CANS newsletter

President's Letter

Deborah C. Henry, CANS 2014 President and Associate Editor

It is time to start planning the Annual Meeting of the California Association of Neurological Surgeons this coming January in Newport Beach. This will be the 42nd meeting of a proud organization that incorporated on July 20, 1973 when Secretary of State Edmund (Jerry) Brown affixed the Great Seal of the State of California and Cone Pevehouse served as our first president.

Times have not changed much in many regards since then. CANS was organized partially in response to the need for malpractice reform in the state. Because of excessive jury awards and the need to defend frivolous lawsuits, malpractice carriers increased premiums by as much as 400%. The California Medical Association website summarized the 1975 Los Angeles Times saying that eight thousand physicians in seven Southern California counties faced loss of their malpractice insurance. The situation was no better in the North as the San Jose Mercury reported that premiums were so high that physicians were leaving California or retiring, and many in high-risk categories were unable to obtain insurance.

Eight hundred healthcare workers rallied at the Capitol calling for a special session of the legislature. On May 19th, at the request of then Governor Jerry Brown, a special session was called. On September 11, 1975, the Malpractice Insurance Compensation Reform Act was passed and then signed into law twelve days later.

Now we have Proposition 46 on the November ballot whose official title is: Drug and Alcohol Testing of Doctors. Medical Negligence Lawsuits. Initiative Statute. The unofficial title is the Troy and Alana Pack Patient Safety Act of 2014 named for the children of Bob and Carmen Pack who were killed by a drunk and overmedicated driver. One part, section 1714.85 of the proposition, presumes professional negligence if the doctor tests positive for drugs or alcohol or if the doctor refuses to be tested, i.e. guilty first. The fiscal impact from raising the cap on medical malpractice is expected to "increase state and local government health care costs…likely ranging from the *tens of millions of dollars to several hundred millions of dollars annually* (www.ballotpedia.org). The measure is endorsed by Barbara Boxer.

Interestingly, Euclid had a proposition 46 that in simple terms states that with any straight line, one can always construct a square by making right angles to the line. Let's just hope that we can use the straight-line approach and say that this proposition has so many angles to it that none of them are right. ❖

INSIDE THIS ISSUE:

Letter to the Editor:

If I may, I would like to comment upon the CMA issue and the letter to the CMA written by CANS President Deborah Henry and published in the CANS June newsletter, which I firmly support. I have been comfortably retired for 11 years and out of the usual loop; however, before that I was President of CANS, Chairman of CALPAC, chaired the CMA Professional Liability Committee, sat on the CAPLI Board, sat in the CMA HOD, and represented the AANS for 7-8 years in the AMA HOD. As such, the issue is hardly a new one.

Problem #1 is that membership in the AMA is in real trouble and (although I don't know it for sure) I would suspect CMA has the same problem. Increasing number of doctors are finding little reason to belong to the CMA and wonder what benefits come from such membership. Decades ago membership took a huge upward tick when the malpractice crisis erupted - but that was a long time ago and the current physician population has lived under MICRA comfortably with little concern of the future. Short of finding their underwear held to the fire I fear more and more doctors will not belong and it makes it difficult for CMA to claim that it represents California physicians (even if there is no alternative).

Problem #2 is that CMA (and AMA) has historically felt that its foundation was the component county associations. It was these societies that provided the numbers of members that CMA claimed and historically CMA leadership bubbled up from the component societies. (When I first entered practice one had to belong to the county society to obtain malpractice insurance and most county societies had joint membership with CMA so one became automatically enrolled in both.) To the degree that specialty societies have represented increasingly the actual concerns of most physicians, CMA regards this as a threat rather than a plus. (This is even more fervently felt at the AMA level where the whole structure has rested upon component state societies).

Specialty societies have not always been loyal members and have often gone their own ways. CANS for a time was active in CAPP and contributed individually to it independent of CMA input. For the most part we sided with CMA, which has often battled with the liability carriers in MICRA-defense strategy (Steve Thompson really battled with them openly and intensely). At AMA this has been a problem where the specialty societies have formed virtually a competing group.

There has been a long question about what to do with specialty societies in the AMA HOD and, I am sure, in CMA leadership as well. At AMA the Specialty Section is held in some suspicion because it has grown to contain so many specialties (some are ridiculously minute but they still belong) and has become embarrassingly large. Ascent in AMA leadership from the Specialty Section is quietly discouraged. When I was Chair of Calpac and a vacancy occurred on the AMPAC Board I was bluntly told that while my recommendation was appreciated there was no intent to nominate me since I was a member of the Specialty Delegation (representing AANS) and not the California Delegation - surely just as well.

