CANS newsletter

Georgia has figured out a Med Mal solution that makes MICRA obsolete

Randall W. Smith, MD, Editor

Our good friend neurosurgeon Jeff Segal, who runs *Medical Justice,* has penned a good article on the pending state of Georgia Patient Compensation Act as circulated by *Medscape*. The Georgia legislation would create a Patients' Compensation System in which a patient who thinks he/she has been injured by a doc appeals to the System to investigate (with the help of an assigned advocate). A full record of care is reviewed by a rotating collection of medical experts in the relevant field. If this panel agreed that (1) the doc provided care, (2) a medical injury occurred resulting in damages and (3) that the treatment was the proximate cause of the damages, and (4) that an accepted method of medical services was not used for treatment or (5) that an accepted method of medical services was used for treatment, but executed in a substandard fashion, then the case would be referred to a compensation committee to make payment. The patient would not need a lawyer to propel his or her case forward; however, if desired, a lawyer could help the patient ensure that due process was followed.

The Patients' Compensation System would be a state-based entity and payments would not be reportable to the National Practitioner Data Bank (NPDB). Physicians would not need to purchase medical malpractice insurance, because they could not be sued. Instead, they would pay an annual contribution to administer the program. A family practitioner, for example, would pay $3900 per year; an orthopedic surgeon, $15,600 per year; and a spine surgeon, $17,500 per year. The specialists with the highest contribution rate, pediatric neurosurgeons, would pay $25,300 per year. These rates would be significantly below the current market rate for professional liability premiums—which typically cover only $1 million of liability.

In the Patients' Compensation System, there is no claim to defend. A doctor need only provide the patient's medical record. He or she may ignore any other procedural nuance, if desired. Alternatively, he or she may provide an explanation of care that was rendered. And if the doctor wants to advocate for the patient, he or she may sit with the patient. If a doctor, for example, misses a critical diagnosis that could have easily be made, and that error cost the patient an extra month in the intensive care unit, the doctor could apologize to the patient and work with him or her in a nonadversarial setting to help the patient achieve reasonable compensation. Furthermore, there

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would be no depositions, no cross-examinations, and no shutting down of a practice for 3 weeks to sit in a courtroom. Unlike the current system, there would be no reason to deny and defend.

In the Patients' Compensation System, all complaints would be reviewed. Currently, low-value claims are generally ignored by plaintiffs' attorneys because the cost of prosecuting such claims exceeds the estimated recovery. In contrast, because low-value claims would be heard under the Patients' Compensation System, more claims would be paid; in other words, more patients would have access to justice. Payment would be made in months rather than years, as is common now. And the amount paid would be rational, reasonable, and predictable. Physicians would be able to speak openly and plainly about medical errors—enabling broad patient safety initiatives to be implemented.

The bill would also allow a three-doctor panel to report any practitioner to the state licensing board who is an imminent danger to the public. A physician who poses such a risk would come to the attention of the board much sooner than under the status quo.

The Georgia bill has yet to pass the legislature and will need the governor's signature and will likely generate a lawsuit from attorneys. California neurosurgeons can only dimly hope we could install such a system in the Golden state but if it goes in Georgia, maybe it can go here. ❖

Position wanted:

Alexa Reeves Smith, MD, is interested in joining a practice in southern California (Ventura on south including the inland empire). Dr. Smith is a graduate of the Med School at the University of Washington and the neurosurgery program at UC Irvine. She recently completed a fellowship in pediatric neurosurgery at UCSD but also would be interested in an adult practice. Michael Levy MD, her mentor at UCSD, happy to provide a reference (mlevy@rchsd.org) as well as CANS consultant Marc Vanefsky, MD (marc.a.vanefsky@kp.org).

CSNS Report

By Deborah Henry, Southwest Quadrant Secretary

Dr. Mark Linskey concluded his 2-year term at the helm of the Council of State Neurosurgical Societies. In those two years of exceptional service, he had 10 initiatives including committee work advocating for strong state societies and forming at ad hoc committee that authored 11 papers on patient safety. Forming the California delegation to the May 1-2, 2015 CSNS meeting were Moustapha Abou-Samra (Regional Director), acting Southwest Quadrant Chair Ken Blumenfeld (in the absence of the injured Dr. Vanefsky), John Ratliff (QIW Chair), Pat Wade (CMA delegate), Ripul Panchal (CMA alternate delegate), Jack Bonner (Associate editor CANS newsletter), and myself (Southwest Quadrant secretary).

