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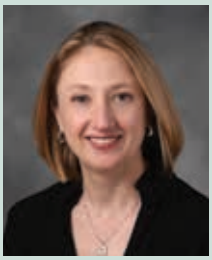
Congress of Neurological Surgeons

EDITOR'S NOTE



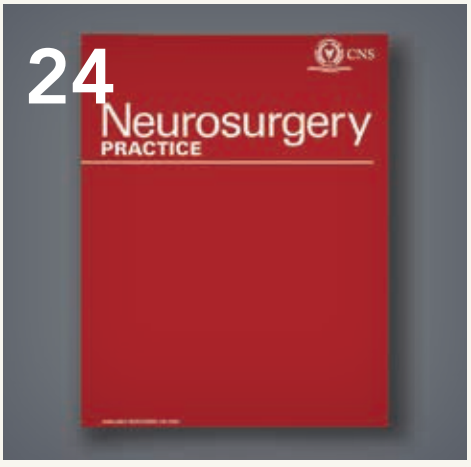
Ellen L. Air
2022-23 Co-Editor

Clemens M. Schirmer
2022-23 Co-Editor

As much as Americans love being the top dog, the United States actually trails Germany, Sweden, Israel, and Austria as the most litigious country in the world (torts per 1,000 population). Never fear, the United States still outstrips everyone else for lawyers per capita! Regardless, every physician feels the weight of the medical-legal environment in their daily practice. Most days, we navigate the mundane aspects: has CMS approved this new procedure? Will insurance pay? How many more hours must I spend documenting to be paid appropriately? The authors in this issue of *Congress Quarterly* help us understand these issues. Laura Ngwenya provides insight into the many ways EMTALA has impacted the provision of Neurosurgical care. We then look at the intersection of clinical expertise and scientific literature with Beverly Walters. Whether it is navigating a simple deposition or being an expert witness, Craig Van der Veer emphasizes being an unbiased reference. Similarly, the synthesis and analysis of literature provided through the guidelines process serves as a similarly unbiased reference for neurosurgeons in navigating their practices.

For those challenging times when a malpractice suit arises, we are fortunate for the expertise of Randall Phillips, Clancey Bounds, and David Ernst. As attorneys who have first-hand experience navigating these from both sides of the courtroom, they provide practical and reassuring advice. The legal perspective is wonderfully balanced by the personal perspective of Benjamin Gelber. All of us, particularly residents and fellows, can learn from the "Anatomy of a Lawsuit" by Gary Gilden and Elias Rizk. Katie Orrico highlights tort reform among the many ways in which the Washington Committee advocates for neurosurgeons on Capitol Hill. We hope this issue serves as a resource for navigating the mundane and not so mundane ways medicine and law intersect.

CONTENTS



PRESIDENT'S MESSAGE

Elad I. Levy, MD
President, Congress of
Neurological Surgeons

It is a great privilege to serve as the 72nd President of the Congress of Neurological Surgeons. With the accelerating rate of biotechnology innovation, we are fortunate to practice in the most innovative specialty in medicine. Given CNS' rich history of cultivating and connecting neurosurgical leaders, we are uniquely poised to serve as a catalyst for continued innovation in the field. As I step into my role as CNS President, I am honored to be working alongside my colleagues in the CNS Executive Committee, so we may continue to serve you and your communities in order to elevate neurosurgical care together.

In my role as president, I continue to reach out and talk with our membership, in order to learn of the challenges unique to community-based practices, hospital employed models, and university/academic practice plans. Increasing administrative and regulatory burdens of practice, changing compensation and reimbursement, workforce shortages, and navigating medicolegal issues are stressors rarely addressed during residency training. The CNS is committed to helping our membership develop nuanced and granular understanding of all these health care challenges through the creation of new member services and novel online educational products. This year we have created a new committee tasked with the sole purpose of identifying challenges and solutions unique to community-based neurosurgeons, doubling our advocacy efforts of our representatives on the Washington Committee.

This issue of *Congress Quarterly* examines the intersection between medicine and law, addressing many of the medicolegal issues affecting your practice. The editors have taken care to include personal perspectives from neurosurgeons as well as legal perspectives from attorneys on both sides of malpractice litigation. Our Senior Vice President of Health Policy and Advocacy, Katie O. Orrico shares an update on recent legislation related to medical liability that will be especially interesting to our members, along with an update on all the activities of the Washington Committee.

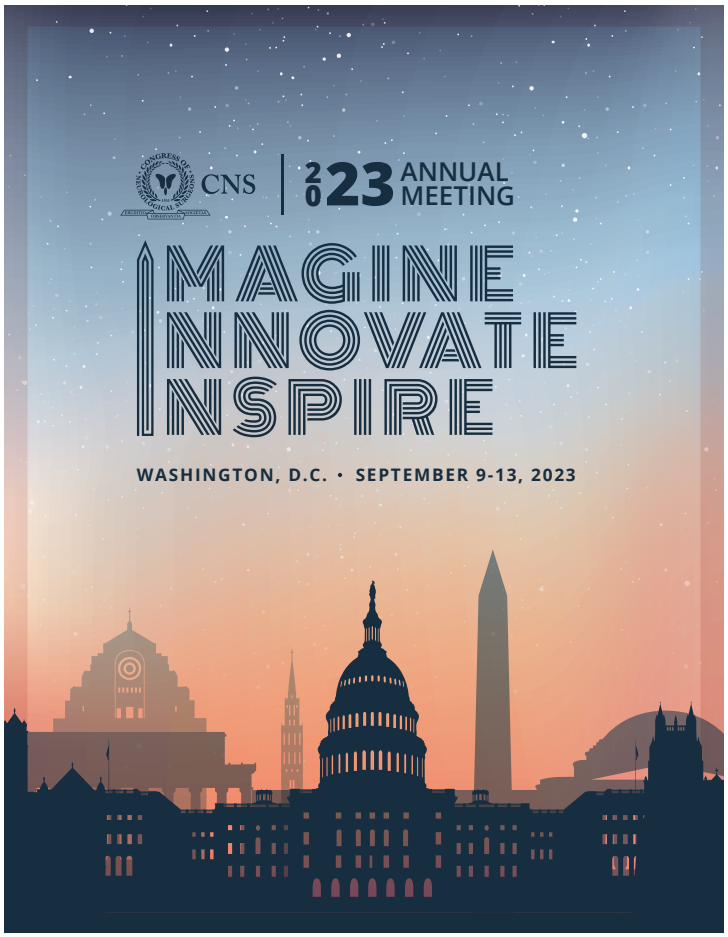
In this issue, we are pleased to feature an update from our new Editor-in-Chief, Douglas Kondziolka on the re-launch of *Neurosurgery Open*, CNS' official open access journal focused primarily on clinical issues. Dr. Kondziolka has demonstrated a passion and unique vision with respect to disseminating medical information through multimedia. He will share the many novel changes that continue to establish Neurosurgery Publications as the premier brand of peer-reviewed neurosurgical literature.

"We continue to be at the forefront of improving approaches to manuscript writing with best practices for information inclusion, and to broadly disseminating our authors, work using digital and print copy, our unique High-Impact Manuscript Service, open access, language translations, and social media. "

– Douglas Kondziolka, Editor in Chief, Neurosurgery Publications.

In 2023, the CNS is launching inaugural innovative lectureships, online platforms, and meeting content—all of which will be detailed in forthcoming issues of the *CNSQ*. I am personally excited to welcome you all this fall to our nation's capital, Washington D.C., for the 2023 CNS Annual Meeting. Our meeting theme, Imagine, Innovate, Inspire – or I3, challenges the way we perceive evolving neurosurgical care, life-long training, and the role of the neurosurgeon in the health care ecosystem.

In keeping with the theme of I3, our featured speakers have challenged convention through imagination and innovation, as well as inspiring global awareness and change transcending geopolitical and industry norms. I want to personally extend you and your family an invitation to join us in Washington next fall, and encourage you to reach out to me (elevy@ubns.com) or the CNS Executive Committee (info@cns.org) to let us know how the CNS can better help you address the challenges in your practice and advance your neurosurgical career. Thank you for being a CNS member, and for your commitment to elevating our specialty.



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Laura B. Ngwenya, MD Sanjit Shah, MD

The Impact of EMTALA on Neurosurgery

The Emergency Medical Treatment and Active Labor Act (EMTALA), passed by Congress in 1986, was a landmark legislation designed to codify protections to patient access to emergency medical treatment. In large part, this law was intended to prevent the transfer of patients from private to public hospitals based on insurance status, a common practice known as "dumping." The law is enforced by the Centers for Medicare and Medicaid Services (CMS), and while provisions in the law allow for punitive actions to be taken against hospitals that fail to adhere to its requirements, this has been uncommon in practice. With the recent strain on health systems due to the SARS-Cov-2 (COVID) pandemic, it is essential to review the impact of laws such as EMTALA on the practice of Neurosurgery and medicine as a whole.

Evaluating EMTALA requires an understanding of its core provisions. To be compliant with the law, hospitals treating a potentially unstable patient must adhere to the following regulations, regardless of payor status or socioeconomic background:[1,2]

- Provide an adequate medical screening examination (MSE) to include or exclude an emergency medical condition (EMC).
- Stabilize the patient's EMC(s) medically to the best of the hospital's capabilities to the point where their condition will not decline upon transfer.
- Provide timely consultation, treatment, and hospitalization for the EMC(s) within the capacity of the treating hospital and medical staff by maintaining a list of on-call physicians.
- Transfer patients to a facility providing a higher level of care if necessitated by the EMC(s) and if the benefits outweigh the risks. If the receiving hospital has specialized capabilities greater than the referring hospital, they must accept all patients for transfer unless there is no physical space in the hospital or necessary equipment is not functioning.
- Report known violations by hospitals and physicians for noncompliance with the legislation.

Responsibility for adhering to the law falls on both the facility at which the patient is initially evaluated and the receiving or consulting facility. As both the individual physician and the hospital system can be penalized for EMTALA violations, all caregivers have a vested interest in ensuring these criteria are met.

