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## From the Chair

### The ER Calls: How Will Neurosurgeons Answer?



*Alex B. Valadka, MD*

The delivery of neurosurgical emergency care is becoming increasingly contentious and complicated. Fortunately, the Trauma Section has benefited during the last two years from the leadership of Don Marion, MD. Don deserves our gratitude not only for the many hours and

years he has devoted to the section, but also for his exemplary efforts in so many different areas of neurotrauma: clinical work, translational and clinical research, education and dissemination of new knowledge, and advocacy and public service, to name just a few. I am honored to succeed him as chair of the Trauma Section, and I am also humbled by the challenge of living up to the standards he has set.

Because of the nature of its focus, the Trauma Section is different than the other sections. Most neurosurgical subspecialists try to build large referral networks for elective conditions that are of particular interest to them, and conversely, elective cases that are outside their areas of expertise or interest can be referred to other neurosurgeons with appropriate interest or training. Trauma is different. Not many neurosurgeons have practices that are based exclusively, or even predominantly, on neurotrauma. Furthermore, leisurely referral of emergency cases to a colleague is not an option. I am convinced that, instead, most members of the Trauma Section are general neurosurgeons or non-trauma subspecialist neurosurgeons who periodically have to take their turn on the emergency call schedule. To be perfectly honest, they probably would rather not be on call, but they take their responsibilities seriously. These neurosurgeons are the backbone of the Trauma Section. They want to do their best when they are on call for the emergency patients who inevitably turn up.

### EMTALA, Unfunded Mandates Among the Challenges

Unquestionably, it has become increasingly difficult for these neurosurgeons to take care of emergency patients. A generation ago, physicians covered emergency rooms as part of the responsibilities of medical staff membership and as a way to serve the community. A lot has changed since then. The Emergency Medical Treatment and Labor Act, EMTALA, transformed this noble duty into yet another legal requirement. At the same time, most neurosurgeons report that their emergency rooms have become much busier in recent years. Finally, although practice expenses have been skyrocketing recently, our relative rates of reimbursement have not kept up for many years—assuming that the emergency patients for whom we get out of bed in the middle of the night have financial resources, which is often not the case. These unfunded emergencies continue to displace reimbursed elective cases even though neurosurgeons have had to increase the volume of their clinical work simply to meet expenses and keep their practices open. In effect, the moral obligation to provide emergency care has been replaced by an unfunded federal mandate that penalizes the failure to provide such care.

The frustrations of practicing neurosurgery in this climate have driven many of us to retire early. The Boston Globe reports that, between 1998 and 2002, the number of practicing neurosurgeons in the United States decreased by 11 percent. The result? Fewer hands to divide the growing workload.

And yet the emergency rooms keep calling us.

### Trauma Section's Among the Solutions

The mission of the Trauma Section is to improve the care of the injured or otherwise critically ill neurosurgical patient. Because problems like those described above represent the biggest obstacles to

### What Needs To Be Done

John A. Andryszak, JD

The crisis involving medical malpractice lawsuits, the availability and affordability of medical malpractice liability insurance, and the impact that the crisis is having on access to and availability of healthcare is multifaceted and complex. It has been developing for a number of years, has many causes and unfortunately does not have a simple solution.

Lawmakers at the national level and in a number of states are grappling with the issue, some for the first time since the major medical malpractice liability reforms of the mid 1970s and early 1980s were enacted. In the last two years the U.S. House of Representatives has voted on a reform package and reform proposals have been considered in over 15 states. In the past year, however, the issue has moved to center stage. The delay in attracting legislative attention is due in part to a tendency by legislators and legislative bodies not to act until the problem they must address has reached truly widespread proportions or receives significant media attention. While the current legislative attention is welcome and necessary, it is important that the legislative solutions be comprehensive if true relief to the crisis is to be realized.

