

**2007 NEUROSURGICAL EDUCATION SUMMIT MEETING Minutes**  
**Washington Court Hotel, Washington DC**  
**Thursday, November 29, 2007 - 12:00 noon to 5:00 pm.**

**Participants:** P. David Adelson, MD, FACS, CNS; Anthony L. Asher, MD, CNS; H. Hunt Batjer, MD, FACS, ABNS; Deborah Benzil, MD, CSNS; Gary Bloomgarden, MD, CSNS; Frederick A. Boop, MD, FACS, CSNS; Ralph Dacey, Jr., MD, RRC; Arthur Day, MD, FACS, RRC; Steven Giannotta, MD, FACS, RRC; M. Sean Grady, MD, ABNS; Robert Harbaugh, MD, FACS, AANS; Charles Hodge, Jr., MD, SNS; Paul McCormick, MD, AANS; A. John Popp, MD, SNS; Donald Quest, MD, AANS; Jon Robertson, MD, AANS; Charles L. Rosen, MD PhD, CSNS; Richard P. Schlenk, MD, CSNS; Nathan Selden, MD, PhD, SNS; Troy M. Tippet, MD, Washington Committee; Craig A. Van Der Veer, MD, ABNS; Christopher Wolfla, MD, CNS

**Staff:** Thomas A. Marshall, AANS Executive Director; Joni L. Shulman, AANS Associate Executive Director; Mary Louise Sanderson, ABNS Administrator; Katie Orrico, JD, AANS/CNS Director, Washington Office; Meg Borst, AANS Executive Assistant to the Executive Director

**Invited but unable to attend:** Nicholas M. Barbaro, MD, SNS; James Bean, MD, AANS; Laurie Behncke, CNS Executive Director; Kim Burchiel, MD, FACS, SNS; William Couldwell, MD, PhD, ABNS & SNS; Catherine Mazzola, MD, CSNS; Edward Oldfield, MD, SNS; James Rutka, MD, PhD, AANS; Robert Solomon, MD, ABNS; Volker Sonntag, MD, RRC; Dennis Spencer, MD, SNS

	<b>Agenda Item</b>	<b>Action Items</b>
I.	<p><b>Welcome &amp; Approval of Minutes from July 14<sup>th</sup> meeting Summary to Date &amp; Overview of Day –</b> (see Dr. Popp’s PowerPoint presentation #1 for detail)            The goal of this meeting is to put the concepts that have been discussed into operation.</p> <p>Tactical Issues – Themes that are starting to emerge:</p> <ul style="list-style-type: none"> <li>• Completely Recover PGY1</li> <li>• A Strategy for Research</li> <li>• Varying Size and Depth of Individual Training Programs</li> <li>• Generalists vs Specialists Training – Core Curriculum/Fellowships/Research</li> <li>• The Match Process &amp; Specialists Match</li> <li>• Length of Training</li> </ul> <p>Each organization that is involved in this Summit has its own responsibilities and it should be decided which tasks are going to be taken on by each organization.</p>	<p>Leaders of all involved organizations should put Education Summit on their agenda</p>
II.	<p><b>Education Summit: Where do we go from here?</b>(see Dr. Quest’s PowerPoint presentation #2 for detail)</p> <ul style="list-style-type: none"> <li>• Going forward, the four current subcommittees could be merged into two subcommittees:               <ul style="list-style-type: none"> <li>• Curriculum/Procedural/Sociopolitical</li> <li>• Technology/Data Management/Financial</li> </ul> </li> <li>• Challenges that need to be met include: controlling PGY1; enfolding fellowship experience within the residency; defining the core experience for neurosurgical training; eliminating irrelevant material and tasks from training; maintaining a meaningful research experience; and liberalizing duty hour restrictions for Chief Residents - RRC Pilot Project under consideration.</li> </ul> <p><b>PGY1:</b>            See slides for current PGY1 requirements.</p>	

