CANS newsletter

REGISTER for the 42nd CANS Annual Meeting, Newport Beach!

President's Letter

Deborah C. Henry, CANS 2014 President and Associate Editor

I had the opportunity to chat with Hunt Batjer this weekend. He was up in Chicago attending one of the various organizations that he belongs to. After all, he has been Chair of the Congress, the Society of University Neurosurgeons, the Neurosurgical Society of America and the American Board of Neurological Surgery. Currently, he is head of the ACGME Neurosurgery Residency Review Committee and President-Elect of the AANS.

He also volunteers more of his time as the Co-chair of the NFL's Committee on Head, Neck and Spine Injuries.

I first met Hunt when I was a medical student and he was Associate Professor under Duke Samson at University of Texas Southwestern. I spent two weeks there on an elective in the hallowed hospital that once took care of JFK and watched him clip aneurysms with the same steady voice and hand he constantly exhibits. His office door was always open, and if I remember correctly about the boots, he would sling his cowboy booted feet on the desk and talk with you like you were an old friend. He hasn't changed. He called me during a break during his Chicago meeting to talk about his upcoming presentation at the CANS meeting on January 17th. He wanted to know a little bit more about CANS and was intrigued to find out that CANS is mostly a socioeconomic organization.

We batted about several ideas. He recently gave a speech on his work with the NFL and commented how one play made all the difference in the direction the NFL has taken. I mentioned how one patient, Libby Zion case, changed residency work hours forever.

Hunt has had an amazing career. In some ways, he reminds me of the first day in medical school when you find out that no longer are you the smartest one in the class. He is that smart student sitting in the front row. I struggle with all that I do and yet it does not even come close to what this humble man does. So, I mentioned how he has come full-circle from starting at UT Southwestern as a medical student and faculty to returning to his roots but now as Chair. He has a wealth of experience in all things surgical and socioeconomic. His answer to all that was he has been extremely blessed. I took pause at that. Sometimes in the cacophony of life, we forget how truly blessed we are to being able to do what we do.

In the end, we decided on the title *The Serendipitous Neurosurgeon*. It will be an amazing tale of a special journey from a thoughtful man.

INSIDE THIS ISSUE:

On behalf of the Board of CANS including the editors of this newsletter, I wish you a safe and blessed thanksgiving. ❖

To What Tune Do We Docs Dance

Randall W. Smith, MD, Editor

The following is an Op Ed published in the November 18th issue of the New York Times. Well said!

How Medical Care Is Being Corrupted

By PAMELA HARTZBAND and JEROME GROOPMAN

When we are patients, we want our doctors to make recommendations that are in our best interests as individuals. As physicians, we strive to do the same for our patients.

But financial forces largely hidden from the public are beginning to corrupt care and undermine the bond of trust between doctors and patients. Insurers, hospital networks and regulatory groups have put in place both rewards and punishments that can powerfully influence your doctor's decisions.

Contracts for medical care that incorporate "pay for performance" direct physicians to meet strict metrics for testing and treatment. These metrics are population-based and generic, and do not take into account the individual characteristics and preferences of the patient or differing expert opinions on optimal practice.

For example, doctors are rewarded for keeping their patients' cholesterol and blood pressure below certain target levels. For some patients, this is good medicine, but for others the benefits may not outweigh the risks. Treatment with drugs such as statins can cause significant side effects, including muscle pain and increased risk of diabetes. Blood-pressure therapy to meet an imposed target may lead to increased falls and fractures in older patients.

Physicians who meet their designated targets are not only rewarded with a bonus from the insurer but are also given high ratings on insurer websites. Physicians who deviate from such metrics are financially penalized through lower payments and are publicly shamed, listed on insurer websites in a lower tier. Further, their patients may be required to pay higher co-payments.

These measures are clearly designed to coerce physicians to comply with the metrics. Thus doctors may feel pressured to withhold treatment that they feel is required or feel forced to recommend treatment whose risks may outweigh benefits.

