



# CANS

# NEWSLETTER

California Association of Neurological Surgeons

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## President's Message: Future Direction of CANS

*William L. Caton III, M.D.*

**T**he future of neurosurgery and the future of CANS in California are certainly intertwined. The theme of our meeting in Carmel was that of change – change in society, change in medicine, and change in neurosurgery.

As the country's leadership changes, there will also be major changes planned for the organization of healthcare delivery and the financing of healthcare in the United States. At the level of Congress and of the new President, new directions will be pursued. These will encompass new organizations, re-organization of existing systems, new ideas, and a redo of some of the old ideas as well. In particular, a re-organization of Medicare is pending. President Obama is on record to put a high priority on changes in information technology in medicine and to create a healthcare system that is more streamlined, more responsive, and less expensive. He is certainly also considering the reorganization of payment and payment mechanisms. At the current national level, the reorganization of Medicare is planned. In particular, a revitalization of the care and reimbursement for chronic illness is at the forefront.

The CMS looks upon new ways and innovative ways to be reorganized. The changes to be accomplished in the Medicare program include saving on expenditures by including the bundling of payments for chronic illnesses into a lump sum for a given year. This will be based upon the DRG model. The funds are planned to be shared by all the treating physicians. A simple example would be that of a 66-year-old male with diabetes mellitus type II and associated coronary artery disease. It is planned for the care of this patient to be accomplished by the internist, cardiologist, endocrinologist, and others, and they are all going to share in a set sum of reimbursement. Not so easy is how the distributions are to be done. The government plans to use this model to move patients into physician groups who will compete with each other at a capitated rate to care for the patients. The plan is for multiple competitions for patient populations at variable rates determined by the bidding of the physician groups to the government. It is planned that these physician organizations and groups will then determine their own payment mechanism to their member physicians. Similarly, plans are being made to try to further expand the physician report card system. There is a keen interest in trying to continue to measure outcomes, complications, length of stays, and to have physicians and health plans be more answerable to the government in this response. It is planned that bonuses will be given to physicians that are the most compliant.

All these plans in place still are centered around the treatment of chronic illness. The changes that are occurring in planning for reimbursement have been complicated to such a degree that the heads are not yet able to consider how to treat reimbursement for acute illnesses. Certainly, the majority of neurosurgical patients will fall into the category of the more acute problems.

The Federal approach at this time is to push for the reorganization around larger groups of physicians, in particular health maintenance organizations and IPAs. These larger groups, including PPOs, EPOs, and other groups will be encouraged to take on large risk for patient's and determine their own reimbursement patterns. Ruled out at this time at the national level is a single party payer system. This is certainly, in part, the result of the lobbying by the major insurance companies in the United States. All these changes are actively being planned by the new HHS secretary and CMS officials. At this time, there are no plans in place for neurosurgery, but rather they are looking at the broader patterns of medicine.

How shall we respond in CANS, and how shall we respond as practicing neurosurgeons in California to these changes? First and foremost, CANS needs to remain the voice of California neurosurgery. We need to be able to respond to the state bureaucracy and insurance carriers in an organized and thoughtful fashion. We need to be able to represent neurosurgery in the socioeconomic arena. We are certainly in the best position to do so in view of our broad membership of the neurosurgeons in California

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in our organization. We need to continue to maintain and to further expand our membership so as to be fully representative. It is certainly advantageous for CANS to be a spokesperson group for neurosurgery. Indeed, at times, CANS has been outspoken and has better represented California neurosurgery than our national organizations. We must maintain this ability into the future.

How shall we respond to these major societal and the socioeconomic questions? First and foremost, neurosurgeons are at a uniquely situated level in the delivery of healthcare. There are not enough of us to go around, and the patient population continues to grow. Our services are constantly in demand and continue to be even more in demand. If, indeed, we doubled the number of neurosurgeons in training at this time, it would take 17 years to get back to the level of the 4000 neurosurgeons in the United States that existed in the early 1990s. I believe this is not going to happen. This manpower shortage shall continue indefinitely into the future.

Yet the hospitals and the healthcare systems need neurosurgery to be able to respond to the inpatient treatments in the emergency room and emergency care needs. There are twice as many hospitals in California as there are neurosurgeons. Hospitals need to respond to the community needs for emergency care. The rising stipends for neurosurgical care are the result of the indication of the need of our services statewide. Similarly, health maintenance organizations need to meet the demands of the Knox-Keene licensing for having adequate panels of neurological surgeons. The new changes at the Federal level will certainly increase the demand for our services. If there are going to be larger groups competing for a portion of the patient population, they will need active neurosurgical participation.

