



# CANS

# NEWSLETTER

California Association of Neurological Surgeons

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## President's Message: California Universal Health Care

*Kenneth Ott, M.D., F.A.C.S.*

**R**emember the Martin Scorsese thriller "Cape Fear?" Remember the evil antagonist (played by Robert De Niro) kept being killed, only to emerge again and again from nowhere? So it is with health care reform. It seems dead, only to be revived by the evil antagonists (played by Nancy Pelosi and Harry Reid). But wait, emerging from another nowhere is another monster ... universal health care in California!

This experiment is currently underway in the Commonwealth of Massachusetts. Universal health care was enacted in 2006. In those days about 500,000 residents were uninsured and MA provided a fund of \$700 million to fund hospitals for their care. Additionally the state received about \$385 million from the federal government for indigent hospital care. The health bill in many ways is echoed by current, proposed federal legislation for healthcare...a distant mirror as Barbara Tuchman would have said.

In some ways the experiment in Massachusetts has been a success. The uninsured rate went from approximately 8% to less than 3%. However the commonwealth's access to primary care is challenged and ER visits have not declined; in fact, the visits became more frequent. Hospitals are feeling the crunch as their decline in direct indigent funding from the state has not been covered by the new insurance plans.

I have recently contacted a few neurosurgeons in private or academic practice in MA. They have seen no changes in revenues or numbers of patients treated in the last four years. Many were unaware of the troubles the state is having paying for this massive entitlement.

But in most ways the plan is a failure...the basic problem is the commonwealth cannot print money. Its health care costs have risen more than 40% since 2006 and its insurance rates are the highest in the nation. The costs will completely overwhelm the state budget and already have led to rationing: legal immigrants are no longer eligible for state subsidized health care. Per capita healthcare spending is 27% greater than the national average. The state now plans to limit spending by hard price controls which would freeze hospital and physician expenditures...in effect the state would become an HMO with fixed salaries for beleaguered physicians within a few years.

The California legislature has passed three bills aimed at establishing universal health care within our state. The last attempt, Senate Bill 810 sponsored by Senator Mark Leno (D Senate District 03, San Francisco-Sonoma), was vetoed by Governor Schwarzenegger in January. This enormous entitlement was proposed despite a current state budget deficit of more than \$20 billion. How about the unfunded state obligations to the teachers and state workers for health and pension benefits...now more than \$100 billion! We have more than 10 times the number of uninsured in our state than Massachusetts did in 2006. The budget stress on our state would be one order of magnitude greater than Mass. We will be one order of magnitude more broke.

Another movie metaphor...Stephen Spielberg's "Jaws." Remember the leitmotif...Baa Bum, Baa Bum, Baa Bum... while innocent children swam in the ocean (off the coast of Massachusetts...how perfect!). Then the fin appeared and the shark attacked. Baa Bum... we are one governor's signature away from universal health care in California. Baa Bum... a few seats away from 2/3 Democrat majority within the state senate and assembly which could override a veto. I asked Attorney General Jerry Brown's office for an

*California Neurosurgeons – Please take the membership survey (see next page) if you have not already completed it.*

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indication if he would sign such a bill if he became governor. Lila, from his office e-mailed: "Should he declare a run for Governor, he'll begin to address all the issues and concerns that Californians will find important in choosing their next Governor." Well yesterday he did declare for governor.

Another distant mirror reflection: in a health care forum in 1992 Jerry Brown declared: "I see health care in the larger context of where we are in America. The failure to achieve real social and economic justice is also reflected in our health care policy, with 40 million people not covered and millions more not able to attain the kind of coverage they really need. To overcome this, we're going to have to do something very different...I believe the only health care system that makes any sense is a single-payer system, similar to what has been adopted in Canada, where everyone would be in one universal system but maintaining the right of private physicians and private hospitals and private choice, emphasizing a respect for a diversity of healing practices, emphasizing prevention and wellness and occupational and environmental health. But I don't see any way, after having worked on this problem in the largest state in the union, which, after all, has the highest medical costs, to really contain costs without establishing a single payer for all basic services."

