

Neurosurgery

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Tracking the Neurosurgery Subspecialties

Growth on the Rise in Some, Leveling Off in Others

By Bonnie Darves

One of the most interesting aspects of the historical emergence of subspecialties in neurosurgery is that subspecialization wasn't supposed to happen. The thinking was that neurosurgery is such a small specialty that neurosurgeons should be not just broadly enough trained to handle any neurosurgical need or situation but also committed philosophically to being a generalist.

That was fine for the most part, until about a decade ago, notes Robert Harbaugh, MD, president of the American Association of Neurological Surgeons, when the trend toward subspecialization in other subspecialties began to take hold. "It's been an interesting decade—and that's exactly right. A decision was made that

surgery, and anesthesia were encroaching on turf traditionally managed by neurosurgery, observes William Gormley, MD, MPH, director of neurosurgical critical care at Brigham and Women's Hospital in Boston. "In hindsight, being slow to subspecialize was a bad idea. When critical care became a specialty, all of these other specialties got involved and their volume grew," said Dr. Gormley, noting that it was neurologists who initially propelled the neurocritical care movement. "We, as neurosurgeons, were about to find ourselves in a space where if we didn't pursue a subspecialty, we couldn't go into the ICU."

That's changing now, for the positive, Drs. Gormley and Harbaugh report, as neurosurgery

"I tell my residents that one thing I'm pretty sure of is that what we're teaching them to do today, isn't what they will be doing in 10 years."

- Robert Harbaugh, MD



neurosurgery was so small—there are only about 3,800 board certified neurosurgeons and not all of us are actively practicing—that if we subspecialize we would have groups that were so small that we would have little influence in what was going on with our field," says Dr. Harbaugh, who is director of the Penn State Institute of the Neurosciences and chair of the university's department of neurosurgery. "Then we were seeing increasing demand from patients and certifying agencies to recognize subspecialty expertise—and now we recognize that no neurosurgeon actually practices general neurosurgery anymore. We all practice some subspecialty of our field."

In the meantime, other specialties such as orthopedic surgery, general and trauma

moves toward training and supporting subspecialty expertise. "To address those outside forces," Dr. Harbaugh explains, "we have hammered out a process to do that, involving our own board and our senior society, The Society of Neurological Surgeons. We're working together to recognize subspecialty expertise."

CAST: Accrediting Entity is Positive Force

One good example of this field-driven "solution," Dr. Gormley points out, is the Committee on Advanced Subspecialty Training (CAST). The group, started by the American Board of Surgery, functions in neurosurgery under the Council of The Society of Neurological

continued on page 2

IN THIS ISSUE...

[Tracking the Neurosurgery Subspecialties](#)
PAGE 1

[Practice Profile: SUNY Upstate](#)
PAGE 5

[After the Site Visit](#)
PAGE 6

[Upcoming Neurosurgery Events](#)
PAGE 7

[Opinion: Gauging Neurosurgeons' Value](#)
PAGE 8

[In Brief](#)
PAGE 10

[Legal Corner](#)
PAGE 11

[Neurosurgery Positions & Featured Opportunity](#)
PAGE 12

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Tracking the Neurosurgery Subspecialties

(continued from Page 1)

Surgeons. CAST has assumed responsibility for accrediting neurosurgery subspecialty training fellowships and subspecialty certification of fellows, as well as updating subspecialty training requirements. Most CAST-accredited programs are one year in duration.

“We were late to the game, but CAST is neurosurgery’s answer to this whole problem of having no neurosurgery subspecialization recognition,” Dr. Gormley said. “Dr. Harbaugh has actually been the driving force in all of this.”

Neurosurgery now has CAST-accredited endovascular and critical care fellowships, for example, as well as spine, functional, neurosurgical oncology and pediatric neurosurgery, and neurotrauma and peripheral nerve. “I now have people calling me all the time asking if I have any CAST-fellowship approved trainees,” Dr. Gormley said. “So it’s clearly making a difference for our field.” His own training program, he adds, will probably turn out approximately 75% of its fellows as CAST-certified critical care fellows in the next few years. Increasingly, he predicts, many CAST fellowships will be “internal” to neurosurgery training programs—or neurosurgeons will move among training locations to complete them during their formal training years.