The legislative process often requires compromises in order to pass a particular bill. In the case of medical malpractice reform, compromises that eviscerate or eliminate one or more of the key components of a comprehensive reform package may result in legislation that does not produce the intended result of reducing jury awards and settlements, which ultimately will stabilize or reduce medical malpractice insurance costs.

#### The MICRA Approach

When the Medical Injury Compensation Reform Act, known as MICRA, was enacted in California in 1975, it was the most comprehensive and effective medical malpractice reform package passed anywhere. It has been the model for reform efforts in the U.S. Congress and in several states, and has the following six main components:

1. periodic payment of future economic damages;
2. limitations of \$250,000 on noneconomic damages (pain and suffering);
3. offsets for collateral sources (reimbursements for medical care and expenses paid to the claimant from health policies, disability policies or other sources);
4. elimination of joint and several liability (a defendant is only responsible for injury caused by its negligence);
5. limitations on attorney's contingency fees; and
6. a uniform statute of limitations on when lawsuits can be brought.

The reform legislation introduced in Congress also included certificate of merit requirements, limitations on punitive damages, and requirements for who may serve as an expert witness in medical malpractice cases.

This package of proposals produces a structure for medical malpractice litigation that brings a modicum of rationality and predict-

ability to the awards in these types of lawsuits. MICRA has worked well since its enactment, but even in California, escalating jury awards and settlements are driving malpractice premiums higher. Many of the access-to-care problems that other states are experiencing are surfacing in California as well.

#### Physician Responses

Physicians are taking radical steps in response to the lawsuit explosion and concomitant medical malpractice insurance premium increases. Doctors, especially those in high-risk specialties, are restricting or retiring from their practices, refusing to serve on-call at emergency rooms or trauma centers, and even refusing to treat plaintiff's attorneys and their families except in emergency situations. The American Medical Association at its June 2004 meeting was scheduled to consider Resolution 202 (introduced by a South Carolina neurosurgeon), which would have permitted the AMA to advise its members that they may ethically refuse to treat plaintiff attorneys and their families. The sponsor's stated reasoning was to have these patients experience the access-to-care problems firsthand. The sponsor of Resolution 202 withdrew it prior to a vote, but it was a focus of discussion at the meeting.

Throughout the country, trial court verdicts and settlements in medical malpractice liability cases are rising at an astronomical rate, producing very large increases in medical malpractice insurance premiums, especially in high-risk specialties. At the same time, efforts over the past two decades to control healthcare costs and changes in the system for delivering healthcare services, have limited the fees and reimbursement amounts physicians are paid for their services. The confluence of high underlying costs (including escalating medical malpractice premiums), reduced reimbursements, increased numbers of uninsured, and more uncompensated care has greatly exacerbated the problem of patient access to care.

#### What Needs To Be Done

Any comprehensive solution to this multipronged problem must address the availability and affordability of healthcare and the compensation levels for services by healthcare providers, as well as the increased verdicts in medical malpractice lawsuits and the escalating cost of medical malpractice insurance. Solutions to the first two issues are beyond the scope of this paper. With regard to the medical malpractice liability issue, it is clear that a comprehensive package of reforms, including the MICRA-based reforms and others, is necessary to stem the spiraling costs associated with the lawsuit crisis.

Undoubtedly, part of the access-to-care problem, especially in emergency rooms and trauma centers, is due to the increased number of uninsured patients, and the low levels of reimbursements to healthcare providers for those patients who are insured. Medical malpractice lawsuits and rising awards also are significant contributors to this access to healthcare problem.

Since the enactment of MICRA and related reforms in other states, the plaintiff's bar has become very effective at "black boarding"

or demonstrating extremely high estimates of present and future economic damages in medical malpractice cases, and juries are increasingly more willing to hand down multimillion dollar awards in cases involving a severely injured claimant notwithstanding evidence that the medical treatment was state of the art or in accordance with best practices. It is becoming routine to see demands of \$10 million to \$25 million in cases involving difficult births or prenatal problems that result in serious injury, but that may have little or no relation to the quality of medical care or treatment that was delivered. Similar excessive demands are commonplace in lawsuits involving difficult surgical procedures that result in a severely impaired patient, with little regard for the quality of care that the patient received.

