CANS newsletter

President's Letter

Deborah C. Henry, CANS 2014 President and Associate Editor

California, like the rest of the nation, continues to struggle with the cost of medical care. As doctors, we remain the most visible human health care cost, thus we are often viewed as the source to solve any monetary problem either through cuts in our payments or services or occasionally as a resource to understand the complexity of the cost of providing medical care.

In past decades, we earned significant respect in society and sufficient reward financially for all the hours we devoted to our careers. Hand in hand with the respect we gardened were the high ideals we carried. Next to the clergy, no one was held in higher esteem and with more moral integrity than one's personal physician.

Our status among the ethically elite and financially secured has eroded over the years, so much so that we have been demoted to health care provider and our service deemed equivalent to those with less education and experience. But perhaps no single insult is greater than the recent push in California via the trial lawyers to introduce on the ballot an initiative to raise the punitive damages cap on malpractice cases. However, like most initiatives, hidden in its body is the intent to require mandatory, random drug screening. Now I know that there must be impaired physicians, though this number undoubtedly pales in comparison to the impaired drivers. Additionally, impaired lawyers have probably addressed the courtroom. However, with an initiative that promotes guilt before innocence, are we not driving a wedge further between us physicians and our patients? How much does the bureaucracy of mandatory random testing increase medical costs? Imagine introducing a breath analyzer in every car, every OR, every courtroom. Just because you can do this does not mean you should.

By 2025, the American Association of Medical Colleges predicts a shortage of 130,600 physicians, equally spread between primary care and specialists. Medical school debt continues to rise at approximately 6.3% a year to $170,000 in 2012. When Bill Clinton was president, the median debt was $50,000 (1992), as a society, we need to make it easier for those qualified to become a well-rounded, educated physician, not more difficult. Then, as in any business, the goal is to keep those physicians practicing as it is to keep those good employees. Losing good physicians through either the financial or mental and physical stress of practice is the mostly costly for everyone. ❖

INSIDE THIS ISSUE:

What you are Worth is up to You--Mostly

Randall W. Smith, MD, Editor

The Obamacare generated California insurance exchange known as Covered California has been relatively successful as compared to other state run exchanges or the hapless federal exchange. Patients have been pretty successful in signing up for one of the plans offered by the CA exchange but have been frustrated by the misinformation they have been given by the Web site as to which docs are on an insurance offering provider list (Kaiser's health plan excepted). Because of this, the provider lists have been removed from the Covered California Web site twice for revision, once in October/November and most recently in early February and the list is not scheduled to be reinstated until autumn.

Even the provider lists maintained by the insurance companies have proven to be pretty inaccurate and there has been finger pointing by the insurance companies complaining that docs who have turned patients away were in error and were indeed contracted while the docs maintain that they did not sign a contract for those company plans. The truth as usual probably lies somewhere in between but we think one of the problems has been that the insurance companies published provider lists were/are more of a wish list than a done deal. We suspect that a whole lot of docs refused to sign the contracts offered because of the compensation rate but the health plans continued to put those docs in their provider lists presuming we would all bow down and accept their crummy compensation rates just for the purported wonderful volume kick we would get and that working harder for less per patient is something we are pleased to do for them.

We sincerely hope that the docs that didn't sign up got a new contract offer at an acceptable rate and that as the published provider lists become mostly accurate, it will be because the docs held out for what they think they are worth and not what the insurance industry thinks they are worth. ❖

CANS MISSION STATEMENT

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

DO YOU KNOW A NEUROSURGEON NEW TO CALIFORNIA?

Tell them about CANS and Direct them to the CANS website: www.cans1.org! There is a membership application on the site!

Meet Your President-Elect

Phillip Kissel, MD, is a central costal neurosurgeon having practiced in San Luis Obispo since he joined a senior colleague there right after his residency at UC Davis. Phil got his BA in Biology at UCSD and then his MD at the Chicago Medical School at Rosalind Franklin University. He returned to California for his internship at UCLA and then on to UCD. He has been the mainstay of neurosurgery in SLO and at the Sierra Vista Regional Medical Center for over 20 years and is a well-known fixture in this town of 45,000 where he lives with his wife Janice on a few acres with assorted animals especially horses which Janice raises professionally. He remains a solo practitioner (read: on call EON) but still found time to be Chief of Staff at Sierra Vista and continues his passion for surfing. The Kissel's three adult children are well launched as a pediatric resident in Cincinnati, a UCD Vet school freshman and a Northwestern film school graduate.

