "the Neurosurgeon as a translational scientist." His lecture nicely brought together many of the concepts discussed during the week and clearly ended the week on an inspiring note. After the final lecture, the course concluded with a delicious Cape Cod-style lobster bake and farewell ceremony.

Perhaps the most rewarding aspect of the week though was the interaction among the participants. Whether during lecture, over meals, or at the nightly trips to Captain Kidd's (Wood Hole's most happening, and only, nightspot in the off-season), fellow residents discussed everything from research topics and career paths to our respective programs and NFL football. Many lasting relationships were formed. It was wonderful to be able to interact with fellow residents and some of the leading neurosurgeons in the country in a collegial atmosphere, and I am sure that many of the friendships I formed while at the RUNN course will persist throughout our future careers in neurosurgery. While I know we were fortunate to hear lectures by world-renowned physician scientists, I am sure the pre-eminent academic neurosurgeons of tomorrow were actually sitting alongside me in the audience. ■

## More and Improved Neurosurgical Research

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

Within the last year, the Congress of Neurological Surgeons organized a new committee with the goal of providing organizational support to improve the impact and depth of research in neurosurgery. The Committee for the Enhancement of Neurosurgical Research (CENR) therefore has as its mission to evaluate the current status of neurosurgical research and to implement a number of initiatives aimed at improving our ability to perform research critical to our specialty, both clinical and basic.

Current conditions generate significant challenges that are detrimental to our ability to perform scientific investigation and to train our residents. Among the most critical challenges is the precipitous decline in NIH pay-lines. Shrinking research dollars result in significantly greater competition and difficulty in securing funding, potentially marginalizing further neurosurgical research. Furthermore, the increased difficulty for residents to have protected research time, which is for the most part related to the 80-hour work week guidelines, results in potential and real detriment for the training of the "future neurosurgical generation" in scientific pursuit. Restricting further the time available for a neurosurgeon-investigator are the increased mandated, unfunded regulatory constraints imposed by IRB, IACUC, compliance



training requirements, etc.

Thus far, specific issues that the CENR has been involved with include:

- 1) **CENR web-page:** Posting in the CNS web-page information providing helpful information for neurosurgeons writing NIH grant applications. Within this page, one can find general information on the preparation of a grant application, neurosurgeons who have written successful grants and are willing to provide assistance and advice on the process. In addition, we have posted a number of RO1 and KO8 actual applications from neurosur-

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SUMMARY STATEMENT (Privileged Communication)		
ROBERT FINKELSTEIN 301-496-5745 finkelsr@inds.nih.gov	Release Date: 11/04/2004	
Application Number: 1 R01 NS051439-01		
EMORY UNIVERSITY DEPT OF NEUROSURGERY 1365B CLIFTON ROAD SUITE 6400 ATLANTA, GA 30322		
Review Group: ZR01 CMBT (01) Center for Scientific Review Special Emphasis Panel		
Meeting Date: 10/14/2004 Council: JAN 2005 Requested Start: 04/01/2005	PCC: FINKERN0 Dual PCC: R1DI Dual IC(s): CA	
Project Title: Molecular Targeting and Imaging of Pituitary Adenomas		
SRG Action: Priority Score: 141 Percentile: 1.6		
Human Subjects: 30-Human subjects involved - Certified, no SRG concerns		
Animal Subjects: 30-Animals involved - no SRG comments or concerns noted		
Gender: 1A-Both genders, scientifically acceptable		
Minority: 1A-Minorities and non-minorities, scientifically acceptable		
Children: 1A-Both Children and Adults, scientifically acceptable		
Clinical Research - not NIH-defined Phase III Trial		
Project Year	Direct Costs Requested	Estimated Total Cost
1	250,000	382,500
2	250,000	382,500
3	250,000	382,500
4	250,000	382,500
TOTAL	1,000,000	1,530,000
ADMINISTRATIVE BUDGET NOTE: The budget shown is the requested budget and has not been adjusted to reflect any recommendations made by reviewers. If an award is planned, the costs will be calculated by institute grants management staff based on the recommendations outlined below in the COMMITTEE BUDGET RECOMMENDATIONS section.		
NEW INVESTIGATOR		

A goal of the CENR is to increase the number of successfully funded neurosurgeon R01 "pink sheets."

## Neurosurgical Research

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geons. These can serve as a model by which new investigators can determine the general framework of these complex applications. In addition, we have the summary statements ("pink sheets"), to serve as reference.