Two socio-economic abstract awards, named for prominent California neurosurgeons, were announced. The **Byron Cone Pevehouse Award** went to Gabriel Zada and the **Robert Florin Award** recipient was Kimon Bekelis. The **Randall W. Smith Award**, given for meritorious service to the CSNS, was awarded for the third time since its inception. The 2015 recipient was Ben Rosenbaum, a neurosurgical resident at Cleveland Clinic, who as a medical student in 2007, was tasked with creating a workable CSNS web site. He has created and maintained this very interactive web site, complete with tool boxes and password protected sites. The website can be viewed at csnsonline.org. The **Lyal Leibrock Award** recipient was Dr. Gary Blumgarden for his endless service to the CSNS and organized medicine. The meeting adjourned with Dr. Linskey turning over the gavel to Dr. Ann Stroink. Wonderful job, Mark!

Randall W. Smith Award to Benjamin Rosenbaum

Lyal Leibrock Award to Gary Blumgarden

Seven resolutions were debated. The results were as follows:

Resolution I-2015S
Action: Adopted Substitute Resolution
Title: Gauging the Impact of hospital system mergers on the practice of neurosurgery
BE IT RESOLVED, that the CSNS study the issue of imminent changes related to economic factors and a changing landscape of fee for service to value based medicine and develop a white

paper on how neurosurgeons and neurosurgery practices can define their value in this new environment.
BE IT FURTHER RESOLVED, that the CSNS work with the AANS and CNS to educate neurosurgeons on how to thrive amid these ongoing changes.
Fiscal Note: $0

Resolution II -2015S
Action: Adopted Amended Resolution
Title: Creation of a AANS/CNS Safety Fellowship at the Institute for Health Care Improvement
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 member neurosurgeons or 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).
Fiscal Note: none

Resolution III 2015S
Action: Adopted Amended Resolution
Title: Creation of Joint AANS/CNS workgroup for Patient Safety
BE IT RESOLVED, that the CSNS petition the parent organizations (AANS and CNS) to create a patient safety 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.
Fiscal Note: None

Resolution IV-2015S
Action: Rejected
Title: Programmable Shunts
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.
Fiscal Note: none

RESOLUTION V-2015S
Action: Rejected
Title: Nominations of Future CSNS Leaders
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.
Fiscal Note: zero

RESOLUTION VI-2015S
Action: Adopted
Title: Surveying Stress, Burnout and Professional Pursuits among Neurosurgeons-in-Training
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-2015S
Action: Rejected
Title: Permit Medicare Drug Price Negotiation
BE IT RESOLVED, that the Council of State Neurosurgical Societies will support all reasonable efforts to eliminate the prohibition on Medicare drug price negotiation.
Fiscal Note: none

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

Brain Waves is celebrating its five-year anniversary. In May 2010, this column started as "*Brain Waves-the meandering thoughts from a neurosurgeon.*" It was relegated to the last page and stayed there for two months with its lofty title. By July, it had moved up to the middle of the newsletter, and its title shortened to just "*Brain Waves*". December 2011 was the only time it was the lead article, appropriately so, as it touted our upcoming Annual Meeting and my attempts at going green and recycling New Year's resolutions.

When I started *Brain Waves*, I was faculty at Loma Linda and training our future generation. Since that time, most of those residents have graduated and moved on, the Accountable Care Act went from conception to reality, and medical school debt has gone from 29% of graduating medical students having debt greater than $200,000 to 43%, an increase of 14%. One in ten medical students now owe more than $300k by the time they pick up their diploma.

Wow!

I thought long and hard prior to applying to medical school. It wasn't the time commitment, the long hours, blood and guts, or the fear of making a mistake that I was most worried about. It was going into debt. I had managed to make it through college by working summers at Anderson-Clayton foods extracting Vitamin A and B-carotene from margarine and jobs during the school year teaching in the biology and embryology labs. I did not think working and going to medical school would be an option. I was fortunate, however. The oil business was still happily supplying money to the state coffers, and medical school in Texas was a bargain. Baylor College of Medicine's tuition was $400 (yes, that it correct) a year for my first three years. That number did not include insurance, school fees, any living expenses, but it allowed me to get through medical school borrowing only $25,000. I still worked the odd jobs such as cleaning all the microscopes for $100 and delivering babies at the County Hospital during a break for $4 an hour. In a 24-hour shift, that usually amount to eight deliveries. And of course, there was the sell your body to a clinical scientific study. I stayed away from the high-paying ones such as the "will Toradol give you a gastric ulcer?" This one involved a pre-test endoscopy, a trial of the NSAID or placebo and a post-trial endoscopy. Instead, I did the $100 post-doc study that involved placing a metal object on my frontal bones at the frontal sinuses and recording stimulation in my auditory canals. He couldn't get the experiment to work just right and was constantly adjusting the metal object on my forehead, enough so that after forty-five minutes of pressure on my frontal sinuses, I was ready to pay him $100 to stop. I went through the rest of the day with a bright ruby-red circle of erythema on my forehead.

