CANS newsletter

California Association of Neurological Surgeons Volume 39 Number 3 March 2012

CANS Board of Directors Meeting

Randall W. Smith, M.D., Editor

At a hotel adjacent to LAX on March 31st, the CANS Board of Directors held their spring meeting which was attended by Drs. Colohan, Kaczmar, Robbins, Page, Henry, Vanefsky, Ott, Blumenfeld, Holly, Minassian, Hsu, Abou-Samra, Wade, Bonner, Smith and Javed Siddiqi.

President Colohan reported that **CME credits** for the 2013 CANS annual meeting on the **Queen Mary in Long Beach** will be awarded with the actual number of hours to be determined by the final program. The cost to CANS for the ability to award the hours will be $2,700. He further reported that as program director for the meeting, the Saturday speakers and topics are in the developmental stage but that he remained committed to having a Sunday morning scientific session with papers from residents in the California training programs and a keynote speaker on the topic of getting that first job after graduation. CANS will pay for resident travel and lodging as necessary for residents from Stanford, UCSF and Davis.

The 2012 meeting in January at Disneyland was profitable to the tune of 11.5K predominantly because of substantial commercial support by the 20 vendors that exhibited their products. They included Hitachi-Aloka, Biomet Spine and Bone, Bluewater Instruments, BrainLab, CAP-MPT (professional liability), Covidien, IMRIS, Lanx, Medtronic, Neurologica, OsteoMed, Physiom, PMT, Prime Clinical Systems, Sophysa, Stryker, Synthes, Surgical West, TeDan Surgical and Biomet Microfixation. It was noted that **Medtronic** has been the most consistent exhibitor over the years closely followed by **Hitachi-Aloka** and **BrainLab**.

Ian Beaudoin Ross, MD, McGill trained neurosurgeon and endovascularist in Pasadena, was voted into membership.

The Executive Secretary was requested to get the By-laws posted on the Web site and to explore the option of creating a Members Only section for minutes and other items.

At the request of CANS member **Scott Lederhaus**, CANS will conduct a survey to assay, among other potential items, the number of California neurosurgeons who have **opted out of Medicare**. It was noted that the rules for opting out are well described in an AMA document easily accessed via the Council of State Neurosurgical Societies (CSNS) website at www.csnsonline.org.

Janine Tash, long-time CANS Executive Secretary, tended her resignation effective May 1st of this year. She will be replaced by **Emily Schile** who has assisted Janine with the annual meeting for a number of years. Ms. Tash will continue as a consultant to Ms. Schile until March 1st, 2013 to effect a smooth transition.

The Board approved a $1,000.00 donation to the **Melany Thomas Socioeconomic Fellowship Fund**. Ms. Thomas provided considerable assistance to CANS delegates to the CSNS during her 20 years as CSNS staff coordinator.

Finally, the Board reviewed the 17 resolutions to be debated and potentially adopted at the forthcoming meeting of the CSNS in Miami just before the AANS annual meeting. Any CANS member wishing to provide input about the resolutions can contact the CANS delegation leader, Dr. Colohan, at acolohan@yahoo.com. Those resolutions (some of the "Whereas" are edited) and Board opinion appear on pages 5-11. ❖

INSIDE THIS ISSUE:

Tidbits from the Editors

When the patient/family wants to record the office visit

The American Medical News had an interesting article about patients recording doctor visits in their March 12th issue. The author, AMA staff reporter Alicia Gallegos, points out that such a recording can be introduced as evidence in a malpractice trial if the patient can prove to the judge's satisfaction that the recording has not been manipulated such as to not include parts of the conversation that might not support the patient's allegation. In some states a patient can record the visit without the doc's knowledge but in California the doctor has to give permission if the visit qualifies as a private matter which it certainly should. One might guess that your malpractice carrier would prefer you don't allow any recordings and clearly post such policy in the waiting room to forstall even having to discuss the issue. On the other hand, some feel that allowing a recording helps the patient remember what you have recommended, particularly if you are seeing an unaccompanied senior patient. Carolyn J. Oliver, MD, from a patient advocate foundation, feels that patients forget between 30-70% of what you tell them within minutes of leaving your office and allowing a recording leads to increased understanding of and compliance with your recommendations. Each neurosurgeon needs to make his/her own decision on this matter but this writer had a fairly simple policy of allowing recording of the discussion with the patient *after* taking the history, doing the exam and viewing the diagnostic studies, if any. If you allow such a recording, you must be particularly thorough in your discussion of pros and cons and especially the risks of following your advice and the pros and cons and especially the risks of *not* following your advice. Surgeons that practice what might be called giving preemptive opinions, meaning walking into the examination room after viewing a scan and with little or no history taking or examination open with "You need surgery" or some similar statement (and after doing a few thousand 2nd surgical opinions this writer can attest to the not rare existence of such docs), such surgeons should never allow recording since if things turn out badly, such a recording will tend to document a failure to allow the patient to make an informed decision. ❖