In practice, EMTALA has largely achieved its major aim. Data published around the time of passage of the legislation in 1986 noted that uninsured patients were more likely to be transferred to a public hospital in unstable condition and were 300% more likely to die than non-transferred similar patients in a public hospital.[3–5] After passage of EMTALA, adequate MSE's to stabilize EMCs has become standard of care, and only rarely are hospitals found to be in violation. Of 6,316 complaints made under the law between 2004-2015, only 2,436 violations were found and only 192 settlements made public by the Office of the Inspector General (OIG) for the Department of Health and Humans Services (HHS).[6] In fact, McKenna and colleagues reported a sharp decline in violations from the law's passage to the early 2000s, and even noted settled violations declined 87% between 2002 and 2015.[7] During the COVID pandemic, EMTALA was amended to allow facilities to triage more effectively and implement telemedicine to improve triage and treatment for a heavily taxed healthcare system.[8] In particular, the CMS waived the need for on-site medical screening, allowing for off-site MSEs to be completed by appropriate medical personnel for quicker triage. In addition, the administration allowed for waivers to forgo the requirement precluding transfer of an unstable patient, provided that the transfer was medically necessary and did not account for insurance status or demographic background.[9] These changes facilitated better triage of medical conditions requiring ED evaluation or inpatient admission, and helped to offload the pandemic burden on hospitals. Most importantly, in keeping with the initial spirit of the law, insurance status has been eliminated as a primary reason for transfer, as multiple recent studies have demonstrated no difference among insurance types between ED and inpatient transfers.[10,11]

Despite EMTALA's achievements in preventing inappropriate transfers of patients based on insurance or socioeconomics without MSEs, it has also faced criticism on several fronts. A major concern is that the law reduced the availability of consulting services. One study noted that only 12.4% of ED providers rated the on-call availability of neurosurgeons to be improved over a three-year period from 2003 to 2006, while 28.9% suggested it was worse. In addition, 47.4% of ED providers rated the ability to transfer to a higher level of care for neurosurgical issues had worsened, in contrast to the 8.4% who felt it had improved.[3] This same survey of California ED medical directors noted that for neurosurgical transfers, 37% of higher level of care transfers were delayed more than three hours to find an accepting medical facility and 41% of the transfers were reported to have complications from these delays in transfer.[3] While these numbers reflect a California statewide survey of ED directors and not

national hospital or insurance data on transfers, they echo a common sentiment expressed by physicians with regards to EMTALA. In fact, there has been a trend for neurosurgeons and other specialists at non-tertiary care centers to significantly decrease ED availability secondary to EMTALA provisions, decreased compensation, and increased liability.[12] It is worth noting that while actual numerical data for this phenomenon is not readily available, a survey by the California Medical Association indicated that 40% of specialists had curtailed ED coverage due to increased liability associated with EMTALA, and the four most commonly reported shortages of on-call specialties included neurosurgeons.[12] The limited data suggest that neurosurgeons, similar to many other specialists, have curtailed call availability as it is fraught with liability, but often little to no compensation.[3,12] Another shortcoming of EMTALA is the strain it places on tertiary care centers, in particular level 1 trauma facilities. One study found that almost 20% of hospital admissions were due to EMTALA transfers, with the majority of the patients transferred for complex, nonoperative trauma and neurosurgical care or for orthopedic injuries.[10] Kuhn and colleagues showed that nearly 20% of neurosurgical transfers did not require further neurosurgical diagnostic testing, intervention or intensive monitoring, and roughly 23% of patients were transferred out of the ICU within 24 hours of transfer, suggesting inappropriate triage.[13] Indeed, an estimated 8-10% of these patients are believed to have had an inaccurate diagnosis at transfer.[13,14] The combination of high patient load, high level of care, and inaccurate diagnosis places tremendous strain on neurosurgeons at tertiary centers and inappropriately sequesters resources otherwise necessary for other admitted patients.

Evaluation and stabilization of neurosurgical patients is certainly not straightforward, nor should its complexity be underestimated. However, as noted above, the provisions put forth by EMTALA and subsequent modifications to the law have seen a tendency for neurosurgeons to decrease call availability outside of tertiary centers, led to inappropriate transfers, and stressed an already fatigued health care system. We previously reported that over the period from 2002-2015, the OIG only settled four cases involving neurosurgical patients, each with a fairly blatant breach of accepted medical standards of care, suggesting that neurosurgeon liability for accepting patients under EMTALA may be greatly exaggerated.[1] Nonetheless, the trend towards limited call availability by many neurosurgeons suggests that the complex nature of neurotrauma, the possibility for imminent decline of the patient, and the perceived risk of liability due to EMTALA are ongoing factors. Improved electronic medical records (EMR) and availability of better communication with referring facilities may help to reduce unnecessary transfers, as inaccurate diagnoses may be a result of poor communication between the two parties.[11] Additionally, the integration of telemedicine provides an opportunity to perform an appropriate MSE for neurosurgical patients without requiring transfer, freeing up hospital resources to be allocated more appropriately. Dario and colleagues implemented a telemedicine protocol to provide neurotrauma care to surrounding hospitals, and found that 72% of neurosurgeons responded within one hour of consultation and that interfacility transfers reduced by 84%.[15] Other studies have demonstrated similar reductions in transfers, with one network reported nearly $4.2 million in saved costs over a 14-year study period. We previously proposed a framework for the adoption of telemedicine within neurosurgery, which offers an inroad to reduce unnecessary neurotrauma transfers.[1] In addition to the utilization of EMR and telemedicine, education of both neurosurgeons and community providers at large can help to facilitate more appropriate transfers, as physician comfort with managing neurosurgical issues is often limited. Educating physicians on EMTALA and the impact it has on neurosurgical care is also of paramount importance.

EMTALA dramatically altered medical practice in the U.S. by offering protection of access to emergency medical services to all patients. It has been largely effective in achieving its goals, but has also provided new challenges, particularly for neurosurgeons. Neurosurgical call availability has decreased due to increased liability associated with EMTALA, among other factors, and transfers place a large burden on accepting tertiary facilities, especially in the context of inaccurate diagnosis. Despite exceedingly rare punitive action taken by OIG for EMTALA violations for neurosurgical care, this trend to opt out of on-call responsibility at community hospitals has persisted because of concerns for physician liability. One possible avenue for alleviating the burden of EMTALA in the modern medical climate is to increase telemedicine to allow for more appropriate MSE prior to transfer. Coupled with advances in EMR, this could drastically alter transfer patterns, more appropriately delegate hospital resources, and reduce costs across healthcare systems. Ultimately, educating neurosurgeons on EMTALA, its challenges, and opportunities for improvement is required to address some of its pitfalls.

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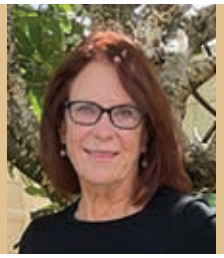

Beverly C. Walters, MD, MSc, FRCSC

How Neurosurgical Specialty Guidelines Can Impact Legal Procedures

The development of the Practice Guideline movement within neurosurgery occurred over the end of the twentieth century, progressing from the overall interest in evidence that supported the chosen methods of treatment for patients in all the subspecialties. Having originally begun the 1990s, the guidelines effort eventually evolved into the Joint Guidelines Review Committee (JGRC). This was established in 2008 with the primary charge to "evaluate clinical practice guidelines of potential relevance to neurosurgical practice" (JGRC governance). The JGRC is a standing committee of the Washington Committee, representing both the Congress of Neurological Surgeons (CNS) and the American Association of Neurological Surgeons (AANS). It serves the essential role of review and endorsement of all neurosurgical-related guidelines, whether developed by CNS or another organization.

In 2012, the CNS further developed the extensive infrastructure for the development and dissemination of high-quality clinical practice guidelines to help clinicians confront a rapidly changing healthcare environment and improve patient outcomes. Guidelines developed by the CNS Guidelines Committee and its associated subcommittees and work groups and are reviewed and endorsed by the Joint Guidelines Review Committee, representing both the CNS and the AANS.

One of the key purposes of the creation of guidelines was to gather and critically appraise the literature dealing with particular treatments for various clinical problems. With the increasing number of publications, guideline development provided help to practicing as well as in-training neurosurgeons to gather the literature and combine and summarize it in one place, thus getting to know the "bottom line" and to evaluate it for accuracy and utility. As the literature began to grow in numbers of publications, it also began to become more scientific—a challenging direction requiring knowledge about how to achieve strength with various clinical research approaches. Through the development of methodology that was adopted by the neurosurgical organizations, a clearer understanding of what was known as "evidence" and hands-on application of this in practicing "evidence-based" medicine was aimed for.

Understanding the concept of evidence in providing health care to patients included not only the scientific data that is examined in studies of various kinds, but also the interpretation and evaluation of available literature by clinical experts such as neurosurgeons and other clinicians for specific application for utility in patient care.

The value of the guidelines as the center of providing care that is based, as much as possible, upon scientific evidence can become central to their worth in providing legal evidence in establishment of factual claims. But even prior to the development of organized guideline practice recommendations in neurosurgery, there was the use of scientific evidence in legal actions regarding neurosurgical practice. The largest example of this is a late-nineties class-action case series centered around the use of the pedicle screw fixation apparatus.

First of all, let's explore the Federal Court setting and how it was being used in this potentially horrendous medical practice class action lawsuit. Imagine a well-known federal judge whose ability to listen fairly let us know that both sides had his ear. Secondly, there were many lawyers representing the plaintiffs, as well as the defendants, but each side of the court case had a single attorney involved directly in the proceedings during the court action. Significantly, the defendants had professional clinical epidemiologists (one of whom was also a neurosurgeon) with academic attachments, both at well-known and high ranked northeastern universities. Both of these experts in clinical research design had, as well, significant amounts of experiences in legal testimony as experts. Of equal interest, the lead attorney for the plaintiffs had become exceedingly knowledgeable about the generation of evidence being used in clinical decision-making within patient care. Therefore, the questions posed to those clinical epidemiologists testifying in support of practicing neurosurgeons were asked at a very careful level of depth regarding the carrying out of research. Before that, it's important to understand the conceptual differences between science and law regarding the meaning of "evidence".

In court, evidence is the information gathered and presented to build support for each side. Expert testimony is just one form of evidence in the legal scenario. It is the expression of well-known information in the witness's area of expertise, generally from the

> THE CONCEPT OF EVIDENCE IN LEGAL SCENARIOS IS FACTUAL INFORMATION SUCH AS FINGER PRINTS, DNA,...OR DOCUMENTS WITH PRINTED DATA. THEREFORE, PRACTICE GUIDELINES, CREATED FROM SPECIFIED DATA GATHERED IN MANY DIFFERENT WAYS QUALIFY AS EVIDENCE, THUS CREATING THE CONCEPT OF EVIDENCE-BASED PRACTICE. <

individual's experience and given in opinion format. The concept of evidence in legal scenarios also includes factual information such as fingerprints, DNA, blood on clothing, possession of weapons, etc., in person-harming cases, or documents with printed data, most commonly, supporting claims or charges in corporate lawsuits, for example. Therefore, practice guidelines, created from specified data gathered in many different ways --from published reports of studies from randomized controlled trials to case series -- also qualify as evidence, thus creating the concept of evidence-based practice However, there are points of clinical decision-making with individual or small numbers of patients that are not covered by guidelines, and, most likely, never will be. Therefore, that is why the supported concept of clinical skill is still unavoidable and important in certain circumstances, though avoiding such basic psychological traits like intuition.

In our neurosurgical pedicle fixation scenario, the clinical epidemiologists provided academic knowledge that helped to define how neurosurgeons continue to use treatments, including pedicle screw fixation systems, as part of clinically appropriate care. As the importance of needing (but lacking) high quality data-driven substantiation for their use became the key discussion stimulated by those against the uses of such device, an in-court exploration of scientific evidence became a turning point. The various details that were approached, discussed, decided upon, and then applied in any sort of clinical trials that always begin testing the appropriateness of clinical usage were explored in detail, such as in a senior classroom on the subject. Not only were the attorneys for both sides the learners in the situation created, but also the judge was quite willingly in this role. What this provided was suitable support for the defense's case, and was utilized in the judge's decision-making, fortunately. As a side point of potential interest, when the clinical epidemiologists were asked by the plaintiffs' representative how much they were being paid for providing their expressed knowledge, the academic leader in the field stated the amount, whereas the clinical epidemiologist who was also a neurosurgeon stated that there was no payment for the testimony, thus shocking the court. When asked why no compensation or fee was required, the double-certified witness stated that it was in the interest of supporting, not only colleagues in the specialty, but of patients needing help from the surgeons that could include procedures mostly of benefit to them.

