CANS newsletter

President's Letter

Deborah C. Henry, CANS 2014 President and Associate Editor

Patrick Wade, our board consultant to the California Medical Association, recently sent me an email regarding the restructuring of the CMA and its desire to eliminate specialty delegations. A 2013 resolution passed at the House of Delegates decreases the 52-member Board of Trustees to no more than 30 by 2015. In order to do this, the Board of Trustees recommended elimination of both seats held by the Specialty Delegation. At a time when our state faces another malpractice crisis, this is one of the worst times to eliminate specialty delegation leadership, especially the voice of a society that may be most effected by the potential ballot-changing future in November.

Dr. Wade has asked for CANS support in the endeavor to maintain specialty delegation representation at the Board of Trustee level of the CMA. To this end, I have modified a letter of specialty delegation support that I received in order to better emphasize my and hopefully your point of view. The letter is as follows:

The California Association of Neurological Surgeons is a society representing over 400 of California physicians. We have been a staunch supporter in representation and support of the CMA over the past decades with many members actively involved.

The practice of medicine faces new threats each year especially in the specialty fields. Ideally, physicians would respond as a united front when policies threatening any area of the practice of medicine arise.

CANS physician leadership offers long-standing experience of vetting issues spanning the entire state and crossing all modes of practice to reconcile differences for an overarching goal. Our unique perspective at issues can be utilized to the advantage of CMA.

The private forum that the HOD Specialty Delegation provides for us to come to common ground with our colleagues in other specialties and direct connection to the CMA leadership is the most important CMA membership benefit to us.

Neurosurgeons are at the forefront of malpractice changes. We have the highest cost of malpractice of any specialty. Losing this voice at this time in our state's political environment would be detrimental to both CANS and the CMA.

Speaking on behalf of the membership of the California Association of Neurological Surgeons, we respectfully reject the recommendations of the GTAC and request maintenance of the Board of Trustees positions for the CMA Specialty Delegation.

Please email me (**dchenry.md@gmail.com**) with your thoughts, support or suggestions. ❖

INSIDE THIS ISSUE:

The California Medical Association is proposing to restructure its Board of Trustees in a manner that would reduce the size of the BOT and eliminate the Specialty Delegation from its current two seats. In the past, one of the Specialty Delegation seats has been occupied by a delegate from CANS but more recently we have not been particularly involved. There is considerable concern by many CANS BOD members that this restructuring should be resisted (see Dr. Henry's article above) and if it goes forth, then perhaps a state organization of specialists should be formed that specialists could join while relinquishing their membership in the CMA.

The CMA proposal is attached to the email you received that included this newsletter. At press time the CANS BOD was in the process of taking a formal stand on this issue.

BC/BS being Audited for Adequacy of Provider Network

Randall W. Smith, MD, Editor

The Department of Managed Health Care (DMHC) recently began conducting a "non-routine audit" of Anthem Blue Cross and Blue Shield of California to investigate the accuracy of the plans' provider directories and identify whether either plan violated any network adequacy laws. According to the DMHC, consumer complaints about access issues for both plans prompted the investigation. Blue Cross and Blue Shield are the only two Covered California exchange plans using narrowed provider networks for their exchange and "mirror" products. The state is looking at whether the networks are too narrow in some counties, making it difficult for enrollees to find participating providers. With roughly 1.4 million Californians newly enrolled in Covered California products since January, it has been difficult for both physicians and patients to identify who is in and who is out of the narrow provider networks.

A California Medical Association (CMA) survey of California physicians found that there is widespread confusion about exchange plan contracting amongst providers, with 80 percent of physicians stating they had been confused about their participation status.

