



# CANS

# NEWSLETTER

California Association of Neurological Surgeons

Volume 38 Number 3

March 2011

## President's Message

*Marc Vanefsky, M.D.*

**A**s Neurosurgeons we routinely take care of patients with Glioblastoma. But we are not the only ones who treat these patients. Typically post operative management is coordinated by the oncologist and radiation oncologists. Advances in the care of these patients have been slow, but I think we can all agree that any improvement in longevity and quality of life is something that patients should have access to.

Let's take a step back and look at how incentives drives behaviors and how this affects patients. I'm going to leave the neurosurgeons out of this discussion for the time being. Let's take a patient and sit him down for a discussion with a Radiation Oncologist. Typically the radiotherapist will discuss a number of different options with the patient. These may include whole brain radiotherapy (WBRT), stereotactic radiosurgery (SRS), Brachytherapy, Intensity modulated radiotherapy (IMRT). Depending on what part of the country you are in you will get widely varied opinions about which therapy results in the greatest longevity, but routinely patients will get treated with what reimburses the most. Patients don't understand that there is typically a financial incentive that drives the recommendation of what type of XRT they will receive for their brain tumor. As we continue in the post operative care of these patients we need to have a discussion with the medical oncologists. Now the medical oncologists are incentivised to put patients into infusion centers and give them IV chemotherapeutics. They typically own the infusion centers and the associated pharmacies and make their living by infusing patients with these medications.

Since August of 1999 an agent known as *temodar* became available in the United States. This is a medication that patients with Glioblastoma would typically take in the morning with a cup of coffee and a bagel. This medication was much better tolerated by most patients than most of the IV chemotherapeutics and resulted in slightly longer life expectancies. The problem is that patients were still being treated by the older IV agents because the oncologists were not incentivised to write out a prescription for a medication the patients could take at home when they were brushing their teeth in the morning or, even worse, their insurance didn't pay for oral chemotherapeutics. Schering-Plough Corporation actually recognized this loophole and started making an IV form. So, because of the incentives, there are still GBM patients being treated with CCNU or BCNU who don't even know that temodar is an option. Incentives drive behavior. We need to make sure that the incentives align with what's best for the patient. ❖

### 2012 CANS Annual Meeting



January 13-15, 2012

Martin Luther King weekend

Hotel group rate - \$219.00

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## CANS Board of Directors Meeting 3/26/2011

Randall W. Smith, M.D., Editor

The BOD met near LAX last Saturday for its spring gathering. In attendance were **Marc Vanefsky**, President and officers/directors/consultants Caton, Colohan, Kaczmar, Kissel, Ott, Blumenfeld, Henry, Mummaneni, Rhoten, Rosario, Bonner, Rich, Smith and Wade.

The group voted to accept the applications for membership from **Lars Ankar** (Orange), **Odette Harris** (Stanford), **Brian Pikul** (Los Angeles), **Daniel Yanni** (Orange), **Daniel Lu** (Los Angeles), **David Westra** (Ventura), **Lyman Whitlatch** (Chico) and **Larry Wainschel** (Chico). It was noted that the By-laws are unclear about when new active members officially become CANS members and Dr. Colohan, Chair of the By-laws Committee, will work to suggest changes to clarify this issue.

The Board adopted a policy to formalize the process of making nominations for elected positions in the AANS and CNS. The policy will assure that any nomination put forth by CANS will be researched so that the person put forth has been determined to be eligible for and will accept the nomination.



A proposal by the California Neurology Society, with whom CANS shares office space in Sacramento, to have an integrated combined annual meeting was rejected but it was decided that if that Society chose to have its annual meeting at the same time and place as CANS, we would welcome their paid attendance at our opening reception and banquet dinner.

