CANS newsletter

One Neurosurgery and a AANS/CNS Merger

Randall W. Smith, MD, Editor

The movement to amalgamate the American Association of Neurological Surgeons and the Congress of Neurological Surgeons into one national organization as promulgated by the One Neurosurgery Advocacy Committee (ONAC) continued recently when Charles Rosen, M.D., from West Virginia penned his reasons for just having one national organization in an email sent to, one presumes, every neurosurgeon in North America. His argument featured these points:

1. Vendor support for two neurosurgical meetings per year is going to decline because companies cannot support two large national meetings each year.
2. AANS and CNS members will be making less money in the future which will jeopardize their ability to pay dues and attend annual meetings of both organizations.
3. The expense of maintaining two separate national organizations each with its own infrastructure is unsustainable.
4. The recent meetings of the AANS and CNS 6 months apart in San Francisco was folly.
5. Only having one national meeting a year frees up members to attend joint section meetings and subspecialty meetings.

Before I comment, a disclosure. I was elected Vice President of the AANS running on a platform of pursuing an amalgamation of the two organizations. When I got to the AANS Board, it was detailed to me that the AANS and CNS had multiple meetings considering the issue and that the CNS was not interested in a merger so I could just save my breath. I believe that the meetings occurred and that no way was discovered to accomplish merger.

Now to ONAC. I personally don't buy that the poor vendors can't afford to exhibit at two meetings. For most sizeable companies (the ones in the major aisles at the meetings), exhibit costs have to be chump change. Although some company admin folk might have told Dr. Rosen (as he claims) that they " . . could not justify supporting two large national meetings in the long term.", that is blowing smoke. Showing the neurosurgical bees about corporate pollen to fertilize the surgical suite is part and parcel of what these companies do and with the Sunshine Act baring big time corporate largesse, exhibiting at meetings is one of the few remaining ways to get to the bees.

I agree that neurosurgeons are very likely to make less money in the future but I also don't buy that the cost to pay dues or attend meetings is so onerous that we neurosurgeons will have to skip funding our life styles, retirement funds or our kid's college plans because of the cost of AANS and CNS dues or attending their meetings. What we are short of is time.

INSIDE THIS ISSUE:

The expense of maintaining two national organizations is not unsustainable as long as each year's P&L for the AANS and CNS remains in the black as I understand they have without much trouble for the last decade. These organizations appear robust and I suspect they see no reason to change their MO.

Tandem meetings in one city is rare and is hardly a cause for revolt, particularly if one lives in or near such a city. So don't go to one of the meetings.

Finally, since time for meetings is indeed an issue for a neurosurgeon, having fewer annual meetings of the AANS or CNS would potentially help but as long as the meeting attendance requirements are reasonable (as they are for the AANS—once every 5 years; as they are not for the CNS—once every 3 years), there is plenty of opportunity to skip the national organizations' meetings leaving a goodly amount of time for other kinds of meetings.

In short, I believe the ONAC should stop baying at the moon and take concrete steps to create useful change. First, working within each organization's by-laws, the ONAC should have little difficulty in getting their agenda to a democratic vote of each organization's membership. A bare earth approach would be to force a vote on a by-laws change that would state: **The AANS/CNS will merge into one organization with a single infrastructure and a single annual meeting within X years of passage of the by-laws change**. That could be a stretch since changing the by-laws of either organization requires a 2/3 majority to pass. Alternatively, and much more likely to get the 2/3 vote, would be for ONAC to propose a by-laws change for the CNS to reduce its meeting attendance requirements to one in 5 years. And while they are at it, they should sponsor by-laws changes in both organizations to abolish the requirement to obtain CME credits to maintain membership (CNS-90 hours/3 years; AANS 60 hours/3 years). The AANS and CNS have no business requiring CME which is appropriately handled by the ABNS's MOC process requirements and state licensing boards.

I really don't believe if I had to attend the AANS and CNS annual meetings once every 5 years, I would not have enough time or money to go to local, regional or subspecialty meetings of my choice dictated in part by what the Medical Board of California requires which is 50 Category I hours every two years. I personally get those hours pertinent to neurosurgery every two years with one national meeting, and three local or regional meetings (two 2-day CANS meetings and one 3-day Western Neurosurgical Society meeting). You can mix and match a lot of ways but going to one in five meetings of the bigs isn't terribly onerous. I must say that when mixing and matching, having two big meetings a year with over 20 hours of CME to choose from is an advantage.