- 2) **Increase Neurosurgical representation in NIH study sections:** A perceived problem in study sections is that at times the evaluation of neurosurgical grant applications are being done by individuals who may not have the required expertise in the subject. This may result in the potential downgrading of the impact of the application. Lack of appropriate neurosurgical expertise results due to the fact that there are few neurosurgeons who actually serve in study sections. In part, the problem is that not many neurosurgeons have traditionally been willing to dedicate the time required to appropriately tackle this significant and important responsibility. This committee has gathered the names of a significant number of members of neurosurgery departments (most being neurosurgeons) who are willing and able to serve as members of study sections. We are working with the NIH to try to increase the neurosurgical representation in these study sections.

- 3) **Evaluate the current status of neurosurgical research:** We have distributed a questionnaire to all the neurosurgery programs in the country with the goal of procuring information on the current status of neurosurgical research. Items queried pertain to the effects of the 80-hour resident work week on research, the number of faculty participating in research, as well as levels of research funding. Thus far we have secured information from two thirds of the programs in the country. Interesting trends are being observed which should assist in the further development of strategies to improve the status of neurosurgical research. The results of this survey will be made available in the near future.

If you have any ideas or suggestions, please do not hesitate to contact me. This committee will be meeting in Boston, and if you are interested to participate, please let me know. The future of neurosurgical research is at significant risk, and we need to be proactive to defend our standing in the scientific community. ■

## Congress of Neurological Surgeons Treasurer's Report

**Douglas Kondziolka, M.D., M.Sc., F.R.C.S.(C)**

Treasurer, CNS

The CNS recently conducted its annual audit, the results of which will be presented at the business meeting in Boston. Organizational finances are in good order. Dues remain flat at \$335.00 per year, and this fiscal year the CNS has created a number of new initiatives, particularly in regard to education and web technology. Efficiencies in our headquarters office and committee activity have allowed us to transfer funds into the CNS Endowment for Fellowships and Education. More than \$2.29 million dollars has been placed into this fund to support education. Monies from this fund currently support CNS fellowships. The CNS Reserve Fund currently has approximately \$7.5 million dollars. The 2005 fiscal year finances were recently

completed with income over expenses of \$1.26 million dollars.

In June, the CNS Executive Committee passed the 2006 fiscal year budget. The budget has income of \$7.36 million over expenses of \$7.05 million. The main sources of income to the organization include publications, dues, and annual meeting revenues. The CNS remains the best membership value in medicine through efficient management and neurosurgical volunteerism. Your annual dues support the following: \$125 for your annual subscription to *NEUROSURGERY*, \$117 to support the Washington Committee of the AANS and CNS, \$15 for your subscription to *Clinical Neurosurgery*, and \$78 for other CNS projects. All other CNS projects and initiatives are funded from non-dues sources. Such projects include our support of *Neurosurgeons to Preserve Health Care Access*, the *SANS-Wired* project, Information Technology projects, the

World Directory of Neurological Surgeons, the *CNS Guidelines Projects*, *CNS Fellowships*, and numerous other works organized and directed by CNS members. A significant increase in CNS spending is going towards expanded information technology projects that focus on education, maintenance of certification, and other member needs. The CNS completed its promised contribution to *Neurosurgeons to Preserve Health Care Access* in June.

To expand the ability of the CNS to work on behalf our members in the socioeconomic arena, the CNS has activated its 501 C-6 organization. This will allow participation in socioeconomic and educational programs with a specific taxation advantages. This organization has been named the Congress of American Neurosurgical Education. Overall, the finances of the Congress of Neurological Surgeons are stronger than ever, allowing the organization to be well positioned to address the ever growing complexities of neurosurgical practice and education. The focus remains on innovation. ■

## Washington Update

**Alexander M.L. Mason, M.D.**

CNS Public Policy Fellow

Trading in my surgical scrubs and mask from the Cleveland Clinic this year for a suit and tie in Washington D.C., I had little understanding of the complexities of neurosurgical public policy. Awarded the CNS's Charles Plante Public Policy Research Fellowship, I was to study public policy on Capitol Hill and become fluent in the many issues affecting neurosurgery. Fluency, I have found, has been difficult to find, as the issues involved with neurosurgery are numerous and complex. I have found that as one of the few physicians in

