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Working Together

Fragmentation Within Our Specialty Benefits No One

As AANS President for the past nine months, I have observed that some threats to neurosurgery are not coming from outside our specialty. Rather, I am dismayed by the mounting competition from within our field. Neurosurgery is a small specialty, but also an exciting one. With other organizations lobbying hard and fast for influence and reimbursement advantages, it is up to organized neurosurgery to hold onto its own piece of the pie. We have to put away our individual differences and work together as colleagues for the benefit of the profession as a whole.

Working Together

Over the years, organized neurosurgery has worked very hard to correct past wrongs, and as a result, the AANS and Congress of Neurological Surgeons (CNS) are now working together in stronger alliance. The result has been the development of many joint projects between the two groups including our Website, the SMART marketing communications program, several outcomes projects, the Washington Committees, the CPT Coding Task Force, and the Fellowship Task Force. This is the direction in which I believe organized neurosurgery should continue to move, and it is the philosophy that I will continue to endorse as long as I am an AANS Officer.

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is President of the AANS and a neurosurgeon in private practice in Lexington, Kentucky.

The question of segmentation is not new in neurosurgery. This is a battle we have been fighting among ourselves for nearly 20 years. We have seen the advent of special interests in pediatric neurosurgery, trauma and critical care, spine and peripheral nerve surgery, craniovascular and stroke care, and pain management to name a few. Our Sections have been successful in harnessing and enhancing these sub-specialties and have certainly enriched the practice of neurosurgery. However, while this sub-specialisation can help improve the quality of care for our patients, there can be an unintended side effect: if we are not careful, the feuding of neurosurgery can lead to two sectors of our specialty. We have begun to see signs of this in the past couple of years including reimbursement and funding research funding, manpower, and enrollment from other specialties. We also are seeing signs of segmentation as a result of attempts to create sub-specialty professional credentials. These are the most recent manifestations of this phenomenon to occur in the arena of spine surgery. You may have been asked by the American Board of Spine Surgery to pursue certification as a spine surgeon. Your Board of Directors opposes this program and has developed an official position statement on the proposed opting out. With other organizations lobbying hard and fast for influence and reimbursement changes, it is up to organized neurosurgery to hold onto its own piece of the pie. We have to put away our individual differences and work together as colleagues for the benefit of the profession as a whole.

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The Internal Revenue Service has undergone some challenges. During 1998, we had to re-allocate some key staff members, including Robert E. Drake, MD, the AANS Executive Director. But, rest assured, the AANS is alive and well. My thanks to Laurie Edborne, Associate Executive Director of Programs, and Robert Cowan, Associate Executive Director of Administration, who have worked hard to keep the Internal Revenue Service on track during this transition. If some of you have suffered inconveniences as a result of these recent changes, we appreciate your indulgence.

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The relationship between the AANS, CNS, and the Sections is complex and far from perfect. But, I believe there is a place for each within organized neurosurgery and these groups should continue to work together. I view organized neurosurgery as one big family. And, like most families, there are good and bad moments. One of the most important jobs of the President of a spokes organization has to be to encourage consensus. After taking the reigns of President AANS, I view organized neurosurgery as one big family. And, like most families, there are good and bad moments. One of the most important jobs of the President of a spokes organization has to be to encourage consensus. After taking the reigns of President AANS last April, it did not take long to remember what I had learned through my years of service on the Council of State Neurosurgical Societies (CNS) and the Washington Committee. The job of the AANS President is not just to express an opinion, but also to help blend the views of our members together and speak for organized neurosurgery with one voice. I frequently remind myself of the much quoted sentence from Eleanor Roosevelt’s White House: “A foolish consistency is the hobgoblin of little minds.” The leadership of the AANS is committed to represent your best interest with a unified voice, but only after careful debate.

Transitions

Looking to the future, we have undergone a number of changes at the national organization level that will improve access to members in the future. First, you will notice that the Bulletin has taken on a new persona. I am happy to report that the year 2000 will impact the healthcare industry, visit HCFA’s Web site at www.hcfa.gov/Y2K or the Food and Drug Administration’s Web site at www.fda.gov/cdrh/year2000.html.

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Congress Battles Over Drug Costs

Congress has created a new Prescription Drug Task Force aimed at bringing down the retail price of drugs. Task Force organizers believe that there is a growing gap between what most favored buyers (i.e., managed care plans and federal agencies buying under the Federal Supply Schedule) and those without special access to these drugs (i.e., the elderly) are paying for prescription drugs. One legislative proposal drafted by Representative Marion Barry (D-DC), co-chair of the Task Force, would let retail drugstores buy drugs for their Medicare patients at Federal Supply Schedule prices and pass on the savings to those over the age of 65—a change projected to cut prescription prices for seniors by 40 percent.

HCFA Prepares for the Next Millennium

With the year 2000 fast approaching, the Health Care Financing Administration (HCFA) is conducting a campaign to combat the millennium bug. The bug, which affects computers, software, medical devices; monitoring equipment; smoke alarms; telephone systems; spreadsheets; treatment equipment; and safety vaults.

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AANS/CNS Sue HCFA Over Practice Expense Phase-in Rules

On November 4, 1998, The American Association of Neurological Surgeons and Congress of Neurological Surgeons, along with nine other national medical societies, filed suit in federal district court in Chicago, Illinois, challenging the government’s just-released rules for phasing in the new practice expense component of the Medicare physician fee schedule. The lawsuit, which was brought against the Secretary of Health and Human Services (HHS) and the Health Care Financing Administration (HCFA), asked the United States District Court for the Northern District of Illinois to declare HCFA’s practice expense transition formula unlawful and invalid. HCFA is the HHS agency responsible for administering Medicare and Medicaid. The Medicare physician fee schedule consists of three factors: physician work, practice expenses, and malpractice expenses. This lawsuit involves only the practice expense component.

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Danger of Fragmentation

The question of segmentation is not new in neurosurgery. This is a battle we have been fighting among ourselves for nearly 20 years. We have seen the advent of special interests in pediatric neurosurgery, trauma and critical care, spine and peripheral nerve surgery, craniovascular and stroke care, and pain management to name a few. Our Sections have been successful in harnessing and enhancing these subspecialty interests and have certainly enriched the practice of neurosurgery. However, while this sub-specialization can help improve the quality of care for patients, there can be unwanted side effects. If we are not careful—that is, if we fragment neurosurgery—then this can have serious and dangerous consequences. The result has been the development of many joint projects between the two groups including our Web site; the SMART marketing communications program; several outcomes projects; the Joint Coding Task Force; and the Fellowship Task Force. This is the direction in which I believe organized neurosurgery should continue to move, and it is the philosophy that I will continue to endorse as long as I’m an AANS Officer.

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On a more somber note, the AANS National Office also has undergone some challenges. During 1998, we saw key staff members, including Robert E. Drabek, PhD, the AANS Executive Director. But, rest assured, the AANS is alive and well. My thanks to Laurie Belford, Associate Executive Director of Programs, and Robert Cowan, Associate Executive Director of Administration, who have worked hard to keep the National Office services on track during this transition. If you have been frustrated or inconvenienced as a result of these recent changes, I appreciate your indulgence. It will ultimately be the members, not the leadership who decides the fate of organized neurosurgery.

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Specialist's Compensation Decreases. In 1997, the annual compensation for primary care physicians increased 0.86 percent to $135,791, while compensation for specialists decreased by 0.48 percent to $220,476, making it the second year of a downward trend in salary, according to a report from the Medical Group Management Association (MGMA) published in the November 2, 1998 issue of Health News Daily. "Increased difficulty in collections, increased competition, managed care, reimbursement rates of third-party payers, escalating costs of care, and lower use of health care services are some of the reasons for the stagnation," said Robert Bohm, a consultant for MGMA, in his report. The report is based on MGMA’s annual survey of 1,675 physician practices in various geographic areas, levels of managed care, and years in specialization.

Clinical Trials Data Bank in the Works. By the end of this year, the Food and Drug Administration (FDA) and the National Institutes of Health (NIH) will be well underway in creating a data bank of government and privately-funded clinical trials that test the efficacy of experimental treatments for serious or life-threatening illnesses. At that time, all NIH-funded trials testing the efficacy of new, developing drugs for serious or life threatening diseases will be accessible through one Internet address.

HCFA Makes Y2K Commitment. The Health Care Financing Administration (HCFA) is incorporating a requirement into contracts and agreements with Medicare contractors to ensure that all contractors "are making the commitment and taking necessary action to meet our requirements" regarding the Y2K computer compliance, according the December 11, 1998 Federal Register. HCFA is also "requiring each contractor to certify... that it has made all necessary system changes and has tested its system in accordance to the guidelines we have established," the report states. The notice is effective immediately.

NINDS Supports Parkinson’s Disease Research Centers. The National Institute of Neurological Disorders and Stroke (NINDS) will award investigators at Emory University, Massachusetts General Hospital, and Johns Hopkins University School of Medicine a total of $14 million for Parkinson’s Disease and related movement disorder research. Over the next five years, the three university hospitals will explore the causes of Parkinson’s Disease and seek new ways to diagnose and treat it. In addition, they will provide state-of-the-art, multidisciplinary training for young scientists preparing for research careers investigating neurodegenerative disorders.

Tribute to Henry G. Schwartz, MD. Henry Gerard Schwartz, MD, President of the AANS from 1967-68, died on December 24, 1998. Dr. Schwartz, a 53-year member of the AANS, was August A. Busch Professor Emeritus of Neurosurgery at Washington University School of Medicine (St. Louis, Missouri). Dr. Schwartz received his undergraduate degree from Princeton University and his medical degree from Johns Hopkins University, where he also served his residency in general surgery. In 1956, he completed his residency in neurological surgery at Washington University School of Medicine and, ten years later, was appointed Professor and Chairman of the Division of Neurological Surgery at Washington University. Dr. Schwartz served as Chair of the Editorial Board of the Journal of Neurosurgery (1988), as President of the Southern Neurosurgical Society (1952-53), as President of the Society of Neurological Surgeons (1968), and as the first Vice President of the American College of Surgeons (1972).
Many physicians hope that representation through unionization will be an effective way for them to voice their anger over the intrusive control exerted by their payers. They say they are outraged at the insurance company bureaucrats who are “calling the shots” in the health care system, and that physicians’ primary responsibility is to their or her patient, not to the managed care industry’s bottom line. Through unions, physicians hope to bring their issues to the table when negotiating with health care contractors.

Arnold C. Lang, MD, and Guillermo A. Pasarin, MD, are two neurosurgeons who, frustrated with managed care and the corporatization of health care, joined a chapter of the Federation of Physicians and Dentists—a 3,500 member union based in Tallahassee, Florida, that is affiliated with the AFL-CIO. Today, they serve as the Vice Presidents of the Federation.

“I believe that the practice of medicine should rest in the hands of those responsible for patient care—physicians,” said Dr. Lang. “We have lost total control of our profession and unionization is about standing together to say ‘no more.’”

Dr. Pasarin added, “In our specialty, patient care and medical services are increasingly being rationed by HMOs. Unions enable neurosurgeons to practice their craft without any extraneous factors.”

The Downside to Unionization

Physicians who decide to unionize, however, face many difficulties. The laws that define who can and cannot unionize sometimes inhibit physician unions from gaining government recognition, which is essential when negotiating with employers. And, for those that do receive acceptance, there is stiff resistance from other physicians who are adamantly opposed to the ultimate weapon of unionization: a strike.

Why Unions?

Under current labor laws, only non-supervisory employees may form unions. Self-employed doctors are termed independent contractors and, as such, are barred from forming unions because of federal anti-trust laws against price-fixing and other collective actions.

As dissatisfaction with managed care grows, so does interest in unions and other collective bargaining arrangements.

Any doctors see these arrangements as a means to regain leverage against hospitals, clinics and managed care companies, attain financial control, maintain physician autonomy, and increase the amount of time spent with patients. However, issues such as the impact of unionization on the medical profession, the possibility of striking, and the ethics behind collective bargaining remain a heated debate.

A Brief History

Following World War II, legislation was passed that exempted insurance companies from anti-trust laws and allowed them to share data and set prices. This position made independent contractors as competitors and, as such, prohibited the contractors from fixing prices.

Physicians, at the time, didn’t see a need for collective bargaining—they practiced independently, set their own fees, and determined which insurance plans they were going to work with on an assignment basis. However, during the 1970s and 1980s, as managed care started to rear its head, physicians’ attitudes began to change.