So there it is. The aim is to achieve social justice and control medical costs...just like Massachusetts. I believe the real aim in California, Massachusetts and the nation is to bankrupt the health care system in the short term and force health care to become one big HMO. The macroeconomic model of guns versus butter will become guns versus bandages. When healthcare spending reached 20 to 25% of the GDP it will perforce threaten military spending. Healthcare spending will threaten national security. It's all so obvious. ❖

## EXECUTIVE OFFICE REPORT

*Janine Tash*

### **Membership Survey for California Neurosurgeons only**

To help CANS find ways to better serve you, please click on link below for a quick survey. If you have already answered the survey when it was originally sent to you in early March, please do not answer again. Survey results will be published in the April issue of this newsletter.

<https://www.surveymonkey.com/s/surveyCANSmarch2010>.

### **CMA Help for Practice Managers and Office Staff**

CMA's Center for Economic Services (CES) is developing a monthly newsletter focusing on practical tips and tools to assist physicians and their office staff improve practice efficiency and profitability. Features will include a Know Your Rights column, Ask the Expert Q & A, Tips for Getting Paid, and practical tools (spreadsheets, forms, scripts, check lists) to assist our members with the business of medicine so that they can focus on patient care. If you would like to get on CMA's distribution list, contact Aileen E. Wetzel at [awetzel@cmanet.org](mailto:awetzel@cmanet.org).

### **2011 Annual Meeting**

The beautiful Ritz-Carlton Hotel (with contracted room rates of \$225 per night) in the heart of San Francisco has been selected as the site of the January 14-16, 2011 CANS Annual Meeting. Watch the CANS website for information as program plans are developing. Interested exhibitors can contact Janine Tash at 916 457-2267 or [janinetash@sbcgobal.net](mailto:janinetash@sbcgobal.net) to reserve space at the hotel.

## Work Comp about to run off the cliff

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

Approximately 75% of CANS members treat patients in the California Workers' Compensation system. Although the paperwork can be a pain, once a doc has mastered that, the payment rate for WC is about the best around, particularly for surgical procedures. The Division of Workers' Compensation (DWC) is in the process of a mandatory re-examination of the current Official Medical Fee Schedule that pays us pretty well and it is their plan to shift to a RBRVS system much like that used by Medicare. The DWC has hired the Lewin Group to make some suggestions about this change and that group has delivered its final opinions this month. The Lewin Group has basically

recommended using the RBRVS system in a budget neutral way which means picking reimbursement rates such as to overall spend no more than the last year's total for medical fees by lumping all the CPT RVU's delivered and picking a conversion factor that, when applied, results in the total dollars spent. That conversion factor would be about \$43/RVU (current surgical WC value is about \$56/RVU; Medicare is currently \$36/RVU for all docs) and considering how the RBRVS system is designed to increase cognitive income and reduce procedural income, that maneuver would result in an immediate 23% reduction in surgical fees while increasing E&M fees by 27%. Anticipating some push back by proceduralists, the Lewin Group has a stealth recommendation which initially creates a separate conversion factor for surgery at \$56/RVU (no change from current factor) but phases out over 4 years ultimately resulting in the \$43/RVU rate when all the animals will be equal. The phase out option should fool no one who recognizes it as the ploy it is.

The DWC is proposing to adopt the RBRVS system with the separate conversion factor for surgery model initially with a transition to a single factor for everyone in three years. "Because we are mindful of the economic realities facing all Californians, we will ease this change into place over four years" says the DWC director. Well, thanks a lot. There has been no increase in surgical fees paid by the DWC for 25 years in this state. Since most of us have to give a discount of 10% to 30% to be listed in a WC insurance company's Medical Provider

Network and since our overhead has risen mightily over the last quarter-century and since most of our treatment options are now limited by the ACOEM guidelines and some utilization reviewer in Missouri quoting whatever guidelines suits him/her to justify a denial, we haven't exactly been cleaning up with WC over the last 5 years. Do they really think there will be a big army of surgeons out there wanting to thrash with the WC system for a \$7/RVU increase over Medicare? They appear to want eager surgical providers for a low cost. They can have one or the other.

If you think the DWC is about to put their head where the sun never shines, you have an opportunity to comment until April 5th by going to the DWC forum at <http://www.dir.ca.gov/dwc/DWCWCABForum/PhysicianFeeSchedule.htm> and letting them know your thoughts about the whirlwind they are about to reap. ❖



### Thought for the month

The government cannot give to anybody anything that the government does not first take from somebody else.