It is not just treatment targets but also the particular medications to be used that are now often dictated by insurers. Commonly this is done by assigning a larger co-payment to certain drugs, a negative incentive for patients to choose higher-cost medications. But now some insurers are offering a positive financial incentive directly to physicians to use specific medications. For example, WellPoint, one of the largest private payers for health care, recently outlined designated treatment pathways for cancer and announced that it would pay physicians an incentive of $350 per month per patient treated on the designated pathway.

This has raised concern in the oncology community because there is considerable debate among experts about what is optimal. Dr. Margaret A. Tempero of the National Comprehensive Cancer Network observed that every day oncologists saw patients for whom deviation from treatment guidelines made sense: "Will oncologists be reluctant to make these decisions because of an adverse effects on payments?" Further, some health care networks limit the ability of a patient to get a second opinion by going outside the network. The patient is financially penalized with large co-payments or no coverage at all. Additionally, the physician who refers the patient out of network risks censure from the network administration.

When a patient asks "Is this treatment right for me?" the doctor faces a potential moral dilemma. How should he answer if the response is to his personal detriment? Some health policy experts suggest that there is no moral dilemma. They argue that it is obsolete for the doctor to approach each patient strictly as an

individual; medical decisions should be made on the basis of what is best for the population as a whole.

We fear this approach can dangerously lead to "moral licensing" — the physician is able to rationalize forcing or withholding treatment, regardless of clinical judgment or patient preference, as acceptable for the good of the population.

Medicine has been appropriately criticized for its past paternalism, where doctors imposed their views on the patient. In recent years, however, the balance of power has shifted away from the physician to the patient, in large part because of access to clinical information on the web.

In truth, the power belongs to the insurers and regulators that control payment. There is now a new paternalism, largely invisible to the public, diminishing the autonomy of both doctor and patient.

In 2010, Congress passed the Physician Payments Sunshine Act to address potential conflicts of interest by making physician financial ties to pharmaceutical and device companies public on a federal website. We propose a similar public website to reveal the hidden coercive forces that may specify treatments and limit choices through pressures on the doctor.

Medical care is not just another marketplace commodity. Physicians should never have an incentive to override the best interests of their patients.

Pamela Hartzband and Jerome Groopman are physicians on the faculty of Harvard Medical School and co-authors of "Your Medical Mind: How to Decide What is Right for You." ❖

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!

In Memoriam

We were most saddened to learn of the death of **Douglas Enoch**, MD, long time Sacramento neurosurgeon in private practice. Doug was a stalwart member of CANS and was prominent in its early years. The organization was looking for a place to lay its collective head in the early 1980's and when Doug served as President in 1982-1983, he offered his office as a place to keep our stuff and for our Executive Secretary to hang out and develop the workings of the Association. It was a pleasure to know him and his enthusiasm for CANS which was infectious.

Douglas was born April 20, 1933 in Waukegan, Illinois and attended Northwestern University undergraduate and medical schools. He completed his residency in neurosurgery at the Mayo Clinic in Rochester, Minn. and received his Master of Science degree from the University of Minnesota. At Northwestern, he was president of Lambda Chi Alpha fraternity

and a member of Alpha Omega Alpha Medical Honor Society, and Phi Beta Kappa. He began his neurosurgical practice in Sacramento in 1967 but took a 2 year military leave serving as a Cmdr. in the U.S.Navy Medical Corps. Returning to Sacramento in January 1970 he resumed his medical practice. He was also a founding member of the Sacramento Neurological Society and a board member of the Sacramento Symphony and the Sacramento Opera.

