



CANS

NEWSLETTER

California Association of Neurological Surgeons

Volume 38 Number 10

October 2011

ANNUAL MEETING January 13-15, 2012 Grand Californian, Anaheim

Reserve your hotel room now at the conference rate of \$219. Book online at <http://www.mydisneymeetings.com/gcaa12b> or call (714) 520-5005, M-F from 8 am to 5 pm PST by December 21, 2011 or before the group rooms are sold out.



ATTENTION

Exhibitors & Sponsors

Contact janinetash@sbcglobal.net to receive an exhibit registration packet and reserve your space.

We hope that some of our exhibitors will once again be able to sponsor a neurosurgical resident by covering 2 hotel nights and the Saturday banquet for one resident from each northern California program; sponsors also needed for the Saturday banquet for those southern California residents who do not require a hotel stay.

PROGRAM REGISTRATION

CANS Meeting registration forms will be distributed in about a week.

- Friday Board Meeting
- Friday evening reception for all guests & exhibitors
- Saturday Socioeconomic session
- Saturday evening banquet
- Sunday half-day QME course ❖

President's Message

Marc A. Vanefsky, M.D.

As the presidential race heats up, healthcare reform continues to be front and center on the national political stage. Parts of the affordable healthcare act are already being chipped away. Recently the administration abandoned the CLASS Act that was supposed to provide long term care for disabled Americans.

Here in our state, it is being reported today that California got approval from the Feds to cut Medi-cal by 10% today. That equals hundreds of millions of dollars that won't be available to provide healthcare to the poorest Californians.

As the debate continues to rage on a state and federal level, I urge you all to attend our yearly meeting this January at the Grand Californian in Anaheim. There has never been a more important time to hear about the future of Neurosurgery in the state of California. Please mark your calendars for January 13-15th and take part in the debate. I look forward to seeing you all there. ❖

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Good Luck with Adding a Colleague

Randall W. Smith, M.D., Editor

For those practicing neurosurgery in California, whether it be academic, Kaiser or the solo-single specialty group-multiple specialty group private practice options, and who are looking to add another neurosurgeon, a recent survey reveals some eye-opening trends among those about to complete their residency training. As reported by the AMA in their on-line AMNews and based upon a survey of 302 about to graduate residents responding to a survey carried out by physician recruiting firm Merritt Hawkins & Associates in Irving, Texas, hospital employment is the most popular choice for a practice setting, according to the survey released Oct. 5. The survey said 32% of residents would be most open to this possibility. This was true for only 3% in 2001. Meanwhile, about half the residents were interested in working in private practice, down from 73% in 2001. Interestingly, only 2% of responders were most interested in an academic position with only 1% most interested in solo practice.

With California's prohibition against corporate practice of medicine, a neurosurgeon can't be employed by a hospital but since the foundation model gets around this prohibition like an NFL wide receiver past a linebacker, this desire for simple employee status can't be ignored. For those survey responders who were most interested in the private practice group setting, most wanted a salary with a production bonus when starting and a full partnership option within two years. This desire may reflect the resident's indebtedness—19% of residents owed 200-250K. Up there among the resident's strong desires, along with a good financial package, were work and call hours and lifestyle considerations. Further, small rural towns are in real trouble with almost 70% of the respondents wanting to practice in cities of 250,000 or greater.

Just what kind of competition we CA neurosurgeons have in the recruiting game is reflected in the survey numbers of how many recruiting contacts each resident experienced. 78% received 51 or more recruiting contacts.

Albeit 302 is not a large number and the recruiting company may not deal with a broad spectrum of specialties (for instance, they report less than 1% interested in an HMO but in the neurosurgery game, Kaiser's 600K beginning salary positions are snapped up like a free ticket to the Super Bowl) their numbers are cause for concern for the CA solo doc or small group practice trying to recruit a new neurosurgeon. One would imagine the academic path is initially more popular among graduating neurosurgical residents but how long they stay on campus once they survey the local Kaiser, private practice options is another matter. ❖

Meet Your CANS Board: Treasurer Phillip Kissel, M.D.