## **TIDBITS from the EDITOR**

### **CANS BOD Meeting--your input welcome**

The next CANS Board of Directors meeting will occur on April 24th in Oakland. Any issues you wish to have discussed are welcome; call or E-mail any of the BOD members listed on page 6 and give him/her your thoughts. The Board will consider taking a position on the four resolutions to be acted on at the Council of State Neurosurgical Societies (CSNS) meeting in Philly on April 30-May 1. Again, your input is welcome. Those resolutions are:

#### **RESOLUTION I**

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

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

**WHEREAS**, diseases of the brain and spine represent a significant portion of medical care; for example, subdural hematomas are increasing rapidly, almost tripling in incidence in the past 15 years, and mechanical back pain is the fifth most common reason for outpatient visits; and

**WHEREAS**, medical students generally have little to no formal exposure to neurosurgical education, and may not have adequate knowledge regarding common conditions, such as the consequences of anticoagulation or basic back pain management; and

**WHEREAS**, primary care physicians who received inadequate medical school training may produce improper, delayed or absent referrals; and

**WHEREAS**, data suggests medical students with exposure to neurosurgery are far more adept at managing both routine and emergent cerebral and spinal conditions; and

**WHEREAS**, spinal care represents a large portion of neurosurgical practice and yet referring physicians may not consider neurosurgeons as spine care specialists, which may hamper neurosurgical practice by encouraging referrals to other spine physicians; and

**WHEREAS**, only one neurosurgical program in the U.S. currently is known to have routine medical student exposure; therefore

**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**

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

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

**WHEREAS**, state neurological society surveys indicate that solo and small group practice remains a dominant mode of practice in many regions; and

**WHEREAS**, AANS, CNS, CSNS, ABNS and ACS leadership is dominated by academic and employed neurosurgeons working for large organizations; and

**WHEREAS**, recent and future attempts at healthcare reform have special implications and consequences for private in solo and small group environment; therefore

**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****Title: Neurosurgeons Lead Public Awareness Campaign to Repeal the Flawed Sustainable Growth Rate (SGR) Formula****Submitted by: Mick Perez-Cruet, M.D.**

**WHEREAS**, the Sustainable Growth Rate (SGR) formula was instituted to “rein in healthcare cost” by reducing reimbursement for physician services; and

**WHEREAS**, it appears that the SGR has failed to do this and in fact may markedly increase healthcare delivery cost by forcing physicians to see more patients, do more procedures and conversely use more health care dollars; and

**WHEREAS**, CMS reimbursements for physician services are primarily used by the Medicare population and further cuts in reimbursements may lead to restricted access to care for these patients; and

**WHEREAS**, reimbursement cuts mandated by the SGR formula are typically followed by private insurance companies leading to increase insurance company profits while providing little or no benefit to patient care; and

**WHEREAS**, the discussion of restricted access to care, non-sustainable physician practice economic environment, yet extremely high cost healthcare delivery system which rewards those that are not serving the patients’ interest; therefore

**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****Title: Examining the Interplay between Device Innovation and Physician Compensation****Submitted by: Robert Heary, M.D.**

**WHEREAS**, Congress and the public continue to intensely scrutinize the relationship between the healthcare industry (pharmaceutical companies, device makers, etc) and physicians most notably with introduction of the Grassley-Kohl Physician Payment Sunshine Act of 2009; and

**WHEREAS**, nation-wide, hospitals associated with academic institutions have recently instituted stringent limitations on the compensation received by physicians serving on company boards and banned speaker fees paid by pharmaceutical companies; and

**WHEREAS**, surgeons, from all specialties, recognize the importance of surgeon input in designing, developing, and improving existing surgical and patient-focused devices; and

**WHEREAS**, several studies highlight the importance of innovation in operating room technology utilizing the perspective and experience of surgeons; for instance, ergonomic improvements in operative devices have relied on surgeon input to enhance surgeon ease of use and ability to perform complex procedures with reduced physical strain; and

**WHEREAS**, additional case studies, based on fields such as orthopedics, have demonstrated the value of iterative surgeon input on improving devices and making them suitable for patient implantation (e.g. hip arthroplasty); and

