CANS newsletter

CANS Board of Directors meets in LA

Randall W. Smith, MD, Editor

The CANS BOD met for 5 hours on 4/13 at a LAX hotel. In attendance: Officers Kaczmar, Henry, Mummaneni, Blumenfeld and Colohan; Directors Holly, Hsu, Kliot and Rosario; Consultants Bonner, Wade, Rich, Abou-Samra and Smith. Items considered or acted on by the Board:

1. Voted to pursue holding a late afternoon **CANS reception** at the October meeting of the CNS in San Francisco. Goal would be to create interest in and more membership for CANS with the target audience being CA residents and CA neurosurgeons not members of CANS, residents considering locating in CA after training and practicing neurosurgeons from other states considering a move to California.

2. Noted that the **One Neurosurgery Committee**, a grass roots group favoring unification of the AANS and CNS into one organization, reports that of the 222 California responders to its survey of interest, 209 favored the unification. This compared favorably with the 2,030 who took the poll with 90% (1,834) voting for unification and 9.7% (196) voting against it.

3. Adopted a mission statement reading "**The California Association of Neurological Surgeons is dedicated to the advocacy of the practice of neurosurgery in California**".

4. Noted 407 total members with 178 active, 64 senior and 140 residents. The active group is 2/3 private practice and 1/3 academic. Membership was approved for **Hamidreza Aliabadi, M.D.** from Roseville and **Ciara Harraher M.D.**, Assistant Clinical Professor at Stanford.

5. Noted that the **January annual meeting on the Queen Mary** was attended by 62 members plus 13 residents and 30 exhibitors and was profitable to a degree still being run through the accounting process. Those claiming CME credits for attendance should have had it posted by now on the AANS website. (www.aans.org--My AANS—CME Transcripts).

6. Listened to a piped in phone call from **CMA lobbyist Carolyn Ginno** about topics of interest to the Board including MICRA, CA legislative activities and government bodies particularly the Division of Worker's Compensation. She noted hearing some anecdotal stories regarding major difficulties by docs getting WC carriers' authorization for surgeries. She suggested sending her incidences (with patient identification redacted) of egregious problems so she can collect enough information to approach the DWC for action (cginno@cmanet.org).

7. Noted hearing that the **DWC Medical Evidence Evaluation Advisory Committee** is working on opioid use guidelines but details are unknown and CANS' representative on the MEEAC. Michel Kliot, confirmed that all committee members have to sign

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non-disclosure agreements.

8. Laid plans to have another **Long Range Planning meeting** on January 16th in Monterey just before the 2014 annual meeting.

9. Discussed the 14 resolutions to be considered at the forthcoming meeting of the **Council of State Neurosurgical Societies** April 26-27 in New Orleans, taking positions to be expressed on an assigned basis by one of the 9 CANS delegates appointed for the meeting. (These positions are included on the outcomes of the resolutions listed below.) ❖

Brain Waves

Deborah Henry, MD, Associate Editor

It's been a helluva month. First the Boston marathon bombing on the 15th, then 2 days later, the explosion at the fertilizer plant in West, Texas. Interspersed have been floods, tornadoes, avalanches, and ricin attacks. In an amazing show of courage, many individuals ran toward the bombings in Boston to aid those in need; several responders were in the medical field. Three individuals died at the marathon finish line and Sean Collier, the MIT police officer, died in the line of duty 3 days later. Likewise, in the small town of West, Texas, located just 20 miles north of my alma mater Baylor University, 14 individuals lost their lives. Twelve of them were volunteer firefighters who rushed to the scene to help any possible survivors.

These individuals exemplify what it means to be a first responder. To be the person who rushes in where others dare not go and to do it willingly and not begrudgingly. As neurosurgeons, we are also first responders. To this day, I never minded arriving in the emergency room when I was really needed. I can't say that was the case when I sensed the call to the ER was more a slightly positive CT means get a medical-legal consult just in case. The latter can really wear one down. To hear of those who voluntarily rushed to a fire humbles me immensely.

