CANS newsletter

President's Letter

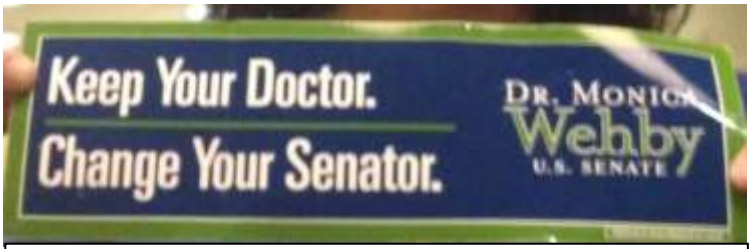
Deborah C. Henry, CANS 2014 President and Associate Editor

Your California delegation was well represented at the Council of State Neurological Surgeons in San Francisco on April 4th and 5th. Representing out Board of Directors were Phil Kissel, Ken Blumenfeld, John Ratliff, Moustapha Abou-Samra, Pat Wade, Marc Vanefsky, Larry Shuer, Randy Smith and myself. Dr. Ripul Panchal also joined us at his first CSNS meeting, and we were so pleased to have him there with us. After all, a big part of leadership is nurturing our future leaders.

From the left: *Dr. Wade, Dr. Blumenfeld, Dr. Ratliff, Dr. Wehby, Dr. Henry, Dr. Shuer, Dr. Kissel. San Francisco April 4, 2014*

Speaking of future leaders, a dear colleague of mine, Monica Wehby, is running for state senator of Oregon. Monica and I have known each other for a long time. She was in the 1988 graduating class of Baylor College of Medicine while I two years ahead of her. Being in the exclusive women going into neurosurgery club meant our paths often crossed. When they did, we would spend a few minutes catching up on each other's lives. She went on to become the first woman graduating resident from UCLA's neurosurgery program and then she headed off to the University of Utah for her pediatric neurosurgery fellowship. Since 1998, she has served the community of Portland, Oregon in pediatric neurosurgery.

Monica and I would tag team throughout medical school. Both of us were involved in the Texas Medical Society, but Monica took promoting change to an art form. She was Chair of the TMA's medical student section, a start to her budding second career. She moved on to serve as President of the Portland Medical Society, the Oregon Medical Association, delegate to the CSNS, and the Board of Directors of the AANS.



Join me in supporting Monica Wehby, M.D in her run for the next Senator of Oregon.

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INSIDE THIS ISSUE:

Highlights of CSNS Meeting in City by the Bay

Randall W. Smith, MD, Editor

The Council of State neurosurgical Societies met in San Francisco on April 4-5 and CANS was well represented by a full contingent of delegates including Drs. Henry, Kissel, Blumenfeld, Panchal, Ratliff, Abou-Samra, Wade, Vanefsky and Smith. All the actions taken on the 12 submitted resolutions are noted below. Of some interest were three reports beginning with the report given by Hunt Batjer of the RRC who indicated that the ACGME recognition of DO neurosurgical training programs has reached the point that if the DO training program wants ACGME recognition it must be directed or co-directed by an MD neurosurgeon and that it must pass an RRC inspection like all allopathic neurosurgery programs do. California's only DO neurosurgery training program at Arrowhead Regional Medical Center under the direction of Javed Siddiqi, MD would seem to be poised to fulfill the criteria which means that in the future, those DO's that complete the program would be allowed to take the ABNS exam as a completion requirement for the residency and be allowed to become ABNS certified after some time in practice and satisfactory complete of the ABNS oral examination.

Brian Asmussen, the President of NERVES, the national group for neurosurgical practice managers, reported that the most recent survey of their members indicated that the average take home pay for a neurosurgeon was $743K as a result of $942K in collections per neurosurgeon who on average turned out 10,300 RVU's per year which included 279 operations per neurosurgeon. He also noted that the average stipend for ED coverage was about $2,000 per 24 hours ranging from $1,500 for a private non-trauma hospital to $2,200 for a trauma center.

The politically active New Jersey Neurosurgery Society is currently employing a lobbyist to the tune of $4,000 per month. They are having a hard time knowing what they are getting for their 4K much as CANS did when it tried this some years ago. They are able to afford this lobbyist in great part because of their annual dues of $2,500/year (CANS dues are $350).

