NEWSLETTER
CONGRESS OF NEUROLOGICAL SURGEONS

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The Congress begins its 25th year with 1592 members, the largest neurosurgical organization in the world. This newsletter is designed to keep the members informed of Congress news including information about the next annual meeting, appointments and honors received by members, reports of various Congress committees, a calendar of coming events, and other items contributed by members. It is sent to all neurosurgery residents. Any additions or corrections to the mailing list should be sent to the secretary, Dr. David Kelly, Bowman Gray School of Medicine, Winston-Salem, North Carolina 27103.

Members and residents are invited to contribute news items and comments to the editor.

—Kenneth Smith, *Editor*

VANCOUVER MEETING

The 24th annual meeting was attended by more than 1500 people including 537 members. The first day was devoted to simultaneous special courses in neuropathology and neuroradiology. The scientific program focused on monitoring the neurosurgical patient. Dr. Guy Odom, honored guest, spoke on cerebral arterial spasm and neurosurgical manpower and training. Workshops, luncheon discussion groups and the open scientific session again were popular features.

The Annual Meeting Committee and the many members of each of its subcommittees deserve our thanks for their long hours of work. Dave Kelly was program chairman assisted by Gary Vander Ark, George Ojemann, Fred Simeone, Thor Sundt, John Tew and Don Becker. Other committees were headed by Dave Kline (exhibits), Bob Grossman (host), Gordon and Sally Thompson (host), Bill Buchheit (public relations), Fletcher Lee (registration), Don Long (residents registration), and Byron Annis (sergeant-at-arms). Ian and Janis Turnbull made the arrangements for the supplementary scientific session in Victoria which was enjoyed by more than 250 participants.

RESIDENT AWARD

An innovation this year was the Residents' Award for the best paper presented by a resident. Dr. Arthur Kobrine of Washington, D. C. received the award for his paper "Autoregulation of Spinal Cord Blood Flow."

The second annual Resident Award for the best paper submitted by a resident in neurological surgery will be presented at the annual meeting October 25, 1975 in Atlanta, Georgia. The paper should be primarily related to a clinical problem or clinical research. It is open to any resident from an approved residency program in the United States or Canada. The work must be submitted while a resident or within one year of completing residency. It must not have been published or presented by the time of the annual meeting of the Congress. The resident should have been the principal author and investigator and the paper should be certified by the program director.

The applicants should submit a 1,000 word abstract by May 1, 1975. The winner will receive an award at the open scientific session. His transportation and room will be paid by the Congress.

Please submit abstracts to Stewart B. Dunsker, M.D., Chairman, Resident Award Committee, 506 Oak Street, Cincinnati, Ohio 45219.

JIM ROBERTSON ELECTED PRESIDENT

At the 24th annual meeting in Vancouver, Dr. James Robertson of Memphis, Tennessee was elected to the presidency, succeeding Dr. George Tindall of Altanta, Georgia. Other newly elected officers were: Robert Ojemann, president-elect, Kenneth Smith, vice-president and David Kelly, secretary. Bruce Sorensen remains in the office of treasurer.

Newly elected members of the Executive Committee for 3-year terms are: John Tew, Cincinnati, and Fletcher Lee, San Antonio. Other members of the executive committee are: Perry Black, William Buchheit, Jim Story, Robert Wilkins, George Tindall, Albert Rhoton, Bernard Patrick and Don Dohn.

The new officers of the auxiliary are: Valeria Robertson-president, Jean Ojemann-president elect, Marjorie Smith—vice-president, Helen Buchheit, secretary, Suzanne Sorensen, treasurer. The Board of Directors includes: Suzie Tindall, Sally Thompson, Sally Kelly, Gloria Wilkins, Ann Peerless, Joyce Rhoton, Phyllis Vander Ark.

CONGRESS OF NEUROLOGICAL SURGEONS
TWENTY-FOURTH ANNUAL BUSINESS MEETING

Hotel Vancouver — September 26, 1974 — Vancouver, British Columbia

The meeting was called to order at 5:00 p.m. by President George T. Tindall. The minutes of the 1973 meeting were read by the Secretary, Dr. Robert G. Ojemann. The minutes were approved by the membership.

Dr. Ojemann then presented the Annual Report of the Executive Committee. A copy of this report is attached.

The report of the Treasurer was presented by Dr. Bruce F. Sorensen. This report has been submitted in writing to the Executive Committee and has been made a part of the permanent record. A written statement was presented. Dr. Sorensen presented a series of slides summarizing the financial position of the Congress. It was recommended that the dues remain at $40 for members in the United States, Canada, Mexico, and Puerto Rico and $15 for International members. A motion was made and seconded to accept this recommendation. The motion was approved.

