Neurotrauma & Critical Care NEWS

Fall 2002

AANS/CNS Section on Neurotrauma & Critical Care

Editor:
P. David Adelson, MD

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Chairman's Message

Donald Marion, MD, FACS

With this issue of *Neurotrauma and Critical Care News*, I provide my inaugural Chairman's Message. I first want to thank Ross Bullock, MD, for his remarkable achievements as our past chair. Highlights of Dr. Bullock's tenure include shepherding through a position statement on reimbursement for on-call coverage for trauma, which has been endorsed not only by the Neurotrauma Section's Executive Committee, but also by the executive committees of the American Association of Neurological Surgeons and Congress of Neurological Surgeons. In addition, we now have Current Procedural Technology codes for decompressive craniectomy, and lobectomy for contusions or intractable intracranial hypertension. Perhaps more importantly, Dr. Bullock continues to lead the way toward a better understanding of the mechanisms of secondary brain injury through his pioneering research, and the Neurotrauma Section's membership is indebted to him.

Neurosurgery Gets CMS Attention on EMTALA

The section's leadership also is grateful to the Washington Committee and particularly, Katie Orrico, JD, director of the AANS/CNS Washington Office, for their flurry of recent activity regarding clarification of Emergency Medical Treatment and Labor Act regulations. For the past several years, Neurotrauma Section members, including John McVicker, MD, and Alex Valadka, MD, have done an excellent job of presenting informative lectures at our national meetings to try to educate our membership about these regulations. As these individuals and others more carefully researched the issues, however, it became increasingly clear that the EMTALA guidelines were confusing. In an attempt to clarify several issues, Trent Haywood, chief medical officer of Centers for Medicare and Medicaid Services Region V, was invited to address attendees at the recent AANS Annual Meeting in Chicago. Unfortunately, his remarks raised even more concern.

Specifically, he suggested that while neurosurgeons were not required to take call every day of the year, hospitals could require this and CMS did not prohibit it. He stated that simultaneous call at several hospitals was prohibited unless backup coverage had been arranged in advance by the neurosurgeons. Finally, he strongly suggested that elective surgery could only be allowed when the neurosurgeon was on call if backup coverage was arranged in advance by that neurosurgeon.

AANS/CNS Letter Evokes Action

The AANS and the CNS quickly responded. On May 30, the presidents of the AANS and CNS sent a letter to Thomas Scully, administrator of CMS, strongly urging that:

- neurosurgeons be permitted to take simultaneous call at more than one hospital, particularly in view of the fact that there are almost twice as many hospitals as there are practicing neurosurgeons;
- treating or on-call physicians be permitted to request transfer of patients to hospitals where the on-call neurosurgeon is physically located;
- CMS provide explicit language that prohibits hospitals from requiring constant call coverage;
- neurosurgeons be permitted to perform elective surgery when they are on call; and
- neurosurgeons should only be required to be on call for emergency services within the scope of their usual practice.

This letter led to a very positive early June meeting between Katie Orrico and CMS staffers, and a June 13 CMS reversal of its position on simultaneous call. The Neurotrauma Section very strongly supports these efforts on the part of the AANS and CNS.

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Highlights of the 2002 CNS Annual Meeting in Philadelphia

Check www.neurosurgery.org for registration, updates, and additional information.

Saturday, Sept. 21, 2002

Practical Course

PCO3 Pediatric Traumatic CNS Injury and Critical Care: Management Guidelines and Case Studies **1–5 PM**

Course Directors: *P. David Adelson, John Ragheb*
Faculty: *Douglas L. Brockmeyer, Mark S. Dias, Paul A. Grabb, Stephen L. Huhn, Mark R. Proctor*

This course will focus on the pathophysiologic treatment and critical care issues in traumatic pediatric CNS injuries. A panel discussion will follow.

Sunday, Sept. 22, 2002

Practical Courses

PC19 Contemporary Management of Severe Traumatic Brian Injury, and Controversies **8 AM–12 PM**

Course Directors: *Geoffrey B. Manley, Domenic P. Esposito*
Faculty: *John H. McVicker, Jamshid Ghajar, Claude J. Hemphill, III, Donald W. Marion, Randall M. Chesnut*

Current concepts regarding pathophysiology and management of neurotrauma patients will be reviewed. Emphasis will be given to management by the private practice neurosurgeon. The guidelines will also be reviewed.

