CANS newsletter

President's Letter

Deborah C. Henry, CANS 2014 President and Associate Editor

I received my California General Election official voter information guide and turned to the section on Proposition 46, attempting to read it as a novice voter on the issue. When I do this, I realize how misleading many of the statements are. The section discussing MICRA states that the reform act was enacted due to a concern that "high medical malpractice costs would limit the number of doctors practicing medicine in California", not that it was actually the affordability and availability of malpractice *insurance*. I learned that the cap on attorney fees is 40% for the first $50,000 and 15% after $600,000. No mention in the article what the amount the attorney can collect on settlements between $50,000 and $600,000. The current cost of malpractice insurance, whether through an insurance company or self-insurance, is approximately 2% of the total annual health care spending in California. There is no mention in the article what this amount really is, so I took to looking at the data from the CMS web site. The estimated annual cost of health care in California in 2009 (last year it is available) was $230,000,000,000 or roughly $6570 per person. Two percent of this means Californian health care providers and their insurance companies pay 4.6 trillion dollars annually for malpractice coverage and costs. Wow.

Next I turned to reading about CURES: Controlled Substance Utilization Review and Evaluation System. My voter guide states that approximately 12% of providers are now registered, but that the web site does not have sufficient capacity to handle all providers required to register by 2016. Upgrades are supposed to be done by summer 2015. I checked out the current web site and went to the FAQ section. I wanted to know what to do with the information if I suspected that my patient was "doctor shopping". **This is the reply:** Work with your patient to obtain the help they may need. Refer to the Medical Board of California "Guidelines for Prescribing Controlled Substances for Pain" and the California Department of Alcohol and Drug Programs for assistance in your county.

Then I read the physician drug testing section. Testing can be done randomly and also in the following specific instances: 24 hours prior to an adverse event (my question - how do you determine that an adverse event is going to happen?), or when a physician does not follow the standard of care, or when the physician is reported to be *possibly* using drugs or alcohol. The hospital must bill the doctor for the testing. The hospital must then report any positive test or any refusal to do the test. The State would pay its administrative costs for drug testing by "a fee assessed on physicians". I don't see anything good coming from this.

So, have you started your own campaign for **Vote No on 46 yet**? Buttons, stickers, pamphlets, and yard signs are available. Please check out the web http://www.noonprop46.net/. I am wearing my button. This week, I am going to get my yard sign.❖

INSIDE THIS ISSUE:

The Good, the Bad and the Unpleasant

Randall W. Smith, MD, Editor

An interesting article published in the September issue of the journal Spine (with a least one author being a neurosurgeon—Ed Benzel) compared some surgical outcomes when spine surgeries were done by orthopedists as compared to neurosurgeons. It was a little hard to be sure the procedures compared were exactly the same for the two groups, but the main findings were:

1. When orthopedic surgeons performed the elective spine surgeries, patients were twice as likely to have a prolonged hospital length of stay as when neurosurgeons were performing the procedure.

2. Patients who underwent treatment by orthopedic surgeons were also more likely to:
   - Receive a perioperative transfusion
   - Have complications
   - Require discharge with continued care

3. Differences in 30-day postoperative outcomes were minimal.

Lest the above go to our heads, our malpractice data are worse than any other surgical specialty, In a talk given by Katie Orrico (Director of the AANS/CNS Washington Committee) at the Western Neurosurgical Society annual meeting on August 19th using some national data and Doctor's Company and NERVES data, she indicated we get sued more often and our cases generate higher awards than the orthopods (439K vs. 260K). And it isn't because of our unique cranial work since a great majority of our claims are generated by spine issues.

Finally, Merritt Hawkins, the physician recruitment outfit, reported that although neurosurgeons were generally offered on average $591,000/year (vs. $488,000 for orthopedic surgeons) during the 2013-2014 time period, that amount was down from $710,000 in 2011-2012.

So it would seem we are better surgeons during and right after surgery but with outcomes and/or attitudes that ultimately generate more malpractice suits and we are gradually getting paid less for all of that. ❖

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!

