



CANS

NEWSLETTER

California Association of Neurological Surgeons

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President's Message: When Doing Nothing is ... Best!

Moustapha Abou-Samra, M.D., F.I.C.S., F.A.C.S.

Doing Nothing?

Last week was a veritable whirlwind!

I attended the CSNS meeting in Orlando, FL, representing CANS. Our delegation included Ken Blumenfeld, Bill Caton our president elect, Deborah Henry, Mark Linsky who is also the corresponding secretary of CSNS, Randy Smith who is also the historian of CSNS, and Marc Vanefsky. CANS clearly has some influential voices at CSNS. I will add that the South West Quadrant is really dominated by California, though Texas' delegation is growing in size.

- I served on the reference committee, a completely new experience for me. I enjoyed learning and tried to do my best. I imagined my self on a jury. The resolutions were representative of the way neurosurgeons in attendance felt.
- The issue that generated a lot of discussion is now before the California courts: is operating on the wrong disc level a malpractice issue, or is it battery? Of course the answer to, us neurosurgeons, is clear, and reaching a conclusion that operating on the wrong level can be construed as battery will be nothing less than travesty! CSNS will support CMA in its amicus brief to the California Supreme Court. And CSNS will also ask AANS and CNS to join the anticipated AMA brief and possible lawsuit.
- CSNS will be mailing a survey to assess the level of Medicare participation of all neurosurgeons. It is an exceptionally important survey and I encourage each of you to participate. The issue is: the government and CMS say that 95% of neurosurgeons take care of Medicare patients. While this maybe technically true, it is far from representing what goes on in the trenches; the reality is a lot of neurosurgeons restrict, some very severely, the number of Medicare patients they see every week. Having accurate information will be helpful in the ongoing effort to fight for a more equitable compensation system for surgeons in general and neurosurgeons in particular.

Then I attended the CNS meeting. As we have grown accustomed, it was a big meeting with an awful lot of people. There was a lot to take in, but I enjoyed two talks in particular.

- Maya Angelou, an amazing woman who gave a warm talk about hope. She should tell the government what she told us: we are, each of us, a rainbow in the clouds for our patients. It is difficult to place a monetary value on giving Hope!
- Muhammad Yunus, the Nobel Laureate who developed the micro loan program in his native Bangladesh: he was so impressive that I felt ready to work for him when I stop practicing my beloved neurosurgery. His humility was amazing. His idea of starting "social business" is simply ... genius!

While we were attending to "neurosurgery" and neurosurgical problems, our government was ready to spend \$700 Billion to help what they say is "a loss of confidence in the market" and a "potential" disaster. Not knowing anything about money, except how to spend it faster than I make it, I felt glad to

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have Secretary Paulson and Chairman Bernanke at the helm. But, then, the more I read, the more I realized that the people that benefit the most from the bailout, maybe the people that got us in this mess in the first place, the people that benefited the most from Wall Street. Did you know that the bonuses of Wall Street executives added up to \$62 Billion year?

A common man, a farmer from the Midwest, was quoted by several of the newspapers: why would we rescue the executives who at best were incompetent and at worst criminal?

My favorite humor writer Joel Stein opted in a very wise op-ed in the LA Times, September 26, 2008, for the “doing nothing” option!

Doing nothing is an option we select with regularity in our clinical practices, particularly when we face tough problems. When I was young, it was rare that I considered such an option, but as I grow older and gain experience, I find myself more and more willing to take a wait and see approach to difficult problems, often with better long term results.

Why is it possible to find a trillion dollar to save Wall Street and we can't find the appropriate funds to fix health care?

Maybe we need more Joel Steins in Government!

See you in Carmel. ❖

The MBC Police Force

Randall W. Smith, M.D., Editor

The Medical Board of California (MBC), at the direction of the California State legislature, recently conducted a survey of the physician peer review process commonly known as the 805 process. It was felt that the “. . . Medical Board is not receiving information to which it is statutorily entitled about civil judgments, settlements, and arbitration awards against physicians, criminal convictions against physicians, or hospital disciplinary (peer review) actions against physicians as required by law.” A related section of the Business and Professions code, section 809, which allows a physician who has been found wanting by hospital peer review to request a fair hearing challenging any potential 805 action, was also studied. The survey was carried out by Lumetra, a non-profit healthcare consulting organization hired and paid for by the MBC which is entirely funded by license fees of docs and others.

