



CANS

NEWSLETTER

California Association of Neurological Surgeons

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Escape to Carmel...
See page 3

President' Message

Moustapha Abou-Samra, M.D., F.I.C.S., F.A.C.S

What do CANS and NPR have in common?

No, it is not their liberal tendencies!

I enjoy listening to KCLU, my local NPR station that broadcasts from the campus of California Lutheran University in Ventura County. But, I must admit that I find the membership drives in the spring and fall ... irritating. They are usually aimed at people who listen to the station but don't provide their financial support, which is problematic because NPR is listeners supported!

CANS is the only neurosurgical socio-economic organization in California that represents ALL neurosurgeons: it was born out of the necessity to deal with the malpractice crisis in 1976. It succeeded in getting MICRA passed and has since been a model for other states neurosurgical societies and a leading force in CSNS.

Over the years, unfortunately, and because of a multitude of reasons our membership has decreased: it is crucial that we increase our ranks and continue to be the vibrant and effective organization that we are.

Our April board meeting-see summary below- confirmed what I already knew: our board members and consultants are dedicated, knowledgeable and hard working individuals and leaders who represent not only CANS members but also ALL California neurosurgeons.

We discussed the many benefits of membership but concentrated on our Newsletter. Randy Smith takes most the credit for transforming it into a must read monthly report that is enjoyed by many, not only here in California but across the Nation; I hear this, a lot. Janine takes credit for the beautiful aesthetics and organization.

Your board felt that such a wonderful newsletter should be shared with ALL neurosurgeons regardless of their membership status: it is that important. This month not only our members, but ALL California neurosurgeons, will receive it.

So, what do CANS and NPR have in common?

We provide a service that is valuable to ALL but is paid for by a few!

Consider this our spring membership drive! ❖



[CANS Membership Information](#)

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Robbing Peter (neurosurgery) to Pay Paul (primary care)

Randall W. Smith, M.D., Editor

The angst du jour for we brain guys is the move afoot at the federal level to improve access for our seniors to a good primary care doc. Seems the abysmal increases in Medicare payments for all docs over the past half decade (increases only because of annual congressional shenanigans to forestall the corrupt Medicare pay formula) have so poorly kept pace with inflation (read that as distinct overhead cost increases for all practitioners) that our primary care colleagues are on the brink of losing their shirts. I accept that a huge number of our generalists derive a very substantial portion of their practice income from Medicare patients who are likely to constitute a larger and larger proportion of their practices as the baby boomers hit the federal healthcare street. If the Medicare Relative Value Unit conversion factor, recently somewhere around the mid-thirties, effectively stays there while the cost of providing an RVU approaches the conversion factor, our generalist colleagues will find it nigh unto impossible to make a reasonable if any buck delivering medical care, at the least to Medicare patients.

Now, most neurosurgical practices should be able to keep their cost of delivering an RVU somewhere in the 20's so treating a Medicare patient should result in some blackness on the bottom line. In addition, neurosurgeons can cut some deals with the Blues at better than Medicare rates and in California sprinkle their practices with Work Comp which still is at a premium to Medicare rates. Add a little ED work which should include a stipend and we are still doing fairly well, albeit working harder for fairly well. About the only care we have flatly declined is MediCal since no small business person can tolerate a pay scale that may well cover only half of the cost of providing that care.

Following the Feds primary+/specialist- approach to its logical conclusion we will eventually hit the point at which no one can stay in business treating Medicare patients. In the absence of realistic increases in the conversion factor, you can only shift so much of our income to the primaries before we all go bust. The 59% of America's docs that purportedly want one payer national health insurance that covers everyone (Annals of Internal Medicine, April 1, 2008) can't appreciate what it would be like to have our CMS and our Congress decide what care is allowed and how much we get paid to deliver it.

Americans, their elected officials and the plaintiff's bar want, heck, demand the best of medical care for those that access the care system. We could argue endlessly what constitutes "best"; it is inarguably costly and contains some lipid. We can and will improve our decision making as we approach and embrace evidenced based medicine. But to think that even the most austere "best" will substantially reduce the cost of medical care is an illusion. You just can't squeeze Lexus care out of Buick prices. What we need is more money in the system. We have got to get over the media and political horror of US medical care constituting 16% or more of the GDP. It probably needs to be more. If you want our best effort on behalf of the patient's problem, that's what it will cost. Pay up or shut up and stop trying to ratchet down what we docs honestly earn while ignoring the real issue which is underfunding. ❖