With fees and reimbursement cut by HMOs and PP0s and an increasing trend toward interference in medical decision-making by prior approval and utilization reviews, physicians began feeling a reduction in income and erosion in autonomy and clinical authority. Physicians started looking for a way to regain control of their practices by forming Independent Practice Associations (IPAs), including network-model HMOs, as one way to negotiate as a group with insurers. In the years that followed, as managed care grew and power became concentrated in fewer and fewer hands, doctors became increasingly frustrated and took their first steps toward unionization. Unions hoped to circumvent physicians from anti-trust laws and enable doctors to collectively bargain.

Today, interest in unions has intensified. More than 42,000 physicians—or 5 percent of the nation’s doctors—are labor union members, many of which are interns or residents. Critics contend that with an increasing number of residents adding the right to collectively bargain, medicine will see an unprecedented surge of doctors beginning their careers as card-carrying union members.

“The Medicare allowable needs to be our minimum wage, and no one should be allowed to ratchet it down.”

— Arnold C. Lang, MD

What physicians hope to gain through unions is the ability to collectively put pressure on managed care companies to do things that have been impossible within our current system. The goal is to put our patients first and to return control of medicine to the people who practice it—the physicians.

The rules that define who can and cannot unionize sometimes inhibit physician unions from gaining government recognition, which is essential when negotiating with employers. And, for those that do receive acceptance, there is stiff resistance from other physicians who are adamantly opposed to the ultimate weapon of unionization: a strike.

While understanding the difficult working conditions we, as physicians, sometimes face, I do not see how a strike could ever benefit the best interest of our patients,” said James R. Bean, MD, Chairman of the Council of State Neurosurgical Societies (CSNS). “To withhold patient care is not only an abandonment of our ethics but a stain on our image as professionals. It would also be the beginning of the end of organized neurosurgery. Without physicians, there can be no organized neurosurgery.”

Why Unions?

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As dissatisfaction with managed care continues to challenge the way we practice medicine, the battle over unionization will intensify. Superspecialists are a mission to reclaim their profession. They argue that as long as HMOs remain monopolistic, physicians will continue to suffer and thrive.

Critics, however, disagree and believe that unions are not the solution to the problems plaguing our health care industry. Rather, they say, the fix lies in eliminating the problem rather than the people who are responsible for it.

The American Medical Association (AMA) is exploring alternatives to help doctors stand up to insurers and employers. “We believe you can get the impact desired through collective bargaining without any of the philosophies and by-products of unionization,” said AMA President Nancy W. Dickey, MD (Physician News Digest, November 1997).

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Physician Collective Bargaining: Are Unions the Best Solution? by Deia Lofendo


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Many physicians hope that representation through unionization will be an effective outlet for them to voice their anger over the intrusive control exerted by their payers. They say they are outraged at the insurance company bureaucrats who are “calling the shots” in the health care system, and argue that a physician’s primary responsibility is to his or her patient, not to the managed care industry’s bottom line. Through unions, physicians hope to bring their issues to the table when negotiating with health care contractors.

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A Brief History

Following World War II, legislation was passed that exempted insurance companies from anti-trust laws and allowed them to share data and set prices. This position independent contractors as competitors and, as such, prohibited the contractors from fixing prices.

Physicians, at the time, didn’t see a need for collective bargaining—they practiced independently, set their own fees, and were their own bosses. As managed care started to rear its head, physicians’ attitudes began to change.

With fees and reimbursement cut by HMOs and PPOs and an increasing trend toward interference in medical decision-making by prior approvals and utilization reviews, physicians began feeling a reduction in income and erosion in autonomy and clinical authority. Physicians started looking for a way to regain control of their practices by forming Independent Practice Associations (IPAs), including network model HMOs, as one way to negotiate as a group with insurers.

In the years that followed, as managed care grew and power became concentrated in fewer and fewer hands, doctors became increasingly frustrated and took their first steps toward unionization. Unions hoped to circumvent physicians from anti-trust laws, and enable doctors to collectively bargain.

As dissatisfaction with managed care grew, so did interest in unions and other collective bargaining arrangements.

Many doctors see these arrangements as a means to regain leverage against hospitals, clinics and managed care providers. Attain financial control, maintain physician autonomy, and increase the amount of time spent with patients. However, issues such as the impact of unionization on the medical profession, the possibility of striking, and the ethics behind collective bargaining remain a heated debate.

Why Unions?

Under current labor laws, only non-supervisory employees may form unions. Self-employed doctors are termed independent contractors and, as such, are barred from forming unions because of federal anti-trust laws against price fixing and other collective actions.

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The Downside to Unionization

Physicians who decide to unionize, however, face many difficulties. The laws that define who can and cannot unionize sometimes inhibit physician unions from gaining government recognition, which is essential when negotiating with employers. And, for those that do receive acceptance, there is stiff resistance from other physicians who are adamantly opposed to the ultimate weapon of unionization: a strike.

“While I understand the difficulties that physicians sometimes face in organizing, I do not see how a strike could ever benefit the best interest of our patients,” said James R. Beall, MD, Chairman of the Council of State Neurological Societies (CNS). “To withhold patient care is not only an abandonment of our ethics but a stain on our image as professionals.”

Critics also argue that, instead of giving doctors more control over the practice of medicine, unions would result in medical and hospital services being administered by organized groups and paid for by funds obtained through assessments and taxation. They also contend that unionization would accelerate an erosion of the physician-patient relationship and drastically reduce health services.

“Widespread unionization is not the solution to the problem plaguing our health care industry, rather, it would only serve to make the problem worse,” said Dr. Beall. “Neurosurgeons joining unions must realize their limitations. The pressure to raise primary care income at the expense of specialty income will guide policy, just as it does in any current multispecialty medical organization.”

Dr. Lang disagrees: “Neurosurgeons represent a small specialty and, as such, will benefit from a large, collective voice. Unions are not meant to be substitutes to organized neurosurgery; rather, they are a means to help organized neurosurgery improve patient care.”

Union Alternatives?

The American Medical Association (AMA) is exploring alternatives to help doctors stand up to insurers and employers. We believe you can get the impact desired through collective bargaining without any of the philosophies and by-products of unionization,” said AMA President Nancy W. Dickey, MD (Physician News Digest, November 1997).

To demonstrate this, the AMA has publicly supported the Quality Health Care Coalition Act of 1998 drafted by Representative Tom Campbell (R-CA). The bill exempted self-employed health care professionals, including doctors in private practice, from anti-trust laws and allow them to collectively bargain with HMOs.

“The AMA has long believed an anti-trust exemption for self-employed physicians is needed to level the playing field,” said AMA Trustee Donald J. Palmisano, MD, JD, in a recent testimony before the U.S. House of Representatives Judiciary Committee. “Too often, the individual physician and the individual patient stand alone against health plan bureaucracies. This must change. The Campbell bill improves patient care and refocuses the medical decision-making process toward the physicians and patients—where it belongs.”

The Battle Intensifies

As managed care continues to challenge the way physicians practice medicine, the battle over unionization will intensify. Supporters are on a mission to retain their profession. They argue that as long as HMOs remain monopolistic, physician unions will continue to thrive and thrive.

Critics, however, disagree and believe that unions are not the solution to improving negotiations with payers. They believe that supporters need to realize that pulling down their patient’s charts in exchange for picket signs would not only be a disservice to their patients but to the medical profession as a whole.
WHILE PHYSICIANS REPRESENT diverse groups who have many different interests, unions are seizing a common set of themes to promote physician unionization. Though the emphasis may differ depending on the campaign, unions attempting to organize physicians generally address the following issues:

1. Professional Authority. Concerns about maintaining professional authority are among the most common reasons physicians give for unionization. Physicians state that their professional authority to care for the patient has been blunted by the various managed care plans. Physicians see practices such as administrative review of decisions, limitations on the number or type of tests, limitations on the specialists to whom physicians can refer to, and gag rules, as anathema to physicians’ professional authority. The unions are happy to market themselves to physician discontent. According to a Union of American Physicians and Dentists (UAPD) spokesperson, “The whole movement toward managed care has been a driving force in seeking more power for the physician. Unions are a means to gain back the power and respect that physicians perceive themselves to be losing.”

2. Job Security. Some of the job insecurity that physicians face related to mergers or closure of hospitals is a fertile ground for unions seeking to organize physicians. Physicians are worried about being fired for the cost of maintaining the workforce. With many institutions reducing workforce requirements for physicians, this will become more of an issue in the future.

3. Compensation. Compensation matters, while sometimes hidden behind other issues, are important in the drive to unionize physicians. Physicians are cognizant that falling wages are a threat to physicians’ lifestyles, especially as the cost of medical education and the amount of loans needed rise. This is an important factor that physicians consider when they are contemplating unionization. As the percentage of employed doctors grew from 25 percent in 1985 to 45.4 percent of all doctors in 1995, unions have been looking at as a vehicle for protecting and enhancing income.

4. Benefits. The subject of benefits is another issue physicians focus on when considering unionization. This can be particularly important when it involves physician malpractice insurance. The mere perception of reductions in malpractice coverage is an issue that drives physicians to consider unionization. The American Medical Association’s (AMA) house of delegates provided further momentum for physicians organizing when on July 24, 1997, it voted for resolution 239. This states that the AMA is to “seek means to remove restrictions, including drafting of appropriate legislation for physicians to form collective bargaining units.” The House of Delegates also adopted recommendations of the Board of Trustees Report 41, which calls for the AMA to form a Division of Representation “to work with state and county medical societies that also want to respond to physicians’ desires to be represented more aggressively.” Unfortunately, as presently structured, the AMA and other professional societies cannot enter into economic negotiations on behalf of their constituents.

Grace Budryk, PhD, in her book, When Doctors Join Unions, states that in the future doctors will have no alternative but to organize collectively to gain control over their work. “Whether unions or union-like organizations emerge is difficult to predict,” she said. “That will depend on the number of physicians in an area, the extent of managed care penetration, the political and social environment, and whether the courts change their interpretation of labor law.”

JOHN A. KUSKE, MD
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The Pros and Cons of Physician Unionization

Issues Driving Physician Unionization: Some Reasons Why They Make Sense

JOHN A. KUSKE, MD

YES!

Physician service contracts, whether with commercial insurers, managed care organizations, government sponsored programs (Medicaid/Medicare), or other payers have become so common as to be the rule, with charge-based or indemnity reimbursement the exception. This means that for most physicians, the payment rate is determined by a fee schedule affected by the payer—take it or leave it. Some physicians can negotiate, or haggle over the prices. But for the most part, the insurer, with the insured clients (potential patients) to offer or withhold, holds the upper hand and can set prices at a competitive market rate, regardless of the physician charge. Service contracts also include an array of other working conditions, such as timely submission of claims, appointments, balance billing restrictions, acceptance of preauthorization and utilization restrictions, formal grievance procedures, and more. These conditions also leave some room for modification, depending on the size of the insurer and the physician’s uniqueness or competition.

Thus bargaining, or the wish to bargain, has become a keystone of physicians’ professional lives. The problem for physicians is large, organized insurers setting conditions, and individual, dispersed physicians accepting them. Physicians feel unfairly disadvantaged and seek a way to level the playing field. Since bargaining is necessary, and organ...
Doctors moved away from solo, fee-for-service practice, which is the structure of practice central to the definition of medical professionalism. Establishing group practices was rational response to the increasing cost of maintaining an office, especially the administration of administrative and medical record keeping. Initially, office managers, together with other clerical staff, could handle the administrative load for a group of physicians. However, things not only got more complex, but there was an underlying shift in the nature of the task. The effect of this has forced doctors to consider what the alternatives might be. When one considers the situation more closely, one can see that doctors are confronting a difficult, far more complex, choice between two alter- natives, namely to opt for identifying with corporate management or with labor. In the past, doctors avoided the issue by asserting that medical professionalism required them to protect their patients first, and to other authorities second. By law, doctors were defined as small businesspersons and there was no need to prorate their profit. But, that is all changing.

The escalation of administrative demands associated with medical record keeping. Doctors, who not only are constrained to negotiate by the “messenger” model if the subject is non-risk reimbursement, is there an advantage a union can make heavy dues. Is there a disadvantage? Yes, for the members: they have to pay them.