PC27 Critical Care for Neurovascular Disorders **1-5 PM**

Course Directors: *Joshua B. Bederson, J. Paul B. Elliott*
Faculty: *E. Sander Connolly, Jr., L.N. Hopkins, III, J. Max Findlay, Scott E. Kasner*

This course will discuss diagnostic and therapeutic options and perioperative management in the following conditions: ischemic stroke, intracerebral hemorrhage, subarachnoid hemorrhage and vasospasm.

Monday, Sept. 23, 2002

Luncheon Seminars

M11 Case Management of Complex Head Trauma in Adults and Children **1–2:30 PM**

Moderator: *P. David Adelson*
Faculty: *Ann-Christine Duhaime, Thomas G. Luerssen, Raj K. Narayan, Alex B. Valadka*

This seminar will address the medical and surgical treatment of complex head injury.

M17 Spinal Cord Injury Management: Guidelines and New Advances **1–2:30 PM**

Moderator: *Beverly C. Walters*
Faculty: *Russ P. Nockels, Daniel K. Resnick, Jack E. Wilberger, Jr.*

The recently published guidelines for spinal cord injury management will be reviewed.

Section Meeting

Penetrating Brain Injury

Section on Neurotrauma and Critical Care I **2:30–5:30 PM**

Moderators: *Domenic P. Esposito, Geoffrey T. Manley*

2:30–2:50 Open Papers 738–739
2:30–2:40 Synthes Award for Resident Research in Brain and Craniofacial Injury
2:40–2:50 Synthes Award for Resident Research in Spinal Cord and Spinal Column Injury
2:50–3:30 Do I Focus on the ICP or the CPP?
2:50–3:05 Case for ICP Focused Management *Alex B. Valadka*
3:05–3:20 Case for CPP Focused Management *Michael J. Rosner*
3:20–3:30 Questions and Answers
3:30–4:00 Refreshments with Exhibitors
4:00–5:30 Open Papers 740–750

Tuesday, Sept. 24, 2002

Luncheon Seminars

T21 Neurotrauma for the Neurosurgeon: Standards and Socioeconomic Issues **1–2:30 PM**

Moderator: *Donald W. Marion*
Faculty: *Domenic P. Esposito, Jamshid Ghajar, John H. McVicker, Jamie S. Ullman*

This seminar will discuss the roles of the neurosurgeon in the management of neurotrauma with an emphasis on the community neurosurgical perspective.

T35 Odontoid Fractures: Surgical Options

Moderator: *Michael G. Fehlings*
Faculty: *William C. Welch, John A. Wilson, Jr., Christopher E. Wolfla*

This seminar will address the diagnosis and management of fractures of the odontoid. Participants will be able to discuss the various treatment options for odontoid fractures and treatment outcomes.

Wednesday, Sept. 25, 2002

Luncheon Seminars

W47 Contemporary Management of Head Injury **1–2:30 PM**

Moderator: *Brian T. Andrews*
Faculty: *Julian E. Bailes, Jr., Austin R.T. Colohan, James M. Ecklund, M. Sean Grady*

Participants in this seminar will review the management issues, both in the acute and chronic setting and within the intensive care unit, and describe surgical management as well as techniques for the management of the clinical problems of head injury.

Section Meeting

Spinal Injury

Section on Disorders of the Spine and Peripheral Nerves III **2:30–5:30 PM**

Moderators: *Daniel K. Resnick, Andrew T. Dailey*

Learning Objectives: Participants will be able to describe the available management paradigms for thoracolumbar spinal column injuries.

2:30–3:30 Open Papers 817–823
3:30–4:00 Refreshments with Exhibitors
4:00–4:40 Oral Posters 76 – 88
4:40–5:30 Open Papers 824–829

Committee Updates

Coding and Reimbursement Committee

John Wilson, MD

It was announced at the Neurotrauma Section Executive Committee meeting in April 2002 that four new current procedural technology codes had been approved: decompressive craniectomy with duraplasty; trauma lobectomy without evacuation of hematoma or contusion; implantation of craniotomy flap in the abdominal wall; and retrieval of bone flap from the abdominal wall with reimplantation into the skull. These codes will appear in the 2003 CPT book. These codes were valued through the American Medical Association's Relative Value Update Committee (RUC) process through a survey that had been sent to 130 randomly selected members of the Neurotrauma Section, a sample size that represented approximately 10 percent of the section's membership. Though the response to the Coding and Reimbursement Committee was poor, it at least met the required number of 30 evaluations. Through this process, the CRC learned that future projects of this type would be more likely to succeed if they worked with section liaisons to identify individuals who would complete and return the surveys promptly.