Some neurosurgeons in California have already adopted the Hospital-based foundations concept which is to buy individual practices and keep the docs on at high salaries. This has been partly the result of a ban on corporate practice of medicine by the hospitals, yet there is still a constant effort by the hospital organizations to repeal these laws. At this time, our services are still in high demand. The demand for our service continues to increase as the population ages. New procedures will certainly be developed in the realm of neurological/neurosurgical illness, and the current ones will need to be further refined and improved. Technologies will change. Imaging studies will change. The technological tools that we used intra-operatively are also going to continue to change.

Certainly, we face challenges. Our busy neurosurgical centers are continuing to be besieged by higher level of care transfers. Insurance companies will continue to try to find ways to avoid payments. Certainly, the ruling by the Supreme Court in California recently to not allow balance billing is of concern. Covering all the emergency rooms in California at this time is impossible for the neurosurgical population. Rulings such as that by the Supreme Court make it even more difficult for physicians to be reimbursed for their coverage and most likely will result in even less manpower available.

There is certainly going to be more Federal tracking of our outcomes. There will be more bureaucracy set up and more demands placed upon our time. The lawyers in California continue to try to repeal MICRA. We need to remain ever vigilant to protect our rights and to keep our malpractice premiums as low as possible.

There will be continued challenges to our professionalism, and we need to maintain this in a very strong fashion. Certainly, proactively, we can band together. If, indeed, the Medicare approach is to push patients into care by larger physician groups, we will hopefully be able to band together into larger groups within California to help share in the call and coverage, the ability to contract if we wish, and the ability to form



*Dr. William Caton*

new clinical entities and organizations that will provide representation for us to the groups that wish to contract with us. We can continue to band together to form more comprehensive neurosurgical and neuroscience centers in California, where we include neurosurgeons, neurologists, neuroradiologists, neurooncologists, and rehab specialists in conjunction with radiation therapy centers, surgery centers, and imaging centers. This should also include other ancillary physicians.

We certainly need to continue to help organize emergency neurosurgical care in California and to help our State system remain viable. We have the strongest system in the United States, yet it is frayed due to lack of manpower and more and more demands upon our neurosurgical colleagues. We need to help strengthen the training institutions in California and to help our colleagues in academic medicine be able to survive the needs and demands of higher levels of care as well. I hope that we will be able to expand our contacts with the State and Federal legislators. We are the ones who are responsible for developing the changes in our system, and we need to maintain a very active role.

We can use CANS to network with each other. We can reach out to new neurosurgeons in practice to help share knowledge, to help them develop their practices, to offer practical advice such as setting up an office, joining in

partnerships, contracting, etc. We certainly need to continue to involve the young neurosurgeons in California and be able to help them to perpetuate the role of a strong State Neurosurgical Society. We need their input and their activities in our organization. We need younger physicians to join us constantly to perpetuate our organization.

CANS will continue to be a voice for neurosurgery in California representing us collectively. We need to continue to send representatives of the Council of State Neurosurgical Societies (CSNS), continue an active role in legislation, and at the committee level of this national organization. Organized neurosurgery needs frequent input from the State societies such as CANS. We need to continue to represent our state at Workers' Compensation hearings about our feelings about changes in the state insurance within the state insurance carriers.

We need to continue to maintain our annual meeting to make it effective and a good outreach to our fellow neurosurgeons. We will continue to maintain the newsletter as a strong forum for sharing information with the California neurosurgeons. Proactively, we will maintain a voice for California neurosurgery in the private practice, as well as the academic practice and corporate practice.

We certainly should encourage our members to develop ties with state and federal officials. Our elected officials are very important to us. We need to make them aware of our problems, the pitfalls of inadequate legislation, and we need their help to maintain strong medical care in California and to help solve some of the pressing societal issues. We need to continue to be a resource to our members, both young and old. We should be involved in resolution of disputes among neurosurgeons. We should have a panel of members available to help in this fashion.

We need to continue maintain our annual meetings in a self-sufficient fashion. We need to be financially sound, as well as intellectually strong as we manage our annual meetings.

We have the opportunity as an organization to work together to remain the voice of neurosurgery for California to be a source in a consistent fashion when asked to comment upon newsworthy events in a very thoughtful fashion.

Our members have been active in the CMA and AMA. Especially in these changing times, CANS can help promote a cohesive front representing neurological surgery.