Phil joins two other costal neurosurgeons who have been CANS President (Mel Cheatham and Moose Abou-Samra, both from Ventura) and is a reflection of his commitment to CANS when just staying home and minding the store would have been a lot easier. He joined CANS in 1987 and has served as a northern Board director, Treasurer, Secretary and 2nd Vice-President. His forthcoming tenure as CANS President should be marked by congeniality and hard work which will reflect his pleasant, sensible and reliable personality. ❖

Brain Waves

Deborah Henry, MD, Associate Editor

Did you watch the Olympics? I can recount my life on the moments of Olympic history- from Nadia Comaneci scoring the first perfect 10 to Kerri Strug vaulting with a sprained ankle, to Debbie Thomas winning the bronze medal in the free skate in 1988. Debi Thomas you say? Yes, I remember her for many reasons: she was an African American ice skater, nearly unheard of at the time, she was named Debi (a name I am partial to), and she eventually went on to medical school. Then there is Dot Richardson, the softball pitcher from southern California who won the gold medal in 1996. Both Debi and Dot trained in the art of orthopedic surgery at southern California institutions.

One of my favorite events this February was the American sweep of the medals in slope style skiing. The gold medalist Joss Christensen, just 22, almost did not make the team. He learned a switch triple 1440 jump two days before his gold medal performance and had the guts to

insert it into his program. What an amazing accomplishment from a young man who lost his dad 5 months earlier. Gus Kenworthy, the 21 year-old silver medalist, is now infamous for bringing home four stray puppies and their mom. And 19 year-old Nick Goepper sold candy bars and mowed lawns to get a ski pass, something he needed to do if he was going to learn snowboarding in Lawrence, Indiana.

What all these athletes have in common is an immense dedication to their sport and to achieving the best that they can do. They persevere despite amazing personal challenges. They constantly push themselves to the limit.

Sometimes I am asked what it takes to be a physician. Having been surrounded by amazingly intelligent and devoted individuals since medical school, I often forget the dedication that it required. However, the tools needed to succeed as a neurosurgeon surpass dedication and intelligence and include stamina for long cases and long days and the ability to withstand the emotional roller coaster of tremendous highs of saving lives and the darkest lows of losing them. Maybe we could give out Olympic medals with medical degrees. Or maybe I still have time to learn curling. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

Many changes have taken place in our practice of medicine, especially for those of us who are older and remember what is was like to practice years ago.

Initially, in my experience, all physicians knew and interacted with each other. Interpersonal discussion between colleagues of the same specialty as well as trans-specialty communication about patient care was the norm. This practice of physician collaboration was very frequent and was appreciated, not only by the treating physician, but by patients as well.

However, few of us recognize the practice of medicine these days. Electronic records, standardized computer forms for nurse and physician input, and the emergence of hospitalists and physician-assistants have really changed the delivery of care. Indeed, all of these appear to limit the treating physician's role in patient care. Perhaps most troubling is what seems to be the lack of personal contact and relationship between the physician and patient. Unfortunately, most internists and other specialists no longer go to the hospital to care for patient needs. Further, the patient may not be aware of or appreciate what is being offered by such a hospitalization: the original treating physician is likely not to participate in hospital care or even visit their hospitalized patient. Lastly, as the delivery of medicine becomes more "efficient" with the implementation of Obamacare (by inserting the government in the physician-patient relationship), I suspect that the lack of personal contact between and among physicians and between physicians and patients will become more apparent.

This development, in my opinion, is not good for medicine. ❖

CANS NEEDS SOME HELP!

Ken Blumenfeld, MD CANS Treasurer, is also the Chairman of the CMA Council on Legislation (COL). Ken was a longtime member of the council representing CANS but as Chair, can no longer represent CANS. Ken is looking for an interested CANS member to join him on the Council. The CMA COL formulates policy recommendations to the Board of Trustees regarding sponsored legislation or positions on anticipated major legislation affecting physicians. The council generally meets twice a year in person, with telephone conference calls, as needed, to address amended legislation. All council members must be CMA members. Contact Ken at **kennethblumenfeld@mac.com** if you are interested in serving.

To be part of the Council of State Neurosurgical Societies—volunteer here!