Neurosurgical Board Eligibility Now Limited

Newly minted neurosurgeons can and should list themselves as "Board Eligible" because that means the new doc has completed an approved residency and has passed the American Board of Neurological Surgery written exam. We all know that to become Board certified in Neurosurgery one needs to practice a while, accumulate cases, apply to take the ABNS oral exam, get in the queue and then take the exam—all this chewing up more than two if not three or four years. During those years it is fair to claim Board eligibility as an indication you are tracking along the certification trail. Apparently there are a cadre of docs out there who do not proceed along the pathway or fail the exam and have to come around a time or two again or never pass or even take the exam. The ABNS has announced a new policy effective January 1st of this year that you have no more than 7 years to become certified following residency completion and failing to do so in that time frame removes the option of claiming eligibility. Dan Barrow, MD, from Emory and Chairman of the ABNS, has been quoted as saying, "There are a very small number of physicians who will maintain the status of board eligible for an extraordinarily long amount of time", which he feels is " . . .dishonest, and it sends the wrong message to the public.". If the neurosurgeon doesn't meet the time restrictions, he or she cannot claim eligibility and will have to restart certification which includes retaking the ABNS written exam and submitting a fresh 150 operative cases. Doing those things twice has got to be a real body blow so the smart money is to track along as soon as adequate cases are operated on. ❖

California Docs are Work Comp Cheap

The Workers Compensation Research Institute, an independent, not-for-profit research organization in Massachusetts has published its 2012 findings regarding, among other things, the rates paid to docs for providing care to WC patients. Turns out California docs get the lowest rates in the country when compared to

24 other large states who collectively paid nearly 80% of workers' benefits in 2011. Docs are paid the highest in Wisconsin which does not have an official fee schedule so one presumes they are paid usual and customary fees. Our low men/women on the totem pole position would seem to not be in any jeopardy since Governor Brown has requested a major revamp of WC rates in the Golden State with all "stakeholders" agreeing that permanent disability rates need to be increased for the poor injured worker. The caveat, of course, is that increasing the PD rate should come at no increase in premium rates paid by the poor employer so compensatory cuts in other WC costs need to reduced accordingly. Guess what will get cut—the surgical fee schedule which has not been raised since forever and was adjusted downward by 5% in 2004 as part of the last WC overhaul. The only reason California surgeons work for comp rates is that they are a definite cut above what we get for Medicare, Medicaid and the Blues. We must love the sun and ocean. ❖

Transitions in Neurosurgery

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

The United States Supreme Court has recently considered the constitutionality of Obamacare. How the High Court will rule probably will not be revealed until June, when the opinion is most likely released. The recent review of the Obama Administration's Health Care Plan by the Supreme Court does suggest that the justices may be concerned and hesitant about the legal status of the plan. Thus, the version of the Obama Health Plan that emerges after Supreme Court review may be different than the current version, or may be completely eliminated.

Nonetheless, sources with recent information indicate that the expense of the program is much larger than ever proposed. Evidently supporters of Obamacare did appreciate that the federal government could never support the Plan on its own, as it was developed as only government-supported not totally government-financed. However, the Plan likely will eliminate private insurance programs, and thus may implode due to lack of government financial support. The number of individuals aging and thus most likely requiring increased health care is expected to expand soon, particularly with the aging of Baby Boomers. Certainly physician fees would be decreased under Obamacare, as one would expect diminished financial availability in all aspects of the Plan. Anecdotally, I find little physician support for the Plan, although the press does report such support,

perhaps to influence public opinion. I am concerned that the AMA did originally support the Plan, hoping to gain influence in its formation, which did not occur. I believe the AMA did not properly inform physician-members and the public that a majority of physicians, and I believe the AMA itself, ultimately did not support the final version of the Obama Administration's Health Care Act. ❖

Brain Waves

Deborah Henry, M.D., Associate Editor

I flew home to Houston a fortnight ago to visit my octogenarian parents. One night while sitting at the dinner table, my mother whips out an EOB to show me. She doesn't understand a word. She doesn't quite know if it's a bill. The statement came from her secondary insurance, AARP. Apparently now, for the first time, she has a Medicare Part B deducible of $140.