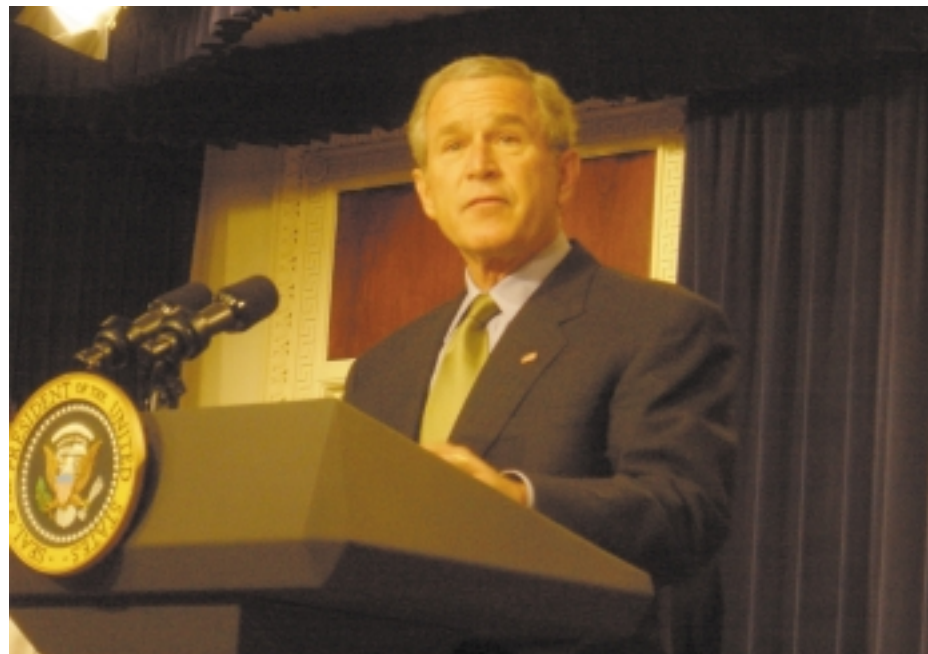
Washington who "practices" neurosurgery full time, and is a temporary politician and advocate, I am reassured that we, as organized neurosurgery, have a real, non-token presence in our capital. Representing the more than 4000 neurosurgeons in the United States and elsewhere, we have a voice, under the leadership of Katie Orrico and the Washington Committee, that is far out of proportion to the size of our specialty. Yes, this is reassuring, but the complexity of the issues remains. At stake in the next year, more than ever, are important decisions regarding pay-for-performance, also known as value-based purchasing, reimbursements, and autonomy within our specialty, as well as within the medical field in general. Medical safety was successfully passed

with common sense legislation this summer, but health information technology legislation continues to circulate without consensus or common goal. And finally, medical liability reform continues to be on the short list of items that we are hoping will be addressed this fall by Congress.

### Medical Liability Passes again in the House

For the ninth time since 1990 and the third time in as many years, the House of Representatives passed federal medical liability reform that includes the essential cap on non-economic damages. The specialties are hopeful for a vote this fall in the Senate, where it has been repeatedly filibustered in the past. The Doctors for Medical Liability Reform (DMLR) group, representing more than 230,000 specialty physicians in the United States, continues to lobby for local and national changes, and they are coordinating efforts to win additional Senatorial votes, although currently the necessary consensus in the Senate is lacking.

President Bush had vowed to make Medical Liability reform an important part of his second term, citing the real need to "curb lawsuit abuse with needed medical liability reform." His administration points to the need for reform because of reduced access, and the increased cost of health care because of defensive medical practices. The specialties, including neurosurgery, largely agree. Additionally, recent challenges in previously non-crisis states reiterates the need for national reform. The issue of medical liability reform continues to be at the front of many specialties concerns, and a major concern for neurosurgeons throughout the country.



President Bush signing the Patient Safety Bill into law on July 29, 2005.

## Washington Update

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### Reimbursement Cuts

Reimbursements under the current Medicare physician system are currently scheduled to be reduced by nearly 30% over the next 6 years. Starting with a 4.3% cut on January 1, 2006, reimbursements will be cut by approximately 5% per year over the next 6 years. The problem is the current system, called the sustainable growth rate formula (SGR), which places an overall cap on the amount the government will spend each year on Medicare Part B physician spending. Over the past 4 years, the volume of services has increased significantly, so that yearly cost overruns have caused a deficit in the system. The system now must make up the cost overruns incurred in the past several years and also bring the current year's spending back under the target. The SGR formula will reduce the amount paid in order to account for this recent unplanned increase in volume, thus allowing a Part B spending to be "budget neutral." Regardless of the method, reimbursement cuts of 30% over the next 6 years would have "a drastic and devastating impact on the Medicare system" said Nancy Johnson (R-CT), chair of the House Ways & Means Subcommittee on Health.