Brain Waves

Deborah Henry, MD, Associate Editor

If you have kids, watch or read the news, or look at the Internet, you probably know that Minecraft's company Mojang was purchased by Microsoft on September 15th for 2.5 billion dollars-all cash. If you are one of the few people who have not heard of this game, it was invented by Markus Persson, a Swedish programmer, and released for play in 2009. It is a sandbox game, and like playing in a sandbox, one is given tools (like the shovel and pail in a sandbox) and is free to create their own world. My son, when he is not playing League of Legends, will put hours of time in building with these virtual Legos online. Now an educational version has made it to the Orange County school district here in southern California. Eight teachers signed up for a class and each tugged along a child to help out. Minecraft has been used for recreating colonial Jamestown and constructing the human digestive system. Hopes in the OC are for students to use it to build any local city, migrate through buildings on college campuses, and improve math and critical thinking skills.

If we can use Minecraft in the education world, why not in the healthcare world? I know that there is someone out there (even Google has neurosurgeons working for them) who can create Healthcraft. Imagine it-I want to go out and eat an ice cream sundae. But to do that, I would need to burn off a certain amount of calories ski jumping first. Or maybe I could make a lower calorie sundae with substitute ingredients. I could go virtual shopping and look at nutrition labels and see how much I would weigh being a couch potato eating potato chips or how healthy I might become training for a triathlon.

Or how about using Healthcraft to create virtual surgeries? Residents, given a certain set of tools, can figure out how to take out a tumor or clip an aneurysm. Or maybe they would have to earn their tools by answering set questions first. Maybe they would need to construct their own tools. Patients could use Healthcraft to see what their lumbar disc looks like and attempt to take it out. Then they could see what would happen if they went horseback riding right afterwards. Yes, I had a patient do this. It was not on my checklist at the time of things not to do right after surgery.

You might say that since I think this is such a great idea, why don't I just figure out how to do it. But I guess that means I would have to play the game first. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

In efforts to push pharmaceuticals utilized in patient care, drug companies are increasingly focused toward hospitals and away from individual physicians. This is, in part, due to the increased number of physicians who are employed by hospital systems and the decreased number of physicians in private practice. According to the Wall Street Journal, 42% of physicians now practice as salaried employees of hospitals, compared to 24% in 2004. ("As doctors lose clout, drug firms redirect pitch," The Wall Street Journal, September 25, 2014, pp. A1, A18.) Consequently, pharmaceutical firms make their case to hospitals and not to individual physicians. The Wall Street Journal reports that the drug companies' shift from lobbying physicians to hospitals for pharmaceutical use has resulted in a sales trend towards efficiency in cost rather than efficacy in patient care. (Ibid., p. A18.) As Pratap Khedkar, head of the global pharmaceutical firm ZS, stated to the WSJ, "Doctors mostly cared about how the drug worked… [while at health systems] the sales emphasis has shifted to not just how the medicine works but how it also lowers the total cost of managing disease." (Ibid.)

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Unfortunately, physicians are increasingly unhappy in their practice, and this declining morale has hurt patients. ("Our ailing medical system, Wall Street Journal, August 30, 2014, pp. C1-C2.) A 2008 survey of 12,000 physicians found that only 6% had a positive morale about practicing medicine. (Ibid., C1). The article notes that, "most" physicians surveyed indicated that they did not spend enough time with patients because of paperwork. (Ibid.) Almost half surveyed said that, over the next three years, they planned to stop seeing patients or planned to decrease the number of patients they would see. (Ibid.)

The WSJ noted that the "golden years" of practicing medicine were from around 1940 to 1970; during this period, physicians were "content." (Ibid.) A fee-for-service system was in place, with patients accountable for costs either "out-of-pocket" or with "fledgling" insurance programs, like Blue Cross/Blue Shield. (Ibid.) In 1940, the mean income for physicians, adjusted for inflation, was approximately $50,000 a year; while in 1970, it was approximately $250,000. (Ibid.) However, the increase in salary resulted in public perception that doctors were "bilking the system," the view being that patients were subjected to unnecessary procedures and tests, with "rampant" waste and fraud in the health care system. (Ibid.) This, in turn, resulted in the creation of Health Maintenance Organizations (HMOs) around 1970, to help control costs and make doctors accountable for prescribed tests and procedures. (Ibid.) With the onset of HMOs, physician dissatisfaction with medicine increased: in 1973, fewer than 15% stated that they had "doubts about [medicine] as a career path," but in 1981, about 50% reported that they "would not recommend the practice of medicine as they would have a decade earlier." (Ibid.) Doctors' unhappiness is concomitant with decreased time spent with patients and with increased time dedicated to paperwork for insurance companies (now about an hour each day; and about $83,000 a year). (Ibid.)