The Board reaffirmed its commitment to subsidizing, as necessary, resident attendance at the annual meeting. Since CANS declares all residents training in California as CANS resident members (just as the AANS does with all US neurosurgery residents), their class of membership may be treated differently than active or

senior members whose attendance at the annual meeting is not subsidized. The Board also approved sending each resident who attends the annual meeting a certificate of attendance for use by the resident's program director to assist in meeting the RRC requirement for resident education in socioeconomic issues.

It was noted that the annual meeting in San Francisco resulted in a profit of some 14.5K due in large part to the fees paid by the 27 exhibitors. Included in the cost of the meeting was 3 months of our Executive Secretary's salary which in effect reduces our routine operating costs by 8K. The banquet was attended by 99 folks and was self supporting by those attending so as not to require subsidization by meeting income.

Finally, the Board studied the 11 *Council of State Neurosurgical Societies* resolutions submitted for action in Denver on April 8-9. The following actions were taken (*italics*):

### **RESOLUTION I** [*CANS position: No position—resolution unclear*]

**Title:** Centralization of Information Technology for the AANS, CNS, Joint Sections and CSNS

**BE IT RESOLVED**, that the Communications and Education Committee of the CSNS coordinate an evaluation of the web resources currently utilized by the AANS, CNS, Joint Sections and CSNS and make a presentation to the AANS Board of Directors and Executive Committee of the CNS that summarizes their date; and

**BE IT FURTHER RESOLVED**, that the CSNS Executive Committee send a letter of support and interest to the AANS Board of Directors and Executive Committee of the CNS regarding this effort.

### **RESOLUTION II** [*CANS position: Support*]

**Title:** Support of Resident Socioeconomic Education

**BE IT RESOLVED**, that the CSNS request of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) that resources, including financial and logistic, be allocated for the purpose of providing additional opportunities for formal resident education in socioeconomic issues in neurosurgery; and

**BE IT FURTHER RESOLVED**, that these resources include (but not necessarily be limited to) mechanisms for subsidizing resident participation in practice management workshops (6), coding and billing seminars (7), and other, formal programs in socioeconomic education that are currently presented by the AANS or CNS.

**RESOLUTION III** [*CANS position: Support*]

**Title:** Establishment of a Formal Socioeconomic Curriculum

**BE IT RESOLVED**, that the CSNS stimulate our parent organizations, AANS, and CNS to protect the graduating resident physician and empower them through the institution of a formal socioeconomic curriculum during residency; and **BE IT FURTHER RESOLVED**, that the CSNS and the Washington committee support an emailed cross-sectional survey to recent graduates and current residents, in order to study their socioeconomic educational needs prior to the implementation of a formal socioeconomic curriculum into residency programs.

**RESOLUTION IV** [*CANS position: Support +add indications for use as well*]

**Title:** Payor Policy Response for Cervical Artificial Discs

**BE IT RESOLVED**, that the CSNS collect and review the current payor policies related to cervical disc arthroplasty; and **BE IT FURTHER RESOLVED**, that the CSNS work in conjunction with the AANS and CNS to develop a policy response and position statement for cervical disc arthroplasty; and **BE IT FURTHER RESOLVED**, that the CSNS coordinate a multi-society support of this response and position statement and disseminate to the payors.

**RESOLUTION V** [*CANS position: Support*]

**Title:** Urgent Organized Neurosurgery Response to the Leapfrog Group

**BE IT RESOLVED**, that the CSNS petition the AANS and CNS to take immediate and effective action, potentially working with the ABNS and the Society of Neurological Surgeons, in response to the Leapfrog Group's position vis a vis neurosurgeons as recognized neurocritical care intensivists potentially including pursuing legal action against the Leapfrog Group.