Let the national organizations sink or swim with their dues structure and meeting income. As long as they make a buck—let them do so. If they fail to make enough money to continue to exist, they will die or amalgamate. Remember, if one can't afford the AANS/CNS dues and meeting attendance bucks they charge, one can always quit since as we all know, no one has to be a member of any neurosurgical organization including CANS, the AANS, the CNS, the NSA, the SNS, the Western, the Southern, The Rocky Mountain or the New England. If you want to be left alone, you can be—only go to the meetings you want to and need for CME *as a guest*. CME credits know no allegiance. ❖

In Memoriam

Stanford neurosurgeon **Paul Kalanithi, MD**, who wrote eloquently and movingly about facing mortality after being diagnosed with lung cancer, died of the disease March 9. He was 37. Paul had recently completed his neurosurgery residency at the Stanford, as well as becoming a first-time father, and was an instructor in the Department of Neurosurgery and fellow at the Stanford Neurosciences Institute.

Kalanithi went to college at Stanford, where he was involved in the University Marching Band. He graduated in 2000 with bachelor's and master's degrees in English literature and a bachelor's in human biology. He earned a Masters degree in History and Philosophy of Science and Medicine from the University of Cambridge before attending medical school at Yale graduating cum laude in 2007 and winning the Lewis H. Nahum Prize for outstanding research as well as membership in the Alpha Omega Alpha medical honor society.

His poignant essay "Before I Go: A Stanford neurosurgeon's parting wisdom about life and time" is reproduced elsewhere in this newsletter.

A link to Stanford's obituary for Dr. Kalanithi is: http://med.stanford.edu/news/all-news/2015/03/stanford-neurosurgeon-writer-paul-kalanithi-dies-at-37.html ❖

Paul Kalanithi and his daughter Cady
Photo courtesy of Mark Hanlon/Stanford University School of Medicine

Guest Essay

Before I Go: A Stanford neurosurgeon's parting wisdom about life and time

In residency, there's a saying: The days are long, but the years are short. In neurosurgical training, the day usually began a little before 6 a.m., and lasted until the operating was done, which depended, in part, on how quick you were in the OR.

A resident's surgical skill is judged by his technique and his speed. You can't be sloppy and you can't be slow. From your first wound closure onward, spend too much time being precise and the scrub tech will announce, "Looks like we've got a plastic surgeon on our hands!" Or say: "I get your strategy — by the time you finish sewing the top half of the wound, the bottom will have healed on its own. Half the work — smart!" A chief resident will advise a junior: "Learn to be fast now — you can learn to be good later." Everyone's eyes are always on the clock. For the patient's sake: How long has the patient been under anesthesia? During long procedures, nerves can get damaged, muscles can break down,

even causing kidney failure. For everyone else's sake: What time are we getting out of here tonight?

There are two strategies to cutting the time short, like the tortoise and the hare. The hare moves as fast as possible, hands a blur, instruments clattering, falling to the floor; the skin slips open like a curtain, the skull flap is on the tray before the bone dust settles. But the opening might need to be expanded a centimeter here or there because it's not optimally placed. The tortoise proceeds deliberately, with no wasted movements, measuring twice, cutting once. No step of the operation needs revisiting; everything proceeds in orderly fashion. If the hare makes too many minor missteps and has to keep adjusting, the tortoise wins. If the tortoise spends too much time planning each step, the hare wins.

The funny thing about time in the OR, whether you frenetically race or steadily proceed, is that you have no sense of it passing. If boredom is, as Heidegger argued, the awareness of time passing, this is the opposite: The intense focus makes the arms of the clock seem arbitrarily placed. Two hours can feel like a minute. Once the final stitch is placed and the wound is dressed, normal time suddenly restarts. You can almost hear an audible whoosh. Then you start wondering: How long till the patient wakes up? How long till the next case gets started? How many patients do I need to see before then? What time will I get home tonight?

