



# CANS NEWSLETTER

California Association of Neurological Surgeons

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## They don't make 'em like this anymore

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

All too often, men or women whose lives have made laudable contributions to the fabric of human endeavor are characterized as "giants" when they at best should be described as just fairly tall. On April 16th, neurosurgery in general and CANS in particular lost a true giant. **Byron Cone Pevehouse** was to California neurosurgery what John Adams and George Washington were to the creation of our republic. Like Adams, he played a crucial and dominant role in the formation of CANS in 1973 and like Washington, he was our first CANS President and led us in our fight for independence from the plaintiff's bar by, along with a few others, creating MICRA and getting then Governor Jerry Brown to sign it into law. That he did his homework on that one was reflected by the California Supreme Court upholding MICRA against an assault by the lawyers. He created the California Relative Value Scale, long used by neurosurgeons nationwide to determine reasonable billing procedures until the advent of the CPT system. He was the major force behind changing the AANS by-laws to create some geographical representation on their generally hierarchical Board of Directors. He devised the matching program for medical students applying for neurosurgical residencies.



Although he subsequently served the wider neurosurgical community as President of the Western Neurosurgical Society, the Society of Neurological Surgeons, and the AANS, served on the American Board of Neurological Surgery and was a recipient of the Cushing Medal, he is annually remembered by CANS as we bestow the Pevehouse Award upon a neurosurgeon who has contributed mightily to the betterment of California neurosurgery. Every recipient of that award has been worthy but never could match the award's namesake.

About the only questionable decision he made was to retire to the Seattle area with his lovely wife Lucy some years ago, so we in California were deprived of seeing him except occasionally at national meetings.

Those of you who never met Cone and had a chance to sit and chat with him really missed a wonderful experience. He was warm and kind and considerate. This writer had some long conversations with him and I should have taped them all. It was like going to neurosurgical practice school.

How can you characterize someone like him in a word? In Yiddish, the term is *mensch*. In Spanish, *macho*. In American, it is *Giant*. ❖

### President's Message:

#### Corporate Bar of Medicine in California

*Kenneth Ott, MD, FACS*

California has long banned the corporate practice of medicine. Along with four other states, California has maintained this prohibition and preserved a trust which exists between physician and patients. Some would say this is a sacred trust. When physicians are employed by corporate entities, the corporate interest (profit) will subvert this trust, trumping patients' interests (their health).

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There is a maldistribution of physicians in California as elsewhere in our country. In an effort to correct this perceived maldistribution the state legislature passed SB 376 (Chesbro) which became effective January 1, 2004. Qualified district hospitals were allowed to employ up to 2 physicians each and 20 physicians state wide. Qualifications included hospitals operating at a net loss in 2000 - 2001; counties with small populations; and counties caring for a significant number of welfare recipients. Predictively the law forbade hospitals from interfering with the professional judgment of physicians. This experiment ends January 1, 2011.

Senator Ashburn has recently proposed SB 726 as an extension and expansion of SB 376. The proposed bill removes the limit of physicians to be employed in California; and allows profitable hospitals in large counties with a minority of welfare patients to participate.

I think back to the time I went to Sunnyvale to learn the Accuray software treatment planning programs for Cyberknife radiosurgery. There were several younger neurosurgeons also training in the program (less than 55 years old!). Anyway they were all from "back East" and employed by hospital systems or seeking employment by a hospital. This was their ideal career.

I think again about French youngsters whose dream is to have a civil service job... have a month off in August..., retire at age 55 on a French pension. This is the dream of a significant number of the young people of France... but not the dream of 500 million young people in China. Hey 1/3 of Greeks are employed by the Greek government, while Norway employs nearly 1/2 of its population. Norwegians are the 6th largest oil and gas producer in the world. Their population is about the same as San Diego County. Greeks produce olive oil from sandy soil...bet on Norway.