To Unionize or Not…

Whether unionism is a viable option is to consider the alternatives. When one considers the situation more closely, one can see that doctors are confronting a difficult, far more complex, choice between two alter- natives, namely to opt for identifying with corporate management or with labor. In the past, doctors avoided the issue by asserting that medical professionalism required them to protect their patients first, and to other authorities second. By law, doctors were defined as small businesspersons and there was no need to prorate their profit. But, that is all changing.

The recent wave of physician unionism across the country indicates that doctors are so angry and frustrated that they are willing to try unionizing as a last resort. Whether this turns out to be a good decision or not depends on whether those who join are able to maintain their frustration and turn their energies toward creating an effective organization. But, that’s getting ahead of the story.

Managed care organizations were entering into a particularly active phase, expanding, merging, and changing in the tireless pursuit of...
The Pros and Cons of Physician Unionization

The Road Ahead
Is there a future for physician unions? Maybe, but doubt it. There certainly is a future for unions as a bargaining agent for physicians in independent practices. As a transitional vehicle, they ease the traditional physician status change from sole proprietor and individual entrepreneur to employee of larger organizations. They help physicians under duress believe that they have gained a bargaining advantage, which they ultimately find to be elusive.

The interest in unionization of physicians will likely be brief—a flash in the pan. View it as a memory-augmented reaction to change, to professional frustration, and to a sense of powerlessness, futility and gloom. As older physicians adjust to and younger physicians enter into the new world of contractual, market-driven fees, of greater professional competition, of tighter management of resources, and of limitless expanding technical capabilities, they will find a new economic equilibrium and an expanded sense of opportunity. Neurourologists are not yet ready to substantiate their independence, initiative, income, and self-image to the leveling discipline of trade union membership.

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Physician Unions Resources on the Web
Go site seeing on the information super highway to learn more about physician unions.

Physicians and Dentists
http://www.tpsdu.com

The American Federation of State, County, and Municipal Employees
http://www.afscme.org

Office Professionals and Employees International Union
http://www.copeiu.org

Union of American Physicians and Dentists
http://www.uapd.com/index.html

University of California Association of Interns and Residents
http://www.ucmg.org/ucar

When to Think: Pro or Con?
The American Association of Neurological Surgeons is interested in hearing your thoughts on physician unionization. Please post your comments, questions, and concerns on the official Web site of the AANS and the AANS/DONIC Union Call.

To access the AANS/DONIC site, go to www.aans.org and click on the "Professional Pages." Then, you will see a link for the Bulletin Board. Select the link and tell us your views on physician unionization.

The Pros and Cons of Physician Unionization

GUEST COLUMN
Grace Budrys, PhD

To Unionize or Not...
Why Do Doctors Join Unions?

A s most physicians will tell you, unionizing means retreating to the ultimate weapon used by unions—the vote—and that is unthinkable. What’s the point of joining a union if you don’t intend to strike? Besides, it’s just too onerous.

However, an increasing number of doctors are saying that it is now not only reasonable but necessary to join a union to protect their livelihood and their freedom to negotiate. Even an occasional strike can be a powerful reminder to an employer that doctors are not just part of the assembly line but are full professionals who are not just a cost of maintaining an office, especially the small ones, but a business expense. By law, doctors were defined as small businesspersons and there was no need to press the matter. Now, that has all changed.

A reasonable place to start in deciding whether unionism is a viable option is to consider what the alternatives might be. When one considers the situation more closely, one can see that doctors confront a difficult, foridable choice between two alteratives, namely to opt for identifying with corporate management or with labor. In the past, doctors avoided the issue by asserting that medical professionalism required them to be responsible to their patients first, and to other authorities second. By law, doctors were defined as small business persons and there was no need to press the matter. Now, that has all changed.

How it all Started
It all began innocently enough, when doctors banded together into groups sometime after the World War II recessionary period ended during the 1960s.

The effect of this has fostered doctors to choose between the available legal options in identifying the nature of the organizations that they chose to form to represent them and their occupational interests. One option is to assume a corporate, business identity. And, many doctors have done just that. They have accepted the designation assigned to them by the industry and allow the market for physicians’ services to operate based on fundamentalsupply and demand principles. That is the market model.

Managed care organizations were quick to take advantage of the market model. The fact that most patients (doctors, patients, and health centers) in the health care delivery system are now involved in contractual arrangements with large organizations means that the stakes have been raised, and more disagreements leading to legal disputes have come before the courts. This has put pressure on everyone to make their organizational objectives clear and put into contractual language.

The benefit of this has forced doctors to choose between the available legal options in identifying which organizations have market power, physicians inevitably see the value of— if not the urgent need for—collective bargaining. Collective bargaining in American medicine makes the emergence of physician unions.

Furthermore, physicians do not qualify for collective bargaining rights, and federal antitrust laws are unlikely to be altered to allow for all payment. Their relationship with a health insurer does not fit the definition of employer-employee relationship, and they do not qualify for the minimum-wage, overtime, and health benefits of collective bargaining.

That’s why it is important for physicians to consider whether or not to join a union. Although there may be some advantages to excluding physicians from unionization, these advantages are outweighed by the disadvantages of exclusion.

What’s the point of joining a union if you don’t intend to strike? Besides, it’s just too onerous.

Physicians are saying that it has all, most notably managed care, gone too far and that joining a union is the one action that will capture the HMO bean counters’ attention.

The recent wave of physician unionism across the country indicates that doctors are so angry and frustrated that they are willing to try unionizing as a last resort. Whether this turns out to be a good decision or not depends on whether those who join are able to maintain their frustration and turn their energies toward making an effective organization. But, that’s getting ahead of the story.

A major reason to start in deciding whether unionism is a viable option is to consider what the alternatives might be. When one considers the situation more closely, one can see that doctors confront a difficult, foridable choice between two alteratives, namely to opt for identifying with corporate management or with labor. In the past, doctors avoided the issue by asserting that medical professionalism required them to be responsible to their patients first, and to other authorities second. By law, doctors were defined as small business persons and there was no need to press the matter. Now, that has all changed.

And, that in a nutshell explains why doctors now confront a forced choice in how they are defining themselves. It is because doctors’ organizations suddenly became so large that they began to attract the government’s attention.

The government became concerned that doctors’ groups were becoming monopolistic. It started with one or two doctors who were asked to leave such groups and responded by taking the groups to court, arguing that they were being pre-empted from earning a living. That touched off government anti-trust legislations.

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good business practices, which is, of course, the essential problem in the view of others. Critics argue that good business practices is not the same as good medical practice.

**Profit Versus Patient**

Theorists that competition, in this case competition among doctors, requires holding costs down to keep prices down. Holding costs down is not bad in and of itself. It becomes objectionable, however, when it is achieved through the restriction of services — more precisely, restriction of efficacious services. While drawing the line on what is or is not efficacious is clearly debatable, the principle remains. The problem that a number of medical professionals have pointed out is that doctors who choose to embrace business principles which place greater value on efficiency rather than efficacy, risk being viewed as having a greater commitment to maximizing their profit than to their patients’ health.

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Picking Sides

Steep HMO Premium Increase Ahead

The other forced-choice option is aligning oneself with workers rather than management. How is this an improvement, especially given that talk of unionization brings to mind factory workers with smutty fasces on the picket line with the threat of violence hanging heavy in the background? That has certainly been a problem for doctors. The imagery associated with unionism in this country brings industrial unions to mind, which includes the tactics used by industrial unions to achieve better wages and working conditions for their members. This is not the image of unionism held by people in other highly industrialized countries. In European countries people treat unions instrumentally. Whether they are professionals or not, they see themselves as having a legitimate interest in improving their wages and working conditions. Union representatives can carry on these negotiations. The idea that members of a prestigious occupation will lose status if they join unions and use them to carry out negotiations with the organizations that determine wages and working conditions is not an issue. Indeed, virtually all European countries have strong doctors’ unions.

It is worth considering when and why European physicians formed unions. They did so for the service-to-service practice began to disappear. There were really no alternatives. Everyone understood that large organizations, whether it was the central government, as in Sweden or locally established sickness funds as in Germany, were not interested in negotiating with doctors on an individualized basis. As health care organizations grew, the doctors who treated patients were more likely to be patients themselves, and if they felt that the doctors who treated them were not being treated well, the physicians’ unions were organized to ensure that the physicians’ needs were met. This is not the case in the U.S., where professional organizations have largely taken over the role of medical associations, and where the interests of physicians are more closely aligned with those of the organizations that control the market and control the market’s rules.

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Very month, HMOs lose up their contracts over patient choice and contractors take place among providers. In many ways, it looks like a fight being played out by the government.

**Pickering’s Point**

Will the Trend Toward More Consumer Choice (and Rising Costs)Continue?

Will this trend toward more consumer choice, which will raise costs, play out in larger numbers of lives enrolled? No one knows. Will such plans take the steam out of efforts by physicians and hospitals to organize into systems that can go at risk under capitalization agreement? Maybe.

**Tumol in the HMO Market**

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**Health Care Costs and the Future**

With health care costs on the rise again, and the first generation of managed care having matured itself into market grid-lock, it is inevitable that there will be a second employer revolt. Kaiser Permanente also could face sizable lig-ger than 1997’s deficit of $266 million. Modern Healthcare reports that the annual loss may approach $600 million and Kaiser officials have stated that this amount is fairly accurate. Just two years ago, Kaiser posted a profit of $265 million.

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The other forced-choice option is aligning oneself with workers rather than management. How is this an improvement, especially given that talk of \"employee-friendly\" unions is a double bind? European physicians formed unions. They did so because as fee-for-service practice began to disappear, there was really \"little\" left to do other than organize. Everyone understood that large organizations, whether it was the central government, a national or locally established sickness funds as in Germany, were not interested in negotiating with doctors on an individual basis. As health care organizations in the U.S. become larger and more centralized, they, too, expect to deal with physician groups and small businesses in certain types of markets. According to data in Integrated Healthcare Report, these products known as \"No Deductible PPO Plans\" will combine the cost-saving features of an HMO with the open access network of a PPO. Individual members, for example, can select a 20% co-insurance or $50 per visit co-payment for an office visit, and with this co-payment there is no annual deductible and no prescription fee. Moreover, doctors are not restricted to a narrow network of providers, and may choose from a range of doctors and hospitals, and access network specialists without prior authorization. Will this trend toward more consumer choice which will raise costs, play out with larger numbers of lives enrolled? No one knows. Will such plans take the steam out of efforts by physicians and hospitals to organize into systems that can go at risk under capitation agreement? Maybe.

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It is worth considering when and why European physicians formed unions. They did so because as fee-for-service practice began to disappear, there was really \"little\" left to do other than organize. Everyone understood that large organizations, whether it was the central government, a national or locally established sickness funds as in Germany, were not interested in negotiating with doctors on an individual basis. As health care organizations in the U.S. become larger and more centralized, they, too, expect to deal with physician groups and small businesses in certain types of markets. According to data in Integrated Healthcare Report, these products known as \"No Deductible PPO Plans\" will combine the cost-saving features of an HMO with the open access network of a PPO. Individual members, for example, can select a 20% co-insurance or $50 per visit co-payment for an office visit, and with this co-payment there is no annual deductible and no prescription fee. Moreover, doctors are not restricted to a narrow network of providers, and may choose from a range of doctors and hospitals, and access network specialists without prior authorization. Will this trend toward more consumer choice which will raise costs, play out with larger numbers of lives enrolled? No one knows. Will such plans take the steam out of efforts by physicians and hospitals to organize into systems that can go at risk under capitation agreement? Maybe.

Profit Versus Patient

The critics say that competition, in this case competition among doctors, requires holding costs down to keep prices down. Holding costs down is not bad in and of itself. It becomes objectionable, however, when it is achieved through the restriction of services—more precisely, nontariff restrictions of efficacious services. While drawing the line on what is or is not efficacious is clearly debatable, the principle remains. The problem that a number of medical professionals have pointed out is that doctors who choose to embrace business principles which place greater value on efficiency rather than efficacy, risk being viewed as having a greater commitment to maximizing their profit than to their patients’ health.

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Outcomes Initiative

Concepts and Strategies for Implementing an Outcomes Initiative

Megan Morgan

In the world of medicine, as in the world of any endeavor, quality and safety are paramount. With the growing emphasis on outcomes, the need to develop outcomes initiatives to improve quality and cost effectiveness is critical. The reasons cited for this lack of involvement vary, but having a conceptual understanding of outcomes is certainly a challenge shared by all.