CAST may well be the answer in terms of positioning neurosurgeon subspecialists to easily move into the clinical areas where they want to focus their practice. What’s more difficult to determine is where the overall neurosurgery services market will go, observes Deborah Benzil, MD, a Mount Kisco, N.Y., neurosurgeon who is a principal with the neurosurgery consulting firm Benzil Zusman LLC and a member of the Columbia University faculty. “The key with the subspecialties now is that it’s difficult to predict which will be the ‘rainmakers’ five years from now,” said Dr. Benzil, a neuro-oncologist with a specialty in spine stereotactic radiosurgery. “The aging population is a predictor to some extent, but what we don’t know is

what the next big functional neurosurgery treatment will be—though it’s clear there will be increasing indications.”

Dr. Benzil advises neurosurgeon trainees who are interested in the functional subspecialty area to ensure they target practice opportunities that are well supported by a comprehensive multidisciplinary base. “The reimbursement is low, so neurosurgeons will need a collaborative environment with substantial [organizational] support,” she said. She notes that endovascular and spine have been the fastest-growth areas in recent years, and that neuro-oncology tumor treatment is showing an uptick in demand, in part because of the aging population.

Dr. Benzil also predicts that skull base will be “a shrinking world” but that neuro-trauma services will grow and remain an economic driver for hospitals. “Neuro-critical care is also an attractive area for trainees who want to have more control over their life-style—because it’s essentially shift work,” she said.

Multidisciplinary Model a Key Driver

Neurosurgery trainees shouldn’t let macroeconomic or market considerations drive their subspecialty choice, but they should at least be aware of the forces reshaping healthcare generally, advises Edie Zusman, MD, a California-based neuro-oncologist and researcher who, with Dr. Benzil, advises neurosurgery practices on growth and alignment strategies.

“The neurosurgeon will play a key role in the multidisciplinary [care] model approach going forward, because that model incorporates great quality and collaborative care,” said Dr. Zusman, who is medical director at the Sutter Health East Bay Neuroscience Institute. “When you look across the neurosciences spectrum—brain tumor, stroke, neuro-trauma and spine—and offer comprehensive services, you deliver the best level of care. The key thing trainees should keep in mind now is

GUIDANCE FOR THE GOING

The neurosurgeons interviewed for this article offered a range of tips and practical strategies that their younger colleagues might find helpful as they map out their early-career plans. Following are some of the key ones:

“If you are planning to go into academic practice, CAST accredited fellowships are relevant and important. Programs really want people with dual skills now, such as endovascular and critical care.”



– Dr. William Gormley

“When choosing a fellowship, remember that accredited fellowships are regulated, while others might not be. Beware of programs that attract people by ‘promising’ a job—there’s no absolute guarantee.”

– Dr. Timothy Vogel

“Even if you’re just starting out in neurointerventional surgery, if you’re helping to establish a new service line or expand an existing one, it’s important to have a five- and 10-year plan—and to make sure you choose a practice or organization that supports your plan.”

– Dr. Donald Frei

“Choose a sub-specialty because you love it, and because you are willing to help build or strengthen that component of a practice or program. But if you join an organization that has problems, don’t expect that you will be able to fix those when you get there.”



– Dr. Deborah Benzil

that increasingly, organizations are looking for people who play well in the sandbox—people who have had a multidisciplinary approach to education and who, as individuals, exhibit that sense of collaboration.”

What does all of this maneuvering mean for neurosurgeons in training? It’s important to keep in mind in designing an individual career path, but the overall picture is bright in terms of opportunities for neurosurgeons generally, all sources concurred. Neurosurgeons who perform well in training and who approach their fellowship and practice choices strategically, have reason to be optimistic about the choices available to them, according to Timothy Vogel, MD, a pediatric neurosurgeon and assistant professor of neurosurgery and developmental biology at Cincinnati Children’s in Ohio.

“There is always space in our field for good people, even in academia. And that’s what I always tell our trainees,” said Dr. Vogel, who has conducted extensive research in hydrocephalus. At the same time, he urges neurosurgeons to be proactive in staying abreast of trends in their subspecialty and the field as a whole—particularly when looking at fellowships. He recommends that trainees get involved with the AANS pediatrics subsection early on, and also familiarize themselves with organizations such as the Accreditation Council for Pediatric Neurosurgical Fellowships (ACPNF).

“It’s also important to reach out to your program directors, who tend to be very aware of trends in the subspecialties,” he said. “But be sure to go in with your eyes wide open. Also take the time to talk to fellows in the programs you’re interested in, to ask them what it’s like.”