Physician income and patient care is now significantly varied. In the name of "cost efficiency", physicians are submerged in a sea of paperwork, with less opportunity for patient interaction. In my opinion, new physicians, unfortunately, do not now have the opportunity to realize the benefit, responsibility, and pleasure associated with traditional patient care.

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With the increased use of MRI as a diagnostic tool for ovarian tumors, there has been, also, an increase in the number of surgeries to remove suspected cancerous tumors. ("Caution is urged on tumor treatment", The San Francisco Chronicle, pp. A1, A13.) However, a recent study in the American Journal of Oncology and Gynecology notes that this practice of immediate surgery to remove small, complex ovarian tumors from patients (patients with large tumors were excluded from the study) has resulted in many unnecessary surgeries, as the tumors were rarely cancerous. (Ibid., p. A1.) The study reports that of the nearly 1,400 patients with small, complex tumors, only seven had ovarian cancer (but early detection led to an increased chance of successful treatment of ovarian cancer). (Ibid.) Dr. Elizabeth Suh-Bergmann, lead author of the study, commented "Greater consideration should be given to an initial short-term observation of many of these masses rather than immediate surgery." (Ibid.)

Tidbits from the Editor

CANS survey on Prop 46

CANS recently sent an email survey to its membership (121 private practice, 65 academic, 60 retired) requesting input on what the member would do if Prop 46 (the anti-MICRA, doc drug testing and check the state database before prescribing opioids proposition) passed this coming November. 63 responses were received. The 11 responses from the retired group, as might be expected, indicated Prop 46 passage would make no difference to them. The 15 responses from the academic group were generally similar to the retired group although 3 said they would leave California. The private practice responses, numbering 31, pled as follows: 6 would leave CA, 7 would retire, 4 would give up doing surgery but still practice in some capacity, 10 would continue as usual paying the higher cost of med mal and 4 would go to employee status or do locum tenens work.

A recent poll showed 50% of likely voters are against Prop46, 37% are in favor and 12% are undecided suggesting the NO on 46 campaign has been effective. Although about half the No on 46 war chest comes from med mal carriers, considerable support has been provided by docs

and organizations who will have to pay higher med mal premiums like hospitals and clinics. If the NO on 46 campaign was solely sponsored by docs, we would be toast. But when big business would also be gored by the proposition, we garner some real allies with the big bucks. Stay tuned.

Neurosurgery loses a great one

Too often these days, people are declared giants in their field when just being considered a bit taller would be more appropriate. Such is not the case with Edwin Amyes, M.D. who was indeed a giant when it came to neurosurgical socio-economics. In the 1950's and early 60's the older gentlemen in the AANS and the younger gentlemen in the CNS hewed to a strictly scientific educational role for both organizations. Crass subjects like socioeconomics were not to be addressed. The CNS was the first organization to create a SE committee in 1963 which was combined with a nascent AANS committee to form the Joint Socio-Economic Committee (JSEC) in 1972 with co-chairman, one from the AANS and one from the CNS. Ed Amyes was the CNS co-chair and remained so until 1977 when the JSEC created the Council of State Neurosurgical Societies (CSNS) a majority of whose members were chosen by the state societies (JSEC itself was populated by appointees made by the AANS and CNS). Ed Amyes was the first Chairman of the CSNS and held that post until 1980 and was instrumental in establishing the role and operation of the CSNS. Socio-economics had come out of the closet.

It is with sadness that CANS learned of the death of Ed Amyes on September 10th.