	<p><b>PGY1 - Proposal</b></p> <ul style="list-style-type: none"> <li>• 3 months: Surgical Critical Care, Emergency/Multisystem Trauma</li> <li>• 3 months: Neurology</li> <li>• 6 months: Neurosurgery</li> <li>• Maintain 60 months of Neurosurgical Residency AFTER PGY1 or change Neurosurgical Residency to 72 months beginning with PGY1</li> </ul> <p>It is imperative that training is kept to 6 years</p> <p><b>Neurosurgical Residency - 6 years</b></p> <p><b>Possible Format</b></p> <ul style="list-style-type: none"> <li>• PGY 1 : Fundamental Clinical Skills</li> <li>• PGY 2 &amp; 3: Core Neurosurgical Training</li> <li>• PGY 4: Elective/Research</li> <li>• PGY 5: Focused Training</li> <li>• PGY 6: Chief Residency</li> </ul> <p><b>Curriculum</b></p> <ul style="list-style-type: none"> <li>• Standardization of core and non-clinical competencies – The core curriculum needs to be defined by the Senior Society, the ABNS, the RRC, etc.</li> <li>• Role of research</li> <li>• Focused training/Sub-specialization</li> <li>• Patient Responsibility</li> </ul> <p>See slides for procedural requirements and Technology/Data Management information.</p> <p><b>Who?</b></p> <p>Curriculum/Procedural: Responsibility -ABNS, RRC. Input: SNS, Ad Hoc</p> <p>Technology/Data Management/Finances: Responsibility - AANS/CNS/SNS/ABNS. Input: Ad Hoc</p> <p>Funding was discussed at this time and it was noted that details were not known and need to be investigated.</p>	
III.	<p><b>Discussion</b></p> <p>For the process to become operational areas of responsibility must be assigned and activities should then be reported at the upcoming Neurosurgical Summit meeting for the purpose of coordination</p>	<p>Summit Meeting at AANS Annual Meeting, Sunday AM 10 – 12 noon/ SNS Annual Meeting</p>
IV.	<p><b>Tandem Initiatives</b></p> <p><b>1) PGY1 Survey</b> (see Dr. Popp's PowerPoint presentation #3 for detail)</p> <p>Some questions that are necessary to address: What do we want to accomplish with PGY1? Are rotations necessary or desirable? How much time should be spent on neurosurgery? How do we synchronize the RRC &amp; ABNS requirements? Should we be mindful of local politics?</p> <p><b>Value PGY1</b></p> <ul style="list-style-type: none"> <li>• Transition</li> <li>• Pre &amp; Post-op Management <ul style="list-style-type: none"> <li>- Critical care of surgical patients</li> <li>- Emergency care of surgical patients</li> </ul> </li> <li>• Basic surgical skills</li> <li>• Beginning of neuroscience core</li> </ul> <p><b>Problems Perceived by Residents of Albany Program:</b> (some generic, others program specific)</p>	

- Not enough time in OR
- ER too focused on medical emergencies
- Transplant surgery too little resident involvement
- Not enough neurosurgery
- New York State 405 Regulations
- Too focused on Service

See slides for survey questions and results.

Comments:

- Question 4 is probably the most important question in the survey (If the education of residents in PGY1 included significantly more time on the Neurosurgical service, do you believe that the Neurosurgical residency should be shortened?). There have been discussions for numerous years about shortening the residency and program directors are not in favor of it.
- There are many variants in terms of learning environments that need to be taken into consideration. Program Directors need to be able to gain control of the PGY1 year without micromanaging the curriculum – this will be very different with each institution.
- Should PGY1 be where the neurology rotation be taken in every circumstance? There are a number of reasons to put neurology in PGY3 instead of PGY1.
- We need to take more control of PGY1 because the nature of surgery has changed.