After his retirement, he was very active in Rotary, partaking in as many activities as his degenerative spine disease allowed. He is survived by Sylvia, his wife of 38 years, his stepson Mark Bliss (Lisa) of San Antonio and his grandchildren Sarah Bliss of Ann Arbor, MI and Evan Bliss of Long Beach, CA. At his request no services will be held. The family will honor him with a celebration of his life after the first of the year, and friends will be notified of the date and location. In lieu of flowers, memorial gifts may be made to Sacramento SPCA, 6201 Florin Perkins Rd., Sacramento, CA 95828 or online at www.SSPCA.org ❖

CANS MISSION STATEMENT

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

Brain Waves

Deborah Henry, MD, Associate Editor

I have often thought about getting a personalized license plate but have debated whether it will draw too much undesired attention. The special interest plates in California run the gamut from pet lovers, kids, veterans, and the parks from Yosemite, Coastal (with the whale tail) and Tahoe. One can support the arts, support agriculture or simply have a memorial plate.

For the longest time, I thought I would put 2MCH2DO on my plate, but then coming out to my car after work and seeing that I thought I had too much to do every day would be a bit of a drag. My favorite that I have seen was TOPLUS on a nice red convertible. I looked online to see what other doctors have. There is the LUB DUB for the cardiologist and the CME 2P for the urologist. The variant on the latter is NOPCME. The proud surgeon had LUV2CUT, the

gastroenterologist had 1BM QD, and the radiologist C THRU. The psychiatrist's plate could work for the neurosurgeon as HEADDOC.

New York has a personalized medical doctor plate with the Caduceus and the letters M and D on each side of the staff. New Jersey's plates can have the word physician on the bottom. One has to call for the application, so perhaps you do have to be a professional to get a professional license plate. I was warned long ago not to have MD on a license plate for fear of someone breaking into the car for presumed drugs, though I don't think I have had more than an Excedrin or ibuprofen in mine and not when I needed one.

Recently I saw a news article about the Snoopy plate coming to California. The state needs to sell 7500 before they will start issuing them. The happy little beagle is dancing his heart out. Six letters and Snoopy can be personalized. Maybe the DOCISN would work. But perhaps the best is what Snoopy and I truly are: THNKFL.

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Transitions in Neurosurgery

John Bonner, MD, Associate Editor

The Obamacare health plan signups started again on Saturday, November 15, 2014, with the hopes that it will be more effective than the previous year. The signup is supposedly easier than last year, but there is no evidence yet available to determine whether coverage will be more effective, whether claimants will be able to obtain the medical treatment they desire, or whether physicians will accept lower reimbursements to the point that more will accept patients with Obamacare insurance.

Neither physicians nor hospitals are enthusiastic about Obamacare as evidenced from last year's performance. Last year we saw the obstruction of health care delivery to many patients due to limited Obamacare coverage i.e., patients often were unable to see their treating physicians, and instead were forced to find new physicians to provide care. Further, Obamacare insurance reimbursements were not adequate enough for physicians and patients to continue their pre-Obamacare relationship.

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A recent report from the California Department of Managed Health Care indicates that Covered California insurers, Blue Cross and Blue Shield, did not present an accurate listing of in-network physicians. More than 25% of the physicians listed as participants in the Plans' directories were

not accepting these patients or they were no longer at the location listed by these companies. Auditors were unable to confirm Covered California participation status for more than 40% of physicians listed as participating in the plan directories after three attempts to contact them. According to the Report, these inaccuracies present such a burden to accessible health care that they are a violation of state law. The Report notes that Blue Cross and Blue Shield provide nearly 60% of patient enrollment in Covered California.

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We are now close to the end of another year – a year that, as usual, passed by much too quickly. Yet, this time of year is often very pleasant, with Thanksgiving, Hanukkah, Christmas and New Year's Day. Hopefully all of us will be able to enjoy these holidays. Indeed, it is a time to reflect on, and appreciate, the benefits that family and friends bring all year long. ❖

Thank you
to these confirmed exhibitors of the
CANS Annual Meeting:

Boston Scientific
Monteris Medical
NeurOptics
PMT Corp
KLS Martin
Globus Medical
ExamWorks

WHO'S NEXT?-CLICK HERE for more information!