**RESOLUTION VI** [*CANS position: Support + create protocol and only allow MD/DO to follow it*]

**Title:** Neurosurgical Sports Injuries

**BE IT RESOLVED**, that the CSNS request that the AANS and CNS encourage neurosurgeons to participate in the care of neurologically injured professional and non-professional athletes; and **BE IT FURTHER RESOLVED**, that the CSNS work with the Joint Section of Neurotrauma and Neurocritical Care to provide a tool kit with protocols and indexed references for those neurosurgeons interested in caring for athletes; and **BE IT FURTHER RESOLVED**, that this Neurotrauma Toolkit will be housed on the CSNS website and be password-protected; and **BE IT FURTHER RESOLVED**, that the CSNS ask the AANS and CNS to publicize and advocate for neurosurgeons taking a primary role in the management of neurological sports injuries.

**RESOLUTION VII** [*CANS position: No position—would be extremely expensive*]

**Title:** The Neurosurgical Safety Coalition

**BE IT RESOLVED**, the CSNS will issue a pilot project for clinicians at various institutions to voluntarily offer their databases of IOM cases to the Coalition; and **BE IT FURTHER RESOLVED**, that these databases will be pooled to provide a very large sample size from which to glean information regarding the incidence of waveform changes and surgeon responses to changes; and **BE IT FURTHER RESOLVED**, the Coalition will draft a White Paper by the Spring 2012 CSNS meeting for consideration by the CSNS Executive Committee to submit for publication.

**RESOLUTION VIII** [*CANS position: Support*]

**Title:** Increasing Neurosurgical Content on National Board of Medical Examiners Subject Exams

**BE IT RESOLVED**, that the CSNS work with the AANS and CNS to petition the NBME and FSMB for increased representation on the USMLE Examination Committee for the purpose of ensuring that common neurosurgical problems are appropriately represented on these examinations.

**RESOLUTION IX** [*CANS position: Support, plus creating better measures for neurosurgery*]

**Title:** Physician grading in surgical field; exploring the scope and recognizing the pitfalls.

**BE IT RESOLVED**, that the CSNS study the scope of insurer-based quality rating programs and the surgical fields that are currently graded; and

**BE IT FURTHER RESOLVED**, that the CSNS study the parameters tracked (e.g. wound infections, pulmonary embolisms, urinary tract infections, etc) so that the potential pitfalls and methodological flaws affecting measurement tools can be recognized.

**RESOLUTION X** [*CANS position: Not support—unlikely to be useful*]

**Title:** Congressional Contact Information Database for Neurosurgical Patients

**BE IT RESOLVED**, the CSNS will house on their website, an online database of contact information for government representatives for neurosurgical patients that they may contact them and may impress upon them the volume of procedures that neurosurgeons do and the improvement in patients' lives that we make.

**RESOLUTION XI** [*CANS position: Support*]

**Title:** Development of Core Curriculum

**BE IT RESOLVED**, that the CSNS develop an educational webinar series addressing socioeconomic issues in medicine in each of the residency training core competencies; and

**BE IT FURTHER RESOLVED**, that this webinar material be marketed as a CSNS product to residency programs of all medical specialties throughout the United States. ❖

## MEET YOUR CANS BOARD

**President-Elect: Austin R. T. Colohan, M.D.**

Austin R. T. Colohan, who next year will be the first President of CANS who is also an academic department chair, has a peripatetic past. He was born in England in 1950 and educated in Canada where he received his B.Sc. from Guelph University and his M.D. from McMaster University, both in Ontario. After internship and 2 years of neurosurgical residency in Charlottesville, he functioned for 2 years as a neurosurgical registrar, first in Cape Town, South Africa and then in Plymouth, England. Following completion of his neurosurgical training and a Cerebrovascular fellowship in Charlottesville, he was off to McGill for 3 years and then on to Emory for 8 where he achieved full professorial rank.

He then served a 2 year stint on the faculty of the Robert Wood Johnson Medical School at Camden, NJ where he ultimately saw the light, namely California sunshine, and, career crossing the Mississippi for the first time in 1999, joined the neurosurgical faculty at Loma Linda University as departmental Chairman.