Dr. Amyes was born on November 20, 1920 in Edinburg, Scotland. He earned his medical degree from Loma Linda University School of Medicine in 1944. He enlisted in the Army in 1945 and attended the Army School of Military Neuropsychiatry. He completed his internship and residency in Neurology at White Memorial Medical Center in 1953 and his residency in Neurosurgery at LAC-USC Medical Center in 1955. From 1953 to 1967, he served as Chief Neurological Surgeon at Rancho Los Amigos in Downey. Along with establishing his practice in Orange County in 1966, he was an Associate Clinical Professor of Neurological Surgery at the University of California, Irvine and from 1968-1990. Dr. Amyes practiced in Newport Beach until his retirement on February 13, 2001. He played an active role in the creation of the Orange County Emergency Medical/Paramedic System and Trauma Centers in the 1970s. Dr. Amyes was a past Chair of the Neurosurgery Department at Hoag Memorial Hospital where he practiced. In 1980, he received the Exceptional and Distinguished Service Award from the Congress of Neurological Surgeons for founding the Council of State Neurosurgical Societies (CSNS), for sponsoring nearly 40 new state societies, and for spearheading the actions that led to the formation of a physician-owned medical liability insurance company. The CSNS, somewhat belatedly, presented its Leibrock Lifetime Achievement Award to Dr. Amyes in 2008. Oddly enough, Ed never served as President of CANS or received the Pevehouse award.

This writer knew Ed quite well and was always impressed by his general friendliness and his sharp mind which continued to generate important thoughts about neurosurgery and how it should be practiced well into this second decade of the 21st century.

He is survived by his children, Nina and Christopher, and his loving wife, Louise. Donations may be made in Dr. Amyes' name to the Hoag Hospital Foundation.

Another Federal Hoop

The Drug Enforcement Administration (DEA) has announced that it is rescheduling all hydrocodone combination products (HCPs) from federal Schedule III to federal Schedule II effective October 6, 2014. The DEA has stated that it will allow refills on HCPs written and initially filled before October 6 (under Schedule III requirements and limitations), to be dispensed up to six months from October 6, 2014 (until April 8, 2015). This extends the Schedule III treatment of prescriptions for HCPs written and initially dispensed prior to October 6, 2014 to the maximum allowable period for Schedule III refills.

The Impact on Prescribers Starting on October 6, 2014:
• Prescriptions for HCPs must be written on a hard copy, original prescription or electronically transmitted where e-prescribing of C-IIs is allowed by state law, the prescriber is certified to e-prescribe C-IIs, and the pharmacy is certified to accept electronically prescribed controlled substances. Fax transmission is not allowed.
• Prescriptions for HCPs cannot be called into a pharmacy.
• Prescriptions for HCPs cannot be refilled (unless the prescription was issued before October 6, 2014). Note that many health insurers will not honor these refills and that many pharmacies will not be able to refill prescriptions issued prior to October 6, 2014 due to state law limitations and some pharmacy safety and quality systems and processes.

The DEA permits multiple prescriptions authorizing a patient to receive a total of up to a 90-day supply of HCP where a prescriber has determined it is appropriate to see the patient only once every 90 days. Each prescription must "be dated as of, and signed on, the day issued" and include written instructions on each prescription indicating the earliest date on which that prescription may be filled.

CANS loses one and gains one

Michel Kliot from UCSF, a northern CANS Director halfway through his 3-year director term, has relocated to Illinois to pursue other opportunities. The CANS BOD has appointed Ripul Rajen Panchal, DO, to complete Dr. Kliot's term. Dr. Panchal is a graduate of Javed Siddiqi"s neurosurgery program at Western University, Arrowhead Regional Medical Center, after which he took a spine fellowship at UCD and then stayed on as Assistant Professor.

Dr. Kliot was also the neurosurgery representative on the Work Comp Medical Evidence Evaluation Advisory Committee and the WC Medical Director will need to name a replacement. We are informed that the Medical Director's search MO is to call Mitch Berger and get a recommendation which explains why all neurosurgery reps to the MEEAC have been UCSF neurosurgeons. CANS has been fortunate in having the UCSF reps be excellent but Dr. Berger might consult with CANS if he is asked to recommend a replacement for Dr. Kliot.