Pediatrics, Neurointerventional Subspecialties See Challenges

On the market reality front, Dr. Vogel also urges pediatrics neurosurgery trainees to be

aware of developments in the field in recent years. For instance, a decade ago organizations were scrambling for pediatrics-specialized neurosurgeons, but as increasing numbers of trainees moved into the sector, supply has begun to outstrip demand—if slightly.

“It’s important to remember that in small subspecialty areas like pediatrics craniofacial surgery, the numbers [of graduates] used to be in the single digits. But now there are 25,

of neurointerventional services at Swedish Medical Center in Denver.

Dr. Frei predicts that the advances in “clot-grabbing” devices and specialists trained in their use will keep the field in a solid position in the years ahead. He cautions, however, that because of the shifting in medicine generally, with health reform, and reimbursement changes specifically, trainees should be very diligent about seeking a

“The key thing trainees should keep in mind now is that increasingly, organizations are looking for people who play well in the sandbox—people who have had a multidisciplinary approach to education and who, as individuals, exhibit that sense of collaboration.”



- Edie Zusman, MD

so some people have experienced difficulties finding a good academic position in the last few years,” he said. On the other side of the equation, Dr. Vogel points to vascular and tumor as pediatrics neurosurgery areas where demand appears to be on the rise. He also sees the private setting as a growing option for trainees.

Neurointerventional surgery is another area where market forces in recent years have affected the opportunity market for trainees. Programs and practices were scrambling to hire the subspecialists a few years ago, but demand has leveled off as supply has caught up—there are now 750 U.S. neurointerventional surgeons. “We’re seeing some ‘self-selecting’ decrease in the number of fellows in the field, because the demand matches the supply pretty well now,” said Donald Frei, MD, president-elect of the Society of Neurointerventional Surgery and director

practice opportunity that will support them long term. “I think it’s important to look for a practice that wants to be comprehensive—and that has a deep bench,” he said, “and an established neurointerventional service and an administration that’s committed to the surgical services 24/7 and to supporting the practice.”

In addition, Dr. Frei encourages trainees to look beyond their own specialty or subspecialty to ensure the organizations they join are equipped to provide a multidisciplinary operation. “It’s really all about the team approach anymore,” he said. “And if your organization wants to become a designated stroke center, for example, you have to make sure they’ll provide the resources.”

Dr. Harbaugh also stressed the importance of neurosurgeons planning ahead to ensure they’re professionally equipped to obtain the credentials they need to do the work they hope to pursue in the setting of their choice.

continued on page 4

Tracking the Neurosurgery Subspecialties

(continued from Page 3)

“I think that trainees are aware of what’s going on [with competing specialties and turf issues], and they recognize that if they finish an accredited neurosurgery training program and get the skills they need, they won’t have trouble getting credentials to practice cranial or spine or functional neurosurgery,” Dr. Harbaugh explained. “But in areas where we compete with other specialties, having the recognition of additional training is very helpful to assure they can get credentialed into various hospitals.” Today’s neurosurgery trainees are increasingly aware, he added, of which fields require that additional recognition and which ones don’t—and he expects they’ll plan their advanced training pursuits accordingly.

Identifying Subspecialty Trends

In the big picture, the market forces that are moving the neurosurgery field as a whole will soon—or in some cases already are—shifting demand in the subspecialties. One of the most pronounced trends, in Dr. Harbaugh’s view, is the increasing indications for functional neurosurgery. “I see great potential for growth in this area,” he said. For example, while deep brain stimulation (DBS) has been performed in Parkinson’s disease for many years, there is emerging evidence that DBS holds significant promise for ameliorating conditions with a

“neuro” component that, for many patients and physicians, have proved particularly challenging to treat—such as depression, addiction and obesity.

“Those diagnoses are so prevalent that they completely swamp the traditional diagnoses, like aneurysm, that neurosurgeons treat,” Dr. Harbaugh observed. “So if it proves that functional neurosurgery is effective for these kinds of neurobehavioral problems, we can’t train neurosurgeons fast enough to meet the demand.”

At the same time, such emerging developments make it very difficult to predict what work force neurosurgery will need, Dr. Harbaugh and other sources concurred, because it really depends on what neurosurgeons end up doing in response to medical and technology advances. “I tell my residents that one thing I’m pretty sure of is that what we’re teaching them to do today, isn’t what they will be doing in 10 years,” Dr. Harbaugh quipped.