The experience that organized neurosurgery had in this court challenge underscored the necessity of two other aspects of neurosurgical practice. First, the necessity of carrying out practice guideline development continuously was clear. Secondly, the necessary obligation to undertake more clinical research to validate and warrant the treatment in question, especially in, where possible, the highest levels demonstrating patient benefit. The current situation in societal and legal behavior provides continued drive to achieve these goals. The CNS is committed to maintaining the infrastructure to develop guidelines into the future. <

Craig Van Der Veer, MD

How to be a Responsible Expert Witness

I have had the privilege to practice in Charlotte at Carolinas Neurosurgery and Spine Associates for 35 years. During that time, I have performed a considerable amount of medical legal work for local hospital networks as the Chief of Staff and Chairman of the Department of Neurosurgery, as well as for the AANS Professional Conduct Committee and the ABNS Credentials Committee. I've run a medical legal business for the past 25 years as VDV Neurosurgical Consulting, mainly defending colleagues, but occasionally evaluating plaintiff cases when I feel that the physician has committed clear malpractice. I have also reviewed neurosurgical practices for hospitals.

Midway through my practice career, a medical malpractice attorney asked me if I usually testified for the plaintiff or the defense. I answered, "Neither." He looked a bit puzzled as I continued, "I am here to give unbiased neurosurgical information and opinion, which can be used by either side." In retrospect, I liked the answer and used it as a guide throughout my interactions with the legal profession. It captures the essence of a neurosurgeon's responsibility to the community and profession.

If you are considering being a medical legal expert witness, you must always remember that your words and actions will profoundly impact your colleagues, their medical liability carrier, their state license, their hospital, their patients, and especially your reputation. If you take on this expert witness mantle as a path to an easy payday, you will shame yourself and cheat each of the aforementioned groups.

So, when in your career are you truly ready to be considered an expert witness? Board certification is obviously not enough. True expertise requires time to experience the nuances that a wide range of patient experiences brings. Superb training along with board certification and 10 years of experience in practice puts the "expert" into the term "expert witness".

In my experience with the medical legal process, you can count on several phases in each episode of providing expert witness: engagement, medical records review, situational review, deposition and testimony.

Engagement

In requesting your services as an expert witness, a law firm will contact you to request your review of the patient's medical chart. You will need to present them with your CV, a W9 form for tax purposes, a contract for the review including your hourly rate for records review, and your rates for deposition, paperwork, and testimony. This is simply an agreement for a review of records, usually based on a set fee for initial review, which can be applied against your hourly rate. It does not obligate you to provide trial testimony. This is an opportunity to review medical information and see if you think the case is within or outside the standard of care in that community. If you cannot defend the medical or surgical care, then advocate for a settlement. Neither the defense nor the plaintiff desires proceeding with a bad case. It will burden both with significant debt without the promise of a return. In my experience, a thorough review, more often than not, negates the progression of a lawsuit if you feel it falls within the standard of care. On initial review, a written opinion may or may not be requested.

Record review

Once engaged, request all pertinent medical and legal records including prior related issues, both medical and surgical, and digital copies of all radiographs, both prior to care and the index images of the care at issue. I strongly suggest you personally review all images and include in the review your reading of the images, especially if you disagree with the official reading in the medical record. You will be asked to opine on the selection of medical care offered, and especially the selection of surgical options. It is of critical importance that the review be from the viewpoint of "what a reasonable neurosurgeon would do," not necessarily how you personally do it. It must reflect care contemporary with the incident.

Timeline

During the record review, it is helpful to develop a timeline inserting all pertinent medical information laid out both before and after the index event, the exam pre-and post-operatively, pre-operative

testing, and details of the operation and care. Include the timing and dates of post-operative exams, opinions, and radiographs through recovery. In depositions and testimony, having a timeline to refer to is an excellent source of information and keeps you from being impeached regarding dates and times. Fumbling around with a pile of 500-page notebooks during deposition and trial, looking for the critical date of postoperative MRI or EMG will make you look confused and uncertain. With your trusty timeline, you will look thorough and in control.

Situational review

This is a review of the delivery of care in the geographical area of the incident, and should include the size of the hospital, local physician call arrangements, and the use of physician extenders. It may require you to make inquiries into the hospital capabilities, the physician training, and the physician's familiarity with the pathology involved. If you have spent your training and practice in a level one trauma center with helicopters on the roof and a wide-ranging medical staff, that does not translate well into testimony regarding a single neurosurgeon practicing at a 250-bed local hospital with no backup. Research the hospital size, the number of admissions, the number of MDs on staff, the call situation, and whether call is shared with partners or competitors. Knowing the number of similar cases per year and staffing levels is also useful.

Deposition

The deposition is a record of your opinions on the case, which you will expound upon during trial. It will be used to try to impeach your trial testimony, so answers should be short, concise, straightforward, and factual. Do not try to impress the legal profession with the breadth of your considerable knowledge or convince the opposition of the errors of their ways. You are not there to do the oppositions work for them, but you are required to give them full access of your knowledge. In a deposition, use your timeline liberally, take your time to formulate cogent answers and do not hesitate to admit their question may be outside the area of your expertise.

In scheduling a deposition, ask the attorney how much time will be required and have them pay your hourly fee prior to scheduling the deposition. Depositions are frequently used as leverage for settlement of the case prior to trial, and may be canceled at the last moment, leaving you with two to four hours of empty time. You may want to develop your own policy for depositions canceled within a week and the amount of the deposition cost you retain. This should be included in your retention contract.

When doing routine depositions on your own patients for insurance or disability, do not take the offer to auto-sign the documents. Instead have it sent to you for correction and signature and read every word. You'll be amazed how inarticulate you may sound in the official record. It is an opportunity to become much more precise in your communications, replacing "yeah" with "correct" or "no".

Trial testimony

When called to testify in court, maintain respectful dress and posture and a professional attitude. Casual conversations with the bailiff and staff are fine, but joking banter is not useful to the jury or the litigants and will undermine your credibility. The attorneys will ask you questions, but make sure that you address your answers to the jury, as they are the ones deciding the veracity of your opinions. Do not try to impress them with medical jargon or Latin. It is a real art form to make the complex issues we deal with in our professional lives easy to understand for someone with a high school education. Try to be courteous to both the plaintiff and the defense, even when one or the other is trying to get you off your mark, fluster you, or make you angry. Always remember you are there to provide unbiased medical information, so maintain your equanimity, and smile.

In summary, remember these key ideals:

1) You represent an unbiased source of medical information in your area of expertise, useful to both the plaintiff and the defense
2) You are not there to take sides in the dispute.
3) You are there to explain what a well-trained and reasonable neurosurgeon would do in that situation. If there are alternatives to treatment that differ from your normal practice routine, that does not represent the failure of the standard of care. You are to present options and give reasons for each option.
4) You must know the social and practice situations present at the time of the incident and the implications for care contemporary to the incident, not the trial.
5) You must treat the situation with the respect it deserves. You represent your specialty to both the medical legal community and the community at large.
6) You know more medicine and neurosurgery then they do. Make sure you also know as much about the case.
7) Do us proud.

Randall J. Phillips J. Clancey Bounds

Neurosurgical Malpractice Claims: Perspective from the Plaintiff Attorney

Know Thy Enemy

Some variation of the oft-quoted advice to know one's enemy has been attributed to Napoleon for 200 years, and for longer and more properly to Sun Tzu's *The Art of War*. There is no shortage of articles analyzing malpractice claims, nor is there a scarcity of risk management bulletins offering tips on how to avoid them. Most, if not all, of those resources are authored by risk management professionals, health care providers, law school professors, or defense attorneys. The goal of this article is to share some observations and insights from the other side, based on nearly 60 years of combined experience representing patients and their families in medical negligence cases.

In writing this article, we analyzed what trial lawyers look at and how we come to conclusions regarding case acceptance or rejection. We asked these questions: Where are the weak links in the chain of the provision of care that result in significant injuries and the oft-resulting litigation? Where do physicians and health care providers routinely fail to act, leading to injuries? What are the actions and inactions of health care providers that are difficult to defend in the context of a lawsuit? While different lawyers can have different criteria for accepting a case and moving forward with it, those criteria are universally met when certain factual scenarios unfold in patient care.

The Weak Links

The majority of claims brought in cases involve a failure of communication. Those failures are of two general types. The first is communication with patients and their families. The second is failure of communication among the health care providers themselves leading to patient injuries.

Patient Communication Is Key

Two recent articles that examined neurosurgery malpractice claims emphasized the importance of communication and the frequency with which it was found to be a factor in these types of claims. Larkin, et al., suggest that among the primary motivations for filing medical malpractice suits, "seeking an explanation for the adverse outcome" was more important than both holding the provider accountable and financial reward.[1] Similarly, in a closed claim analysis by The Doctors Company of more than 300 neurosurgery malpractice claims, the authors concluded that communication with patients and with other providers was among the most frequent and important factors across all case types.[2]

Our experience is similar. The most common reason cited by clients for seeking legal help is that they are looking for answers after an adverse outcome. It is not revenge. It is not financial gain. It is simply looking for an explanation that was not given by their surgeon or other providers. Patients and their families are not motivated to seek out legal counsel for financial gain or reward. Patients who do not get answers from their surgeon may resort to internet research to try to satisfy this need, but most will turn to experienced medical malpractice counsel for answers.

It is the exception rather than the rule, that patients or loved ones turn to counsel motivated by money. In addition to the desire for answers, many seek to prevent another patient from experiencing the same outcome, or to change policy or procedure. This is consistent with Larkin, et al's accountability motivation. Those patients who are motivated by money to contact a lawyer often seem to have the weakest liability claims coupled with the least amount of damages, and therefore are unlikely to have their cases accepted by experienced medical malpractice counsel. It is a giant red flag to counsel if a potential plaintiff raises the subject of money in the early stages of investigation, and most who do this work recognize it as such. Money does become a factor, however, when the nature of the injuries require significant ongoing care and there is no health insurance coverage or other source of payment.

Communication builds trust with patients and clients alike. Patients who trust and have good communication with their surgeons are far less likely to seek counsel after a bad outcome, particularly if the possibility was explained during the informed consent process. This has been studied and proven beginning with the University of Michigan's "Sorry Works" program, now called the Michigan Model[3], and more recently with the Agency for Healthcare Research and Quality's CANDOR program[4].

There do not appear to be strong correlations along perceived lines of political leaning, race, age or socio-economic status when it comes to motivation to seek counsel, and certainly not enough to outweigh the communication issue as a motivating factor. Some of the most motivated lawyer-seeking patients start out their first consultation with, "I've never sued anyone, but… wait until you hear what happened to me."

Poor Communication Between Health Care Providers

According to the Risk Management Foundation of the Harvard Medical Institutions, communication failures in U.S. hospitals and medical practices were responsible, at least in part, for 30% of all malpractice claims, which themselves resulted in 1,744 deaths and $1.7 billion in malpractice costs, over a five-year period.[5] A study conducted by the Joint Commission found that 80% of serious medical errors were the result of miscommunication between caregivers during patient handovers.[6] Those patient handovers included nurse-to-physician, physician-to-physician, physician-to-nurse, nurse-to-nurse, and so on.