**2) CILE** (see the Procedural subcommittee slides 4 & 5 for detail)

- CILE was designed to ensure quality of care and to evaluate innovations in residency training.
- A proposal was submitted for approval which states that neurosurgical chief residents will be exempt from hour restrictions and that chief residents needs to retake ownership of teaching and administrative responsibilities. This proposal was turned down by the ACGME.
- The revised submission proposes suggests that the residents will continue weekly duty hour restrictions, but will be exempt from daily and time off restrictions. This would promote better continuity of care and better ownership by the chief resident.
  - It was suggested that a number of programs participate in a pilot study – half of which would have chief residents exempt from rotation and the other half not and after a year or so, study the results.

Comments:

- One concern is that residents aren't seeing patients prior to their operation.
- Other issues are complication management and continuity. There is a pilot project of the ACGME that has been approved that will be presented in January to address these issues. The project calls for 88 hours with 36 hours on call instead of 24. Neurosurgical programs (and all surgical specialties) can elect to be a part of this project to see if it works. If this proposal is not accepted, a similar proposal probably will be. This is a topic for the Sociopolitical group to discuss further.

**3) CSNS Post Residency Survey** (see Dr. Benzil's PowerPoint presentation #4 for detail)

The CSNS has gone through a strategic planning process and is interested in becoming more involved with education, particularly in the socio economic area. They have begun to develop some instruments to measure how their membership is doing in practice.

Origin of Survey

The CSNS has had a series of resolutions which culminated in the resolution in the fall of 2007 regarding initiatives to

Dennis Spencer, MD

	<p>review resident education from various standpoints. From the fall CSNS meeting, Resolution V: Evaluation of Neurosurgical Resident Education and Training. A committee was assigned to develop a survey to provide a comprehensive, anonymous, global evaluation of Neurosurgery Resident training, which was distributed throughout the CSNS and to some members of the Education Summit for feedback before it was distributed to residents. The survey is to be completed after residency to determine how residents perceived their training and to assess their perception of their preparedness for practice. The hope is to obtain a baseline now so that if there are changes made to residency training, the survey can be given again in 5 years or so to see if the perceptions have changed.</p> <p>(see slides for sample questions)</p> <p>The results will be distributed, collected and analyzed by CSNS, made available to appropriate parties and could provide essential feedback to improve NS resident experience.</p> <p>Comments:</p> <ul style="list-style-type: none"> <li>• The question was raised about how the information received from the survey would be validated and the response was that it depends on the return rate and the consistency of the answers. The survey will be resent until it is felt that a reasonable response has been received</li> <li>• As part of the ACGME, the Program Directors are supposed to be doing evaluations. One methodology is to try to do this survey through the Program Directors. Not all Program Directors are doing post-residency evaluations and since this survey is being done in conjunction with the parent organizations of the CSNS (AANS/CNS), Program Directors can then say that they participate in this evaluation through the survey. The question that is raised is how people will respond to an anonymous survey as opposed to a one-on-one evaluation through the Program Director. There is a chance that people will be more honest if it is done anonymously. To make the request more powerful and elicit a greater response, the cover letter should be from the Senior Society as well as the CSNS (or multiple societies) requesting participation in the survey and should be targeted at people who have just completed their oral boards.</li> <li>• How did the CSNS develop this survey? Program Directors were asked for copies of evaluations they were using. This survey follows the evaluation used at The University of Pittsburgh because it was comprehensive; it was then adjusted using feedback from the CSNS and members of the Education Summit. It is imperative that the right questions be asked. There is concern that the answers received will be predictable. It is necessary to ask about experiences in practice and if training was adequate for those experiences.</li> <li>• Moving forward, the survey will be re-circulated to the Summit members to ensure that it is seen by all. It will be very difficult to validate the answers. Trends rather than definitive answers will more likely be uncovered.</li> </ul>	<p>CSNS to circulate draft survey to members of Education Summit for review</p>
<p>V.</p>	<p><b>Breakout Groups: Progress to Date</b></p> <p><b>1) Curriculum subgroup</b> (see Dr. Grady's PowerPoint presentation #5 for detail)</p> <ul style="list-style-type: none"> <li>• Neurosurgery training should be 72 months in duration. <ul style="list-style-type: none"> <li>• Increase the amount of neurosurgery in PGY1 year</li> </ul> </li> <li>• PGY1 year will no longer be a preliminary year, but is to part of Neurosurgery <ul style="list-style-type: none"> <li>• By using the NRMP, residents apply to the NRMP neurosurgery match solely.</li> <li>• The first 3 years should be flexible to accommodate each training program. Fundamental clinical skills training would be accomplished in those years; the sequence when they are done within those 3 years would be at the discretion of the program director.</li> </ul> </li> <li>• It is felt that 36 months of clinical neurosurgery is sufficient. <ul style="list-style-type: none"> <li>• Elective – doing subspecialty training before senior residency will not be accepted by most of the AANS/CNS Specialty Sections.</li> </ul> </li> </ul>	