The actions on the 12 CSNS resolutions:

RESOLUTION I Creation of a Resident Occupational Safety Protocol
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
ACTION: Referred to Executive Committee (*This means the EC will assign implementation to a working committee and expect to report the result at a future CSNS meeting—Ed.*)

RESOLUTION II (Combined with Resolution V) Towards More Effective and Efficient Resolution Authorship
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 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.
BE IT FURTHER RESOLVED, that the resolution guidelines be amended to include a check list of suggested actions prior to resolution submission
ACTION: Adopted

RESOLUTION III Socioeconomic Posters at the CSNS National Meetings
BE IT RESOLVED, that socioeconomic scholarly works, are solicited and selected for display at the 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.
ACTION: Adopted

RESOLUTION IV Study of the Socioeconomic and Ethical Implications of Informed Consent in Neurosurgery
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.
ACTION: Rejected

RESOLUTION V Combined with Resolution II—see above

RESOLUTION VI Removal of CME requirement to maintain AANS/CNS membership
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.
ACTION: Rejected (*Presidents of the AANS and CNS noted that anyone pursing MOC will not be required to fulfill the respective organizations' CME requirement, that senior (CNS) and Lifetime Active (AANS) members need not pursue CME's {unclear per their posted by-laws} and active members of the AANS and CNS who are grandfathered ABNS certificate holders should have some CME requirements and unless and until the ABNS establishes such requirements, the AANS and CNS should require some CME by those active members—Ed.)*

RESOLUTION VII Development of Educational Materials to Prevent Wrong Level Spine Surgery
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.
ACTION: Rejected

RESOLUTION VIII Educating the public about restrictive practices of health insurance companies
BE IT RESOLVED, that the CSNS support the efforts of the Minnesota Neurosurgical Society to study this issue 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.
ACTION: Adopted

RESOLUTION IX The creation of a working group to provide up-to-date education regarding the management of anticoagulation and anti-platelet therapy in neurosurgical patients.
BE IT RESOLVED, that the CSNS petition the AANS and CNS to work with the CSNS to develop continually updated resources to which practicing neurosurgeons can refer when treating patients who are currently on anticoagulation and/or anti-platelet therapy.
ACTION: Adopted

RESOLUTION X Centralization of Insurance Approval for Commonly Denied Neurosurgical Procedures
BE IT RESOLVED, that the CSNS establish a working group to develop a common approach, 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 initiate a pilot program, in which a single specialty specific protocol will be introduced, to an insurance company at the local or state level, for consideration for adoption.
ACTION: Referred to Executive Committee (*This means the EC will assign implementation to a working committee and expect to report the result at a future CSNS meeting—Ed.*)

RESOLUTION XI Withdrawn by author.

RESOLUTION XII Disclosure of Conflict of Interest for CSNS delegates
BE IT RESOLVED, that CSNS recognize the need for COI disclosures by participants in CSNS plenary sessions and committees; and
BE IT FURTHER RESOLVED, that the CSNS consider mandating the use of the existing AANS/CNS COI Governance disclosure form at the corresponding AANS/CNS meeting as part of a mandatory electronic registration process for the CSNS biannual meeting; and
BE IT FURTHER RESOLVED that the CSNS work with the respective IT committees of the parent organizations to implement the seamless collection of COI disclosure for CSNS meeting registrants and reporting back of COI disclosure information to the CSNS meeting; and
BE IT FURTHER RESOLVED, that the CSNS conceive an appropriate way to disclose such COI information during the biannual meetings
ACTION: Adopted

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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!

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Brain Waves

Deborah Henry, MD, Associate Editor

I am in a dilemma. I have been here before with my father and his health. About a decade ago, his benign prostatic hypertrophy nearly led to renal failure and a life on dialysis. Somehow I thought that if the frequency and difficulty in urination bothered him enough, he would go see an urologist. It took a twenty-five pound weight-loss, jaundice skin, and a BUN of 70 to get him to go. His BPH was so severe that he had marked retrograde flow of urine and significantly dilated renal calyxes. Medications did not help (unlike the men in the fishing boat on the evening news), and he eventually underwent a transurethral resection of the prostate. Miraculously, his kidney function returned to almost normal.