The Council is holding its spring meeting in San Francisco on April 4-5 just before the annual AANS meeting. This deliberative body, composed of delegates from each state's neurosurgical society, is designed to make recommendations (as well as to do some work on its own) to the AANS/CNS that come from grass roots neurosurgeons in the various state societies. The meeting begins at noon on Friday the 4th and ends at noon on Saturday the 5th with its major goal to hold numerous committee meetings (at which all delegates are welcome) and to consider resolutions submitted by delegates and state societies (see the resolutions for SF elsewhere in this newsletter). Each delegate gets lunch on Friday, a reception Friday night, breakfast on Saturday morning and lunch on Saturday. Delegates need not attend the AANS meeting. Delegates need to be members of either the AANS or CNS. Any CANS active or senior member who would like to attend the meeting as a delegate representing CANS should **contact the CANS delegation leader Deborah Henry at** dchenry.md@gmail.com.

Tidbits from the Editor

Private practice: the typewriter of the future

It is difficult to know just how much the chance of being independent and working for oneself rather than a company motivated people to go to medical school in the past. This writer personally never thought much about it but it was pretty much presumed that we all would become small business persons just like docs had been for eons if you didn't count Kaiser and the military. I mean, how difficult could it be to rent an office, get some equipment (including a high-tech electric typewriter) and a person or two, hang out the shingle, see who showed up, bill the insurance companies and Medicare what we thought we were worth and get paid exactly that? Such is what we had in 1970. We were fat, dumb and happy.

Then came the Federal bean counters and Medicare pay started a long dive, the insurance companies shrank their pay scale and increased their paperwork all of which was crowned by RBRVS, HMO's, PPO's and a flurry of paperwork that kept one employee working full time to satisfy even in the leanest solo practice.

In 1970 we had a contract with our patients to do our best and the sole wolf at the door came in the guise of a med mal plaintiff lawyer. These days our contract is with the money changers and their multitudinous rules as to what's OK and purported to be quality. We are still held to a very high standard as we care for the sick but such commitment is deafened by the myriad requirements involved in running a private practice office in 2014.

Little wonder then that Merritt Hawkins, a physician placement firm, recently noted that in 2013 64% of job offers they filled involved hospital employment versus 11% in 2004 and they expect the employment jobs to constitute 75% of filled offers in another two years. The AMA notes that about 60 percent of family doctors and pediatricians, 50 percent of surgeons and 25 percent of surgical subspecialists – such as ophthalmologists and ear, nose and throat surgeons – are employees rather than independent. Those numbers mean that three-quarters of neurosurgeons are still relatively independent (and masochistic). So this means that our President-elect Phil Kissel will probably die before giving up his independence while his pediatrician-in-training daughter's chances of being independent when she turns into a butterfly will be essentially zero. She will be served up to a hospital system—on a platter.

AANS takes a first step—we need CNS to follow—and a second step

As AANS President Bill Couldwell promised, by-laws changes have been introduced via the AANS By-laws Committee and the AANS BOD that will reduce the AANS annual meeting attendance requirements from once every three years to once every 5 years. The changes will be discussed at the annual AANS business meeting April 7th in San Francisco. If passed by an electronic vote of the AANS membership in May, it will apply to AANS members in the fellow, provisional and associate category. It's a little unclear whether Lifetime members will have to attend one in five meetings but since Lifetime Members who are permanently and fully retired from operative neurosurgery need not maintain current medical licensure or Maintenance of Certification by the American Board of Neurological Surgery it would seem they should not be required to attend meetings. Maybe the By-laws Committee should consider some clarifying changes.

The reason stated for the change is "*To address increasing burdens on members' professional time and travel availabilities*". Now if the CNS would institute a similar change to their by-laws, it would mean that attending two meetings every 5 years would be enough to maintain respective membership in both organizations. This is a good beginning. Now we need to work on discontinuing the AANS and CNS requirement for a certain number of CME hours every three years to maintain membership. We need to have the AANS and CNS provide the CME opportunities but we don't need them to police our CME's. A good member should adhere to the ethics and goals of the organizations, partake in the organization's activities (attendance requirement) and pay dues but the number of CME hours we obtain are the appropriate concern of the ABNS MOC process and our various state licensing boards and not the AANS and CNS.

CANS Board Meeting March 1st

The CANS Board of Directors met this last Saturday at a hotel at LAX and highlights included:

1. CANS filed a clarification with Noridian, the CA Medicare intermediary, about the clinical requirements for Vertebral Augmentation in patients with compression fractures to improve the likelihood of approval.