She developed knee and back pain earlier this year and underwent a series of plain X-rays. Part of the deductible is listed on this EOB. My dad joins us at the table with an unpaid bill from January of about $90 from a radiology department for her knee X-ray. It was already the second bill, as he didn't think he was obligated to pay the first one.

I read her EOB and explained that she would be receiving another bill for the X-ray of her back for $50 (the remainder of her deductible), and yes, my dad should pay the bill in his hand. Interestingly, there were no CPT or ICD codes on the EOB, just the date of service. There is no mention of the type of X-ray taken. Medical bills haven't become anymore transparent than when I started practice. I pointed out which charges were for her office visits, how much the doctor charged and what they were paid. My dad pipes in that his doctor never charges more than Medicare and despite my saying that he probably does but only gets paid what Medicare allows, my dad was adamant.

When I was in medical school, my mom was diagnosed with hypertension. She went to her physician and returned home with a prescription. Being the dutiful daughter weeding her way through third year medical school, I asked her for the name of the drug. She spells out T-a-g-a-m-e-t. Hmmm. I knew even then that something did not make sense. "Mom, did you talk about something else while you were there?" I inquire. That is when I learned she was also having a bit of esophageal reflux. It taught me a lesson early on to write out what I tell my patients and then also to write my prescriptions with a reason so that pain meds were taken for pain and seizure medications to prevent seizures.

Sometimes I think that I went to medical school in order to police the network of insurance, diagnoses, prescriptions and EOBs that my parents, siblings, and sometime even I receive. Sometime I think I need more than medical school to do this. ❖

Meetings of Interest for the next 12 months:

AANS/CNS Joint Pain Section Bi-Annual Meeting, April 13, 2012, Miami, 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 16-20, 2012, Maui, HI
New England Neurosurgical Society: Annual Meeting, June, 2012, TBA
American Society for Stereotactic & Functional Neurosurgery: Biennial Meeting, June 3-6, San Francisco, CA
Western Neurosurgical Society: Annual Meeting, September 7-10, 2012, Colorado Springs, CO
CANS Board of Directors Meeting: September 29, 2012, Airport Hilton, Oakland, CA
Congress of Neurological Surgeons: Annual Meeting, October 6-10, 2012, Chicago, IL
North American Spine Society: Annual Meeting, October 24-27, 2012, Dallas, TX
AANS/CNS Joint Pediatric Neurosurgery Section: Annual Meeting, Nov 27-30, 2012, St. Louis, MO
North American Neuromodulation Society: Annual meeting, December 6-9, 2012, Las Vegas, NV
Cervical Spine Research Society: Annual Meeting, December 6-8, 2012, Chicago, IL
CANS: Annual Meeting, January 18-20, 2013, Queen Mary Hotel, Long Beach, CA
AANS/CNS Joint Spine Section Annual Meeting, March 6-9, 2013, Phoenix, AZ
Southern Neurosurgical Society: Annual Meeting, March, 2013, TBA

(continued from page 1)

RESOLUTION I (CANS: Oppose--hubris)

Title: Patient Comprehension of Online Education Materials on Spinal Cord Injury

WHEREAS, the spinal cord injury (SCI) patient education material currently available online from the National Institute of Neurological Disorders (NINDS),[1, 2] Centers for Disease Control (CDC),[3] and American Association of Neurological Surgeons (AANS)[4, 5] is written at approximately a twelfth grade level, according to the Flesch-Kincaid Grade Level Readability Test[6, 7]; and

WHEREAS, the average reading level of an American adult is between the seventh and eighth grades[8]; and

BE IT RESOLVED, that the CSNS work with the AANS and CNS to evaluate patient comprehension of education materials and make appropriate changes such that the readability level of patient materials is appropriate; and

BE IT FURTHER RESOLVED, that the CSNS request the AANS and CNS contact the NINDS and CDC and urge them to assess the readability level and patient comprehension of their educational materials for spinal cord injury; and

BE IT FURTHER RESOLVED, that the CSNS conducts a study to evaluate whether patient education materials need to be written at a reading level lower than that required for the average American, given that most victims are young males, involved in risk-taking behaviors, and as such, may have a lower reading level than the general population; and

BE IT FURTHER RESOLVED, that in future studies, the CSNS also surveys such patients on degree of internet use, given that people utilizing the internet as their principal source of medical information may read with a different degree of proficiency than those patients who are less computer-literate.