At the other end of the spectrum, spine is likely to continue as a mainstay of neurosurgery, with some qualifications. Spine procedures now account for the majority—more than two thirds—of all procedures neurosurgeons perform. And neurosurgeons do more slightly more than half of all spine surgeries, with orthopedic surgeons performing the remainder.

Although this will remain a major market for neurosurgeons generally and those who focus on spine, the field should be prepared for some shifting, Dr. Harbaugh cautions. In particular, he expects, based on what AANS and neurosurgery leaders are hearing, that there will be a push to decrease instrumented procedures overall. “There’s a growing concern that patients are getting more of these procedures than is necessary, and there may be some pullback by insurers—unless we see better evidence that these [treatments] really improve outcomes.”

The AANS is working actively to develop that evidence base, to determine “what’s helpful and what isn’t,” he added, for patients with serious spine problems. But neurosurgeons might see some market disruption in the reimbursement realm in the interim, industry observers suggest.

“That is one threat to the neurosurgery marketplace—if the amount of instrumented procedures drops precipitously,” Dr. Harbaugh said. “That’s a lot of what neurosurgeons in the community do now.”

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Bonnie Darves is a Seattle-based independent healthcare journalist and editor of Neurosurgery Market Watch.

CONTRIBUTORS WANTED!

Neurosurgery Market Watch welcomes submissions of articles of potential interest to practicing neurosurgeons. We are particularly interested in opinion articles about how trends occurring in the neurosurgery marketplace or in the health policy arena might affect the practice environment.

► To discuss a potential idea, please contact Bonnie Darves at **425-822-7409** or **bonnie@darves.net**

PRACTICE PROFILE

SUNY Upstate: Making the Most of the ‘Hybrid’ Model

By Bonnie Darves

By many standards, Neurosurgical Associates of Central New York has been ahead of the curve in adapting neurosurgery services to meet marketplace needs. The practice, affiliated with SUNY Upstate in Syracuse, N.Y., and also known as Upstate Medical University Neurosurgery, has one foot firmly planted in academia and the other in the private-practice realm. It’s a thriving hybrid, with an interesting history, its chairman, Lawrence Chin, MD, points out.

“We’re university based, we run a residency program, and everyone in our group has a faculty appointment. But our practice has always been set up as an independent group practice,” say Dr. Chin, who directs the Gamma Knife Center and the neuro-oncology program. “It’s a true hybrid model.”

The practice, which includes 10 surgeons, differs somewhat from the traditional neurosurgery practice in either the academic or private sector in that it also includes an orthopedic surgeon. In addition, the practice boasts a far more flexible compensation model than most university-based groups support. In January, Neurosurgery Market Watch spoke with Dr. Chin about the several factors that give the practice its unusual blend of academic and independent characteristics.

In what key ways does your group differ from the traditional academic neurosurgery departments?

Our surgeons don’t have to be based at the university or just one hospital, so there’s more flexibility in terms of working at other facilities and practicing at satellite locations—including two other hospitals in the region. Many academic institutions are moving toward contracting with other hospitals and clinics now, but we’ve had this in place for several years.

We also offer a compensation model that’s more flexible than most university-based groups offer, in that it’s based less on academic rank than on individual performance—we don’t really use an academic-rank salary structure.

Instead, our surgeons have a great deal of financial autonomy, to be rewarded for doing more clinical work. So there’s not the sense that if you’re extremely busy you won’t be rewarded financially for that extra activity. We have a very strong incentive component built into our compensation plan.

In addition, every surgeon receives some component of compensation from the state, to support the teaching and research activities here. That component can vary depending on how the surgeons focus their practice. There’s also a hospital component that reflects things such as the on-call stipend and the leadership roles people pursue.

have some surgeons who are 100% clinical and some who are doing a lot of research and running a basic science lab, working on a range of interests—from hydrocephalus, to stroke, to traumatic brain injury or brain-tumor immunotherapy. We’ve got a robust research program here, with lot of opportunity.

We’re also fortunate to a good residency program and top-notch facilities and equipment. Those are big draws for some of our people, especially those who want to work with the residents.

Another big attraction, I think, is that we offer an environment that definitely rewards people who take a leadership role in terms of building the practice. We look for neurosurgeons who don’t want to just be a cog in the wheel—people who want to build our program and who want to have enough autonomy to pursue new directions. We’re a little unusual in that

“We look for neurosurgeons who don’t want to just be a cog in the wheel—people who want to build our program and who want to have enough autonomy to pursue new directions. We’re a little unusual in that way—surgeons can assume a leadership role right out of training if they want.”