It's not until the last case finishes that you feel the length of the day, the drag in your step. Those last few administrative tasks before leaving the hospital, however far post-meridian you stood, felt like anvils. Could they wait till tomorrow? No. A sigh, and Earth continued to rotate back toward the sun.

But the years did, as promised, fly by. Six years passed in a flash, but then, heading into chief residency, I developed a classic constellation of symptoms — weight loss, fevers, night sweats, unremitting back pain, cough — indicating a diagnosis quickly confirmed: metastatic lung cancer. The gears of time ground down. While able to limp through the end of residency on treatment, I relapsed, underwent chemo and endured a prolonged hospitalization.

I emerged from the hospital weakened, with thin limbs and thinned hair. Now unable to work, I was left at home to convalesce. Getting up from a chair or lifting a glass of water took concentration and effort. If time dilates when one moves at high speeds, does it contract when one moves barely at all? It must: The day shortened considerably. A full day's activity might be a medical appointment, or a visit from a friend. The rest of the time was rest.

With little to distinguish one day from the next, time began to feel static. In English, we use the word time in different ways, "the time is 2:45" versus "I'm going through a tough time." Time began to feel less like the ticking clock, and more like the state of being. Languor settled in. Focused in the OR, the position of the clock's hands might seem arbitrary, but never meaningless. Now the time of day meant nothing, the day of the week scarcely more so.

Verb conjugation became muddled. Which was correct? "I am a neurosurgeon," "I was a neurosurgeon," "I had been a neurosurgeon before and will be again"? Graham Greene felt life was lived in the first 20 years and the remainder was just reflection. What tense was I living in? Had I proceeded, like a burned-out Greene character, beyond the present tense

and into the past perfect? The future tense seemed vacant and, on others' lips, jarring. I recently celebrated my 15th college reunion; it seemed rude to respond to parting promises from old friends, "We'll see you at the 25th!" with "Probably not!"

Yet there is dynamism in our house. Our daughter was born days after I was released from the hospital. Week to week, she blossoms: a first grasp, a first smile, a first laugh. Her pediatrician regularly records her growth on charts, tick marks of her progress over time. A brightening newness surrounds her. As she sits in my lap smiling, enthralled by my tuneless singing, an incandescence lights the room.

Time for me is double-edged: Every day brings me further from the low of my last cancer relapse, but every day also brings me closer to the next cancer recurrence — and eventually, death. Perhaps later than I think, but certainly sooner than I desire. There are, I imagine, two responses to that realization. The most obvious might be an impulse to frantic activity: to "live life to its fullest," to travel, to dine, to achieve a host of neglected ambitions. Part of the cruelty of cancer, though, is not only that it limits your time, it also limits your energy, vastly reducing the amount you can squeeze into a day. It is a tired hare who now races. But even if I had the energy, I prefer a more tortoiselike approach. I plod, I ponder, some days I simply persist.

Everyone succumbs to finitude. I suspect I am not the only one who reaches this pluperfect state. Most ambitions are either achieved or abandoned; either way, they belong to the past. The future, instead of the ladder toward the goals of life, flattens out into a perpetual present. Money, status, all the vanities the preacher of Ecclesiastes described, hold so little interest: a chasing after wind, indeed.

Yet one thing cannot be robbed of her futurity: my daughter, Cady. I hope I'll live long enough that she has some memory of me. Words have a longevity I do not. I had thought I could leave her a series of letters — but what would they really say? I don't know what this girl will be like when she is 15; I don't even know if she'll take to the nickname we've given her. There is perhaps only one thing to say to this infant, who is all future, overlapping briefly with me, whose life, barring the improbable, is all but past.

That message is simple: When you come to one of the many moments in life when you must give an account of yourself, provide a ledger of what you have been, and done, and meant to the world, do not, I pray, discount that you filled a dying man's days with a sated joy, a joy unknown to me in all my prior years, a joy that does not hunger for more and more, but rests, satisfied. In this time, right now, that is an enormous thing.