I spent many evenings these past two months training to become a member of the local Certified Emergency Response Team. Newport Beach's CERT was nationally recognized last year as the best training program in the country. Two to three times a year the city offers this free 24-hour training program to its residents to help prepare us to respond to natural and other types of emergencies. In addition to basic first aid, we learn search and light rescue, fire suppression, and how to triage. Being a doctor, I thought triaging would come natural to me. I was wrong. It is very difficult to leave those that CPR could potentially help in exchange for those who have a higher likelihood of survival. It is difficult to do a cursory exam of just respiration, capillary refill, and mental status and then move on. With my graduating class, Newport Beach now has over 1000 volunteer certified emergency responders, the vast majority who are not in the medical field.

Perhaps my most memorable first-responder was a priest. A hospital I was covering accepted a patient with a subarachnoid hemorrhage from another hospital over an hour away. This elderly woman arrived intubated and on a dopamine drip to maintain her pressure. It is two in the morning when I am called to see her. Her pupils are fixed and dilated and her pressure is falling even on the dopamine. I am angered that she was sent over an hour away with this exam and that her family was asked to drive this distance only for me to deliver the bad news. The patient was Catholic and

the family asked that a priest come to perform the last rites know as the anointing of the sick. Just as I am leaving, the priest arrives. Here it is three in the morning, and he is doing volunteer work helping the dying and comforting the living. That's what it means to be a first responder. ❖

Tidbits from the Editors

AANS/CNS benefits worthwhile but still no free lunch

If you sometimes wonder what your annual dues to the AANS and CNS get you besides their journals and an invitation to spend more money at their annual meetings, the recent activities of the CMS reflect the results of some of your dues. Due to the encouragement by the AMA, AANS and CNS to make the Physician Quality Reporting System (PQRS) and the Electronic Health Records (EHR) Incentive Programs more applicable to specialties, the CMS issued a Request for Information so it can potentially allow participation by docs in their own specialty specific registries as satisfying the PQRS and EHR meaningful use requirements. Interestingly, only 19% of neurosurgeons participate in the federal PQRS program.

The AANS and CNS responded to the RFI with a very knowledgeable and well written document detailing why the neurosurgical registry, the National Neurosurgery Quality and Outcomes Database (N2QOD) should qualify for satisfying the Feds requirements. The document was created by the Washington Office of the AANS/CNS whose entire budget is covered by the AANS/CNS.

It now falls to the N2QOD folks to create a product useable by the hundreds and hundreds of neurosurgeons not in large group practices. The N2QOD has so far only been used by large groups who can afford the 5 figure registration fee and the additional practice FTE it takes to enter the data. Currently there are only 33 centers using the database which is for lumbar spine and 4,000 patients have been entered. A preliminary report on that 4K patient database will be presented at the AANS meeting during the Tuesday April 30th plenary session. A cervical spine module is currently being rolled out and the N2QOD –lite for the solo/small group neurosurgical practices (cheaper registration/less data uploading so current office staff can handle it) is yet to be fielded. Assuming the Feds bless N2QOD, the issue for the small groups/solo docs may come down to whether the benefits of satisfying the Federal reporting standards for PQRS and EHR meaningful use requirements are enough of a carrot to offset the N2QOD cost/labor stick. ❖

Georgia may have gotten it right—for a price

Some angst has been generated about the plaintiff's bar using federal quality-of-care and payment reform measures, such as those authorized by the Affordable Care Act, to fuel negligence accusations against individual physicians. The AMA has proposed model legislation to prevent such activity and the Georgia legislature has passed such legislation which is expected to be signed by Governor Nathan Deal. The Georgia law prevents federal health reform metrics from being used as evidence in liability cases. Georgia's law states that payer guidelines and quality criteria under federal law shall not establish a legal basis for negligence or a standard of care for the purposes of determining medical liability. Congress has approached a similar measure that was introduced in

the last congressional session by Rep. Phil Gingrey, MD (R, Ga.) but died in committee; it is being re-introduced this year.