to be done in multiple locations for a full week or pare the proposed curriculum.

Competency measures

- The Northwestern CPT based system - Encyclopedic
- The UCSF selective system - Representative

Need - Definition of what Neurosurgery should look like in 10-15 years

Comments:

- Comment on the third point under “Need to do”: There is an increasing crisis in the ability to provided general neurosurgery care and there is a need for some degree of competency for emergency training in pediatric, spine and intracranial. We see increased numbers of neurosurgeons who are relying on their sub-specialization as a way to avoid call obligation which worsens manpower shortages. Our efforts have to be the opposite – we have to be pushing core privileges with hospitals that include a wide breadth. We need to recognize that there are some basic neurosurgical urgent/ emergent problems that need to be addressed and it behooves us to be sure that all residents are trained for this. All are in agreement that trainees should be trained in all competencies.
- If the Boot Camp could be done for possibly 1 hour a week via web cast, then all PGY1 residents around the country could participate for a fraction of the cost. On the other hand, if Program Directors are to take control of the PGY1 year, they have the obligation to be sure that the basic skills are covered in PGY1. Medical students have less experience when they come into PGY1 than years ago. This training should be done during medical school before coming to neurosurgery.
- The baseball industry is run as a business and has a significant amount of control over the culture and soul of its business – they have a sense of ownership. We are trying to define who we are by defining our training. We should emulate the baseball industry and take ownership.

**3) Sociopolitical / Financial subgroup** (see Dr. McCormick’s PowerPoint presentation #7 for detail)

This group is dependent on the outcome of the other sub-committees which makes it difficult to produce specific action plans. Anticipated issues include players, the process to effect change, the content of that change and the cost.

Stakeholders Roles

- Who is going to develop and access these changes? ABNS, SNS, RRC, CNS, AANS, CSNS, YNS
- Who are going to be the regulatory bodies for approval? ACGME (RRC, ABMS, AMA, AAMC, AHA, CMSS)
- What is the fiscal effect? CMS (D-GME, IME)
- Who is going to be affected directly and indirectly? Residents, resident training programs, institutions, program directors directly and patients/populations (workforce and distribution) /facilities indirectly.

Residency Redesign

- Currently the Neurosurgical training requirements are 12 months fundamental clinical skills, 36 months clinical neurosurgery and 24 months elective.
- Potential elements of redesign are format, requirements, curriculum, enhancements/adjuncts and duration.

ACGME Requirements for Training (see slides for detail)

- States that there should be one year of training in fundamental clinical skills which should be completed before the 3<sup>rd</sup> year of neurosurgical training. The requirements state: “Three months of training in a ACGME-accredited neurology training program preferably included in the PGY1-year”. Specified as PGY1 year, but there is enough flexibility there to do it in the first 3 years of training.
- If we were to go to 6 months of neurosurgery, the ACGME would have to be petitioned to get approval.
- Training is 60 months in duration with 36 months of clinical neurological surgery. It doesn’t specify what the rotations should be which provides flexibility and is even more vague about the 24 months of elective time. The program requirements do not require research.