As the amounts demanded in lawsuits increase, and as juries become more unpredictable in their verdicts, notwithstanding the evidence, the risk of a verdict in excess of the physician's medical malpractice insurance limits increases. This circumstance often compels physicians and their insurers to settle these cases at or near policy limits rather than risk a jury verdict at an amount above the policy limits, especially in cases involving a severely injured or sympathetic claimant. Unfortunately, the societal attitude that someone should pay whenever an adverse result occurs will not be remedied by the current battery of tort reform proposals.

The reality of a jury's willingness to award substantial sums to sympathetic plaintiffs, coupled with the reality of inevitable legislative compromises when lawmakers are considering controversial legislation, suggest that a totally different approach to solving the medical malpractice liability crisis may be needed. Possible alternatives include removing medical malpractice cases from the existing tort system through the use of special courts similar to "technology courts" that exist in some jurisdictions to handle complex technology litigation, or a system where a schedule of awards exists for certain injuries (similar to a workers compensation system) that could include exceptions for certain egregious situations.

These novel alternatives will not be easy to achieve. However, nontraditional alternatives must be considered since traditional reforms are not being readily enacted, and even if enacted may not bring immediate reductions to the high cost of medical malpractice insurance since many currently filed cases may not be subject to the new reforms. It is imperative that lawmakers act decisively, and soon, to change the existing paradigm. Even if there are increases in the level of physician reimbursement for medical services, the upward spiral of malpractice awards and the associated insurance costs under the current tort-based system will continue to be an unacceptably large cost of doing business to a physician in a traditional practice. As long as this is the status quo, physicians will continue to reject the alternative of paying these higher costs as a "cost of doing business" because they simply cannot afford to do so any longer, and increasing numbers of physicians will pursue other options. The consequences of their decisions to pursue other options will be disastrous to the healthcare system. ■

the care of these patients, the Trauma Section expects to devote a lot of time over the next several years to working towards their resolution. It would be foolish to think that we could solve the problems by ourselves. We will need to continue to work closely with the other sections, with the American Association of Neurological Surgeons and Congress of Neurological Surgeons, with the Washington Committee, and with Neurosurgeons to Preserve Health Care Access and Doctors for Medical Liability Reform, among others.

What kind of solutions are we looking for? Quite simply, we need legal, regulatory, and financial relief that will make it possible for us to go back to taking care of our patients. Avenues of attack include tort reform, changes in the structure of professional liability insurance, increases in Medicare reimbursements, regulatory relief, and continued pressure on health maintenance organizations.

These are all long-term solutions that will take place at high administrative and organizational levels. The Trauma Section is also working to help the individual neurosurgeon with his or her more immediate attempts to cover emergency rooms and on-call panels. Several questions have become topics of often heated debate. Should organized neurosurgery support or oppose the insertion of intracranial pressure monitors by physician extenders? Will general surgeons successfully change their training structure so that trauma surgeons will be trained to perform emergency craniotomies? Will neurosurgeons at designated trauma centers continue to need a large amount of annual trauma-related continuing medical education credits? Should more hospitals compensate their neurosurgeons for taking call, or are such neurosurgeons "bankrupting the entire trauma system and holding it hostage"?

Reasoned debate by intelligent and well informed experts is the only way to make progress. In this newsletter, Jeff Lobosky, MD, questions the existence of a relationship between professional liability reform and improved emergency room coverage, and John Andryszak, JD, presents an attorney's perspective on the professional liability crisis.