Paul Kalanithi, M.D.Republished with permission from Stanford Medicine magazine. A link to the original story is at: http://stanmed.stanford.edu/2015spring/before-i-go.html ❖

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

The Germanwings plane is headed over the French Alps when the pilot asks the co-pilot to prepare for landing. The co-pilot responds "hopefully" and "we'll see." The pilot leaves the cockpit to use the rest room. It then takes thirteen minutes for the co-pilot to purposefully fly the plane into the French Alps, committing suicide and taking with him the lives of 149 others including children and Americans.

We give certain people, including those of us in healthcare, a tremendous amount of trust to care for us and deliver us safely. Like the passengers in a plane, a patient puts his or her life in our hands whether it is an ICU nurse, a respiratory therapist, or a brain surgeon.

Pilots are perhaps the most scrutinized workforce in the world, undergoing physical exams as well as skills assessment and random drug screening. All of this is in an effort to keep passengers safe. In healthcare, we continually work to do the same, often copying what the Federal Aviation Association does. We have checklists for the operating rooms and have developed protocols for the ICU. Maintenance of Certification has added another layer of protection, with neurosurgery having one of the most rigorous processes. We limit our resident training to an 80-hour workweek (which ironically has not increased patient safety). After this recent air tragedy, the aviation industry in Europe is asking that two people be in the cockpit at all times. In the US, that second person can be a flight attendant. It is unknown if this would have made a difference last week.

For most of my neurosurgical career, I have operated alone, that is without an assistant surgeon. I would imagine, given the scarcity of neurosurgeons, that this is true in most of this country. Where I first stated practice in Texas sometimes only one of us was available to cover the hospital for a week at a time while the other neurosurgeon was on vacation. This was also true when I did locum coverage. Often, there is never a choice to have an assistant, especially in emergency situations. Then there is the issue of physician fatigue, a topic that is often ignored in medicine as the demand for service becomes greater, external rules require us to be available at all times, and yet the number of doctors is inadequate for this. Physician fatigue is difficult to access. We have all been there, working long past the times when our bodies and minds needed rest. Solving this problem is no simple matter. It is far easier to cancel a plane flight than it is to cancel an emergency surgery. As a whole, we do pretty good keeping our patients safe. But like the airlines, we can always do better. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

As a semi-retired disability consultant for the State of California, I've noticed changes in the way a patient is evaluated by a physician. Specifically, in my early experience and private practice as a neurosurgeon, I used to see much attention placed on

histories, physical exams (including DTRs, physical abilities, and sensory exams), and laboratory results. But, over time, I've seen a change in emphasis, with more attention to MRIs, CTs and other advanced studies than on history and physicals. In addition, I see that history and physicals are more commonly performed by physician assistants and nurse practitioners, rather than having physicians themselves do them. Generally, I've noticed that there seems to be less physician contact with patients -- occasionally no physician contact. While this may reflect the advancement in medical technologies and increased demands on a doctor's time, I still wonder whether physicians are being properly trained in evaluating a patient.

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The *Wall Street Journal* reported (February 2, 2015, p. A1) that the government will now release doctors' billing for Medicare patients. The first set of data, released in April 2014, detailed the 2012 Medicare payments made to over 880,000 individuals and organizations, for more than 5,000 procedures, which totaled some $77 billion. In 1979, a federal judge agreed with the AMA that doctors' privacy interests outweighed the public interest in reporting Medicare payments, and issued an injunction prohibiting the government from releasing these payments. In March 2013, a federal judge lifted this injunction, making these payments public.

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You may recall that last month, I indicated that the Daughters of Charity were attempting to sell six not-for-profit hospitals to Prime Healthcare Systems. I must report now that the Daughters of Charity were not successful in selling their hospitals. A tip of the hat goes to Phil Lippe, who provided me with this information. ❖

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!

Tidbits from the Editor

CANS Board Meeting scheduled for April

The CANS Board of Directors will hold its spring meeting on April 18th at the Sheraton LAX commencing at 9 AM. Items to be considered are the usual housekeeping issues plus choosing a final place and date for a Long Range Planning Committee meeting designed to address some perceived shortcomings in the functionality of the Association. The Board will also consider taking positions on Council of State Neurosurgical Societies resolutions

(listed below) to be considered in Washington DC on May 1-2 just before the AANS meeting. Any CANS member who wishes to bring an issue to the attention of the Board or to comment on the resolutions is encouraged to do so by communication with our Executive Secretary Emily Schile at emily@cans1.org.

