CANS newsletter

AANS responds to AANS-CNS merge endeavor

Randall W. Smith, MD, Editor

As we noted in last month's CANS newsletter, the One Neurosurgery Advocacy Committee, an ad hoc self-appointed small group pushing for amalgamation of the AANS and CNS, continued to try to get the attention of the AANS and CNS by leading a email deluge of the national organizations asking for merger, one annual meeting and abolition of annual meeting attendance requirements. The AANS heard them and has responded via a letter from AANS President Bill Couldwell to the AANS membership in which he states that with the failure of a concerted effort to merge the two groups which occurred 10 years ago, another attempt would be futile and consume time and resources better spent elsewhere. This writer, who was elected to the AANS Board in 2003, was privy not to the actual negotiations but to their outcome as personally detailed by Roberto Heros who was AANS President in 2002-2003 and who was intimately involved the mediator led negotiations. Dr. Heros assured me a major effort was expended and that the AANS was agreeable to a merger to include a naming of the merged group as something like the American Congress of Neurosurgery and a preservation of the CNS's educational arm to include directing an annual autumn meeting. He further told me that the CNS balked primarily because their leadership felt that amalgamation would inexorably result in the disappearance of the CNS philosophy which was unique enough to be worthy of preservation. I believe that Dr. Heros is an honorable man and I accept his explanation which Dr. Couldwell's letter aptly describes.

Dr. Couldwell went a step further in his letter, promising that if the AANS Board approves, a by-laws amendment will be put forth changing the once every three years meeting attendance requirement to once every 5 years. Such a change should be welcomed by the One Neurosurgery Advocacy Committee and is about what they can expect to accomplish short of a grass roots submitted by-laws amendment totally abolishing meeting attendance requirements. The CNS, which has a meeting attendance requirement of one every three years and requires obtaining 90 hours of type unspecified CME every three years for active members, has yet to be heard from.

Redoing the AANS by-laws Article III, B, 3 which currently requires Fellows and Provisional members one in three year meeting attendance should include abolition of the Continuing Education Award in Neurosurgery. That Award, which requires 60 hours of CME every three years, said CME recommended (but not mandated) to be 40 hours neurosurgical, is at best redundant and at worst a documentation pain in the behind. It is a legitimate membership maintenance goal of the AANS to require occasional meeting attendance but it should not be policing our CME. The only CME police should be the ABNS and our various state medical Boards. ❖

INSIDE THIS ISSUE:

President's Message

Theodore Kaczmar Jr., MD, CANS President

It is with great sadness that I report the death of my dear friend Scott Conner, Santa Barbara neurosurgeon and CANS member since 1993. According to his wife Maryann, Scott passed while resting at home on June 1 after spending "an absolutely perfect day" with his family. He was only 62 years of age.

I met Scott in 1978. He was a first year resident on the neurosurgical service at the Massachusetts General Hospital, where I was doing a neurosurgical rotation as a fourth year medical student. I was immediately drawn to his quick mind and dry sense of humor, and we became fast friends. Remarkably, we met our future wives that same summer, both of them neurosurgical nurses and already best friends. Scott and Maryann moved to California in 1984, and Debra and I followed shortly thereafter in 1985. We remained close ever since. I found Scott to be keenly insightful, a true "Renaissance Man." Art, music, history, and literature all excited him, and he was conversant in practically any field of human endeavor. He had a talent for looking at events and situations in a unique and unconventional way, which would cause you to challenge your own assumptions and preconceived notions. At the same time, he was soft spoken, gentle, kind, and compassionate.

Maryann & Scott Conner ~2013 CANS Annual Meeting

Many of us at CANS have followed the antitrust suit brought by an orthopedic spine surgeon against Cottage Hospital and Scott's neurosurgical group. The burden of this trial weighed heavily on Scott for the past year and a half. While Cottage and the neurosurgeons were vindicated by the recent jury verdict, I cannot help but think that this unimaginable stress contributed to Scott's untimely death. In reading through Scott's memorial webpage, I was struck by one entry in particular, which I reprint here.

'Tears are flowing after reading all of these lovely sentiments and remembrances of Dr. Conner. He was not my doctor, nor did I come to know him in a regular course of interaction. The first time I "met" Dr. Conner was as a juror in a case brought against him, Cottage Hospital and three other doctors. I was Juror Number 5 in a long hard trial lasting months.