This experience has been shown to be universal. In 2016 CRICO issued a press release on a study it performed which demonstrated that thirty percent of all claims for medical malpractice involved a communication failure. The claims-made analysis demonstrated communication breakdowns where facts, figures, or findings got lost between the individuals who had the information and those that needed it.[7]

Communication errors account for greater than 50% of the cases analyzed and accepted by the authors over the past five years. The most common communication errors in our accepted cases were miscommunications of important information concerning the patient's condition, symptoms and lab work. Often a major component was a lack of documentation that the patient's information had been communicated to the provider who was in need of it. Telltale, also, was a lack of action taken upon the information allegedly communicated.

Lack of communication cases are very hard to defend for care providers. The following is taken from an actual neurosurgical case, recently resolved, that involved a lack of communication between the physician extender and the neurosurgeon.

A post-laminectomy patient became significantly hypotensive within hours of the surgery. The surgeon had not consulted a hospitalist and thus remained responsible for the patient care while the patient was admitted. The nurses alerted the physician assistant of the hypotension several times throughout the day shift. There was no documentation that the physician assistant informed the attending neurological surgeon of the change in condition and the physician assistant took no action other than to order fluids and take a wait and see approach. The patient expired from hypovolemic shock later in the evening. There were no notes that the physician assistant notified the surgeon, though the PA testified that a notification had been made. The surgeon testified that he had not been informed of the change. The case was resolved, without protracted litigation, for the policy limits of the surgeon, the physician assistant, and the group.

This matter and its outcome were all about a lack of communication. The nurses met their duty, but the PA and surgeon did not.[8] In the state where the case took place, the surgeon was liable as a matter of law for his assistant's negligence, as he chose to use an extender for patient care. Further, the surgeon violated the physician bylaws of the hospital when he did not personally see his patient in the post-operative period.

The lessons to be drawn from the data and experiences noted is to communicate: communicate with your patient and his or her family, and communicate with the nurses, physician extenders and care providers about your patient. When information does not flow, patient care is affected. When the effect of a lack of communication is an injury, potential litigation is not far behind.

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David D. Ernst

You've been sued, Now What?: A Defense Attorney's Perspective

When a medical malpractice lawsuit is filed, a summons may be legally served on a physician defendant in one of several ways:

- Personal service by a constable or other authorized process server;
- Certified or registered mail;
- By leaving it at a defendant's last known residential or work address; or
- Through publication in a legal periodical.

Assuming this summons is timely served, it generally does not make any difference how it was served. However, the way a defendant physician reacts to receiving this unwanted and unfortunate news may be vital to the defensibility of the case. With this warning as a backdrop, this article reviews the dos and don'ts for a defendant physician who has been served with a summons for a medical malpractice lawsuit.

Rule #1: Talk with a lawyer, but not to others if the conversation is not protected.

No spoiler alert needed here. It should be intuitive for a physician being served with summons to talk with a lawyer first, but that is not always what happens. Often, the shock of being sued for medical malpractice produces strong emotions, which may cloud an individual's judgment and lead to inadvisable, if not catastrophic, decisions, such as (1) opening up the chart and adding additional information; (2) picking up the phone and calling a physician codefendant to discuss the case; (3) contacting the patient's lawyer to try talking sense into them; (4) accessing UpToDate to see if you ordered the right test or made the correct diagnosis; or (5) any of a myriad of other things that you absolutely *should not* do without first discussing the matter with your lawyer.

But why is contacting a lawyer the very first thing that you should do in this circumstance? The answer is plain and simple: the *attorney-client privilege*. Once you are meeting with your lawyer or talking with him or her over the phone, everything you say is protected by the attorney-client privilege and cannot be disclosed by your attorney, unless you agree to disclose it because it is helpful in defending your actions in the matter. By talking with your attorney first, you not only have a safe space to vent your doubts and anxieties about the treatment you provided for this patient, but you can also learn immediately all of the dos and don'ts of being a defendant in a medical malpractice lawsuit.

Another compelling reason to contact your attorney first is to help reduce the stress and anxiety that goes hand in hand with the fear of the unknown. Your attorney will be able to explain to you the entire litigation process, the use of interrogatories and requests for production of documents to gather information, the taking and giving of depositions, and what your personal involvement will be in each phase of the lawsuit. Your attorney will be able to provide you with a reasonable estimate of the timetable to expect in terms of the discovery process, pretrial preparations, and trial itself, and he or she can help you understand the different possible outcomes of this litigation.

Importantly, your attorney can and should assure you that this litigation will eventually come to an end, and that being sued in a civil lawsuit will not, in and of itself, have any impact on your professional license to practice medicine. Doctors do not lose their medical licenses just because a medical malpractice lawsuit was filed against them, even if that lawsuit should result in an adverse decision. If a separate license action is filed against you by the patient or someone acting on his or her behalf, then your insurance carrier will retain a lawyer to represent you in connection with the license action, who may or may not be your malpractice attorney.

Also importantly, if you meet with your attorney before doing anything else in this matter, once he or she explains the process and eliminates or dramatically reduces the fear of the unknown for you, your attorney will likely advise you to try to compartmentalize this litigation, to put it up "on a shelf" in between events which require your attention and assistance. Lawsuits move along in fits and starts, and there are often long periods of inactivity between events, such as answering interrogatories, preparing for your deposition, and if applicable, preparing for trial itself. It is best to try to keep the lawsuit in a compartment and only open it up on the several occasions when you are required to do so.

> WHILE AT THE BEGINNING (OF LITIGATION) IT MAY SEEM AS IF YOU ARE IN A LONG, DARK TUNNEL, THERE IS INDEED A LIGHT AT THE END. <

Rule #2: Get the support you need.

A physician's first lawsuit as a defendant often brings up one or more different emotions, including sadness, anger, fear, guilt, shame, and, often, the feeling of being very much alone. Many malpractice insurance carriers have resources available to help you deal with these feelings and emotions, often another physician who has been through a similar experience. If available, you should not hesitate to take advantage of this resource, as it may help you cope with the mixed bag of emotions you are facing. Additionally, you may feel free to discuss the lawsuit with your spouse or with clergy, as these types of communications are protected by laws of spousal and clergy immunity.*

Rule #3: Cooperate with Defense Counsel.

While it may seem obvious to recommend cooperation with defense counsel, this author has experienced a wide variance of degrees of cooperation by represented physicians over the years. While, as stated above, it is best to try to compartmentalize the litigation and not obsess over it on a daily basis, when your assistance is requested by your attorney, it is imperative that you provide your full cooperation and assistance. There will be certain deadlines associated with the discovery proceedings in your case, and your attorney will need timely input responding to written discovery requests, such as interrogatories and requests for production of documents, and the scheduling of depositions.

Your deposition in the malpractice litigation will be one of the most important events in terms of your own ability to impact the defensibility of your case. It is vitally important that you be well prepared for your deposition, and your attorney will likely want to meet with you at least once or twice in advance of your deposition in order to prepare. Your attorney will have some important suggestions on how to conduct yourself during your deposition and will likely want to engage in some mock deposition questioning to help get you battle-tested for the deposition event. Even if you have been through numerous depositions in the past, you should indulge your attorney and give them whatever time and assistance they need to prepare you for your deposition.

If the case proceeds to trial, you should plan to be present for the entire trial, and not just on the day you testify. It will be important for the jury to believe you are fully invested in the outcome of the action, and since they will have to be present for the entire trial, they will not like it if you are not also there for the entirety of the proceedings. If this will create a severe hardship on your practice, you should discuss this with your assigned counsel at the earliest opportunity.

Rule #4: Trust the Process.

The worlds that doctors and attorneys operate in are vastly different from one another. The operating room is a far different milieu than the courtroom. The languages we speak are foreign to each other. Just as patients must have trust and faith in their surgeons before undergoing an operation, defendants in a medical malpractice lawsuit must have faith and trust in their trial lawyer. Each has been chosen because of their expertise. If your lawyer is an experienced medical malpractice defense attorney, he or she will explain to you that the litigation process is fair and that in the main it works extremely well, but it takes time and much patience. In most cases, you will be far better off having your case decided by a jury of 12 lay persons than by a single judge or a panel of your true medical peers.

Epilogue

Being a defendant in a medical malpractice action can be far from pleasant, and the first time a physician is sued for malpractice is a jarring, emotional event. However, by becoming familiar with the litigation process and engaging in healthy discussion with your assigned defense counsel, a great deal of anxiety and fear can be reduced, if not completely eliminated. While at the beginning it may seem as if you are in a long, dark tunnel, there is indeed light at the end. In the vast majority of cases, the right outcome will ultimately be achieved, and you will be able to move on in your practice a bit wiser and more experienced in the realm of medical malpractice litigation. <

* ***Editor's note:*** *Laws may vary by state. Individuals should consult their attorney for specific laws pertaining to their case.*

Benjamin R. Gelber, MD

Lessons Learned from my Experience with a Medical Malpractice Suit

You have just been served with notice of a malpractice suit against you. Thoughts race across your mind. "They shouldn't be suing me, after all I did to help the patient!" You're angry because you're accused of being the worst doctor ever. You doubt yourself and think 'Am I really as negligent as they claim?' Or you worry that any negative publicity will hurt your practice.

My advice is to replace those thoughts with these:

- The suspense is over. You suspected that patient was going to sue you.
- You never have to see the patient again, as they have severed the doctor-patient relationship.
- Now the patient and the family are the plaintiff's attorney's problem, not yours.

Malpractice cases are civil suits and, unlike criminal cases, they are about settling disputes, not about justice. They are also about money. In days gone by, disputes might have been settled by trial by ordeal or by duels. We now, hopefully, are more civilized and less violent. Although your adversary may claim that the motivation for the suit is to 'teach the doctor a lesson," don't believe it. The suit is about money. Sometimes the patient's need for money is real, such as an accident victim with a spinal cord injury who needs expensive long-term care. Many times, it is about greed. The plaintiff's attorney needs to earn a living and is paid a percentage of the client's award and therefore needs to obtain an award large enough to cover expenses and compensation for time spent. The malpractice carrier wants to pay out as little as possible. You want the suit to go away quickly with no economic loss. The defense attorneys have it best. They are paid by the hour, win or lose. Your self-esteem is irrelevant. No one cares about your ego except you. There is no money involved there.

It is helpful to talk about your feelings and concerns about the lawsuit. This will help put the situation into proper perspective, but be careful. The plaintiff's attorney will ask you with whom you have discussed the case and might call that person as a witness. You can safely talk to your spouse, your attorney (covered by attorney/client privilege), or a mental health professional (covered by patient/physician privilege)*. Some medical societies have programs to help support their members. Don't hesitate to ask for help and support.

You may worry about getting an entry in the national physician data bank. The data bank is usually not consulted unless you move. But even if your entries are reviewed, I believe most potential employers or partners know that malpractice experience is not an accurate measure of quality. Neurosurgeons are second only to obstetrician-gynecologists for frequency of lawsuits. If lawsuits correlated with quality, then we would have to conclude that the dumbest, least motivated and least competent doctors chose neurosurgery as a career. That is obviously not true.