As the reader should know, an 805 report to the MBS is required when a hospital peer review body finds it necessary to change, limit or revoke hospital privileges for medical cause or reason. The peer review process is usually triggered because of a complaint, as the result of a routine quality screening study, a sentinel or egregious event or an unexpected adverse outcome or other triggers.

Although the study was hampered to some extent because of the determination by many hospitals not to share a lot of peer review data upon advice of their legal counsel, Lumetra felt they got enough cooperation and data to come up with opinions and recommendations.

Lumetra found that most hospitals and docs made a good faith effort to follow the 805 rules but the whole concept of this self-reporting process fails because of hesitation by docs to make a career altering or ending 805 finding against a colleague or the extensive delay in any action cause by the 809 fair hearing rule that frequently cranks in one to two year delays in any final action. They also found peer review rarely leads to actual 805 or 809 actions, perhaps due to the confusion over when to file a report, that entities do not understand what should trigger a peer review, an 805 or 821.5 (physical or mental illness or substance abuse) report or that the costs in time and money associated with 805 reporting are high and may influence an entity's desire to actively pursue a case against a physician and choose a less expensive alternative (e.g., resignation, remediation, etc.).

Now comes the punch line. Lumetra recommended the following changes:

- Continue to allow healthcare entities to provide first level quality/safety screening of physician practice through **random record review of each physician no fewer than twice every year.**
- Define specifically what is required in the first level screens; these could be **screens recommended by a professional accrediting agency.**
- Refer any physician whose actions related to patient care do not meet the standard of care of the screening, or “fall out” of the screens for any reason, to an unbiased independent peer review organization that has no vested interest in the review outcome except protection of the public.
- **The independent organization will be selected by the MBC or the appropriate legislative committee. All further responsibility for making decisions about taking any action toward the physician including 805 or 821.5 reporting would be removed from the healthcare entity.**
- After the initial identification by the healthcare entity, the independent organization would take over all further investigation of the issue and make a recommendation to the healthcare entity regarding either filing an 805 report or other action such as recommending physician education and training, recommending PACE (UCSD Physician Assessment and Clinical Education Program) or recommending anger management training. **A copy of all recommendations would be sent to the MBC.** The healthcare entity would decide to follow or not follow the recommendation.
 - If a healthcare entity has an event (serious event or sentinel event) that requires an expedited or “fast track” review, that **event would be reported to the independent entity within five hours.** The independent organization would expedite the review/investigation (no longer than three days) and make an action recommendation to the MBC and to the healthcare entity (805, summary suspension if not already imposed, or other action).
 - The independent organization would create a **tracking system to follow patient-related care issues by physician** over time to monitor trends.
 - If a physician is not affiliated with an entity that performs peer review, **the physician is responsible for initiating peer review at least twice annually through a professional entity. There would be substantial financial penalties for failing to being subject to peer review twice annually.**
 - **All patient, physician, or employee complaints related to patient care would be referred by the healthcare entity to the independent entity for investigation.**
 - The independent organization would randomly select entities for assessment of the initial peer review process no fewer than once every three years. The independent entity would perform site audits of quality and safety programs, similar to Medi-Cal site audits. *(All bolding and underlining above is mine—Ed.)*

There are some obvious concerns docs should have about imposition of the above rules and creating the “unbiased independent peer review organization”, or in my opinion, the Patient Safety and Physician Behavioral Police. Some of the reporting and self peer review requirements are onerous and whoever wrote the report has never tried to oversee a medical staff that has a few things to do besides review every doc twice a year. In addition, no matter what the hospital does with a Police report the simultaneous filing of that report with the MBC one would think would take the matter out of the hospital’s hands. Further, the complete lack of any local doc input into the investigational process is troubling. Finally, the immediate police report required if a patient or hospital employee makes a complaint about a physician sounds like witch hunt abuse just waiting to happen. It will be interesting to see what the MBC, the legislature and the California Medical Association have to say about all this. ❖

NEUROSURGEON WANTED

Board Certified/Eligible Neurosurgeon needed to join busy neurosurgical practice and trauma center in **Northern California**. FT or PT position will be considered for qualified individual. Competitive salary, bonus and benefits. Please fax or email resume to: 916/773-8702 or laura@snamg.com, www.snamg.com. ❖