My mentor, Ed Tarlov, just e-mailed me a few days ago. He wrote that he is in a "socialist system" at Lahey Clinic, outside Boston. At near retirement he is happy with his career move from the Massachusetts General Hospital to Lahey many years ago. He wrote that his father, Isador (Tarlov cyst) told him that "a direct bill from his office to a patient was the way to ruin a perfect relationship!"

Let's face it; a significant number of neurosurgeons in California are already directly or indirectly employed by hospital systems: Military surgeons, foundation surgeons, university based surgeons and those of us in private practice accepting stipend for trauma/ER care, probably most of us. The rationale for SB 376 was economies of scale: hospital billing, office space, office staff would help allow higher physician reimbursement in underserved areas. Add to this collateral income from institutional fees for imaging, lab fees, reimbursement for instrumentation, etc. could also add to physician salaries and attract physician to understaffed counties.

After the passage of Obama Care we will all find our autonomy challenged because of the threat of income reduction. Some see the corporate practice of medicine a safe refuge in response to this challenge. I rue the loss of control of patient responsibility that corporate practice threatens. It is our ability to place the needs of the patients above the needs of the hospitals and insurance companies which make our profession special. Let's support the trust of our patients by opposing SR 726. ❖



### Thought for the month

*At 71, I realize I am over the hill.  
What I can't seem to recall is when I was actually on top.*

## TIDBITS from the Editor

### **CANS BOD Meeting--April 24, 2010, Oakland Airport Hilton**

Twenty of the 23 Board members were present. Significant actions were as follows:

1. The absence of the Executive Secretary, Janine Tash, was noted. She is recovering from a brief hospital stay. The Board voted to continue her annual bonus in the same range as in previous years.
2. The death of **Byron Cone Pevehouse** on Friday the 16th of April was noted with particular sadness by all present (see article on first page). His contributions to CANS were legendary and the Board asked the President to write a personal letter to his wife Lucy and consider a named lecture in his honor at the annual meeting in addition to the Pevehouse Award.
3. Voted to approve the applications for membership from:
  - a. **Manish Aghi**, Assistant Professor at UCSF
  - b. **Jason Lifshutz**, San Jose
  - c. **Rene Sanchez-Mejia**, Scripps Clinic, La Jolla
  - d. **SooHo Choi**, Kaiser, Anaheim
4. Noted a 17k profit on the 2010 annual meeting in January. President Ott appointed a Vendor Presentation Committee (Robbins, Prolo, Caton) to recommend additional involvement in the meeting by the vendors to maximize exhibitor income which was the predominant reason for the 2010 meeting's profits.
5. President Ott confirmed the 2011 annual meeting hotel as the San Francisco Ritz-Carlton with a \$225/night room rate.
6. At the request of the newsletter editor, President Ott appointed John Bonner and Deborah Henry as Associate Editors. He also asked Nominating Committee Chairman Vanefsky to canvas the membership for suggestions for nominees for AANS elected positions and prepare an investigated and vetted list for the CANS Board to consider (**see call for suggestions boxed announcement in this newsletter on page 6**).
7. The Board voted to oppose the California Division of Workers' Compensation's plan to convert the Official Medical Fee Schedule to an RBRVS system which will result in a substantial drop in surgical fees (see March CANS newsletter for details). President Ott will write to the Division expressing our opposition.
8. President Ott presented the results of the recent **CANS survey** of all 732 California neurosurgeons (including residents) of which 113 returned the survey. 75% of responders were CANS members. Half the respondents are in private practice, 20% are academic, 8 are at Kaiser, three are residents and 14 are retired. Practice size was predominately 1-2 docs (40%) and 3-6 (28%). 67% cover EDs and less than half get paid to do it while 57% cover trauma and 35% get paid to do it. Major concerns expressed were compensation rates, rising overhead and malpractice costs and dealing with ED coverage issues. CANS responders most valued CANS' endeavors in legislative/political areas, national neurosurgery organizations, work comp, ED coverage and MICRA and the newsletter. 18% would prefer a one-day annual meeting at an airport hotel, 30% preferred a 2-3 day meeting at a resort and 38% had no preference. Annual meeting topics rated highest were socioeconomic, practice contingencies and medico-legal with work comp and scientific/CME issues less important. 78% preferred the current one meeting a year.
9. In an attempt to improve attendance at the annual meeting (54 docs attended this January) and to assist in new member recruitment, it was decided to create a guest attendee program in which a CANS member who registers for the 2011 annual meeting will be allowed to invite a California neurosurgeon non-member to attend the meeting and the banquet at no charge.