In terms of evaluation of the new codes, responses were very consistent. Respondents agreed that decompressive craniectomy was most comparable to a craniotomy for acute subdural hematoma, but the decompressive craniectomy was valued a bit higher. The RUC also looked at the intensity of the work and though the valuation was low, it was consistent. The concern expressed was that the RUC usually gives very short notice about these surveys, so it would be difficult to take the time to better educate respondents of future surveys and details to be taken into account. Despite these difficulties and inherent problems, the system worked well and four new codes will be available that more closely match the work being done.

John Wilson, MD, is the AANS Relative Value Update Committee adviser.

Spinal Cord Injury Committee

Michael Fehlings, MD, PhD

The Dec. 15 issue of *Spine* dealt with spinal cord injury, including the GM1 ganglioside data. Additionally, members of the Neurotrauma Section Spinal Cord Injury Committee organized a practical clinic on spinal cord injury and its treatment. Held over the weekend prior to the AANS meeting, the clinic attracted approximately 40 attendees. Finally, it was noted that the Surgical Treatment for Acute Spinal Cord Injury Study was still viable and plans were being made to further develop the study for a clinical trial. Michael Fehlings, MD, distributed an executive summary of the trial and noted that all the STASCIS centers can begin entering patients as soon as patients arrive at the hospital. A pilot study involving several of the centers is currently underway. The hope in the near future is that the STASCIS investigators will reapply to National Institutes of Health for funding.

The question arose as to whether reapplication for NIH funding was worth the time and effort, given that a previous funding application had been rejected. In reality, only the NIH could contribute enough funding to make such a large trial feasible. The general feeling was that funding could be more likely obtained now, as compared to several years ago. Specifically, it was felt that the NIH was more interested in trials of this type at this time, and the biological rationale of the grant has been further supported with the appearance of two peer-reviewed articles: "Guidelines for Management of Acute Cervical Spinal Injuries" (published in *Neurosurgery*) and the other an evidence-based review. Interest in such a trial has also increased within the National Neurotrauma Society and the Christopher Reeve Paralysis Foundation.

Other additions to the proposal that have likely strengthened the application include: improved imaging analysis; more American involvement in addition to Canadian involvement in the organization, administration, and data analysis; more multidisciplinary approach; Web-based data entry; decreased cost of the trial; and evaluation of the window of opportunity for treatment with surgical intervention. Seed money from the Neurotrauma Section was sought to establish and maintain a database and $10,000 was approved to support this venture.

Recognition at the Neurotrauma Section Executive Committee meeting was made of Dr. Fehlings' contributions to the section in that he has been instrumental in raising over $150,000 for Neurotrauma Section grants and awards over the last few years.

Pediatric Neurotrauma Committee

P. David Adelson, MD

Members of the Pediatric Neurotrauma Committee remain active in multiple areas making excellent progress on a number of projects. They will be highlighted in this committee update.

The Pediatric Severe TBI Guidelines. Excellent progress continues on the Pediatric Severe Traumatic Brain Injury (TBI) Guidelines. Drafts of each of the chapters are being completed and compiled this summer. The Guidelines draft will be distributed on compact disc to all of the national societies for initial review and comments. A September 2002 meeting is planned to finalize the different revisions and complete the final product. The Guidelines will then be published simultaneously in the *Journal of Trauma* and *Pediatric Critical Care Medicine.* Randy Chestnut, MD, has led the group, which has included a cross section of pediatric specialists in neurosurgery, critical care, emergency medicine, trauma, and epidemiology. Neurosurgical involvement included David Adelson, MD, Nathan Selden, MD, and Michael Partington, MD.