RESOLUTION II (CANS: Oppose—we have enough committees)

Title: Establishment of a CSNS Ethics Committee

WHEREAS, the ethical administration of a profession should be of paramount concern to a group purporting to be the "socio-economic arm" of said discipline; and

WHEREAS, the volume of resolutions, presentations, and discussions, referring to ethics- related neurosurgical topics at CSNS meetings are paltry at best; and

WHEREAS, the Medical Practices Committee, who currently oversees the realm of ethics-related discourse at the CSNS, is tasked with an overabundance of other practice issues; and

WHEREAS, ethics-related considerations need to be a part of virtually all issues discussed and acted upon by the CSNS; therefore

BE IT RESOLVED, that a new Neurosurgical Ethic Committee be created; and

BE IT FURTHER RESOLVED, that said committee reports directly to the Executive Committee; and

BE IT FURTHER RESOLVED, that said committee presents a pertinent issue at each CSNS Meeting plenary session.

RESOLUTION III (CANS: Neutral—await debate)

Title: Stewardship of CSNS Resolutions

WHEREAS, there can seem to be a level of disconnect between the leadership of the CSNS and rank and file members; and

WHEREAS, the current method of appropriation and distribution of CSNS actions in response to specific resolutions may suggest a degree of cronyism; and

WHEREAS, the active involvement of resolution authors in the activities generated by resolutions will facilitate the interaction between members and the CSNS leadership; and

WHEREAS, on the other side of the coin, it is not uncommon for authors to drop unformulated, impractical, and/or work-intensive, "resolution bombs" upon the CSNS body, with no intention of assisting in affecting the actions requested or desired; and

WHEREAS, said behavior of filing a resolution and then walking away from all further responsibility for its sequela only potentiates the perception of the CSNS as merely a "wailing wall" for disgruntled and disaffected neurosurgeons; and

WHEREAS, a sense of ownership, stewardship, and responsibility for the work products generated by a resolution would encourage authors to craft careful, thoughtful, and realistic resolutions; and

WHEREAS, inclusion in the practical process of generating work products inspired by a resolution would encourage a sense of empowerment and inclusion of authors within the CSNS; therefore

BE IT RESOLVED, that the CSNS adopts a policy of Resolution Author "Stewardship" for CSNS activities generated by each adopted resolution; and
BE IT FURTHER RESOLVED, that said stewardship requires that Resolution Authors, or authorship groups, are included in, and are actively encouraged to participate in, subsequent CSNS activities relating to their resolution, regardless to which committees and workgroups said resolution is assigned; and
BE IT FURTHER RESOLVED, that Resolution Authors, or authorship groups, are included in final review of any work product generated by adopted resolutions, regardless to which committees and workgroups said resolution is assigned.

RESOLUTION IV (CANS: Oppose—self serving to employed physicians negotiations)
Title: RVU Value of Acute Neurosurgical Call
WHEREAS, a sizeable proportion of neurosurgeons are, or are in the process of becoming, employees of hospitals, clinics, and/or health care systems; and
WHEREAS, many systems use RVU based production measures to evaluate the performance of employed neurosurgeons; and
WHEREAS, RVU based production measures grossly underestimate the work entailed in, and indeed the overall worth to the parent system of, acute care neurosurgical call coverage in a busy institution and/or trauma center; and
WHEREAS, such call is valued monetarily at extraordinary rates in institutions without employed neurosurgeons; and
WHEREAS, it would be desirable for RVU assignments to be realistic representations of the market value of neurosurgical acute care call coverage; therefore
BE IT RESOLVED, that the CSNS studies and makes recommendations as to the realistic and appropriate RVU valuation of acute care neurosurgical call coverage.

RESOLUTION V (CANS: Support)
Title: An Investigation and Analysis of EMR Use and Utility Among Neurosurgeons
WHEREAS, the Health Information Technology for Economic and Clinical Health Act (HITECH) provides $18 million in incentives through Medicare and Medicaid reimbursements for the adoption of electronic medical records (EMR); and
WHEREAS, more physicians, surgeons and hospitals are adopting EMR for use in their offices, departments and clinics; and
WHEREAS, neurosurgeons have specialized needs and requirements that may be specific to the practice of neurological surgery, it may be beneficial for all of us to understand what EMR options exist, and how these software applications have been utilized in practice, and what their benefits and costs have been; therefore
BE IT RESOLVED, that the CSNS develop a survey of all neurosurgeons investigating the use and utility of EMR so that all neurosurgeons may benefit from this information.