### **Reinforcing Research and Education**

At the same time, it cannot be emphasized strongly enough that the section remains firmly committed to research and education. Solid support from industry has been invaluable in helping the section reach new levels of excellence in these areas. The Codman research fellowship and the Synthes awards for resident research in neurotrauma continue to attract outstanding applicants. Negotiations are in progress to secure external funding for the J. Douglas Miller visiting fellowship as well. The section has more than enough talent among its membership to maintain the excellence of these programs and to create new ones while simultaneously tackling the socioeconomic problems affecting the delivery of care.

The problems, challenges, and hassles surrounding neurotrauma and critical care affect just about every neurosurgeon. Our job is to help you deal with these problems so that you can give your patients the best possible treatment. Please let us know how we are doing and, most importantly, how we can help you. ■

### Will Malpractice Reform Solve The Crisis?

Jeffrey M. Lobosky, MD

**A**t the recent AANS Annual Meeting in Orlando I was disappointed to see our colleague, Steve Haines, MD, verbally excoriated by several members of the audience for having the audacity to suggest that it was improper for neurosurgeons to refuse to provide care for life-threatening emergencies. Some of our colleagues recently have dropped cranial surgery privileges or refused to provide on-call services altogether, leaving emergency departments in many communities across the country without neurosurgical coverage. The prevailing argument in support of those opting out of ER call coverage is that medical liability issues have created an even greater crisis, and thus many have been left with no choice but to refuse to care for critically ill or injured patients and to avoid high-risk procedures.

We must be cautious when suggesting that the reason America's neurosurgeons are abandoning hospital emergency rooms is related solely to the medical liability risk, for it implies that if and when this crisis is resolved, they will return to provide the coverage so desperately needed. The fact of the matter is that the ER call coverage problem is a more complex and multifaceted issue, and to attribute it primarily to rising malpractice premiums contradicts experiences in my own state of California and elsewhere.

In the mid-1970s California passed the most sweeping medical malpractice reform legislation in the country. The Medical Injury Compensation Reform Act, known as MICRA, rapidly stabilized malpractice premiums and became the benchmark for rational liability tort reform. However, despite the fact that California had one of the most favorable malpractice climates in the United States, in the late 1980s and early 1990s trauma centers across the state began shutting down at an alarming rate. In addition, neurosurgeons nationwide began dropping off of emergency room call panels, making it difficult for many trauma centers to maintain their certification.

The debate began to rage at neurosurgery's annual meetings with regard to this disturbing trend and the subsequent effort by trauma surgeons to obtain privileges for the evacuation of subdural hematomas and the insertion of intracranial pressure monitors. Even more provocative was the suggestion that intracranial pressure monitors could be placed by nurse practitioners and physician assistants. Both of these proposals were the direct result of neurosurgeons abdicating their role in the management of acute head injury. Furthermore, these issues surfaced long before the current medical liability crisis came to the forefront.

#### What Affects Neurosurgical ER Coverage?

So what are the factors that affect neurosurgeons' willingness to provide emergency room coverage, and more importantly, what are the solutions?

**Medical Liability** Without question, the medical liability crisis the single most important challenge facing neurosurgeons across the country. Irrational and exorbitant malpractice awards have

propelled insurance premiums far beyond reasonable and affordable limits in many communities. As a result, a number of neurosurgeons have been forced to relocate to more favorable venues or retire from practice altogether as the difference between these outlandish costs and diminishing reimbursement has widened. Others have opted to refuse to treat patients in the emergency room, have dropped cranial surgery privileges, or have even suggested denying care to plaintiffs' attorneys and their families both as an economic necessity and a punitive measure to force legislative reform.

Statistically, most malpractice actions brought against neurosurgeons are the result of elective spinal surgery. Yet very few of our colleagues have recommended abandoning lumbar disc surgery or anterior cervical fusion to protest the current liability crisis. Could their willingness to continue to provide these services in the current litigious climate reflect the fact that reimbursement is more lucrative for inserting pedicle screws than for getting out of bed at 1 a.m. to remove a subdural hematoma in an uninsured patient?