Tidbits from the Editor

The Aging Surgeon and Credentialing

In a recent article (*Annals of Surgery*. 2014;260(2):199-201), Mark R. Katlic, MD and JoAnn Coleman, DNP, ACNP-BC write about the aging surgeon and how to manage questions that can arise regarding continued competent practice in the senior surgeon population. They note that most hospitals by-laws do not contain any provision for dealing with the aging staff physician. They detail a new Aging Surgeon program launched this year at the Sinai Hospital of Baltimore that is designed to thoroughly and confidentially evaluate a surgeon as described below:

"The goals of the program are as follows: protect surgeons from arbitrary or unreliable methods of assessing competence or cognitive capacity; identify potentially treatable or reversible disorders that, if treated, could restore or improve functional capacity; aid surgeons in deciding when to retire; protect patients from unsafe surgeons; protect surgeons and hospitals from liability risk; rely on existing structures for using results to make credentialing and privileging decisions; and provide objective, comprehensive, unbiased evaluation.

Our multidisciplinary team includes experts in Surgery, Geriatric Surgery, Neurology, Neuropsychology, Physical Medicine and Rehabilitation, Ophthalmology, Internal Medicine, Legal Services, and Ethics. The program includes a pre-visit screen of medical history and appropriate recent radiographs (eg, magnetic resonance imaging), and then travel to Baltimore. Day 1 begins with general physical and neurologic examinations, physical therapy/occupational therapy evaluation (reaction time, distance judgment, coordination, dynamic visual-spatial acuity, fine-motor function, and more), and then lunch. The afternoon comprises neuropsychology testing (attention, memory, executive functioning, emotional status, and more), and then dinner and sleep. Day 2 encompasses a morning of neuropsychology, lunch, physical therapy/occupational therapy, ophthalmology, and an exit interview.

The resulting report will be sent as an encrypted locked electronic file to the individual who contracted and paid for the program, likely a chief of surgery, hospital president, or the surgeon him- or herself. The report will include only objective findings; decisions about privileges, retirement, or even lifestyle changes must be made by those who receive the report."

Such a program would be nice to have in California but to this writer's knowledge there is no such comprehensive evaluation service in the Golden State. There is something called RecoveryWorks which is a new intensive outpatient treatment program for the treatment of alcoholism and addiction. "In addition to helping individuals from the general public with alcoholism and addiction dependency issues, RecoveryWorks aims to assist people in positions of trust cope with their own substance abuse problems." said its founder, Clark Smith, a forensic and addiction psychiatry expert and founding director of the Sharp McDonald Center Chemical Dependency Recovery Hospital in San Diego. Maybe this program might be modified to attend to the aging surgeon question. RecoveryWorks Web site is at http://recoveryworkssd.com/

New CANS Officer Slate for 2015

The CANS Nominating Committee has prepared the following slate of officers for 2015 after reviewing all nominations submitted by the membership.
(New officers are in ***bold, italic***)

Praveen Mummaneni, MD President-Elect
Kimberly Page, MD 1st Vice President
Kenneth Blumenfeld, MD 2nd Vice President
Marshal Rosario, MD Treasurer
John Ratliff, MD Director-North
Mitch Berger, MD Director-North

Nominating Committee:
Praveen Mummaneni, MD (Chairperson),
Northern California: ***Lawrence Shuer, MD,***
Donald Prolo, MD
Southern California: ***Scott Lederhaus, MD,***
Marc Vanefsky, MD

Further nominations to the slate of officers will be accepted until December 3, 2014.

According to the CANS bylaws, each of these nominations must have three supporting signatures of active CANS members and written permission of the candidate for placement on the slate. **The nomination form is attached to the email which includes this newsletter.** On December 16, 2014, ballots will be mailed to all active members of CANS. The candidate for each office receiving the majority vote of active members will be elected. In order to be counted, ballots must be received by the Executive Secretary on or before January 12, 2015, 72 hours prior to the Annual Business Meeting.