To repeat, I have been out of the loop for a long time. However, if push comes to shove, I would insist that CANS remain with a voice on the Council on Legislation and that notice be given that CMA can have either CANS positive participation or CANS will go its own way.

Anyway, I am not sure if this helps but I support CANS standing up firmly. I suspect you will not be alone.

George Koenig, MD
Palm Springs ❖

Guest Editorial

I am writing to encourage each of you to support the Neurosurgery PAC. It is the National lobbying arm of the AANS and organized neurosurgery. In coordination with the Washington Committee of the AANS/CNS, the PAC reaches out to our elected officials to make our position clear regarding important issues that affect all of us and the practice of neurosurgery.

I realize that each of us here in California, at the State level, is committed to the MICRA fight; indeed we must pool our resources to defeat Proposition 46. Disguised as a proposition that is meant to help discover impaired physicians by randomly testing them, its real purpose is to essentially repeal MICRA. We can't let this happen: MICRA is such an important legislation, it is the model that other states that are interested in tort reform are using. And there have been important successes.

But this is not enough to divert our attention from what is going on in Washington. A lot of work must be done on the National level to safeguard our interests as a profession.

In fact, this being an election year, the stakes are very high. There are several people running for Congress who are sympathetic to our cause, and several who are not. Your PAC needs the financial means to show our support to the people in Congress who are willing to go to bat for us.

Please contribute as generously as you can to your PAC. It is crucial that you do so. I will remind you that Neurosurgery PAC is a non-partisan group.

You may contribute online. It is a simple process that will take only a few minutes of your time. https://myaans.aans.org/MyAANS/DonationPAC.aspx

Thank you,

Moustapha Abou-Samra M.D.
Ventura, California
Board Member and Immediate Past Chairman /Neurosurgery PAC ❖

Sunshine Act requires Docs to jump through some hoops

Randall W. Smith, MD, Editor

The Sunshine Act continues to unfold and the Feds are now processing registrations from physicians so they can review and potentially challenge what a company plans to report about any company to doc payments. The CMS Enterprise Portal is now available for physicians to begin the registration process (Phase 1). **Note that registration in the Enterprise Portal is a separate process from registration in the Open Payments system.** But, Enterprise Portal registration is a required first step to allow for registration in the Open Payments system (see below).

Although registration in the Enterprise Portal and the Open Payments system is a voluntary process, it is required if the physician wants to be able to review and dispute any of the data reported about them by applicable manufacturers and applicable group purchasing organizations (GPOs).

- **Phase 1**: Includes user registration in CMS' Enterprise Portal. Use the Phase 1 Step-by-Step CMS Enterprise Portal Registration for Physicians and Teaching Hospitals presentation for guidance on how to complete this portion of the registration; this resource is also posted on the Physicians and Teaching Hospitals pages of the Open Payments website.
- **Phase 2:** Includes physician and teaching hospital registration in the Open Payments system, and allows you to review and dispute data submitted by applicable manufacturers and applicable GPOs prior to public posting of the data. Note: Any data that is disputed, if not corrected by industry, will still be made public but will be marked as disputed.

The Open Payments review, dispute and correction process begins on July 14 and ends on August 27. The initial 45-day period (July 14 through August 27) is for physicians to review and initiate any disputes they may have regarding the data reported about them by applicable manufacturers and applicable GPOs. The remaining 15-day period (August 28 through September 11) is additional time that has been provided to industry to submit dispute corrections. CANS Director John Ratliff has navigated the registration process and notes that it takes about an hour to work through the process which took about 4 tries because of site glitches. He did find, once registered, that the data the Feds had received about him was accurate.

Although each doc should receive notification from manufacturers and applicable GPOs if they plan to submit data about you to the Feds and exactly what the data is, you cannot rely on them to do so. Since a great majority of us don't get any largesse from anyone, going through the above noted registration is not necessary. If you did receive some compensation or suspect that some relationship you have with an outfit might qualify for reporting (such as getting a free dinner to listen to a company pitch), it is best to go through the registration process and check it out for accuracy. ❖