When Dr. Conner was on the stand and began testifying, I was struck by his humility and gentle nature. At the end of the testimony and those of others, I had a good grasp of who this man was. I honestly recall the feeling and knowledge of being in the presence of greatness.

When I read today of Dr. Conner's passing, the first thought I had, was that I hoped the intense trauma of the legal persecution he had endured had not ended his life earlier than it should have. I will be forever proud to have battled hard in the jury deliberation room to vindicate Dr. Conner, the other doctors and Cottage Hospital. I got a taste of the injustice of what Dr. Conner and the others had to face after the trial ended but it was all worth it in order to acquit these great men and the institution they worked/work for. Dr. Conner was a true servant to his patients, to his community and to humanity. I hope that in some small way, through jury duty, I was able to give something back to him and to make his life easier.

Dr. Conner was the example of someone willing to make sacrifices in order to follow the calling to help others. May blessings be upon his family and many friends who are mourning the loss of this extraordinary man.'

I was left speechless after reading this entry and could not hold back my tears. That Scott could have such a profound effect on this juror during the course of a trial speaks volumes about his character. We mourn the loss of a truly exceptional man, one whom I had the privilege to call a friend. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

I am happy to report that I recently returned from my 50th Medical School Reunion in Chicago, which was a very pleasant experience. It was fun to see previous friends. We had 72 in our class (with only three women in the class at that time). I enjoyed my medical school years, which convinced me to enter neurological surgery.

As I reminisce of my experience at the University of Chicago, I remember well my med school training. In Medical School, there were Professors like Douglas Buchanan, a Scottish pediatric neurologist who had a real talent for teaching. I particularly remember Dr. Buchanan's Saturday morning conferences, where he would spin a tale of the history of the selected disorder and provide patient demonstrations. I also had a research advisor, Ruth Rhines, M.D., Ph.D. who was a wonderfully supportive faculty member. For neurology, Drs. Richter, Sidney Schulman, Howard Barlow, and Robert Cutler were excellent teachers. Chicago neurosurgical resident influences were Drs. Raimondi, Torres, Jane and Hekmatpanah. But it was Joseph Evans and Sean Mullen who became my neurosurgical idols at that time – superb gentlemen, teachers and surgical technicians, excellent examples to identify with. As it turns out, Dr. Evans' sister, who lived in Fresno, would much later become a patient of mine, and I had the good fortune of commonly seeing Dr. Evans when he would travel to Fresno, California to visit his sister. Dr. Mullan has remained a good friend and advisor for many years, continuing to today.

(Incidentally, while a student at Chicago, I also met a very attractive Intensive Care nurse who attended a party my roommates and I were hosting. The nurse was from St. Mary's Nursing School, later a graduate of DePaul University, a girl named Romona. She swore that she would never marry a doctor, but she became my wife, much to my benefit.)

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A recent study by the University of Texas M.D. Anderson Cancer Center reports that use of Avastin (Bevacizumab) to treat Glioblastoma Multiformi and Grade III Gliomas (such as an anaplastic astrocytoma) may result in significant deterioration of neurocognitive function, and quality of life. Compared with placebo, patients with Avastin demonstrated greater decline in global neurocognitive function, executive function (skills involved in tasks such as planning, organizing and multi-tasking) and processing speed. Avastin was also believed associated with higher rates of toxicities, including hypertension, bleeding, deep vein thrombosis, pulmonary embolism and gastrointestinal perforation. It was advised that the use of Avastin, as it is found to have some benefit, be reserved as a later treatment for most patients.

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The May 2013 CANS Newsletter noted the fantastic history of care for those most vulnerable in society that Melvin Cheatham, former President of CANS, and his wife, Sylvia, have provided over the years. He and his wife are to be congratulated by all of us. ❖

Brain Waves

Deborah Henry, MD, Associate Editor

It is a late evening in spring of 1988 and I am walking through the marbled halls of a private hospital in Upstate New York with my chief resident. As we enter the pediatric floor, a little girl of about 5 years of age is sitting in the middle of the hallway, a doll in her lap and a play stethoscope around her neck. She is carefully listening to her patient's imaginary heartbeats. Enthralled, I bend down to ask her if she wants to be a doctor when she grows up.