2. Adopted a budget for this fiscal year that continues to suffer from a considerable number of members that don't pay their dues—44 have yet to pay 2013 dues.

3. Noted good news and bad news about the 2014 annual meeting in Monterey—the meeting resulted in almost 20K in profit but was only attended by 41 CANS members (out of 179 active and 65 senior members). The support of 31 exhibitors made the P&L difference this year but future attendance by exhibitors may be impacted by limited meeting attendance.

4. Confirmed the Balboa Bay Resort in Newport Beach as the location of the January 16-18, 2015 CANS annual meeting.

5. Took positions on the resolutions to be considered at the Council of State Neurosurgical Societies meeting to be held in San Francisco on April 4th and 4th (See resolutions and CANS' position below).

The following resolutions will be considered at the CSNS meeting in San Francisco on April 4th. Any CANS member can provide input to our delegation Chair dchenry.md@gmail.com. The CANS BOD positions on the resolutions are listed in italics.

RESOLUTION I *(Support)*

Title: Creation of a Resident Occupational Safety Protocol
Submitted By: Doniel Drazin, Chaim Colen

WHEREAS, there is an increasing awareness of occupational hazards to surgeons and the lifelong implications of such hazards; and

WHEREAS, an essential component of protecting neurosurgeons, operating room staff and patients from occupational hazards is thru fostering the culture of safety within neurosurgery; and

WHEREAS, by educating neurosurgeons and their operating room staff to adopt new occupational hazard protocols; and

WHEREAS, a lower incidence in occupational events can be achieved without changing any surgical maneuvers or protocols; and
WHEREAS, the ACGME has not established guidelines for monitoring occupational hazards in neurosurgery residents and there is currently no uniform protocol across all residencies to monitor and report occupational events; therefore
BE IT RESOLVED, that the CSNS assist the SNS/AANS/CNS to establish guidelines on monitoring occupational events to neurosurgery residents in training and develop criteria for monitoring occupational hazard exposure during residency.

RESOLUTION II *(Neutral-await debate)*

Title: Towards More Effective and Efficient Resolution Authorship
Submitted by: Gary Simonds, MD
WHEREAS, resolutions are the critical drivers of the deliberative and productive processes of the CSNS; and
WHEREAS, resolutions can be hastily cobbled together, loosely organized, and difficult to follow and understand; and
WHEREAS, resolutions with important concepts and/or action plans can be shelved due to poor construction; and
WHEREAS, the original intent and concern(s) of a resolution's author(s) can be completely lost in the reworking of a poorly constructed resolution; therefore
BE IT RESOLVED, that authors of CSNS resolutions familiarize themselves with the resolution writing process by reviewing the "Resolution Guidelines" section of the CSNS website prior to resolution submission; and
BE IT FURTHER RESOLVED, that authors of CSNS resolutions review previous resolutions listed in the "Resolutions" section of the CSNS website prior to resolution submission; and
BE IT FURTHER RESOLVED, that a "hard stop" is created in the resolution submission process where authors are asked to attest to their review of the "Resolution Guidelines" and "Resolutions" sections of the CSNS website prior to resolution submission; and
BE IT FURTHER RESOLVED, that the CSNS considers production of a powerpoint and/or video presentation on the effective and efficient authorship of resolutions; and
BE IT FURTHER RESOLVED, that said powerpoint/video presentation is made available in the "Resolution Guidelines" section of the CSNS website, and is distributed electronically to all State Neurosurgical Societies.

RESOLUTION III *(Support)*

Title: Socioeconomic Posters at the CSNS National Meetings
Submitted by: Gary Simonds, MD
WHEREAS, attendees of the CSNS national meetings do not necessarily stay for the ensuing CNS or AANS national meetings; and
WHEREAS, attendance of socioeconomic poster sessions, and CSNS presentations and seminars, at CNS and AANS national meetings is often sparse; and
WHEREAS, members of the CSNS therefore often miss socioeconomic presentations of original scholarly work at CNS and AANS meetings; and
WHEREAS, members of the CSNS may be quite unaware of the diligent work in socioeconomic studies being done by their colleagues; and
WHEREAS, the CSNS national meetings provide an ideal forum for poster presentation of CSNS-derived socioeconomic scholarly works; and