When I first looked at practices after residency, there was a nice private practice in Austin, Texas offering $60,000 a year (that is not a mistype). I eventually took the employed position offering more and the ability to start operating right away. When I moved to California in 1995, my first year's salary in private practice was that $60,000 (again, not a mistype).

It took me less than 4 years to pay off that $25,000. I cannot even imagine how long it will take to pay off $300,000, especially with today's wages in private practice. It is no wonder why solo private practice is becoming a dying field. No one can afford it. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

My wife and I recently went to the AANS and CSNS meetings this May in Washington, DC. The sessions for the CSNS were very good and interesting, very supportive of neurosurgery. Overall I agreed with the decisionmaking by the CANS delegation.

The AANS started Sunday May 3, 2015. These Sunday sessions offered practical clinics which I assume were very good (not having taken them myself this year). The opening reception was at the Smithsonian Museum of American History, a very crowded event. If I have any misgivings about the opening reception, it is that it was so crowded that my wife and I hardly saw anyone we knew. The majority of attendees were from the East Coast and Midwest.

Overall, the morning sessions were very good. Those who presented the history films were very well accomplished and appreciated. The History Section Dinner at George Washington's Mount Vernon was very well attended and enjoyed. The majority of the plenary sessions were well prepared and informative, especially that of psychiatrist and political commentator Charles Krauthammer, M.D., as well as various neurosurgical history presentations.

However, I considered many of the afternoon presentations of neurosurgical residents and medical students to be subpar. Unfortunately, many of these presenters were poorly prepared and not well organized. The presentations were hurriedly given, not well understood, and, in some cases, hard to hear. While students from previous meetings were generally well prepared, with good presentations, I was disappointed with the student presentations at this year's AANS Meeting.

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There are various neurosurgical concerns that need attention, such as Medicare overpayments to hospitals, as noted in the April 16, 2015 Wall Street Journal. There are further neurosurgical concerns over Obamacare. The immediate future of health costs for many state residents across the United States hinge on the upcoming Supreme Court ruling. (Wall Street Journal, May 20, 2015, p. A1). The Supreme Court's ruling is also very important to medicine's status. I plan to review these issues in next month's CANS Newsletter, as the Supreme Court's ruling is expected this June. ❖

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

End of Life bill gets boost from the CMA

Following up on the editorial in last month's newsletter, the CMA has officially declared itself neutral on California Senate Bill 128 " End of Life Options Act" which would allow physicians, if they wish, to prescribe lethal amounts of medication to terminally ill patients. As with a similar Oregon law, the California proposal would require that two independent doctors affirm that a patient has the mental capacity to make an informed request and has less than six months to live. The patient would have to make two verbal requests separated by at least 15 days, followed by a written request. Only the patient would be allowed to administer the lethal drugs.

The bill's co-authors accepted amendments requested by the CMA to more clearly state that participation by doctors is strictly voluntary and that no doctor may be disciplined in any way for either abiding by a terminally ill patient's request or refusing to do so.

The bill is presently before the Senate Appropriations Committee and if passed there, goes on to a full Senate vote. Governor Brown has yet to indicate whether or not he would sign such a bill.

Cleanliness reduces fusion surgery infections

An article in May 2015 issue of *JAMA Surgery* by Serge P. Bebko, MD; David M. Green, MD and Samir S. Awad, MD, MPH entitled **Effect of a Preoperative Decontamination Protocol on Surgical Site Infections in Patients Undergoing Elective Orthopedic Surgery With Hardware Implantation** noted that the postop infection rate in 365 patients who watched an educational video about MRSA decontamination and were given chlorhexidine washcloths and oral rinse and nasal povidone-iodine solution to be used the night before and the morning of scheduled surgery experienced one-third the postop infections as compared to the 344 patients who did not pursue the decolonization. It would seem that any practice could institute the protocol even minus the video and potentially reap the benefits of the idea.