One of the first things you will read after being served are the pleadings which lay out in painful detail the grounds for the suit. DO NOT TAKE THESE PERSONALLY! The plaintiff's attorney is just doing his job, which is to make you look like the most negligent, careless, and stupid doctor ever to practice medicine. Next are the interrogatories which are framed as accusations. For example, 'Have you ever been convicted of drug abuse?'. You and your attorney will be required to answer these questions.

Your defense attorney will be appointed by your malpractice carrier. The attorney will probably be very good. Insurance companies don't like to pay claims if they can avoid them. Some writers have recommended that the defendant doctor hire his own attorney in addition to the one chosen by the insurance carrier. I believe this is rarely necessary.

> REMEMBER, YOU ARE NOT AT WAR WITH YOUR FORMER PATIENT. YOU ARE TRYING TO SETTLE A DISPUTE. YOU PREPARE LONG BEFORE THE SUIT BY PRACTICING GOOD MEDICINE, LISTENING TO THE PATIENT AND FAMILY, KEEPING THEM INFORMED, AND BEING HONEST. <

Your job is to help your attorney prepare your defense. Remember, you are not at war with your former patient. You are trying to settle a dispute. You prepare long before the suit by practicing good medicine, listening to the patient and family, keeping them informed, and being honest. You must also keep accurate records, don't alter them, and do this with every patient you treat. Under promise and over deliver. Don't hesitate to obtain consultations on difficult cases. Be honest and don't blame others. If you do these things on every patient, you will not fall into the trap of imagining each patient is a potential adversary, and you will be ahead in the game should a suit be filed.

Your goal is not to win. Your goal is to settle the dispute and make the lawsuit go away. It is usually better to settle than to go to trial.

In my experience, you should strongly consider settlement if:

- You were probably negligent and have a weak case.
- The cost of the settlement is less than the cost of trial, especially if the risk of loss is high. Your insurance carrier and defense attorney will help you decide this.
- The plaintiffs and their attorney may accept a settlement if it is enough to cover the economic issues discussed earlier. If that's the case, take it.

Note that these decisions will depend on the case at hand and should be discussed with an attorney.

These are my rules to ensure success and longevity in neurosurgery, and minimize the risk of a malpractice suit.

- Pace yourself.
- Don't bite off more than you can chew.
- Use all the help you can get—consultants, physician assistants, radiologists, partners, etc.

You will have opportunities to testify in court, give depositions, or even be an expert witness as part of your medical practice. These are great opportunities to hone your medicolegal skills and get experience with the legal system. Don't miss the chance to gain this experience when you are not the defendant.

When my senior partner, the late Louis Gogela, MD finished his training at Mayo Clinic, Dr. Adson said to him, "if you don't lose a few, you're not doing enough work." The same applies for lawsuits. If you are never sued, you're not doing enough work. Remember, you have successfully negotiated pre-med, medical school, neurosurgery residency and fellowship, and practice, so you already have the resilience to endure a malpractice suit. <

**** Editor's note:** Laws may vary by state. Individuals should consult their attorney for specific laws pertaining to their case.*

Gary S. Gildin

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The Anatomy of a Lawsuit: Medicolegal Considerations for Fellows and Residents

I. Introduction

Nearly 20% of neurosurgeons will face a malpractice lawsuit next year.[1] Neurosurgical residents and fellows—who may perform unsupervised procedures if qualified and approved by hospital bylaws—are subject to the same liability as practicing neurosurgeons. Even if not sued, residents and fellows may be subpoenaed to give testimony. Yet, the Residency Review Committee for Neurological Surgery does not require a core curriculum for competency in the basic principles of legal medicine.[2] Similarly, chief residents in internal medicine training programs lack basic medicolegal knowledge.[3] This raises the important question of whether preparing our graduates to tackle better medicolegal issues should be a core competency.

Being sued by a patient is a gut-wrenching event. From the law's perspective, however, the case is a garden-variety means to compensate the injured patient; to deter doctors from rendering unreasonable care; and, through insurance, to spread the loss among all who seek treatment. This article examines three stages of the medical negligence lawsuit: 1) pleading, 2) discovery, and 3) trial.

II. The Pleading Stage

A medical malpractice lawsuit is initiated by the serving of a complaint on behalf of the patient (designated as "plaintiff') specifying the factual and legal basis of the claims against the doctor (designated as "defendant," even though no criminal penalties are sought). The role of the defendant doctor at this stage largely is limited to providing information to enable their lawyer to file a written Answer admitting or denying each of the facts alleged in the complaint. Outside the doctor's gaze, their attorney will be engaged in an array of tactical decisions; the surgeon, however, is consigned to watchful waiting.

III. Discovery

Contrary to movie trials, the rules are designed to eliminate surprises by giving each lawyer access to information known by the opposing party. For example, the plaintiff's lawyer will request all records relating to the patient's treatment and propound written questions which the defendant-doctor must answer. However, the discovery device that will most influence the outcome is the deposition.

The deposition is an in-person proceeding where the plaintiff's attorney poses questions to the neurosurgical resident or fellow—whether deposed as a witness or as one of the named defendants. A court reporter will place the doctor under oath and generate a verbatim transcript of every question and answer. Plaintiff's lawyer will use two surgical tools. First, for each topic of inquiry, they will funnel questions culminating in the resident or fellow pledging they have disclosed all knowledge of the matter; should the surgeon attempt to offer added facts at trial, the lawyer will display relevant passages of the transcript of the to the jury, making clear that the doctor invented testimony to justify the treatment afforded the patient. Secondly, the plaintiff's lawyer will ask leading questions pressing the resident or fellow to admit individual facts about the diagnosis, treatment, and prognosis of the patient; at trial, should the surgeon attempt to deny or offer context for a fact they admitted without qualification at the deposition, the lawyer will again wield the transcript to show the jury the doctor unequivocally admitted the fact they are now trying to evade.

While conducted outside the courtroom, the answers given at the deposition write the script for the trial from which the surgeon may not deviate without being impeached. Therefore, the resident or fellow must prepare thoroughly for the deposition, reviewing all the

medical records and insisting the lawyer prepare them on how best to avoid testimony that unintentionally and unfairly suggest flaws in the care afforded to the patient.

IV. The Trial

Three aspects of the trial should be of greatest interest to the neurosurgical resident or fellow, whether a named defendant or a witness: 1) Who are the decision-makers; 2) What evidence will they consider; and 3) What role does the surgeon play?

Who decides whether the neurosurgeon is liable?

The citizens seated in the jury box will render the verdict as to whether the neurosurgeon is liable for damages. The process by which jurors are selected usually will guarantee that no juror has medical expertise. The judge will excuse any prospective juror whose experience renders them incapable of impartially deciding the case solely on the evidence presented at trial. Each attorney is afforded a number of peremptory challenges to dismiss a prospective juror for any reason other than race or gender. Concerned that a juror with expertise will exert disproportionate sway during deliberations, attorneys typically use peremptory challenges to strike those with medical training.

While the ultimate decision-makers are laypersons, the trial includes an element of peer review. In some states, the plaintiff's lawyer cannot file a malpractice lawsuit unless they first have procured an expert in the field prepared to opine that the doctor violated the standard of care. At trial, the plaintiff's attorney is required to present testimony of a qualified expert establishing the standard of care; how the doctor failed to treat the patient consistent with that standard; and how substandard treatment caused the condition and injuries the patient suffered.

What evidence will the jurors consider?

One would expect that the jurors' verdict would turn solely on evidence regarding the medical care afforded. Ironically, trial lawyers' understanding of how the human brain receives and processes information has led them increasingly to rely on facts outside the operating room to argue what caused the doctor to err. The patient's lawyer may elicit various forces that interfered with the ability of the neurosurgeon, resident, or fellow to provide full attention to the patient, including economic incentives to increase the number of patients treated; pursuit of academic positions which, while offering prestige and compensation, add teaching and research duties to the doctor's already overflowing plate; service on committees and consultancies that further draw on the surgeon's time and attention; and other events in the surgeon's personal or professional life that could distract from the care rendered the patient.

The Role of the Neurosurgeon at Trial

For the first days or weeks, the defendant doctor is relegated to silently watching the selection of the jury, opening statements by both attorneys, and the presentation of all of the witnesses called by the plaintiff, who lay out the alleged deficiencies in medical care. When finally called to the witness stand, the defendant doctor is allowed to tell their version of what occurred only in response to questions rather than offer an uninterrupted narrative. The doctor then faces cross-examination by the patient's lawyer whose primary strategy is to ask only leading, one-fact questions, the order of which suggests a conclusion which, if given the opportunity, the doctor would deny. But the plaintiff's lawyer never asks that conclusory question, leaving the innuendo resonating in the jurors' minds. Although the defendant's lawyer will conduct a re-direct examination where the doctor may refute the unasked conclusion, that colloquy cannot fully erase the perception created by the cross examination.

As with the deposition, the best tool of the neurosurgeon, resident, or fellow for trial is thorough preparation. Beyond intimate familiarity with the medical records and deposition transcript, the doctor must collaborate with their attorney to master the art of answering questions on direct and cross examination so that the jury understands, and is persuaded, that proper care was rendered.

V. Conclusion

A more in-depth understanding of the medical negligence trial would better prepare neurosurgical residents and fellows to defend treatment decisions as well as suggest measures to reduce the risk that the patient will initiate a lawsuit. More generally, presenting a medicolegal curriculum using a seminar and home-study guidebook will substantially improve neurosurgical residents' and fellows' medicolegal knowledge, and better prepare them for their future practice. This topic is well-suited to didactic teaching with significant potential for collaborative research across different specialties in medicine and law. We encourage neurological surgery educators to reassess their efforts and provide well-rounded tutoring in the medicolegal arena.

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Advocacy for Tort Reform

Neurosurgeons continue to rank medical liability reform high on their list of advocacy priorities. Working with our coalition partner—the Health Coalition on Liability and Access—the Washington Committee is pursuing various federal medical liability reforms.

Context for Reform

Our nation's medical liability system is broken—it costs too much, takes too long to resolve claims, and does not serve the needs of patients or physicians. The Medical Professional Liability Association (MPL, formerly PIAA), a trade association of medical liability insurers, has shown that most liability claims are without merit. For example, between 2016 and 2018, 65 percent of claims had been dropped, dismissed or withdrawn. Furthermore, of the six percent of claims that went to trial, the defendant won the vast majority (89%).

For neurosurgeons, this lawsuit lottery system is particularly challenging. Annually, 20 percent of all practicing neurosurgeons in the United States face medical malpractice litigation, with an average payout of $439,146—the highest of all medical specialties. Most claims result from elective spinal surgery. However, cranial surgery claims tend to be costlier. These large payouts result in high malpractice premiums for neurosurgeons (the highest of all specialties). According to unpublished data from The Doctors Company, in 2022, neurosurgeons in parts of Illinois paid an annual premium of nearly $350,000 for $1,000,000/$3,000,000 malpractice insurance coverage. In contrast, neurosurgeons in California paid as little as $34,000. One reason for this difference is attributed to the tort reforms in place in California since the mid-1970s.