### The Sustainable Growth Rate: a Fix?

While most in Congress agree that such cuts are not acceptable, the solution is less apparent. There is real concern about how to pay for "the Fix," as any money used to correct the current system, currently estimated to cost between \$154 and \$185 billion over 10 years, will need to come from somewhere else in the bureaucracy. One popular and potentially realistic solution is to remove the costs of outpatient physician-administered drugs, such as outpatient chemotherapy, from the costs counted against physicians in the SGR formula. Regardless of the solution, funding the changes in the formula is really at the heart of the problem. The deficit is real, and if the outpatient drugs are removed from the formula, they must be paid by another area of the administration. The consensus among physician groups, including neurosurgeons, is the same: repealing, rather than repairing the SGR is what is required.

### A New System

Despite a lack of clear direction regarding the SGR within the Administration, the direction regarding changing the reimbursement payment of physicians is clear. Pay-for-performance, also known as value-based purchasing, is widely supported as a system that will address many of the desires of the administration, while, in theory, tying contemporary standards of care to physician payment. Under such a model, a small portion of a physician's Medicare reimbursement, currently proposed at 1 to 2%, would be tied to

whether certain "quality" and "efficiency" measures were being reported and met.

Although neurosurgery has not been generally supportive of the change, other medical groups have agreed to sign on to the concept and both Congress and the Center for Medicare Services (CMS) are moving forward with the concept. "At this point, the only thing worse than pay-for-performance is a pay-for-performance system that is designed without our input, by some

bureaucrat in Washington, D.C. setting neurosurgery's quality measures" said Troy Tippett, M.D., chair of the AANS/CNS Washington Committee for Neurosurgery.

### Two Bills, No Solution

Two pay-for-performance bills have been introduced in Congress so far: S. 1356, the "Medicare Value-Purchasing Act of 2005" in the Senate and H.R. 3617, the Medicare Value-Based Purchasing for Physicians Services Act" in the House. Neither bill is considered

by neurosurgery or other specialty societies as ideal; however, the house bill, known as the Johnson Bill after sponsoring House member Nancy Johnson (R-CT), is far superior from the neurosurgeon's perspective. The bill specifically repeals the SGR formula, and replaces it with the Medicare Economic Index (MEI), a much more favorable and realistic inflation formula. Additionally, quality measures will be developed by specialty societies such as the

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## Washington Report

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CNS and AANS, and approved after being evaluated in a national approval process. Physicians will begin reporting these quality measures in 2007, and those that do will receive the full inflationary payment update, while those physicians that do not report such measures will receive one percent less. Starting in 2009, a similar reimbursement will be instituted for physicians who meet and report the approved quality measures. Also in 2009, the reporting of such quality measures will be made public through different quality assurance organizations.

The Senate bill, sponsored by Senators Grassley (R-IA) and Baucus (D-MT) would also implement pay-for-performance systems for physicians. Although the bill does not specifically address the impending cuts, the Senators have stated that they expect the bill to be brought to the floor with separate legislation addressing such cuts. As currently drafted the Senate bill will allow CMS significant control over quality measures, with relatively less autonomy by specialty groups. Beginning in 2006, CMS will be required to begin collecting physician utilization information. In 2007, the physicians will be required to report quality measures to CMS, and then in 2008, physicians will be graded on the quality measures they are reporting. For those physicians not meeting certain criteria at each stage, payments will be cut by 2%. A "bonus" system will be established for those physicians meeting or exceeding certain quality measures. However, this payment bonus is budget neutral, and thus, it is not truly a bonus.

Although neither bill is perfect, the Johnson bill is generally preferred by most specialties as it repeals the SGR, allows a greater involvement of specialties in quality measure creation, and has a more realistic timeline. The issue of public reporting has drawn sharp criticism from neurosurgeons and other specialties. Without adequate risk stratification, there is little chance that such data can be accurately reported, and unless thoughtful analysis and review are conducted, exposure of such raw data could be damaging to medical and surgical specialties alike.