Simplified multiple state licensure takes a step forward

The Federation of State Medical Boards (FSMB) is an organization composed of every state medical board plus medical boards of USA territories. The FSMB has primarily served as a place for the various component boards to meet and greet and exchange ideas and try to spread

the news when a doc in one state has his/her license revoked so the other states in which the doc is licensed can be alerted.

The average doc hasn't received much of use from the FSMB—at least not until now. On May 19th, Alabama became the 7th state to join a FSMB sponsored Interstate Medical Licensure Compact Commission which thus keyes the Commission to move forward. This commission will consist of physicians, administrators, and members of the public who have been appointed to medical boards in the participating states. It will meet later this year to discuss the management and administration of the compact, according to the FSMB. Twenty other states have introduced legislation that would allow their medical boards to join the Commission (California not among them).

Under the compact, physicians who wish to practice in more than one state can be licensed in additional states without having to fill out a formal application or provide another set of records to each state medical board. If physicians meet the eligibility requirements spelled out in the compact, they can have the medical board in their "principal state" attest to their qualifications, and other states can license them. However, they must still pay the application fees set by each state's medical board.

This process is expected to be useful to physicians who practice in metropolitan areas that straddle state lines. Doctors who practice telemedicine across state lines can also benefit since much of telemedicine is defined as care occurring where the patient is and requiring the tele-doc to be licensed there. So can locum tenens physicians who frequently move from state to state.

Such a program would be helpful to California neurosurgeons who might want to have a 2nd practice location in Nevada or Arizona or Oregon and sure would help those of us that do locum tenens work. It may be a while, though, before we Californians can benefit since the only states opting into the Commission at this point are Minnesota, Alabama, Idaho, Montana, South Dakota, Utah, West Virginia, and Wyoming.

Medical Ethics group offers disclosure form

Scott Lederhaus, MD, neurosurgeon, CANS member and President of the Association for Medical Ethics, based out of UC Irvine, calls our attention to a disclosure form the Association has created. He feels that every spine surgeon should discuss the issue with every patient on whom he/she is planning to operate and also complete the following form:

Disclosure of Potential Conflicts of Interest:

A conflict of interest may occur when a physician has a financial relationship with a medical manufacturing company that could be perceived as influencing the surgeon's choice of drugs or devices to treat their patients. The relationship can be direct or it can be indirect through a family member or relative. A financial interest includes being paid money by a company as an employee, consultant, or patent holder with royalties, or being paid to promote the company's products such as in lectures or medical courses. Owning stock in the company is also a conflict of interest.

Legal relationships such as these may be beneficial to advances in medicine in many cases. Accepting money or stock from companies for the work physicians may do is not inherently bad. The important issue for the patient is that they be made aware of the existence and degree of financial relationships prior to treatment for the sake of transparency and patient rights.

A Physician Owned Distributor (POD) is a company that is owned in part by the physician and the manufacturers or other owners of a POD to buy implants. The implants are then surgically implanted in their patients. The physician then profits by the implants used through the POD from the sale of those implants to the hospital where the surgery occurred. If I am a participant in a POD and I plan to use implants from a POD then I will inform the patient which implants will be used and if I stand to make profits from such implants. I will also inform the patient if I stand to make profits from the use of spinal implants through a consulting arrangement with any implant company.

I _____ have NO conflicts of interest and do not receive money from any medical manufacturer.

I _____ have the following conflicts of interest (Listed below):

_____

_____

_____

_____

Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____

If you wish to download and print the form for your use, it is attached to the email you received announcing this issue of the CANS newsletter. ❖

Opinion for the Month:

I love water. Frozen into small cubes. Surrounded by Vodka.

Observation for the Month:

For the 120th straight month, the CANS newsletter has failed to garner a Pulitzer prize.

Insight for the Month:

There may be some relationship between the Opinion and the Observation.

Meetings of Interest for the next 12 months:

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
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
California Neurology Society: Annual Meeting, November 13-15, 2015, San Francisco, CA
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, Pismo Beach, CA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, 2016 TBA
Southern Neurosurgical Society: Annual Meeting, March 2-5, 2016, San Antonio, TX
AANS/CNS Joint Spine Section: Annual Meeting, March 16-19, 2016, Orlando, FL
Neurosurgical Society of America: Annual Meeting, June 19-26, 2016, Dublin, Ireland
CSNS Meeting, April 29-30, 2016, Chicago, IL
AANS/CNS Joint Pain Section Bi-Annual Meeting**, April 29, 2016,** Chicago, IL
AANS: Annual Meeting, April 30-May 4, 2016, Chicago, IL

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.
- 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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