"No," she answers rather emphatically.
"Why not?" I ask.
With conviction she answers, "Because girls don't grow up to be doctors."

My chief resident chuckles and ribs me with his elbow. "Yeah," he teases me. Today, his second daughter is halfway through medical school.

This Father's Day, I thought a lot about dads and daughters. When I entered medical school over three decades ago, my dad did not think there was a snowball's chance in Houston that I would get accepted. Once there and making that leap-of-faith decision to go into neurosurgery, I sought the advice of my chairman Dr. Grossman. Bob Grossman's daughter Amy was my classmate. Amy had chosen the field of ophthalmology. As I sat in her father's office, we discussed women in neurosurgery. He had had three women residents. The first did not pass her written boards, the second left in her fourth year as motherhood called, and the third finished albeit with a colorful history. Dr. Grossman looked at me and said earnestly, "I don't think women belong in neurosurgery." I could not take offense. I think he was seeing his daughter sitting across from his desk, and this is the advice he would have given her. Years later, I met Bob and his daughter at national meeting. He looked surprised to see me, still that rarity in neurosurgery.

As our male neurosurgeon colleagues have taken on the added identity of father over the years, I have been amazed at the change in support for daughters. These daughters are growing up to be lawyers, engineers, and doctors-because girls can grow up to be doctors. In fact, I think more of my male colleagues' daughters are in the neurosciences than their sons. What a pleasant surprise to see this growing support of women in neurosurgery come from the men who trail-blazed through their residencies without a female resident in their ranks. Just seventeen years ago, I became approximately the 35th board certified woman neurosurgeon in this country. We now have 237 (as of 2012). Way to go Dads. ❖

Tidbits from the Editors

Utilization Review by California docs subject to MBC oversight

It is of some interest to note that the Medical Board of California, in response to a pointed inquiry by Henry Perea, a California State Assemblyman from Fresno who is no fan of the MBC, has indicated that they do consider utilization review by a licensed CA physician as constituting the practice of medicine and UR docs can be held accountable and their licenses subject to review if complaints are brought against them. The MBC had previously held that they did not have jurisdiction over UR decisions.

The Board's response included the statement that, "The fact that a (patient) was able to get an original UR decision modified or overturned, thereby potentially reducing or avoiding harm, would not shield the UR physician from discipline, if discipline is otherwise warranted. Patient harm need not occur to establish a violation of the Medical Practice Act, as it is far more desirable to discipline before a licensee harms any patient than after harm has occurred."

Of course, if the UR doc is in Illinois, the MBC can go fly a kite. That is why the CA legislature had passed a bill requiring that UR only be done by CA licensed docs but the Gov. vetoed that bill because he found it disruptive to the insurance industry. That bill has been reintroduced in the legislature in the hopes that "disruption" time has come.

Potpourri

According to a ***Medscape*** report, on-call pay for surgical specialists dropped last year, though surgeons are still compensated more highly than primary care physicians for their time on-call. According to the MGMA Medical Directorship and On-Call Compensation Survey: 2013, a report based on 2012 data, 70 percent of all physicians received payment for on-call coverage in 2012, a 10 percent increase over the previous year. Surgical specialists, including orthopedists and neurosurgeons, are most in demand and average daily stipends were reported as $900 in 2012. Despite receiving more than primary care physicians — who reported on average $250 daily stipend for on-call coverage — surgical specialists saw a 10 percent rate decrease in 2012.

Medscape also released their Orthopedist Compensation Report: 2013 which revealed the following:
1. Orthopedists who were employees received on average $347,000 in 2012.
2. Independent contractors in orthopedics received average compensation of $250,000.
3. Solo-owners of orthopedics practices received $405,000 on average.
4. Orthopedists who are partners in a practice received $480,000 on average.
5. Around 9 percent of orthopedists reported participating in an accountable care organization currently.
6. Another 13 percent said they were not in an ACO but planned to join one in the coming year.
7. Two percent of orthopedists reported having cash-only practices.
8. Another 2 percent reported being in a concierge practice.

One wonders just how much longer the amount in 4 will exceed that in 1.