This fall, both the Senate and the Johnson bills, and possibly others including a separate House bill introduced by Congressman Thomas (R-CA), will be debated, although it is not yet clear when they will be voted on. As the negotiations develop, neurosurgery will be working to ensure the payment cuts and SGR repeal are part of any pay-for-performance legislation; public reporting is eliminated, minimized or at least delayed; the implementation of pay-for-performance is delayed until quality measures can be developed and pilot-tested across a variety of practice settings; and appropriate risk adjust-

ments to any measures can be developed, tested and included.

### Patient Safety Signed into Law

On July 29, 2005, after years of negotiations and revisions, President Bush signed into law the Patient Safety and Quality Improvement Act of 2005. The bill creates a new voluntary reporting system for medical 'near misses' and errors. The anonymous patient data will be submitted to established or newly created "patient safety organizations" that will analyze the errors, and make recommendations for system changes to prevent future errors. With this law, we'll be able to obtain more accurate information about medical treatments. And by providing doctors with information about what treatments work, and what treatments cause problems, we will reduce medical errors that injure and cause the deaths of thousands of Americans each year" said President Bush at the signing.

The issue of medical errors was highlighted in 1999 with an Institute of Medicine report, which concluded that between 44,000 and 98,000 Americans die every year from errors in health care. The IOM report emphasized that most of the medical errors are systems-related and are not attributable to individual misconduct or negligence. The topic of medical errors has been an important issue with the press and politicians alike, and has been often discussed in forums on improving medical quality and medical liability reform.

### Patient Safety Organizations as Watchdogs

The Patient Safety and Quality Improvement Act defines patient safety organizations (PSOs) as independent organizations certified by the United States Department of Health and Human Services (HHS) every 3 years. The PSOs will collect anonymous incident and patient information that will then be forwarded to a national database for analysis. Recommendations from HHS will be made from this, and will include methods to reduce errors and improve patient safety. Importantly, the bill preserves confidentiality of patient information under the Health Insurance Portability and Accountability Act (HIPAA). Additionally, the information and recommendations will not identify specific providers or individuals, and appropriate fines would be administered for such disclosures. The bill does not, however, shield information available outside the patient safety evaluation system, such as billing and medical records.

The medical error legislation highlights the aggressive stance of lawmakers regarding medical quality in the marketplace. New legislation being proposed from lawmakers regarding patient safety, value-based purchasing, health information technology and medical liability reform highlight the

importance of patient safety in the national spotlight. Although the bill has no direct connection with value-based purchasing or medical liability reform, it certainly sets the stage for closely following patient safety in the public eye in the coming years.

### Health Information Technology

On July 20, 2005, the Senate Health, Education, Labor, and Pensions (HELP) Committee approved legislation in the form of Senate bill 1418, the Wired for Health Care Quality Act, which is designed to further the adoption of information technology by the health care providers. The bill would create a collaboration panel, which would be charged with making health IT recommendations to the Department of Health and Human Services (HHS) within a year. The bill also established a National Coordinator of Health IT within HHS to oversee the newly developed infrastructure, as well as establishing grants to health care providers to further health IT. Mike Enzi (R-WY) said in a statement "All of us believe that if we move from a paper-based health care system to secure electronic medical records, we will reduce mistakes, save lives, save time and save money."

One of the major hurdles regarding health IT has been interoperability different IT systems, and, from a practitioner's standpoint, who is going to pay for the mandates. Although Vista, a federal medical record system used by the Veterans Administration is available for no charge to interested health providers, the general concern voiced by specialties has been the cost of infrastructure and implementation of directives that are, as of yet, unproven, and unpaid for. HHS Secretary Leavitt suggested that "the federal government is responsible for 46 percent of health care spending, and a push by federal programs as Medicare and Medicaid to adopt health IT will create an incentive in the private market to adopt IT...we know we will move markets" he said in regards to the adoption of health IT by federal health care programs.

### Incentives for Health IT?

Although most experts believe health IT has the potential to reduce both medical errors and health care costs and medical errors, there is concern among the specialties of how health IT will be implemented. It has been suggested in the administration that the federal government could play an important role in the widespread use of health IT, and the government should use their purchasing power to help facilitate its introduction and reduce costs, although details are sketchy.

Although many hospitals and physician offices have some form of electronic medical record in place, there is a broad concern that resources will be wasted if many different standards exist, as is

currently the case. This has many lawmakers, such as Congressman Thompson (D-CA), worried about what will happen to physicians who adopt health information technology before national standards are set "What about people who already have health IT and whose system may differ from the national system. Will they be punished for doing what we told them to do?" Thompson asked David Brailer, the national coordinator of Health IT within HHS during a recent hearing. His response partially confirmed specialty concerns: "I suppose that, yes, there is a risk that doctors could be put in a place where they may have a system that is not compatible with national standards...That is why we have always advocated incremental changes to reduce the likelihood of that happening." Regardless of the path and timeframe, neurosurgeons can expect to have interoperable IT systems in place in the years to come, ideally with federal subsidies and a realistic timeframe.