In many regions insurers significantly reduce premiums for individuals who voluntarily relinquish cranial and emergency room privileges. It is hard to criticize someone for making such a decision when the economic factors are so overwhelming. More difficult to defend are those who maintain cranial and spinal surgery privileges yet abandon their communities' emergency room patients. However, a number of our colleagues do just that and continue to cite "malpractice risk" as the reason.

**Workforce** The number of practicing neurosurgeons in the United States continues to decline. At the same time neurosurgery residents in significant numbers are choosing academic careers, leaving vacancies in suburban and rural areas where at the same time dramatic population increases create additional strains on available neurosurgeons' time.

Providing emergency room coverage is taxing, even in academic settings where call is shared among a sizable faculty pool. In private practice venues, call can become overwhelming when as few as two or three neurosurgeons attempt to provide adequate coverage for a busy trauma center. In many of these situations, it is common to find that neurosurgeons are working as hard as, if not harder, than when they were residents.

Physician burnout frequently results. Overburdened surgeons become disenchanted with their practices and experience an enormous stress on their personal lives as well. As a result, we see neurosurgeons retiring at a younger age or dropping off their ER call rosters, which only exacerbates the situation further.

**On-Call Stipends** Neurosurgeons deserve equitable compensation for the services they provide, yet they are faced with declining reimbursements that stem from a managed care system which is tied to Medicare and Medicaid fee schedules. At the same time the costs of practicing medicine continue to rise, and many neurosurgeons are struggling just to keep pace. Indeed, liability insurance

premiums are a major component in that struggle, but increased overhead for personnel, office space, and worker's compensation and healthcare coverage further influences the bottom line.

In most communities a large portion of ER patients either are uninsured or underinsured to the point that, from a purely economic perspective, there is little incentive for a neurosurgeon to provide services. Why get up in the middle of the night or interrupt the daytime surgical schedule to provide undercompensated care to an ER patient, especially if the cost of the liability insurance necessary to provide that care is greater than the compensation for doing so?

To reiterate, California faced this very issue back in the early 1990s. Many hospitals, specifically those with trauma center designations, began offering on-call stipends to neurosurgeons, orthopedists and general surgeons. This strategy had a stabilizing effect on the trauma system in California, and the rash of trauma center closures abated. But it also had a ripple effect on other medical staff members, and soon dermatologists, ophthalmologists and other specialists began demanding compensation for ER availability.

The financial impact of this solution on hospitals has been significant. Indeed, hospitals face the same economic challenges as their physicians with regard to governmental and private insurers, and in many communities these financial constraints limit a hospital's ability to purchase state-of-the-art technology or expand services. Although compensation for on-call panels continues to gain acceptance, in the near future I suspect that this solution will fail as well. Indeed, in some trauma centers, hospitals are still unable to fill their call panels even though ER stipends are offered.

### Possible Solutions

I do not presume to have the answers to the ER coverage crisis. This issue is complex and multifaceted, and its solution will be as well. I do agree with Dr. Haines that using patients' lives as a bargaining tool is not an option. Once we break that bond of trust with our patients by refusing to respond to the emergency room, we begin a journey down a slippery slope. The end of that road is an abyss that contradicts all tenets of the Hippocratic oath and may, as Dr. Haines put it, cost us our collective souls.

When California faced its malpractice storm in the 1970s, the legislature was finally forced into action when the state's physicians went on strike. They closed their offices, canceled scheduled surgeries and vowed to treat only emergency room patients until the crisis was addressed. It was resolved quickly, and the physicians' status as caring and responsible doctors was preserved. I fear that the current trend to continue to provide elective surgery while refusing emergency care will have the opposite effect.