No more Cowboys

Readers may be aware of **Saleem I. Abdulrauf, MD,** a St. Louis neurosurgeon who is the force behind the **Walter E. Dandy Neurosurgical Society** and is its President. His 2014 Presidential Message outlines what he thinks will be in the best interests of neurosurgical patients going forward. He feels that outcomes should drive not only who does what but should also point the way to change neurosurgical training. He proposes that the first four years of training should cover (without a general surgery year) Acute Neurosurgical Training so every neurosurgeon can handle the brain threatening acute stuff and be qualified to cover an ED/Trauma center. After those 4 years, trainees must pass written and oral boards and then move on into a year of research pertinent to their specific interests and then embark on two years of training in one of 12 areas (see below) of subspecialty at a high volume institution pertinent to the subspecialty. After those final two years, oral and written boards specific to each of the twelve subspecialties are taken and if passed result in a final certification in Neurosurgery with a certificate of added qualification in the subspecialty.

He thinks it makes no sense to have all neurosurgeons be considered experts in all of neurosurgical treatment and really masters of none. He thinks it is crazy to have cities/catchment areas of 700,000 or larger with a bunch of neurosurgeons all or nearly all in competition with one another when the neurosurgeons should all be in one group with each member concentrating on one or two areas so high volume experience is brought to bear which will generate better outcomes as well as data useful in contracting with insurers and malpractice carriers.

Dr. Abdulrauf isn't the first person to suggest that the days of the solo cowboy neurosurgeon should be over. His training concepts are a bit more original.

*See next page

Proposed Model for Restructuring the Practice of Neurosurgery

Coalesce into larger groups each providing expertise in every area of the field.
In this model each neurosurgeon would need to select one of the 12 categories listed below as his/her main area of practice.

Outcome Based Elective Practice Subspecialty Classification in Neurosurgery	
1. **Cerebro-vascular & Endovascular Surgery**	For neurosurgeons whose practice is dedicated to both endovascular and microvascular procedures. In addition to the standard cerebro-vascular procedures, these neurosurgeons provide stroke coverage for their centers. The proportion of endovascular, as compared to open microvascular procedures, is up to the practitioner, provided that the above cerebrovascular practice is no less than 80% of their total elective neurosurgical practice.
2. **Cerebro-vascular & Skull Base Surgery**	For neurosurgeons whose practice is dedicated to complex microvascular and skull base surgery. The above must be no less than 80% of their total elective neurosurgical practice.
3. **Functional & Pain Neurosurgery**	For neurosurgeons whose practice is dedicated to functional and pain related procedures. The proportion of the functional work, as compared to pain related procedures, is up to the practitioner, provided that the above practice is no less than 80% of their total elective neurosurgical practice.
4. **Neurotrauma & Critical Care ***	For neurosurgeons who are dedicated to neurotrauma and critical care practice. The above must be no less than 80% of their total neurosurgical practice.
5. **Pediatric Neurosurgery ǂ**	For neurosurgeons whose practice is dedicated to pediatric neurosurgery. The above must be no less than 80% of their total elective neurosurgical practice.
6. **Peripheral Nerve Surgery ǂ**	For neurosurgeons whose practice is dedicated to peripheral nerve surgery. The above must be no less than 80% of their total elective neurosurgical practice.
7. **Tumor Surgery & Neuro-Oncology**	For neurosurgeons whose practice and research is dedicated to tumor surgery. The above must be no less than 80% of their total elective neurosurgical practice.
8. **Tumor & Skull Base Surgery**	For neurosurgeons whose practice is dedicated to tumor surgery, as well as skull base surgery for complex base of the skull tumors. The above must be no less than 80% of their total elective neurosurgical practice.
9. **Tumor & Functional Surgery**	For neurosurgeons whose practice is dedicated to tumor surgery and functional neurosurgery. The proportion of tumor surgery, as compared to functional neurosurgery, is up to the practitioner, provided that the combined practice is no less than 80% of their total elective neurosurgical practice.
10. **Spine Surgery**	For neurosurgeons whose practice is dedicated to spine surgery. The above must be no less than 80% of their total elective neurosurgical practice.
11. **Spine & Pain Surgery**	For neurosurgeons whose practice is dedicated to spine surgery and pain procedures. The proportion of spine surgery, as compared to pain related procedures, is up to the practitioner, provided that the combined practice is no less than 80% of their total elective neurosurgical practice.
	OR
12. **Spine & Peripheral Nerve Surgery**	For neurosurgeons whose practice is dedicated to spine surgery and peripheral nerve surgery. The proportion of spine surgery, as compared to peripheral nerve surgery, is up to the practitioner, provided that the combined practice is no less than 80% of the total elective neurosurgical practice.