As our average age of the neurosurgeons in CANS gradually increases, we need to maintain our relevance to our younger neurosurgical colleagues. We need to enroll as many as possible in CANS and, indeed, our goal should be to try

to have participation of all the neurosurgeons in California if possible. Our CANS members have served representing our organization on various legislative committees and to the counties themselves. We have played an active role in the neurosurgical care in the Los Angeles County trauma system.

In the past two years, we conducted a poll on emergency room stipends. We were able to share the information with members, and many found it fruitful. Indeed, it was advantageous for some of the neurosurgeons, as they developed new contracts with their hospitals, allowing them to have important data as they worked through the details of their contracts. We should continue to try to gain socio-economic information in a timely fashion that would be helpful to the neurosurgeons in practice in California. In these changing times, the CANS members have the opportunity to pool their knowledge together to pursue appropriate socioeconomic courses under the auspices of our annual meeting. This will allow us to gain academic credits with CME category 1 hours for our meetings.

Certainly, we need to maintain our financial viability in our statewide organization. In the past, we have been able to contribute to some pressing national causes in the realm of neurosurgery. We need to be able to continue to do this. With the greater participation of neurosurgeons in California, we are able to fulfill our needs. The future of CANS is strong, as long as we all work together to remain relevant to the future of neurological surgery and its practice in California. ❖

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## CANS Meeting in Carmel

*Randall W. Smith, M.D., Editor*

In addition to a great affordable venue at the Quail Lodge, much better than average food and a spectacular Banquet at the Monterey Aquarium at which **Dr. Ulrich Batzdorf** received the Byron Cone Pevehouse Distinguished Service Award, the 2009 annual gathering of CANS attended by 59 docs was noteworthy as follows:

### 1. The Friday Board of Directors meeting at which:

- a. **Dr. Phil Kissel** from San Luis Obispo was appointed to fulfill the rest of Austin Colohan's tenure as a Director as Dr. Colohan will be elected 2<sup>nd</sup> Vice President.
- b. Approved active membership for **Lance Gravely** of Pasadena, **Praveen Prasad** of Sacramento and **Alois Zauner** of Santa Barbara.
- c. Noted that the current active members of the Association number nearly 200, and with all other member categories including residents, totals over 400.
- d. Noted the demise of CANS members Lawrence Arnstein, Francis Williams and William Wright.
- e. Continued annual dues for active members at the \$350 level for 2009.
- f. Noted a reserve of about 50K and that 2008 came in on budget.
- g. Requested input from Californians Allied for Patient Protection as to accomplishments and their budget expenditures for 2008 before making CANS' annual \$1500 contribution.
- h. Heard a presentation from **Don Prolo**, CANS representative to the CMA, about his many years working for meaningful change at the CMA and AMA level. He now feels that organized medicine in general and organized neurosurgery in particular would better spend their time and dollars on direct involvement in the state and national political process to effect change rather than be active in and rely upon the CMA and AMA where he feels that policy determined by elected CMA and AMA delegates is infrequently truly pursued by the officers and boards of those organizations. He encouraged CANS to support Tom Campbell (author of the national malpractice reform bill that twice passed the House and twice died in the Senate) who has announced his candidacy for governor of California.
- i. Noted the Committee assignments made by incoming president Caton among which, potentially to the consternation of long suffering readers of this newsletter, included reappointing **Randy Smith** as newsletter editor for 2009.
- j. Noted with thanks the exhibitors at this year's meeting: **Aesculap, Aloka, Anulex, Apatech, Bayer, BrainLab, Codman, Cooperative of American Physicians, Eisai Inc. (Gliadel Wafer), Elekta, IMRIS, KLS Martin, Mizuho, Porex, PMT, Romine Bronze Sculptures, Stryker and Synthes Spine.**



*(from left) Dr. Abou-Samra, Dr. William Lewis, Ellen and Dr. Ulrich Batzdorf*

### 2. The Saturday program which included:

- a. **John Kusske**, CANS historian, gave an account of the early years of CANS noting the pivotal influence of Cone Pevehouse in the creation of CANS in 1973, that the impetus for forming CANS was the 1972 PSRO (Professional Standards Review Organizations) legislation and not the 1975 malpractice crisis in California and that CANS' finest hour was the role it played in the design of and passage of the 1976 MICRA legislation.
- b. **Jim Bean**, current AANS president and special invited guest, who felt that there will be no merging of the AANS and CNS unless one or both experience fiscal failure, that in addition to its role in education, the future concentration of the AANS should be in the area of national political activism through the Washington Committee and the creation of guidelines based upon what works, with what works to be determined by our analysis of our results not an analysis by some statistician working with the Medicare database.
- c. **Richard Rush**, president of Cal State University/Channel Islands in Santa Barbara, who noted that women currently make up 60% of collegiate enrollment and what we might do to re-engage the boys and that curriculum determination should be the result of a college engaging local community leaders and what they perceive they need in terms of a workforce to be successful.