Dr. Albert L. Rhoton gave a report of the Bylaws Committee. The proposed bylaws changes concerning sexual discrimination and committee organization were presented. A motion was made to approve the proposed changes in the bylaws. The motion was seconded. The motion was approved.

Dr. Bernard S. Patrick gave a report regarding the status of the collaboration between the Congress of Neurological Surgeons and Surgical Neurology. A history of the negotiations was presented. The relationship will be on a continuing trial basis.

Dr. Bernard S. Patrick, Chairman of the Nominating Committee, proposed the following slate of nominees:

President-Elect . . . . . Robert G. Ojemann
Vice President . . . . . Kenneth R. Smith, Jr.
Secretary . . . . . David L. Kelly, Jr.

Executive Committee (Terms of three years each)

J. Fletcher Lee — John M. Tew, Jr.

There being no other nominations made, it was moved and seconded that the slate of nominees be accepted. The motion was unanimously approved.

Dr. Tindall called for new business. There was none.

A motion for adjournment was heard, seconded, and all approved.

— David Kelly

Neurosurgical Procedure Terminology

All Congress members please note that the AANS-CNS is printing a new corrected Neurosurgery Procedural Terminology book. The section on the nervous system in the AMA Current Procedural Terminology (3rd. ed.) is out of date and should be replaced by this new publication edited by Dr. Byron Pevehouse and promised for distribution to all members of CNS and AANS in 1974. All neurosurgeons and state neurosurgical societies should use this revised terminology.

NEWSLETTER

Published quarterly by the
Congress of Neurological Surgeons

President — James T. Robertson, M.D.
Memphis, Tennessee

President-Elect — Robert G. Ojemann, M.D.
Boston, Massachusetts

Vice-President — Kenneth R. Smith Jr., M.D.
St. Louis, Missouri

Secretary — David L. Kelly, Jr., M.D.
Winston-Salem, N. C.

Treasurer — Bruce F. Sorensen, M.D.
Salt Lake City, Utah

PRESIDENTIAL ADDRESS
CONTINUING EDUCATION FOR THE NEUROSURGEON*

George T. Tindall, M.D

* An abridgment of the address by Dr. Tindall at the 24th Annual Meeting of the Congress of Neurological Surgeons, Vancouver, B.C., September 26, 1974. The complete text will appear in *Clinical Neurosurgery*, Vol. 22.

Introduction

I believe that the establishment of continuing education programs for the practicing neurosurgeon is one of the most important, unresolved items facing our specialty today. True, socioeconomic matters are ever pressing and potential governmental involvement in many of our professional affairs is a growing area of concern, and often we become overly preoccupied with these issues, usually at the expense of structuring and pursuing some types of continuing educational program. The importance of continuing education is obvious when one considers that one of our primary goals is the constant delivery of high quality neurosurgical care and the most important key toward this end is an effective, on-going continuing education program in neurosurgery.

Rationale for Continuing Education in Neurosurgery

The modern physician is confronted by what often seems to be an impossible task in attempting to keep himself abreast of the latest developments. The only hope of catching up would appear to be a well-planned continuing education program designed and implemented by individuals knowledgeable in medical education. Howard believes that physicians have been stimulated and encouraged to greater efforts in continuing education by pressures both inside and outside the profession.[1]

Item 1. — There has been a substantial annual growth in participation of physicians in continuing education programs in recent years. In 1972, it was estimated that there were more than 300,000 physician registrations in formal continuing education programs:

Item 2. — There is increasing emphasis on continuing medical education by state, medical and medical specialty societies (25 state medical associations sponsored formally structured courses for physicians in 1972- 73).

Item 3. — Action has been taken by at least three state legislatures to make formal participation in continuing medical education a requirement for periodic relicensure.

Item 4. — There has been major growth and development of self-assessment procedures by medical specialty societies. There are now 14 national medical specialty societies with self-assessment programs in operation.

Goals

The broad general goals of continuing medical education programs include:

1. Improved quality of patient care.
2. Self-satisfaction in learning.
3. Preparation for some type of recertification or relicensure process.

There are several state medical associations that have already made policy decisions that will in effect require continuing education as a condition of membership. Of the twenty-two specialty boards, 19 now endorse recertification and 4 of these specialty boards have even announced dates to activate this plan. The only specialty that is on record as opposing recertification is neurosurgery and I am not at all certain that this decision reflects the beliefs of all neurosurgeons. At any rate with this momentum among the various specialties, it is reasonable to anticipate that, when a sufficient proportion of physicians have passed recertification, the Joint Commission for Accreditation of Hospitals will probably use recertification as a criterion for granting hospital staff privileges.[2] It is essential that the movement toward recertification or relicensure be under the control of the medical profession.