Georgia's lawyers were not asleep at the switch, however, as they signed on to support the measure. The Georgia Trial Lawyers Association worked with Georgia's docs on the state legislation and was pleased with how the final bill turned out, said Bill Clark, GTLA's director of political affairs. Why? Because the lawyers successfully pushed for including a "goose-gander" provision in the bill. As Clark said, "The only way we were willing to allow the bill to go forward was to have it go both ways. If a physician can't be held accountable for malpractice for failing to adhere to a payment guideline, then they also shouldn't be able to use their compliance with a standard as evidence that they complied with the standard of care. If it can't be used against you as a sword, you also can't use it for a shield."

So is the trade-off worth it? Medical organizations and med-mal reform groups have favored the guideline shield concept as a way to reduce litigation. Giving up that potential shield may cost Georgia's docs more than they bargained for. ❖

New neurosurgical ranks nicely filled

The recent results from the National Resident Matching Program (NRMP) demonstrated an increased number of applicants for the 29,171 U.S. residency positions. A huge majority of U.S. seniors matched but unfortunately, a growing number of U.S. seniors did not obtain a residency position, either through the Match or in the NRMP's post-Match Supplemental Offer and Acceptance Program, or SOAP. In fact, this number doubled this year, from 262 in 2012 to 528 in 2013.

The 99 USA neurosurgery training programs offered 204 positions all of which filled save one. Interestingly, there were only 314 applicants (241 U.S. seniors) for the 204 positions and 93% of the slots were filled with U.S. seniors. Question is: Are 200 new neurosurgeons a year enough to deliver care to America with its swelled insured base with Obamacare implementation? Stay tuned. ❖

Family docs dinged on ordering MRI scans

Some Canadian docs from the University of Alberta in Edmonton had MRI referrals to two large teaching hospitals reviewed by an "expert panel" and determined that only 34% of lumbar MRI's ordered by family physicians were "appropriate" with another 27% or so deemed of "uncertain value". The study, published as an online research letter in *JAMA Internal Medicine*, also noted that neurosurgeons ordered the scans appropriately 76% of the time while orthpods and neurologists were appropriate less than half the time. The only indication for lumbar spine MRI among the 1,000 outpatient referrals examined that routinely received a rating of "appropriate" by the expert panel was postoperative leg or back pain.

Presuming that the Canadian payment system, which does not reward surgeons with big bucks for fusing dark discs, weeds out the surgeon entrepreneur, such statistics suggest Edmonton's neurosurgeons are restrained and sensible and not afraid of the demanding patient. Or, by the time that patients wend their way to a neurosurgeon, a real potential surgical problem is likely to exist. Or, that most MRI's ordered by neurosurgeons are on failed surgical patients with persistent post-op pain. Or, that neurosurgeons are indeed tight with God and family physicians need mandatory guidelines.

Or, that the docs who ran the study probably aren't often in the clinic. Feel free to add another "Or". ❖

Neurosurgeons worth $2.6 million for employer

In case you are trying to sell yourself/practice to some entity, Jackson & Coker, a physician-staffing firm providing permanent physician placement plus locum tenens, has published their current concept of physician salaries based upon 1573 neurosurgeons in their database. They report an average straight salary for a neurosurgeon of 690K which goes to 828K if benefits are included. They don't break down the data by state so one would guess California might run a bit less. If you are doing locum tenens, they report an average hourly rate of $400 (with benefits). Since they also report that a neurosurgeon generates an annual $2.63 million for whomever they work, value yourself accordingly. ❖

Council of State Neurosurgical Societies meeting in New Orleans

Moose Abou-Samra M.D., from Ventura and Chairman of the CSNS Southwest Quadrant, reports that the CSNS meeting April 26-27 resulted in **Mark Vanefsky M. D.** from Kaiser Anaheim being elected to the Quadrant's Chairmanship for 3 years. Moose finishes a 3 year stint but may not be about to step away as he was nominated for the position of Southwest Regional Director to the AANS Board of Directors. **Deborah Henry, M.D.** was elected to the Secretary position in the Quadrant.