WHEREAS, such presentations at the CSNS national meetings would likely reach a potentially larger and more invested audience that they do at the CNS and AANS national meetings; and
WHEREAS, further exposure of CSNS-derived socioeconomic scholarly works would likely serve to reward the efforts of authors, and inspire further investigation and scholarly work in CSNS members; therefore
BE IT RESOLVED, that socioeconomic scholarly works, surveys, and white papers, produced by CSNS members, are solicited and selected for poster display in the plenary session hall throughout CSNS national meetings; and
BE IT FURTHER RESOLVED, that CSNS fellows are particularly encouraged to submit work for such displays; and
BE IT FURTHER RESOLVED, that works selected for display are also archived on the CSNS website.

RESOLUTION IV *(Oppose- unsure of intent)*

Title: Study of the Socioeconomic and Ethical Implications of Informed Consent in Neurosurgery
Submitted by: Gary Simonds, MD
WHEREAS, specialty medicine, in particular neurosurgery, has become exceptionally complex and sophisticated; and
WHEREAS, the amount of time budgeted for a neurosurgeon to evaluate a patient, synthesize their problems into a diagnosis and action plan, and educate the patient about every facet of their diagnosis and planned therapeutic intervention, is relentlessly decremented ; and
WHEREAS, the heightened complexity of neurosurgery as a specialty and the diminished available time for surgeons to educate and counsel their patients raises the question of whether true "informed consent" for neurosurgical interventions can routinely be arrived at in the modern clinical setting; and
WHEREAS, the socioeconomic impact of ill-informed and incompletely consented patients in neurosurgery can be profound; and
WHEREAS, such impact would not necessarily be solely medical-legal in nature, but may also greatly effect patient selection, patient acquiescence to interventions, performance rates of various procedures, and the establishment of an ethical patient-surgeon relationship; therefore
BE IT RESOLVED, that the CSNS formally studies the issue of Informed Consent in Neurosurgery; and
BE IT FURTHER RESOLVED, that such a study may involve surveys, interviews, legal consultation, collation of anecdotes and other methods in order to generate a white paper and plenary session presentation.

RESOLUTION V *(Support)*

Title: Resolution submissions citing prior related work
Submitted by: Lawrence M. Shuer, MD, FAANS, CANS
WHEREAS, some resolutions presented for consideration to the CSNS often have some connection or relevance to resolutions previously presented to this body; and
WHEREAS, it is beneficial for both the authors and the members of the CSNS to review resolutions that may be repetitive or in some way related to resolutions previously debated and considered; and

WHEREAS, the CSNS website now maintains a searchable listing of resolutions submitted as well as the final outcome of the resolutions; therefore
BE IT RESOLVED, that persons submitting new resolutions be expected to search the database and reference any related resolutions in the body of the submission or else by footnote so that all are aware of any related resolution previously considered.

RESOLUTION VI *(Support)*

Title: Removal of CME requirement to maintain AANS/CNS membership
Submitted by: California Association of Neurological Surgeons
WHEREAS, the AANS and CNS are recognized as providers of excellent Continuing Medical Education as is consistent with their mission statements but the requirement to obtain a certain number of hours of CME to maintain membership does not bear any clear relationship to those mission statements; and
WHEREAS, obtaining CME credit hours clearly falls within the purview of state licensing boards and the American Board of Neurological Surgery in order to maintain licensure and certification as it pertains to safeguarding and improving quality medical care; and
WHEREAS, requiring CME hours to maintain AANS/CNS membership is redundant and serves to add to the administrative burdens of neurosurgical practice without a clear benefit for either patients or neurosurgeons; therefore
BE IT RESOLVED, that the Council of State Neurosurgical Societies request that the by-laws committees of the AANS and CNS submit to a vote of their memberships a change in their respective by-laws that removes the CME requirement for maintaining membership.
Fiscal Note: None; the resolve falls under routine committee functions of the AANS/CNS
References:
CNS bylaws Article IV, Section 3, D. Active Members residing in the United States, Canada, or Mexico shall be required to obtain a minimum of 90 Category I continuing education credit hours for every three-year period.
AANS bylaws Article III, B, 3. Fellows and Provisional Members shall be required to document receipt of the Continuing Education Award in Neurosurgery at least every three years and to attend at least one of every three consecutive annual meetings of the Association.