RESOLUTION VI (CANS: Oppose—ACS did this for all surgeons)
Title: Career Satisfaction, Stress and Burnout Among Neurosurgeons
WHEREAS, the issue of career satisfaction, stress and burnout has been extensively investigated in many specialties in medicine but very little data currently exists for neurosurgery; and
WHEREAS, high levels of dissatisfaction and distress at work can not only negatively impact the quality of care rendered by the physician but also other aspects of the job and personal life, it may be beneficial for all of us to understand the degree and sources of stress, satisfaction/dissatisfaction and burnout among neurosurgeons; therefore
BE IT RESOLVED, that the CSNS will distribute and promote to all neurosurgeons a recently developed and tested survey assessing stress and burnout so that all neurosurgeons may benefit from the information in effecting positive change at the local, state and national levels.

RESOLUTION VII (CANS: Support)
Title: Opposition to Changes in ACGME Common Program Requirements
WHEREAS, the ACGME plans significant changes in their Common Program Requirements; and
WHEREAS, said changes will exclude graduates of Osteopathic Neurosurgery residency programs from

ACGME certified fellowships; and
WHEREAS, such exclusion is prejudicial, cynical, arbitrary, and lacking sound and evidence-based rationale; and
WHEREAS, such an action will serve to drive a wedge between osteopathic and allopathic neurosurgeons rather than unite them; and
WHEREAS, such an action would potentially jeopardize the solvency of practices of allopathic neurosurgeons in regions of high Osteopathic physician penetrance; and
WHEREAS, such an action could potentially result in a rush of litigation against various fellowship program; therefore
BE IT RESOLVED, that the CSNS urges parent institutions CNS and AANS to vociferously oppose the current wording of ACGME changes to their Common Program Requirements; and
BE IT FURTHER RESOLVED, that the CSNS supports a delegate campaign of letter generation to the ACGME and to Members of Congress in opposition to said changes.

RESOLUTION VIII (CANS: Support)
Title: Privileging and Credentialing of Neurosurgeons
Submitted by: Kenneth Blumenfeld, M.D. and the California Association of Neurological Surgeons
WHEREAS, the ACGME and ABNS have defined core curriculums and expected competencies to be achieved by neurosurgical residents and subsequently maintained by diplomats and candidates of the ABNS; and
WHEREAS, post-residency subspecialty training is available by way of formal fellowship or focused areas of practice; and
WHEREAS, practice patterns vary from academic to large group to private practice requiring different scope of practice and opportunity for sub specialization; and
WHEREAS, no national or other standard for credentialing and privileging of neurosurgeons exists; and
WHEREAS, in some geographic locales, CMS and the DPH reviews have been conducted (which in most instances have been for reasons unrelated to the practice of neurosurgery) that have demanded specific procedures normally considered among core privileges be separated into advanced privileges requiring additional training and volume parameters; and
WHEREAS, the scope of neurosurgical practice is broad and many of the conditions we treat occur infrequently and thus some of our skills may be infrequently used; and
WHERAS, the standards for neurosurgical privileging and methods for determining competency should be developed from within the specialty of neurological surgery; therefore
BE IT RESOLVED, that the CSNS asks its parent and affiliate organizations including the AANS, CNS, ABNS, ACS & ACGME to develop a position statement & policy with respect to neurosurgical privileging and competency; and
BE IT FURTHER RESOLVED, that the policy be consistent with the MOC program already in place; and
BE IT FURTHER RESOLVED, that any such policy take into consideration workforce issues that vary greatly between institutions and different geographic regions.

RESOLUTION IX (CANS: Support)
Title: N2QOD project: improving recognition and participation
WHEREAS, after three years of design and development, a broad coalition of neurosurgical societies (AANS, CNS, ABNS and SNS) operating cooperatively as the NeuroPoint Alliance and led by the American Association of Neurological Surgeons (AANS), formally launched the National Neurosurgery Quality and Outcomes Database (N2QOD); and
WHEREAS, the N2QOD is primarily designed to serve as a continuous national clinical registry for neurosurgical procedures and practice patterns; and
WHEREAS, private insurers, the federal government, advisory councils, employer groups, the media and our patients are all are insisting that physicians account for the quality of care we provide, and the only rational and meaningful way to do this is to collect and analyze data about the scientific validity, efficacy and value of medical care. The N2QOD project will allow neurosurgeons to address this challenge, and respond to the needs of our society on our own terms, with solutions that we as clinical experts devise and implement; and
WHEREAS, the N2QOD will, for the first time, link the community of NS , directly and continuously, and as we increase the opportunities for widespread collaboration within our unique specialty, we will surely enhance our collective ability to advance the science of care, provide our patients with the best and most essential neurosurgical services, and chart our own unique course in the emerging quality care; and

WHEREAS, most meaningful data will rely on massive data sets and require participation from diverse geographic locations and practices, therefore
BE IT RESOLVED, that the CSNS work with its parent organizations to disseminate information at the grassroots level through state and regional organizations the rationale and importance of joining the N2QOD project; and
BE IT FURTHER RESOLVED, that the CSNS help identify barriers as to why organizations and practices have not yet entered into this registry so that adaptions can be made to improve participation.