The Quadrant also selected its resident fellows for the next year who are **Debraj "Raj" Mukherjee M.D., M.PH.** from Cedars Sinai, **Hasan Aqdas Zaidi, M.D.** from the Barrow Neurological Institute in Phoenix and **Jerome Milton Volk III, M.D.** at Louisiana State University in New Orleans.

During the main CSNS meeting, the 14 resolutions listed in last month's newsletter were acted on as follows:

RESOLUTION I (CANS position—await debate)
Title: Welcoming of Osteopathic Neurosurgeons into American Neurosurgical Professional Organizations, in the Advent of ACGME Certification
Action: Adopted Amended Substitute Resolution
BE IT RESOLVED, that the CSNS recommends that its parent bodies, the CNS and the AANS, begin accepting Osteopathic trained Neurosurgeons as full members once Osteopathic residency training programs are ratified and approved under ACGME accreditation.

RESOLUTION II (CANS position—support)
Title: Expanding AANS/CNS Conflict of Interest Statement to Include Physician Owed Distributorships (POD's)
Action: Adopted Amended Resolution
BE IT RESOLVED, that the AANS and CNS be petitioned to update their position statements on conflict of interest to include the relationships created by Physician Owned Distributorships; and
BE IT FURTHER RESOLVED, the position statement should affirm that the neurosurgeon should disclose to the patient of his or her financial interest that is related to any aspect of a patient's evaluation and care related to use of POD products.

RESOLUTION III (CANS position—support)
Title: Creation of a Patient Safely Committee within Organized Neurosurgery

Action: Referred to CSNS Executive Committee
BE IT RESOLVED, that the AANS, CNS, and CSNS be petitioned to create a Patient Safety Committee in the CSNS modeled after the Society of Thoracic Surgeon Workforce on Patient Safety or the Patient Safety Committee of the American Association/Academy of Orthopedic Surgeons; and
BE IT FURTHER RESOLVED, the AANS, CNS, and CSNS be petitioned to create patient safety online learning module and educational tools be created and incorporated into current neurosurgical training such as SANS, Neurosurgery Boot Camp program, residency-training milestones, Maintenance of Certification, Patient Safety Fellowships, etc.., similar to the American Board of Medical Specialties Patient Safety Improvement Program; and
BE IT FURTHER RESOLVED, the AANS and CNS be petitioned to create a fund to support research proposals for projects to explore the safety practices such as checklists, timeouts and debriefings as there has been no rigorous study of their effectiveness in this field; and
BE IT FURTHER RESOLVED, the Neuropoint Alliance be petitioned to develop quality metrics which assess safety and serve as an early warning system to detect systemic patient safety pitfalls, and disseminate this information to practicing surgeons.

RESOLUTION IV (CANS position—support)
Title: Defining Neurosurgical Quality by Neurosurgeons
Action: Adopted Substitute Resolution
BE IT RESOLVED, that the CSNS request the AANS and CNS to direct the Washington Committee/Quality Improvement Workgroup to identify appropriate neurosurgical quality metrics and report on these recommendations.

RESOLUTION V (CANS position—support)
Title: Encouragement of neurosurgeon participation at State level neurosurgical organizations
Action: Adopted Amended Substitute Resolution
BE IT RESOVLED, that the parent bodies of the CSNS (AANS and CNS) should strongly encourage participation of neurosurgeons at state level neurosurgical organizations; and
BE IT FURTHER RESOLVED, that a check box option to join the member's state neurosurgical society be made available on AANS and CNS applications and membership renewal forms; and
BE IT FURTHER RESOLVED, that the CSNS request the AANS and CNS to provide membership information to component state societies on an annual basis.