More recently, he has developed increasing difficulty with his balance and trouble walking. His thinking is not as clear as in the past. Granted, since he has marked difficulty hearing even with hearing aids, it is hard to discern how much his trouble communicating maybe early dementia versus hearing loss. My friend's mom has such profound hearing loss that she just nods her head. Last time they were at the airport, the security person asked her if she was carrying any firearms or flammables, and she nodded yes.

My dad's gait disturbed me enough that I thought he might have normal pressure hydrocephalus. I mailed him a note to take to his doctor and suggested this diagnosis and at least a CT scan of his head. According to my dad, his doctor did not feel he needed any tests, and that he was too old for any surgery. At this time, he was probably in his early 80s.

The last time I was home visiting them in Houston, my mother volunteered that my dad was wetting his underwear. Clearly his gait had worsened; he started slower and was very unsteady if he stood too long. But now he is 87. He has always been fearful of doctors and hospitals, hence delay in diagnosing the renal insufficiency. Would he want brain surgery? My family is quite divided. My mother says "yes", my sister the physical therapist says an adamant "no", and my brothers won't weigh in on the decision. Ask my dad you say. I don't think I could explain informed consent to him. So here it is in my lap. I know I could force the issue and just get an MRI. If the ventricles are not dilated, we could end the discussion right there. However, if he never would agree to surgery, then I have become another consumer of an unnecessary test. But what if the ventricles are dilated? Lumbar punctures, ventriculoperitoneal shunt, third ventriculostomy? Or nothing.

In many respects, I wish his family doctor would have done the studies years ago and taken this decision off of my hands. But he didn't, perhaps because of ignorance of treating the disease or ignorance of the risk factors. Of course, if my dad did have NPH and was over shunted and developed subdurals, he could be dead now. He could have died from bacterial meningitis. But then again, perhaps he would be walking his mile on the treadmill each morning. Where is that magic crystal ball when you need one?

It's been thirty years since I was a medical student. I had no lectures on back pain. I am certain that there were none on normal pressure hydrocephalus. But I distinctly remember learning about Fanconi's anemia, Menkes kinky hair syndrome, and all those mucopolysaccharidoses. As neurosurgeons, we have gotten better at teaching our non-neurosurgical colleagues and the public about treatable neurosurgical diseases so that there is a higher likelihood that these patients come to our offices. But even with more informed healthcare providers, I think I might still be in this dilemma. ❖

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.

Tidbits from the Editor

Be Careful With Your Public Portal

For those of you out there who have a professional Website/portal that allows patients to communicate and interact with you, there are some ground rules of which you should be aware. An organization called Medical Justice, founded and run by a neurosurgeon, which helps in avoiding and combating med mal lawsuits, has recently published (medicaljustice.com; click on Blog) an article that should be helpful in avoiding legal problems that can arise as patients interact with your Website. As the article notes, ". . . patient portals can be a blessing or a curse.", so you need to create an agreement of how the portal will be used that binds both you and the patient.

Medicare Fusion Numbers—where there is smoke there may be/probably is fire

If you haven't heard the brouhaha related to the CMS release of physician Medicare payment data particularly as it pertains to spine fusions, you must be living under a rock. The 4/24/14 CBS report by Ben Eisler entitled "Tapping into controversial back surgeries" looked at some depth into the issue particularly as it pertained to 4 spine surgeons (two are supposed to be neurosurgeons but the article doesn't define the surgeons by specialty). In that report, he quotes Dan Resnick, Vice Chair of Neurosurgery at the University of Wisconsin School of Medicine and President of the Congress of Neurological Surgeons as saying that while the majority of spine surgeons are careful about recommending fusions, some may be "operating outside of the generally agreed upon

(based on common practice and literature supported guidelines) parameters." He indicated that Dr. Resnick also felt that Medicare, medical societies, and credentialing boards should use data like this to follow practice patterns and patient outcomes and that surgeons with the highest numbers should be looked at closely and asked to explain themselves.