- Lawrence Chin, MD, Chairman

What are the draws, culturally and logistically, for surgeons who join your practice?

For one, there’s a great deal of collegiality within the group, and that’s apparent right away. We also offer considerable autonomy, to enable people to tailor their practice to their clinical or research interests. For example, we

way—surgeons who come into the group can assume a leadership role right out of training if they want.

I think our location is also a draw for some neurosurgeons. Central New York is a very family oriented environment, with good schools and a lot of outdoor activities—and a relatively low cost of living, too.

After the Site Visit: Moving Forward



By Katie Cole

You have returned home for your first site visit, and you realize you just visited a place where you could see yourself working. Now what?

This is when the details really start to come into the picture. You only have time for so many visits, but opportunities are very hard to differentiate until you actually visit the town, get a look at the hospital, and meet with administrators and, hopefully, another neurosurgeon or two with whom you would work.

Given the rigors of training, you likely will make very few second visits, perhaps only one but more likely two or three. That means that your site visit is one of the last opportunities you will have to get a feel for the potential position before making a decision.

Compile Details on the Visit

After you've sent your thank-you note, write down notes about your visit—detailing who you met, what you liked about the place, and any questions you thought of after your visit. Write down what stood out most during your initial visit. This not only helps “separate” your visits from one another but also triggers you to remember the information you still need to obtain, via phone or during your next site visit.

The second visit will be longer than the first, and it should give you a very good idea of the opportunity as a whole, as well as the community where you might relocate. So set this expectation prior to your visit: that you will leave with complete information about the opportunity and with all of your questions answered. This includes your potential

to get your questions answered, don't lose sight of the fact that it's still an interview. Be prepared to articulately respond to questions key administrators, practice leaders and potential colleagues may pose during the interviews.

Relatively speaking, a smaller percentage of the interview will focus on your background and history, while a larger percentage should address what your potential employer expects from the relationship, or how you will add value to the current group or department.

It is also important to include anyone who will be involved with your decision in this second visit, obviously a spouse/partner, and possibly your children as well if they are old enough to be involved in decision making.

Occasionally, employers will have prepared a contract draft or letter of intent either at the

“If you want to return for a second interview and would consider accepting the job, conclude your thank-you note by indicating this. State definitively that you are interested in learning more about the opportunity, and the facility or group.”

The first thing to do is to write a proper thank-you note, and send it right away by traditional “snail mail” or email. (Some savvy candidates make sure the note goes out the day they leave the visit.) Today, email is perfectly acceptable. A short note, simply thanking the individuals for their time and welcome, will suffice.

If you want to return for a second interview and would consider accepting the job, conclude your thank-you note by indicating this. State definitively that you are interested in learning more about the opportunity, and the facility or group, and that you look forward to communicating further and taking the next steps. Basically, confirm that you want to move forward. The letter needn't be long, but if you like, you might also mention the value you would bring by accepting the position.

employer's expectations of you coming on board; what call will be; and whether there is a partnership track.

Drill Down to Specifics

You should also obtain specifics about dedicated time for research, potential growth opportunities, and, if you will be expected to “grow a program,” what the timeline is and what resources will be available. It's also important to have a firm grasp of the long-term goals your potential employer seeks to accomplish by hiring you.

On the practical front, you should obtain complete information about education options for your children (throughout their school career), and a good sense of neighborhood options. While the second site visit is a tremendous opportunity

second visit or soon afterward. So regardless of how your second visit goes, be prepared to start the negotiation process right away if it's an opportunity you plan to pursue.

Ms. Cole, a Denver resident, is publisher of Neurosurgery Market Watch.

UPCOMING U.S. NEUROSURGERY EVENTS/CMEs

AORN Surgical Conference & Expo

☐ March 8 - 10
Denver, Colorado

Managing Coding & Reimbursement Challenges in Neurosurgery

☐ March 12 - 14
New Orleans, Louisiana

Live Interventional Neuroradiology & Neurosurgery Course

☐ March 27 - 28
New York, New York

3rd Spine Deformity Solutions: A Hands-On Course

☐ April 9 - 11
Houston, Texas

International Society for the Advancement of Spine Surgery (ISASS) 15th Annual Conference