Rational tort reform is a must, yet the MICRA model may no longer address all the necessary components. As Jack Andryszak, JD, points out elsewhere in this issue, effective tort reform will require much more than capitation of awards. In Orlando, Stewart Dunsker, MD, and Stan Pelofsky, MD, made an impassioned and

compelling plea for neurosurgeons to unite in the endeavor to support a political force that will make our voice heard in legislatures across this country. Their effort may be our best chance at confronting this challenge and deserves every neurosurgeon's support.

The workforce issue may be one of numbers as well as distribution. The leaders of the American Association of Neurological Surgeons and the Congress Neurological Surgeons have grappled for some time with the perceived shortage of neurosurgeons. It is imperative that our residency programs provide sufficient numbers of well-trained practitioners to meet the growing demand across the United States. Program directors must recognize the value of the private practitioner in neurosurgery and encourage their residents to consider such a career with the same enthusiasm with which they advocate the academic pathway.

Alternatives like regionalized centers for neurosurgical care would still put many patients with life-threatening conditions at a geographic disadvantage that could likely result in their demise. It is one thing to transfer a patient with an aneurysm or brain tumor several hundred miles, but quite another to do the same with a victim of a critical head injury or acute shunt obstruction. It is also possible that an enhanced reimbursement schedule for those who practice in rural or semi-rural regions with sizable referral bases might attract talented young neurosurgeons to such areas and solve some of the distribution inequities which currently exist.

An option currently under consideration in California's state legislature would force hospitals to demand participation in ER call panels as a requirement of medical staff appointment. In addition, some have recommended tying licensure renewal to ER coverage. Theoretically, this would ease the burden by forcing all practitioners to carry their fair share of the load. Undoubtedly, however, either of these proposals would be met with significant resistance by California physicians.

Finally, compensation for trauma and critical care procedures must recognize not only the life-saving nature of these services, but also the high level of risk, the prolonged follow-up care, and the significant inconvenience emergency room responsibility entails. These emergency services should be among the most highly reimbursed in our specialty not only in the private sector, but by Medicare and Medicaid as well. State and federal agencies must be willing to provide reasonable compensation for the many uninsured victims of trauma who frequent emergency rooms. Our hospitals will be unable to shoulder that burden through compensated call panels much longer. I am convinced that adequate reimbursement for emergency care is key to solving the ER coverage crisis.

These problems will not be resolved overnight. But neither will they be resolved if we fail to address each of the complex issues inherent in ER coverage. It is imperative that the debate be rational, objective and, as much as possible, unemotional. It may be dramatic and provocative to suggest denying care to lawyers and their families or to refuse to care for life-threatening emergencies, but such rhetoric does little to promote a sustainable solution. ■

# Neurotrauma & Critical Care at the CNS Annual Meeting

## Sunday, Oct. 17 8 AM–5 PM PRACTICAL COURSE

### Traumatic Adult & Pediatric Brain Injury

Course Fee: \$350

Course Directors: *John Ragheb, Raj K. Narayan*

This course focuses on current thinking regarding the non-surgical and surgical treatment of traumatic brain injury in adults and children. Newer monitoring techniques, as well as promising new therapies, will be discussed.

## Monday, Oct. 18 2 PM–5:30 PM

### JOINT SECTION ON NEUROTRAUMA AND CRITICAL CARE I AND AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

#### Fluid Management in Neurosurgery

Moderators: *Jamie Sue Ullman, Bizhan Aarabi*

- 2:00 – 2:15 Synthes Award for Resident Research on Spinal Cord and Spinal Column Injury
- 2:15 – 2:30 Synthes Award for Resident Research on Craniofacial and Brain Injury
- 2:30 – 2:50 Fluid Management in the ICU: The Use of Colloids  
*J. Claude Hemphill III*
- 2:50 – 3:10 Fluid Management in the ICU: The Use of Hypertonic Fluids  
*Geoffrey T. Manley*
- 3:10 – 3:30 Fluid Resuscitation Options in the Field and on Arrival in the ED  
*Gregory L. Henry*
- 3:30 – 4:00 Refreshments with Exhibitors
- 4:00 – 5:15 Open Papers 722-729
- 5:15 – 5:30 Oral Posters 27-31