CSNS Resolutions to be considered on May 1-2 in Washington, DC:

Resolution I

Title: Gauging the Impact of hospital system mergers on the practice of neurosurgery

Submitted by: Shelly Timmons, Ann Stroink, Deborah Benzil

WHEREAS, today's rapidly changing world of healthcare is increasingly being driven by hospital systems and more global medical system mergers, and

WHEREAS, these mergers have the potential to alter and significantly impact neurosurgeons in any number of ways such as:

1. A Nonacademic system may purchase an academic system radically changing the rules of faculty compensation
2. Hospitals where neurosurgeons primarily practice and gain substantial referrals may be acquired by a large system with a competing neurosurgical practice
3. Quality programs, promotion, and similar assessments may become the purview of a remote administrator unknown to the neurosurgeon
4. Multi specialty practices may find their affiliated hospitals being bought or administered by competing systems
5. Neurosurgery hospitals may find they suddenly have new "bosses", rules of employment, competition, therefore

BE IT RESOLVED, that the CSNS design and implement a study to assess the current impact of, and the principle concerns about, the imminent changes related to medical system mergers on individual neurosurgeons and neurosurgery practice; and

BE IT FURTHER RESOLVED, that the results of this study will be presented to the CSNS EC and present preliminary information at the fall 2015 plenary session with specific recommendations about future advocacy, policy or educational efforts required.

Resolution II

Title: Creation of a AANS/CNS Safety Fellowship at the Institute for Health Care Improvement

Submitted By: Greg Smith, Clemens M. Schirmer, on behalf of the Ad-hoc Safety Committee, CNS Caucus, AANS Caucus.

WHEREAS, the importance of patient safety has always been a mainstay of neurosurgeons; and

WHEREAS, patient safety has become much more prominent in the lay press and in the public's eye, as well as in the governmental review processes in place for reimbursement and for facility and program accreditations; and

WHEREAS, Organized neurosurgery has also made patient safety prominent by including principles and review processes in medical education, graduate medical education, board certification process and in MOC process; and

WHEREAS, there exists a need to develop a level of expertise within neurosurgery to guide, develop and promote patient safety within the profession, and allow organized neurosurgery to attain a prominent position as a leader in the field of patient safety; and

WHEREAS the CSNS Ad Hoc Committee for Patient Safety has identified and secured the opportunity to seat a Fellow within the Institute for Healthcare Improvement annually; therefore

BE IT RESOLVED, that the CSNS petition the parent organizations (AANS and CNS) to sponsor and endorse a fellowship position within the Institute for Healthcare Improvement or any other similar entity of the parent organization's choosing through the AANS/CNS Quality Improvement Workgroup (QIW); and
BE IT FURTHER RESOLVED, that the CSNS request that such fellow be chosen by the parent organizations jointly through the AANS/CNS Quality Improvement Workgroup (QIW), with eligibility for residents supported by the research/elective component year of their training program; and
BE IT FURTHER RESOLVED, that such fellowship will be continued on an ongoing basis as determined by the AANS/CNS Quality Improvement Workgroup (QIW).

Resolution III
Title: Creation of Joint AANS/CNS workgroup for Patient Safety
Submitted By: Gregory Smith, Chair and on behalf of the CSNS ad hoc Committee for Patient Safety
WHEREAS, patient safety is a salient issue for the neurosurgeon and the neurosurgical community; and
WHEREAS, currently it has been identified by the CSNS ad hoc Committee for Patient Safety that much effort and creation of work product is needed for the neurosurgical community to attain higher levels of awareness, understanding and competency for the safety for our patients; therefore
BE IT RESOLVED, that the CSNS petition the parent organizations (AANS and CNS) to create a workgroup under the AANS/CNS Quality Improvement Workgroup (QIW), soon to be known as the Neurosurgical Quality Council; and
BE IT FURTHER RESOLVED, that this workgroup should consist (in part) of members from the CSNS with interest in the field of patient safety; and
BE IT FURTHER RESOLVED, this newly created subgroup of the QIW shall be tasked with the identification, recommendation and promulgation of patient safety initiatives within organized neurosurgery.