CMA Committee Opportunities

The California Medical Association is soliciting nominations for various committees effective October 2008. These are the Council on Ethical Affairs, Council on Judicial Affairs, Council on Legislation, Committee on Medical Services, Committee on Quality Care, Committee on Professional Liability and the new Council on Information Technology. If you are interested in any of these, contact the CANS office (janinetash@sbcglobal.net) for committee descriptions and nomination forms. Nominations are due to CMA by May 23. ❖

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CANS 2009 Annual Meeting –something for everyone

Janine Tash

Reserve the weekend of **January 16-18, 2009**. Escape to a Carmel Valley legendary resort and relax at the beautiful [Quail Lodge](#), a 850-acre destination resort surrounded by spectacular scenic beauty situated beyond Carmel's fog belt on the sunny side of town. The resort's uniqueness comes from natural beauty which beckons the senses to enjoy sparkling lakes, lush gardens and rolling hills with many species of wildlife and abundant wildflowers.

All guestrooms have private decks, skylights, oversized built-in window seats, Plasma-screen TVs, DVD players, featherbeds, down comforters, Italian linens, hammered copper sinks, spacious marble baths with deep tubs and separate showers.

Choose your favorite recreational temptations:

At the resort:

Tennis, bocce, swimming, hiking or biking
 Golf on one of Monterey Peninsula's most acclaimed courses
 Savor lush spa treatments and massages enhanced by the sounds of nature
 Stroll past swans, deer and quail
 Experience the thrilling Land Rover Driving School...
 or simply lounge on your deck with a glass of fine wine.

In the surrounding areas:

Carmel Valley Village – wine tasting and antique shopping
[Monterey Bay Aquarium](#) – site of the CANS Banquet on Saturday, January 17
 Cannery Row – the subject of the classic John Steinbeck novel
 Carmel-by-the-Sea – beach, exclusive art galleries and boutiques
 17-mile drive – winding road with spectacular coastline views
 The Lone Cypress – the most photographed tree in the world
 Carmel Mission Basilica – established in 1880 by Father Junipero Serra
 Point Lobos State Reserve – wildlife sanctuary 2 miles south of Carmel
[Steinbeck Center](#) – a Sunday afternoon visit for meeting attendees

Monterey Peninsula Airport (20 minutes from resort) is serviced by United, American and America West Airlines. San Jose International Airport (65 miles from resort) offers a full range of service from a variety of airlines.

The CANS Annual Meeting format will be a little different this time. Meetings will be held on Saturday and Sunday mornings. Saturday afternoon will be free for golf or other activities. Saturday evening's banquet will be at the Monterey Bay Aquarium – a special event for the whole family. On Sunday afternoon, the Steinbeck Center will be available for our group.

Expect some exciting speakers! ❖

More News from the Editor

Work Comp Treatment Rules Mostly Unchanged

One of our CANS member's offices sent in a question about what the treatment rules presently are in the Work comp arena. Here goes:

Prior to the passage of SB899 in April of 2004, there were no real treatment guidelines other than those imposed by various Comp carriers through their Utilization Review process. SB899 mandated the use of the 2004 American College of Occupational and Environmental Medicine (ACOEM) guidelines, second edition, unless and until the Department of Workers' Compensation adopted other guidelines. The DWC has adopted other guidelines regarding acupuncture, post-operative care, elbow treatment and chronic pain treatment but no others, so the great majority of treatment including that for the spine still is controlled by the ACOEM guidelines, second edition.

The DWC has recognized that the ACOEM guidelines do not adequately address a lot of the care associated with the spine, particularly surgery and is in the process of evaluating other guidelines to replace the 2004 ACOEM guidelines on low back injury treatment. This evaluation is being conducted by the Medical Evidence Evaluation Advisory Committee (MEEAC), a committee appointed by the DWC which includes a neurosurgical representative, Dr. Praveen Mummaneni, from UCSF. The committee is looking at the new 2007 ACOEM guidelines and the ODG guidelines regarding low back treatment but has yet to make a recommendation. CANS has supplied input to Dr. Mummaneni as has the Joint Section on Spine of the AANS and CNS. Once the committee makes its recommendations, it will be reported in this newsletter.

A recommendation by the MEEAC is only advisory to the DWC who can choose to implement what it feels like but after umpteen hours of MEEAC work, the DWC is likely to embrace most if not all of what the committee recommends.