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

Jack Bonner, MD, Associate Editor

Choosing which medical school to attend is a very difficult decision. Since I grew up in Montana, a state without a medical school within its borders, I knew I would have to leave home to receive medical training. In my situation, I ended up a significant distance away from home, but was right where I desired: at the University of Chicago for medical school, Duke for surgical internship, and the University of Washington for residency. (I did consider returning to Chicago for residency, but chose to get a diversity of training by attending Washington.) While enrolling in different schools far from home required me to uproot, move, and establish new friends, most importantly, it brought with it exposure to many different training personalities and colleagues that I cherish to this day. From the reserved gentlemen who first taught me neurosurgery at Chicago, Sean Mullan and Joseph Evans, to the demanding Guy Odom at Duke, to the colorful Art Ward at

Washington, I think I am not overreaching when I say that these formative medical experiences helped make me a well-rounded neurosurgeon. Certainly, if nothing else, I learned to deal with a variety of personalities, which in itself is a good lesson. I think it was the Marquette Basketball Coach, Al McGuire, who advised that a good way to learn how to deal with people is to become a cab driver or bartender. While I was neither a bartender nor cab driver, I did live in different regions of the country, and care for individuals with wide ranging attitudes and beliefs, which I consider a benefit. Fortunately my choices were very good and pleasant. Unfortunately, not everyone has noted this experience with their choice of medical training.

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There is much uncertainty in Medi-Cal renewals. Currently, about 600,000 individuals are waiting for applications to be assessed. Some of these are patients who applied since last year. These patients are still wondering whether needed care is adequately covered. It is not clear to me, since many physicians cannot afford to take such low reimbursement offered by Medi-Cal, whether these many individuals will remain without adequate care -- or without any care at all. The Obamacare aspect is not a developed program, but a work in progress. Our future as physicians, as well as the future in providing medical care to the public, is still uncertain. ❖

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!

Brain Waves

Deborah Henry, MD, Associate Editor

Almost two years ago I became a community emergency response team member (CERT) for the Newport Beach area. I renewed my CPR, learned cribbing in order to create leverage to lift heavy objects off of an individual, and practiced how to triage appropriately in an emergency situation. Skills acquired are put to the test in a Drill the Skills day where local high school students perform community service hours acting as injured victims. Triaging was harder than I anticipated. One quickly accesses mental status, breathing, and capillary refill. In a disaster situation, after two attempts of checking respirations, if the individual is unconscious, not breathing, and their capillary refill is greater than two seconds, they are left to fate and attention is turned to those with a higher likelihood of saving. Leaving a potentially salvageable patient was difficult at best. My first assignment with CERT, however, was not a disaster situation. Last weekend, the CERT volunteers were called out to do something never done before in the City of Newport Beach. We were asked to serve at the paddle-out and memorial service of lifeguard Ben Carlson.

Ben Carlson was a fifteen-year seasonal lifeguard at Newport Beach. In his 32 years of life, he had learned to become one with the water. He loved to surf, swim, and play water polo. On the 4th of July weekend, waves swelled to twelve feet and dangerous rip currents endangered the shoreline. On Sunday, July 6, a swimmer struggled in the water. The Newport Lifeguards had already made 200 rescues that weekend. Around 5PM, Ben dove in from the rescue boat in an effort to save the swimmer. The turbulent waves drove Ben under the water. His body was found 3 hours later. The swimmer made it to shore and survived. In Newport's 100-year lifeguard history, this was the first loss of life in the line of duty. My first CERT duty was to hand out flowers to some of the 2000-plus people who paddled out into the Newport waters in recognition of the life and service of Ben Carlson. The dedication and irony of a life lost while attempting to save a swimmer still brings tears to my eyes, and I suspect it will for some time to come.

This past week, a Liberian doctor, Samuel Brisbane, died from Ebola virus and a 33 year-old American physician, Dr. Kent Brantly, and another American volunteer have contracted the viral illness. All had responded to the nationwide outbreak that has claimed more than 670 lives in West Africa. To die doing something you truly love in the service of others is a sacrifice beyond anything Hippocrates ever imagined. Rest in peace Ben and Samuel. ❖

Tidbits from the Editor

ESI's not helpful in stenosis

It has never been clear as to why epidural steroid injection (ESI) should be beneficial in patients with central canal lumbar stenosis (LSS) and neurogenic claudacatory leg symptoms. This entity is a bit unlikely to involve inflammation of anything and this writer's personal experience was so poor as to basically stop ordering them to treat LSS. One must admit there was the very occasional patient who did seem to respond but the risk/benefit ratio was really low. The PCP, Neurology, Physiatric and Anesthesia/Pain crowd always used them and as a neurosurgeon, I could never know how much success there was in patients who, because of the great success of the ESI, I never saw. Now comes a study in the July 2nd issue of the New England Journal of Medicine that took 400 patients with LSS + leg symptoms and gave 200 ESI's and 200 got Lidocaine alone. ESI's were no better than Lidocaine alone but there was no "no injection at all" control group.