As part of the audit, DMHC has hired pmpm Consulting to contact practices to ask about their participation status with the two plans. If contacted by pmpm Consulting, the **CMA strongly encourages the practice to respond to their questions**. This is an investigation into the accuracy of the plan directories and whether the plans have violated any laws, not an investigation of physician practices. ❖

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

Reimbursement rates for providing care for individuals who cannot pay for treatment has always been an issue in California. Certainly, there is a great need for physicians to provide such care. However, government reimbursement rates often have not been adequate to cover physician expenses for providing care for the indigent. This problem, though, has gotten worse of late. The Governor recently expanded Medi-Cal to include an influx of patients; yet, the Governor left in place a 10% cut in reimbursement to most doctors and others providing care for those on Medi-Cal. This action by the Governor will have the effect of increasing the pool of those seeking care, while decreasing the reimbursement for those providing such care. Indeed, California is adding 1.9 million new Medi-Cal enrollees as part of the Obamacare rollout. The average amount Medi-Cal pays for a doctor's visit is $41.48, compared to Medicare, which pays, on average, $102.45. This level of reimbursement is not enough to cover physician needs, let alone physician expenses, leading to a decrease in those able to provide care for those on Medi-Cal. Dr. Richard Thorp, President of the CMA, commented on this problem: "[Patients] might have an insurance card and not be able to get into a doctor's office anywhere."

In addition, I believe the decreased reimbursement for providing care for the increased pool of Medi-Cal patients will have the effect of changing the way medicine is practiced. Most patients seeking care will not be seen by a physician, but, instead, will see a nurse practitioner or physician's assistant – neither of which has the training or, likely, the experience, that a physician has in treating patients.

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Summer is now upon us, which is, I believe, the best part of the year -- despite the heat (although I may be biased in this observation because I am from Western Montana, and endured many a brutal winter). In any event, summer is the time when one may travel more easily as the children are out of school, and the weather more inclined to cooperate with efforts to fly or to drive to various sites around California and the country. I wish all a good summer vacation. ❖

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

The LA Times reported on June 20, 2014 that 144 incarcerated women underwent bilateral tubal ligation between July 2005 and June 2013. In 27 of those sterilizations, the operating surgeon failed to sign a form indicating consent was given. This article made me think not only of the number of women in our history who have had everything from a BTL to a total hysterectomy without consent to the many operations that I have performed in life-threatening surgical emergencies of comatose patients when there is no consenting individual available.

According to an article by Michael Millenson (Medscape, 2012:3), the legal fight over informed consent started at the turn of the last century when the Supreme Court (1905) decided in favor of a 40 year-old female epileptic who underwent a total hysterectomy without any knowledge that this was happening. The surgeon's argument was that the patient consents to any operation that the surgeon deems "proper and essential to her welfare" unless that patient specifically prohibits it. The Supreme Court decision was adamantly against this argument and called this a violation of the bodily integrity of his patient.

In a similar situation, Mary Schlendorff agreed only to an examination under anesthesia (ether at the time) of a fibroid tumor to see if it was malignant. She specifically mentioned to a doctor that she did not want an operation for its removal. During the examination, the fibroid was found to be malignant and was removed. She developed post-operative gangrene in her left arm resulting in fingers being amputated. In 1914, the New York court found in her favor. Justice Benjamin N. Cardozo went so far to as to say that "a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." (https://bioethics.georgetown.edu/publications/scopenotes/sn33.pdf). However, Shloendorff had sued the non-profit hospital and not the doctor. The court decided that a non-profit hospital could not be responsible for its employees. This precedent of hospital immunity was later overturned in the 1957 case of Bing V. Thunig.

The phase *informed consent* first appeared in the 1957 case of Salgo v. Leland Stanford Jr. in California. In this case, fifty-five year old Martin Salgo underwent an aorto-femoral diagnostic angiography. The next morning, his legs were paralyzed. Salgo argued that the risks of the procedure were never told to him. In their discussion, the Court stated that the physician must not withhold any facts that are needed for a patient to give consent and that when discussing risk, the physician shall be "consistent with the full disclosure of facts necessary to an *informed consent.*"

The definition of informed consent advanced further in 1972, in the landmark California case of Jerry Canterbury, a 19 year-old who underwent two operations for back pain. Apparently Canterbury underwent a laminectomy (some reports say vertebrectomy) and while recovering, fell out of bed and developed paralysis. He underwent a second surgery apparently resulting in improvement. Canterbury sued based on the fact that risks of the surgery were not explained, and the hospital did not equip his bed with a rail. The initial court found in favor of the doctor; however on appeal, the court found that "a physician should convey the risks of an operation when a reasonable person would be likely to attach significance to the risk in deciding"…and that "there are two exceptions to this general rule:
(1) where the patient is unconscious and harm from a failure to treat is greater than any harm threatened by the proposed treatment; and (2) where disclosing the risk to the patient poses a threat to the patients well-being". (http://www.lawnix.com/cases/canterbury-spence.html).