SB899 also mandated using the AMA Guides to the Evaluation of Permanent Impairment, fifth edition, to determine permanent disability when we declare an injured worker permanent and stationary. I understand those guides are being revised by the AMA and a new edition is imminent. It is not totally clear to this writer whether the DWC can mandate the use of a new edition of the AMA Guides or if that would take an act of the state legislature. I would estimate that the fifth edition of the AMA Guides will continue to be used in California for the next couple of years. ❖



Five-Hour Board Meeting Productive: Highlights of the CANS Board meeting on 4/19/2008:

1. A collective sigh of relief from the Board as our Executive Secretary, Janine Tash, rescinded her planned retirement following the 2009 annual meeting. She will still man the helm but have a lower profile using temporary help during the summer months so as to recharge her batteries.
2. Approved new active members Farbod Asgarzadie (Loma Linda), Robert Dodd (Stanford), Sherwin Hua (Valencia), Mark Liker (Valencia) and Jongsoo Park (Stanford).
3. Noted with sadness the death of long time friend and former CANS President William H. Wright of Pasadena. The Board held a moment of silence and asked Dr. Smith to write his dear wife Libby with our condolences.
4. Decided to trial a mid-monthly E-mail news alert listing internet available items of interest.
5. Decided to mail the monthly newsletter and mid-monthly E-mail alert to all California neurosurgeons, not just CANS members, consistent with CANS' mission statement to serve California neurosurgeons.
6. Noted the January annual meeting basically broke even vs. a previously anticipated loss of 5K.
7. Decided to hold the 2009 meeting in Monterey over a two day period with a formal program on Saturday and Sunday mornings, leaving the afternoons free for golf, sightseeing, shopping, etc., particularly considering the Monday following is the Martin Luther King holiday.
8. Decided the Long Range Planning Committee should also function as an annual meeting site selection committee.
9. Requested the By-laws Committee consider creating a position of Historian. ❖

Neurosurgery in DC Focuses on 9 Issues

The Washington Committee of the AANS and CNS, discussed in the February newsletter, has released its legislative agenda which is reproduced below. They state that the Washington Committee monitors virtually all health care issues, but given neurosurgery's small size and resources, they are trying to focus on (a) those issues where neurosurgery really has a unique perspective or is more affected than other physician specialties and (b) issues that affect the daily lives of most neurosurgeons.

The list reads like Mom and apple pie good stuff. The devil is in the execution.

Improve Trauma Systems and Access to Neurosurgical Emergency Care

There are significant gaps in our trauma and emergency health care delivery systems, and trauma is the leading killer of Americans under the age of 44. With only approximately 3,100 board certified practicing neurosurgeons in the U.S., the AANS and CNS want to work with Congress to develop and implement a system for the regionalization of emergency neurosurgical care. As recommended by the Institute of Medicine (IOM) in its ground-breaking 2006 report, "the objective of regionalization is to improve patient outcomes by directing patients to facilities with optimal capabilities of any given type of illness or injury." In addition, neurosurgery actively supports increased funding for the HRSA Trauma-EMS Program, which provides grants to states to improve critically needed state-wide trauma care systems.

Champion Improvements to the Medicare Physician Reimbursement System

We thank Congress for stopping the 10.1 percent cut that was scheduled to go into effect on January 1, 2008. Unfortunately, physicians now face a 10.6 percent cut in Medicare reimbursement on July 1, 2008, and payment cuts totaling 40 percent over the next 8 years, beginning in 2009. The AANS and CNS are committed to working with Congress to pass both short- and long-term solutions to the Medicare reimbursement system crisis.

Preserve Quality Resident Training and Safe Patient Care

Concerns about resident fatigue must be balanced with the need to adequately train neurosurgical residents and ensure quality patient care. The AANS and CNS believe that further reductions in resident work hours will have a negative impact on resident training and education and will produce a generation of neurosurgeons who will not be as skilled or committed as their predecessors and will fall short of public expectations. In addition, adherence to strict work hours can lead to medical errors attributable to more frequent patient handoffs, fragmentation and loss of continuity of care. The Accreditation Council for Graduate Medical Education (ACGME) is effectively addressing these issues and legislation on this matter is therefore unnecessary.

Alleviate the Medical Liability Crisis

The AANS and CNS support legislation to provide common sense, proven, comprehensive medical liability reform. Federal legislation modeled after the laws in California or Texas, which includes reasonable limits on non-economic damages, represents the "gold standard," but other solutions should also be explored. One option, which could help improve access to neurosurgical emergency care, would apply the Federal Tort Claims Act to EMTALA-mandated services. EMTALA, the Emergency Medical Treatment and Labor Act, is a federal mandate to provide emergency care and puts neurosurgeons at an increased liability risk. Another idea worth exploring is to replace the current system with specialized Health Courts.