**WHEREAS**, other studies question the relationships between device company compensation and patient care, suggesting device company compensation constitutes a “quid pro quo” to stimulate implantation volume of devices; and

**WHEREAS**, other specialty societies (including the American Academy of Orthopedic Surgeons) have begun open discussions of surgeons’ roles in device innovation and compensation for this advice; and

**WHEREAS**, the role of surgeon compensation has important implications for teaching surgical residents appropriate ways to share vital insights learned from caring for patients with industry, and see this knowledge translated into technology to improve patient care; therefore

**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.

**2010 CANS - BOARD ROSTER**

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**The Red Flags Rule--Act III**

This newsletter has previously called attention to the Federal Red Flags Rule which was created to protect against identity theft of citizens who deal with creditors, usually banks and credit card companies. The Federal Trade Commission has decided that the Rule also applies to docs and lawyers because we all carry accounts due by the very nature of how we get paid and thus are "creditors." The Feds have postponed the compliance date a couple of times at least in part due to the outcry from docs about yet another unfunded mandate that shouldn't apply to physicians. The attorneys decided to can the griping and go for the jugular and filed a suit which they won in November that excludes them from the Red Flag requirements because the U.S. District Court for D.C. held that application of the rule to lawyers "is both plainly erroneous and inconsistent with the purpose" of the Red Flags Act. The current compliance date for us docs is now June 1, 2010. We hope the FTC will be sensible and exempt us from implementation but who knows. Maybe we should stop playing nice and sue like the lawyers did. For now we recommend doing nothing. We will keep monitoring this issue. ❖

**More EMR**

For those of you considering or beginning to implement Electronic Medical Records and also wishing to feed at the Federal trough made available to docs who install these systems as part of the federal stimulus package (\$44,000/doc), you must meet "meaningful use" standards. The Feds are going to certify certain vendors and products that will allow docs to meet the standards starting with a temporary certification process to begin this year. The Feds will hire an organization to early and temporarily certify EMRs that will qualify to meet the meaningful use standards. We broach this issue at this time to suggest that whomever you are planning to or currently using to setup a EMR system, you ask questions about your vendor's plans to apply for certification. If you get a blank stare, switch vendors. ❖

## Letter to the Editor

I read my colleague Moustapha Abou-Samra's Letter to the Editor in the February issue. I essentially agree with his remarks dealing with "You get what you pay for..." and the fact that American medicine still is (but for how long?) the best in the world. Our current health care payment system is, however, terminally ill, and we are slowly reaching the point where the deterioration may become irreversible.

While there may be drawbacks and abuses within the provision of medical care in the USA, these are matters which, in good faith, could be handled by diligent collaboration between providers and others who are directly involved with such care services. Both President Obama's and the Clinton "solutions" share the same defect, the relative absence of people "in the trenches" of healthcare in the groups which put forth the changes needed. We need more practicing physicians (and other practicing healthcare professionals) to be part of the development of any new programs. When people of the proper expertise and good faith get together in this way, I have little doubt that the effort would succeed.

The major villain in our current crisis is, in my opinion, the insurance industry. The recent obscene raising of premiums by up to 39% by Blue Cross for their Individual coverage is simply the most egregious of such raises. My own daughter, covered by a medium-deductible PPO through California Blue Shield, 22 years old and perfectly healthy, was made subject to a 28% premium increase in late 2009 (a previous 15% raise was instituted the year before!), and when she reported to the Company that she could not afford such a catastrophic markup, she was offered the opportunity to triple her deductible and "save" about a quarter of the increase. For someone just out of college and in an internship, this young woman is very likely to join the ranks of the uninsured. Looking at my own personal situation, as a semi-retired neurological surgeon, were it not for my Medicare and Supplemental insurance having rates stabilized by governmental control, I might well be uninsured also.