RESOLUTION X (CANS: Support)
Title: Assessing the effect of closed intensive care units on residency training.
WHEREAS, ACGME based alterations to the neurosurgery residency training program, including new work hour restrictions[1], have necessitated a paradigm shift in management of neurosurgical patients, particularly those requiring ICU level care; and
WHEREAS, an increasing number of hospitals are shifting towards a closed intensive care unit model in response to financial and regulatory initiatives; and
WHEREAS, closed critical care unit staffing models and associated educational arrangements may exclude neurosurgical residents from being involved in the full spectrum of critical care for neurosurgical patients;
BE IT RESOLVED, that the CSNS study the prevalence of closed ICUs in US hospitals involved in neurosurgery resident training; and
BE IT FURTHER RESOLVED, that the CSNS study the access provided to neurosurgery residents and faculty in such closed units, including the level of involvement afforded in treatment decisions for neurosurgery patients in these closed units; and
BE IT FURTHER RESOLVED, that the CSNS study whether the curricular goals of the Society of Neurological Surgeons Committee on Resident Education (CoRE) and Neurosurgery RRC for resident training in neurosurgical intensive care are met in such closed ICU units.

RESOLUTION XI (CANS: Oppose—NERVES does this annually)

Title: ER Coverage by Neurosurgeons: Are we Selling our Value Short?
WHEREAS, a component of the accreditation process for designated Level I or Level II Trauma Centers is to have neurosurgical care available in the Emergency Department [1]; and
WHEREAS, neurosurgeons managing acute traumas has been a necessary component of the trauma work-up and routine Emergency Department care; and
WHEREAS, financial remuneration for Emergency Department coverage by neurosurgeons is determined by fair market value; and
WHEREAS, hospital administrations often use poor or outdated fair market value analyses to determine compensation rates; and
WHEREAS, use of this outdated data in contract negotiations may result in neurosurgeons undervaluing their provision of essential, emergency health services; and
WHEREAS, the last CSNS survey on this matter resulted in excellent data from over 1,000 participating neurosurgeons, which complemented the NERVES survey data; and
WHEREAS, providing Emergency Department coverage is a vital component of the financial health of many neurosurgical practices, especially small group practices; therefore
BE IT RESOLVED, that a confidential survey be performed every two years for the purpose of updating Emergency Department coverage payment information within the neurosurgical community; and
BE IT FURTHER RESOLVED, that hospital-owned neurosurgery practices be included in this survey to assess remuneration for Emergency Department coverage within service contracts; and
BE IT FURTHER RESOLVED, that the CSNS ask the AANS and CNS to assist with funding for this survey.

RESOLUTION XII (CANS: Support)
Title: The Lure of Employment: Are Trainees Being Misled to Join Employed Practice?
WHEREAS, in 2009, more than half (65%) of established physicians accepted employment in hospital-owned practices and almost half (49%) of physicians hired out of residency or fellowship were placed within hospital-owned practices [1]; and
WHEREAS, primary care and specialty care physicians in hospital-owned practices were offered more in first- year

guaranteed compensation than in non hospital-owned practices. First-year guaranteed compensation has decreased by 2.1% since 2006 for specialists in single specialty practices whereas primary care first-year guaranteed compensation has increased by 17.4% in the same period. Meanwhile, first-year guaranteed compensation for specialty care physicians in multispecialty practices has increased 3.2% since 2006 while first- year guaranteed compensation for primary care physicians in multispecialty practices has increased 14.3% [1]; and

WHEREAS, according to a 2009 report by the American Medical Association, one in six physicians works for a hospital, and the number is quickly growing [2]; and

WHEREAS, for many hospitals, hiring doctors is crucial to their strategies. Having more doctors in the fold guarantees a steady stream of patient referrals and, say hospital executives, bolsters care through better coordination of services. They also emphasize the impact of the new health overhaul law: it rewards creation of more efficient, integrated models of care [3]; and