Enhance Medicare and Other Quality Improvement Programs

While Congress has taken the first steps towards implementing quality improvement programs, it must also support additional approaches, such as clinical data collection systems, which are more applicable to surgeons and will encourage the full participation of all physician specialty groups. A "one-size-fits-all" approach will not accomplish the lofty goals that we all hope will be the end result of these quality-based initiatives – better patient outcomes. The AANS and CNS support a pay-for-participation system where clinical data collection occurs in a non-punitive environment; data is appropriately risk adjusted; physicians continually receive performance feedback; and individual data is not publicly reported.

Increase Funding for Health Care Research

Neurosurgeons are committed to advancing the public health by fighting diseases, developing treatments, and finding cures through continued medical research. Institutions such as the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC) and the Agency for Healthcare Research and Quality (AHRQ) are leading the way to help improve our nation's health and save lives. The AANS and CNS urge Congress to increase funding for these vital public health programs.

Safeguard Patient Access to Specialty Care in Health Care Reform

Health care reform must ensure that every patient has access to appropriate quality care, by the appropriate doctor, at the appropriate time. The AANS and CNS believe it is imperative that all health care reform proposals ensure that patients are provided adequate details about health plan options and physician specialist networks and patients have adequate access to timely, affordable specialty care, including the doctor of their choice.

Advance Measures to Improve the Neurosurgical Workforce

While neurosurgery continues to fill its residency slots across the nation, these slots have not kept pace with growth in the U.S. population. As baby boomer enrollment in Medicare continues to climb, the future supply of all surgical specialists will be woefully inadequate to provide the health care that these seniors will require. The AANS and CNS support reevaluating the residency-funding caps that were established by the Balanced Budget Act of 1997.

Protect Patient-Centered Healthcare

Diagnostic imaging is an integral component of neurosurgical care, and the ability of neurosurgeons to provide in-office diagnostic imaging services to their patients ensures they get the best possible and timely care available. Ambulatory Surgery Centers (ASCs) and physician-owned specialty hospitals provide cost-effective care; have low infection, complication and mortality rates; and produce a marked increase in patient satisfaction. The AANS and CNS urge Congress to protect patient access to these services.

Anyone wishing to comment on this agenda can contact:

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Letter to the Editor: Comments on Dr. Abou-Samra's March President's Message

George Koenig, M.D., Former Chairman, CMA Political Action Committee

As usual I thoroughly enjoyed the March newsletter. Your trip, Moose, to Washington was most interesting and prompted this note, which should in no way be taken as a criticism since I have made umpteen similar trips to Sacramento and Washington myself.

I note your observation that even MD Congressmen can talk out of both sides of their mouths; it is truly amazing how rapidly they learn this art. Especially when standing before a group the material rapidly becomes irrelevant, the bigger the crowd the greater the baloney.

Personally I found it much more useful to catch the legislators in their home district in their offices where contact is less harried, there are no calls for voting, and a much more honest discussion invariably follows. The group meetings (like the one CMA will shortly be hosting in Sacramento) are great tourist events and function well as introductory sessions for neophytes. One thing I never have figured out is whether this has application to Congress (it functions much better with state legislators) because of the nature of national legislation (generally much more omnibus in nature), the numbing effect of caucuses, and the 3000 mile distance from the scene of the "crime".

It is still critical to have neurosurgical presence and input and I am glad you went. ❖

UC Irvine Neurosurgery Training Program

(Each month we plan to feature one of the California Neurosurgery residency programs. It is hoped these program highlights will acquaint our readers with our colleagues, how they are running their programs, their interests and some of their clinical research projects to which you might want to refer a patient. The programs will be presented in an order totally at the whim of the editor. This month: UC Irvine. –Ed.)

The UC Irvine Department of Neurosurgery is in the process of reestablishing its residency training program. The original program was in place from 1948 -1998, initially started with the Long Beach VA Hospital after WWII and transferred over to UC Irvine in 1972. The original program was voluntarily relinquished in 1998 by Dr. Keith Black when the department faculty retention, departmental stability, and operative case load fell on hard times. Four years ago, UC Irvine embarked on a rebuilding of its neurosurgical department by recruiting Mark Linskey from the University of Arkansas to assume neurosurgical command. As department chairman, Dr. Linskey has righted the ship by expanding the faculty, solidifying and expanding patient material and aggressively pursuing the building of multidisciplinary clinical and research programs across key neurosurgical disciplines. A new UC Irvine residency training program with a hybrid design including Children's Hospital of Orange County (CHOC), Kaiser Foundation Hospital in Anaheim, and the Hoag Memorial Hospital Presbyterian Gamma Knife Center has been approved to again commence neurosurgery residency training in July 2008.