RESOLUTION VI (CANS position—oppose)
Title: One Annual Neurosurgery Meeting
Action: **Not Adopted**
BE IT RESOLVED, that the CSNS work with the AANS and CNS to create a national meeting schedule of one major national meeting per year; and
BE IT FURTHER RESOLVED, that the CSNS work with the AANS and CNS such that the meeting requirement is reduced to 2 meetings in total per every 4 year cycle.

RESOLUTION VII (CANS position—support)
Title: One Neurosurgery Organization
Action: Not Adopted
BE IT RESOLVED, that the CSNS work with the AANS and CNS to create a single neurosurgical entity that takes on the joint mission statements of both organizations.

RESOLUTION VIII (CANS position—oppose)
Title: Towards a Better CSNS Plenary Session
Action: **Not Adopted**
BE IT RESOLVED, that the CSNS Meetings are restructured such that at least 50% of the plenary sessions are dedicated to resolution-related deliberative activities and open discourse amongst delegates; and
BE IT FURTHER RESOLVED, that Committee reports and other non-deliberative reports are submitted for dissemination through the website and/or newsletter; and
BE IT FURTHER RESOLVED, that the president and executive council of the CSNS decide on reports that warrant presentation at the plenary session; and
BE IT FURTHER RESOLVED, that awards ceremonies, CSNS Fellowship introductions, and other such non-deliberative activities are moved to the Saturday luncheon time.

RESOLUTION IX (CANS position—support)
Title: Addition of CSNS meeting to AANS and CNS meeting registration forms
Action: Adopted Amended Resolution
BE IT RESOLVED, that the CSNS work with the AANS and the CNS to include registration and housing for the CSNS meeting on the same registration form for the AANS and CNS annual meetings.

RESOLUTION X (CANS position—oppose)
Title: Ask the CSNS delegates to adopt a name change of the CSNS from "Council of State Neurosurgical Societies" to "Council of State Neurosurgical Societies, the Socioeconomic Joint Section of the AANS/CNS" and petition the AANS and CNS to recognize the CSNS as a Joint Section in concordance with the intent of this name change and their bylaws.
Action: **Not Adopted**
BE IT RESOLVED, that the CSNS adopt a name change from "Council of State Neurosurgical Societies" to "Council of State Neurosurgical Societies, the Socioeconomic Joint Section of the AANS/CNS"; and
BE IT FURTHER RESOLVED, that the CSNS adopt bylaw language to reflect that it abides by all AANS and CNS "Joint-Section" bylaws on (1) membership, (2) section rules, (3) activity reporting and (4) financial reporting; and
BE IT FURTHER RESOLVED, that the CSNS petition the Board of Directors of the AANS and the Executive Committee of the CNS to recognize the "Council of State Neurosurgical Societies, the Socioeconomic Joint Section of the AANS/CNS" as a Joint Section of the AANS/CNS.

RESOLUTION XI (CANS position—support)
Title: Resident Duty Work Hours
Action: Not Adopted
BE IT RESOLVED, the CSNS shall work with the AANS and CNS and other surgical and medical specialty societies to encourage the ACGME to decrease the existing duty hour restrictions in recognition of their deleterious effect on surgical education and unproven effectiveness in improving patient safety, and allow individual societies to set duty hour restrictions that are optimized for a particular specialty; and
BE IT FURTHER RESOLVED, that our CSNS asks the neurosurgical delegations to the AMA to offer a resolution at the Annual meeting in 2013 to direct the AMA act to decrease or remove existing duty hour restrictions, recognize their deleterious effects on education and unproven effectiveness in improving patient safety and work with other delegations to gain support.

RESOLUTION XII (CANS position—support)
Title: Exploring the Feasibility and Strategy for Developing a Concussion Registry.
Action: Adopted Amended Resolution
BE IT RESOLVED, that the CSNS petition the AANS and CNS to form a task force to explore the feasibility and strategy for developing a registry for concussions, and
BE IT FURTHER RESOLVED, that by developing this registry, we neurosurgeons reclaim our role as leaders in the research, evaluation, and treatment of concussion.