Phillip Kissel is originally an Illini whose family moved to coastal California during his childhood years. His educational path led to a B.A. in biology from UCSD, followed by two years of research in the neurosciences at that esteemed institution. Medical school brought him back to the Midwest and the Chicago Medical School at Rosalind Franklin University. He returned to California doing an internship at UCLA/Harbor and neurosurgical training at UC Davis. Immediately thereafter in 1989 he joined the senior neurosurgeon in San Luis Obispo where he continues to maintain a busy solo practice.

Phil has been a CANS member since 1987 and has served as a Board member from northern California before being elected Treasurer in January. He and his wife Janice (who breeds show horses on their 7 acre SLO ranch) have three children all through college, with the eldest daughter, Bianca, a third year medical student at UCI. Phil enjoys surfing the Central Coast and traveling with the family in his limited spare time. ❖



Thought for the month

Politicians and diapers need to be changed often and for the same reason.

Council of State Neurosurgical Societies Actions

CANS was represented by members Abou-Samra, Blumenfeld, Caton, Henry, Vanefsky, Kusske and Bonner (filling 7 of the 8 slots allotted to CANS) at the recent CSNS meeting in Washington, DC. At the October 1st plenary session, the following actions were taken by the Council on resolutions submitted:

RESOLUTION I--Adopted

Title: Fairness and Transparency in calculation of Fair market Value for Administrative non-clinical work

BE IT RESOLVED, that the CSNS create a white paper to educate CSNS members detailing how independent contracting entities define fair market compensation for neurosurgeons' administrative non-clinical work and outline desirable strategies to assure fair remuneration and audit compliance for same; and

BE IT FURTHER RESOLVED, that the CSNS work with NERVES to gather data regarding non-clinical administrative compensation for neurosurgeons to better assist members in negotiations with health care entities.

RESOLUTION II—Adopted

TITLE: Studying the changing training environment: Are we eroding the neurosurgical residency?

BE IT RESOLVED, that the CSNS study the impact of mid-level providers on resident education; and

BE IT FURTHER RESOLVED, that the CSNS better understand the institutional financial impact of hiring mid-levels versus investing in a training program; and

BE IT FURTHER RESOLVED, that the CSNS systematically identify methods programs utilize, or may consider, to compensate for the 80 hour rule and the consequent diminished exposure of trainees to patient volume.

RESOLUTION III--Defeated

Title: Neurosurgery Lead Patient Outcomes Analysis

BE IT RESOLVED, that the AANS, CNS, and CSNS create a process whereby patient outcomes may be reported in the literature without the need for IRB approval.

RESOLUTION IV--Adopted

Title: Quality of Neurosurgical Care As Defined By Patient Satisfaction

BE IT RESOLVED, that the CSNS develop a white paper regarding the validity, reliability and responsiveness of patient satisfaction metrics and the influence of the scores in neurosurgical patient care; and

BE IT FURTHER RESOLVED, that the CSNS develop a survey to determine the growing influence of patient satisfaction metrics in the neurosurgical practice; and

BE IT FURTHER RESOLVED, that the CSNS request that the AANS and CNS formulate a position statement regarding the proper assessment and reporting of patient satisfaction in defining the quality of neurosurgical care.

RESOLUTION V--Adopted

Title: Neurosurgical Practice Disparities Based on Standard of Care Versus Peer Reviewed Literature

BE IT RESOLVED, that the CSNS develop a survey of neurosurgeons to assess the relative impact of clinical practice guidelines, third party payer reimbursement policies and conventional local practice patterns in choosing neurosurgical patient therapy for common neurosurgical conditions.

RESOLUTION VI--Adopted

Title: AANS & CNS Scientific Planning Committee Liaisons from CSNS

BE IT RESOLVED, that the CSNS requests that a formal liaison position to the Scientific Planning Committees of the AANS and CNS be requested from the Board of Directors of the AANS and the Executive Committee of the CNS.

RESOLUTION VII—Referred back to Committee

Title: Lobbying for States to Adopt Motorcycle Helmet Laws

BE IT RESOLVED, that the CSNS request its member state societies, to contact state legislators within the states that have either no requirements or limited requirements for motorcycle helmets to urge them to enact motorcycle helmet requirements for all motorcycle riders.