States with Some of the Highest Malpractice Premiums

State $1m/$3m Coverage	**2022 Rates for**
Illinois	$349,800
New York	$287,740
Connecticut	$286,307
District of Columbia	$235,320
Florida	$280,829
Ohio	$175,352
Washington	$ 110,873

States with Some of the Lowest Malpractice Premiums

State $1m/$3m Coverage	**2022 Rates for**
Texas	$66,821
Minnesota	$57,414
Indiana	$49,943
South Dakota	$41,110
Tennessee	$38,899
Wisconsin	$36,171
California	$33,770

Beyond these direct costs, the increasing prevalence and expenses related to the current system lead neurosurgeons to practice defensive medicine—the practice of rendering a diagnostic test or medical treatment that may not necessarily be the best option for the patient but mainly serves to protect the physician against the threat of a lawsuit. Michelle Mello and her colleagues estimate that defensive medicine adds $45 billion to the cost of health care. They also point out that other noneconomic factors related to medical lawsuits impact neurosurgeons: "Physicians can insure against malpractice awards by purchasing insurance, but they cannot insure against the psychological costs of being involved in litigation, including the stress and emotional toll. Nor can they avoid the reputational effects of being sued, which affect their income as well as their status."

Against this backdrop, the Congress of Neurological Surgeons (CNS) and the American Association of Neurological Surgeons (AANS) continue to push for solutions to address the challenges of the medical-legal system.

Federal Legislation

While some states—including California, Texas and Louisiana—have adopted effective medical liability reforms, many states have not, or their highest courts have struck down such reforms as violative of the state's constitution. Thus, since the mid-to late-1970s, organized neurosurgery has advocated for adopting federal medical liability reform.

Comprehensive Tort Reform

The CNS and AANS have collaborated with Reps. **Richard Hudson** (R-N.C.) and **Lou Correa** (D-Calif.) in the U.S. House of Representatives in the Senate to introduce comprehensive reform legislation. The Accessible Care by Curbing Excessive lawSuitS (ACCESS) Act is modeled on the laws in California, Texas and many other states around the country that have committed to affordable access to patient care by reducing medical lawsuits. Key provisions of the bill include:

- **Encouraging speedy resolution of claims.** The statute of limitations is three years after the injury or one year after the claimant discovers the injury, whichever occurs first. For a minor, the statute of limitations is three years after the injury, except for a minor under six years old, for whom it is three years after the injury, one year after the discovery of the injury, or the minor's eighth birthday, whichever occurs later. These limitations are tolled under certain circumstances.
- **Compensating patient injury.** Noneconomic damages are limited to $250,000, and juries may not be informed of this limitation. Parties are liable for the amount of damages directly proportional to their responsibility. These provisions do not preempt state laws that specify a particular monetary amount of damages.
- **Maximizing patient recovery.** Courts must supervise the payment of damages and may restrict attorney contingency fees. The bill sets limits — on a sliding scale — on contingency fees.
- **Future damages.** The bill provides for periodic payment of future damage awards.
- **Product liability.** A health care provider who prescribes or dispenses a medical product approved by the Food and Drug Administration may not be named as a party to a product liability lawsuit or a class action lawsuit regarding the medical product.
- **State Flexibility.** Protects the rights of states that have already enacted comprehensive medical liability reforms or will do so in the future.

In addition, the bill includes provisions defining who qualifies as an expert witness, requirements for an affidavit of merit before bringing a lawsuit and allowing a physician to apologize to a patient for an unintended outcome without having the apology count against them in the court of law and requiring a 90-day cooling off period before lawsuits can be filed to facilitate voluntary settlements.

Similar versions of this legislation passed the House of Representatives multiple times over the years, but forward progress has stalled in the Senate.

> "PHYSICIANS CAN INSURE AGAINST MALPRACTICE AWARDS BY PURCHASING INSURANCE, BUT THEY CANNOT INSURE AGAINST THE PSYCHOLOGICAL COSTS OF BEING INVOLVED IN LITIGATION, INCLUDING THE STRESS AND EMOTIONAL TOLL. NOR CAN THEY AVOID THE REPUTATIONAL EFFECTS OF BEING SUED, WHICH AFFECT THEIR INCOME AS WELL AS THEIR STATUS." <

— Michelle Mello

Protecting Good Samaritans

Because of the steep hurdle the CNS and AANS face in passing comprehensive federal medical reform legislation, the Washington Committee is also pursuing narrower reforms. One such effort involves so-called Good Samaritan protections. The Good Samaritan Health Professionals Act — sponsored by Reps. **Raul Ruiz**, MD, (D-Calif.) and **Larry Bucshon**, MD, (R-Ind.) in the House, and Sens. **Angus King** (I-Maine) and **Bill Cassidy**, MD (R-La.) in the Senate — would afford health professionals providing voluntary care in response to a federally declared disaster with medical liability protections. While federal and state laws are intended to protect volunteer health professionals from unwarranted lawsuits, as many inconsistencies may leave physicians vulnerable.

COVID-19 Medical Liability

As part of the ongoing efforts to provide health care providers with protections from unfounded lawsuits, the CNS and AANS joined HCLA and a chorus of stakeholders in calling on Congress to pass legislation to safeguard medical professionals and the facilities in which they practice from COVID-19-related medical liability lawsuits. Examples of increased liability risks that providers are confronting because of COVID-19 include:

- Suspensions of elective in-person visits and delays in treatment for patients with symptoms unrelated to COVID-19;
- Workforce shortages that forced physicians to provide care outside of their general practice area;
- Shortages of equipment—such as ventilators—that resulted in providers having to ration care; and
- Delayed or inaccurate diagnosis due to inadequate testing supplies.

Bipartisan legislation that would provide targeted relief from these lawsuits—the Coronavirus Provider Protection Act—was introduced in the House of Representatives by Reps. Lou Correa (D-Calif.) and Michael Burgess, MD, (R-Texas).

EMTALA Liability Protections

As on-call specialists, neurosurgeons perform lifesaving feats daily, often making quick, life-and-death decisions with minimal information about the patient. This lifesaving care is inherently risky and exposes these specialists to an increased likelihood of litigation because emergency and trauma patients are often sicker, have more severe complications and usually have no pre-existing relationship with the emergency physician or the on-call specialist. Unfortunately, the high risk of being sued and the increased professional liability costs—far higher than those who do not provide such care—have resulted in fewer neurosurgeons taking emergency calls.

If adopted, legislation such as the Health Care Safety Net Enhancement Act would address this problem by extending liability protections to on-call and emergency physicians through the Federal Tort Claims Act. Specifically, the bill would ensure that emergency department and on-call physicians who are providing medical services under the Emergency Medical Treatment and Labor Act receive the same liability coverage currently extended to employees of Community Health Centers and health professionals who provide Medicaid services at free clinics. In such lawsuits, the federal government would be the defendant rather than the on-call specialist.

Sports Medicine

One recent bright spot is the enactment of the Sports Medicine Licensure Clarity Act in 2018. The law extends the malpractice insurance coverage of a state-licensed medical professional to another state when the professional provides medical services to an athlete, athletic team or team staff member pursuant to a written agreement. Before delivering such services, the medical professional must disclose to the malpractice insurer the nature and extent of the service. This extension of malpractice coverage does not apply at a health care facility or while a medical professional is transporting the injured individual to a health care facility.

Conclusion

Medical liability remains a continuing concern for neurosurgeons. It affects both how and where they practice. The ramifications of the broken liability system are wide-ranging, from patients with limited access to health care to the financial implications on the health care system as a whole. The above reforms will ensure full and unlimited recovery of economic damages for deserving patients for expenses. They will help ensure a faster resolution of claims and that patients — not attorneys — receive the bulk of any damage awards. And they will save the health care system money (for example, a Congressional Budget Office analysis found that reforms such as those in the ACCESS Act would reduce national health care spending and save the federal government nearly $28 billion). The CNS and AANS will continue to advocate for medical liability reform legislation in Congress vigorously.

Additional Resources/Information of Interest

American Medical Association **Medical Liability Reform Now!**
Health Coalition on **Liability and Access Protect Patients Now!**
American Tort Reform Association **Judicial Hellholes**
Neurosurgery Focus: **Medicolegal issues in neurosurgery**

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FOUNDATION UPDATE

Dear Colleagues,

2022 was an incredible year of growth for the CNS Foundation as we granted a record number of awards to neurosurgeons and trainees around the globe, including several awards in new categories. I was both honored and inspired to meet many of these awardees during our CNS Annual Meeting in San Francisco, California and I can't wait to see the work these promising young surgeons will do on behalf our specialty in the year ahead. I also enjoyed meeting with so many of you at our donors and awardee reception. We could not have this tremendous impact without your continued generosity. Work is well under way to continue this success in 2023. We are in the process of reviewing applications for another 4 awards and we look forward to announcing the winners in Spring.

If you have not yet made your first donation of the new year, I urge you to give today. Your gifts will help the CNS Foundation continue to grow these incredible opportunities in 2023 and beyond

– Martina Stippler, MD, Chair, CNS Foundation

2022 CNS Foundation Awards Top $700,000!

The CNS Foundation was honored to award more than $700,000 in 2022 for 30 awardees across all Mission Pillars: Diversity, Equity, Inclusion; International Philanthropy; CNS Guidelines; Clinical Scientist Career Development. Congratulations and thank you to these awardees for joining us at the 2022 CNS Annual Meeting in San Francisco!

Awardees pictured on page 24, from left to right.

1. **Stephen Miranda**, CNSF/DEI Abstract Award
2. **Adela Wu**, CNSF/DEI Abstract Award
3. **Oliver Tang**, CNSF/DEI Abstract Award
4. **Clara Martin**, CNSF/CV Visitorship to Emory
5. **Rajesh Nair**, CNSF/DEI Abstract Award to SiemmesMurphy
6. **Diego Devia**, CNSF/DEI Abstract Award at University of Pennsylvania and Thomas Jefferson University
7. **Remesh Vasuvdevan**, CNSF Cerebrovascular Visitorship
8. **Chrystal Calderon**, CNSF/MGH International Observership at Massachusetts General Hospital
9. **Sukirti Chauhan**, CNSF Future Women Leaders in Neurosurgery Scholarship
10. **Smruti Patel**, CNSF Future Women Leaders in Neurosurgery Scholarship
11. **Alphadenti Harlyjoy**, CNSF Future Women Leaders in Neurosurgery Scholarship
12. **Thomas Larrew**, CNSF Quality Guidelines Scholar
13. **Franly Vásquez**, CNSF Neurotrauma Visitorship
14. **Daniel Sexton**, CNSF Data Science Award

Donate today to support these awards and fellow neurosurgeons in 2023!

Would you like to join the group making a difference in our next generation of neurosurgeons and their patients?

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Annual Gifts of $500 and more.