No matter which way the current debates regarding health insurance reform go, the insurance companies must be curtailed in their avid pursuit of exorbitant profit; and, if they do not modify their positions, the "Public Option" (Government insurance) must be made available. Together with elimination of non-coverage policies for pre-existing conditions, limitations on the salaries of insurance executives (what executive deserves a salary higher than that received by the most powerful person in the world, our President?), and a limitation on the uncontrolled raising of premiums, the insurance companies should be forced to comply with such reforms. And if they do not respond to such, then let the "Public Option" put them out of business. That is called good old-fashioned American competition! ❖

**Robert A. Fink, M.D., F.A.C.S.**  
**Berkeley, California**

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

Neurosurgical Society of America: Annual Meeting, April 11-14, Pebble Beach, CA

**CANS: Board Meeting, April 24, Oakland, CA**

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

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

## Letter to the Editor

**O**K! The Health Care Reform Act was passed by Congress and was signed into Law by President Obama.

Although we hoped that such a monstrosity will not pass we should not have been surprised, given the political climate. But we are justifiably distressed that this whole bill was passed without us, the physicians of America, taking our rightful place at the negotiating table. We will soon be affected, but most of the serious provisions will be felt after 2014; by then a lot of the readers of this column will be retired, possibly early, from practicing our beloved profession!

We know that this is not “the” comprehensive health care reform bill we were promised; it is, instead, an attempt to reform insurance and one that will present tremendous advantages to insurance companies and hospitals at the expense of physicians and yes, patients; not to say anything at all about the cost!

There are glaring omissions; tort reform and patients’ responsibility are very obvious; had they been addressed, a more comprehensive reform would have become feasible. I would like to address patients’ responsibility, particularly as it applies to end of life care, here.

In the few weeks leading to final Health Care Debate in Congress, there were several newspaper articles outlining the problem. Some dealt with personal experiences that resulted with the decision of “doing everything!”

One article, in particular, was of concern to me because it was written by someone who is well informed, not only about medical matters and end of life issues, but also about public policy. Please refer to: “An Ill Father; a Life-or-Death Decision”, by Alicia Von Stamwitz, The New York Times, January 26, 2010.

The author, an editor and a writer in a major city, who was chagrined that her father has been living a life that cannot be associated with quality, allowed him, while in an extreme condition in an Emergency Room, to “signal” his intentions to “do everything” thus committing him to an additional few months of ventilatory support and even dialysis! The father was an alcoholic with a bad liver; he has already undergone two coronary bypass procedures and was doing very poorly. Add to that: the author was clearly under the impression that her father would not want any heroics; he had signed a durable power of attorney stating his wishes and giving her the tough role of making decisions on his behalf.

The author wrote a very touching account about the difficulties she encountered, while under pressure in the Emergency Room, to make a decision. I will say that no doubt such a decision is not only intellectually difficult but also heart wrenching. She also described the reaction of the emergency room personnel when they heard her decision to “intubate.”

This is how she described her father’s course after her decision: “My father never really recovered. He could never again breathe without a respirator, he never left the hospital bed, and he eventually needed dialysis and a feeding tube. Six months later he died of heart failure.” How sad for the father; and how ... irresponsible! And why is it a nothing or all decision? Intubating is one thing, but starting dialysis is an altogether different level of care.

She ended her essay by saying: “I suppose my father’s decision was a mistake. But it was his mistake to make, not mine. My role was to support my father, no matter what, and to tell the truth, no matter how hard.”

One can say that it is indeed his mistake to make if he were paying the hospital bill; in this case it is probably in the quarter million dollars range.

Everyone reading this knows that this is NOT an uncommon occurrence; it is repeated day in and day out in every emergency department across the U.S.

It is puzzling to me that under the circumstances the writer found it logical to let her father who, in actuality, was neither coherent enough, nor informed enough to make a decision of “doing everything.” In fact, I think that the responsible thing to do would have been to say that her father had had enough and it was time to go. And no, I am not talking about death panels. I am simply accepting the serious responsibility to make a decision about a loved one. Is it too much to ask: what would I do if I were this hopelessly sick person?

I wonder what would the author have done, if she were actually responsible for paying the entire hospital bill? One solution: each of us must start thinking, no actually believing, that we are, in fact, paying the entire hospital bill!

**Moustapha Abou-Samra, M.D.**  
**Past President, CANS**

### 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 ([rhs-avopro@sbcglobal.net](mailto:rhs-avopro@sbcglobal.net)) or fax (858 683-2022). ❖

Comments can be sent to the editor, Randall W. Smith, M.D., at [rhs-avopro@sbcglobal.net](mailto:rhs-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).

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*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.*

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