BE IT RESOLVED, that the CSNS ask the AANS and CNS to henceforth schedule national meetings only in states that legislate helmets requirements for all motorcycle riders, boycotting states that have not enacted such requirements; and **BE IT FURTHER RESOLVED**, that the member state societies of the CSNS contact and ask the AANS and CNS to contact state legislators within the states that have either no requirements or limited requirements for motorcycle helmets to inform them of our boycott and urge them to enact motorcycle helmet requirements for all motorcycle riders.

RESOLUTION VIII--Adopted

Title: Assessment of AMA Advocacy Resource Center tools in response to insurance denials of coverage for neurosurgical treatment

BE IT RESOLVED, that the CSNS request that the AANS and CNS, through the Washington Committee, the Coding and Reimbursement Committee, and appropriate staff, seek advice and assistance from the AMA, through the ARC and any other appropriate bodies, in maintaining patient access for neurosurgical services.

BE IT FURTHER RESOLVED, that the CSNS will request that the AANS and CNS direct their AMA Delegates to submit a resolution at the AMA House of Delegates. This resolution will request that the AMA lobby for national legislation to require transparency from commercial insurance companies with regard to creation of their payment and coverage policies.

RESOLUTION IX--Defeated

Title: CSNS News Filter

BE IT RESOLVED, that the CSNS Website Subcommittee of the CEC develop a news filter platform to provide content, to offer opportunity for discussion, and to foster greater utilization of social media networking opportunities

RESOLUTION X--Adopted

Title: Profiling Today's Neurosurgeon- Academics, Group or Hospital Employment?

BE IT RESOLVED, that the CSNS draft a cross-sectional survey to be e-mailed to recent graduates and current chief residents, in order to study their level of understanding of the various practice settings as well as assess factors driving initial career choices; and

BE IT FURTHER RESOLVED, that the CSNS create a white paper for the purpose of describing and defining practice models for residents.

RESOLUTION XI--Adopted

Title: A Survey of Charitable Activity Amongst Neurosurgeons

BE IT RESOLVED, that the CSNS implement a one-time survey of neurosurgeons nationwide to:

- 1) quantify charitable habits (e.g. charity consultations and surgeries, donations, foreign or domestic teaching/supplies);
- 2) identify and rate the importance of motivations for charitable activity;
- 3) identify barriers to additional charity (e.g. time, financial limitations, paperwork, liability, motivation);
- 4) collect demographics of recipients of neurosurgical charity (e.g. percent of foreign versus domestic patients, adults versus pediatrics);
- 5) identify associated demographics of neurosurgeons (e.g. sex, age, location, size of practice, academic v private. ❖

Tidbits from the Editors

CMS has Made Health IT Incentive Payments of \$872 Million

The Feds have paid out more than \$872 million for electronic health-record system incentive payments to programs under Medicare and Medicaid by the end of September. The CMS incentive programs, created by the American Recovery and Reinvestment Act of 2009, have registered 114,644 organizations or individual providers through Sept. 30. Medicaid program payments for hospitals, physicians and other eligible professionals that have adopted, implemented or upgraded to a certified EHR system have totaled \$515 million. Medicare, which has a higher eligibility

threshold, has made incentive payments of \$357 million. The Medicare \$357 million seems fairly paltry considering it includes the hospitals which get the big bucks. One suspects the number for just docs is pretty low. A recent survey showed about 75 percent of practices with more than 26 physicians had EHRs, compared with 31 percent of solo practices. EHR adoption rates rise steadily with the size of the practice. Medical offices with more than 11 exam rooms had a 64 percent adoption rate, compared with 28 percent for practices with a single exam room. ❖

MICRA News

For the second time in two years, trial lawyers were unsuccessful in attempting to overturn MICRA's \$250,000 cap on non-economic damages in the courts. On September 1, the Fifth District Court of Appeal upheld MICRA's provisions in *Stinnett v. Tam*. The trial lawyers argued that MICRA is no longer justified because the crisis the law was intended to alleviate no longer exists. The court rejected this argument as well as the trial lawyers' other arguments.