Following are some compelling reasons for surgeons to implement outcomes initiatives into their practice:

• Achieve improved clinical outcomes
• Generate short-term successes
• Improve efficiency
• Collect data to support negotiations with managed care
• Improve management skills through the collection and analysis of data

Challenges in Implementation and Facilitating Change

Physicians were trained to practice medicine. They have not been trained in total quality management, and implementing an outcomes initiative requires new skills. Internal resources within practice are stretched. The perception that implementing an outcomes initiative is too burdensome must be overcome.

Most significantly, the development and implementation of a broad outcomes initiative represents change and requires commitment. The causes for the failure in implementation can most often be found in a lack of commitment by the leadership and a failure to manage the change process. Although an in-depth analysis of leadership and change goes outside the scope of this discussion, the following basic concepts should be kept in mind:

• Develop a vision and strategy
• Create a team to create goals and objectives, as well as overall strategies.
• Make certain that the members include representatives of the leadership within the practice.
• Improve management skills through the collection and analysis of data.
• Establish a sense of urgency. Everyone resists change. A major factor in overcoming reluctance to create a sense of urgency is the perception that implementing an outcomes initiative is too burdensome. Organizational resistance to change and requires commitment. The causes for the failure in implementation can most often be found in a lack of commitment by the leadership and a failure to manage the change process. Although an in-depth analysis of leadership and change goes outside the scope of this discussion, the following basic concepts should be kept in mind:

In order to survive and thrive, practices must measure their outcomes and seek to implement improvements. Decisions must be data driven in order to successfully negotiate with managed care.

Phase I: Planning

Developing an effective plan is the most critical segment of implementing an outcomes improvement system. Key elements of the planning phase include:

• Assessing your practice and your health care marketplace. In order to effectively implement meaningful changes and keep your efforts small and simple, look at your practice and the marketplace in which you practice.

Review the following questions: 1) Is there a disease process or procedure for which we have significant variance in outcome? 2) Do we know whether our patients are satisfied with the care they are receiving? 3) Are we being faced with negotiating capital contracts? If so, do we have the data that will allow us to have an accurate picture of our patients and the cost of their treatment? 4) Are we required to obtain approval from managed care plans prior to implementing treatment? 5) Would the collection and presentation of data affect the process that we use? 6) How will looking at the process of care within our practice increase profitability? 7) Are there variations in the treatment process among the physicians in our practice which lead to difficulty in the care process and/or variances in outcome?

Create a team to create goals and objectives, as well as overall strategies. Make certain that the members include representatives of the leadership within the practice. Once the team is created, begin to develop a written plan that clearly sets out the approach being used, the reasons for implementing an outcomes initiative, and who is responsible for various tasks and how you will measure success. An important part of the plan will be the development of a clear vision, mission statement, and overall strategy for the practice.

Develop an outcomes initiative, in any setting, represents a continuum. Each step along the continuum must be carefully planned for and developed prior to implementation. Beginning an outcomes initiative also requires both a significant planning process and a willingness to change. Although the process seems daunting, it is possible to develop an outcomes initiative that yields valid data in a cost-effective, efficient manner.

Phase II: Implementation

During this phase, the team will finalize what data will be collected, what measures will be used, and how the collection of data will be integrated into the clinic routine. It is suggested that the final implementation design be tested on a small group of patients (10-15) to see how the process works and if there are modifications that will streamline the process. Typical issues dealt with during this phase include: 1) Do we need to have a database in designing this plan and analyzing the data? 2) What outcome measures will be collected? 3) Which instruments or measures will we use? 4) Which patients will we select for collecting and how will they be followed? 5) What data will we collect and when? 6) When will the process begin?

Phase III: Analysis

Data analysis is a key factor in achieving success. If you have collected simple, useful measures, analysis should lead to answering the questions posed during your planning phase. Typical questions include: 1) Does the patient population differ or are patient characteristics similar? 2) Do the collected data support your plans? 3) How can the analysis be displayed in a way that leads to a prompt understanding of the results? 4) What does the analysis reveal about areas requiring improvement or change within our practice?

Phase IV: Feeding the Data Back

Once the data analysis is complete, the data should be distributed to all members of the practice in an effort to define what areas require improvement. Implement changes to improve the targeted areas, and continue to measure the outcomes to verify the effectiveness of the changes. In addition, developing a reporting mechanism to physicians is critical. For example, if one of the managed care plans is critical of your length of stay, a report showing length of stay information will be critical in challenging their position. Practices often view the collection of outcomes data and the implementation of an outcomes initiative as an overwhelming burden. The truth is that it does not have to be. Resources, however, can be used effectively and lead to achieving favorable information. In order to survive and thrive, practices must measure their outcomes and seek to implement improvements. Decisions must be data driven in order to successfully negotiate with managed care.

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The growing demand for data and the increasing level of accountability will continue. Practices that proactively begin to implement outcomes improvement systems will be able to prosper in a competitive health care marketplace. Practices that fail to address the need to collect outcomes data will find themselves continuously reacting — a time-consuming and ineffective response.

Megan Morgan is the Project Manager for the AANS/CNS Outcomes Initiative— a team convened to provide tools to AANS/CNS members for use within their practices to measure, monitor, and manage selected outcomes; and provide the capacity to store outcomes data on a national level through a data repository which will allow for aggregation of data and individual comparison against a national benchmark.
he world of medicine has changed and physicians must be prepared to adapt and prosper. Despite the growing interest in outcomes, relatively few organizations have become involved in developing outcomes initiatives to improve quality and cost effectiveness. The reasons cited for this lack of involvement vary, however, many of the conceptual tools to implement outcomes initiatives are clearly a challenge shared by all.

Following are some compelling reasons for surgeons to implement outcomes initiatives into their practices:

- **Achieve Improved Clinical Outcome**
- **Reduce Costs and Increase Cash Flow**
- **Improve Efficiency**
- **Collect Data to Support Negotiations with Managed Care**
- **Improve Management Skills Through the Collection and Analysis of Data**

**Challenges in Implementation and Facilitating Change**

Physicians were trained to practice medicine. They have not been trained in total quality management and implementing an outcomes initiative requires new skills. Internal resources within practices are already stretched. The perception that implementing an outcomes initiative is too burdensome must be overcome. Most significantly, the development and implementation of a broad outcomes initiative represents change and requires commitment. The causes for the failure in implementation can most often be traced in lack of commitment by the leadership and a failure to manage the change process. Although an in-depth analysis of leadership and change goes outside the scope of this discussion, the following basic concepts should be kept in mind:

- **Organizational commitment must be present.** Without the support and input from physicians, an outcomes initiative is impossible. Likewise, without the support and involvement of key non-physician staff (i.e., nurses, administrators, etc.) any data collected will be at best, incomplete. Identifying both physician and non-physician champions will assist in motivating others and provide momentum to move the process along.

- **Develop a vision and strategy.** There are a number of reasons to collect outcome data. The vision developed for the outcomes initiative should include as many reasons as possible for its implementation. The strategy created should directly link to that vision. Lastly, and most importantly, the vision and strategies must be communicated frequently to all staff; at all levels of your practice.

- **Remove obstacles.** Even with the most motivated clinical staff, there are obstacles to implementing outcomes initiatives in every practice. For example, the sign-in process might not support distributing patient reported outcomes instruments. Financial data may not be linked electronically to patient records. Whenever possible, review those obstacles and find ways to remove them. The processes within your practice must be retooled to support the systematic collection of outcomes data.

- **Generate short-term successes.** Select projects at the beginning of the implementation process that will yield meaningful data in a relatively short period of time. For example, implementing a report card for selected outcome indicators or a patient satisfaction survey can produce an early success that yields useful data.

- **Establish a sense of urgency.** Everyone resides change. A major factor in overcoming resistance to create a sense of urgency. Organizations fail to implement system to assess and improve outcomes will be at best, unable to remain profitable, survive and prosper.

**Concepts and Strategies for Implementing an Outcomes Initiative**

Megan Morgan

In order to survive and thrive, practices must measure their outcomes and seek to implement improvements. Decisions must be data driven to negotiate with managed care.

**Phase I: Planning**

Developing an effective plan is the most critical segment of implementing an outcomes improvement system. Key elements of the planning phase include:

- **Assessing your practice and your health care marketplace.** In order to effectively manage meaningful improvement and to keep your efforts small and simple, look at your practice and the marketplace you are practicing within.

- **Review the following questions: 1) Is there a disease process or procedure for which we see significant variance in outcome? 2) Do we know whether our patients are satisfied with the care they are receiving? 3) Are we being faced with negotiating capital contracts? 4) So, do we have data that will allow us to have an accurate picture of our patients and the cost of their treatment? 5) Are we required to obtain approval from managed care plans prior to implementing treatment? 6) Would the collection and presentation of data influence the process that we use process? 7) How will looking at the process of care within our practice increase profitability? 8) Are there variations in the treatment process among the physicians in our practice which lead to difficulty in the care process and for variances in outcome? 9) Create a team to create goals and objectives, as well as overall strategies. Make certain that these goals and objectives, as well as overall strategies are included as representatives of the leadership within the practice. Once the team is created, begin to develop a written plan that clearly sets out the approach being used, the reasons for implementing an outcomes initiative, the assignment of responsibility for various tasks, and how you will measure success. An important part of the plan will be the development of goals and objectives that answer the following questions:

- **What are we trying to measure?** 1) What are we trying to measure? 2) What process are we trying to improve? 3) How will we measure improvement? 4) How will we improve the process once the data is collected? 5) What will we do with the data once it is collected?

- **Phase II: Implementation**

During this phase, the team will finalize what data will be collected, what measures will be used, and how the collection of data will be integrated into the clinical routine. It is suggested that the final implementation design be tested on a small group of patients (10-15) to see how the process works and if there are modifications that will streamline the process. Typical issues dealt with during this phase include:

- **1) Do we need outside help in designing this plan and analyzing the data? 2) How will the outcomes measures be collected? 3) Which instruments or measures will we use? 4) Which patients will we collect the data from and over what period of time? 5) Once we have the data, how will we analyze it?**

**Phase III: Analysis**

Data analysis is a key factor in achieving outcomes. If you have collected simple, useful measures, analysis should lead to answering the questions posed during your planning phase. Typical questions include:

- **1) Does the patient population differ so that risk stratification is required? 2) How can the data be analyzed in a way that answers the questions we have posed? 3) How can the analysis be displayed in a way that leads to a prompt understanding of the results? 4) What does the data analysis reveal about areas requiring improvement or change within our practice?**

**Phase IV: Feeding the Data Back**

Once the data analysis is complete, the data should be distributed to all members of the practice in an effort to decide what areas require improvement. Implement changes to improve the nearest targeted and continue to measure the outcomes overtime to assess the effectiveness of the changes.

In addition, developing a reporting mechanism to payers is often valuable. For example, if one of the managed care plans is critical of your length of stay, report showing length of stay information will be beneficial in challenging their position. Practices often view the collection of outcomes data and the implementation of outcomes initiatives as an overwhelming burden. This is, of course, true, but when integrated into the clinical routine, it is possible to develop an outcomes initiative that yields valid data in a cost-effective, efficient manner.
Questions and Answers

The AANS/CNS Task Force on CPT Coding Answers Some Common Coding Questions

I have been coding 67900-52 for percutaneous glycerol bathing of the trigeminal ganglion, which I term a neurolysis. However, I’m not sure that this is the correct code given that it is not a stereotactic procedure. Do you have any coding suggestions?

There are two possible codes for a glycerol injection to the gasserian ganglion—usually 64620, where glycerol is considered a form of chemical neurolytic agent or possible 61790. Some might consider facial landmarks and intraoperative fluoroscopic guidance as a form of stereotaxis, thus reporting 67900. The latter coding approach is a gray matter that could be interpreted either way, so we suggest using 64620 for safe coding.

I have some discrepancies with coding surgery done with two other physicians for carpotery and fusion. There is usually a general surgeon for approach, a neurosurgeon for his portion and an orthopedic surgeon for the fusion and instrumentation. There is a question as to whether this is assisted surgery, co-surgery or team surgery. Depending on this, I would then have to question the codes to use.