Multicenter Trial: Phase II Study of Hypothermia for Severe TBI in Children and Evaluation of Initial and Outcome Assessments in Children Following Severe TBI. The Phase II multicenter trial for hypothermia following severe TBI in children

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In Focus Stipends for On-Call Coverage: Two Views

Trauma Contracts Improve Trauma Care: Trauma Stipends May Not

John McVicker, MD, FACS

Why can't we be reliably available for neurotrauma? Op-ed columns in major newspapers opine that as a specialty neurosurgery can't, or won't, cover trauma in our nation's emergency departments. I do not accept the thesis that the problem is neurosurgery's collective bad attitude. In 1992, an often-quoted report from the Office of the Inspector General (OIG) of the Department of Health and Human Services addressed the problem of specialty trauma call coverage in the nation's emergency departments and found neurosurgery to be the worst. Sixty-six percent of specialty physicians surveyed stated that fear of increased malpractice liability had persuaded them not to participate in on-call activities. Forty-seven percent of the physicians considered Emergency Medical Treatment and Labor Act anti-dumping laws a serious drawback to participation in emergency care, and 44 percent reported that reimbursement for emergency services was inadequate. Nearly half of the hospitals claiming to have neurosurgical services in their emergency departments had difficulty ensuring coverage. The OIG concluded that many specialists don't participate in trauma care because they are engaged in more reliably compensated activities.

Hospitals' Neurotrauma Commitment Implies Responsibility

If a hospital has made a commitment to neurotrauma care, it is responsible for ensuring neurosurgical availability. As hospital systems expand, market trauma care and often profit from it, the neurosurgeon's time for reliably compensated elective cases shrinks. The situation is made worse by comparatively fewer neurosurgeons relative to other high-demand trauma specialists. Even though neurosurgery is a small specialty, 57 percent of all high acuity trauma patients have some neurological injury, and half of the 150,000 injury-related deaths that occur annually in the United States involve a serious brain injury that is primarily responsible for the patient's demise. Yet as of 1995 there were over three times as many emergency room physicians, four and one-half times as many orthopedists and over six times as many general surgeons to cover the needs of the emergency room.

Is there a simple answer to this complex problem? Is reimbursement for on-call availability (call stipends) the gold at rainbow's end?

Data recently collected suggests that a cohort of surgeons, unreimbursed for trauma availability, performed significantly better at trauma program requirements such as QA meeting attendance, trauma continuing medical education and emergency department response times than their reimbursed colleagues (J. Wilberger, personal communication). These two groups may not be comparable for critical variables such as academic versus private practice, the presence of resident staff, and other coexisting means of reimbursement for trauma participation, but the answer may be obvious: stipends alone don't guarantee quality neurotrauma care.

> **With or without a stipend, contracting for ED coverage is an appropriate and necessary step to protect yourself and your patients.**

Contracts Help Ensure Neurosurgical Availability

We need a solution that addresses the complexities of the problem. Careful contracting with a hospital or system to provide tailored services with specific safeguards and responsibilities for both parties may be the answer.

Every community possesses unique demographics, differences in neurosurgical workforce, strengths and weaknesses of the regional trauma system. Funding sources, managed care prevalence and aggressiveness, and competing hospitals and systems alter the landscape. Regardless, neurosurgical availability is key to the success of any major trauma program. Contracts between trauma hospitals and neurosurgeons can ensure neurosurgical availability, mandate neurosurgical participation in quality assurance, education, protocol and program development, and promote trauma program outreach. Contracts could improve the institution's ability to meet EMTALA obligations, help assure that the institution meets standards required for trauma center verification, and improve coordination among trauma specialists. Contracts may provide the funds necessary to bring needed neurosurgical workforce to a community with limited elective cases, and may be the only way some neurosurgeons can afford to remain on a medical staff that requires participation in trauma.

Despite anti-kickback "payment for referral" issues, legal analysis suggests that physicians can expect fair market compensation for services that go beyond usual medical staff obligations. When limited workforce and high demand are considered, it is apparent that neurotrauma coverage demands more from the neurosurgeon than general emergency coverage does of the average medical staff member, and is worthy of additional compensation at fair market value.

Neurosurgeons engaged in a trauma program should be able to require the hospital to provide adequate equipment for neurosurgical procedures, maintain nursing and ancillary staffing at appropriate levels, and enter into defined transfer agreements when the on-call doctor unavoidably becomes unavailable. The contract can define fair compensation or the provision of other methods of compensation such as billing services, trauma data management, neurosurgical recruitment, etc. With or without a stipend, contracting for ED coverage is an appropriate and necessary step to protect yourself and your patients. As a member of the Neurotrauma Section's Executive Committee has phrased it, "No neurosurgeon should be expected to cover a trauma service beyond the limits of a safe and reasonable workload.…"

But we must not hold our hospitals hostage. An institution should be able to expect a participating neurosurgeon to agree to reasonable and specific frequency and duration of call periods, response times, and if necessary, back up call schedules. It could reasonably expect trauma QA committee involvement, neurotrauma protocol development and maintenance, trauma specific CME, and participation in nursing education and trauma outreach programs.