☐ April 15 - 17
San Diego, California

Managing Coding & Reimbursement Challenges in Neurosurgery

☐ April 16 - 18
Orlando, Florida

American Society of Neuroradiology Meeting

☐ April 25 - 30
Chicago, Illinois

83rd AANS Annual Scientific Meeting

☐ May 2 - 5
Washington, D.C.
Meet us there! Booth # 633

Advanced Endoscopic Skull Base and Pituitary Surgery: Hands-On Symposium

☐ May 8 - 9
New York, New York

Neuro and Intensive Critical Care: Review and Hands-On Workshops

☐ May 14 - 16
Orlando, Florida

Goodman Oral Board Review Course

☐ May 17 - 19
Houston, Texas

World Live Neurovascular Conference

☐ June 8 - 10
Chicago, Illinois

National Neurotrauma Symposium 2015

☐ June 28 - July 1
Santa Fe, New Mexico

Managing Coding & Reimbursement Challenges in Neurosurgery

☐ August 6 - 8
Chicago, Illinois

Advanced Practice Provider Course

☐ September 3 - 5
San Antonio, Texas

Annual Neuro-Critical Care Society Meeting

☐ October 7 - 10
Scottsdale, Arizona

Managing Coding & Reimbursement Challenges in Neurosurgery

☐ November 5 - 7
Philadelphia, Pennsylvania

Goodman Oral Board Review Course

☐ November 8 - 11
Houston, Texas

Minimally Invasive Spine Surgery and Navigation: Hands-On Symposium

☐ December 17 - 19
New York, New York

UPCOMING INTERNATIONAL CMEs

British Association of Spine Surgeons 2015

☐ March 18 - 20
Bath, United Kingdom

5th International Congress on Neuropathic Pain

☐ May 14 - 17
Nice, France

International Spine Intervention Society 2015 European Congress

☐ May 22 - 24
Vienna, Austria

International Neuromodulation Society 12th World Congress

☐ June 6 - 11
Montreal, Canada

OPINION

Gauging Neurosurgeons' Value: Let's Look Beyond the Numbers



By Albert J. Camma MD, FAANS, FACS, MBA

I read the recent update on Neurosurgery compensation in Neurosurgery Market Watch (Volume 4, No. 2, Fall

2014) with much interest. This article described several different compensation levels for neurosurgeons. They were all based on surveys from NERVES, AMGA and MGMA and on what various payers are reimbursing. But the organizations in these three surveys

cervical disc degeneration conservatively, or will you recommend and perform a multilevel anterior cervical-disc fusion supplemented with a posterior multilevel instrumented screw and rod fixation?

I should be fair here: Are the young neurosurgeons really choosing the most complex procedures for personal gain, or are they simply manifesting the Einstellung Effect—an attitude or disposition that predetermines a person's responses to and

Of course, hospitals benefit from all this service through the referrals and its ED's ability to accept trauma and very sick neurological patients. (The ratio of hospital revenue to neurosurgeon compensation in 2013 was 2.52:1, according to a Merritt Hawkins survey, so it's worth considering the value the hospital receives from neurosurgeons' uncompensated services.)

Measuring True Quality

In private practice, a surgeon's value is determined by the "customers"—a term I abhor. If you are "good," you have patients. If you aren't good, patients go elsewhere. However, now that neurosurgeons are increasingly hospital employed, things are changing. In this evolving environment, how do we attach a value to a surgeon other than through RVUs? I urge hospital and practice administrators to ask—and answer—these questions:

- What value to patients is there in having a neurosurgeon review their data to determine if they should have an expedited appointment, or additional studies before their appointment?
- Is there value to the patient and hospital to have a neurosurgeon sitting on several committees?
- Is there value to the patient and hospital to have a neurosurgeon immediately available at all times for emergencies?
- Is there value to the patient (and colleagues newly entering the field after training) to have access to physicians with one or more decades years of experience in the field?

The bigger question is this: What is the value of "compassionate quality care" and how do you measure it? I don't know how to measure compassion, but I know that it cannot be

"The bigger question is this: What is the value of 'compassionate quality care' and how do you measure it? I don't know how to measure compassion, but I know that it cannot be done simply with patient satisfaction surveys."

based the compensation, the salaries, only on relative value units (RVUs). (In some contracts, it was revealed that 25.7% of the salary was for "ancillary services" and "non-direct patient care" services.)

Here's my dilemma: Nowhere in the article did I see any indication that organizations reporting on neurosurgery compensation place any value on compassionate, caring, quality patient care—or on non-surgical, alternative care. To the contrary, in 74.3% of contracts, 100% of salary was based purely on surgical care, and in the remaining 25.7%, 74.3% of the surgeon's salary was based on surgical care.