The use of several surgeons operating is simply resolved by having the surgeon code for his part of the operation. The general surgeon should code the main operative code with a -62 modifier to address the issue of the approach. The neurosurgeon would code for his contribution (disectomy, carpotery, etc.), which may have a -62 modifier attached. The orthopedic surgeon should code for the arthrodesis and the instrumentation. Under Medicare rules, the orthopedic surgeon and the neurosurgeon cannot use -80 modifier to describe their assisting on the other parts of the operation since they are billing a full operative cadence that patient at the same operative session. The -66 surgical team modifier is risky to use because there is not a reimbursement rules for that modifier and you are therefore leaving it up to the discretion of the insurance company to decide the reimbursement. Beginning in 1999, the CPT rules will only allow use of the -66 modifier on a single code per operative visit. However, one might now be able to use the -80 modifier on any other code in which one surgeon assisted the other.

What coding procedures should be used for anterior cervical discectomy and fusion with iliaco aorta graft?

See examples in the chart shown in Figure 1. Several important observations should be made regarding these examples. In the last example, the payer identification number will not allow the carrier to differentiate between the two neurosurgeons. Since specialists are not recognized, one of the partners should expect a 50 percent reduction in either your 67900 or 22554, as seen in the first example. There are no examples of two neurosurgeons as co-surgeons since the -62 modifier applies to surgeons of different specialties.

Also, there are no examples of one surgeon acting as the primary surgeon for the disectomy while the other is assisting, then, via versa. One surgeon must either be primary or assistant in a single operator situation, but not both.

Jeffrey Fischbein, MD is a neurosurgeon at Thomas Jefferson University and is faculty member for the AANS/CNS course on Reimbursement Foundations.

Kim Pollock, RN, MBA, is an instructor for the AANS CPT Courses on Coding and Reimbursement, and a consultant specializing in coding and reimbursement issues for neurosurgeons at Karen Zupko & Associates, a medical practice management consulting firm based in Chicago.

Kim Pollock, RN, MBA

The neurosurgeon performing the entire procedure would code: 22554

A general neurosurgeon performing the disectomy and the patient neurosurgeon performing the graft harvest and arthrodesis would code: Neurosurgeon: 63075-51 Anterior Cervical Discectomy with Osteophytectomy 12.57 RVU

22554-62 Anterior Cervical Arthrodesis 41.95 RVU

26075-52 Anterior Cervical Interbody Fusion 26.22 RVU

26932-52 Anterior Cervical Arthrodesis with Instrumentation 68.42 RVU

Harvest Procedure 67900-52, including discectomy, removal of Osteophytectomy 5.03 RVU

Harvest Procedure 67900-52, including discectomy, removal of Osteophytectomy 40.19 RVU

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I have some discrepancies with coding surgery done with two other physicians for carpentry and fusion. There is usually a general surgeon for approach, a neurosurgeon for his portion and an orthopaedist for instrumentation. There is a question as to whether this is assisted surgery, co-surgery or team surgery. Depending on this, I would then have a question as to the codes to use.

The issue of several surgeons operating together as co-surgeons would code:

A general neurosurgeon performing the discectomy and an orthopaedist performing the graft harvest and arthrodesis would code:

The neurosurgeon performing the entire procedure would code:

The neurosurgeon performing the discectomy and the orthopaedist performing the graft harvest and arthrodesis would code:

The neurosurgeon and orthopaedist working together as co-surgeons would code:

The neurosurgeon and orthopaedist working together as co-surgeons would code:

The neurosurgeon and orthopaedist working together as co-surgeons would code:

A general surgeon performing the discectomy and the orthopaedist performing the arthrodesis and graft harvest would code:

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A general surgeon performing the discectomy and the orthopaedist performing the arthrodesis and graft harvest would code:

Stay On Top of Coding Issues

The rules and regulations for accurate coding and documentation are becoming more complex. New American Medical Association—Health Care Financing Administration (AMA/HCFA) guidelines for Evaluation and Management (E&M) documentation were proposed in 1997 only to be tabled for further revision. However, if your documentation is audited now by Medicare, their 1997 rules will apply.

Current Procedural Terminology (CPT) describes the rules for coding procedures and patient encounters. Insurance carriers, Medicare, Medicaid, managed care plans, and worker compensation carriers are all at liberty to interpret these rules. Where CPT guidelines are unclear, Medicare administrators, in particular, might choose to apply their own interpretation.

Coding Corner

Kim Pollock, RN, MBA, is an instructor for the AANS PDP Course on Coding and Reimbursement, and a consultant specializing in coding and reimbursement issues for neurosurgeons at Karen Zupke & Associates, a medical practice management consulting firm based in Chicago.

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The “Getting SMART About Neurosurgery” education and practice marketing program was created in 1996 to respond to many changes impacting neurosurgical practice—particularly the challenges arising from competing specialties that have expanded the scope of their practices to include many procedures and services once the primary domain of the neurosurgeon. Its primary focus is to increase awareness with referring physicians, patients, and the media about the role neurosurgery plays in treating common medical conditions. The first SMART program, which focused on lumbar spinal stenosis (LSS), was launched in September of 1997 and has exceeded its enrollment, financial and material distribution goals. In fact, a recent survey of Ambassadors revealed that program users were satisfied with the quality of the materials and their usefulness, and that they have received patient referrals as a result of their participation in the SMART initiative.

Now, the AANS and CNS are building upon the success of the lumbar stenosis program to begin Phase II of the SMART program, “Getting SMART About Cerebrovascular Disease: An Educational Program on Stroke.”

Bruce Kaufman, MD, was selected as the overall Project Chairman and Warren R. Selman, MD, serves as Scientific Chairman.

Getting SMART About Cerebrovascular Disease

In broad terms, stroke is a growing threat to the well being and productivity of aging Americans, including those who are now entering middle age. Each year, more than 700,000 people suffer a stroke—a number equivalent to the entire population of Wyoming. It is the third leading cause of death in America. Just as important, stroke also is the number one cause of disability, with more than 3,000,000 people currently living with physical and mental impairment from brain damage caused by a stroke. The AANS and CNS want to help healthcare professionals identify patients who are at high risk for stroke, and to recognize patients who are in need of urgent care for stroke. Stroke is preventable and it is treatable. Educating the public and healthcare professionals about preventative therapies and the urgency of treatment is the key to reducing stroke incidence and its disastrous outcomes.

Neurosurgeons, as cerebrovascular specialists, are unique in their ability to evaluate, use, and recommend medical management, microsurgery, endovascular surgery, and stereotactic radiosurgery to treat or present all types of strokes and the complications of each form of treatment. In order to be in a position to have their opinions sought after, neurosurgeons must be viewed as stroke specialists, and not solely as technocrats with a narrow skill.

“The key issue is not whether an individual neurosurgeon can or should practice all the techniques used in the treatment of stroke, but rather neurosurgeons as a group must be perceived as stroke specialists, or their influence on the treatment of these diseases will be lost,” said Dr. Selman.

As with the LSS SMART program, distribution of the CV SMART materials will be accomplished through recruitment of neurosurgeon Ambassadors. This approach will allow neurosurgeons the opportunity to establish new referral patterns for CV patients, as well as re-establish contact with old or diminishing referral sources.

Objectives

The CV program objectives include:

- Raise awareness of the neurosurgeon’s expertise in preventing and treating stroke and cerebrovascular disorders;
- Position neurosurgeons as the best resource to teach family physicians and first responders about the treatment of stroke;
- Increase CV/Stroke case referrals to neurosurgeons; and
- Establish neurosurgeons as leaders in the organization of stroke teams and stroke centers.

Program Materials

As with Phase I, the CV program will include the materials aimed at referring physicians, as well as patients. The materials include:

- Comprehensive presentations (with teaching syllabi) for both professional and patient audiences;
- 200 patient and 100 referring physician brochures;
- Sample letters to referral sources; and press releases.

The print materials can be used as leave-behinds at presentations and in mailings to primary care providers and other referral sources. All materials will cover hemorrhagic and ischemic stroke, warning signs and risk factors; the role of carotid endarterectomy in prevention; aneurysm procedures; conservative and surgical treatment options; and the neurosurgeon’s role—as an integral member of the stroke team—in assessing the patient.

The Ambassador kit also will include guidelines for developing a stroke team at your medical center.

Joining the Program

A brochure on the program will be mailed to AANS and CNS members in March. To purchase the program use the order form enclosed with the brochure; call AANS Customer Service (847 692 9900); or download the order form at www.neurosurgery.org. The program is $300, plus shipping. Program materials will be available in April.
The AANS Board of Directors gathered in Chicago, Illinois, on November 20-21, 1998 for their fall meeting. Some of the highlights of their actions are presented here.

Executive Director

The Board accepted the resignation of Robert E. Draba, PhD. Dr. Draba had been the Executive Director of The American Association of Neurological Surgeons since May 1, 1996.

“It is with great regret that we accepted Dr. Draba’s resignation,” said Russell L. Travis, MD, President of the AANS. “We are grateful for his leadership over the past two-and-a-half years and wish him well in his future endeavors.”

Norman Broadbent International, Inc., an executive recruitment firm, has been hired to conduct the search for a new AANS Executive Director.

CSNS

James R. Bean, MD, Council of State Neurosurgical Societies (CSNS) Liaison to the Board presented the following two resolutions for review and approval:

- Request that the Committee on the Assessment of Quality make the Committee’s Report Card on performance measures, as well as new performance measures specific to neurosurgery, available to members of The American Association of Neurological Surgeons and Congress of Neurological Surgeons, to compare with performance measures as defined by health care plans.

CSNS

Endorsement of the American Medical Foundation’s concept program called the Foundation for Advancement of Medical Education (FAME) was approved. The proposed FAME Specialty Society Program is an outgrowth of FAME’s experience in peer review of surgical outcomes. It is designed for Board-certified or Board-eligible neurosurgeons and orthopedic surgeons who wish to obtain a “Certificate of Completion” as evidence of completion of a prescribed course to use interbody fixation devices in Lumbar Interbody Fusion (LIF). The program represents an enormous opportunity to improve the current ad hoc training in new technologies and procedures.

FAME

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Membership

Eighteen applications for Active membership were approved, as were 30 applications for Active (Provisional) membership, 12 applications for Associate membership, and 16 applications for International Associate membership. Sixty-eight requests for membership class transfers from Active (Provisional) to Active membership also were approved.

In addition, one transfer from Associate to Lifetime (inactive) was approved, as well as one transfer from Active (Foreign) to Lifetime (inactive), and one transfer from International Associate to Lifetime. Lastly, 34 transfers from Active to Lifetime membership were approved.

NOTICE OF AANS MEMBERSHIP SUSPENSION

On November 21, 1998, The American Association of Neurological Surgeons (AANS) Board of Directors approved the recommendation of the Professional Conduct Committee that an Indiana neurosurgeon’s membership in the AANS be suspended for a period of six months due to unprofessional conduct while giving testimony in a civil action. The Board of Directors agreed that in his testimony, the Indiana neurosurgeon misrepresented his level of expertise in the subject of lateral mass/lumbar fusion with instrumentation, failed to adequately research the subject of lateral mass/lumbar fusion with instrumentation, assumed the role of an advocate for the party who paid for his services, and failed to present the broad spectrum of neurosurgical thought on the issues involved in the case.
Repatriations are nearing completion for the 67th Annual Meeting of The American Association of Neurological Surgeons, to be held April 24–29, 1999 in New Orleans, Louisiana. L.N. Hopkins, MD, 1999 Annual Meeting Chairman, said, “The Planning Committee has set the stage for an energetic and educational program, while the Local Arrangement Chairs, Dr. and Mrs. Lucien Miranne, have organized some fabulous social activities.”

“The meeting promises to be spectacular,” Steven L. Giannotta, MD, 1999 AANS Annual Meeting Scientific Program Chair added. “The Scientific Sessions and exhibits will showcase contemporary innovations and research advances from all realms of neurosurgery.”

Program Highlights

- **Opening Reception Sunday, April 25 at 6:30 p.m.** The AANS will welcome members to New Orleans with an exciting evening in the Grand Ballroom of the New Orleans Hilton and Towers. The event will be the perfect place for you to visit with old and new friends. Shuttle buses will be provided from each hotel and hors d’oeuvres and beverages will be served.