New prescription drug prior authorization form required on October 1

Over the next several months, a new law in California will take effect that streamlines and standardizes the prior authorization process for prescription drugs. The new law (SB 866) requires all

insurers, health plans (and their contracting medical groups/IPAs) and providers to use a standardized two-page form for prior authorizations of prescription medications.
The law also requires plans and insurers to make a determination on prescription drug prior authorization requests within two days of receipt, and if they fail to do so the requests will be deemed authorized. The new law does not expand the list of medications that require a prior authorization. The Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) jointly developed the standardized authorization form and implementing regulations.

The two agencies, however, will be enforcing the regulations on different timetables. The regulation for DMHC regulated products, which includes all HMOs, their contracting medical groups/IPAs and most Blue Cross and Blue Shield PPOs, becomes effective January 1, 2015. However, the regulation for DOI regulated products, including all other PPOs and the Blue Cross and Blue Shield Life & Health products become effective on October 1, 2014.

Go to http://www.insurance.ca.gov to access the new form. The form (Form No. 61-211) will also be available on the payor websites by October 1 and can be submitted via paper, electronic transmission, fax, web portal or another mutually agreeable method. ❖

Executive Office News

The Annual Meeting information is available on our website: www.cansl.org! Reserve your room today!

Quotation for the Month:

Of all the paths you take in life, make sure a few of them are dirt—John Muir

Council of State Neurosurgical Societies to debate 9 Resolutions

The following are the resolutions to be considered at the CSNS meeting on October 17-18 in Boston. Any CANS member who wishes to voice an opinion about any of the resolutions should contact the CANS delegation chairperson, CANS President Deborah Henry, at dchenry.md@gmail.com.

RESOLUTION I-2014F
Title: Maintaining a centralized public repository of quality improvement projects
Submitted By: Ben Rosenbaum, Amit Goyal, Chaim Colen
WHEREAS, the ACGME practice-based learning and improvement competency states:
Residents are expected to develop skills and habits to be able to meet the following goals: systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and
WHEREAS, residents, neurosurgeons, and neurosurgical practices are undertaking quality improvement projects at their local institution(s); and
WHEREAS, such quality improvement projects may not be submitted to neurosurgical conferences because they are not mature enough to be accepted as socioeconomic content (poster or presentation); and
WHEREAS, sharing of such quality improvement projects would serve to benefit the ACGME and ABNS milestones of neurosurgery resident education and align with the CSNS education mission; and
WHEREAS, the neurosurgical community would benefit from the availability of a centralized repository of the types and results of quality improvement projects implemented throughout the country that might be undertaken elsewhere; therefore
BE IT RESOLVED, that the CSNS add a self-sustaining, publically available feature to the CSNS website to permit submission and ongoing sharing of educational quality improvement projects (and results, when available).

RESOLUTION II-2014F
Title: CNS and AANS Membership Tied to Neurosurgical Acute Care "Citizenship"
Submitted By: Gary Simonds
WHEREAS, common opinion is that Neurosurgery faces a manpower shortage for at least the next decade; and
WHEREAS, an expanding number of graduating residents are limiting the scope of their practices to subspecialty fields (honed either in enfolded or post-graduate fellowship training); and
WHEREAS, an increasing percentage of practicing neurosurgeons are eschewing the acute care demands of their communities and regions (for example: refusing to see or care for a patient with an acute subdural hematoma or acute VP shunt failure); and
WHEREAS, such behaviors exacerbate the shortfall in neurosurgeon availability and adversely affect the care of patients in need; therefore
BE IT RESOLVED, that the CSNS requests of the AANS and CNS to assert that neurosurgeon participation in the neurosurgical acute care needs of their communities/regions is a fundamental component of neurosurgical "citizenship;" and
BE IT FURTHER RESOLVED, that the CSNS requests of the CNS and AANS that they withhold/withdraw membership from those active neurosurgeons who clearly decline/refuse reasonable participation in a set of critical acute care evaluations and interventions within their communities/regions; and
BE IT FURTHER RESOLVED, that the said set of acute care interventions are clearly defined and published in multiple neurosurgery media (example: "Core Competencies in Neurosurgery for Emergency and Acute Care"); and
BE IT FURTHER RESOLVED, that the AANS and CNS request of the SNS and RRC to include said set of acute care evaluations and interventions in their expectations of neurosurgical graduate medical education (through matrix/milestones functions); and
BE IT FURTHER RESOLVED, that the AANS and CNS request of the ABNS to include said set of acute care evaluations and interventions in their expectations of required competencies for Board Certification and Maintenance of Certification