I had at two cases of patients with ependymomas who initially refused surgery, both preferring to try dietary methods to reduce their tumor burden. Both cases required utmost patience on my part to refute the unproven nutrition-will-cure-me method in favor of surgery. Both eventually consented to informed surgery-not only of the risks of surgery, but of the risks waiting and trying unproven techniques. Informed consent, despite its pitfalls, is a needed and necessary part of our daily practice.

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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

When Informed Consent May Not Be

There of course is no end to the brambles strewn by the plaintiff's bar in the path of a reasonable neurosurgeon. Consider this: your Medicare patient has very symptomatic spinal stenosis and you offer a decompression discussing all the risks and benefits and the patient decides to proceed. Post operatively the patient doesn't do well and experiences one of the complications you discussed before surgery. An attorney surfaces claiming malpractice because you didn't realize (and should have) that the patient had early AD which was not apparent during the office visits and thus informed consent was not really obtained. And away we go.

One might consider making a simple maneuver whenever you plan on operating on a senior person: Have them complete a simple test that screens for mild cognitive impairment and early AD. There are a number of such tests but the one called SAGE developed by Ohio State University is quite simple, is free and takes about 10 minutes and can be graded by your office staff. If the result indicates some problems, you better have the significant family member co-sign the permit or get an opinion from a neurologist as to whether the patient is capable of informed consent.

The test and how to grade it can be downloaded from:
http://medicalcenter.osu.edu/patientcare/healthcare_services/alzheimers/sage-test/Pages/index.aspx

Oneneurosurgery Point of View

Don Prolo, he of Bay area fame and as a former President of CANS and current CANS Historian, proposed we circulate the link to a video created by the Oneneurosurgery group which advocates for the merger of the AANS and CNS. The CANS Board of Directors voted to indeed circulate it since it is a legitimate point of view about neurosurgery but without adopting it as CANS policy. The link to the video is:
https://www.youtube.com/watch?v=nC_qgfn0Acg

Neurosurgery Publishes its Don't Do It List

The AANS and CNS have posted 5 recommendations of things to avoid on the Choosing Wisely Web site. The things to avoid:

1. Steroids in severe head injuries,
2. Scans in acute low back pain,
3. CT scans in kids with mild TBI,
4. Seizure prophylaxis in stroke
5. Screening for aneurysms in the asymptomatic patient

To visit the Web site for more detail, go to http://www.choosingwisely.org/doctor-patient-lists/american-association-of-neurological-surgeons/

Avoiding AD—what to ingest

At the recent annual meeting of the American Academy of Neurology, H. Glazer and associates reported on a meta-analysis of all studies related to diet and Alzheimer's disease. In a subsequent interview, Dr. Glazer's take home message was that since AD starts in the brain 20-30 years before first symptoms, it should be useful to practice certain lifestyles to ameliorate that process. He stated, "physicians should consider recommending a Mediterranean diet across the spectrum of AD (stages 1-3), specific omega-3 fatty acids for MCI patients, and flavonoids and B vitamins to those with MCI, as well as to those at risk". With that in mind, the senior neurosurgeon probably should be sure that each day's vitamin pills include a omega-3 fatty acid football plus a multivit with lots of B vitamins plus a diet featuring flavonoid rich parsley, blueberries, black tea, citrus, red wine and dark chocolate. It couldn't hurt. Now if only someone could find that gin is protective—they would be worthy of a Nobel Prize.

Reference: Glazer H, Greer C, Barrios D, et al. Evidence on diet modification for Alzheimer's disease and mild cognitive impairment. Program and abstracts of the 66th Annual Meeting of the American Academy of Neurology; April 26-May 3, 2014; Philadelphia, Pennsylvania. Abstract P5.224. ❖

Thought for the Month

If you don't read the newspaper you are uninformed;
if you do read the newspaper you are misinformed
-- Mark Twain

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, 2015, TBA
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: Ann. 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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