- **Presidential Address Monday, April 26, 12:20 p.m.** Russell L. Travis, MD, will deliver his Presidential Address to the AANS membership and pay tribute to some of organized neurosurgery’s past and present heroes, as well as discuss their role in leading this specialty to the forefront of medicine.

- **Cushing Oration Tuesday, April 27, 11:30 a.m.** The 83rd President of the United States, George Herbert Walker Bush, has been invited to deliver this year’s Cushing Oration.

- **Schneider Lecture Tuesday, April 27, 12:15 p.m.** AANS members are invited to attend an exclusive presentation by Malcom R. DeLong, MD, the William Timmie Professor and Chairman of the Department of Neurology at Emory School of Medicine, and the 1997 recipient of the Alfred E. Winterer Award. Dr. DeLong will discuss “The Neurosurgical Treatment of Movement Disorders: Past, Present, and Future.”

- **Special Lecture III Wednesday, April 28, 11:15 a.m.** Steven Ramee, MD, will discuss the move among international specialists to pool their talents and create programs that address the care of the whole patient in his talk, “Global Revascularization: A Paradigm for the 21st Century.” His presentation will explore the growth of endovascular therapy and the role of clinicians in the management of vascular patients throughout the world. He also will touch upon the potential for the development of aneurysm and endovascular neurosurgeons.

- **Special Sociocranic Symposium Wednesday, April 28, 11:45 a.m.** Senator John Breaux of Louisiana will discuss “The Future of Medicine” and immediately following, David Kelly, MD, and Sidney Tolchin, MD, will debate whether there are too few or too many neurosurgeons being trained.

- **Annual Reception and Dinner Wednesday, April 28, 7 p.m.** Join your colleagues for a spectacular evening of dinner and dancing at this year’s Annual Reception and Dinner. The site of this year’s event is the Armstrong Ballroom in the New Orleans Sheraton Hotel—a spectacular space that houses a retraceable skylight. The evening includes a reception, followed by a world-class dinner and the musical talents of Chris Clifton—an exceptional trumpeter and student of Louis Armstrong. Reserve your tickets for this one-of-a-kind event on your Annual Meeting advanced registration form.

- **Special Course I: Video Surgical Tutorial Thursday, April 29 at 9:45 a.m.** Expert faculty will discuss surgical techniques for a variety of intracranial approaches in video format. Presentations will emphasize microsurgical anatomy and operative techniques. Attendees will observe a variety of intracranial surgical procedures, as performed by experienced neurosurgeons, in order to solidify their comprehension of the pertinent microsurgical anatomy and learn specific techniques helpful in limiting morbidity and optimizing outcome.

- **Special Course II: Treatment Algorithms in Complex Intracranial Disease Thursday, April 29, 9:45 a.m.** This course will present a sequential treatment decision analysis for patients with complex intracranial pathologies, including complex aneurysms, acoustic neuromas, arteriovenous malformations, and large glioblastomas.

- **Special Course III: Advances in Spinal Fusion and Reconstruction Thursday, April 29, 9:45 a.m.** This state-of-the-art course will discuss future directions of minimally invasive fusion and stabilization, interbody implants, biological and electrical enhancement of fusion and bone growth, graft extenders, and artificial disc replacement.

- **Annual Meeting Promises an Outstanding Scientific Program.**

- **Musicians on the Mississippi River. Photo courtesy of Riverview Photography.**

- **Creole Queen Riverboat. Photo courtesy of New Orleans Paddlewheel.**
New Orleans

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If you are interested in learning how the latest computer technology can help you build your practice, stop by the Annual Meeting Technical Pavilion, located inside the Exhibit Hall. The Technology Pavilion will provide a hands-on learning opportunity for Annual Meeting attendees. There will be a computer learning center with Internet access; e-mail stations; a NEUROSURGERY®/ON CALL® demo area; online literature searches; PubMed help booths; and several technology information booths. In addition, leading technology-oriented companies will exhibit their products and services in the booths surrounding the Technology Pavilion.

Muscianis on the Mississippi River. Photo courtesy of Riverview Photography.

1999 Annual Meeting Highlight Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
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<tbody>
<tr>
<td>Monday, April 26</td>
<td>Practical Clinics, Opening Reception, 8 a.m. - 5 p.m.</td>
</tr>
<tr>
<td>Tuesday, April 27</td>
<td>Scientific Sessions, 9:45 a.m. - 11:15 a.m.</td>
</tr>
<tr>
<td>Wednesday, April 28</td>
<td>Special Lecture, 9:45 - 9:30 a.m.</td>
</tr>
<tr>
<td>Thursday, April 29</td>
<td>Special Course III, 9:45 - 9:30 a.m.</td>
</tr>
<tr>
<td>Friday, April 30</td>
<td>Special Session II, 9:45 - 11:30 a.m.</td>
</tr>
</tbody>
</table>

New Orleans Jazz and Heritage Festival

While you’re in town for the AANS Annual Meeting, set aside time to experience the New Orleans jazz and Heritage Festival. An international food and entertainment extravaganza organized by the New Orleans Jazz and Heritage Foundation, Inc., the festival will take place at the city’s Fair Grounds Race Course April 23-25, 1999. The festival is famed for its cornucopia of musical performances, including jazz, gospel, rockabilly, country, and blues, as well as its creative craft fairs. Each year, the 10-day festival attracts more than 300,000 visitors. To learn more about this one-of-a-kind party, visit the New Orleans Jazz and Heritage Festival Web site at http://www.nojazzfest.com.
Commitment to Education

Thanks to a Dedicated Teacher, the AANS Orals Review Course Holds Its Fifth Session in May.

The next course is slated for May 12-15, 1999, in Baltimore, immediately preceding the spring Oral Board exam. Dr. Goodman has had a career-long interest in medical education. In addition to serving as Chair of the Oral Board Review Course, he is Clinical Professor of Neurosurgery at Indiana University School of Medicine and a member of the Indianapolis Neurosurgical Group.

If you would like to learn more about the Oral Board Review Course, please contact the Professional Development Program at (800) 692-9500.

1998 Professional Development Program Faculty Appreciation

The Professional Development Program would like to thank the following faculty members who participated in the 1998 Professional Development courses.

* Indicates Course Chair or Co-Chair

1998 Campaign Update

There’s Still Time to Contribute to the 1998 Research Foundation Campaign.

Even though we have entered 1999, there is still time to make a contribution to the 1998 Research Foundation of the AANS campaign. Your name can still be included on the donor wall at the AANS Annual Meeting in New Orleans. We will publish the names of all of our donors on the next issue of the Bulletin, and on our Web-site, NEUROSURGERYONCALL.

Make sure your name is included along with those of your peers who have helped provide for the future of our specialty with a generous contribution. We hope this year’s campaign is our best ever, both in terms of total funds raised, and in the number of members who contribute.

Endowment Fund

Donations are placed in the Foundation’s board-designated endowment fund. The earnings from that endowment are used to provide Research Fellowships, and Young Clinician Investigator Awards. Over the past 15 years, this Foundation has provided more than $2 million to 50 promising young researchers in addition.

These “seed grants” have generated approximately $20 million in subsequent research funding.

Fourteen of our past winners are now, or have been, directors of research laboratories, four are program directors.

An estimated 25 prominent Universities or major medical facilities have had staff neurosurgeons receive Research Foundation funding.

Past grant recipients serve on the editorial boards of more than 50 peer-reviewed journals and have more than 90 journal publications and 10 book chapters published with Research Foundation funds.

More than 85 percent of all contributed funds have been spent on funded research. And, total expenses over the last five years have averaged less than 13.5 percent of total revenues.

Y ou can still make a contribution to the 1998 Research Foundation of the AANS campaign. Your name can still be included on the donor wall at the AANS Annual Meeting in New Orleans. We will publish the names of all of our donors on the next issue of the Bulletin, and on our Web-site, NEUROSURGERYONCALL.

Make your contribution today!
Commitment to Education

Thanks to a Dedicated Teacher, the AANS Oral Boards Review Course Holds Its Fifth Session in May.

n 1997, Julius M. Goodman, MD, proposed that the AANS Professional Development Program include an Oral Boards Review Course. He felt that there was a need for such a course and that it would be of the best quality if sponsored by organized neurosurgery. The purpose of the course would be to familiarize candidates with the mechanics of the Board examination and, at the same time, provide a broad review of clinical neurosurgery.

The AANS Board approved the concept, and the first course was held in San Diego, California, in May 1997. The fourth course, which met with resounding success, had 40 participants (course capacity) and immediately preceded the Oral Boards Review Course and the annual AANS annual meeting. Last year, 35 of the 60 who enrolled in the course went on to pass the Oral Boards examination.

The AANS Oral Boards Review Course, held in May 1999, was attended by 45 participants. Dr. Goodman has had a career-long interest in medical education. In addition to serving as Chair of the Oral Board Review Course, he is Clinical Professor of Neurosurgery at Indiana University School of Medicine and a Member of the Indiana Neurosurgical Group.

1998 Professional Development Program Faculty Appreciation

The Professional Development Program would like to thank the following faculty members who participated in the 1998 Professional Development Courses:

- Bihan Adani, MD
- Mark A. Adams, MD
- John Adler, MD
- Cory Albers, MD
- Robert Alonso, MD
- Ronald Alterman, MD
- Mark A. Altepun, MD
- Joel B. Albay, MD
- David W. Allen, MD
- Terry A. Albin, MD
- John R. O'Connell, MD
- Cheryl A. Amott, MD
- John A. Anderson, MD
- John B. Andrews, MD
- John B. Applegarth, MD
- Raj A. Arora, MD
- Todd D. Asher, MD
- Robert J.巴斯, MD
- Terry A. Boll, MD
- George Borrero, MD
- Tan Bourns, MD
- David E. Boutilier, MD
- Julie W. Boyer, MD
- Richard Braimbridge, MD
- Kim K. Brown, MD, FACS
- Jacqueline Cermak, MD
- Paul S. Cermak, MD
- Jeffrey Chen, MD
- Alan S. Cohen, MD
- Christopher H. Corkey, MD
- James D. Craig, MD
- Jeffrey V. Crossen, MD
- William T. Crossen, MD
- Carroll Cooper, MD
- B. Roger Dalrymple, MD
- Steven O. Danner, MD
- Shailendra S. Das, MD
- Michael S. Schirmer, MD
- Max A. Ecker, MD
- Jaime Echeverria, MD
- Nancy L. Fischer, MD
- Bruce W. Flicker, MD
- Jan F. Fonda, MD
- Kenneth A. Follett, MD
- Herbert E. Fuchs, MD
- Regan Galster, MD
- Dileepa Garcia, MD
- Jerome Gil, MD
- John F. Glick, MD
- Steven Goodwin, MD
- Kenen J. Glucksman, MD
- Julius Goodman, MD
- Ziya Gokaslan, MD
- Jeremy Goodman, MD
- Scott Graham, MD
- Daniel Grady, MD
- Joseph M. Grill, MD
- Jeffrey G. Glass, MD
- Robert Grissom, MD
- Regis V. Haas, MD
- Andrea Halkin, MD
- Robert E. Hellpach, MD
- Haynes L. Hynes, MD
- Samuel M. Haxo, MD
- Mary Hays, MD
- Brett Henderson, MD
- Matthew Hedden, MD
- Paul M. Hepler, MD
- Karen Hubert, MD
- Lucia J. Hupp, MD
- Patrick J. Johnson, MD
- Frederick L. Jones, MD
- Ian H. Kallmann, MD
- Karen Kallman, MD
- Prabhat Khoury, MD
- John N. Kincl, MD
- Robert R. Kistler, MD
- Stuart D. Keeler, MD
- Thomas L. Keane, MD
- Jeffrey A. Klein, MD
- Matthew Klafke, MD
- John D. Klunk, MD
- Joseph S. Koehler, MD
- M. William Lee, MD
- Dieter Miller Leheny, MD, FACS
- Christopher M. Liptak, MD
- Robert Maciunas, MD
- Nancy E. Madsen, MD
- Christian Malats, MD
- Paul M. Marshall, MD
- Michael A. Matarasso, MD
- Alan Mehta, MD
- Ruth P. Nockels, MD
- Steven Ojemann, MD
- B. Joe Osofsky, MD
- Thomas C. O’Keefe, MD
- Richard Orland, MD
- T. Ooi, MD
- Rich P. Poulin, MD
- Aron Petterson, MD
- John P. Ralston, MD
- Greg Pagonis, MD
- Glenn Raddatz, MD
- Mark J. Redwine, MD
- Richard A. Rossi, MD
- Michael P. Ross, MD
- Dan Sigal, MD
- Daniel Sipple, MD
- Joel E. Scott, MD
- William U. Shih, MD
- Peter H. Shinaber, MD
- Brett Shroff, MD
- Richard E. Silver, MD
- Michael P. Stahl, MD
- John H. Takei, MD
- Robert Trem, MD
- William Sable, MD
- Susan Valec, MD
- Richard Wassil, MD
- J. Alvin Weiss, MD, FACS
- Gregory A. White, MD
- Jeremy W. White, MD
- Eric J. Woodard, MD
- Paul A. Young, MD
- Paul H. Young, MD

* Indicates Course Chair or Co-Chair

In 1999, Julius M. Goodman, MD, is Chairman of the AANS Oral Board Review Course.
There shall be the following Joint Committees. From time to time for specific purposes as may be deemed necessary by the Board of Directors, the Association may form one or more joint Committees with one or more other neurosurgical organizations.