RESOLUTION III-2014F
Title: Assurance of a voice for grass roots neurosurgeons in the functions of the CSNS
Submitted By: Thomas Origitano, Gary Simonds
WHEREAS, the stated purpose of the CSNS is to provide a national forum for the State Neurosurgical Societies regarding socioeconomic issues and concerns; and
WHEREAS, State Neurosurgical Societies represent "grass root" Neurosurgeons of ALL practice backgrounds; and
WHEREAS, the CSNS therefore empowers individual neurosurgeons with a voice in organized Neurosurgery's approach to local and national socioeconomic issues and concerns; and
WHEREAS, CSNS bylaw-prescribed ratios assure proportionate representation of individual neurosurgeons (1 delegate for every 50 neurosurgeons); and
WHEREAS, CNS and AANS appointees to the CSNS are by definition representatives of neurosurgical organizations and do not represent a defined number of individual neurosurgeons; and
WHEREAS, a perception exists that CNS and AANS appointees to the CSNS are disproportionately made up of academic neurosurgeons (who already would have proportionate representation through their state neurosurgical societies); and
WHEREAS, CNS and AANS appointees indeed give extra weight within CSNS proceedings to organized neurosurgery and possibly to neurosurgeons of academic backgrounds; and
WHEREAS, by bylaw, CNS and AANS appointees are never to exceed one third of the overall body of delegates to the CSNS; and
WHEREAS, small-group and private practice neurosurgeons may have more difficulty attending two CSNS meetings per year due to coverage demands, than do academic and/or large-clinic neurosurgeons; and
WHEREAS, a risk exists of uneven weighting towards academic and politically-oriented neurosurgeons over "grass-root" neurosurgeons in CSNS proceedings; therefore
BE IT RESOLVED, that the ratio of CNS and AANS appointees to total delegates (state and appointed) attending each CSNS national meeting be ascertained; and
BE IT FURTHER RESOLVED, that said ratio is posted prominently at the plenary session of the CSNS national meeting at the time of resolution debate and voting; and
BE IT FURTHER RESOLVED, that said ratio is recorded and published alongside resolution voting results in CSNS official documentation (minutes, newsletter, website, etc.); and
BE IT FURTHER RESOLVED, that if said ratio is greater than 1 CNS/AANS appointee for every 3 total delegates, for three consecutive meetings, the matter of correcting the ratio to the CSNS bylaw-prescribed level is formally addressed by the executive council.

RESOLUTION IV-2014F
Title: The Socioeconomic Ramifications of Significantly Increasing the Volume of Graduating Subspecialized Neurosurgeons
Submitted By: Gary Simonds
WHEREAS, the Society of Neurological Surgeons (SNS), in conjunction with the Neurosurgery RRC, has designed and enacted a minimum standard for procedural experience in neurosurgical residency training (Neurological Surgery Case Log Defined Case Categories and Required Minimum Numbers); and
WHEREAS, the Committee on Advanced Subspecialty Training (CAST) of the SNS is developing a process for accrediting neurosurgical subspecialty fellowships and for certifying fellows training in all major neurosurgical subspecialty disciplines; and
WHEREAS, momentum builds in organized neurosurgery for a change in the structure and process of Neurosurgery residency training such that residents would acquire a defined minimum cross-spectrum procedural experience (as prescribed by the minimum requirements directive), and then spend 1-3 years in "enfolded" subspecialty training (procedural and research based) with the end result of CAST certification in said subspecialty; and
WHEREAS, this is a major departure from traditional neurosurgical residency training and begs multiple socioeconomic questions such as:
-Will human nature dictate that some residents will seek bare minimum procedural experience in required categories (in as short of time as possible) and then focus on their chosen subspecialties?