- d. **Pat Wade**, one of the most politically active California neurosurgeons, discussed the Council of State Neurosurgical Societies and how the Council is the best conduit for CANS generated ideas to percolate up to the national level and potentially affect the activities of the AANS and CNS to our benefit.
- e. **Moustapha Abou-Samra**, about to become the immediate past president of CANS, presented his dour view of neurosurgical subspecialization which he sees as more of a career minimalization with most community docs choosing a spine only practice leaving cranial neurosurgery, acute or otherwise, to the universities or to those willing to attend an acute epidural with the latter not necessarily being a neurosurgeon as we know a neurosurgeon today.
- f. **Rick Batzdorf**, senior UCLA faculty member, discussed the training of a neurosurgeon in the future within the confines of the 80 hour work week which he feels is immutable and predicted that one of the faculty of the future will be a Blackberry.
- g. **Thom Steinbeck**, son of the Steinbeck who is memorialized at the National Steinbeck Center in Salinas, shared his thoughts that out of adversity comes a community of people all pulling together (the theme of Grapes of Wrath) and that he is optimistic that just as America pulled together to come out of the great depression it will do so again in the current national morass. As a boy he once asked his Dad what he did for a living and Steinbeck said "I remind people of their own humanity."
- h. **Dustin Corcoran**, CMA Vice President of Government Relations, discussed the Prospect decision by the CA Supreme Court prohibiting balance billing of ED patients by non-contracting physicians indicating it is wisest to balance bill no one even though there are some insurance plans that are not covered by the decision. He further noted that the decision encouraged dissatisfied docs to sue the carriers and the legislature to decide what is UCR (usual, customary and reasonable) which may get the carriers more misery than they expect. Although there is no generally accepted UCR, some audience members suggested 300% of Medicare would be defensible in small claims court (\$50 to file, \$7500 limit on recovery). Apparently the CA Department of Managed Care, whose balance billing prohibition was upheld by the Supremes, will monitor/audit those carriers paying less than 180% of Medicare. Mr. Corcoran also noted that since the ruling is on a California issue, there will be no appeal to the US Supreme Court.
- i. **Terry Sanders**, academy award winning documentary filmmaker, first introduced, then showed his most recent effort "Fighting for Life" which in a very moving fashion depicts the medical care provided to soldiers wounded in Iraq from initial triage to final stateside rehabilitation. The film is to be shown on PBS on Memorial Day.
- j. Finally, the new officers for 2009 were elected: **Bill Caton**, President; **Kenneth Ott**, President-Elect; **Marc Vanefsky**, 1<sup>st</sup> Vice President; **Austin Colohan**, 2<sup>nd</sup> Vice President with Ted Kaczmar and Mike Robbins continuing as Secretary and Treasurer respectively.



*Thom Steinbeck signing his book for Dr. Robert Meredith*

### 3. The Sunday program which included:

- a. A talk by **Rich Wohns** from Tacoma, Washington about how well physician owned outpatient surgical centers work to save money for insurance companies and capture more of the healthcare dollar for the physician owners.
- b. A presentation by **Colonel Rocco Armonda** about how military neurosurgery is practiced in Iraq with particular note of how decompressive craniectomy for traumatic brain swelling is performed early and often in consideration of the limited therapeutic options on the long plane flights from Iraq to Germany.
- c. Addresses by **Deborah Henry** about women in neurosurgery (she was actively discouraged from pursuing a career in neurosurgery years ago; male chauvinism these days is on the wane), **Praveen Mummaneni** on practicing in the academic model (he gets to pay the University of California 40K a year from his practice income to underwrite the UC "self insured" malpractice program; academic promotion

a bit easier these days for those who concentrate on clinical research and teaching vs. NIH sponsored lab investigation) and **Marc Vanefsky** detailing the Kaiser model of practice (the joy of no preauthorization for diagnostic studies or surgery; the efficiency of binding arbitration for claims of malpractice). All three predicted or implied the demise of solo or even a 2-3 man private practice.