So I ask you: If your salary is wholly dependent on whether or not you operate, and if you do operate, on how complex vs simple an operation you do, human nature being what it is, what are you going to choose? Will you treat the 70-ish woman with multilevel

interpretations of situations—as a consequence of their training? Are our residencies teaching conservative, non-surgical alternative treatments for the problems we typically see in a neurosurgeon's office?

The Financial Driver

Understandably perhaps, our administrators will counter with the question: How can I place value on that nonsurgical treatment, when insurance companies won't pay for office visits to monitor and re-evaluate conservative treatment anywhere close to the amount they will reimburse for surgery? And they certainly won't pay for neurosurgeons to sit at their desks reviewing MRIs, CTs or hospital records to determine if a patient's appointment is urgent and should be expedited, or can wait. Nor will they reimburse answering the incessant phone calls or the committee work we're asked to do.

done simply with patient satisfaction surveys. In my view, high-quality neurosurgical care can be measured and quantified—but not by Crimson and not by the federal government's quality measures.

“It is time, as a field, to consider what is truly important about what we do.”

Organized neurosurgery has developed a quality measuring program called N2QOD. Although it's expensive for a smaller hospital,

the program's parameters and ideas could easily be adapted to a simple database program at the local hospital level. Even simple measures such as patients' "return to work" and "decreased narcotic usage" would provide some idea of the individual neurosurgeon's work quality.

In the "olden days," a surgeon's reimbursement was arrived at by the chief hospital administrator and the physician sitting down and discussing what the surgeon's care was worth. Clearly, that's no longer practical, but in my view, many hospital leaders have lost touch with the people who actually keep the hospital going and increasingly rely on

consultants to help them determine what constitutes quality. And many rely on what I consider an artificial value—RVUs—to gauge neurosurgeons' performance.

It is time, as a field, to consider what is truly important about what we do. It's time to constantly remind ourselves that the only reason all of us—whether we're neurosurgeons, administrators or payers—have a job is because of patients, not ourselves.

Dr. Camma is an Ohio-based neurosurgeon who trained at the University of Pennsylvania—Pittsburgh.

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Advanced Endoscopic Skull Base and Pituitary Surgery: Hands-On Symposium, May 8-9, 2015

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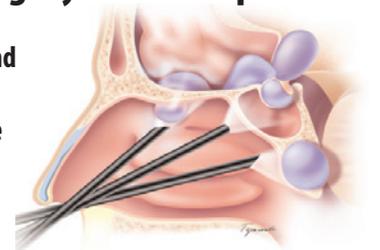
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Weill Cornell Medical College

Minimally Invasive Endoscopic Skull Base and Pituitary Surgery Fellowship

The Endoscopic Skull Base and Pituitary Program at Weill Cornell Medical College is offering a 6-12 month operative fellowship



Candidates will acquire operative experience in extended endonasal skull base approaches, perform cadaver dissection, and acquire neuroendocrine and ENT experience. Clinical research projects are encouraged and mentoring will be provided. Participants will receive a stipend that is dependent upon their level of training. The fellowship is under the direction of Dr. Theodore H. Schwartz in the Department of Neurosurgery at Weill Cornell Medical College.

Interested candidates should send a CV and cover letter to:

Melanie Simmons

mes2038@med.cornell.edu

212-746-5620

weillcornellbrainandspine.org

IN BRIEF

Neuroprosthetics Market on the Rise

In concert with the aging population and the push to find relatively low-risk treatments to ameliorate damaged sensory, motor or cognitive functions, the neuroprosthetics market is growing rapidly, according to a new report from Allied Market Research.

The report projects that the global market for neuroprosthetics that utilize such technologies as deep brain stimulation, vagus nerve stimulation and spinal cord stimulation, among others, will grow at approximately 15% annually in the new few years, and will top \$14 billion by 2020.

The report acknowledges that reimbursement and cost issues may affect growth but predicts that demand will offset those forces.

FDA Clears New Aneurysm Device

The U.S. Food and Drug Administration has approved the Pipeline Flex invasive flow diversion device to treat unruptured large or giant brain aneurysms. The device, manufactured by Medtronic, is intended for minimally invasive endovascular treatment of complex intracranial aneurysms that are not candidates for surgical clipping. The device targets aneurysms that are attached to parent vessels that measure between 2.5 and 5.0 mm in diameter.

The device will see a limited launch in the United States beginning in February 2015.