President Tindall

As an alternative to recertification examination of neurosurgery, a system could be devised similar to that which has been developed by many state medical organizations which requires proof by the physician of a certain number of credit hours spent in continuing education programs over a specified period of time. Both the Congress of Neurological Surgeons and the American Association of Neurological Surgeons have been formally approved for an accredited program in continuing medical education by the AMA Council on Medical Education.

Characteristics Desirable in Continuing Education Education Programs:

Any national plan that intends to implement continuing professional education runs the risk of becoming an inefficient bureaucratic system unless it meets highly personalized criteria. According to Dryer[3] these criteria are: personal satisfaction, freedom of choice, continuity, accessibility and convenience. To this list I would add a 6th criterion — relevance.

One may justly argue that we already have ample opportunity for continuing education. Several neurosurgical organizations meet annually and conduct excellent scientific programs that range from 2 to 6 days. But there are at least 2 shortcomings to medical societies providing continuing education at their annual meetings. First, the programs are usually restricted to the members of the particular society and thus denied to the majority of other neurosurgeons. The other and more important reason is that annual meetings do not provide an on-going curriculum, i.e., they lack continuity of learning. What is needed is a high quality opportunity arranged in some practical way suited to the physician's pattern of work, with a long-range, organized, sequential plan of participative learning,

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i.e., a modern curriculum. Continuity is probably best achieved on a local level with well-planned weekly conferences, ward rounds, clinical-correlation basic science presentations, and the regional workshop on specific and needed topics. Continuity could also be effectively maintained by well-designed and available home study course similar to that available for all ophthalmologists.

Proposal for Organizing and Implementing Continuing Education in Neurosurgery

Among the first major steps to consider is the concept of a single continuing education committee to represent all neurosurgery, i.e., a central committee on continuing education in neurosurgery. It is my opinion that one committee should be empowered with the authority to plan, approve, alter, implement, and accredit all continuing education programs in neurosurgery in the United States. It is essential that this committee be truly representative of all neurosurgeons. It will serve the purpose of consolidating and coordinating all aspects of continuing education. It should have a line of communication to other organizations (AMA, ACS, etc.) and this should be through the official spokesman organization for neurosurgery, the American Association of Neurological Surgeons.

Practically all five of the national neurosurgical societies have in one way or another made independent attempts to develop continuing education programs and in some instances there were concerted endeavors to establish liaison committees in continuing education between two or more societies. However, in general, the efforts have been identified with the individual society and conseuqently, there has been no real fusion of effort. Even now, there are at least three and possibly four committees actively and largely independently involved in some aspect of continuing education in neurosurgery. Fortunately, there is a current opinion among many of the individual members of these committees that only through amalgamation into a single committee with appropriate representation from the community of neurosurgery, can we accomplish and develop worthwhile continuing education programs.

I believe that appropriate representation can be achieved by the American Association of Neurological Surgeons and the Congress of Neurological Surgeons taking combined action and forming a joint committee on continuing education in neurosurgery. In the beginning, the size of the committee should be kept relatively small and initially, I would recommend that 5 members be appointed from each organization. Election of officers, term of office, etc., should be decided within the committee, not by the parent organization.

I am aware of the interest of other national neurosurgical societies in continuing education. I would not want anyone to conclude from my recommendations that I am intentionally ignoring the important input from other societies. However, virtually no one in the other national neurosurgical societies is being deprived of representation as most, if not all, of these members belong to either the AANS or Congress, or both, and thus, will be represented on the continuing education committee. The establishment of standards for continuing education programs by this committee will be one of the several important tasks to be accomplished.

The executive director: There is a need for a single executive administrative director of the continuing education programs in neurosurgery. Determining specific educational needs, leading, supervising and coordinating an effective program is best done when this type of responsibility rests with one individual holding and exercising administrative authority. Budgetary support for this individual should come from the two parent societies. Ultimately, as our programs become well established, much of the cost can be covered by tuition and registration fees. Among the responsibilities of the director would be:

1. Determining the specific needs and desires of the profession in a given region for the subjects of courses and other programs.
2. Stimulating the faculty to plan programs well in advance, with stated specific objectives for each program.
3. Making certain that the facilities needed will be available at the time scheduled.
4. Supervising adequate enrollment records in courses.
5. Serving as liaison with local and national medical societies.

Budget: Solid financial support must be available, and in my opinion, should be provided on a 50-50 basis from the Congress of Neurological Surgeons and the American Association of Neurological Surgeons. As the programs become established they will gradually begin to partially support themselves through tuition, etc.