**CANS Annual Meeting  
Ritz Carlton Hotel, San Francisco**



**January 14-16, 2011**

10. Although the Board approved the letter sent by President Ott to California State Senator Ashburn who is the author of a bill to weaken the corporate bar on the practice of medicine, there was some concern that the continuation of the bar may put California docs at a disadvantage going forward in the era of healthcare reform as close alliance including employee status with hospitals and IPAs may almost become necessary to protect our practices and income.

11. The Board took the following positions on the four resolutions to be acted on at the Council of State Neurosurgical Societies (CSNS) meeting in Philly on April 30-May 1. Those resolutions are:

**RESOLUTION I--SUPPORT (CANS is co-author)**

**Title: Advocacy for Increased Exposure to Neurosurgery for Medical Students**

**Submitted by: Paul Kalanithi, M.D.; California Association of Neurological Surgeons**

**BE IT RESOLVED**, that the CSNS recommend that the AANS and CNS construct educational materials to help neurosurgery programs increase medical student exposure to neurosurgery, including lectures and medical student rotations in neurosurgery; and

**BE IT FURTHER RESOLVED**, that the CSNS aid neurosurgery programs in advocating for mandatory medical student participation in neurosurgery, independently or as part of their neurology or general surgery rotations.

**RESOLUTION II--SUPPORT (Data worth knowing)**

**Title: Representation of Solo and Small Group Neurosurgeons**

**Submitted by: Kenneth Blumenfeld, M.D.**

**BE IT RESOLVED**, that the CSNS request that the AANS and CNS conduct a mode of practice survey of their memberships to fairly assess component constituencies; and

**BE IT FURTHER RESOLVED**, that delegates from all modes of practice be fairly represented in CSNS leadership roles in order to address their meritorious, unique concerns; and

**BE IT FURTHER RESOLVED**, that review of national healthcare reform proposals include consideration of how those proposals will specifically impact solo and small group physicians, as well as implications for neurosurgeons in large group and academic institutions; and

**BE IT FURTHER RESOLVED**, that CSNS position statements, policies, and directives to the Neurosurgery PAC reflect the interests and concerns of all member neurosurgeons including those in solo and small group practice.

**RESOLUTION III--NOT SUPPORTED (Too expensive; beyond Neurosurgery)**

**Title: Neurosurgeons Lead Public Awareness Campaign to Repeal the Flawed Sustainable Growth Rate (SGR) Formula**

**Submitted by: Mick Perez-Cruet, M.D.**

**BE IT RESOLVED**, that organized neurosurgery begin a national public campaign to raise the awareness of the harm of the government imposed SGR system on access to quality medical care.

**RESOLUTION IV--NOT SUPPORTED (Too vague and setting compensation unwise)**

**Title: Examining the Interplay between Device Innovation and Physician Compensation**

**Submitted by: Robert Heary, M.D.**

**BE IT RESOLVED**, that the CSNS explore the role of neurosurgeon input on device innovation and improvement; and

**BE IT FURTHER RESOLVED**, that the CSNS develop a white paper to explore and define the extent of neurosurgeons' roles in device innovation and examine related fields to determine how neurosurgeons insights, developed through years of training and experience, ought to appropriately be compensated.