More News from the Editor

The Oregon Trail Looks Good From Here—Part II

In the June newsletter, we reported on the Oregon Work Comp imbroglio wherein surgical fee rates were being cut to something north of 200% of Medicare and the docs were howling. We expressed envy for those rates considering the 150% of Medicare we receive in California. Well, the other shoe fell when the Oregon WC division administrator created an emergency rule requiring medical providers to treat injured workers at PPO rates which are often in the Medicare rate range. Now the docs are screaming and threatening to stop treating injured workers altogether. The emergency rule was instituted because physical therapists, who were being paid at PPO rates by WC carriers, successfully appealed those rates and some carriers, now forced to deal with unending appeals they would lose thus having to pay the higher PT rates, were threatening to leave the state. The WC administrator was worried such an exodus would require increased WC premiums and solved the problem with the emergency rule which of course caught all the docs as well. Oregon's WC Medical Advisory Committee, the one that recommended prohibition for payment for artificial disc replacement surgery, is making a major protest. So now the bad news from Oregon is really bad. We wish the docs some luck and in the meantime, we probably should stay put in sunny California. ❖

CANS Board of Directors Meeting Summary

The BOD met on 9/13/2008 in LA. In attendance were all Officers and Directors except Drs. Henry, Mummaneni and Minassian (family medical emergency). All consultants were absent save Dr. Smith. The Board voted to:

1. Support the CMA led lawsuit to protect balance billing and authorized a \$1000 contribution to that endeavor.
2. Authorize a registration fee of \$300 for the annual meeting in January.
3. Accept to active membership Dr. Farhad Limonadi (Rancho Mirage), Dr. Albert Meric III (Newport Coast) and Dr. Bob Babak Shafa (Los Angeles).
4. Accept the resignations of Drs. V. Smith, T. Kellar and R. Osterdock.
5. Drop from membership for failure to pay dues: Michael Apuzzo, William Bergman, Sooho Choi, Alan Edelman, David Jones, Olusegun Leramo, A. Makoui, Mark Schnitzer, Edward Smith, Roland Torres, Robert Wayner and Joseph Welsh.
6. Approve the Awards Committee recommendation to bestow the Pevehouse Award to Dr. Ulrich Batzdorf.
7. Approve a policy creating the appointed position of Historian primarily to archive the proceedings of CANS.
8. Confirm the selection of the Disneyland Hotel as the site for the 2010 annual meeting.
9. Take the position that kyphoplasty and vertebroplasty should be covered by Medicare.
10. Take supportive positions of all resolutions to be considered at CSNS Orlando meeting (see CANS Newsletter, August, 2008) except resolutions V and VIII (both too pejorative). ❖

Highlights of Reports presented at the CSNS meeting in Orlando on 9/19-20/2008

Over 50 delegates representing states plus 22 delegates appointed by the AANS/CNS, 13 resident delegates and a smattering of guests heard the following items addressed:

1. Report by ACS representative **Dominic Esposito** noting that young neurosurgeons are not applying for **ACS membership** in droves. He pointed out that fewer neurosurgical ACS members will result in less neurosurgical representation on ACS committees and threatens our present fairly robust representation which was instrumental in derailing the Acute Care General Surgeon concept that was designed to have general surgeons doing some neurosurgical and orthopedic procedures.
2. The **AANS/CNS Washington Committee** (WC) has formed an Institute of Medicine (IOM) Project Team to respond to an anticipated report from the IOM recommending a further reduction in **resident work hours** which presently is at 80 hours/week. Rumor has it the IOM is considering 56 hours per week. Also, the Quality Improvement Workgroup of the

WC continues to feel that pursuing the federal Medicare PQRI program is not cost effective although with some planned increases in payment for participation, it may become so within the next year or so.