One wonders just who should do the close looking and just what are the generally agreed upon parameters, the latter somewhat akin to defining pornography—we know it when we see it but it is hard to define.

Outside of hospital medical staffs (a few of which have pulled operating privileges of some of the high rollers only to have them move to another hospital—and sue the hospital that pulled the privileges) just who will pursue these theoretical excessive surgeons?

This writer thinks it will be hard to investigate the outliers as Resnick suggested. The CNS and AANS have professional conduct committees that might handle the action. Would the PCC's respond to a complaint? And if they did, what would they use as data? There are no public detailed medical records that could be obtained regarding the cases of "excessive" fusions that would allow dissection of what indications for surgery existed or did not exist. I don't think the PCC's have subpoena power.

State Medical Boards have the power to subpoena records and could launch an investigation for the safeguarding of the people of a state but since those state Boards are already busy dealing with myriad misbehavers, one suspects they would not pick up the fusion gauntlet particularly when it would be based on national data regarding a Federal program. Would the ABNS launch an investigation--and like the AANS PCC, what would they use as medical information about the cases? I think they would pass unless a state Board pulled a neurosurgeon's license.

The oversight for this is primarily the Office of Inspector General and the Department of Justice under Medicare Fraud and Abuse. Although the Feds have lots of lawyers, this might be a pretty long shinny up a greased pole even for big brother considering there are no universally accepted and adopted guidelines about fusions against which one could be judged. That then leaves the Congress and the press, both known for bluster signifying nothing.

And so, I don't think anything is going to happen except the high rollers will drop back 5 yards and rehuddle, operate on fewer patients for at least a while and ultimately carry on business as usual unless and until there are mandatory guidelines for fusions adopted by Medicare (and subsequently the Blues) against which a surgeon could be judged, preferably with the Feds doing the judging.

Neurosurgery Training—Modern is better but the old days were nice

The American Board of Neurological Surgery recently published their 2013 Newsletter which detailed the requirements that a resident starting in July 2013 must satisfy in order to be eligible for ABNS certification. Residencies now have to be 84 months long and include exposure as a resident participating in some aspect of 60 craniotomies for adult brain tumor, 40 craniotomies for adult trauma, 40 craniotomies for adult intracranial vascular lesion, etc., etc. Total adult cranial procedures have to number at least 205, while 95 need to be adult spinal cases, 30 need to be various pediatric cases, 90 cases needing critical care management are required which along with 10 epilepsy cases result in a total of 430 cases in all these defined categories as documented in a log book maintained by the resident.

This writer was trained in the late 1960's in a program that was 5 years in length (as were most training programs) and included a year of research. I recall maintaining no log book so I can't say

how many cases of what I was exposed to. It was a simpler time with the program director signing off on my readiness to leave the nest and my realization that upon departure, I was not quite ready to be an independent practitioner and thus spent some years in academia getting seasoned before embarking on a solo private practice.

Time does march on and things are better documented and more thorough now. There is more to know these days, more stuff to master and I would like to think I played some role in creating some of that stuff. Yet as the better trained, better prepared resident spreads his or her wings these days, old folks can harken back to a time when there were fewer police and the neurosurgical welfare of the public was in the hands of honorable program directors whose word was their bond.

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Thought for the Month

"A good rule of thumb is if you've made it to thirty-five and your job still requires you to wear a name tag, you've made a serious vocational error."

(Dennis Miller)

Meetings of Interest for the next 12 months:

Nsurg. Soc. of Amer: Ann. Mt., June 8-11, 2014, St.Andrews-by-the Sea, New Brunswk, 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
Cervical Spine Research Society: Ann. Meet., Dec 4-6, 2014, Hyatt Regency Grand Cypress, Orlando, FL
North American Neuromodulation Society: Ann. meeting, December 11-14, 2014, Las Vegas, NV
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
AANS/CNS Joint Spine Section: Annual Meeting, March 4-7, 2015, Phoenix, AZ
CSNS Meeting, May 1-2, 2015, Washington, DC
AANS/CNS Joint Pain Section Bi-Annual Meeting, May 1, 2015, Washington, DC
AANS: Annual Meeting, May 2-6, 2015, 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. 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.

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