RESOLUTION VII *(Oppose-redundant)*

Title: Development of Educational Materials to Prevent Wrong Level Spine Surgery
Submitted By: Kristopher T. Kimmell, G. Edward Vates
WHEREAS, the Joint Commission has identified wrong site surgery as a critical sentinel event that is targeted for reduction in the current culture of health care quality improvement; and
WHEREAS, several surgical organizations (including the American Academy of Orthopedic Surgeons and the North American Spine Society) have developed programs to address this issue, in addition to the Universal Protocol created by the Joint Commission in 2003; and
WHEREAS, despite these initiatives, wrong site surgery still persists; and
WHEREAS, the rate of wrong site surgery for spine surgeons is higher compared to other surgical specialties based on reports in the literature; and

WHEREAS, recent surveys demonstrate that nearly half of all spine surgeons will be involved in a wrong level spine surgery in their career; and
WHEREAS, the professional and medical-legal ramifications of a wrong level spine surgery can be significant to surgeons; therefore

BE IT RESOLVED, that the CSNS develop educational materials for residents and practicing neurosurgeons on possible techniques and practices that may reduce the likelihood of a wrong level or site surgery, as well as communication strategies that can be used when an incident occurs.

RESOLUTION VIII *(Support)*

Title: Educating the public about restrictive practices of health insurance companies

Submitted by: Minnesota Neurosurgical Society

WHEREAS, surgical care for spinal disease (fusion) has come under increasingly onerous and unvalidated restrictions by some health insurance companies with regards to mandated pre-approval; and

WHEREAS, this pre-approval process is unclear, time consuming, expensive and may unnecessarily delay needed care for patients; and

WHEREAS, there is little or no evidence to support most of the requirements of the pre-approval; and

WHEREAS, recently developed health care exchanges such as MNSure do not provide such information in order to compare the health insurance companies; therefore

BE IT RESOLVED, that the CSNS support the efforts of the Minnesota Neurosurgical Society to study this issue with the intention of establishing a grading system and ranking of insurance companies in the state of Minnesota based upon their findings that will be publicized; and

BE IT FURTHER RESOLVED, that the CSNS make this information available to its membership so that it could be used as a prototype for similar initiatives in other states.

RESOLUTION IX *(Support)*

Title: The creation of a working group to provide up-to-date education regarding the management of anticoagulation and anti-platelet therapy in neurosurgical patients.

Submitted by: Wayel Kaakaji, MD, Medical Practice Committee

WHEREAS, there exists a new generation of anticoagulant and anti-platelet medications for the prevention and management of stroke, atrial fibrillation, and venous thrombotic disease; and

WHEREAS, no consensus exists in the literature regarding the appropriate management of these patients peri-operatively; and

WHEREAS, neurosurgeons are called upon to manage these patients emergently in the setting of cranial or spinal hemorrhage due to iatrogenic coagulopathy; therefore

BE IT RESOLVED, that the CSNS will create a working group to investigate the current state of knowledge regarding the management of iatrogenic coagulopathy in the perioperative setting, as well as in the setting of central nervous system hemorrhagic and traumatic events; and

BE IT FURTHER RESOLVED, that this working group will provide periodic updates as new therapeutic agents and protocols become available;

BE IT FURTHER RESOLVED, that this working group will coordinate with the Trauma joint section and other joint sections to collect and disseminate such education for the use of all neurosurgeons using appropriate print and online media.

RESOLUTION X *(Neutral-await debate)*

Title: Centralization of Insurance Approval for Commonly Denied Neurosurgical Procedures
Submitted by: Darlene Lobel, MD, Medical Practices Committee

