CANS newsletter

The AMA fumbles the ball—big time

Randall W. Smith, MD, Editor

The American Medical Association has decided to cancel the publication of its *American Medical News* which they had published for 55 years. They cited the cancellation as necessary because the bi-weekly publication was losing money in light of gradually increasing production costs (editorial staff, paper, postage, etc.) and decreasing ad revenue. They plan to lay off all 20 of the *News*' staff and simply call it a day.

We all may have some issues with the AMA but this writer has never heard a complaint about the *News* and I personally read each issue carefully as it contained current news items of major importance to docs (all docs not just PCP's) plus good editorials particularly by the AMA President, legal leaning articles, suggestions about running a practice , compliance with myriad federal rules and on and on. It was a comprehensive home for all things medical practice. That it was good stuff is attested to by the myriad journalistic awards it received. I freely admit I often used *News* articles as a take-off for items appearing in this newsletter.

As near as we can tell, there was no effort to survey the 215,000 folk who got the News for their opinion as to how useful it was. The bean counters at the AMA wagged the dog and the dog played dead. It is this writer's opinion that the AMA Board must be populated with has-beens and retired folk and other admin types and not with actively practicing docs trying to fight the good fight.

The AMA says that all the issues dealt with in the *News* will be covered in its other pubs such as the *AMA Wire* and *AMA Morning Rounds.* That is smoke and mirrors. I read these electronic items and they can in no way cover the waterfront, particularly the *Morning Rounds* which is just rewarmed issues that the media thinks are important. Having 20 staff working to create a doc useful publication every two weeks cannot and will not be replaced by whomever is left hanging around the publication offices of the AMA. The AMA stated that a digital *American Medical News* is not feasible because ads could/would not be placed. It is unclear why a digital *News* could not carry ads but even if it can't, that line of reasoning really doesn't address the major issue here which is the failure of the AMA leadership to recognize that an item of particular value to its membership doesn't necessarily have to be profitable to exist. I am sure the AMA Washington lobbyist(s) do not show a profit but are felt to be necessary for the AMA to carry out its mission. The same should apply to the *American Medical News.* There simply are some costs an organization needs to eat when they so clearly benefit its members.

AMA President Ardis Dee Hoven, MD, will have the distinction of her presidency not being remembered for what she created but what she killed. She should have said "Not on my watch!". No guts, no glory. ❖

INSIDE THIS ISSUE:

CANS MISSION STATEMENT

'An organization of Neurosurgeons to promote the professional education and scientific achievement of surgeons and quality care for Californians'

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

There has been much discrepancy with the planned implementation of Obamacare. Recently, the Obama Administration carved out an exemption, until January 2015, for businesses who employ 50 or more workers. No such exemption, however, was made for individuals who do not fall under the employer mandate: such individuals must purchase health insurance by January 1, 2014, or face a penalty for not doing so. (Interestingly, those who inflicted this 'great' piece of legislation upon the American people, namely Congress, have graciously exempted themselves and their staff from Obamacare.) Nonetheless, it is difficult to assess if Obamacare will actually be fully implemented; and, if so, how the effects will benefit the population. My big concern is that it will interfere with the physician-patient relationship.

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Some interesting preliminary effects have occurred as Obamacare has begun to be implemented. Mini-meds, a kind of 'bare-bones' health plan provided for low wage, part-time workers, have been largely discontinued by those firms that used them. Such firms include Darden Restaurants, Home Depot and Trader Joes. These all said that they will stop providing health insurance to part-time workers and direct those workers to Obamacare exchanges. While analysts in the Wall Street Journal reported that "they know of few companies now providing insurance that won't offer it to full-time workers next year," it is unknown if the delay in implementation of Obamacare for employers who have more than 50 workers will change the calculus of employers – i.e., whether they will continue to provide insurance for workers once these companies are subject to Obamacare. This leads to perhaps an unintended consequence of companies cutting hours for employees (to under 32 hours per week, the threshold for employees to be considered full-time under Obamacare) which would then send many more persons to the government exchanges for health coverage (and also fundamentally change the 40-hour work week). One then wonders about the long-term, of the availability of private health insurance for Americans. Indeed, the, perhaps, intended consequence of Obamacare is to lead to a single-payer system. ❖