WHEREAS, critics suggest that hospitals are "buying up" networks of primary care physicians to lock in referral networks for specialists [4], and entice specialists to work for hospital-owned practices due to dwindling referrals, often at a steep pay cut; and

WHEREAS, the decline of private practice may put an end to the kind of enduring and intimate relationships between patients and doctors that have long defined medicine. A patient who chooses a doctor in private practice is more likely to see that same doctor during each office visit than a patient who chooses a doctor employed by a health system [5]; therefore

BE IT RESOLVED, that CSNS work to increase transparency in the marketing techniques used by hospital- owned groups, including methods such as outbidding competing private practices for new talented trainees with high unsustainable first year-only salaries; and

BE IT FURTHER RESOLVED, that the CSNS work through its Young Neurosurgeons Committee in conjunction with the Workforce Committee to develop resources to assist trainees in career decision-making that acknowledges and values all modalities of practice type, including private practice.

RESOLUTION XIII (CANS: Neutral—await debate)

Title: The Impact of the Global Cost of Spine Care for Patients

WHEREAS, neurosurgical evaluation and management of back and neck pain comprise a significant proportion of the practice of many neurosurgeons; and

WHEREAS, there is no comprehensive resource that provides a detailed assessment of the global cost of spine care with emphasis on cost/outcome ratios; and

WHEREAS, neurosurgeons and neurosurgical policy advocates alike would benefit from access to such a resource, therefore

BE IT RESOLVED, that the CSNS create a task force to investigate the average global cost of each incident of back and neck pain, including division of that cost among the neurosurgical evaluation process, surgical and non-surgical management strategies, and rehabilitative care; and

BE IT FURTHER RESOLVED, that this assessment be framed in terms of outcomes measures and quality of life benefit of various treatments vis-à-vis dollars spent; and

BE IT FURTHER RESOLVED, that the work product of this task force will provide a resource that comprehensively addresses the societal impact of the cost of spine care at an individual and national level, including an extensive bibliography of available data on the global cost of spine care that may aid in public relations and advocacy efforts.

RESOLUTION XIV (CANS: Neutral—await debate)

Title: Promoting Global Health Opportunities in Neurological Surgery

WHEREAS, surgical specialties have faced difficulties in promotion of global health opportunities, partially because of concerns about complexity and cost of surgical care, and

WHEREAS, neurosurgeons can meaningfully contribute to trauma, critical care and other surgical initiatives in low-resource countries, and

WHEREAS, organizations such as the Foundation for International Education in Neurological Surgery (FIENS) exist specifically to promote international opportunities for volunteerism and education in neurosurgery, and

WHEREAS, the World Federation of Neurosurgical Societies (WFNS) established a coordinating committee for international collaborative in 2005 whose goal is to coordinate instrument donation, online courses and volunteerism and reduce duplication of efforts by the AANS, CNS and WFNS in these regards, and

WHEREAS, other international initiatives may be independently arranged through academic institutions, industry group philanthropy, NGOs, medical groups and individuals, and
WHEREAS, teamwork is the essence of providing good surgical care whether in developed or developing countries, and
WHEREAS, sustainable global health opportunities in neurological surgery will require long term investment by both organizations and individuals to continue development of educational initiatives as well as promote opportunities for international collaboration, therefore
BE IT RESOLVED, that the CSNS request the AANS and CNS formulate a position statement on neurosurgeon involvement in global health initiatives that reflect the mission and priorities of organized neurosurgery, and
BE IT FURTHER RESOLVED, that the CSNS develop a set of guidelines for neurosurgeons who wish to contribute to health care in low-resource countries, with attention to both ethics and feasibility of such projects, and
BE IT FURTHER RESOLVED, that the CSNS request the AANS and CNS to collaborate with FIENS, WFNS and other relevant organizations to develop a centralized information source for neurosurgeons and neurosurgery residents with interest or experience in global health; that may include initiatives by individuals, groups, and organizations in order to facilitate more effective collaboration.