3. Pursuant to a resolution passed at the spring CSNS meeting in 2008, a point-counterpoint presentation by **Drs. Ed Vates and John Davis** addressing the **MedPac suggestion that surgical fees should be bundled** into the Medicare DRG hospital payment allowing the hospital and the surgeon to divide up the loot by negotiation. It was felt that with very careful construction, a neurosurgeon could well gain by the maneuver but the pitfalls including the Feds valuing the bundle at a sum less than its separate parts could be a killer.
4. The **Neurosurgery Political Action Committee** report by chairman **Rick Boop** noted that we are still 50K shy of our 500K goal for this 2-year election cycle. In addition to requesting that all AANS/CNS/CSNS officers and CSNS delegates and committee chairs need to stand up and be counted (and he presented by name all of the above who have not contributed), he also announced a new \$2500 or greater annual contribution level called the Presidents Circle which, along with some other bennies, includes an invitation to the Cushing Orator Luncheon at the annual AANS meeting.
5. Pursuant to a resolution passed at the spring CSNS meeting in 2008, **Mike Steinmetz** addressed **employment and contracting education** for neurosurgeons. He pointed out there are a number of education modules in the Resources section of the CSNS Web site (csnsonline.org), that at the imminent CNS meeting there was a practical course on coding and one on practice development and negotiating, luncheon seminars on coding and financial growth and the economics of neurosurgical healthcare and that another practical course on contracting, negotiating and other practice issues is planned for the 2009 CNS meeting.
6. Pursuant to a resolution passed at the spring CSNS meeting in 2007, **Charles Rosen** reported on efforts to deal with the non-standardization of **diagnostic study digital data distribution** (translation: to view studies on a CD you need to download various viewing software programs supplied by the imaging companies with which you are not familiar and utilizing which you may be misled about what the studies show). In part related to the CSNS resolution, the AMA convened a meeting at which neurosurgeons, neurologists, radiologists, orthopods and cardiologists were present along with the imaging machine companies such as General Electric, Siemens and Philips. The result of the meeting was that the problem needed to be fixed, that NEMA (an equipment manufacturer's group) and IHE (doc and industry group for improvement in computer systems in healthcare) react to a request by the AMA group for a universal viewer (strongly opposed by industry for proprietary reasons) or at least the ability of the doc to download the raw image data from the CD and then view it with a familiar program. The timeline for a potential resolution that could be embraced by all parties would be mid-2009. Dr. Rosen also said if no compromise can be reached, the issue could be solved by insurance companies who can refuse to pay for studies unless they result in quality data that is easily viewed.
7. **Ann Stroink**, chairwoman of the CSNS Workforce Committee, made a presentation about **medical tourism** (after the potential workforce implications were introduced in committee by resident **Andrew Grande**) pointing out that about 500,000 Americans went out of country for medical care in 2007 and that 6 million are estimated to do so by 2010. She noted that prices for such things as a lumbar laminectomy or an MRI are range from 1/3 to 1/4 the discounted managed care cost in the USA and an even smaller fraction of what hospitals and docs charge cash paying patients as usual and customary. She also noted that Blue Cross in California and South Carolina sell policies that include a foreign care option. She also reported that the Joint Commission has an international arm that blesses institutional quality though not doc qualifications. Some of the concerns about medical tourism include providing follow-up care in the USA and that a number of procedures offered by off-shore institutions have unproven value, a pitfall for the uniformed patient. Dr. Stroink floated the possibility that at some point, American neurosurgeons might entertain traveling to off-shore institutions to ply their trade, pursuing the concept that neurosurgery at a cash discount could be better than neurosurgery for Medicare or the Blues.
8. **Robert Schwetschenau** from Cincinnati received the CSNS **Lyal Leibrock Lifetime Achievement Award** for his nearly unbelievable support for the CSNS over the past 30 years. Dr. Schwetschenau attended all but two of the 62 meetings of the CSNS since its inception in 1978 and has held numerous leadership positions including secretary, quadrant chairman and committee chairmanships as well as serving as historian for 7 years.

9. The **Sam Hassenbusch Young Neurosurgeons award** for the best socioeconomic paper to be presented at the CNS meeting went to **Deepak Aggrawal, M.D.** for his talk *Fiducials: Achilles Heel of Image Guided Neurosurgery: An Attempt at Indigenization and Improvement*. The award for best socioeconomic paper by a resident went to **Scott Y. Rahimi, M.D.** for his talk *Post-Operative Pain Management following Craniotomy Using Atypical Analgesics: Evaluation and Cost Analysis*. ❖

Results of resolutions considered at the Council of State Neurosurgical Societies meeting 9/19-20/2008 in Orlando

Workforce Network-Locum Tenens: The goal is to set up a free national list of neurosurgeons available for locum tenens work that an interested doc could use to obtain coverage without the use of expensive locum tenens agencies. **Referred to Workforce Committee to bring implementation plan to Executive Committee.**

Joint Neurosurgical Research Committee: The goal is to create a committee to establish sources of research funding that does not include device and drug manufacturers. **Adopted; Executive Committee to work with AANS/CNS and others who are forming such a committee.**

Competency in Neurocritical Care. The goal is to have the AANS/CNS/ABNS create a white paper stating the neurosurgical training includes providing critical care and Board eligible or certified neurosurgeons should be automatically privileged to provide such care without additional training as required by some institutions. **Adopted; Letter to be sent to AANS who is preparing white paper.**