	<ul style="list-style-type: none"> <li>Any changes need to be made working with the RRC or other committees of the ACGME which would then submit the changes for approval. See slides for list of organizations that would have to approve any changes. See slides for current requirements and proposal (slides 13 -18).</li> <li>Note: shortening residency from 72 to 60 months does not seem desirable now.</li> <li>Could possibly risk 1 year GME funding if changing from 6 to 5 years, but if training is kept at 72 months, this would not be an issue.</li> <li>Slide 17: Resident's training enhancements do not require ACGME approval, but could prove to be costly.</li> <li>The 24 month elective will be the most complicated.</li> <li>See slide 19 for potential elements of Residency Redesign.</li> <li>All aspects of proposed changes (see slide 20) need to be taken into consideration to develop the financial specifics.</li> </ul> <p>Comments:</p> <ul style="list-style-type: none"> <li>The implications of what we do during resident training touch on other aspects. It is important for this sub-committee to help steer us through this.</li> </ul> <p><b>4) Technology / Data Management subgroup</b> (see Dr. Harbaugh's PowerPoint presentation #8 for detail)</p> <ul style="list-style-type: none"> <li>Goal 1 - Develop a tool-kit on the SNS website from which all program directors can draw for resident data collection and assessment instruments (see slides 3-5 for Goal Objectives) <ul style="list-style-type: none"> <li>Some enhancements to the SNS Program Directors Toolkit will be rolled out in early December 2007</li> <li>The goal is standardization for various data collection and assessment instruments so it is necessary to get input from Program Directors. This standardized suite of tools should be acceptable to RRC.</li> </ul> </li> <li>Goal 2 - Develop a culture of self-assessment during neurosurgery residency training. Rationale - Developing a culture in which individuals assess their own outcomes is essential for teaching the core competencies and for preparing residents for QI programs that will be required in their practice (see slides 7-8 for Goal Objectives)</li> </ul>	
VI.	<p><b>Breakout Sessions:</b> The meeting divided into 2 breakout groups (Curriculum / Procedural / Sociopolitical and Financial / Technology / Data Management) to discuss strategic initiatives and next steps.</p>	
VII.	<p><b>Report Out:</b></p> <p><b>1) Curriculum / Procedural / Sociopolitical</b> (Dr. Grady)</p> <p>72 months of Neurosurgery</p> <ul style="list-style-type: none"> <li>Years 1 – 3 <ul style="list-style-type: none"> <li>3 months Neurology</li> <li>3 months surgery or 3 months fundamental clinical skills</li> <li>6 months Fundamental neurosurgical skills</li> <li>24 months Clinical neurosurgery</li> </ul> </li> <li>Years 4 – 6 <ul style="list-style-type: none"> <li>24 months Advanced clinical and/or research training <ul style="list-style-type: none"> <li>Advanced clinical training must be done within an ACGME accredited program.</li> <li>This needs to be as flexible as possible to allow the Program Directors to work within their restraints.</li> </ul> </li> <li>12 months Senior Residency <ul style="list-style-type: none"> <li>Doesn't have to be the last year, but must be in the last 3 years</li> </ul> </li> </ul> </li> </ul> <p>The strategy is to finalize the language at the ABNS winter meeting and present the proposal to the RRC later that month.</p>	ABNS/RRC