- d. **Bill Caton** gave a thoughtful and well prepared address on the future direction of CANS (see his President's Message in this issue). ❖

## Tidbits from the Editor

### New Regulations for Qualified Medical Evaluators

**N**ew regulations that overhaul the qualified medical evaluator process – first proposed more than a year ago – were approved by the Secretary of State's Office and are scheduled to become effective Feb. 17, 2009. Worth noting if you do AME or QME evaluations:

1. When opposing parties (translation: the patient has an attorney; the carrier may or may not) agree on a Qualified Medical Evaluator (QME) chosen from a 3 person panel generated by the DWC to do a medicolegal evaluation, the report will be paid at the Agreed Medical Evaluator (AME) rate and not at the lower Panel QME rate. As you know, the usual use of a Panel QME is for a sort of second opinion report after a patient without an attorney has been discharged by the treating physician.

2. Requires AMEs to give six business days of notice when canceling appointments without good cause and requires them to reschedule canceled appointments within 60 days. ❖

### Stem Cell Research Allowed by Feds

**T**he FDA is apparently in the stem cell research business since it has just approved a trial therapy utilizing stem cells. Just how and why the FDA gets involved is unclear since their blessing is not necessary for trying an experimental drug or device under an experimental protocol which is usually approved and monitored by a university or hospital human experimentation committee. What is of particular interest is that the study will involve injecting stem cells into the spinal cords of patients recently rendered traumatically paraplegic. No matter what one may feel about the ethical and religious issues involving stem cells, helping out the traumatically paraplegic patient, all too well known to us neurosurgeons who have little to offer these patients, has got to be a pretty acceptable use of research time and money. ❖

### Work Comp and RBRVS—continued

**T**he CA Division of Workers' Compensation (DWC) is in the process of renewing efforts to adopt a formal Medical Fee Schedule incorporating Medicare's Resource Based Relative Value Scale (RBRVS). The Lewin Group, who has acted as consultant to the DWC on this issue to the tune of \$387,241, has published a current update to its previous estimates as to how the RBRVS would affect payments to physicians and about which we have previously reported in this newsletter. Presuming the DWC opts for a "revenue-neutral" conversion to RBRVS, the latest update by the Lewin Group carries the same bad news for specialists: Fees for surgeons would drop an average of 12.1%, neurologists by 4.6% and radiologists by 3.5%. Physical medicine providers, on the other hand, would see an average increase of 12% and fees for evaluation and management doctors would increase 9.7%. An analysis of the top 20 surgical procedures published by the California Workers' Compensation Institute indicates that an RBRVS conversion would reduce them by an average of about 40%.

One presumes that revenue-neutral means looking at total annual payments to physicians which averages \$2.2 billion, cranking in the RBRVS and then adopting a conversion factor that cause the result to equal the \$2.2 billion.

The California Society of Industrial Medicine and Surgery (CSIMS) asked the DWC last year to include in the Lewin Group analysis a breakdown showing the impact of an RBRVS conversion for each current procedural terminology code, but that wasn't done. CSIMS feels individual practitioners need to see how individual codes will change so that they

can analyze the impact of the conversion on their own practices and it is further critical of using the Medicare RBRVS because it was designed as a payment system for Medicare, which serves an elderly population and values “maintenance” medicine more than the aggressive intervention that is more appropriate for injured workers.

If the DWC adopts the revenue-neutral RBRVS as well as the Official Disability Guidelines (ODG) for surgical indications for the spine (which will be tightly hewed to by the Utilization Review companies), surgeons can expect to do less for less.

The DWC is accepting informal public comment on the study as a precursor to formal rule making. To find the report and make comments, go here: <http://www.dir.ca.gov/dwc/DWCWCABForum/lewinReport.htm>. ❖

## How Opinion becomes Doctrine

In the December 16 issue of the Annals of Internal Medicine, a professor of medicine and community and family medicine at Dartmouth Medical School, using the data from the Spine Patient Outcomes Research Trial (SPORT), determined that the benefits of fusion for spinal stenosis with degenerative spondylolisthesis are not enough to offset the costs. The analysis was based upon using the Quality Adjusted Life Year (QALY) scale to measure benefit to patients in comparison to the direct and indirect costs of the surgical procedure. Two years out from surgery, although patients who had the procedure had better clinical results than those treated non-operatively, the benefits gained in functionality and quality of life were not enough to offset the direct medical costs of fusion, combined with indirect costs such as work-time missed. The article found that the surgery for stenosis with degenerative spondylolisthesis (usually fusion) cost about \$115,000 per QALY gained. In the US, \$100,000 is the threshold at which procedures are considered to be cost-effective.