The 2011 California legislative session came to a close without the introduction of a MICRA bill by the California trial lawyers and their trade association, the Consumer Attorneys of California. There were rumors earlier this year a bill would be introduced, but given the state budget crisis and struggling economy, as well as overwhelming MICRA support in the Legislature, trial lawyers opted not to introduce a bill. ❖

Feds Publish New ACO Rules

The Centers for Medicare and Medicaid Services (CMS) published on October 20th a final version of its regulations for accountable care organizations (ACOs) that lowers the bar for physicians to participate in them. The first set of regulations, released in March, were considered too complex and financially risky for physicians and must have been written by people who know little about docs and the practice of medicine.

Under the March regulations, ACOs would have had to meet 65 different quality measures, which organized medicine considered too many. They also said it was too much of a stretch that at least 50% of ACO primary care physicians must eventually qualify as meaningful users of electronic health record (EHR) systems. The final ACO regulations lowered the number of quality measures to 33 and eliminated the original EHR meaningful use requirement, but retained EHR use as a quality measure. Just how making it a quality measure helps is unclear.

Organized medicine also said the initial financial terms of ACOs would deter physicians from participating. To earn a reward for cost-effectiveness, an ACO must come under what Medicare would normally spend for hospital and medical care for a given set of patients. CMS originally proposed giving ACOs a choice of 2 "tracks" to share these savings. In track 1, the ACO would share in any savings for the first 2 years of a 3-year contract but with no downside risk. In the third year, it risked losing money if the cost of its patient care exceeded the Medicare norm. In track 2, the ACO stood to either make money or lose money all 3 years in exchange for the opportunity to share a higher percentage of any savings. Medical societies urged CMS to give physicians the option of a cost-sharing track with no downside risk. In response, CMS eliminated the downside risk in year 3 of track 1.

Another financial concern of organized medicine was that many physician groups, unlike hospitals, would lack the means to invest in the information technology and extra staffing needed to form an ACO. CMS addressed that issue by announcing that it would test an ACO advance-payment model for physician-owned ACOs, as well as those in rural areas. Those advance payments, which could foot the bill for ACO infrastructure, would be repaid with any future savings earned by the ACO. That sounds like an unsecured loan, but a loan and not a gift. The actual details should be interesting. ❖

Author Defends Physicians' Salaries

Sally C. Pipes, president, CEO and Taube Fellow in Health Care Studies at the Pacific Research Institute, wrote in USA Today on 10/11 on the subject of healthcare costs, in response to "a new study from two Columbia University researchers, one of whom is a top health care adviser to President Obama," which concludes that physician earnings are "the main drivers of higher US (healthcare) spending." Come now.

Doc income numbers at first glance would seem to be generous. The average annual income for a primary-care doctor surpasses \$186,000. U.S. orthopedic surgeons make \$442,450 on average. Both figures are substantially higher than the median income in this country — and as much as double the salaries of their foreign counterparts. But U.S. doctors also must spend about 40,000 hours on their education. Loans accumulated through college and medical school can reach \$300,527 and take more than 20 years to pay off — depriving a doctor of \$788,880 in net income.

Even among their peers, American doctors have a tough row to hoe. Education costs in the other five countries examined by the Columbia study — Australia, Canada, France, Germany and the United Kingdom— are lower than in America. In the United Kingdom, for example, medical students pay about \$5,000 a year. At American medical schools, tuition and fees run anywhere from four to 10 times as much.

Once U.S. doctors complete their education, the workload doesn't ease. The average physician works 59.6 hours each week — the equivalent of one and a half full-time jobs. What's more, a doctor's financial responsibilities don't end with medical school payments. According to Princeton professor Uwe Reinhardt, not known for being a friend of docs, close to half of a doctor's income goes toward maintaining his practice. And that excludes payments on college and medical school debt. Doctors devote about 30% of their gross profit toward office overhead, and the required licenses and certifications cost about \$5,000 annually to maintain. Then, there's medical malpractice insurance, which can run tens of thousands of dollars each year. With yearly expenses such as these — before taxes — a doctor's seemingly high income vanishes quickly.

Pipes also warns that "with physicians' take-home pay accounting for just 10% of national health care costs" reduction would have little effect on healthcare costs and "demoralize the American medical corps, discourage bright young people from entering the profession and compromise Americans' ability to access quality care."