His research interests fall in the cerebrovascular and brain trauma spheres and he has published extensively on both topics. He has been book editor for the JNS as well as on the Board of the California Association of Neurological Surgeons since 2003 and currently is the President of the Western Neurosurgical Society.

Dr. Colohan resides in Riverside, CA with his wife Darla who is a professional photographer. Oddly enough, they both enjoy traveling. ❖



## Letter to the Editor: Regulations and more regulations!

*Moustapha Abou-Samra, M.D., Ventura*

The evidence suggests that we are indeed subjected to more and more regulations, regulations that may lead to the demise of our noble profession.

I've been in private practice as a physician and as a surgeon in my small coastal California community almost thirty years; you'd think that by now I know what I am doing?

I am afraid, however, that this is not the prevailing opinion: hospitals, governmental agencies and even some of our own medical organizations feel differently.

Instead of respecting the judgment of a more mature surgeon, we are told that "older surgeons" are more dangerous. Please read: "As Doctors Age, Worries About Their Ability Grow" by Laurie Tarkan, The New York Times, January 24, 2011.

I admit that there are "older" surgeons that should stop practicing, but I believe that most of us are perfectly capable of recognizing "our limits." It is puzzling that we are expected to make life and death decisions daily, but we cannot be trusted in making decisions about our own ability. Airlines pilots are quoted as an example of how we should be regulated, tested and re-tested. Is taking a cognitive and physical screening exam every six months after the age of 65 the way to go? Remember that we are also told that 65 is an arbitrary retirement age and that we should seriously think of working in one capacity or another beyond that, since we are staying healthier and living longer.

With a few exceptions, physicians and surgeons are very careful, and do in fact restrict their scope of practice to fit what they are most comfortable in doing. We all see the wisdom of our elders and we treasure their counsel. Our patients should feel similarly confident when seeking their expertise.

To further illustrate my point about regulations, please read: "Sleep Deprivation, Elective Surgical Procedures, and Informed Consent", by Michael Nurok, M.D., PhD., et al, New England Journal of Medicine 2010; 363:257, December 30, 20107-2579. In this article the authors suggest that a surgeon may not be capable of deciding whether or not he is impaired by virtue of sleep deprivation. I submit that most if not all surgeons will not drive while under the influence of alcohol or drugs and certainly will not operate if sleep deprived and impaired; consequently a new informed consent on Monday morning following a weekend on call is, in fact, not needed.

I agree that airlines pilots are subject to an amazing amount of regulations and that aviation safety records are impressive. But there is a huge difference between a pilot and a surgeon/physician. The pilot is trusted to operate a very complex but predictable machine that happens to carry humans; the surgeon/physician sole job is to deal, interact and care for a fellow human-being who is often in a vulnerable position and whose reactions are seldom predictable.

I am not of the opinion that any regulation is burdensome; I do believe, however, that since most regulations are aimed at the small percentage of colleagues that break the rules of common sense and professionalism, we should limit regulating the vast majority of hard working and honest physicians. Instead, we should let them exercise their professional judgment. And if something must be regulated, I believe that allowing us to "police" ourselves is by far more effective than being regulated by anybody else.

Losing mature and experienced physicians will be a travesty. And I am afraid that unwieldy regulations will lead to many perfectly qualified colleagues leaving our profession in a time when we need more physicians, not less. ❖

## Transitions in Neurosurgery

*John T. Bonner, M.D., F.A.C.S., Associate Editor*

**T**he big ticket item in Sacramento presently is the budget. When the Legislature and the Governor become serious about dealing with it, major cuts in services will almost undoubtedly occur, affecting our patients and us through reduced Medi-Cal fees. The few physicians seeing Medi-Cal patients will probably become even fewer.