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Neurosurgeons and Their Responsibilities to Trauma Centers

Jack Wilberger, MD, FACS

It is unlikely that anyone would disagree with the fact that neurosurgeons are the best trained and qualified to manage neurotrauma. Arguably, we as members of society at large and our particular communities of practice have a moral and ethical obligation to make our talents and services available to deal with emergency neurosurgical problems—especially neurotrauma. Trauma centers evolved and are now accredited by many states primarily because it has been shown in many studies that they save lives—especially of the more seriously injured. Unquestionably, trauma centers need neurosurgeons as a part of the team to accomplish this worthy goal. Unfortunately there are not enough neurosurgeons either available or who are willing to commit their time and energy to support this critical need.

A number of years ago, a true shortage of neurosurgeons in the Western parts of the United States gave rise to payment of stipends to neurosurgeons for trauma call. This practice was rapidly embraced by a number of neurosurgeons around the country. Several years ago the AANS/CNS Section on Neurotrauma and Critical Care officially sanctioned this practice by providing advice on stipend negotiations and even providing "sample" contracts to all neurosurgeons. Has this practice relieved the manpower shortage? Has it made neurosurgeons more responsive to providing neurotrauma care? In my opinion the answer is a resounding no.

> **Many [trauma centers] cannot sustain what will certainly be not only an escalating demand for stipends (with the imprimatur of the Neurotrauma Section), but also increasing levels of payment.**

Stipends Don't Inspire Quality, Survey Says

In a recent survey I conducted of 150 Level I and Level II trauma centers, 101 were providing reimbursement for neurotrauma call. The average reimbursement was $1,175 per day with the maximum being $2,054 per day. In those centers providing reimbursement, neurosurgical commitment was substantially less compared to those centers not providing reimbursement as measured by a neurosurgeon's specific obligations to not only care for patients, but also ensure that the trauma center continues to meet all of the oftentimes rigorous requirements for maintaining accreditation or verification. Thus, the Neurotrauma Section's support of stipends for neurotrauma call has been, in my opinion, a step in the wrong direction.

In addition, most trauma centers operate on a limited margin and many are unprofitable, drawing resources from other hospital operations. Many cannot sustain what will certainly be not only an escalating demand for stipends (with the imprimatur of the Neurotrauma Section), but also increasing levels of payment. Even in the busiest of Level I trauma centers it is very unusual for more than 50 emergency neurotrauma surgeries to be done in one year. Assuming four neurosurgeons taking call (at most Level II centers there are only two), receiving the average daily stipend, each would receive over $8,000 per case; obviously this is an oversimplification as it does not take into account other neurotrauma consultations requiring the neurosurgeon's time and effort.

Checks and Balances are Needed

Therefore, I feel the Neurotrauma Section has unintentionally done an injustice to the necessary and appropriate delivery of neurotrauma care by sanctioning open-ended stipend negotiations without appropriate checks and balances. There are certainly true manpower shortages where the burden of taking neurotrauma call justifies special reimbursement arrangements. However there are many more instances where I am concerned that such stipends perhaps are being used to cover other practice losses, without a true commitment to neurotrauma coverage. I urge the Neurotrauma Section to take a strong stance on this issue. Interestingly, I have yet to hear of anyone asking for stipends to take emergency cerebrovascular call. Is neurotrauma call any less of a responsibility to the patients of our communities who depend on us?

Jack Wilberger, MD, FACS, is past chair of the AANS/CNS Section on Neurotrauma and Critical Care and a member of the American College of Surgeons' Committee on Trauma–Ex-Officio Executive Committee.

Trauma Contracts *(continued from page 4)*

Voluntary Contracts Enable Win-Win

If this give-and-take-relationship is honored, neurotrauma contracts can be a win-win situation. The hospital reduces its EMTALA exposure, improves its performance in the trauma center verification process, and ensures neurosurgical participation in quality assurance and program development by supporting voluntary trauma contracts. For the neurosurgeon, these contracts help alleviate the double burden of providing mandatory uncompensated care even as their reliably compensated elective practice is impacted. Everyone negotiates for and knows what their responsibilities in the provision of trauma care will be. Excessive and unsafe workload on the neurosurgeon can be avoided. These contractual relationships are increasingly prevalent nationwide. Although it will not be easy to reliably confirm, I believe these legal agreements between neurotrauma centers and trauma neurosurgeons will greatly facilitate neurosurgical participation in trauma care, as they become common practice.