- When residents, relatively early in their neurosurgical careers, shift their focus from acquisition of general neurosurgical procedural experience to concentrated experience in their chosen subspecialty, will their general neurosurgical procedural skills and acumen atrophy?
-And with potentially all trainees streaming into subspecialty fields, will a greater number of neurosurgeons refuse to participate in general neurosurgical care?
-Will this potentially compromise the ability of a community (particularly smaller, more rural, and/or more remote) to adequately cover its general neurosurgical needs?
-Will the ability of a community to cover its neurosurgical acute care needs be compromised as potentially fewer neurosurgeons are willing to cross-cover conditions from subspecialties other than their own?
-Will the neurosurgical acute care call needs of a community require multiple neurosurgeons of various (all?) subspecialties on call each night/day?
-Will enfolded fellowship trained subspecialists possess equal or similar professional proficiencies and qualifications to those of post-graduate fellowship trained subspecialists?
- Will enfolded-fellowship-trained subspecialty neurosurgeons anticipate greater remuneration than traditional general neurosurgeons?
- Will a neurosurgical workforce of subspecialists drive up the overall cost of neurosurgical care?
-As the majority of graduates identify with specific subspecialty fields, is there a risk of a "hammer and nail" phenomenon with excess procedures being performed in each of the various chosen subspecialty disciplines?; therefore
BE IT RESOLVED, that the CSNS, through its various committees, study the potential socioeconomic ramifications and challenges of the anticipated shift in residency training towards a model of acquisition of set minimum general neurosurgical procedural experience followed by enfolded subspecialty training; and
BE IT FURTHER RESOLVED, that a white paper is generated from this evaluation; and
BE IT FURTHER RESOLVED, that said study evaluates the potential effects on neurosurgical manpower requirements, neurosurgical acute care coverage, general neurosurgical coverage-particularly in smaller and more remote communities, projected shifts in subspecialty procedural volumes, projected changes in the cost of neurosurgical care, and more.

RESOLUTION V-2014F
Title: Support For Military Neurosurgeon Involvement in Organized Neurosurgery
Submitted By: Thomas Origitano, Gary Simonds
WHEREAS, the CSNS appreciates and salutes the sacrifice and service of its military neurosurgical colleagues; and
WHEREAS, military neurosurgeons are facing repeated reductions in financial support for their involvement and participation in their professional societies; and
WHEREAS, said financial support reductions include loss of reimbursement for attendance at organized neurosurgery national meetings; therefore
BE IT RESOLVED, that the CSNS requests of its parent bodies (CNS and AANS) to waive membership fees and national meeting registration fees for active duty military neurosurgeons; and
BE IT FURTHER RESOLVED, that the CSNS pays for two double-occupancy hotel rooms, for the Thursday and Friday nights of each CSNS Biannual Meeting, in order to house up to four active duty military participants, for the next 5 years.

Resolution VI-2014F
Title: Creation of a Dynamic Timeline of Affordable Care Act Rollouts on the CSNS Website
Submitted by: Chaim Colen, Michelle Smith, Maya Babu, Medical Practice Committee/ Young Neurosurgeons Representative Section
WHEREAS, the Affordable Care Act will invariably affect all neurosurgeons and their practices on a continuous basis, and
WHEREAS, the CSNS has created a Task Force to dissect the Affordable Care Act, and to educate and provide information to the neurosurgery public regarding the significance of its components, and
WHEREAS, the Affordable Care Act will have "rollouts" or stages of implementation, and
WHEREAS, the Affordable Care Act has become a dynamic process of varying rules and regulations that modify our preliminary interpretation of this legislation; therefore

BE IT RESOLVED, that the CSNS provide updates on a webpage while the Affordable Care Act rollouts are continuously implemented, and
BE IT FURTHER RESOLVED, the CSNS will house this "timeline of major events" on our CSNSonline.org website.