As an additional item for digestion, it turns out that in 2009, Medicare paid \$209.6 million for all lumbar spine surgery. In the same year, Medicare paid \$328.5 million for epidurals and \$471.5 million for chiropractic treatment. ❖

The Medical Board Reports

One constantly seems to hear how state medical license boards are not doing their job disciplining miscreant docs and allowing nasty, dangerous ones to continue practicing and threaten the poor public. The Medical Board of California has published its latest year of actions and records that it pulled the licenses of 84 docs for any variety of reasons, mostly commonly for gross negligence, sexual misconduct and conviction of a crime. They also put 97 on probation. That's out of 100,000 physician licensees practicing in California. Now, a bit less than 200 out of 100,000 is a miniscule percentage, but who's to say that such a small number is an indication of poor monitoring? Could it be possible that docs are 99+% good guys (we do seem to go through a modestly severe screening process) and witch hunts to satisfy those that think docs are, much like themselves, frequently bad are not really warranted?

The same annual report indicates there are 550 neurosurgeons licensed to practice in California but if one subtracts out the ones who hold a CA license but practice in another state or who, like this writer, are identified as neurosurgeons, licensed to practice but aren't actually practicing, one might expect the number to be closer to 400. That's one neurosurgeon for every 73,000 Californians. ❖

Nov 1 Deadline for e-Prescription Hardship Exemption

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) established a five-year program of incentive payments to eligible professionals when they use electronic prescribing technology for Medicare patients seen in their offices. Eligible physicians who successfully generate and report one e-prescription for 25 unique patient visits over the reporting year of January 1, 2011 through December 31, 2011 are eligible to receive an incentive payment equal to 1 percent of their total Medicare payments for the year. However, those who are eligible for the incentive payment, but fail to adopt e-prescribing, will face a 1 percent penalty beginning in 2012.

To avoid the 2012 penalty, physicians must report an e-prescription for 10 unique visits from January 1, 2011 through June 30, 2011 or qualify for one of the following hardship exemptions:

- Eligible professional or group practices in rural areas with limited high speed internet access;

- Eligible professional or group practices in an area with limited available pharmacies for electronic prescribing;
- Eligible professionals who register to participate in the Medicare or Medicaid EHR Incentive Program and adopt certified EHR technology;
- Eligible professionals who are unable to electronically prescribe due to local, state, or federal law or regulation;
- Eligible professionals who have limited prescribing activity; and
- Eligible professionals who have insufficient opportunities to report the e-prescribing measure.

Neurosurgeons and group practices have until Tuesday, November 1, 2011 to request a hardship exemption from the 2012 eRx payment adjustment. To apply for the exemption neurosurgeons must go to: www.qualitynet.org/portal/server.pt/community/communications_support_system/234. Requests must include a brief explanation as to why a physician feels he/she should qualify for the exemption.

For more information please visit [CMS's Quick Reference Guide](#) or consult the [AMA Fact Sheet](#). ❖

Brain Waves

Deborah Henry, M.D., Associate Editor

I was driving to see my dentist in Upland, a city on the edge of the relatively poor county of San Bernardino. This county has been hard hit with the recession, though Upland has stayed somewhat immune. I stopped on the exit ramp of the freeway. At the crossroad stood a scrawny man with an unkempt beard holding a tattered sign that was no longer legible. The person in the two-decade old Porsche in front of me handed him a cigarette that he took readily. The woman in the battered car on my right gave him some folded bills. A honk came from the much-used truck behind me, and the man trotted over to receive some additional cash. I simply looked on. I know full well that I was probably better off than all of these individuals except perhaps the person in the Porsche. However, I have always been reluctant to help those on the street. I can count maybe 3 or 4 times doing this. Not much for 50 some years of life. What is my problem with giving to those on the streets in need? I could say the money will be used for alcohol and cigarettes. I could say that there are so many that I don't know where to start. When I was at Queen's Square in London in 1990 for my neurology rotation, I was overwhelmed with the number of beggars on the steps of Westminster Cathedral where I occasionally went to church. But I think my trouble with giving is more that I don't have control of what the money is used for and I want to make sure that my hard earned cash is put to good use. Once, when a young man on the street approached me for money for food, I took him to a nearby restaurant and ordered him lunch. I had control of how my dollars were spent.