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Quality of care, including neurosurgery, is a big issue in medicine, from federal government and insurance company concerns to us in issues of peer review. Establishing the standards for such review is the issue, especially as expressed by the American College of Surgeons, and I believe we all are aware of the professional and patient benefits, but also of the pitfalls (especially medically-legally) in view of issues that are controversial in our delivery of care. Such issues were present during the birth of neurosurgery, as an article in the Archives of Surgery, Vol. 146, No. 2, Feb. 2011 "Harvey Cushing's Open and Thorough Documentation of Surgical Mishaps at the Dawn of Neurologic Surgery" illustrates. These self-reported cases of surgical errors were reported by Cushing at the Johns Hopkins Surgical Records. These mistakes were carefully analyzed and recorded to improve surgical care, just as we do now. Also attorneys and medical malpractice charges were not unknown then. As the article states, Cushing set a high moral standard in this report by publishing statistics on complications for which he is credited, and as we all know, many today do not commit themselves to such high standards and forthrightness. Unfortunately, we are all aware of operation reports, consultation and discharge summaries that have not been absolutely objective. Such concerns are why more medical systems and organizations of scrutiny would like to become active in our evaluation, but such review should remain true peer review, but more precise and objective than much peer review has been. Only medical care experts, qualified physicians, should be in the position to judge quality of care. ❖

## Brain Waves

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

**I** cut my thumb with an Addson elevator last year. Hard to believe I could do that, but I was debriding an infected cranioplasty and pushed upward too hard and the sharp edge (which never seems that sharp when you are using it) sliced my glove and thumb. I did all the appropriate tests and thankfully the patient, who had had multiple prior surgeries, was not a carrier of any testable diseases. I have poked myself with a handful of needles over my years doing surgery and have not always followed through with the appropriate testing, especially earlier in my career. Wearing two pairs of gloves (does this really help?) is not an option for me as my median nerve complains and my first three fingers fall asleep.

According to the occupational health and safety data floating around on the internet, 70% of needle sticks occur among nurses, 6% among physicians (especially anesthesiologists, surgeons, internists and dermatologists) and 4% in the medical student/resident population. Needle sticks with blood infected with hepatitis B carry up to a 30% risk of transmission. The hepatitis B vaccination is 90-95% effective (wow, that still means there is a 1 in 20 failure rate). If the blood is infected with hepatitis C, the risk is less than 2% and approximately 0.3% with infected HIV blood. The diagnosis of HIV is approximately 38.7 per 100,000 according the Center for Disease Control. Therefore, according to my calculations, the risk of a needle stick causing HIV in an unknown sample is roughly 1 in 10,000 (hopefully, I did the math correctly).

Well, last week I bought two lottery tickets. I know the probability of winning is near zero, but there is always a possibility. I make this distinction with my patients all the time when they ask, "Is there a possibility?" That answer is usually "yes", but the probability may be much different. So what are the odds of winning the lottery? In a six number lottery with numbers from 1 to 50, the odds are 1 in 15.89 million. Of course, I still would rather buy a lottery ticket than have a needle stick. ❖

## Tidbits from the Editors

### What was wrong may be right again

Wouldn't you know! After we neurosurgeons spent over 20 years in the 1970s and 80s drowning our bad head injury patients in dexamethazone only to learn it really doesn't help, now comes a study reported in JAMA that giving our head injury patients hydrocortisone for a week reduces ICU pneumonia by 49% as well as time of mechanical ventilation. Granted the mineralocorticoid dexamethazone isn't the same as the glucocorticoid cortisone, but this information highlights that one day's SOP is the next day's anathema which subsequently becomes the modern SOP. This is just one study that surely needs to be confirmed, but it illustrates that progress isn't always a linear process. ❖

### We seem to be pulling our weight

In the March 21 issue of the Archives of Surgery, a study reported that trauma patients with crucial brain or abdominal injuries arriving at Pennsylvania's 32 trauma centers on weeknights or weekends (about 65% of all trauma arrivals) didn't have to wait longer and their outcomes were as good or better than those arriving during the weekday. This would suggest that there are adequate numbers of neurosurgeons available at nighttime and on weekends. It may also suggest that when we brain guys don't have competing issues for our time, such as office hours and elective surgery schedules, we are well able to staff trauma centers and respond in a timely fashion. And so much for the "refuse to take trauma call" movement popular with some spine-only and newly minted neurosurgeons. ❖