This kind of study is helpful but considering the lack of a true control group and the propensity of the injection crowd to do what they do, there may be more study work necessary to curtail the Medicare 500,000 LSS/ESI/year industry.

Online Program Gives Retired Docs Second Career as PCP's

When a neurosurgeon retires and ceases practice (no patient care, no assisting, no consulting), it always struck this writer that there was a lot of horsepower going to waste with no professional outlet. As we know, you can't really do part-time full care/operative neurosurgery; generally you are in or you are out. Doing some general medical clinic work on a part-time basis was an option but who felt competent to act like a GP after a 35+ year distance from medical school?

Recently, Laura Bekin of *Physicians News Network* penned an article about Dr. Leonard Glass, a retired San Diego plastic surgeon who saw this issue as an opportunity and in 2010 founded Physician Retraining & Reentry (PRR) which offers a self-paced on-line program. PRR's chief medical officer, Dr. David Bazzo, told PNN that his job was to design the course along with other UC San Diego School of Medicine professors and primary care physicians. The PRR curriculum consists of 15 online modules. Participants are able to work through each course at an individualized pace before taking the final examination, which Dr. Bazzo said is done live at a location in San Diego (although the PRR Website says it can be taken on-line). Upon completion, graduates are awarded up to 180 hours of AMA PRA Category 1 credits from the UC San Diego School of Medicine and are able to start practicing provided they have an active medical license. Just who will hire graduates of this program is not clear but PRR has an employment service and will obviously tout their graduates as ready for family medicine. The program costs $8,500.

Dr. Michael Feely, a 71 year-old retired neurosurgeon from Pennsylvania now living near San Diego completed the PRR on-line course in 9 months and feels he is ready to work in a family health center or perhaps as a doc doing disability exams.

For any old salt neurosurgeons looking to get out of the house or turn another buck, more information regarding PRR is at http://www.prrprogram.com.

The Downside of Cabernet

Medical Justice, the anti-frivolous lawsuit outfit run by neurosurgeon Jeff Segal, posits the following:

You and your partner are the only neurosurgeons for a small community of 50,000 people. The draw area is larger, say 250,000. The closest major metro area is 80 miles away. And that city has a medical school, teaching hospitals, and full service trauma treatment. You and your partner alternate call for both the practice and the ER. Your partner is on call. You've had a long week, and are ready to kick back. In anticipation of the weekend, you just finished a large glass of Cabernet.

The ER calls and you pick up the phone. You didn't have to. But you did. There was a 3 car pile-up on the highway and the ER is full. You partner has already taken the most serious injury, a patient with a subdural hematoma, to the operating room. He's not expected out of the operating room for some time. The patient with the next most serious injury just returned from CT. He has a large epidural hematoma – and his neurological status is deteriorating quickly. The rest of his scan looks fine. And was awake and talking just prior to going to the CT suite. The ER knows you're not on call, but they hope you will help. They know that calling for the helicopter to transfer the patient to the adjacent metro area will take time. Even in the best of circumstances, the delay will cost a lot of neurons and perhaps the patient's life.

What do you do? Most neurosurgeons will say, "I'll be in shortly. Please help get the OR team in place." The reason: You know you can save a life and preserve function. The procedure isn't technically demanding. It will not take long.

Now put the above in California after passage of Prop 46 (the anti-MICRA and mandatory drug testing of all docs issue on the November 2014 ballot). Could you take the risk of a random blood sample being collected while you are in the doctor's lounge writing post op orders? The consequences of that glass of wine could prove devastating considering the reporting requirements of Prop 46. So the smart money is on never drinking and never taking that Vicodin your orthopod prescribed for your recurring right knee pain. And maybe never answering the phone when your are not on call.

BTF lists indicators of Concussion

The Brain Trauma Foundation (BTF) has analyzed over 5 thousand abstracts and 1362 full-text publications and has come up with the most prevalent signs and symptoms of mild traumatic brain injury. Their results were published in a special supplement to the journal *Neurosurgery*. The goal is to promulgate an evidence-based foundation for diagnostic and treatment guidelines. The study was authored by Nancy Carney, PhD (director of research for the BTF) and Jamshid Ghajar, MD, PhD (President of the BTF) and 9 other co-authors.