## Tuesday, Oct. 19 2 PM–5:30 PM SPECIAL COURSE II

### Controversies in Neurotrauma and Neurosurgical Emergency Care

Course Director: *Alex B. Valadka*

- 2:00 – 2:20 The Argument for Official Designation of Specified Neurotrauma Centers  
*M. Ross Bullock*

- 2:20 – 2:30 Discussion
- 2:30 – 2:50 General Surgeons Should Be Trained to Perform Neurosurgical Operations  
*Robert Mackersie*
- 2:50 – 3:10 General Surgeons Should Not Be Trained to Perform Neurosurgical Operations  
*William F. Ganz*
- 3:10 – 3:30 Discussion
- 3:30 – 4:00 Refreshments with Exhibitors
- 4:00 – 4:20 Is Immediate Spinal Cord Decompression Needed in Spinal Cord-Injured Patients?  
*Daniel K. Resnick*
- 4:20 – 4:30 Discussion
- 4:30 – 4:50 Decompressive Craniectomy for Brain-Injured Patients Is an Over-utilized Operation  
*Alex B. Valadka*
- 4:50 – 5:10 Decompressive Craniectomy for Brain-Injured Patients Is Not an Over-utilized Operation  
*William M. Coplin*
- 5:10 – 5:30 Discussion

## Wednesday, Oct. 20 2 PM–5:30 PM SECTION ON NEUROTRAUMA AND CRITICAL CARE II

### Ethics in Neurotrauma

Moderators: *Shelly D. Timmons, Peter B. Letarte*

- 2:00 – 2:15 Should I Let this Patient Die? When Is Care Futile? Withdrawing Care in the Field  
*S. Marshall Isaacs*
- 2:15 – 2:30 Should I Let this Patient Die? When Is Care Futile? Withdrawing Care in the ED  
*Catherine A. Marco*
- 2:30 – 2:45 Decision Making at the End of Life  
*John Luce*
- 2:45 – 3:00 Discussion
- 3:00 – 3:30 Oral Posters 32-41
- 3:30 – 4:00 Refreshments with Exhibitors
- 4:00 – 5:15 Open Papers 800-807
- 5:15 – 5:30 SINch Oral Posters 910-913

The most up-to-date CNS annual meeting information is available at [www.neurosurgcon.org](http://www.neurosurgcon.org).

## Neurotrauma Awards at the 2004 AANS Annual Meeting



### 2004 Synthes Resident Spine Award— Virany Huynh Hillard, MD

Virany Huynh Hillard, MD, graduated from medical school at New York University in 1999 where she did clinical research in neurosurgery with Fred Epstein, MD, as well as basic science research. During her research year, she studied treatments for spinal cord injury in a rat model under the supervision of Raj Murali, MD, and Kaushik Das, MD, in the neurosurgery department, and Richard Zeman, PhD, and Joseph Etlinger, PhD, in the cell biology and anatomy laboratories at New York Medical College. Dr. Hillard will be doing a spine fellowship after she finishes her residency.



### 2004 Synthes Resident Craniofacial Award— Andrea Kleindienst, MD

Andrea Kleindienst, MD, graduated from the Free University of Berlin Medical School in 1989. She completed her dissertation, "Magnetic Resonance Imaging of the Carpal Tunnel Syndrome," in 1991 at the Free University of Berlin. She trained in neurosurgery at the University of Cologne (1991–1997) and in neurosurgical intensive care medicine at the Charite, Humboldt University Berlin (1997–1998). She was awarded a Traveler's Grant by the German Society of Intensive Care Medicine, and spent three months in 2001 at the laboratory of Ross Bullock, MD. She then began a postdoctoral fellowship in 2002

with Dr. Bullock and Anthony Marmarou, MD, at the Medical College of Virginia, Virginia Commonwealth University.