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LEGAL CORNER

By Roderick J. Holloman



Q: I was presented with an employment contract by a group I am interested in joining, but am not sure the contract is a fair one,

especially regarding my liability for tail coverage. What should I look out for? Is there a current trend toward, or away from employer-provided tail insurance?

A: Your question is quite timely, actually, as I am noticing a trend toward private practices aligning with healthcare systems, and then providing tail coverage in turn. If you are considering employment with a private practice, and looking to become a partner/shareholder in the future, you would be wise to query the practice head(s) regarding their long-term plans—specifically whether there are any potential plans to merge the practice with a healthcare system.

It would also behoove you to ask if the group is considering selling the practice, and/or, if the practice was approached whether it would be receptive to such a merger or acquisition.

Obviously, you would want the employer to pay for your tail regardless of the reason for the termination of your employment, and the employer may want to shield itself from such liability regardless of the reason for the termination of your employment. Ultimately, you may reach a compromise, but make sure that liability for your tail is very clearly stated. If liability for tail is conditioned on the cause of the termination of your employment, make sure that your contract addresses liability should your employment end with cause, without cause, or due a

change in law or regulation and inability to amend the contract to reach a mutually acceptable agreement.

Q: My employer is introducing new metrics for incentive compensation. Going forward, 15% of my incentive compensation will be based on “quality metrics.” While I doubt that this will affect my eligibility for a bonus, I am concerned that by virtue of my practice (I perform neurosurgical procedures that many other surgeons will not take on, due to the risks involved) I will have what may appear to be a disproportionately high number of patient complaints or unsatisfactory reviews. How can my contract be structured address this?

A: Ideally, you would want your contract to omit reference to patient satisfaction surveys; however, this might be an unlikely option. If the employer is unwilling to omit the patient satisfaction survey score from the incentive compensation calculation/criteria, your contract should contain language that indicates your employer’s acknowledgment that your scores/feedback may be skewed by virtue of the procedures you perform.

Also, you might attempt to modify the trigger for a negative impact on your incentive. For example, you could have the contract indicate that your score must fall substantially below the mean in your department (e.g., a 40% lower score than other physicians in your department) before incentive funds will be at risk. This should help to account for the more complicated surgeries you perform and the fact that outcomes might be poorer, expectedly, than for other “traditional” procedures.

Further, you might request that the contract place a cap on the impact of the patient satisfaction score, such as no more than 10% of your incentive compensation may be withheld based on patient satisfaction scores.

Q: My employer wants to amend my contract to reduce the advance notice period. What gives? Should I be very concerned?

A: It might be that your employer is planning to implement personnel changes or wants the freedom to do so in the future. Another possibility is that the management is “posturing” the practice for merger or acquisition, or is perhaps already in talks with a party that is requiring the freedom to terminate contracts with reduced advanced notice as part of an effort to “blend” the respective practices.

If the advance notice period is less than the amount of time it would take you to secure employment elsewhere and/or become credentialed with another hospital, you should try to negotiate for an extended notice period in the event the employer (or any successor in interest) wants to terminate your employment without cause. Otherwise, you risk experiencing a period of unemployment due to the inability to secure employment during the reduced advance notice period.

Author’s note: Roderick Holloman is the principal of The Holloman Law Group, PLLC, a national healthcare law firm. He welcomes readers’ questions and can be reached at 202-572-1000 or rjholloman@hollomanlawgroup.com.

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FEATURED OPPORTUNITY

Pediatric Neurosurgeon with Focus on Epilepsy Surgery

The Brain and Spine Center at Weill Cornell Medical College in New York City is seeking a board-eligible or board-certified neurosurgeon to join our group. The primary focus of this full-time position will be on pediatric neurosurgery, with an additional focus on epilepsy surgery.

The anticipated start date for the position is July 2015. Interested and qualified applicants are invited to send three letters of recommendation, along with a CV and cover letter, addressed to Dr. Mark Souweidane and e-mailed to Marva Melendez at mam2153@med.cornell.edu.

Weill Cornell Medical College is an employer and educator recognized for valuing AA/EOE/M/F/Protected Veterans, and Individuals with Disabilities.



Weill Cornell Brain and Spine Center

- ▶ For more information on these positions, or if you are interested in hiring a neurosurgeon for a permanent position, please contact info@harlequinna.com.
- ▶ If you have any locums assignments available, or if you are interested in locums positions, please contact Aaron Risen at The Surgeons Link at aaron@thesurgeonslink.com.