Thank you, donors, for making record-breaking awards possible to improve patient health worldwide. Make your 2023 donation to continue the good work on behalf of neurosurgery. Foundation.cns.org/donate

INSIDE THE CNS

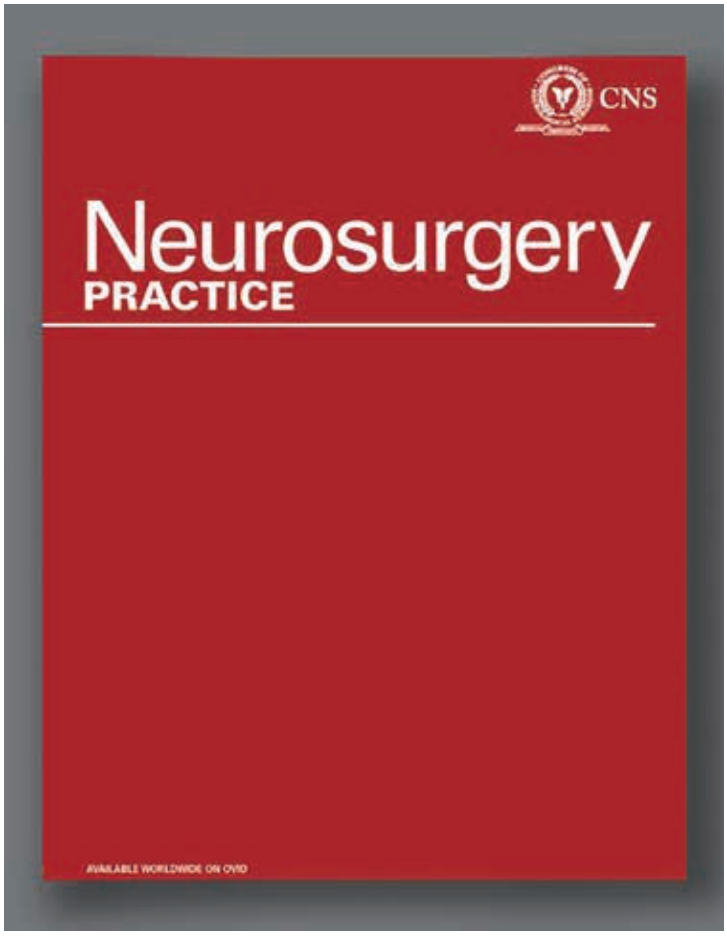
Neurosurgery Publications Update

Douglas Kondziolka, MD, MSc

Hussam Abou-Al-Shaar, MD

Since the introduction of the world wide web in the 1980-1990s[1], there has been a revolution in the dissemination of and access to knowledge and information. This digital revolution has greatly enhanced the ability of academic journals, including those published by **Neurosurgery Publications**, to disseminate medical knowledge more quickly through online publication and more widely through social media[2]. The ability to disseminate medical knowledge more quickly has not always equated to ease in accessing that knowledge, with access to journals largely restricted to those with personal or institutional subscriptions or a sponsoring society membership[3]. The desire to increase dissemination beyond these traditional avenues has in turn led to the significant growth of the Open Access publication model. The concept truly begins in the understanding that knowledge emanating from public funding sources should be easily available to the public. In response to this idea, *Neurosurgery Open* was launched as the Congress of Neurological Surgeons' official Open Access publication in October 2019[4]. On December 15, 2022 **Neurosurgery Publications** relaunched *Neurosurgery Open* as *Neurosurgery Practice*, maintaining the journal's profile as a fully Open Access publication and reaffirming its aim to publish content representing the spectrum of neurosurgical practice with a clear and useful message for readers important for patient care.

The advantages of the Open Access platform of *Neurosurgery Practice* are plenty. Open Access allows for early dissemination of neurosurgical knowledge through social media and shared links. Therefore, authors can publicize their work early and readers from around the globe can access the material in a timely fashion. Additionally, *Neurosurgery Practice*, as the name implies, aims to deliver focused and direct messages that offer rapid reader access on



> NEUROSURGERY PRACTICE WELCOMES BOTH CLINICAL AND EXPERIMENTAL ARTICLES FROM ACROSS THE NEUROSURGICAL SUBSPECIALTIES INCLUDING BUT NOT LIMITED TO VASCULAR, SPINE, PEDIATRICS, AND TUMOR AND ARTICLE TYPES SUCH AS CLINICAL RESEARCH, REVIEWS, AND CASE INSTRUCTIONS. <

practical, mainly clinical issues, without having the walls of "pay and subscription." Even those of us who try to access an article at home using PubMed, perhaps not via our hospital servers, are blocked from reading anything more than a title and limited abstract. We all know that frustration. *Neurosurgery Practice* will aim to serve as the platform for affordability in neurosurgical research access.

Open Access does not affect the peer review process. Articles remain peer-reviewed and published by journals in the same way as for *Neurosurgery* and *Operative Neurosurgery*. *Neurosurgery Practice* involves dedicated Section Editors across the breadth of the specialty. Certainly, there are online archives that can supplement information but do not and should not replace journals particularly if peer review suffers. It has been stated that some authors feared that Open Access and the wider availability of information would increase plagiarism. However, the stronger argument is that Open Access serves to reduce the problem of plagiarism, since wider exposure can facilitate early recognition of this problem.

As a Gold Open Access journal, all content published in *Neurosurgery Practice* receives either a CC-BY or CC BY-NC-ND license meaning all of its content is freely accessible. This free access is subsidized by authors via payment of an article processing charge, or APC. The cost of publishing Open Access is a documented and ongoing concern for authors [5-6], and one *Neurosurgery Practice* takes seriously. *Neurosurgery Practice* is proud to offer modest APCs which for 2023 are $2,060 ($1648 for CNS Members with 20% Member discount) for full length articles and reviews and $1,030 ($824 for CNS Members with 20% Member discount) for all other article types. It is important to note that payment is not required until a paper has been fully reviewed and accepted for publication. There is no payment for submission or review. Green Open Access journals provide self-archiving of accepted versions of articles, also known as post prints. They endorse immediate Open Access self-archiving by the authors.

Neurosurgery Practice welcomes both clinical and experimental articles from across the neurosurgical subspecialties including but not limited to vascular, spine, pediatrics, and tumor and article types such as clinical research, reviews, and case instructions. It is important to state that free access by anyone in the world provides exponentially greater access to articles where otherwise full text is restricted to subscribers alone. We welcome CNS members, neurosurgeons, and physicians from around the globe to submit their work to the journal. <

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INSIDE THE CNS

Washington Committee Report

Katie O. Orrico, Esq

Neurosurgery Leads Amicus Brief in New Surprise Billing Lawsuit

The No Surprises Act, which went into effect on Jan. 1, bans surprise medical bills for out-of-network care and establishes a process for resolving payment disputes between health plans and providers. Unfortunately, the final rule implementing the law continues to give preference to the qualifying payment amount — or median in-network rate — which unfairly favors insurers when settling out-of-network payment disputes. When resolving payment disputes, the law requires arbiters to consider several factors equally — not just median in-network rates — including the physician's training and experience, the severity of the patient's medical condition, prior contracting history, health plan market share and other relevant information.

On Oct. 19, the Congress of Neurological Surgeons (CNS) and the American Association of Neurological Surgeons (AANS) spearheaded a physician-led amicus brief, along with the Physician Advocacy Institute, supporting the Texas Medical Association's (TMA) new lawsuit challenging these rules. Other medical groups, including the American Medical Association, also filed amicus briefs supporting the TMA lawsuit.

Click here to read neurosurgery's amicus brief and here for the accompanying press release.

Senators Urge Action to Mitigate Medicare Payment Cuts

On Nov. 2, 46 senators sent a bipartisan letter to Senate leaders urging them to take action to address Medicare payment cuts set to take effect on Jan. 1, 2023. The senators stressed that "Congress must address these vital payment challenges before the end of 2022 to ensure seniors continue to have access to care through a wide network of providers." The letter also noted that the failure "to act on longer-term reforms will undermine Medicare's ability to deliver on its promises to future seniors and generations."

The CNS and the AANS continue to advocate for Congress to take action to prevent an 8.5% Medicare cut to physician payments, joining the Surgical Care Coalition (SCC) in supporting this senate effort.

Click hereto read the letter and here for the SCC press release.

Neurosurgery Responds to RFI on Medicare Payment and Quality Program Improvements

On Oct. 31, the CNS and the AANS responded to the Request for Information issued by Reps. **Ami Bera**, MD, (D-Calif.); **Larry Bucshon**, MD, (R-Ind); **Kim Schrier**, MD, (D-Wash.); **Michael Burgess**, MD, (R-Texas); **Earl Blumenauer** (D-Ore.); **Brad Wenstrup**, DPM, (R-Ohio); **Bradley Schneider** (D-Ill.) and **Mariannette Miller-Meeks**, MD, (R-Iowa) seeking feedback on ways to improve the Medicare Access and CHIP Reauthorization Act (MACRA). The neurosurgical groups urged Congress to stabilize Medicare payments in the short term by:

- Preventing the scheduled 4.42% Medicare physician fee schedule cut by adopting H.R. 8800, the Supporting Medicare Providers Act;
- Providing an inflation update for at least 2023 based on the Medicare Economic Index;
- Waiving the 4% Statutory Pay-As-You-Go Act sequester cut; and

- Directing the Centers for Medicare & Medicaid Services (CMS) to adjust the post-operative portion of the 10- and 90-day global surgery codes to reflect recent increases in the office/outpatient evaluation and management visit codes.

Long-term solutions for reforming the system should incorporate a core set of principles — Characteristics of a Rational Medicare Physician Payment System — that the CNS and the AANS helped develop and fully support. Detailed actions Congress should take include:

- Adopting an annual inflationary update for Medicare physician services;
- Modifying Medicare's budget neutrality requirements;
- Directing CMS to use the American Medical Association/Specialty Society RVS Update Committee to address any misvalued global surgery codes;
- Streamlining MACRA's Quality Payment Program (QPP) and enhancing the use of clinician-led clinical data registries; and
- Repealing Medicare's Appropriate Use Criteria (AUC) program for advanced diagnostic imaging and incorporating AUC into the QPP.

Click here to read the letter.

CMS Releases Final 2023 Medicare Physician Fee Schedule Final

On Nov. 1, CMS released the final 2023 Medicare Physician Fee Schedule rule. Overall, neurosurgeons face a 4% decrease, due primarily to the expiration of temporary financial relief provided by Congress last year to mitigate steep payment cuts in 2022. In addition, neurosurgeons face a 4% Statutory Pay-As-You-Go Act sequester cut absent Congressional action.

Provisions of interest to neurosurgeons include:

- Restoration of the American Medical Association/Specialty Society RVS Update Committee-passed values for interbody spine fusion CPT® codes 22630 and 22633.
- A one-year delay of a new policy requiring physicians to see patients for more than half of the total time of a split or shared evaluation and management visit to bill for the service. For 2023, CMS will continue to allow physicians and qualified health care professionals to use medical decision making to determine the substantive portion of the split/shared visit.
- Changes to relative weights of the fee schedule components (i.e., work, practice expenses and professional liability insurance (PLI) expenses) that will decrease the value of physician work and PLI expenses, thus leading to future reductions in neurosurgical payments. The final changes will reflect an updated practice expense data collection initiative currently underway.

The final rule also included changes to Medicare's Quality Payment Program. Policies of interest to neurosurgeons include:

- Removing spine-focused quality measures — #460, Back Pain After Lumbar Fusion; #469, Functional Status After Lumbar Fusion and #473, Leg Pain After Lumbar Fusion — from the Merit-Based Incentive Payment System (MIPS). CMS retained #260, Rate of CEA for Asymptomatic Patients, as an available MIPS measure for 2023.
- Requiring reporting of the Query of Prescription Drug Monitoring Program measure under the MIPS Promoting Interoperability category unless an exclusion can be claimed.
- Mandating public reporting of utilization data related to certain procedures on individual clinician profile pages on Care Compare starting as early as 2023.