They found that the most prevalent indicators of concussion as observed in alert athletes (Glascow Coma Scale of 13 to 15) after a force to the head are:

- Observed and documented disorientation or confusion immediately after the event
- Impaired balance within 1 day after injury
- Slower reaction time within 2 days after injury
- Impaired verbal learning and memory within 2 days after injury

At the most, only 14% of concussions were associated with loss of consciousness and less than half of concussions were associated with amnesia or disorientation and confusion. In general, over half of concussions were associated with slowed reaction times.

"Most of the studies used to compile the evidence in this report about what are true indicators of concussion were conducted among athletes," Dr. Ghajar stated. "We know very little about hospital and military populations. We hope our report will inspire a new generation of strong studies designed to fill the gaps in information we discovered and identified. The forthcoming report in our series will focus on evidence-based diagnostic criteria for concussion."

California Hospitals fare well in rankings

The US News & World Report has published their annual hospital rankings which include rankings for specific services such as Neurology and Neurosurgery. We could debate the importance of any such rankings and the criteria upon which they are based, particularly those that lump neurology with neurosurgery (N&N). Nonetheless the rankings are out there and apparently for a fee, a hospital can extol its ranking in marketing efforts. At what rank a hospital is likely to toot its horn is a PR department decision but one can guess that any rank in the top 50 can be exploited since 5,000 institutions are evaluated. With that in mind, the "top" California hospitals for N&N are: UCSF (#5), UCLA (7), Cedars-Sinai (18), UCSD (25), Stanford (36), and UCD (42). That puts a whole lot of California's 38 million residents within a few miles of some pretty darn good neurosurgeons. CANS has active members in all 6 institutions.

Concussion in California

Governor Jerry Brown just signed controversial legislation limiting the amount of full-contact practices for teenage football players in an effort to reduce concussions and other serious brain injuries. The measure prohibits football teams at public middle and high schools from holding full-contact practices during the off-season and bars them from conducting more than two full-contact practices per week, of 90 minutes each, during the season. The bill also requires an athlete who has sustained a head injury or concussion to complete a supervised return-to-play protocol of at least seven days, according to

Assemblyman Ken Cooley (D-Rancho Cordova), who introduced the bill.

"AB 2127's practice guidelines will reassure parents that their kids can learn football safely through three hours of full-contact practice … to maximize conditioning and skill development while minimizing concussion risk," Cooley said.

Nearly 4 million high school students nationwide suffer head injuries every year, according to the U.S. Centers for Disease Control and Prevention. The measure is supported by the American Academy of Neurology, the Brain Injury Assn. of California and the California Interscholastic Federation.

However, some high school coaches say the new law will interfere with their ability to field a quality team that is properly prepared to avoid injury. Many teams decide who will play in regular games by holding pre-season, full-contact scrimmages.

Neurosurgeons who are asked to run the concussed athlete through the "supervised return-to-play protocol" better be ready to innovate since the legislation does not define the protocol.

Blue Shield data breach affects California doctors

The Department of Managed Health Care (DMHC) has notified physicians of a data breach that disclosed the social security numbers as well as names, business addresses, telephone numbers, medical groups and practice areas of over 18,000 physicians who contract with Blue Shield of California.

DMHC discovered that Blue Shield of California had inadvertently included physician social security numbers in public rosters provided to DMHC. These rosters are generally public documents and subject to disclosure under the Public Record Act (PRA). As a result, DMHC produced the rosters, including the social security numbers, in response to 10 PRA requests made to DMHC between March 2013 and April 2014.

DMHC and Blue Shield have instituted additional protections to prevent any future disclosures of confidential physician personal information and recommend that physicians place fraud alerts on their credit files. Blue Shield is also offering affected physicians one-year of credit monitoring services though Experian's ProtectMyID Alert. ❖

Thought for the Month:

One of the hardest things to accept when we are old is the image in the full length bathroom mirror.

Meetings of Interest for the next 12 months:

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, February 8-10, 2015, Nashville, TN
Southern Neurosurgical Society: Annual Meeting, March 25-28, 2015, Naples, FL
AANS/CNS Joint Spine Section: Annual Meeting, March 4-7, 2015, Phoenix, AZ
Neurosurgical Society of America: Annual Meeting, April 12-15, 2015, Newport Beach, CA
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
Rocky Mountain Neurosurgical Society: Annual Meeting, 2015, TBA
New England 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.

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