Educational Campaign on Neurosurgical Spinal Surgery Expertise. The goal is to have the AANS and the CNS consider implementing an educational campaign to inform the public about the special expertise and training that make neurosurgeons uniquely qualified to perform spinal surgery. **Adopted; Executive Committee to explore CSNS involvement in and support of PR activities of the AANS/CNS.**

The Need for More Vigorous Public Relations Activities from Organized Neurosurgery. The goal is to initiate a campaign of substantially increased public relations and educational activities regarding neurosurgeons and their unique qualifications. **Adopted; Medical Practices Committee to implement.**

Program Development of State Neurosurgical Society Meetings. The goal is to have the CSNS develop a multi-media program that explains key issues to help guide the creation of a successful state neurosurgical society and how to conduct a successful annual meeting. **Adopted; Dr. Perez-Cruet to create program.**

Medicare and the Profession of Neurosurgery. The goal is to have the CSNS endorse and promote a Medical Practice Committee survey to address trends in neurosurgeons' participation in the Medicare program. **Adopted; survey being created.**

Wrong Level Surgery as Battery (Emergency Resolution). The goal is to have the AANS/CNS join the California Medical Association and the AMA in challenging a California Appellate Court ruling that spine surgery conducted at the wrong level can be prosecuted as battery even in the absence of intent. **Adopted; Letter to the AANS/CNS.** ❖

Letter to the Editor:

In 2006, Congress opened the physician quality measurement floodgates when it created the Physician Quality Reporting Initiative (PQRI). From the very start, organized neurosurgery questioned the logic and long-term sustainability of the PQRI and other private payer quality improvement programs, and advised its members to carefully assess whether the benefits of participating in these programs outweigh the administrative costs and complexity. Others,

including the American College of Surgeons, felt the train had already left the station and encouraged members to gain experience with quality reporting, even if doing so was not clinically practical or financially viable.

There is no doubt that physician quality reporting is here to stay in one form or another. Congress recently extended the PQRI through 2010, and countless other private payer programs continue to pop up across the nation. But rather than encourage its members to be the guinea pigs of a still green, poorly constructed, and clinically irrelevant program, neurosurgery has instead opted to educate federal officials, private insurers, and other medical specialties about what is wrong with the current one-size-fits-all approach to quality improvement.

Most of today's quality measurement programs, including the PQRI, lack a clear and consistent set of rules, offer little transparency into the mechanisms used to analyze data, and rely on unrealistic timelines. The PQRI, in particular, relies on hastily-crafted claims-based process measures that are not risk-adjusted, rife with inaccuracies, and ultimately provide very little useful data. The PQRI bonus payment—which averaged \$600 for an individual professional reporting over six months in 2007—is woefully inadequate compared to the administrative hassle of participating, and feedback reports offer physicians little useful information. As a result, only about 99,000 medical professionals — or about 16% of those eligible— attempted to report data in 2007, and only half of those professionals were eligible to receive the bonus payment.

If there is a light at the end of the tunnel, it is that public and private payers are now taking positive steps to raise the bar on physician quality measurement, thanks largely to the poking and prodding of neurosurgery. For example, starting this year, CMS will offer alternative mechanisms for reporting PQRI claims data, including the use of qualified data registries. Private insurers have gone a step further, offering to work with neurosurgery to develop programs that recognize prospective reporting of clinical outcomes data, which more accurately reflects the quality of surgical care.

Neurosurgery is taking advantage of this opportunity by working to create a single data collection system that captures the range of clinical situations encountered by each of its subspecialties. The system will allow members to collect clinical process and outcomes data over time, and to identify current gaps in care, as well as areas for future research. Since the ultimate goal is to ease the hassle of reporting, users will be able to use the system to satisfy both MOC case reporting and Medicare and other third-party payers' quality reporting requirements. This all-encompassing system, one of the first of its kind, will offer a more tailored approach to measuring surgical care quality than the ACS's National Surgical Quality Improvement Program (NSQIP), which only collects facility-level data and does not capture care patterns across the ambulatory surgery and physician office settings.