## Current Bylaws

### Proposed Amendments - 1999 • Article IX — Standing Committees

<table>
<thead>
<tr>
<th>Section</th>
<th>Committee Name</th>
<th>Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Annual Meeting Committee</td>
<td>This committee shall be responsible for the planning and conduct of the Annual Meeting of the Association.</td>
</tr>
<tr>
<td>2.2</td>
<td>Archives Committee</td>
<td>This committee shall be responsible for the maintenance and publication of the Association’s historical records.</td>
</tr>
<tr>
<td>2.3</td>
<td>Awards Committee</td>
<td>This committee shall be responsible for the selection of award recipients and the publication of the Association’s awards.</td>
</tr>
<tr>
<td>2.4</td>
<td>Bylaws Committee</td>
<td>This committee shall be responsible for the review and proposed amendment of the Association’s Bylaws.</td>
</tr>
<tr>
<td>2.5</td>
<td>Cushing Orator Committee</td>
<td>This committee shall be responsible for the selection of the Cushing Orator.</td>
</tr>
<tr>
<td>2.6</td>
<td>Committee on Education (CCCE)</td>
<td>This committee shall be responsible for the education of members.</td>
</tr>
<tr>
<td>2.7</td>
<td>Credentials Committee</td>
<td>This committee shall be responsible for the maintenance of member credentials.</td>
</tr>
<tr>
<td>2.8</td>
<td>Board of Governors</td>
<td>This committee shall be responsible for the governance of the Association.</td>
</tr>
<tr>
<td>2.9</td>
<td>Fellowship Committee</td>
<td>This committee shall be responsible for the administration of fellowships.</td>
</tr>
<tr>
<td>2.10</td>
<td>Finance Committee</td>
<td>This committee shall be responsible for the financial affairs of the Association.</td>
</tr>
<tr>
<td>2.11</td>
<td>Foundation Board</td>
<td>This committee shall be responsible for the foundation activities of the Association.</td>
</tr>
<tr>
<td>2.12</td>
<td>Graduate Fellowship Committee</td>
<td>This committee shall be responsible for the administration of graduate fellowships.</td>
</tr>
<tr>
<td>2.13</td>
<td>Governance Committee</td>
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<tr>
<td>2.14</td>
<td>Government Relations Committee</td>
<td>This committee shall be responsible for the lobbying activities of the Association.</td>
</tr>
<tr>
<td>2.15</td>
<td>Professional Conduct Committee</td>
<td>This committee shall be responsible for the enforcement of the Association’s professional conduct policies.</td>
</tr>
</tbody>
</table>
AANS Membership Reaches 5,387

The Board of Directors Recently Approved the Following New Members:

\[\text{ACTIVE (PROVISIONAL) MEMBERS}\]

- Bruce McCormick
- B. Theo Melton
- Richard C. Mendel
- Mark S. Monodey
- Matthew R. Moore
- Jay More
- John C. Mullan
- Brian James O’Grady
- Sean O’Malley
- Philip Osmanski
- Conrad E. Pappas
- Troy D. Payne
- Robert G. Peterson
- Joseph A. Petronio
- Luis A. Ramos
- Patrick A. Roth
- Jackson R. Salazar, Jr.
- James Leonard Sanders, Jr.
- Steven Allen Sanders
- Darla D. Scholder
- James M. Schumacher
- Donald M. Segfried
- Magdy S. Shady
- Mitul V. Shah
- Christopher L. Shaflsky
- Peter M. Sheidt
- Erick Stephenian
- Dale M. Swift
- Samuel Tobias-Milner
- Rudolph Glynem
- Daryl E. Wieder
- David R. Winkel
- Thomas A. S. Wilson, Jr.
- Raul Valeriano

\[\text{ACTIVE MEMBERS}\]

- Randy Lynn Jensen
- James Alexander Killeffer
- Adam Nathaniel Manetto
- Frederick Francis Marciano
- Mahmoud Monair
- Kevin J. Mullins
- Fariborz Nobakht
- Daniel Pieper
- Michael N. Polinsky
- Bradford A. Sellsand
- Allen Kent Sills, Jr.
- Mitchell S. Snyder
- Shelly Diane Timmons
- Victor K. Tso
- Jini Vida
- Gary A. Zimmerman
- Bernhard Zunker

\[\text{ASSOCIATE MEMBERS}\]

- Victor Metich
- Dallas Scott Basham
- Lynne D. Boyd
- John Francis Byrnes, Jr.
- Tracy Newbold Elser
- Sharon K. Elie
- Rebecca Alexander Mason
- Robin L. Mozenter
- Stephen Earl Ochay
- William H. Stelley III
- George P. Teitelbaum
- Van Russell Wadlington

\[\text{INTERNATIONAL ASSOCIATE MEMBERS}\]

- Juan J. Aceves
- Kaushik B. Banerjee
- Tomas P. D. Baptista
- Mohamed E. ElSafi
- Nasir M. El-Gendy
- Charles F. Keck
- John P. Kuolukangas
- Saggio Nogu
- Kaschiro Namura
- Giorgio Rubin
- Hidetsugu Sano
- Toruaki Takeya
- Katsuhiko Ueki
- Alberto A. Valenzuela
- Jose B. Valdivieso
- Peter A. Winkler

For more information or a membership application, contact: Christine L. Hansen

\[\text{CURRENT BYLAWS}\]

\[\text{PROPOSED AMENDMENTS - 1999 • ARTICLE IX — STANDING COMMITTEES}\]

\[\text{AANS Bylaws}\]

The Committee on Education (Joint with the Congress of Neurological Surgeons) was felt to be redundant, as most of the duties of the Committee are being more efficiently performed by the CCC. Therefore, the Board of the AANS has recommended that the Committee on Education be eliminated, with the CCC taking over its duties. The CCE is currently a Special Committee. The Board of the AANS recommends that the CCC be made a standing Committee of the Association.
Section News

Section on Cerebrovascular Surgery: The CV Section hosted its 4th Annual Meeting January 31-February 3, 1999 in Nashville, Tennessee. The meeting, which was held in conjunction with the American Society of Interventional and Therapeutic Neuroradiology and preceded the American Heart Association’s 24th International Conference on Stroke and Cerebral Circulation, brought together cerebrovascular experts to discuss the latest advances emerging in cerebrovascular care. Topics discussed included cerebrovascular revascularization, arteriovenous malformations, and stroke management.

Section on Disorders of the Spine and Peripheral Nerves: The Spine Section recognized Steven Casha, MD, resident at the University of Toronto, as the 1999 Basic Science Mayfield Award recipient. The meeting was held February 10-13, 1999 at Disney’s Yacht and Beach Club Resorts in Lake Buena Vista, Florida.

Section on Pain: The AANS/CNS Section on Pain, along with The American Association of Neurological Surgeons, will jointly sponsor a Pain Satellite Workshop on April 22-23, 1999. The Workshop will immediately precede the 1999 AANS Annual Meeting, and include both didactic and hands-on sessions. It is targeted at neurosurgeons wishing to become more familiar with the various neurosurgical pain procedures and to provide more services to pain multidisciplinary groups.

It is designed to facilitate comprehensive and intensive learning of interventional therapies for pain management and will cover augmentative and ablative therapies at spinal, trigeminal, infraorbital, and peripheral nerve levels. The faculty is composed of 20 leading U.S. pain management neurosurgeons, as well as faculty representation by a pain psychologist and a pain anesthesiologist.

For more information about the Workshop, contact Samuel Hasabou, MD, (733) 752-2400, samuel@hasabou.com.

Section on Pediatric Neurological Surgery: At the Section’s meeting in December, the first Franc Ingraham Lifetime Achievement Award was presented to E. Bruce Hendrick, MD, resident at the University of Toronto, as the 1999 Basic Science Mayfield Award winner and Nicholas Theodore, MD, senior resident at Barrow Neurological Institute, as the 1999 Clinical Science Mayfield Award recipient, at this year’s Section Meeting. The meeting was held February 10-13, 1999 at Disney’s Yacht and Beach Club Resorts in Lake Buena Vista, Florida.

Section on Neurotrauma and Critical Care: With increasing socioeconomic and political concerns emerging in the practice of neurosurgery, the Executive Committee of the AANS/CNS Section on Neurotrauma and Critical Care has established a liaison with the Council of State Neurosurgical Societies (CSNS) through the CNSS Neurotrauma Committee. As the Neurotrauma Committee is moved from all-inclusive to a permanent standing committee of the CNSS, improved interaction, information exchange, and the development of neurotrauma policy can be anticipated. This will better equip neurosurgeons with the information needed to interact with our hospitals’ trauma systems, government agencies, patients, families, and physicians with greater competence and confidence. The interaction between the Section’s leadership and the CNSS should provide for more timely socioeconomic communication and broader interaction with grassroots neurosurgeons.
For more information about the Workshop, contact Samuel Hassebusch, MD, (713) 792-2400, samuel@neosoft.com.

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Section on Microvascular Neurosurgical Issues

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The Spine Section recognized Steven Cash, MD, resident at the University of Toronto, as the 1999 Basic Science Mayfield Award recipient, and Nicholas Theodos, MD, senior resident at Barrow Neurological Institute, as the 1999 Clinical Science Mayfield Award recipient, at this year’s Section Meeting. The meeting was held February 10-13, 1999 at Disney’s Yacht and Beach Club Resorts in Lake Buena Vista, Florida.

Section on Neurotrauma and Critical Care

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Section on Pediatric Neurological Surgery

At the Section’s meeting in December, the first Franc Ingraham Lifetime Achievement Award was presented to E. Bruce Hendrick, MD, Neurosurgeon Emeritus at the Hospital for Sick Children in Toronto. The Award, established in 1996, was created to honor individuals who have dedicated their careers to pediatric neurosurgery and have contributed noteworthy service to the specialty. A graduate of the University of Toronto, Dr. Hendrick conducted his fellowship at the Children’s Medical Center and Peter Bent Brigham Hospital under the guidance of Franc Ingraham. He is a 41-year member of the AANS.

Section on Tumors

In an effort to determine the number of neuro-oncology research opportunities available within neurosurgery residency programs, the AANS/CNS Section on Tumors developed a survey and mailed it to all North American neurosurgery program directors (10) and the other to all North American neurosurgery residents (872). The surveys were sent in May 1997 and a follow-up survey was sent in June 1997 to all non-responders. Overall, 77 program directors (69 percent) and 279 neurosurgery residents (32 percent) responded to the second survey, with the AANS/CNS Section on Tumors planning to present preliminary results to the 1999 AANS/CNS in June 1999.
responded to the survey. Following are some of the highlights:

- Eighty-seven percent of all respondents reported neuro-oncology research rotations (usually less than 12 months) available in his or her residency program.
- Research funding was well distributed among departmental (27 percent), federal (24 percent), institutional (22 percent), and private (19 percent) sources.
- Common basic research areas included molecular biology, gene therapy, and pathology, while image-guided surgery was the most frequent area of clinical research.
- Approximately one-third of responding residents had completed a neuro-oncology research rotation, primarily in an area of basic science, which resulted in an average of two publications and three presentations.
- The most common challenges for residents pursuing neuro-oncology research were concurrent clinical responsibilities, lack of faculty mentors, and insufficient research funding.