In search of understanding why people give, I went to the library to check out Bill Clinton's *Giving*. He spends a good portion of the book on who, where, and how people give and two paragraphs on why we do or do not give. He comes up with four observations: to make the world better, ethical or religious reasons, someone asks us, and because it feels good. Clinton feels the reasons we don't give are just the opposite: the money won't help, no moral obligations, no one asks, and it feels better to keep the money.

Doctors as a profession are often noted for their generosity with their skills and their time, but not necessarily with their monetary donations. I remember Moustapha Abou-Samra (president of this year's neurosurgery PAC) once saying to me that neurosurgeons probably feel that they are giving their services away all the time, which may make giving physical dollars less palatable. Indeed, as neurosurgeons we rank 14th in giving among the medical professional organizations to our own political activity committee (data shown at the September 2011 CSNS meeting). Of course that may not take into account our fewer numbers (am I rationalizing?). And we, as doctors, are always being compared to those politically active lawyers who allegedly give and give.

One of this September's resolutions from the Council of the States of Neurological Surgeons, presented by our own CANS president Dr. Marc Vanesfsky and resident CSNS fellow Dawn Waters from UCSD, asks our CSNS to look at charitable giving among neurosurgeons: who, why, where, how and when. Interestingly, at the very end of the meeting, this resolution almost was voted down, apparently for fear of what it might show and how that information could be used against neurosurgeons. Perhaps we may be pleasantly surprised that we give more than we think. ❖

Transitions in Neurosurgery

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

The word on the street is that the trial lawyers are quite likely to take on MICRA again this coming year – probably a frontal attack through the Legislature, and diversionary tactics such as the attempt in *Stinnett v. Tam* (the Stanislaus Superior Court imposed the MICRA cap, the Superior Court’s action was upheld in the Fifth Appellate District, and the case subsequently has been appealed to the California Supreme Court. As of October 30, 2011, the California Supreme Court has not yet decided whether it will hear the appeal).

MICRA has served the physicians of California well. It was created in 1975 when Governor Brown convened an extraordinary session to remedy the crisis caused by the rapid increase in medical malpractice insurance premiums. (We in medicine owe a lot to the wives of anesthesiologists who “sat in” the Governor’s office to obtain his attention and action). The result was the enactment of the *Medical Injury Compensation Reform Act of 1975 (MICRA)*. This Act attempted to reduce the incidence and severity of medical malpractice injuries in many ways: by strengthening governmental oversight of education, licensing and discipline of physicians and health care providers; by curtailing unwarranted insurance premium increases by authorizing alternative insurance coverage programs; by reviewing substantial rate increases; and by revising legal rules applicable to malpractice litigation. MICRA established a maximum for recovery of non-economic damages to \$250,000 in litigated professional negligence and compensation for pain, suffering, loss of consortium, physical impairment and disfigurement and other nonpecuniary damages. The legislation desired to reduce the cost of medical malpractice insurance premiums to a level physicians and hospitals could afford to resume providing medical care to all segments of the community, also to ensure that insurance awards would be available for patients injured through medical malpractice, as these may not be available from physicians practicing “bare,” not malpractice insurance covered.

MICRA has also recently been attacked by trial attorneys in such legal actions as *Stinnett v. Tam*, where it was alleged that the damage cap was no longer needed to reduce medical malpractice insurance costs, as carriers are now profitable in such coverage. Another claim was that the \$250,000 cap no longer has the purchasing power that it did in 1975, when it was constituted. In this particular case the jury award was \$6 million, which was reduced to the \$250,000 cap – showing the value of MICRA. The subsequent appeal contended that such an award was a violation of the plaintiff-patient’s right to equal protection of the laws, and violated the right to trial by jury. (The fact that the appeal prompted many “friend of the court” briefs from interested parties speaks volumes as to the impending attack. Amici Curiae briefs pitted the Consumer Attorneys of California, AARP, California Nurses Association, Consumer Federation of California, Congress of California Seniors, the Public Interest Law Children’s Advocacy Institute and Consumer Watchdog (as well as others) on the one side against the California Medical Association, California Dental Association, California Hospital Association, and American Medical Association on the other). It appears that MICRA attacks will come from multiple directions, with the *Tam* approach suggesting a discrimination-oriented civil approach.