President Ott finalized the CANS Council of State Neurosurgical Societies delegate list for the forthcoming meeting of the CSNS in Philadelphia, April30-May 1. The delegates will be: **Mark Vanefsky** (delegation Chairman), Mike Robbins, Marshall Rosario, Moustapha Abou-Samra, Ken Blumenfeld, Bill Caton, Deborah Henry, Randy Smith and Pat Wade. ❖

## The Older Patient, Driving and the Neurosurgeon

As you probably know, California is one of 6 states in which there is mandatory reporting requirement for physicians when they suspect a older patient of no longer having the mental ability to safely operate a motor vehicle. Most of the patients we see in this category are those seniors with possible NPH, tumors and post head injury. If you can confirm that the referring FP or neurologist has filed the appropriate report (which they usually have when the issue is seizures), then you are off the hook. If a report (usually a county health agency reporting form that also includes things like TB and sexually transmitted diseases) has not been filed, then the neurosurgeon should file one. That report goes to the county health officer who forwards it to the DMV and they take it from there and you don't have to give the patient any tests. If you don't, and the patient subsequently causes a serious accident injuring a third party, you can rely on a sharp lawyer to come after you for failing to file the report. Further, every time you prescribe narcotics to anyone, your office record should show that you advised the patient not to drive while taking the narcotic.

You can always refer the impaired patient to a neurologist and let him/her do the dirty work but relying on the patient to actually get the neurology consultation can be a problem. The AMA has an extensive free-to-all guide to help you in determining whom to report which can be found at: <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/older-driver-safety/assessing-counseling-older-drivers.shtml>. Another guideline has been published by the neurologists and is available on the Journal of Neurology Web site at <http://www.neurology.org/>. ❖

## The CMA is trying

The California Medical Association appears to this writer as more effective than the AMA. Admittedly, its national agenda is limited to trying to wag the AMA dog but for state issues it is an organization worth the support of us all. The CMA ain't perfect by any means as it suffers from some of the unwieldy governance issues that confound the AMA, but when it comes to looking out for us California docs, they do produce. Examples:

- 1). They have begun to publish a monthly E-mail bulletin entitled "CMA Practice Resources." It is edited by the reimbursement experts in CMA's Center for Economic Services and contains tips and tools to help physicians and their staff improve practice efficiency and viability. It is free to all who wish to receive it although pursuing some of tips provided requires CMA membership. That membership requires you to also be a member of your local medical society. Member or not, the bulletin is worth reading, particularly by your office manager. If you or your staff would like to subscribe, you can do so at <http://www.cmanet.org/news/cpr>. (There is also a pdf subscription form attached there, if you would prefer to print/fax.)
- 2). Various medical insurance carriers want to steer their members to their contracted docs who historically spend the least of their premium revenue providing care. These companies don't want their steering maneuvers labeled as "please use the cheapest doc" so they title their preferred list as delivering "best quality". In the hopes of promoting fairness and transparency (not insurance companies' long suit), the CMA joined the California Physician Performance Initiative (CPPI) project, a group dominated by insurance company representatives, to try to make the "quality" ratings really reflect quality and provide an avenue for docs to review their proposed rating ahead of publication so that any factual errors were corrected. To no avail. Blue Shield is about to publish its "quality" list under the aegis of the CPPI and it is *CMA's conclusion that publication of the CPPI will mislead patients in choosing or retaining their physicians, irreparably harm physicians' personal and professional reputation, and is unlikely to address payor concerns about costs.* The CMA has withdrawn from the CPPI and has warned the insurance companies to refrain from indicating in any way that the CMA endorses the lists. The next steps planned by CMA are to create a good quality measurement product and then get the insurers to buy into it as well as consideration of a lawsuit against Blue Shield. CMA is also pushing AB 2533 which would require insurers who publish these "quality" ratings to file their methodology with the Department of Insurance so that docs and others have an opportunity to review and take action if warranted.
- 3). One of the hot new topics connected to recently passed health reform legislation is the creation of Accountable Care Organizations (ACOs). CMA has created a one-page, question-and-answer summary of ACOs. It is attached to the E-mail you received announcing this newsletter as a .pdf file entitled *ACO\_QA\_2010*.