RESOLUTION XIII (CANS position—support)
Title: Neurosurgery Registry on Structural Head Injury in Sports
Action: Adopted
BE IT RESOLVED, that the CSNS collaborate with Neuropoint Alliance (NPA) to create a registry module for structural head injury in sports to collect national data; and
BE IT FURTHER RESOLVED, that the CSNS and NPA collaborative work include a more expansive definition of sports-related structural injury in order to capture more data; and
BE IT FURTHER RESOLVED, that a companion paper providing an overview of structural head injury in sports and instructions to neurosurgeons on data collection and analysis be created by the CSNS.

RESOLUTION XIV (CANS position—await debate)
Title: Establishing Community and Non-Academic Neurosurgery Coverage of Neurologic Emergencies **Action: Adopted Substitute Resolution**
BE IT RESOLVED, that the CSNS create a local-regional database identifying existing emergency neurosurgical coverage as well as coverage needs as a pilot project to be reported back to the CSNS for assessment for future potential general applicability and updating. ❖

Truism of the Month:

A picture is worth a thousand words, but it uses up three thousand times the memory.


16TH ANNUAL CALIFORNIA HEALTH CARE LEADERSHIP ACADEMY
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Jump Start for Exhibitors

Emily Schile, Executive Secretary

Please consider joining us next year in Monterey at the Monterey Hotel & Plaza! The dates are January 17th – 19th, 2014. It's a great time of year to be near the beach! The Monterey Plaza looks out onto Monterey bay on one side and historic Cannery Row on the other! Please contact me at Emily@cans1.org for more information❖

Meetings of Interest for the next 12 months:

Rocky Mountain Neurosurgical Society: Annual Meeting, June 15-19, 2013, Sun Valley, ID
New England Neurosurgical Society: Annual Meeting, June 27-29, 2013, Brewster, MA
Western Neurosurgical Society: Annual Meeting, September 15-18, 2013, Half Moon Bay, CA
North American Spine Society: Annual Meeting, October 9-12, 2013, New Orleans, LA
Congress of Neurological Surgeons: Annual Meeting, October 19-23, 2013, San Francisco, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 3-6, 2013, Toronto, Canada
North American Neuromodulation Society: Annual meeting, December 5-8, 2013, Las Vegas, NV
Cervical Spine Research Society: Annual Meeting, December 5-7, 2013, Los Angeles, CA
CANS Annual Meeting, Monterey Bay Resort, January 17-19, 2014, Monterey, CA
Southern Neurosurgical Society: Annual Meeting, 2014, TBA
AANS/CNS Joint Spine Section: Annual Meeting, March 5-8, 2014, Orlando, FL
Amer. Soc. for Stereotactic and Functional NS: Meeting, May 31 - June 3, 2014, Washington, DC

Any **CANS** member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a two month posting in this newsletter. Submit your text to the CANS office by E-mail (emily@cans1.org) or fax (916-457-8202)—Ed. ❖

The assistance of Emily Schile and Dr. Ted Kaczmar in the preparation of this newsletter is acknowledged and appreciated.

- To place a newsletter ad, contact the executive office for complete price list and details.
- Comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office emily@cans1.org.
- Past newsletter issues are available on the CANS website at www.cans1.org.
- If you do not wish to receive this newsletter in the future, please E-mail, phone or fax Emily Schile (emily@cans1.org, 916-457-2267 t, 916-457-8202 f) with the word "unsubscribe" in the subject line.

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Executive Secretary Emily Schile
emily@cans1.org

Editorial Committee

Editor
Randy Smith, M.D.

Associate Editors
John Bonner, M.D.
Deborah Henry, M.D.

This newsletter is published monthly from the Executive Office:

California Association of Neurological Surgeons
5380 Elvas Avenue
Suite 216
Sacramento, CA 95819
Tel 916 457-2267
Fax 916 457-8202
www.cans1.org