Color indicates the key subspecialties in neurosurgery, defined based on calculations that approximately 85% of all neurosurgeons would fit into one of these four categories as indicated from review of state and nationwide databases.

* Based on the initiative articulated by the Dandy President, all neurosurgeons are expected to cover all neurosurgical emergencies, especially neurotrauma. This subspecialty category is only for those whose careers, including practice and research, are dedicated to neurotrauma and critical care.

ǂ Based on responses from questionnaire and review of data, it is our conclusion that very few neurosurgeons can have a predominant practice of peripheral nerve surgery. This category has been included in order to present a complete classification system and to assure its formal recognition as a neurosurgical subspecialty.

ǂ Our review indicated that as pediatric neurosurgery centers of excellence emerge, there will be a natural progression towards subspecialties within this field (e.g., tumors, functional, craniofacial, spine, etc.). This specific document does not address those specific issues, which are within the jurisdiction of the subspecialty itself (Dandy Task Force on Outcome-Based Subspecialty Practice Report).

All Subpoenas are not Equal

So you get a subpoena for medical records. You and your office staff just have to comply, right? After all, it's a subpoena. **Medical Justice**, the neurosurgeon Jeff Segal, MD outfit in North Carolina, points out that all subpoenas are not equal.

There are judge signed subpoenas, which have the effect of a court order. But, a lawyer-signed subpoena is not the same as a judge-signed subpoena.

A health care provider may disclose protected health information required by a court order, including the order of an administrative tribunal. However, the provider may only disclose the information specifically described in the order.

A subpoena issued by someone other than a judge, such as a court clerk or an attorney in a case, is different from a court order. A provider may disclose information to a party issuing a subpoena only if the notification requirements of the Privacy Rule are met. Before the doc may respond to the subpoena, the Rule requires that reasonable efforts were made to either:

- notify the person who is the subject of the information about the request, so the person has a chance to object to the disclosure, or to
- seek a qualified protective order for the information from the court.

So the wise doc is he who looks at a subpoena with some attention as to who signed it and be ready to consult an attorney if your patient objects to providing the information.

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Executive Office News

The Annual Meeting information is available on our website: www.cansl.org!
Reserve your room today!
You can download the registration information here:

REGISTER TODAY

Do you have a company you would like to see at that the upcoming meeting? Tell them about the exhibitor opportunity in Newport Beach on January 16 – 18th. 2015! Information is available on our website.

Thought for the Month:

I am in shape. Round is a shape.

Meetings of Interest for the next 12 months:

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, 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, Colorado Springs, CO
New England Neurosurgical Society: Annual Meeting, 2015, TBA
Western Neurosurgical Society: Annual Meeting, September 10-13, 2015, Kauai, HI
California Neurology Society: Annual Meeting, 2015, TBA
CSNS Meeting, September 25-26, 2015, New Orleans, LA
Congress of Neurological Surgeons: Annual Meeting, September 26-30, 2015, New Orleans, LA
North American Spine Society: Annual Meeting, October 26-29, 2015, Boston, MA

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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