WHEREAS, the process of reviewing appropriateness of neurosurgical procedures varies greatly among various insurance companies; and
WHEREAS, decisions regarding approval or denial of procedures are frequently not based on up to date guidelines and the most current medical literature; and
WHEREAS, this process results in frustration for patients who have been recommended for neurosurgical procedures due to delays or denials for surgery; and
WHEREAS, providers are diverted from direct patient care obligations in order to petition reviewers during PEER to PEER calls; and
WHEREAS, cases requiring PEER to PEER review are often assigned to non-neurosurgical providers, resulting in frequent denials even on appeal; and
WHEREAS, centralization of a process for insurance approval may result in lower medical costs to patients by improving bureaucratic efficiency; and
WHEREAS, establishing a standardized protocol for the initial review process would increase transparency of insurance company reviews; and
WHEREAS, establishing a core group of neurosurgeons willing to serve on a subspecialty specific advisory group may streamline and shorten the process for case reviews; therefore
BE IT RESOLVED, that the CSNS establish a working group to develop a standardized protocol, in collaboration with AANS/CNS joint sections for respective subspecialties, for initial review of cases that commonly receive queries or denials; and
BE IT FURTHER RESOLVED, that the CSNS work with the AANS/CNS joint sections to establish an advisory group for subspecialty procedures that will provide consultation to insurance companies regarding updated guidelines and relevant scientific literature;
BE IT FURTHER RESOLVED, that the CSNS initiate a pilot program, in which a single specialty specific protocol will be introduced, along with the advisory group, to an insurance company at the local or state level, for consideration for adoption as a standard of care.

RESOLUTION XI *(Support)*

Title: CNS Engagement With Osteopathic Neurosurgery For Resident Education
Submitted by: Gary Simonds, MD

WHEREAS, Osteopathic Neurosurgeons make up over ten percent of the American Neurosurgical workforce; and
WHEREAS, Osteopathic medical student output is growing at a significantly higher rate than Allopathic output (and thus driving the potential need for further Osteopathic residency expansion and/or creation); and
WHEREAS, despite the recent set-back in joint American Osteopathic Association and ACGME efforts towards universal accreditation of American residency training programs, the overwhelming sentiment is that such universal accreditation through the ACGME is inevitable; and
WHEREAS, anticipation of such an eventual shared accrediting process argues for a convergence of educational activities rather than a divergence; and

WHEREAS, although current Osteopathic residency standards and requirements significantly mirror those of Allopathic neurosurgery, a risk of a divergent drift exists if the two disciplines do not actively engage, and share conceptualization of neurosurgical resident training; and
WHEREAS, Osteopathic Neurosurgical Residents are limited in their access (through outright prohibition or greater economic burden) to the vast array of superb educational opportunities provided by organized Allopathic Neurosurgery; and
WHEREAS, there exists no formal (or informal) engagement, interaction, exchange, dialogue, or discourse between educators in Osteopathic and Allopathic Neurosurgery; and
WHEREAS, the CNS specifically tasks itself with, and is uniformly recognized and celebrated for it efforts in, the advancement of education and scientific exchange in neurosurgery in order to positively effect lives worldwide; and
WHEREAS, the CNS is in an exceptional position to lead in, by example, the opening up of educational opportunities and discourse to all U.S. neurosurgical trainees; therefore
BE IT RESOLVED, that the CSNS formally requests that the CNS extends to residents training in American Osteopathic residencies unlimited and equal access to all organizational educational activities such as conferences, on-line resources, and courses; and
BE IT FURTHER RESOLVED, that the CSNS requests that the CNS encourages and urges the formalized open exchange and sharing of resident educational discourse, philosophies, methods, theories, and resources between directors of Allopathic and Osteopathic Neurosurgery Residencies. ❖

Thought for the Month

Laugh when you can, apologize when you should, and let go of what you can't change.

Meetings of Interest for the next 12 months:

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 Brunswick, Canada
Rocky Mountain Neurosurgical Society: Ann. Meeting, June 14-18, 2014, Victoria, B.C., Canada
New England Neurosurgical Society: Annual Meeting, June 26-28, 2014, Brewster, MA
Western Neurosurgical Society: Annual Meeting, August 16-19, 2014, Sun Valley, ID
CSNS Meeting, October 17-18, 2014, Boston, MA
Congress of Neurological Surgeons: Annual Meeting, October 18 - 22, 2014, Boston, MA
North American Spine Society: Annual Meeting, November 12-15, 2014, San Francisco, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 2-5, 2014, Amelia Island, FL
North American Neuromodulation Society: Annual meeting, 2014 TBA
Cervical Spine Research Society: Ann. Meet., Dec 4-6, 2014, Hyatt Regency Grand Cypress, Orlando, FL
CANS Annual Meeting, January 16 – 18, 2015, Balboa Bay Resort, Newport Beach, CA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, 2015, TBA
Southern Neurosurgical Society: Annual Meeting, 2015, 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. Deborah Henry 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.

Our mission is to improve the lives of patients who suffer from debilitating back, neck, or leg pain by creating cutting-edge products and procedures that revolutionize spine surgery.

CANS Board of Directors

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