### Keeping Informed and Involved

In the short time I have been in Washington, it has become clear to me that neurosurgeons must keep informed and be involved in shaping the nation's health policy. While our principle focus is on taking care of our patients, Federal policymakers are making decisions each day that affect each and every one of us. It is therefore imperative for neurosurgeons to take the time to regularly communicate with our Senators and Representatives. Our voices do matter and we can help shape and influence legislation and regulations that govern the practice of neurosurgery.

For those neurosurgeons attending the CNS Annual Meeting in Boston, I encourage you to stop by the Washington Committee's advocacy booth where you can learn more about these and other issues. ■

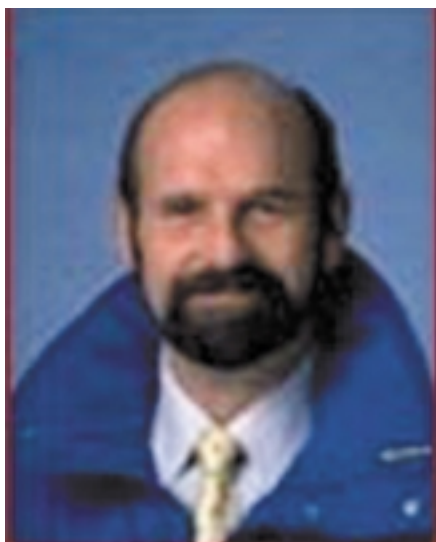
For information regarding upcoming meetings of the CNS, visit <http://calendar.neurosurgeon.org/>

## Dick Button to Deliver the Alexa Canady Lecture

**Holly S. Gilmer-Hill, M.D.**

President, WINS

As neurosurgeons, we are continually awed by the adversities our patients overcome and the courage with which they face them. In conjunction with the upcoming Congress of Neurological Surgeons annual meeting, Women in Neurosurgery (WINS) has the pleasure of presenting figure skating legend Dick Button, who will deliver the Alexa Canady lecture entitled "Hang Up Your Skates: Overcoming Obstacles and Head Injury." Mr. Button is the national spokesperson for the Brain Injury Association of America (BIAA).



Richard "Dick" Button is an internationally-renowned 5-time world figure skating champion (1948–1952) and 2-time Olympic Gold Medalist (1948 and 1952). He was the first skater to successfully land the double-axel jump in competition, as well as the triple loop. He invented the flying camel spin, which became known as the "Button camel." Mr. Button later toured with the Ice Capades and Holiday on Ice. He has been a figure skating analyst for ABC Sports since 1962, and regularly provides expert commentary on ABC's Wide World of Sports as well as the Winter Olympics. His career has overcome many obstacles and naysayers including his first coach who watched his first competition and told him to "hang up your skates!"

In addition to his extraordinary figure-skating career, Mr. Button graduated from Harvard Law School and was admitted to the Washington, D.C. bar. He has acted in several movies and television specials and founded Candid Productions, Inc. Through this company, Mr. Button has created a series of made-for-television sports competitions including The Superstars, The Superteams, and the World Professional Figure Skating Championships.

Mr. Button's multifaceted, dynamic world came to a sudden halt in 2000, when he suffered a closed head injury

and basilar cranial fracture after a fall during a leisurely skate. He states that he doesn't remember the first month after the accident at all, and barely remembers parts of the second month. His family was told he was unlikely to

ever function independently again. After months of rehabilitation, including learning to walk again, he is not only independent, but has resumed his television career with ABC. As spokesperson for the BIAA, he educates the public about head injury and recovery, and tries to dispel the stigma patients feel. He states "I'm old enough and far along enough in this world that I can say I've had a brain injury. I'm also lucky enough to be able to say I have,

I think, to a great deal recuperated from that brain injury."

Mr. Button will speak about overcoming significant obstacles to a successful career and will talk candidly about his journey back from head injury on Tuesday, October 11, 2005 at 6:00 p.m., in Berkeley A & B on the 3rd floor of the Sheraton Boston Hotel. Please join us for what promises to be a fascinating and inspiring event! ■

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## CNS Website

Continued from page 4

mation, as well as a list of grants available through various agencies. A list of residency programs and any available open slots may be found. The medical student and resident curricula have recently been updated and are downloadable. The resident curriculum now includes the six core competencies required for resident training.