### 2004 Codman Fellowship—Ann M. Parr, MD

Ann M. Parr, MD, completed her medical school training at Queen's University at Kingston, Ontario. She began clinical neurosurgical residency at the University of Manitoba and recently moved to the University of Toronto to pursue her research interests. Her current studies investigate a potential role for stem cells in the repair of spinal cord injury in the laboratory of Charles Tator, MD.



### 2004 Douglas Miller Traveling Fellowship Award—Milan Spaic, MD, PhD

Milan Spaic, MD, graduated from the Medical Faculty in Sarajevo in February 1985. After a one-year internship and four years as a general practitioner, he trained for five years in neurosurgery at the Military Medical Academy in Belgrade, the University Institute for Neurosurgery in Belgrade, and the Regional Neuroscience Centre Newcastle upon Tyne, England. He passed his exam in neurosurgery in March 1996, and since has been working as a specialist-neurosurgeon at the at the Military Medical Academy Department of Neurosurgery in Belgrade managing the program of posttraumatic neurogenic pain treatment.



# 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 847-566-AANS, ext. 508, for more information.*

### I. Biographical:

(A) Name: \_\_\_\_\_

(B) Home Address: \_\_\_\_\_

(C) Office Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

(D) E-Mail: \_\_\_\_\_

### II. Category of Membership Requested:

Active       Associate       International       Resident\*

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

### 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

(D) I would like to support  with my donation of

\$50.00 (Recommended)       Other amount \$ \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Please return completed application with your membership fee of \$50 and any donations 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



### AANS/CNS Section on Neurotrauma and Critical Care Leadership

#### Chair

Alex B. Valadka, MD

#### Chair-Elect

P. David Adelson, MD

#### Secretary-Treasurer

Jack I. Jallo, MD, PhD

#### Liaisons

AANS: Alex B. Valadka, MD

CNS: P. David Adelson, MD

CSNS: J. Adair Prall, MD

Military: LTC Rocco A. Armonda, MD

NCS/SCCM: William M. Coplin, MD

Physician Extenders:

Douglas Duffy, PA-C

Think First:

Daniel B. Michael, MD, PhD

Washington Committee:

Jack E. Wilberger, MD

#### Committees

##### Education

Shelly D. Timmons, MD, PhD (Chair)

Michael G. Fehlings, MD, PhD

Jack I. Jallo, MD, PhD

Geoffrey T. Manley, MD, PhD

Jamie S. Ullman, MD

William C. Welch, MD

##### Fellowships/Awards

Michael G. Fehlings, MD, PhD

##### Membership

Shelly D. Timmons, MD, PhD

##### Pediatrics

Cheryl A. Muszynski, MD

##### Spinal Injury

Michael G. Fehlings, MD, PhD

##### Sports Medicine

Julian E. Bailes, Jr., MD

##### Traumatic Brain Injury

Wililam F. Ganz, MD

##### Members-at-Large

Domenic P. Esposito, MD

Geoffrey T. Manley, MD, PhD

### From the Editor

#### Jack I. Jallo, MD

As the incoming editor of Neurotrauma and Critical Care News, I would like to thank P. David Adelson, MD, for all his help in transitioning the editorial position and recognize him for the excellent work he has done in his capacity as secretary-treasurer. I would also like to welcome Alex B. Valadka, MD, in his new role as chair of the Trauma Section and Dr. Adelson in his new role as chair-elect.

In this issue of the newsletter, I draw your attention to the upcoming meeting of the Congress of Neurological Surgeons in San Francisco and the neurotrauma-related highlights for that meeting on page 6. I also present the section's award winners from the May meeting of the American Association of Neurological Surgeons in Orlando.

Finally, I invite you to send your ideas for and comments about the newsletter to me at [jack.jallo@temple.edu](mailto:jack.jallo@temple.edu).