The neurosurgical faculty is involved with multiple program developments, including the comprehensive multidisciplinary Neuro-Oncology Program, a multidisciplinary operative and non-operative Comprehensive Spine Program, a comprehensive multidisciplinary Stroke and CV program, a multidisciplinary Comprehensive Epilepsy Program and a Multidisciplinary Movement Disorder Program. Dr. Linskey is currently recruiting additional faculty with general and endovascular credentials.

Dr. Linskey lists the following as cutting edge departmental endeavors:

- Multidisciplinary skull base team microneurosurgery
- Minimally invasive endoscopic skull base surgery
- Intra-operative MR guided brain tumor resections
- Gamma Knife Perfexion® unit stereotactic RS (UC Irvine faculty treating at Hoag Memorial Presbyterian Hospital)
- Varian Trilogy iMRT for brain tumors and fractionated cranial as well as spinal RS
- Anti-tenascin mAb-II31 up front brachytherapy for newly diagnosed GBM
- EGFRviii immunotherapy for newly diagnosed GBM
- Recurrent GBM Velcade and Avastin clinical trial
- Cranial nerve microvascular decompression for trigeminal neuralgia and HFS
- Motor cortex stimulation for deafferentation facial pain
- DBS for Parkinson's Disease and Essential Tremor
- Onyx® embolization of AVMs
- WingSpan® extension stenting for intracranial arterial stenosis
- Minimally invasive spine surgery
- Prestige® cervical disc replacement
- NPH ambulatory lumbar drainage clinical trial

The UC Irvine Medical Center and UC Irvine School of Medicine, where most neurosurgical department clinical and research activity occurs, is a Level I trauma center, is a JCAHO certified stroke center, has an NCI-designated Comprehensive Cancer Center and has been included in the U.S. News and World Report America's Best Hospitals list. A brand new University Hospital is expected to open in February 2009.

The Department and medical center have been stretched by EMTALA transfers which are often made for less than clear medical reasons and, in the present absence of residents, caring for the general neurosurgical patient load falls entirely on the faculty which is assisted by 4 PAs and 4 NPs.

Three clinical research protocols (with contact persons and phone numbers) that are accepting patients are:

- Phase III randomized trial of Neurodiab (anti- tenascin AB-I131), RT & Temodar vs RT and Temodar in newly diagnosed GBM (Prologue)
- Phase II/III randomized trial of EGRFvIII vaccine (CDX-110), RT and Temodar vs RT and Temodar in newly diagnosed GBM patients who are EGFRvIII positive (Act III-Celldex Therapeutics)
- Phase II clinical trial of Velcade and Avastin for recurrent GBM (Duke University – UC Irvine joint trial)

Contacts for all three trials: Daniela Bota, MD, PhD & Mark E. Linskey, MD (Becky Kirkley RN - 714-456-6966)

UC Irvine's full-time neurosurgical faculty is listed below:

Mark E. Linskey, MD, Assoc Prof. & Chairman, Surgical Director Neuro-Oncology Program
 John Kusske, MD, Prof Emeritus and Vice Chairman in charge of business and program development
 Laura Paré, MD, Assoc Clinical Prof, Dir NPH Program, Acting Co-Director Spine Program
 Devin Binder, MD, PhD, Asst Prof, Surgical Director of Epilepsy and Movement Disorder Programs
 Gowriharan "Ty" Thaiyananthan, MD, Health Sciences Asst Prof, Co-Director Spine Program (Aug 2008)
 Fong Tsai, MD, Prof Radiology and Neurosurgery, NIR
 Binh Nguyen, MD, Asst Clinical Prof Radiology and Neurosurgery, NIR
 Daniela Bota, MD, PhD, Asst Prof of Neurology & Neurosurgery, Medical Director Neuro-Oncology Program
 Yi-Hong Zhou, PhD, Asst Prof, Director of Brain Tumor Research Laboratory
 Os Stewart, PhD, Prof of Neurosurgery, Director Reeves Irvine Research Center for spinal cord injury
 Kim Anderson, MD, Adjunct Asst Prof of Neurosurgery, RIRC for spinal cord injury
 Plus 13 voluntary faculty at CHOC, Kaiser, Hoag, St Joseph's and Mission Hospitals

Their Web site at <http://neurosurgery.uci.edu> can be perused to obtain faculty addresses and phone numbers should you wish to contact them. The departmental number is 714-456-6966. ❖

Neurosurgical Position

Any CANS member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a one time posting in this newsletter. Submit your text to me by E-mail (rws-avopro@sbcglobal.net) or fax (858 683-2022).

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

Questions or 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 issues of the monthly newsletter are available on the CANS website at www.cans1.org. *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 Moustapha Abou-Samra, M.D. 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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