Resolution VII-2014F
Title: Development of a position statement on use of third party virtual consult services to provide neurosurgical care
Submitted by: Darlene A. Lobel, Michelle J. Smith, Medical Practices Committee
WHEREAS, HealthTap has developed a web based service that allows patients to obtain virtual physician consultations (audio, visual, or text based) for a monthly subscription fee, and
WHEREAS, this service is recruiting neurosurgeons to provide consultations for this service by offering a free one year membership and hourly paid consultant services, and
WHEREAS, other similar websites are likely to be developed due to patient interest in virtual "concierge medicine" services that are less expensive and more accessible than traditional medical care, and
WHEREAS, such consultations being hosted by "third party" services raise concerns with patient privacy and safety, physician liability, licensing and reimbursement, and
WHEREAS, the American Academy of Neurology recently released a position statement advocating patient rights to and physician reimbursement for "telemedicine" services; therefore
BE IT RESOLVED, that the CSNS investigate the legal, fiscal, and ethical implications of using third party virtual consult services to provide neurosurgical care, and
BE IT FURTHER RESOLVED, that the CSNS petition the AANS and CNS to develop a position statement regarding neurosurgeon participation in such third party virtual consult services.

RESOLUTION VIII-2014F
Title: Maintaining Open Access to ICUs for All Neurosurgeons
Submitted By: J. Adair Prall, Sharon Webb
WHEREAS, care for the critically injured ICU patient has always been the responsibility of neurosurgeons, both in academic and community settings; and
WHEREAS, historically, neurosurgeons spend 6 (now 7) years learning how to care for these sickest patients, often far more than other specialties; and
WHEREAS, the skill set required to care for these patients requires constant experience to attain, maintain and refine them both in training and throughout one's career; and
WHEREAS, many neurosurgeons have worried that changes in ICU access over the past 10 years may prevent them from providing optimal care for their patients; and
WHEREAS, a recent survey administered by the CSNS has documented that up to 12% of training programs and 46% of community neurosurgeons face limited access to their primary ICU, and that this limitation threatens the learning of and maintenance of their ICU skills; and
WHEREAS, the Leapfrog Group, established in 2000, has established a set of rules which prohibit neurosurgeons with standard training to care for their patients in ICU's that have adopted these rules; and
WHEREAS, organized neurosurgery has approached the Leapfrog group in an effort to have them include neurosurgeons on their list of specialties which they deem adequately trained to care for neurologically injured patients in the ICU; therefore
BE IT RESOLVED, that the CSNS voice its strong support for these ongoing efforts in negotiating with the Leapfrog group, and
BE IT FURTHER RESOLVED, that the CSNS petition organized neurosurgery to continue to work closely with the Neurocritical Care Society, the Leapfrog group, and other pertinent organizations to assure that neurosurgeons both in training and in practice continue to be allowed in all parts of the country to have access to their sickest patients in the ICU.

RESOLUTION IX-2014F
Title: Dissemination of Safe Methodology to Reduce Radiation Exposure During Angiographic Procedures
Submitted By: Elyne N. Kahn, Chaim B. Colen
WHEREAS, endovascular neurointerventional procedures are increasingly common in neurosurgical practice; and

WHEREAS, angiographic equipment utilized in these procedures is a significant source of radiation to patients, operators and to support personnel; and
WHEREAS, harmful effects of radiation exposure are well documented; and
WHEREAS, angiographic equipment settings can be modified with respect to dose per frame and frames per second in acquisition mode and dose per exposure in fluoroscopy mode without compromising image quality; and
WHEREAS, angiographic equipment settings modification is not well publicized; and
WHEREAS, the CSNS is currently working on methods to improve safety in the neurosurgery workplace (1); and
WHEREAS, there have been no organized efforts to educate operators and support personnel regarding dose parameters of angiography equipment and ways to implement reductions; therefore
BE IT RESOLVED, in the interest of protecting our patients, support staff and physicians from excessive radiation exposure, that the CSNS study and electronically disseminate a recommended protocol and educational materials related to a safe method for modification of radiation dose settings of angiographic equipment utilized in neuroendovascular procedures.

Meetings of Interest for the next 12 months:

California Neurology Society: Annual Meeting, October 10-12, 2014, Santa Barbara, CA
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
Western Neurosurgical Society: Annual Meeting, September 10-13, 2015, Kauai, HI

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.

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