Brain Waves

Deborah Henry, MD, Associate Editor

I read a fascinating editorial in the *LA Times* this week on the US-Syrian crisis. The author utilized an approach called "game theory" to analyze this tenuous situation. Game theory is a branch of mathematics that looks for the best possible outcome when neither side knows what the other will do and tries to find the least bad option. In its most basic form, it is like playing a game of "chicken".

Game theory reminds me of that 1983 movie "War Games" where a young Matthew Broderick hacks into a national security computer and sets off a potential nuclear launch. At the end of the movie, Broderick's character breaks into the national security site and under the watchful eyes of the military talks the computer into playing the nuclear launch out as a game to teach it that there is no winning strategy. The winner take all mentality does not work as one may win, but the other loses, and the game is over.

So what does this have to do with neurosurgery? We are often placed in this position to play "chicken" even when we know the high stakes and the likelihood of a bad outcome. In other words, the surgery was a success, but the patient died. Granted, without occasionally playing the game of tackling the insurmountable cases, neurosurgery would never have gotten past the Cushing era. But still there are days when coming to a stalemate can be considered a win.

I think of game theory when it comes to patients with the grade V AVMs. In private practice I took care of several patients with partially treated AVMS. I always felt this was like partially treating a hornet's nest. Often these AVMs where incompletely radiosurgeried or partially embolized, and the patient left more disabled than when they started. One young man arrived at my ER virtually brain dead from a cerebellar AVM. He received embolization at another hospital to shrink the size of this monster that inhabited his entire posterior fossa. In my mind's eye, this lesion was inoperable. Discussing the fatality of the situation with the family, I said that unless an AVM is totally obliterated, it may still rebleed. They were perplexed then that any treatment was done. But when left with nothing to do, we often chose to do what we can in hopes that the situation will improve.

I used the game theory approach years ago (albeit unknown to me at the time) when faced with a reoperation for a temporal lobe glioblastoma in an elderly man. I took out the first tumor, and it was eleven months before the tumor reappeared. However, those eleven months were torture for the man and his wife. He lived every day in fear of the tumor's return-never exiting from the bargaining phase of Elisabeth Kubler-Ross's dictum. He was the only doable recurrent glioblastoma that I refused to operate on again.

As neurosurgeons, we are often placed in the position to operate on the fatal intracerebral hematoma transferred from the outside hospital with the hopeful family anticipating the operation they were told would save their loved one's life. We are painted into that red-line corner. But sometimes it is better just not to play the game. ❖

http://www.sacbee.com/2013/10/01/5784877/blackbird-closes-suddenly-and.html

Tidbits from the Editors

Have an issue?

The CANS Board of Directors is meeting October 5th at the Oakland airport Hilton. Any CANS member can ask that an issue be addressed by the Board. Communicate your comments to our Executive Secretary Emily Schile at emily@cans1.org.

An (almost) perfect SAH rule

The Journal of the AMA (which is filled with ads and can be sold to myriad institutions and libraries so it makes a buck—see above article) carried an interesting article in its September 25th issue by a group of Canadian docs who applied something called the Ottawa SAH rule to 132 patients who presented to the ED with a subarachnoid hemorrhage (SAH). The details of the screening procedure are listed in the article (**Clinical Decision Rules to Rule Out Subarachnoid Hemorrhage for Acute Headache** Jeffrey J. Perry, MD, Ian G. Stiell, MD, Marco L. A. Sivilotti, MD, et al. *JAMA*. 2013;310(12):1248 doi:10.1001/jama.2013.278018) but suffice it to say that the Ottawa rule detected all 132 patients with a SAH from among over 2 thousand presenting with a headache. The rule is:

For alert patients older than 15 y with new severe nontraumatic head- ache reaching maximum intensity within 1 h. Not for patients with new neurologic deficits, previous aneurysms, SAH, brain tumors, or history of recurrent headaches (>3 episodes over the course of >6 mo)

Investigate (CT scan--if negative then a lumbar puncture) if >1 high-risk variable present:

1. *Age >40 y*
2. *Neck pain or stiffness*
3. *Witnessed loss of consciousness*
4. *Onset during exertion*
5. *Thunderclap headache (instantly peaking pain)*
6. *Limited neck flexion on examination*

We must applaud the authors' work designed to help the busy ED doc determine who needs a CT scan or LP rather than a Vicodin, but this writer notes that when I had a Grade 0 SAH in 2011 at age 62, I would not have been detected by the rule since I did not have items 2-6 of the rule (after some hours of denial, I had a CT scan at my request which was ? positive so had an LP which showed cherry pop CSF followed by a real angiogram followed by coiling of a 4 mm ACA). On the other hand, had I gone to the ED, I am sure my ED doc friends would have quickly ordered the CT because of who I am versus clinical judgment. Perhaps there should be one more criteria in the Ottawa rule:

7. Any patient in whom it would be *really* embarrassing to miss a SAH.

Docs to get a raise in 2014

The Hay Group, a global management consulting firm, recently published their take on physician compensation for 2014 based upon 2013 survey. They found that physicians across all organization types can expect to see median salary increases of 2.4 percent for 2014, on par with salary increases last year. Physicians in group-based practices can expect to see larger pay increases (3.7 percent)

than those in hospital-based settings (2.2 percent). Continuing a recent trend, primary care physicians can again expect to see slightly higher salary increases than specialists in 2014, particularly in hospital-based settings.

Hay Group has conducted its independent Hay Group's Physician Compensation Survey for more than a decade. The survey and subsequent reports cover 132 physician specialties. Data is reported as of March 1, 2013. ❖

OBSERVATION OF THE MONTH:

You know you're over the hill when your Insurance Company starts sending you their free calendar...a month at a time.

Application for Exhibitors/Board Members/CANS Members

Emily Schile, Executive Secretary

EXHIBITORS: Exhibitor registration information & form is **NOW AVAILABLE** on our website: www.cans1.org!

BOARD MEMBERS: Please extend an invite to your local representative for our Annual Meeting! They are a huge component in making our meeting successful! You can direct them to the website (www.cans1.org) or email me directly at emily@cans1.org!

ATTENTION 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! The more the merrier!

ALSO: SEE BELOW

CNS RECEPTION: On Monday, **October 21st from 6 – 8 pm**, CANS will be hosting a reception for prospective new members to CANS. Are you attending the CNS meeting? **Do you know of a new to California neurosurgeon?** Please join us for a wine & hors d'oeuvres reception at the Marriot Marquis Sierra I room in vibrant San Francisco! Email Emily@cans1.org if you are able to attend! ❖

Meetings of Interest for the next 12 months:

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
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, Feb. 10-11, 2014, San Diego, CA
Southern Neurosurgical Society: Annual Meeting, February 19-22, 2014, San Juan, Puerto Rico
AANS/CNS Joint Spine Section: Annual Meeting, March 5-8, 2014, Orlando, FL
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
Nsurg. Soc. of Amer: Ann. Mt., June 8-11, 2014, St. Andrews-by-the Sea, New Brunswik, Canada
Rocky Mountain Neurosurgical Society: Annual Meeting, June, 2014, Hawaii
New England Neurosurgical Society: Annual Meeting, June 26-28, 2014, Brewster, MA
Western Neurosurgical Society: Annual Meeting, August 16-19, 2014, Sun Valley, ID

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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