	<p>Procedures</p> <ul style="list-style-type: none"> <li>The RRC sets the rules for procedures, but the SNS Education Committee could provide input</li> </ul> <p>Boot Camp</p> <ul style="list-style-type: none"> <li>The Boot Camp should be regional and voluntary and it should be developed by the SNS</li> </ul> <p>The change to Residency training will likely not take effect until July 2009.</p> <p><b>2) Financial / Technology / Data Management</b> (see Dr. Harbaugh's PowerPoint presentation #9 for detail)</p> <p><b>Goal 1</b></p> <ul style="list-style-type: none"> <li>The email to publicize the present SNS Program Directors Toolkit will go out in January 2008 to all Program Directors. This email will also request that they upload the data collection and assessment tools.</li> <li>The RRC will be involved in developing the online feedback system to grade the various tools. This is currently under development (Dr. Day &amp; Dr. Selden).</li> <li>Cleveland Clinic, University of Florida and Penn State have applied to work with the ACGME to develop portfolio components for neurosurgery. The program roll-out is set for July 2008.</li> <li>January 2010 is the deadline to develop a standardized suite of assessment tools that can be used by all neurosurgery programs. This will allow the Program Directors to assess the various tools that have been downloaded for about a year. The RRC will then review and determine the standardized assessment tools by June of 2009. These will be used by all programs as the RRC approved set of tools.</li> <li>Expanding the links from the SNS website to other sites of value to program directors will be done in January 2008.</li> </ul> <p><b>Goal 2</b></p> <ul style="list-style-type: none"> <li>It is important that residents develop a culture of self-assessment during neurosurgery residency training, and Program Directors as well. They also need to assess not only their own strengths and weaknesses, but their programs'.</li> <li>Define a core group of cognitive and technical requirements that residents need to master by the onset of training and offer online educational materials that can be used at each site to facilitate this.</li> <li>Investigate options for funding the initiatives.</li> </ul> <p>Comments:</p> <ul style="list-style-type: none"> <li>Need a methodology by which to create an atmosphere where learning can occur.</li> <li>The ethos of neurosurgery is a very important aspect of what we are trying to accomplish. There has been an erosion with the shift worker mentality of physicians. The question is how do we prevent this in neurosurgery?</li> </ul> <p><b>Discussion</b></p> <p>How do we keep the Education Summit committee members involved in these projects?</p> <ul style="list-style-type: none"> <li>A committee such as this (the Education Summit) must exist so the members of the various constituencies represented can have open conversations. Coordination is the key.</li> <li>SNS can invite guests (Summit members) to the Annual Meeting so we can get their input.</li> <li>A seven member coordinating group (one member from each society) could meet yearly at the Neurosurgery Summit held at the AANS Annual Meeting.</li> </ul>	<p>RRC/SNS Education Committee SNS</p> <p>SNS</p> <p>RRC/SNS</p> <p>SNS</p> <p>SNS</p> <p>SNS</p> <p>Anthony Asher, MD &amp; Robert Harbaugh, MD, FACS</p> <p>SNS SNS President/ Neurosurgery Summit at AANS meeting</p>
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VIII.	<p><b>Comments by Presidents/Chairs of Sponsoring Organizations</b></p> <p><b>AANS:</b> (see Dr. Robertson’s PowerPoint presentation #10 for detail)  There are two things that the AANS brings to resident education: member benefits and a supportive role. The AANS core mission is education and in that supportive role, the AANS brings the infrastructure to make this happen and the finances to move forward. In the year 2007, of the 12 grants that were given through the NREF, 6 went to neurosurgical residents. With the infrastructure and leadership of AANS, we have been able to move forward in resident education with 5 educational programs this year and will have 7 in the upcoming year. Working with the SNS, the online training modules have been developed. 5 of these modules are complete and online and 25 are in development for this year with the hopes for a total of 250-300 modules in the future.</p> <p>It is most important that AANS and CNS work together to do what we can for education at the resident level. We have a significant role to play because we have the finances and organization to make things happen.</p> <p><b>ABNS:</b> (see Dr. Batjer’s PowerPoint presentation #11 for detail)  It seemed that before the summer meeting, we were interested in abbreviating training, streamlining it and getting people out into the workforce faster and it is a testimony to us all that this did not happen. We are talking about a comparable length with some options to go even longer than we do now.