The Case of the Month and Neurosurgery Trivia are two areas that are very popular and are continuously updated. They allow one to test their knowledge in areas such as history, and to review a challenging case and give their opinion on management.

Jobs may be searched for through our Job Placement Service. Additionally, your personal information may be posted on the site for potential employers. A new addition to the site is the Grantsmanship section. From this section, one may gather advice from those who have obtained government research funding and also be able to see actual examples of successful and unsuc-

cessful grants.

*SANS Wired* is featured on the Education page and is one of the most important educational tools offered by the CNS. It is readily accessible from this page.

A new page called Resident On-Call has been created, which is dedicated solely to resident issues and resources. It can be accessed from every page on the site by clicking on the pager (on-call) button. On this page, one can obtain information on how to become a resident member in the CNS, understand the benefits of such membership, and information about how to get involved in the CNS. An exciting aspect of this site is the visiting professor section, where every 3 months, a recognized expert will be asked to address a key resident issue and opportunity for comments will be provided.

Please visit the educational page and test your neurosurgical acumen by answering some trivia or commenting on the Case of the Month. As always, we appreciate your comments regarding the site and look forward to suggestions. ■



Resident On-Call is one of the many educational features of the CNS website.

## NEW PRODUCTS

# Elekta Announces the Next Generation of Elekta Synergy® with 510k Clearance of New Workflow Tools for 4D Adaptive™ IGRT

Elekta Synergy®, Elekta's digital linear accelerator used in oncology centers worldwide in the fight against cancer, is once again inspiring clinical confidence in Image Guided Radiation Therapy (IGRT). Significant advancements in cone-beam image quality and almost instantaneous reconstruction of large volumetric images indicate Elekta's 4D Adaptive™ IGRT realistically fits into normal, everyday radiation oncology treatment times.

"We promised our customers a healthy upgrade path and with our new suite of enhanced workflow software tools we already are living up to that promise," states Anthony DeCarolis, CEO of Elekta, Inc. and head of Elekta's operations in North America. "Elekta Synergy has proven to be the success story we all hoped it would be. With more than 4,000 clinical images from 20 installations, and more than 50 scheduled to be installed within the next few months, we are confident that this is just the beginning."

Only Elekta gives you the power to apply routinely all three IGRT imaging modes to address complex inter and intra-fraction motion in a seamlessly integrated platform – Elekta Synergy:

- PlanarView™ – allows quick orthogonal snapshots of patient anatomy with exceptional image quality due to the use of KV imaging instead of MV portal imaging
- MotionView™ – fluoroscopic-like, real-time monitoring of high contrast tumors or internal organs in order to accurately characterize internal motion at the time of treatment
- VolumeView™ – very high-resolution volumetric images with more than 25cm of anatomy visible in the cranial / caudal direction for highly precise 3-dimensional anatomic alignment. Up to a 48cm field of view is available with tremendous patient clearance allowing imaging without moving the patient out of the treatment position.

"We are really proud of what we've achieved with Elekta Synergy," says Jill Stief, Senior Product Manager - IGRT Solutions, from Elekta. "Not only is it still the only commercially available clinically-developed IGRT solution

comprising high resolution 3D imaging with a full suite of matching, registration and repositioning tools – it is also the only system which has been designed for IGRT from the ground up".

For further information, please contact:

International:  
Peter Ejemyr  
Group VP Corporate  
Communications, Elekta AB  
Tel: +46 733 611 000  
e-mail: [peter.ejemyr@elekta.com](mailto:peter.ejemyr@elekta.com)

United States:  
Lars Jonsteg  
VP Investor Relations North  
America, Elekta, USA  
Tel: +46 708 78 37 35  
e-mail: [lars.jonsteg@elekta.com](mailto:lars.jonsteg@elekta.com)

### About Elekta

Elekta is an international medical-technology Group, providing meaningful clinical solutions, comprehensive information systems and services for improved cancer care and management of brain disorders. All of Elekta's solutions employ non-invasive or minimally invasive techniques and are therefore clinically effective, gentle on the patient and cost-effective.