Lastly, ***Modern Healthcare*** reports, "Physicians, patients and medical imaging companies" have "talked the CMS out of virtually ending Medicare payment for post-treatment positron emission tomography scans for solid tumors." The CMS "reversed its March proposal to end payment for such post-treatment scans for prostate cancer and limit coverage to one scan for other cancers."
Regarding this issue, ***MedPage Today*** reported that "the final decision to cover up to three scans applies to all Medicare beneficiaries nationwide, whereas the draft proposal had left coverage determinations to local Medicare contractors." The agency "also said that coverage of additional FDG-PET scans beyond the initial three can be reimbursed in individual cases at local contractors' discretion."

Insurers' misbehavior slapped by the Supremes

A recent decision by SCOTUS will allow individual physicians to come together as a group to fight unfair business practices of large health insurance companies. The ruling in *Sutter v. Oxford Health Plans*, stemmed from an allegation by New Jersey pediatrician John Sutter, MD, that Oxford Health Plans had systematically bundled, down coded and delayed payments for his services and those of 20,000 other

physicians in its network. Oxford Health Plans had challenged legal decisions supporting class arbitration of the dispute, appealing the case all the way to the U.S. Supreme Court.

Insurers know that forcing physicians to individually arbitrate their disputes works to the insurers' advantage by allowing contract violations and underpayments to persist for prolonged periods while they sit on the docs cash. The Supreme Court's ruling in favor of allowing physicians to arbitrate as a class gives a boost to the medical profession's efforts to address unfair corporate policies of large health insurers that are harmful to patients and physicians, particularly physicians.

Work Comp switch to RBRVS

The California Department of Workers' Compensation has made public its plan to convert its present official medical fee schedule (OMFS) to an RBRVS system as required by the passage of SB863 last year. The 863 mandate limits the overall WC payments to 120% of Medicare which is an increase from the current overall rate of 111% but the increase doesn't get to us surgeons. The current OMFS for surgery translates to about $55/RVU which is among the lowest rates paid in the country. The DWC plan is to transition the surgery conversion factor over four years; $52.47 for 2014, $50 for 2015, $45.56 in 2016 and $44.23 in 2017 and beyond with some small inflation driven increases over the same period. The general E&M code conversion factor would increase from the current mid-thirtys to $44.23 by 2017 which is of course the goal of the RBRVS system conceived by internists for the benefit of primary care docs treating Medicare patients. This plan would result in a 13.4% drop for surgical procedures offset to some extent by the increase in the E&M payments which surgeons also use.

Officials of the California Society for Industrial Medicine and Surgery are pessimistic about the the RBRVS plan working in California. They point out that every state that has implemented an RBRVS system for Work Comp with a single conversion factor as planned in California has failed. They cite the Texas experience which went to an overall RBRVS of 125% of Medicare but had to subsequently increase that to 160% to keep doctors in the Work Comp system.

The DWC will hold a public hearing on their proposed RBRVS rules at 10 AM on July 17th in the auditorium of the Elihu Harris state office building in Oakland. They are sure to get an earful from CSIMS and the orthopods.

Historical vignette about the beginning of CANS

(The following article was lifted from the CANS newsletter April of 2003. The late Dr. Pevehouse was a shaker and mover in California medicine whose legacy will probably not be equaled by anyone in the future. Note the attendance at the inaugural meeting of CANS (we get about 30% of that these days) and the beginnings of MICRA.—Ed.)

The Founding of CANS by Byron Cone Pevehouse, M.D.

From my perspective on the early days, I first contemplated in the1960s the need for a state neurosurgical organization when I served several roles in the California Medical Association such as (1) Chair of the Neurology Section for the annual scientific assemblies and (2) writing terminology descriptors and (3) collecting survey values of fees during revisions of the California RVS. This led to (4) an invitation to testify at the State Legislature regarding a statute for "Determination of Brain Death" in order to protect Stanford and USC surgeons from charges of homicide in their harvesting of organs for transplant and then (5) a

statute on specific observations required to pronounce a patient dead while on cardio-respiratory support.