### Blue Shield 1; CMA 0

An Alameda Superior Court judge dismissed a lawsuit filed by the CMA contesting that Blue Shield's physician rating program is based upon flawed data and is an effort to economically profile doctors. The judge indicated that the rating program is protected by free speech and that the CMA failed to show that any doctor was actually harmed by the program. Blue Shield maintains that the program, which would award "blue ribbons" to physicians who meet their standards, is based on adherence to "evidence-based medicine." The CMA is considering an appeal.

One wonders how a California neurosurgeon could ever get a "blue ribbon" based upon billings for consults, office visits and surgical fees submitted to Blue Shield. The lack of transparency in how Blue Shield makes its determinations is what ticked off the CMA.

The judge is saying that anyone, including Blue Shield, has the right of free speech, even when that speech may be incorrect and unless and until we docs can show that that speech harmed us (wherein it becomes libel?), they are free to give out blue ribbons. Maybe if enough docs exercised their right of free association and withdrew from Blue Shield's provider list, then BS might work with us to create something truly useful to a patient. ❖

### EHR information site

CMS has a Web site devoted to all things related to the EHR incentive program. As this newsletter discussed last month, you cannot get eprescribing incentives and EHR incentives unless you do the Medicaid EHR approach; doing the Medicare approach won't allow incentives to be claimed in the eprescribing program. Incentives for participating in the PQRS may be claimed no matter which EHR program you choose (<http://www.cms.gov/EHRIncentivePrograms/>). ❖

#### Quote for the month:

**Women and cats will do as they please; men and dogs should relax and get used to the idea-**  
**-Robert A. Heinlein**

*The practice of medicine is about to undergo revolutionary change. Are you prepared?*

## The Next Step: Successfully Negotiating Health Reform

————— 14th Annual California Health Care Leadership Academy —————

June 3-5, 2011 • Renaissance Esmeralda Resort and Spa • Indian Wells, California

- Restructuring of Medical Practice and Payment
- Physician-Hospital Alignment
- Health Reform and Health Care Quality
- HIT: Interoperability, Meaningful Use, Quality Measurement and Reporting
- Health System Reform and the Physician Workforce
- Reengineering Your Practice for Survival
- Physician Leadership in the Era of Reform

### Featured Workshops:

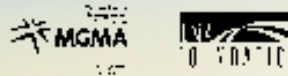
- Strategies for Independent Physicians to Compete
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### Meetings of Interest for the next 12 months:

CSNS Meeting, April 8-9, 2011, Denver, CO

AANS: Annual Meeting, April 9-13, 2011, Denver, CO

New England Neurosurgical Society: Annual Meeting, June 11-12, 2011, Chatham, MA

Rocky Mountain NS Society: Annual Meeting, June 18-22, 2011, Taos, New Mexico

Congress of Neurological Surgeons: Annual Meeting, October 1-6, Washington, DC

Western Neurosurgical Society: Annual Meeting, September 10-13, 2011, Kauai, HI

**CANS: Board of Directors Meeting, September 24, 2011, Oakland, CA**

North American Spine Society: Annual Meeting, November 1-5, 2011, Chicago, IL

Cervical Spine Research Society: Annual Meeting, December 7-10, 2011, Scottsdale, AZ

**CANS: Annual Meeting, January 13-15, 2012, Anaheim (Disney Grand Californian Hotel), CA**

Southern Neurosurgical Society: Annual Meeting, February, 2012, date & locale pending

Neurosurgical Society of America: Annual Meeting, June 10-13, 2012, Park City, Utah

### 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 **two-month 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:** To place a newsletter ad, 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. Marc Vanefsky 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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