CMS Releases 2023 Medicare Hospital OPPS and ASC Final Rule

On Nov. 1, CMS released the 2023 Changes to Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center (ASC) Payment System final rule. In 2023, payment rates will increase by 3.8% for hospitals and ASCs that meet applicable quality reporting requirements. CMS also adopted neurosurgery-supported changes, including:

- Removing the arthrodesis add-on CPT® code 22632 from the inpatient-only (IPO) list;
- Adding the new total disc arthroplasty additional level CPT code 22860 to the IPO list; and
- Approving pass-through payments for the Evoke® spinal cord stimulation system and Aprevo® custom intervertebral body fusion device.

CDC Updates Clinical Practice Guideline for Prescribing Opioids

The Centers for Disease Control and Prevention (CDC) has released updated and expanded recommendations for clinicians providing pain care for adults with short- and long-term pain. These clinical recommendations, published in the CDC

Clinical Practice Guideline for Prescribing Opioids for Pain, replace and addresses the agency's 2016 guideline that caused some patients to experience abrupt loss of access to needed pain treatment.

The updated guideline focuses on the following areas:

- Determining whether to initiate opioids for pain;
- Selecting opioids and determining opioid dosages;
- Deciding duration of initial opioid prescription and conducting follow-up; and
- Assessing risk and addressing potential harms of opioid use.

A summary for physicians, "Guidelines at a Glance," is available here.

Neurosurgeon Appointed to AMA CPT® Editorial Panel

Joseph S. Cheng, MD has been appointed to serve on the AMA' CPT Editorial Panel. The CPT Editorial Panel is tasked with ensuring that CPT codes remain up to date and reflect the latest medical care provided to patients.

Neurosurgical Resident Picked for White House Fellow Program

Jeffrey Nadel, MD, a neurosurgical resident from the University of Utah, has been named to the 2022-2023 White House Fellows class and is working at the U.S. Department of Veterans Affairs. He joins 14 other individuals selected to participate in this prestigious program and follows in the footsteps of neurosurgeons **Jeremy Hosein**, MD (2018-2019); **Lindsey B. Ross**, MD (2016-2017); **Anand Veeravagu**, MD (2012-2013) and **Sanjay K. Gupta**, MD (1997-1998).

The White House Fellows Program was created in 1964 by President **Lyndon B. Johnson** to give promising American leaders "first hand, high-level experience with the workings of the Federal government, and to increase their sense of participation in national affairs."

Neurosurgeon Elected to Prestigious National Academy of Medicine

On Oct. 17, the prestigious National Academy of Medicine announced the election of another neurosurgeon to its ranks: James M. Markert, MD, MPH, chair, department of neurosurgery, University of Alabama, Birmingham. He was recognized as a world expert on oncolytic viruses, an author of the first-ever paper on genetically engineered oncolytic viruses, the primary author on the first-in-human trial of an oncolytic virus and senior author on the first use of an IL12-expressing virus for human glioma. Dr. Markert is currently conducting adult and pediatric brain tumor trials.

Neurosurgeon Featured in Articles Regarding Medicare Payment Cuts

On Nov. 1, the Surgical Care Coalition (SCC) issued a press release urging Congress to protect patients from the proposed Medicare payment cuts set to go into effect on Jan. 1, 2023, by passing H.R. 8800, the Supporting Medicare Providers Act. In the release, the SCC noted that significant medical inflation and staffing and supply chain shortages continue to harm surgical care teams across the country.

Subsequently, **John K. Ratliff**, MD, chair of the Washington Committee, was featured in a *Becker's ASC Review* article *titled, "Physician leaders balk at Medicare 4.48% physician fee cut." Dr. Ratliff stated, "Patients deserve a more stable and durable Medicare system. Though more robust solutions are needed to create that reality, this bill would be a step in the right direction."* In addition, he was featured in a Bloomberg Law article titled "Doctors Face Nearly 4.5% Cut in Medicare Reimbursements in 2023."

Neurosurgeon Pens Op-Ed on Medicare Payment Cuts

On Nov. 1, AL.com published an op-ed by Communications and Public Relations Committee member **Richard Menger**, MD, MPA, titled, "Why is it hard for grandma to see her doctor?" In the op-ed, Dr. Menger discusses how steep Medicare physician payment cuts scheduled to go into effect on Jan. 1, 2023, put seniors at risk for reduced access to care. He noted that the "people most impacted by these cuts will be our Medicare patients. In the backdrop of inflation, practices will not be able to sustain themselves by treating Medicare patients." On Nov. 3, Neurosurgery Blog published a cross-post to amplify Dr. Menger's message.

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IMAGES IN NEUROSURGERY

Cervical Intramedullary Abscess

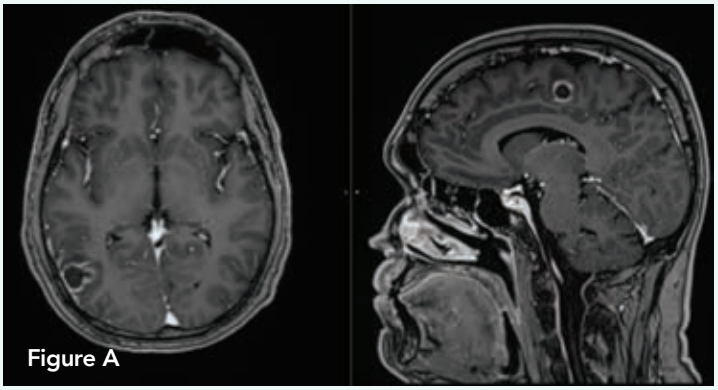
A 43 year-old male with no relevant past medical history presented to the emergency department with a two week history of fever, malaise, and left sided numbness and clumsiness. He was initially sent home and returned to the ER with a headache and neck stiffness. A CT brain demonstrated right frontal and parietal masses with swelling. A subsequent MRI brain with contrast (**Figure A**) demonstrated ring enhancing lesions with diffusion restriction and significant surrounding edema concerning for intracerebral abscesses. He was started on broad spectrum antibiotics, and an extensive workup ensued including dental as well as echocardiogram testing which did not reveal a source for the infection. Patient history was negative for IV drug use, recent dental procedure, diabetes, or cardiopulmonary pathology. The patient opted for a right parietal craniotomy for evacuation of the largest of the abscesses the day after presentation. His post operative CT brain was stable. Cultures returned streptococcus intermedius.

The patient did well after surgery but two days later developed the onset of severe cervical pain and worsening of his left sided paresthesias and weakness with gait instability. He demonstrated 4/5 weakness of the left grip, biceps, and deltoid with diminished sensation below the knees alongside urinary retention. With concern for progressive myelopathy and suspicion for epidural abscess, an MRI of the spine with contrast was obtained, and this revealed a ring enhancing intramedullary cervical abscess centered over C6 (**Figure B**) with significant associated edema from C2 to T4 (**Figure C**). A subsequent diffusion study confirmed that the lesion diffusion restricted.

He was subsequently taken for a C6-7 laminectomy and evacuation of intramedullary abscess. Neuromonitoring was employed for mapping of the dorsal columns. Intraoperative ultrasound was used to locate the abscess closest to the surface of the cord. Frank purulence was encountered (**Figure D**). Cultures returned the same as his intracerebral abscess, a member of the streptococcus anginosus group. The patient recovered well from this operation and was discharged to acute rehabilitation. He completed 14 weeks of antibiotics. At his last follow up, he had recovered most of his strength with left 4+/5 grip, stable gait, and resolution of his urinary retention. The MR Cervical Spine (**Figure E**) prior to completion of antibiotics revealed a small focus of contrast enhancement in the cord with resolution of the edema and his MR brain revealed significantly smaller foci of contrast enhancement and edema surrounding the known abscesses.

Submitted by: Jeremy Hosein, MD
Affiliation: Bryan Health, Lincoln, NE

For more details, view this case on Nexus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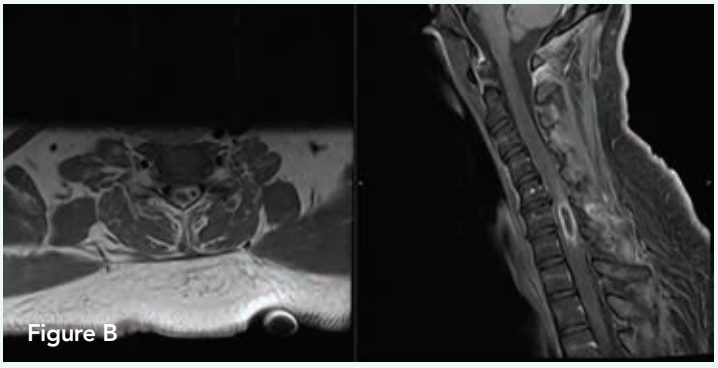
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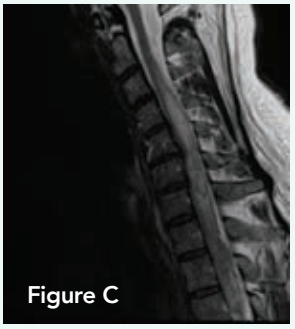
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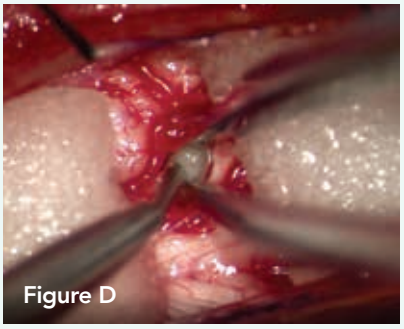
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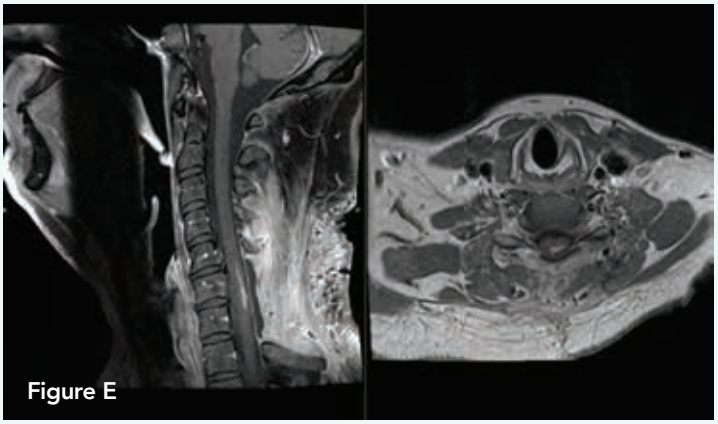
Figure E

Congress of Neurological Surgeons

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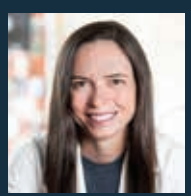
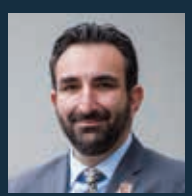


Lola B. Chambless
Annual Meeting Chair



Garni Barkhoudarian
Scientific Program Chair

Edjah K. Nduom
Vice-Scientific Program Chair

(Continued from page 5)

The Impact of EMTALA on Neurosurgery

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