Curriculum: We must provide a curriculum that fills the educational needs of the majority of practicing neurosurgeons. Educational emphasis should be placed on those diseases which are seen most frequently and which result in the greatest disability for the neurosurgical patient population. Methods requiring active participation including live clinics, seminars, workshops and small group activities could be evolved. Also, a practical home study course in neurosurgery should be developed and made available. The curriculum should insure that the appropriate areas of neurosurgery are systematically covered to insure incorporation of new knowledge and skills.

Faculty-Teaching Staff: Faculty will need proper orientation and appropriate guide lines regarding the courses. This indoctrination will be a function of the continuing education committee and the executive director.

Facilities: Regional workshops will play a prominent role in our programs and these can be conducted in a variety of geographic settings including teaching hospitals, large clinics, medical schools, motels adjacent to airports, etc.

Assessment Methods:

1. Self-assessment: This has value but considerable limitations. It may well be that the audit of care to determine true performance may represent a more reliable means of determining educational needs than the self-assessment examination.

2. Professional peer review: The value of PSRO as a means of determining the educational needs of physicians has been overshadowed by other aspects of this system. Standards of care for a specific neurosurgical disorder can be defined. The continuing education committee and faculty could then structure appropriate programs to remedy these educational needs. Some form of protocol evaluation aimed at producing tangible results in terms of improved quality of medical care must be forthcoming on our part. We should determine our own educational needs rather than allow a third party to assume this responsibility.

The AANS subcommittee on self-evaluation, merit award, and recertification, chaired by Dr. Richard DeSaussure, have actively accepted this responsibility as their charge and their findings and recommendations will be extremely valuable in this regard.

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Joint Socio-Economics Committee Recommends Action on Terminology and Medico-Legal Aspects

At its April meetings in St. Louis, the Joint Socio-Economics Committee proposed the following resolutions for consideration by their respective governing bodies, namely, the American Association of Neurological Surgeons, and the Congress of Neurological Surgeons:

1. That the Subcommittee on Terminology and Task Assignment assume continuing responsibility for identifying and evaluating new procedures in neurological surgery, with revision of the Procedural Terminology at regular intervals.

2. That the Socio-Economics Committee request the Boards of Directors of the AANS and the CNS to instruct their representatives and delegates to the AMA to support and implement our recommendation that the section on Nervous System of the third edition of the AMA "CPT" be deleted as soon as possible and replaced by our Procedural Terminology as published.

3. That the Joint Committee request both parent organizations to advise their governors of the ACS to petition for neurosurgical representation on the ACS Committee on Professional Liability.

4. That the AANS arrange overlapping membership between the AANS Committee on Professional Liability and this committee and that minutes be exchanged between the two committees.

5. That State neurosurgical societies be encouraged to form committees on Professional Liability.

6. That all neurosurgeons be encouraged, as a civic duty to appear as witnesses for both plaintiffs and defense in professional liability suits.

7. That the parent neurosurgical organizations support Federal and State efforts to provide comprehensive catastrophic health care coverage and rehabilitation programs.

The above resolutions were approved by the Executive Committee of the Congress of Neurological Surgeons at its meeting in Atlanta, July 12-13, 1974.

The Joint Committee welcomes comments and suggestions from the general neurosurgical community.

Russel H. Patterson, Jr., M.D.
Edwin W. Amyes, M.D. Co-Chairmen

George Ablin, M.D., Liaison Secretary
2828 H St., Bakersfield, California 93301

Presidential Address — *continued*

Summary

1. The continuing education of the neurosurgeon is perhaps the most important problem facing our specialty today.

2. The goals of an effective program in continuing education are to deliver high quality neurosurgical care, provide self-satisfaction in learning, and ultimately, to prepare for some type of recertification process.

3. Neurosurgery should proceed now to move forward aggressively and establish an effective, well-organized continuing education program. The important steps are:

(a) A single, representative national committee charged with responsibility and authority for the management of all continuing education in neurosurgery should be established;

(b) An executive director for our continuing education programs who can assist in developing programs and can coordinate and provide continuity for our nationwide programs should be appointed;

(c) The necessary facilities and budget should be provided by the parent organizations — the AANS and the Congress — for the continuing education committee:

(d) A teaching faculty that will develop and teach the programs should be identified and properly indoctrinated;

(e) A curriculum which places educational emphasis on those diseases which are seen most frequently by the practicing neurosurgeon and which result in greatest disability for the neurosurgical patient population should be developed; and

(f) A practical method for assessment and evaluation of these programs should be evolved.

Effective and useful educational programs are on-going in other specialties such as plastic surgery, ophthalmology and orthopedic surgery. These specialties have taken the necessary steps to provide their membership with ample opportunity to continue their education. It is time the discipline of neurosurgery moved in the same direction.

REFERENCES

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3. Dryer, B. V. Lifetime learning for physicians. *J. Med. Educ.*, 37: 1-134, 1962.