John McVicker, MD, FACS, is a member-at-large of the AANS/CNS Section on Neurotrauma and Critical Care Executive Committee and past chair of the CSNS Neurotrauma Committee.

Chairman's Message (continued from front page)

Section's Committees Restructured

In an effort to make the Neurotrauma Section as efficient as possible and responsive to the needs of the membership, I have reorganized the subcommittee structure. In so doing, I have placed particular emphasis on the liaisons to related, and I think very important, organizations such as the Council of State Neurosurgical Societies, Think First, and the Society of Critical Care Medicine. Thomas Hoyt, MD, Dan Michael, MD, and William Coplin, MD, are the respective liaisons from these organizations. I also have created the Special Initiative Committee, headed by Jamie Ullman, MD.

Over the years, it has become clear to me that a number of very important issues related to neurotrauma do not necessarily fall under any of the previous committee designations and yet are relevant to contemporary practice. For example, issues related to EMTALA, on-call reimbursement, and non-neurosurgeons placing ICP monitors are all currently being debated and deserve focused attention. I have charged this committee, which is composed of some of our more senior members, with drafting responses to these and other current issues. I encourage the Neurotrauma Section membership to contact my office at any time regarding your concerns with neurotrauma or critical care, either locally or in a general way, and I will either address the issues personally or triage them to our appropriate new subcommittees.

Stipends for On-Call Coverage: Two Views

Finally, I have asked David Adelson, MD, the new editor of *Neurotrauma and Critical Care News,* to focus on a major controversial clinical or preclinical issue related to neurotrauma or critical care in each issue of the newsletter. For this issue of the newsletter, we have elected to focus on the controversies surrounding stipends for on-call coverage. Neurosurgeon availability is a prerequisite for any Level I or Level II trauma center. Unfortunately, designated trauma centers outnumber the number of practicing neurosurgeons in this country. In order to help neurosurgeons, and especially those in private practice, provide neurotrauma coverage, the Neurotrauma Section, together with our parent organizations, endorsed the AANS/CNS Position Statement on Improving Access to Emergency Neurosurgical Services, indicating that it is appropriate for hospitals to provide a reasonable stipend for being on the on-call panel at their hospital. As might be expected, many hospitals are resisting this suggestion, and in some locations neurosurgeons have found that they can no longer participate in trauma call, leading to the inability of their particular hospital to continue as a trauma center.

As someone who was involved in the early stages of development of the position statement, which addresses reimbursement for trauma call coverage, I would remind readers that the impetus for the development of the statement was to help private practice neurosurgeons in rural communities where, because of the limited number of people in their practice group, they were finding that they were being asked to take call coverage as often as every other night. Our hope was that if a hospital provided a stipend equal to a neurosurgeon's annual salary, then a small-group practice would be able to hire an extra partner who could significantly relieve the group's on-call burden.

It has never been our intention that this position statement be used for anything other than to restore some normalcy to the lives of hardworking neurosurgeons. I agree, however, that with acceptance of a trauma stipend comes certain obligations and responsibilities. Among these include the responsibility for attending medical audit committee meetings of the trauma program at one's hospital and other administrative duties as required for Level I or Level II trauma center. In this issue of the newsletter, we have invited John McVicker, MD, and Jack Wilberger, MD, to discuss these issues more thoroughly, and I hope the readership will find their comments informative.

I look forward to the next two years as your Neurotrauma Section chair and encourage you to contact me at any point with your concerns or problems related to neurotrauma and critical care.

Committee Updates (continued from page 3)

continues and will likely finish up accrual by December 2002. Most of the aims and goals of the study are being met, including not only the safety and performance study, but studies of the optimal initial assessment in young children and infants and improved outcome assessments in children. The study is likely to be completed as originally projected. Once the data is analyzed, abstracts will be submitted to the different national meetings in order to disseminate the information. The principal investigator was Dr. David Adelson and co-investigators included John Ragheb, MD, Douglas Brockmeyer, MD, Jan Paul Muizelaar, MD, Harvey Levin, PhD, Ann-Christine Duhaime, MD, and Paul Kanev, MD.