The impetus for this kind of analysis is due to the \$16.9 billion spent on spine fusion in 2004 (God knows how much in 2008) and the dramatic rise in the number of fusions over the past decade.

To the authors' credit, it was noted that the analysis only included a 2 year follow-up and that with more time the cost per QALY gained might well drop below 100K but a couple of things come to mind about all this. First, if you decompress a lumbar stenosis with degenerative spondylolisthesis and don't do a fusion as well and the patient has a lot of residual back pain and further slippage requiring a second operation for the fusion, the plaintiff's bar won't have much trouble finding a spine surgeon to testify that your failure to fuse at the decompression surgery fell below a standard. More importantly, who set the \$100,000 per QALY gained as some sort of standard for cost effectiveness? It turns out that \$50,000 per QALY is felt to be a good deal because it represents the approximate cost of one year of renal dialysis treatment which is a federal entitlement to all US citizens and certainly prevents one from having a very bad year such as in dying. Dr. P.A. Ubel, who in his 2003 article in the Archives of Internal Medicine came up with the \$50,000 number, declared it a good deal (Ubel PA. What Is the Price of Life and Why Doesn't It Increase at the Rate of Inflation? Arch Intern Med 2003(163):1640-41). He also felt that doubling the 50K number to allow for other issues such as inflation was OK so between \$50,000 and \$100,000 per QALY gained was an acceptably good deal and anything above 100k not a good deal. Dr. Ubel's values are not totally coming from left field but cost-effectiveness analysis ignores other economic value such as return to work (or golf), and thereby underestimates the true social value of therapies. You can bet that the national medical board being considered by the Feds might take the 100K number as doctrine and then the game would be on.

In the meantime, when the 58 year-old with a L4-5 slip and stenosis causing increasing back pain for two years with 6 months of neurogenic claudication and a dusty set of golf clubs comes through the door, I think a good neurosurgeon would recommend a fusion. ❖

### INSULT OF THE MONTH

*He has all the virtues I dislike and none of the vices I admire.*

- W. Churchill

### US Surgeon General--continued

Finally, and based almost entirely on rumor rather than any facts, the front runners for the SG job in the Obama administration have apparently been lapped. It is rumored that Gail Rosseau, who we highlighted in last month's newsletter (all previous newsletters are on the CANS Web site: [www.cans1.org](http://www.cans1.org)), will not be appointed and that CNN commentator and neurosurgeon-in-part Sanjay Gupta won't be handed or won't accept the baton either. Now comes orthopedic spine surgeon Charles Rosen from UCI who the Orange County Register says is now on the short list. Dr. Rosen is head of the Association for Ethics in Spine Surgery which he founded because he perceived dishonesty by DePuy and bias by its paid surgeon consultants in presenting the data on the Charite artificial disc which was subsequently approved by the FDA. He has more recently changed the name of his organization to the Association for Ethics in Medicine (AEM) presumably because evangelism plays best with a larger audience. His testimony before the Senate Special Committee on Aging last year, urging passage of a bill called the Physician Payment Sunshine Act which would require disclosure of financial connections between physicians and companies, brought him up on the Obama radar. Whether he passes as a brief blip or looms larger and lands in the administration is yet to play out. Since part of the AEM agenda is to promote evidence-based medical research, if he gets the job, we can at the very least anticipate some hard, long bully pulpit sermons about the true indications for spine surgery with metal implants. Where is that nice grandfatherly Surgeon General worried about childhood immunizations when you need him? ❖

### *More photos from the Annual Meeting*



*Dr. Batzdorf receiving the Byron Cone Pevehouse Distinguished Service Award*

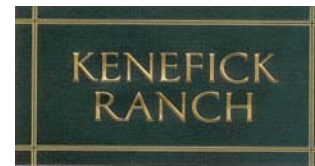


*Dr. Tom Kenefick and Dr. Moustapha Abou-Samra comparing injuries.*



*Dr. DeWitt Gifford greeting Dr. George Koenig*

All photos courtesy of Emily Tash



Thank you to Dr. Tom Kenefick for generously donating the wine for the Aquarium Banquet!

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## 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](mailto: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](mailto:rws-avopro@sbcglobal.net) or to the CANS office at [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net). Past issues of the monthly newsletter are available on the CANS website at [www.cans1.org](http://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 Dr. Bill Caton 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](mailto:janinetash@sbcglobal.net), (916-457-8202) with the word "unsubscribe" in the subject line.*

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