This was pretty heavy stuff to carry with only the backing of CMA. I used mail surveys to members of the Western Neurosurgical Society for fee charge data while realizing it did not accurately reflect charges in just our state. Then in September 1972 I attended the Joint Socioeconomic Committee and annual meeting of the Congress of Neurological Surgeons in Denver and heard a discussion on the need for creation of state organizations to deal with state issues. This stimulated me to do something about it in my own state. During the next several months, I wrote to various California neurosurgeons suggesting that we get together during the annual meeting (April 1973) of the Harvey Cushing Society, selecting the day of April 9, 1973 in Los Angeles at the Century Plaza Hotel. Actual attendance was uncertain up to the designated hour but finally about 14 appeared: George Ablin, Fred Amerongen, Edwin Amyes, Robert Cranston, Ben Crue, Tom Huff, John Marsh, John McRae, Richard Newquist, Jack Pace, Ernest Penka, Anselmo Pineda, Jim St. John and myself.

We started our conversation in the lounge bar and then moved to the Regent's Board Room. We agreed to incorporate and to have our founding meeting in Los Angeles later in the year. For officers and incorporators, I would be President; Jim St. John of Santa Barbara, Vice-President; John McRae of Los Angeles, Secretary; Jack Pace of Fresno, Treasurer. I contacted a San Francisco attorney, Charles O'Brien, who prepared the incorporation papers and the four of us signed them at the Hilton Inn, San Francisco Airport on June 10, 1973. The initial meeting of 189 "founding members" was on December 8, 1973 at the International Hotel, Los Angeles Airport, and the second meeting of more than 200 members was on December 7, 197 4 at Airport Marina Hotel, San Francisco. I set the agenda and malpractice insurance or the cost of premiums was not a concern during those two meetings. We spent a lot of time on topics such as whether board certification was necessary to be an active member, the fee schedule for Workers' Compensation patients, completion of claim forms, Medicare and Blue Shield fee reductions, plans for the 1974 revision of California RVS and the implications of President Nixon's fee freeze for all physicians based on a personal fee schedule of two years earlier.

During the annual meeting of the CMA House of Delegates in February 1975, the only resolution concerned with malpractice insurance had come from the California Hospital Association, stating "A hospital could require adequate malpractice insurance be carried by doctors as a condition of medical staff membership." It was passed, forwarded to Sacramento and enacted later that year. It was not until March 1975 that American Mutual Liability Insurance of Massachusetts announced it would not renew, on May 1, malpractice insurance coverage for doctors in six counties of the San Francisco Bay Area. Panic erupted in our area but a majority of California doctors practiced in the southern half of the state and showed no real interest in our "local problem" until late in 1975 when Travelers' Insurance announced a 365% increase in doctors' insurance premiums in southern California. San Diego County had coverage with a different company. CANS was already established, John Doyle of Los Angeles was President that year and busy with his practice. However, in San Francisco, the Bay Area Anesthesiologists, knowing of my prior activity with the state legislature, persuaded me to become active in seeking new legislation for reform of state laws. I formed a California Physicians' Crisis Committee (CPCC) of local doctors and enlisted John McRae (CANS Treasurer) to be co-Chairman in the south and we began to work collecting funds to support efforts for creating several key elements of what eventually became MICRA - educating the public, lobbying the legislators and fighting the trial attorneys. Therein lies a fascinating story for a future issue of the newsletter. ❖

Thought of the Month:

Wrinkled was not one of the things I wanted to be when I grew up.

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!

ATTN: CANS members! Do you know a neurosurgeon new to California? What about an existing CA neurosurgeon who isn't yet a member? Please direct them to our website: www.cans1.org for more information! ❖

Meetings of Interest for the next 12 months:

Western Neurosurgical Society: Annual Meeting, September 15-18, 2013, Half Moon Bay, CA
CANS Fall BOD: Board Meeting, October 5th, 2013, Oakland, CA
North American Spine Society: Annual Meeting, October 9-12, 2013, New Orleans, LA
CSNS Meeting, October 18-19, 2013, San Francisco, CA
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, February 19-22, 2014, San Juan, Puerto Rico
Nsurg. Soc. of Amer: Ann. Mt, June 8-11, 2014, St.Andrews-by-the Sea, New Brunswk, Canada
CSNS Meeting, April 4-5, 2014, San Francisco, CA
AANS/CNS Joint Pain Section Bi-Annual Meeting, April 4, 2014, San Francisco, CA
AANS: Annual Meeting, April 5-9, 2014, San Francisco, CA
Rocky Mountain Neurosurgical Society: Annual Meeting, 2014,TBA
New England Neurosurgical Society: Annual Meeting, 2014, TBA

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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