</p> <p>See slides for detail on the ABNS Competency Based Curriculum and its content, ABNS current requirements, the primary exam, ABNS perspective and possible strategy.</p> <p><b>CNS:</b> ( Dr. Asher)  CNS functions as a supportive role and has a history of producing specific educational programs that are geared toward residency training. It is important to start looking at developmental programs in conjunction with the various stakeholders and that these programs not be developed in isolation. It is important to keep communication between the organizations and that we all look at this as a partnership.</p> <p>As we move forward, we should look for critical and potential strategic partnerships, to bring individuals in with specific areas of expertise who lend something to this discussion. The challenge is that surgeons are bred for intellectual independence but the modern hospital requires that a focus on cooperation. As we move forward, we need to look at mechanisms for residents to understand the importance of systems based practice.</p> <p><b>CSNS:</b> (see Dr. Benzil’s PowerPoint presentation #12 for detail)  The CSNS has a lot of interest with regards to resident education. The issues of workforce adequacy, competency, patient safety, health policy regulatory issues, medical liability, practice management and leadership development all interact with resident education. A recent study in New York showed that the medical liability issue is the single largest factor in allowing resident education to move forward.</p> <p>We would like to be a resource whenever we can. We are in the process of developing a socio-economic curriculum that will be web based. We also offer leadership programs. We look forward to helping with this process.</p> <p><b>RRC:</b> (Dr. Gianotta)  Bureaucracy brought on rigidity – that was the only way the RRC could get done what they wanted to do. Please keep proposed solutions as flexible as possible.</p> <p>When you think about shortening residency, please think about what part you would take out.</p>	CSNS
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	<p>How do we attract women into residency training? While we need to keep the same high standards that we have for selecting residents, we need to do a better job interacting with medical students.</p> <p><b>SNS:</b> (see Dr. Popp's PowerPoint presentation #13 for detail)  The SNS is made up of Neurosurgical Program Chairs and Directors. Resident education has been an ongoing theme for our organization. We recognize that the SNS educators have a close working relationship with the ABNS and the RRC. We have recently developed a Task Force to look at ways to develop the interaction between the 3 groups to benefit the education of neurosurgeons. There is a recognition that there is an interrelationship between all of us around the table. We are all united by a similar focus – education.</p> <p>We have a number of educational initiatives. The annual meeting is sculpted around the mission of surgical education. (see slides for details of next steps)</p> <p><b>Washington Committee:</b> (Dr. Harbaugh)  The Washington Committee is in a unique position in that they are asked to represent everyone. Much of what they do is reactive, but there is an opportunity to also be proactive in trying to push the neurosurgery agenda forward in the areas of quality improvement and education. The next few years will be a time of turmoil for US healthcare. Turmoil is a time of danger, but it is also a time of opportunity. We need to be prepared to grasp any opportunity to move neurosurgery forward, particularly in the area of neurosurgical education.</p> <p>(Dr. Tippet)  The Washington Committee functions to preserve the practice of neurosurgery so there will be people interested in going into neurosurgery. The entire specialty is under great threat from the outside and at times from within. We need to work together to help preserve what we all feel is the best for our specialty. There is a bill before congress right now called "Increasing Medical Caps on Graduate Medical Education Positions for States with a Shortage of Residents". This will bring everyone up to a median level and is a new potential source of funding. This bill does not take money from anyone, but brings those who aren't there, up to the level with everyone else.</p> <p>Comments:  What is the length of residency that is funded? For a residency of 6 years – 5 are fully funded and the next year is ½ funded, for 7 year programs, the first 5 years are fully funded and the next 2 years are ½ funded. If we take control of PGY1 year, it shouldn't affect the funding. The money stays with the institution, so keep that in mind when considering enfolded fellowships into basic training.</p>	
IX.	<p><b>Next Steps</b>  Both strategic initiatives should compose a summary of their breakout groups for circulation.</p> <p>The draft minutes and PowerPoint presentations will be distributed for all to review.</p>	M. Sean Grady, MD/ Robert Harbaugh, MD, FACS A. John Popp, MD/ Meg Borst