Neurosurgery Clinics of North America: **Non-Accidental Neurotrauma in Children.** This publication was completed and distributed in July 2002. Chapters included identification, evaluation and treatment of these children as well as some interesting chapters on the unique pathophysiology of this injured age group, outcomes, and future issues, hopefully in the area of prevention and education. Also importantly, there is chapter on the medical and legal aspects particularly as they relate to the treating physician. Drs. Adelson and Partington were the editors for this edition.

Cervical Spine Clearance Recommendations for Young Children. A new working group of pediatric neurosurgeons and members of the Pediatric Neurotrauma Committee met at the CNS Meeting in San Diego and in December 2001 at the AANS/CNS Section on Pediatric Neurosurgery meeting in New York to discuss the issues surrounding clearance of the comatose or young child where there is the question of radiological versus clinical clearance. This group is planning, potentially, a multicenter prospective study to look at best practice management in these situations. Members involved include Drs. Adelson, Brockmeyer, and Partington, and Mark Dias, MD, Dachlang Pang, MD, Paul Grabb, MD, as well as others.

Pediatric Critical Care Course at the CNS Meeting. The Pediatric Neural Injury and Critical Care Management practical course has

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Application for Membership

AANS/CNS Section on Neurotrauma and Critical Care

Eligibility: Members of the AANS and/or CNS who are actively interested in Neurotrauma.
Note: Adjunct Membership is available to non-neurosurgeons who are not members of the AANS or CNS. Please contact 847-378-0500 for an Adjunct Membership application.

I. Biographical:

(A) Name: ____________________

(B) Home Address: ____________________

(C) Office Address: ____________________

____

Phone: ____________________ Fax: ____________________

(D) E-Mail: ____________________

II. Category of Membership Requested:

❏ Active ❏ Associate ❏ International ❏ Resident*

III. Membership, Certification and Practice:

(A) Are you certified by the American Board of Neurological Surgery? ❏ Yes ❏ No

(B) For Resident Applicants-Expected Residency Completion Date (month/year) ____________

(C) Are you a member of:

1. The American Medical Association? ❏ Yes ❏ No
2. A Local or Regional Medical Society? ❏ Yes ❏ No
3. A State or Provincial Medical Society? ❏ Yes ❏ No
   Name: ____________________
4. American Association of Neurological Surgeons? ❏ Yes ❏ No
5. Congress of Neurological Surgeons? ❏ Yes ❏ No

____________________ ____________
Signature of Applicant Date

* Membership dues are waived for applicants currently enrolled in a neurosurgical residency program.

Please return completed application with your membership fee of $50 to:
AANS/CNS Section on Neurotrauma and Critical Care
Dept. 77-7550
Chicago, Illinois 60678-7550

AANS/CNS Section on Neurotrauma and Critical Care
5550 Meadowbrook Drive
Rolling Meadows, Illinois 60008-3852

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Traumatic Brain Injury	J. Paul Elliott, MD
Members at Large	Daniel F. Kelly, MD, John H. McVicker, MD

Committee Updates (contuned from page 6)

been well attended in the past. Scheduled for September 2002 in Philadelphia, new faculty and organizers will ensure that the course is fresh and up-to-date. For this year, the teaching will include many of the findings from the Pediatric Severe TBI Guidelines process. Dr. John Ragheb will lead the course going forward.

Fellowships/Awards Committee

Michael Fehlings, MD, PhD

The Neurotrauma Section presently gives out four awards.

The Synthes Corporation supports two awards for resident research, one in brain and craniofacial injury and one in spinal cord and spinal column injury. At the AANS meeting in Chicago, the cranial award was given to *Joseph Neimat* and the spine award was presented to *Edward Smith*. Coincidentally, both awardees are from Massachusetts General Hospital.

The third award administered by the Neurotrauma Section is the Codman Fellowship in Neurotrauma and Critical Care. The 2002-2003 fellowship was awarded to *Bradley Jacobs* of the University of Toronto. The initial commitment from Codman is an annual award for three years. The Neurotrauma Section is hopeful that this commitment will be extended by three more years.

The fourth award is the J. Douglas Miller Traveling Fellowship, which was awarded to *Ivan Ng,* who will be using the award funds to visit the University of Pittsburgh and the Medical College of Virginia.