RESOLUTION XV (CANS: Oppose—delegates can detect issues w/o help)
Title: Communication of the intention of resolutions ensures informed delegates.
WHEREAS, the testimony and discussions amongst the CSNS membership about the resolutions being brought forward at each meeting are in general focused and fruitful it happens in rare circumstances that the intent or "spirit" of a resolution is difficult to interpret from the text of the resolution itself; and
WHEREAS, in equally rare circumstances the authors of a resolution are not present to give testimony or clarification as to the intent of a resolution; and
WHEREAS, several committees are asked to make an educated decision as to their stance on all resolutions considered each year based on the text of the resolutions alone and without the potentially clarifying input of the authors of a resolution; and
WHEREAS, in a few instances the lack of clarification as to the intent or "spirit" of a resolution has lead to unfocused and uninformed testimony, leading to prolonged debate; and
WHEREAS, the concise and focused delivery of the intent or "spirit" of a resolution in a brief oral presentation akin to the delivery of an elevator "pitch" of a business idea following by the inevitable equally brief question and answer session in said elevator has been used in other venues as a means to sharpen the focus on the core of an idea being brought forward; and
WHEREAS, such a session of brief oral presentations and brief question and answer session, in total not exceeding 30-45 minutes for 10-15 resolutions may seem an unnecessary duplication of the lively and desired debate in the plenary session it is the authors opinion that such presentations could increase the understanding the therefore potential support of a resolution and uncover potential issues more readily; therefore
BE IT RESOLVED, that the CSNS consider tasking the executive committee to at least trial a change to the prevalent meeting practice and meeting schedule to include a brief oral presentation and brief question and answer session explaining the intent or "spirit" of the resolution before the beginning of committee sessions at the beginning of each meeting.
BE IT FURTHER RESOLVED, that the CSNS require a representative of the authors or a delegate authorized by the authors to speak on all aspects of the resolution be present throughout the meeting and develop a mechanism to ensure compliance.

RESOLUTION XVI (CANS: Oppose—a liability bag of worms)
Title: Enhancement of medical device company representatives' assistance inside the operating room
WHEREAS, the presence of technical representatives of device manufactures (e.g. spine instrumentation) has become a common adjunct to the operative team due to the nearly constant introduction of new and more complex medical devices; and
WHEREAS, their presence often aids in the delivery of their product in a safe and efficient manner by way of timely and reliable back-table assembly, knowledge of manufacturer specific medical instrumentation, and instrumentation specific procedural knowledge which allows them to anticipate the needs of the operative surgeon; and
WHEREAS, the AMA Code of Medical Ethics states: Manufacturers of medical devices may facilitate their use

through industry representatives who can play an important role in patient safety and quality of care by providing information about the proper use of the device or equipment as well as technical assistance to physicians. AMAssociation. Opinion 8.047 Industry representatives in clinical settings. *Code of Medical Ethics*; and
WHEREAS, by limiting technical representatives such that they not be able to handle their product in the sterile field, but rather be forced to only give oral instruction on its use at a distance to an often less knowledgeable scrub technician frequently results in increased length of procedures and surgeons receiving improper instrumentation, thereby reducing the overall efficiency and safety of the procedure; and
WHEREAS, legal precedent is not clear yet due to case specific, mixed outcomes on legal suites against medical device representatives and manufactures as related to their presence in the operating room whereby they have faced accusation of unauthorized practice of medicine and heightened duty based on representative presence in the operating room; therefore
BE IT RESOLVED, the CSNS coordinate a position statement by our parent organizations (AANS/CNS) regarding support for allowing medical device representatives to handle their own equipment in the operative setting in order to better assist the surgeon, who alone may apply toward patient care.

RESOLUTION XVII (CANS: Support)
Title: Formation of a Nationwide Sports-Related Concussion Registry
WHEREAS, the incidence of repeated sports related concussion in athletes is unknown; and
WHEREAS, the long term impact of repeated concussion is not well understood; and
WHEREAS, no global registry of sports related concussion exists anywhere in the country; therefore
BE IT RESOLVED, that the CSNS request the AANS and CNS to form a task force to develop strategy to encourage neurosurgeons to assume primary roles in the care of sport related concussions; and
BE IT FURTHER RESOLVED, that the AANS and CNS, in conjunction with CSNS and the Joint Section of Neurotrauma and Neurocritical care, take the leading role in developing strategies for delivery of care to sports related concussion by having the task force develop a registry for concussions; and
BE IT FURTHER RESOLVED, that the AANS and CNS publicize the engagement of neurosurgeons in the care of concussion and the establishment of the registry; and
BE IT FURTHER RESOLVED, that the registry is made available to all healthcare providers as long as it is constructed in accordance with HIPAA laws. ❖

Sign of getting really old:
You come to the conclusion that your worst enemy is gravity.

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 the CANS office by E-mail (janinetash@sbcglobal.net) or fax (916-457-8202)—Ed. ❖

The assistance of Janine Tash and Dr. Austin Colohan in the preparation of this newsletter is acknowledged and appreciated.

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This newsletter is published monthly from the Executive Office:

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