The survey results identify several ways the Section can enhance neuro-oncology research opportunities, including:

- encouraging resident participation at national meetings through awards;
- posting neuro-oncology fellowship opportunities and neuro-oncology research funding sources on the Internet; and
- organizing Annual Meeting seminars that address the importance of basic research to clinical practice.

The survey results also indicate several ways the Section can enhance neuro-oncology research opportunities, including:

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**Committee for Military Neurosurgeons**

The AANS/CNS Committee for Military Neurosurgeons, which promotes and inspires communication and collaboration between organized neurosurgery and the Department of Defense, will host its next meeting on Sunday, April 25, 1999, in conjunction with the AANS Annual Meeting. Every resident is invited to participate. For information, contact James Ecklund, MD, Chairman, at (202) 782-9804, ecklund@vs.wranamed.mil.

**AANS and CNS DO NOT RECOGNIZE, ENDORSE OR SUPPORT THE AMERICAN BOARD OF SPINE SURGERY**

A number of members of The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) have received invitations to apply for membership in, and to sit for the certifying examination by the American Board of Spine Surgery. The Board of Directors of the AANS and the Executive Committee of the CNS wish to notify their members that the American Board of Spine Surgery is NOT a member of the American Board of Medical Specialties (ABMS), is NOT authorized by the ABMS, and is NOT recognized, endorsed, or supported by the AANS or CNS.

The AANS and CNS encourage Board Certification for all neurosurgeons. Within the United States, the AANS and CNS recognize only the ABMS as the organization that ensures quality in the Board Certification process across medical specialties. Board Certification of AANS and CNS members is secured through examination by the American Board of Neurological Surgery (the recognized agent of the ABMS). This Board does not recognize or certify any subspecialty Board or Certificate in Neurological Surgery. Neurological Surgery includes the diagnosis and surgical treatment of disorders of the spine, the central and peripheral nervous systems, the vascular supply of these structures, the cranial vault, and the neuroendocrine system in adult and pediatric populations.

The AANS and CNS do not recognize focused interests of individual neurosurgeons by their support of the AANS/CNS Sections, but this recognition is inclusive rather than exclusive for all Board Certified neurosurgeons. The AANS and CNS do not support, recognize, or endorse the development of independent or alternative Boards, or the issuance of any Board Certificates that are not undertaken by the American Board of Neurological Surgery, the Royal College of Physicians and Surgeons of Canada, the Mexican Council of Neurological Surgery, or other agent Boards of the American Board of Medical Specialties.
CSNS Debates Practice Expense Report Cards

JAMES R. BROWN, M D

The Council of State Neurosurgical Societies (CSNS) met in Seattle, Washington, October 2-3, 1998. The number of formal resolutions debated by delegates was small, but the volume and quality of information exchanged was vast and the quality of dialog compelling.

Practice Performance Report Cards

Attention was focused on neurosurgeons’ practice performance report cards created by health plans, and how they are used to rate physician performance and make bonus awards. A resolution from Calvin Kain, MD, was debated, questioning the validity of quality, cost, and patient satisfaction criteria chosen by Blue Cross/Blue Shield of Hawaii for calculating physician bonuses. Like most plans proposing measurable indicators of quality, the criteria were broad, vague, and primitive proxies for quality included: patient mortality, post-operative mortality, post-operative wound infection, and readmission rate.

The resolution originally asked for the AANS/CNS Committee on Assessment of Quality (CAQ) to accept such proposals for review and critique. The CSNS learned from experience that it is important to document the criteria and methodology used by health plans to establish any such report cards.

A second resolution sponsored by the CSNS Young Physicians Committee sought to create a neurosurgical resident category within the CSNS membership. This was rejected, as residents wished to remain part of their respective state societies.

CSNS Resident Membership

CSNS Resident Membership

A second resolution sponsored by the CSNS Young Physicians Committee sought to create a neurosurgical resident category of delegate to the CSNS. After debating the problems of resident interest, time availability, and cost, a substitute resolution was passed, directing the appointment of a CSNS ad hoc committee to develop recommendations for promoting resident participation in the CSNS. The hope is to build interest and experience in socioeconomic issues among future neurosurgeons while early in their career, to develop future leaders, and to benefit from residents’ viewpoints in CSNS discussions about the impact of current socioeconomic changes on their futures.

Practice Expense Survey

Robert Florin, MD, Chairman of the AANS Reimbursement Committee, spoke about the AANS/CNS Practice Expense Survey being gathered and analyzed to develop a database of neurosurgical practice costs. The purpose of the survey is twofold: 1) Build a valid database to correct inaccuracies in the AMA/HCFA database used by HCFA to determine neurosurgeon practice expenses for the new resource-based practice expense RUVs, implemented January 1, 1999, and 2) Develop benchmark costs for categories of office expense within individual office practices to use in comparing an office’s practice expenses with other neurosurgical practices.

With falling reimbursement requiring that practice costs be reduced by making office processes more efficient, this database can show where costs exceed the average and where to focus on reducing expenses or increasing efficiency.

Medical Record Guidelines

The CSNS passed a resolution in April demanding that any medical record guidelines for neurosurgeons conform to the practice of neurological surgery. In follow up discussion, Troy Trippet, MD, who represented neurosurgery in AMA/HCFA discussions, described the odyssey of the Evaluation & Management Documentation Guidelines, begun in 1995, and still the subject of dispute between physicians and HCFA. The disagreement hinges on whether the medical record should be used as an auditing and accounting document, with minimum numerical requirements for elements included in each category of history, physical, and medical decision making.

Luncheon Focuses on Political Action

Michael Dunn, President of Michael E. Dunn & Associates in Washington, D.C., made a compelling presentation at the CSNS luncheon. With graphic clarity and spellbinding rhetoric, Mr. Dunn took the audience on a journey into the labyrinth of politics, showing why personal involvement in candidate support at the local level, and Political Action Committee financing at the national level, are irreplaceable necessities for gaining favorable legislation.

CEREBROVASCULAR DISEASE FUNDING AVAILABLE

The AANS/CNS announce the Pharmacia-Upjohn Resident Research Awards in Cerebrovascular Disease:

- Funding Available
- July 1, 1999
- Up to $15,000 to Support a Specific Research Proposal
- Open to Residents in North American Training Programs
- Research Related to Cerebrovascular Disease
- Deadline for Applications: 3/31/99
- Contact: Issam A. Awad, MD, Yale University School of Medicine, (203) 737-2096, Fax: (203) 785-6916.
Quality Patient Service

Oklahoma Practice Learns the Power of Good Service.

We pay our employees very well and have an exceptionally low turnover rate. This is a very high pressure, high volume, and high stress practice. We place enormous responsibility on our staff and expect them to perform.

Most innovative approach to managing external relationships. We use the telephone. A personal conversation often is critical to getting things done quickly and efficiently. When a neurosurgeon picks up the phone and makes a call, constructive things usually happen. A neurosurgeon can accomplish in minutes what often takes employees hours or days.

Future of neurosurgical private practice. Bigger is not only better but may be the only way. In this day and age, large groups cannot only accomplish economy of scale but also can develop contracting advantages. These solo practitioners and small practice groups will find it very difficult to compete against the large groups in the future.

Closing thoughts. My partners and I respect and admire each other. We work hard and we share profits equally. We are very happy to be practicing in Oklahoma City.

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Advice for neurosurgeons starting their own practice

Neurosurgery is not only a profession, it is also a business. Along with an individual neurosurgeon's talents, skills, education and expertise, he or she also must develop business acumen and run an efficient, cost-contained business operation. The neurosurgeon entering practice should certainly become involved in their state neurological societies as well, most importantly, the Council of State Neurological Societies—where more business knowledge is exchanged in the field of neurosurgery than anywhere else in the universe. Young neurosurgeons must take professional development courses in office management, building a neurological practice, coding, etc. They also must learn that a professional who is knowledgeable in the day-to-day workings of a busy surgical practice is managing their office.

Practice philosophy

Patient service is a “you bet” attitude at the very heart of this very busy practice. We make an effort to see our patients as quickly and efficiently as possible. We also make a very real and constant effort to communicate with our patients, our referring physicians, and third party payers. If we have any problems, we pick up the phone and analyze the problem quickly. We all diligently try to dictate our consultations and follow-up notes to our referring doctors the same day.

We develop our leadership from within and empower our area managers and staff to identify problems, develop solutions and then implement them. We have found that when you give the right people the power to create change, the results are rather remarkable. We hire bright, intelligent employees and develop some of them into area managers if they show the talent and desire. Once we hire, we try to meet with our area managers to discuss problems that need to be solved in a coordinated effort with the practicing neurosurgeons.

Glace Butler, PhD, is Professor of Sociology at DePaul University in Chicago, Illinois, and the author of When Doctors Join Unions, which charts the history of the American Union of Physicians and Dentists. Her basic can be purchased online through Amazon.com for $14.95.

Stanley Pelofsky, MD, President of the Neuroscience Institute and 23-year AANS member.
PERSONAL PERSPECTIVE

A.John Popp, MD

This issue of the Bulletin discusses a topic of considerable interest to many neurosurgeons in today’s chaotic healthcare environment—physician unionization. We have made a special effort throughout the publication to bring you viewpoints and information that have bearing on this timely subject. While the potential leverage gained for physicians by unionization has appeal, the issues involved are complex and have ethical, financial, and professional implications for neurosurgeons.

The level of interest in unionization by neurosurgeons is related to several variables: one’s position as an “employed” or private practitioner, the local managed care environment, and the available options for bargaining with third parties. In fact, federal law currently prohibits union representation for all neurosurgeons except those who are employees of an organization. This, coupled with many physicians’ natural aversion to unions and pressure by colleagues and professional societies against strikes and unionization, leads to a search for other solutions.

It is my personal perspective that while the current healthcare environment in many parts of the country may justify the debate about unions, the impetus is made even more urgent by the need to counteract these pressures. Even if legalized for self-employed physicians, unions that focus on salary, benefits, and working hours, have serious limitations. While the programs described above do not fully counteract all of the negative influences presently impacting health care, they are part of the strategy by the AANS to empower neurosurgeons to re-establish their autonomy, rebuild their physician-patient relationships and regain control over their profession.

The Quest for Empowerment

Viable Alternatives to Unionization.

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The Messenger Model IPA

One alternative to physician unions is the messenger model IPA, or independent practice associations of self-employed physicians who use a “so-called” messenger to negotiate on behalf of the group. Messenger models allow physicians to address issues that are more patient-oriented rather than physician-oriented, thereby enabling doctors to remain committed to the vision and mission of the medical profession. Messenger model IPAs allow physicians to use some of the tools of collective bargaining in negotiating with managed care organizations without using more radical methods, like strikes, that are anathema to physicians.

Broadening the Influence of Neurosurgery

With organized medicine actively developing advocacy strategies that support physicians’ rights in the marketplace, doctors should expect support from their professional and educational organizations. In fact, one of the primary goals of the AANS is to enhance the competitiveness of its members via several strategies. By maintaining liaisons with other groups in organized medicine, such as the Practice Expense Coalition, the American Medical Association and the American College of Surgeons, the AANS broadens the influence of neurosurgery in Washington, D.C., by collaborating with the Congress of Neurological Surgeons in the Council of State Neurosurgical Societies and the Washington Committee, the AANS analyzes and develops tactics pertaining to legislative, regulatory and socioeconomic issues facing our specialty. Through projects, such as the Outcomes Initiative, Practice Expense Survey, Cost Containment Initiative and the Getting SMART marketing communications project, the AANS assists neurosurgeons in building their practices, improving practice efficiency and negotiating with third party payors. The success of such endeavors, however, often correlates with the neurosurgeons’ interest in actively participating in such programs.

Many neurosurgeons feel powerless and frustrated by the radical changes occurring in the healthcare environment and they need an effective means to counteract these pervasive influences. Even if legalized for self-employed physicians, unions that focus on salary, benefits, and working hours, have serious limitations. While the programs described above do not fully counteract all of the negative influences presently impacting health care, they are part of the strategy by the AANS to empower neurosurgeons to re-establish their autonomy, rebuild their physician-patient relationships and regain control over their profession.

The Editors of the AANS Bulletin are interested in hearing your comments or queries on this issue, as well as your ideas for future issues. Write to Dr. Popp, care of the AANS at 22 S. Washington St., Park Ridge, IL 60068; fax (847) 685-2559 or email info@aans.org. We want to hear from you!