As payers increasingly recognize the value of these alternative approaches, other surgical specialties are beginning to see that complacency achieves little. The ACS is now turning its attention to the development of a cross-surgical, physician-level data collection tool and a patient experience survey that more accurately captures the surgical care episode. While these efforts are far from perfect (the database proposal is too lofty of a goal and ignores critical first steps, and the patient survey is cumbersome and fails to reflect the subtle nuances of neurosurgical care), they at least challenge the status quo.

Organized neurosurgery continues to enthusiastically support programs that are truly designed to improve the quality of surgical care. While many programs still fail this test, neurosurgery is encouraged by the direction the quality movement is headed and will continue to push all stakeholders to think outside the box. ❖

Rachel Groman, AANS/CNS Senior Manager for Quality Improvement and Research

Katie O. Orrico, Director Washington Office of the American Association of Neurological Surgeons/Congress of Neurological Surgeons

(Editor's Note: The AMA just published the following: AMNews reports that "Medicare's flagship Physician Quality Reporting Initiative (PQRI) has left in its wake a sea of annoyed physicians who say the pay-for-reporting program is being poorly managed by an unresponsive administration." Notably, the Centers for Medicare & Medicaid Services (CMS) did not begin sending out bonus checks until over "a year after nearly 100,000 doctors started reporting quality measures to Medicare for the first time." In addition, "nearly half of the physicians who tried for a 1.5 percent bonus failed to get one, prompting doctors who never received the anticipated check to download their reports and find out why." Many who attempted this, however, "were defeated by stringent security measures, and some gave up before they could see their performance. Those who did found the data useless in telling them how to improve quality." As a result of such issues, the AMA "called for a much more extensive CMS education campaign, especially given doctors' low success rate.")

2009 CANS Annual Meeting

The weekend at a glance...

(look for detailed registration material in the mail by next week)



FRIDAY January 16, 2009

Afternoon CANS Board Meeting (all members welcome)
 Evening **Opening Reception** (no-host bar and complimentary hors d'oeuvres; all guests and exhibitors welcome)

SATURDAY, January 17, 2009

Morning CANS Socioeconomic Meeting: - **CHANGE: the Good, the Bad and the Ugly!**

Afternoon Physician/Exhibitor luncheon
 Luncheon Speaker: **Thom Steinbeck**
Afternoon free for golf or other activities or to view a dramatic film by Academy Award Winning Documentary Filmmaker Terry Sanders: "Fighting for Life" (A contemporary portrait of American military medicine)

Evening. **Cocktails/Dinner and Award Presentation at the Monterey Bay Aquarium: Byron Cone Pevehouse Distinguished Service Award to Ulrich Batzdorf, M.D**

SUNDAY, January 18, 2009

Morning CANS Socioeconomic Meeting - **CHANGE as it Applies to Our Individual Practices**

Afternoon. **Tour: National Steinbeck Center** hosted by Thom Steinbeck



Hotel Room Rate \$160.00 Reservations: 888.828.8787

Reservation Deadline: December 15, 2008; after this date, reservations will be made based upon the hotel's availability and at the hotel's prevailing rate.

ATTN: Exhibitors

Please register now to exhibit at the CANS Annual Meeting January 16-18, 2009 at the Quail Lodge resort in Carmel, California. We are planning two half-day morning sessions to allow free afternoons for golf at the resort or sightseeing. As always, your company name and product will be showcased in our program booklet. You are welcome to attend all the social functions, including the Saturday evening banquet at the Monterey Bay Aquarium. Your participation is very much appreciated especially in light of the fact that our meeting is a small one in comparison to the national meetings. We like to think of our event as an intimate one where your company representatives can visit with current neurosurgical clients as well as form new relationships.

Please contact janinetash@sbcglobal.net to receive the exhibit registration material.

Neurosurgical Position

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 one time posting in this newsletter. Submit your text to me by E-mail (rws-avopro@sbcglobal.net) or fax (858 683-2022). ❖

ATTN Vendors: CANS is now accepting newsletter ads. Please contact the executive office for complete price list and details.

Questions or comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office at janinetash@sbcglobal.net. Past issues of the monthly newsletter are available on the CANS website at www.cans1.org.

The newsletter is a mix of fact, rumor and opinion. The facts are hopefully clearly stated. The rest is open to interpretation. The opinion is mine. R.S. The assistance of Janine Tash and Moustapha Abou-Samra, M.D. in the preparation of this newsletter is acknowledged and appreciated. If you do not wish to receive this newsletter in the future, please E-mail or fax Janine Tash janinetash@sbcglobal.net, (916-457-8202) with the word "unsubscribe" in the subject line.

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