Resolution IV
Title: Programmable Shunts
Submitted by: Kenneth Blumenfeld, MD
WHEREAS, programmable shunts are now placed routinely; and
WHEREAS, the setting of a programmable shunt made not be known by the patient or any individual other than the treating neurosurgeon; and
WHEREAS, MRI scanning and other events may alter the setting of a programmable shunt; and
WHEREAS, the interrogation and reprogramming of a programmable shunt may be accomplished with minimal or no direct physical contact; and
WHEREAS, other programmable devices such as pacemakers, AICD's, and implanted stimulators are interrogated and reprogrammed routinely by manufacturer representatives; therefore
BE IT RESOLVED, that manufacturers of programmable shunts provide representatives on a routine and emergency basis to interrogate and reprogram shunts under the direction of a neurosurgeon; and

BE IT FURTHER RESOLVED, that shunt manufacturers and neurosurgeons be encouraged to register implanted programmable shunts with current settings into a manufacturer maintained accessible data base; and
BE IT FURTHER RESOLVED, that the above recommendations be forwarded to the AANS and CNS for consideration and implementation.

RESOLUTION V
Title: Nominations of Future CSNS Leaders
Submitted by: Analiz Rodriguez, Sharon Woods Webb
WHEREAS, the CSNS can annually nominate up to three people for an AANS open position for officer, director at large, and/or nominating committee member; and
WHEREAS, the CSNS is invested in promoting and cultivating future neurosurgical leaders; and
WHEREAS, it would be beneficial to create a pipeline of CSNS vetted representatives in the AANS; therefore
BE IT RESOLVED, that 4 weeks prior to the spring CSNS meeting, the CSNS will send out a list of potential CSNS qualifying member candidates to the CSNS membership; and
BE IT FURTHER RESOLVED, that the list and accompanying CVs of the potential candidates be made available at the spring meeting for the attendants.

RESOLUTION VI
Title: Surveying Stress, Burnout and Professional Pursuits among Neurosurgeons-in-Training
Submitted by: Frank Attenello, MD MS, J. Adair Prall, MD
WHEREAS, neurosurgical residency is a formative period for the direction of the young neurosurgeon; and
WHEREAS, recent evaluation of a cohort of matching neurosurgeons from 1990 to 1999 reveal an 86% (n=1171) residency completion rate; and
WHEREAS, the general surgery community has shown success using broad surveys in evaluating markers of burnout and academic pursuits among residents, with a 78% survey response rate among residents; and
WHEREAS, prior studies on physician burnout conducted by the CSNS have targeted the practicing neurosurgical population post-residency; and
WHEREAS, no current studies evaluate residency predictors of burnout, or pursuit of positions in academics, neurosurgery leadership, and socioeconomic committees;
WHEREAS, publishing study results may elucidate predictors of burnout among residents leading to active changes minimizing attrition; therefore
BE IT RESOLVED, that the CSNS will develop a survey assessing resident stressors, personal and work environment, available mentorship, exposure to organized neurosurgery, indicators of burnout, and assess resident professional goals; and
BE IT FURTHER RESOLVED, that the CSNS will distribute this survey and promote to all available neurosurgical residents so that we may better assess predictors of burnout and professional choices among the resident population effecting positive change at the training level in clinical, academic and organized neurosurgical exposure.

RESOLUTION VII
Title: Permit Medicare Drug Price Negotiation
Submitted by: Michael Medlock, MD FAANS, President, Massachusetts Society of Neurosurgeons