Weakening MICRA would cause significant malpractice costs to physicians and other aspects of medical care, and its elimination would be a tragedy. Malpractice insurance costs in states without MICRA-like protection, such as Illinois and Florida, are often in the \$200,000 to \$300,000 per year range, forcing many physicians to practice without such coverage.

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The fashion of medical practice and meetings is now to go paperless, with electronic communication by computer methods, such as IPODs, becoming necessary. In recent medical meetings I have attended, I have observed that the methods designed to reduce costs, conserve resources and enhance education and communication also serve as distractions in the medical meeting environment. I have noted laptops, IPODS, etc. during educational and informational presentations being utilized to “surf the net,” constantly text messaging (Tweet or Twittering?), presumably arranging travel and restaurant reservations with little attention to the program being presented. Perhaps we need a professional policy to curtail such electronics during meetings to restrict such activities geared to the program subject only. I may be old-fashioned, but such distracting use of electronic devices seems rude to the speaker-presenter – just an observation. ♦

EXECUTIVE OFFICE REPORT: Nominations

Janine Tash

The CANS Nominating Committee (*chair Austin Colohan, M.D., Kimberly Page, M.D., J.P. Muizelaar, M.D., J. P. Johnson, M.D. and Javed Siddiqi, M.D.*) has prepared the following slate of officers for 2012 after reviewing all nominations submitted by the membership.

(New officers are in ***bold, italic***)

<i>Austin R.T. Colohan, MD</i>	<i>President</i>
<i>Theodore Kaczmar, Jr., MD</i>	<i>President-Elect</i>
<i>Michael H. Robbins, MD</i>	<i>1st Vice President</i>
<i>Kimberly Page, MD</i>	<i>2nd Vice President</i>
<i>Deborah C. Henry, MD</i>	<i>Secretary</i>
Phillip Kissel	Treasurer
Kenneth Blumenfeld, MD	Director-North
<i>Praveen Mummaneni, MD</i>	<i>Director-North</i>
<i>Marshal Rosario, MD</i>	<i>Director-North</i>
<i>E. Scott Conner, MD</i>	<i>Director-South</i>
Langston Holly, MD	Director-South
Patrick Rhoten, MD	Director-South
Haig Minassian, MD	Director-South

Nominating Committee: southern California: ***J. Patrick Johnson, MD, Phillip Kissel, MD***
 northern California: ***Michael Edwards, MD, Kimberly Page, MD***

Further nominations to the slate of officers will be accepted until November 25, 2011. According to the CANS bylaws, each of these nominations must have three supporting signatures of active CANS members and written permission of the candidate for placement on the slate.

On December 13, 2011, ballots will be mailed to all active members of CANS. The candidate for each office receiving the majority vote of active members will be elected. In order to be counted, ballots must be received by the Executive Secretary on or before January 11, 2012, 72 hours prior to the Annual Business Meeting.

CANS Members: *If you wish to nominate someone other than those listed above, please complete the following so that the name can be added to the ballot in December. The nomination must be supported by 3 active CANS members and accompanied by written permission of candidate.*

Name _____ for Board position _____

Supporting signatures of 3 active CANS members _____

Written permission(signature) of candidate for placement on the slate _____

Nominated by _____

Please return to the CANS office before November 25, 2011 via fax 916 457-8202 or email janinetash@sbcglobal.net.

Meetings of Interest for the next 12 months:

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, March 28-31, 2012, Amelia Island, FL
CSNS Meeting, April 13-14, 2012, Miami, FL
AANS: Annual Meeting, April 14-18, 2012, Miami, FL
Neurosurgical Society of America: Annual Meeting, June 10-13, 2012, Park City, Utah
Rocky Mountain NS Society: Annual Meeting, June, 2012, Maui, HI
New England Neurosurgical Society: Annual Meeting, June, 2012, TBA
Western Neurosurgical Society: Annual Meeting, September 7-10, 2012, Colorado Springs, CO
Congress of Neurological Surgeons: Annual Meeting, October 6-10, 2012, Chicago, IL

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) or fax (858 683-2022). ❖

Comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office at janinetash@sbcglobal.net. Past newsletter issues are available on the CANS website at 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, (916-457-8202) with the word "unsubscribe" in the subject line.

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