Clinical solutions include among others Leksell Gamma Knife® for non-invasive treatment of brain surgery and Elekta Synergy® for image guided radiation therapy (IGRT). Following the acquisition of IMPAC Medical Systems Inc. in April 2005, The Elekta Group is the world's largest supplier of oncology software.

Elekta's systems and solutions are used at over 3,000 hospitals around the world to treat cancer and manage clinical operations as well as to diagnose and treat brain disorders, including tumors, vascular malformations and functional disorders.

With approx. 1700 employees, Elekta's corporate headquarter is located in Stockholm, Sweden and the company is listed on the Stockholm Stock Exchange under the ticker EKTA. ■

## PRESS RELEASE

# Synergetics, Inc. and Valley Forge Scientific Corporation Have Entered into a Merger Agreement

On May 2, 2005, Synergetics, Inc. and Valley Forge Scientific Corporation, the original and current manufacturers of the Malis electrosurgical generators and a publicly traded company, entered into a merger agreement. Valley Forge has been instrumental in the creation and development of the patented aperiodic waveform essential to today's safe application of bipolar coagulation in neurosurgery. These combined companies offer the history and creativity gained during the development of many generations of the Malis Bipolar Generators with the innovation and design capabilities that have allowed Synergetics to introduce new ultrasonic bone

cutting technology into the neurosurgical arena. The Synergetics Omni ultrasonic aspirator uses power ultrasound creating OsteoEmulsification. Using OsteoEmulsification, bone is removed in situ without the use of a drill, eliminating kick, skipping, and chatter, and improving surgeon control and results. The available Omni accessories include the Spetzler Barracuda for fibrotic lesions, and the Spetzler Claw and Spetzler Micro Claw for bone removal. ■



**Editor's Note**

Continued from page 6

be overestimated. When tragedy strikes somewhere, many of us think "How can I help?" but do not go the extra mile to act directly. In fact, an individual can make a huge difference in times of crisis and the internet certainly facilitates this process. My sister is an example of how one person can make a difference. She is a working mother of two. She and a friend in Pittsburgh have a blog site that discusses issues that arise raising families (<http://www.beenthere.typepad.com/>). They decided to use their Blog site as a clearinghouse to connect people in need with those donating goods, supplies, or "sponsorship" of a family after Katrina. They have successfully paired hundreds of people and families.

3) The need for disaster planning and foresight is paramount. The amazing thing about the New Orleans disaster is that it was entirely predicted. Just last year in October, *National Geographic* ran a piece entitled "Gone with the Water." As Joel K. Bourne, Jr. wrote:

*The storm hit Breton Sound with the fury of a nuclear warhead, pushing a deadly storm surge into Lake Pontchartrain. The water crept to the top of the massive berm that holds back the lake and then spilled over. Nearly 80 percent of New Orleans lies below sea level—more than eight feet below in places—so the water poured in. A liquid brown wall washed over the brick ranch homes of Gentilly, over the clapboard houses of the Ninth Ward, over the white-columned porches of the Garden District, until it raced through the bars and strip joints on Bourbon Street like the pale rider of the Apocalypse. As it reached 25 feet (eight meters) over parts of the city, people climbed onto roofs to escape it.*

*Thousands drowned in the murky brew that was soon contaminated by sewage and industrial waste. Thousands more who survived the flood later perished from dehydration and disease as they waited to be rescued. It took two months to pump the city dry, and by then the Big Easy was buried under a blanket of putrid sediment, a million people were homeless, and 50,000 were dead. It was the worst natural disaster in the history of the United States.*

*"When did this calamity happen? It hasn't—yet...It's not if it will happen," says University of New Orleans geologist Shea Penland. "It's when."*

There are many types and levels of disaster. The complete destruction caused by Katrina or the wanton acts of terrorists are not comparable in any way to the forces that potentially threaten our subspecialty or our communities. Nevertheless, these disasters reinforce the need to take stock of our lives and our livelihood. We must appropriately prepare for and, if possible, prevent potential catastrophes that could imperil our homes, families, and chosen field.

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4) We need to be thankful for our good fortune. There are many days when I find reasons to complain: the operating room turnover is too slow, the IRB is again delaying my research, the traffic is unbearable, *Neurosurgery News* is late, my kids don't listen, etc. I take for granted so much that I have, without taking the time to really appreciate how lucky I am. Our Annual Meetings are a celebration of the Congress of Neurological Surgeons and of Neurosurgery. As I head to Boston, I look forward, more than ever, to appreciating the greatness of our field and treasuring the many opportunities and friendships that the CNS provides. ■

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