

**CSNS Report: Neuro Trauma Committee –
Addressing Volatile Neuro Trauma Issues from a Grass Roots Perspective**

AUTHOR: Ann R. Stroink, M.D., on behalf of the CSNS Editorial/Publication Committee

In the U.S. each year, over one million patients are seen in emergency rooms for traumatic brain injury alone, describing only a portion of the neuro trauma that neurosurgeons are asked to see on a daily basis. The high volume of neuro trauma cases tests the available neurosurgical resources to meet this demand and varies from region to region throughout the United States.

Neuro trauma issues affecting neurosurgeons today include, but are not limited to:

- (1) Resident work hours: are we allowing adequate preparation of residents for the rigors of a typical neurosurgical practice, especially in light of recent suggestions that work hours should be further restricted from 80 to 56 hours?
- (2) Should daily neuro trauma coverage be performed on a volunteer basis or contracted with hospitals? Certainly, the increased risk of medical liability has swayed the far majority of neurosurgeons to consider negotiating contracts for this service as opposed to their predecessors who did it voluntarily.
- (3) Do we provide all neurosurgery residents with sufficient training to offer full-scale neuro trauma services for adequate coverage? At the same time, how do we justify general surgeons performing neurosurgical procedures and argue it is in the best interest of patient care?
- (4) In response to an increased need for neurosurgeons providing availability for neuro trauma management, should we consider the concept of modifying the training of neurosurgeons to a fast-track, establishing basic skills for neuro trauma along with basic cranial and spine skills? How do we ensure our role as architects in the regionalization neuro trauma care?
- (5) Finally, how are we going to respond to the expected exodus of veteran neurosurgeons from neuro trauma coverage rosters due to increasing concerns about malpractice and liability and work hours?

These are just a few of the many questions discussed in the Neuro Trauma Committee and remain on the agenda for further debate.

In 2007, Dr. Shelly Timmons assumed the position of Chair of Neuro Trauma, following the fine work of Dr. Dominic Esposito. Her committee takes an active role in formulating responses to resolutions brought forth by members of the CSNS in addition to tackling some of the more volatile issues of neuro trauma care affecting not only neurosurgeons, but society as a whole.

Below, Dr. Timmons participates in an in-depth discussion with the CSNS Editorial/Publication Committee.

How long have you chaired this committee and who was your predecessor? How many members are on this committee and what kind of members are you looking for? Do you have to be a member of the CSNS to work on this committee?

I assumed the chair of the Committee on Neurotrauma in July 2007. Domenic Esposito was the chair who preceded me. We recently changed the name of our committee to the Committee on Neurotrauma and Emergency Neurosurgery to more accurately reflect our activities and to ensure the ongoing relevance of the committee within the CSNS, because we feel that the socioeconomic issues impacting neurotrauma care are reflective of those impacting all emergency neurosurgery.

We have about 15 members currently, all of whom are CSNS members, and anyone attending the CSNS meeting is welcome to attend our committee meetings. We would like to have some residents get involved. We are looking for members who would like to be part of a working committee, who want to have influence on future of emergency neurosurgical care delivery.

Does this committee get involved in the review of levels of evidence for trauma that eventually form guidelines for neuro trauma management? Do the guidelines reflect on any socioeconomic issues?

The committee has reviewed EBM guidelines in the past. Most NT guidelines contain some content regarding delivery of care (organization of trauma systems, e.g.). We would welcome the opportunity to review/participate in future guidelines production related to neurotrauma.

Are you involved in the Brain Death Protocol and do you work in conjunction with other committees on this issue?

The committee did participate in the review of the brain death protocol along with the Young Neurosurgeons Committee. We have also worked with the Education Committee to provide content for the SANS neurosurgical review.

What projects are you currently working on? What involvement do you have with the idea of regionalization of trauma? Any anticipated socioeconomic impact? Any plans for a “white paper” on trauma issues in the near future?

We are working on three major projects currently. The first is a core curriculum for emergency neurosurgery, outlining those aspects of neurosurgery with which every practicing neurosurgeon ought to be competent. This was assigned in response to a resolution and is important in providing guidance for the neurosurgical community and the broader medical community for ensuring that patients receive prompt care within their communities. The second is a white paper on the same subject. The third is an interactive electronic workbook for organization of neurotrauma and emergency neurosurgical care. We will be working with the Communications Committee on this project. The idea is to provide a clearinghouse of information for various geographical regions: hospital locations and levels of care, hospital and physician resources, patterns of transport, etc. as well as other resources for assisting in regionalizing care (call-sharing models, sample transfer agreements, etc.) This could have tremendous socioeconomic impact by providing neurosurgeons with regional data and models of optimizing care within their communities.

Recently, the Institute of Medicine has suggested that work hours for residents in training be dropped from 80 to 56 hours; however, many articles suggest (and confirm) that work hour reductions would negatively impact neurosurgical training and may result in compromising patient safety by way of multiple hand-offs and the lack of continuity of care. Any comments on this subject from your committee?

The committee has discussed the move to curtail resident work hours even further and is not supportive of any further reductions in duty hours, due to concerns over programs' abilities to adequately train residents in

procedures and operations and over patient safety concerns by increasing the number of required "hand-offs" and promoting further lack of continuity of medical care.

There may be a movement to modify the training of neurosurgeons to a fast-track, establishing basic skills for neuro trauma, cranial and spine work, and allow neurosurgeons to pursue "advanced clinical training" or further areas of interest in fellowship programs. Any comments?

At this time, there is no formal committee stance on the subject of modification of neurosurgical training, but the obvious concern would be that the workforce available to provide care to neurotrauma patients (already shrinking) would be further diminished, negatively affecting patient care and outcomes.

Is it true that neurosurgeons are beginning to be less involved and even curtail their privileges in neurotrauma? Is this a state-to-state phenomenon? Any comments?

Yes. This phenomenon has been noted in a variety of regions throughout the country. Our committee is supportive of efforts to make caring for neurotrauma patients less onerous and regionalizing care so that patient can receive the best care possible in the most timely fashion possible.

How can a neurosurgeon join your committee and what type of responsibilities would a working member expect to have?

A neurosurgeon can join the committee by either attending a committee meeting or contacting me by e-mail (stimmons@utm.edu). Responsibilities include meeting attendance and working on specific projects as they are assigned by the reference committee, typically involving researching a topic, writing, and providing content for interactive internet projects. Those with web development skills are welcomed to provide site design contributions as well.