WHEREAS, the prohibition against the Medicare negotiating drug prices as put forth in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" appears to be a significant contributor to rising pharmaceutical cost; and
WHEREAS, pharmaceutical costs have risen dramatically over the past ten years, increasing 114 percent from the year 2000 to the year 2010 (ref 1); and
WHEREAS, the rate of return on research and development by the pharmaceutical industry is at the historic high of 14 percent (ref 2); and
WHEREAS, the cost of pharmaceuticals is leading patients to postpone care, contributing 43 to 50 percent of patients putting off purchasing needed medications, refills, or skipping doses to control costs of care (ref 3); and
WHEREAS, health care costs continue to climb at an unsustainable level, now at 18 percent of GDP in the year 2012, up from 13.8 percent in the year 2000 (ref 4); and
WHEREAS, the increased prescription costs of Medicare are shared by taxpayers, and these drug charges appear to have a broad effect of increasing overall costs for many health care payers; and
WHEREAS, no aspect of healthcare should be immune from cost, efficacy, and value analysis; therefore
BE IT RESOLVED, that the Council of State Neurosurgical Societies will support all reasonable efforts to eliminate the prohibition on Medicare drug price negotiation.

And you thought we have a crummy deal in California

Recently, WalletHub compared each of the 50 states and the District of Columbia along 12 key metrics designed to identify 2015's Best & Worst States for Doctors. Evolution Finance launched Wallet Hub in February 2012 as a one-stop destination for all the tools and information consumers and small business owners need to make better financial decisions and save money. The 12 key metrics:

Opportunity & Competition – Total Weight: 10
Physicians' Mean Annual Wage, Adjusted for Cost of Living: Full Weight
Monthly Average Starting Salary, Adjusted for Cost of Living: Full Weight
Physicians' Wage Disparity: Full Weight
Note: It refers to the wage disparity between 10% percentile and mean annual wage.
Number of Hospitals per Capita: Full Weight
Insured Population Rate: Full Weight
Medically Underserved Areas or Populations: Full Weight
Projected Percentage of the Population over 65 by 2030: Half Weight
Number of Physicians per Capita: Half Weight
Projected Percentage of Physicians per Capita in 2022: Full Weight
Work Environment – Total Weight: 5
The Rate of State Medical Boards' Serious Disciplinary Actions per 1,000 Physicians: Full Weight
Malpractice Award Payouts per Capita (Total Payout for Malpractice per Capita by state): Full Weight
Malpractice Liability Insurance Rate: Full Weight

The results from best to worst:

1. South Carolina
2. Minnesota
3. Texas
4. Mississippi
5. Kansas
6. Wisconsin
7. Tennessee
8. Iowa
9. Idaho
10. North Dakota
11. Michigan
12. Alabama
13. Arkansas
14. California
15. Indiana
16. Florida
17. Nebraska
18. Montana
19. Virginia
20. South Dakota
21. Missouri
22. North Carolina
23. Georgia
24. Oklahoma
25. Nevada
26. Ohio
27. Louisiana
28. Massachusetts
29. Wyoming
30. Vermont
31. Pennsylvania
32. Colorado
33. Illinois
34. New Mexico
35. Kentucky
36. West Virginia
37. Utah
38. Hawaii
39. Washington
40. District of Columbia
41. Arizona
42. New Hampshire
43. Delaware
44. Alaska
45. Connecticut
46. Maryland
47. Maine
48. New York
49. Oregon
50. New Jersey
51. Rhode Island

Apparently, California is not so bad afterall. ❖

Thought of the Month:

I don't need anger management. I need people to stop pissing me off!

Meetings of Interest for the next 12 months:

Neurosurgical Society of America: Annual Meeting, April 12-15, 2015, Newport Beach, CA
CANS BOD Meeting, April 18th, 2015, Sheraton LAX, Los Angeles, 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 Meet., June 20-24, 2015, Colorado Springs, CO
New England Neurosurgical Society: Annual Meeting, June 25-27, 2015, Chatham, MA
AANS/CNS Joint Neurotrauma and Critical Care Section Meeting, June 28, 2015, Santa Fe, NM
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
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 8-11, 2015, Seattle, WA
Cervical Spine Research Society: Annual Meeting, December 3-5, 2015, San Diego, CA
North American Neuromodulation Society: Ann. Meet., December 10–13, 2015, Las Vegas, NV
CANS Annual Meeting, January 22-24, 2016, The Cliffs Resort, Shell Beach, CA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, 2016 TBA
Southern Neurosurgical Society: Annual Meeting, 2016, TBA
AANS/CNS Joint Spine Section: Annual Meeting, March 16-19, 2016, Orlando, FL

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. Phillip Kissel 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.
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