4). Capitol Weekly, an insider rag published for the Sacramento crowd, has released its list of the 100 unelected but most powerful people in state politics. CMA's CEO Dustin Corcoran is #34 on the list. The publication notes that he has molded the CMA into a force in election politics, and he, along with 4 other members of his CMA team who also made the list, are key players in state politics and wield influence over a variety of healthcare issues inside the Capitol. ❖

## CALL FOR AANS NOMINATIONS

The **American Association of Neurological Surgeons** is requesting **nominations** for President-Elect, Vice-President, two Directors-at-Large and three members of the Nominating Committee. Any CANS member can suggest a nominee for any of the positions by E-mailing our Executive Secretary at [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net) who will forward the suggestion to the CANS nomination committee for investigation and vetting and potential submission to the CANS Board for consideration of sponsorship. Any AANS member can submit a nominating letter to the AANS nominating committee but a nomination that comes with the endorsement of an organization should carry more weight. ❖

## EXECUTIVE OFFICE REPORT

*Janine Tash*

**SURVEY/MEMBERSHIP** In case you missed it, your responses to the recent CANS survey are summarized by Dr. Smith on page 3, item #8 of this newsletter. Some respondents expressed interest in becoming more active in CANS but did not leave a name or number. If you wish to apply for membership, see application and membership brochure on the CANS website ([www.cans1.org](http://www.cans1.org)) or contact the Executive Office at [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net) or 916 457-2267.

### NEW MEDICAL BOARD REQUIREMENT

Effective June 27, 2010, California physicians must inform their patients that they are licensed by the Medical Board of California, and include the board's contact information as follows:

#### NOTICE TO CONSUMERS

**Medical doctors are licensed and regulated by the Medical Board of California**

**(800) 633-2322, [www.mbc.ca.gov](http://www.mbc.ca.gov)**

The notice may be printed in sign form from the link below this article. For more information, please contact the Medical Board's information officer, Candis Cohen, at [ccohen@mbc.ca.gov](mailto:ccohen@mbc.ca.gov) or (916) 263-2394. ❖

### **Meetings of Interest for the next 12 months:**

CSNS Meeting, April 30-May 1, Philadelphia, PA

AANS: Annual Meeting, May 1-5, Philadelphia, PA

New England Neurosurgical Society: Annual Meeting, June 17-19, Chatham, MA

Rocky Mountain NS Society: Annual Meeting, June 26-30, Telluride, CO

**CANS: Board Meeting, October 2, Los Angeles, CA**

North American Spine Society: Annual Meeting, October 5-9, Orlando, FL

Western Neurosurgical Society: Annual Meeting, October 8-11, Santa Fe, NM

CSNS Meeting, April 30-May 1, October 15-16, San Francisco, CA

Congress of Neurological Surgeons: Annual Meeting, October 16-21, San Francisco, CA

Cervical Spine Research Society: Annual Meeting, December 2-4, Charlotte, NC

**CANS: Annual Meeting, January 14-16, 2011, San Francisco, CA**

Southern Neurosurgical Society: Annual Meeting, February 23-27, 2011, Orlando, FL

Neurosurgical Society of America: Annual Meeting, March 27-30, 2011, Island of Hawaii, HI

### 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). ❖

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 newsletter issues are available on the CANS website at [www.cans1.org](http://www.cans1.org).

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

*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. Ken Ott 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.*

#### California Association of Neurological Surgeons, Inc.

5380 Elvas Avenue, Suite 216

Sacramento, CA 95819

Tel: 916 457-2267; Fax: 916 457-8202 [www.cans1.org](http://www.cans1.org)

#### Editorial Committee:

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

Associate Editor: **John T. Bonner, M.D.**

Associate Editor: **Deborah C. Henry, M.D.**

President: **Kenneth Ott, M.D.**

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