CANS NEWSLETTER

California Association of Neurological Surgeons Volume 35 Number 5 May 2008

President's Message: CANS Connexion and Self Discipline

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

Since the April newsletter, you must have received two separate installments of "***CANS Connexion***;" I hope that you are enjoying our latest attempt to keep you at once informed and connected. Thank you Randy, for taking on this project and making it a reality.

An article published in the New York Times on May 7, 2008, was not included in the *CANS Connexion*, but will be the subject of this editorial.

The article indicated that "more than 2 percent of all doctors practicing in New York last year landed on the state medical board's watch list because of problems including substance abuse, mental health concerns or their professional conduct." This comparatively large number was attributed to the lower burden of proof that New York State uses in triggering such a watch.

New York's health commissioner, Dr. Richard Daines, was quoted as saying "the higher numbers reflect active, good programs, rather than bad physicians."

This article was prompted by the recent release of a report by the Federation of State Medical Boards, www.fsmb.org, a non profit organization that represents the 70 medical boards of the United States and its territories, and assists various state boards in "developing and promoting high standards for physician licensure and practice."

I'd like to compare New York, the subject of this article, to California.

	New York	California
Total number of physicians	81,641	124,158
Physicians practicing in the state	65,644	97,141
Physicians under monitoring in 2007	1400	672
% of physicians under monitoring	2.14	0.7
Standard of proof required	Preponderance of Evidence	Clear and Convincing

Clearly the burden of proof in California is higher and... I like that! I say this knowing that here in California, we have many effective programs that identify physicians and help them deal with this difficult problem, not only to help individual physicians, but also to protect our patients.

It is generally agreed that "impaired physicians" constitute 8 to 14% of all physicians, and I dare say, though I have no specific data to support my assertion, that 8-14 is the percentage of impaired members of any professional group, such as lawyers, engineers and even teachers.

The fact that a very small percentage of physicians are felt to be in need of monitoring by State Boards, even when a board whose standard of evidence is only based on the preponderance of evidence, was completely overlooked by Danny Hakim, the author of the New York Times article. Nor the fact that Physicians, Organized Medical Staffs, Hospitals and State Medical Societies have succeeded in instituting very strong and effective programs dealing with impaired physicians, was even mentioned. (*continued on next page)*

QUAIL LODGE
RESORT & GOLF CLUB
January 17-18, 2009
CANS Annual Meeting
Banquet at Monterey Bay Aquarium

Inside this issue:

It is clear that as a profession, we have been very effective in detecting the troubled physicians and it is refreshing to read it in the National press; we should use this data to demand more independence in policing ourselves. I believe that given the opportunity and immunity, we are very capable and will be even more effective in self discipline. It is also important to know that generally, across the Nation, the number of disciplinary action by state boards has dropped: further indication of the effectiveness of the already existing monitoring programs.

An interesting facet of this problem that may, and should, be addressed from a myriad of angles is the relatively recent decision, July 26, 2007, of the Medical Board of California to end its physician diversion program by June 30, 2008. (Please see *AMNews* staff. August 27, 2007.) The board felt that its primary objective is to protect the public and rehabilitating physicians at the same time may present a conflict of sorts; I don't agree! Having an effective diversion program can only help the public, even indirectly. Perhaps a better explanation for the board action is its realization that diversion programs exist under other jurisdictions and therefore the board's participation, except in disciplinary action, is not needed.

On July 1, 2008, and after the Medical Board of California stops its diversion program, local medical societies should assume the lion share of dealing with this problem. They will be the logical entity to carry out this responsibility.

Meanwhile we should disseminate this information and boast about it; yet another item for *CANS Connexion*! ❖

RBRVS Circling the Work Comp Fee Schedule

Randall W. Smith, M.D., Editor

The Lewin Group has submitted its $459,000 study on conversion of the current Work Comp Official Medical Fee Schedule to a Resource Based Relative Value Scale. The study was commissioned by the Division of Workers' Compensation that apparently feels such a reimbursement system would be a good idea and is something they have the authority to impose. Just how such a payment scale would affect California surgeons, currently receiving the 9th lowest reimbursement in the country, depends on numerous factors and the report presents a number of options without recommending one option versus another. So to the down and dirty details.

If the conversion includes a revenue neutral concept, then Evaluation and Management codes would see an increase and surgeons would take a 12% to 25% cut. Using this system, the conversion factor for everyone would be $44.57 per RVU or about 115% of current Medicare rates. The neurologists and orthopods have voiced the greatest opposition to such a choice pointing out that in almost all states that have adopted RBRVS for Work Comp fees there has been a major exodus of docs from the Work Comp system.

The Lewin Group was aware of the above and proposed a number of ways of mitigating such a surgical payment hit. One way was to not make it revenue neutral and let the providers make more money. Another non-revenue neutral approach was to have a separate higher conversion factor for surgery and some procedures. They also mentioned implementing the RBRVS in stages, which sounds suspiciously like eventual death due to a thousand cuts. Another idea was to have a geographical kicker. The Lewin Group said the impact on fees would vary by region if the DWC decides to adopt geographic adjustments into its fee schedule. Counties such as San Francisco, San Mateo, San Benito, and Santa Clara with high geographic practice cost indexes could see increases as high as 7% to 12%. Sonoma, Kings, and Santa Barbara counties would also see large increases under the formula. Los Angeles County would see an increase. Sacramento and San Diego counties would see decreases (a major surprise since it is unclear what makes it cheaper to practice surgery in San Diego vs. San Jose).

UCLA neurologist Dr. Steven Levin, at a public hearing about the RBRVS changes held in LA, noted no state that paid less than 133% of Medicare for neurological services had adequate access to neurologists in their workers' compensation systems. He said Texas and Hawaii both had to revise their fee systems to lure neurologists back into their systems. He predicted if the 115% of Medicare were adopted, the participation of neurologists in the California workers' compensation system would fall to just 4% from the present 30%.

How neurosurgeons would react to a $44.57 conversion factor is anyone's guess. One question is, if a surgeon stops taking Work Comp business, which will then be paying about what we are currently getting from Medicare and the blues and which the great majority of us accept, with whom will the surgeon replace those patients? I would guess that unless a surgeon is excessively busy or does little Comp work, dropping Work Comp will mean a definite overall income droop.

It would appear we are going to get RBRVS in Work Comp. The only question is how much our ox will get gored, but gored it will surely get. ❖

More News from the Editor

A New Chicken Little—Should Neurosurgery Run for Cover?

A study from the University of Washington indicates that the USA is experiencing a severe drop in the number of general surgeons available to treat the populace. In 1981, the number of general surgeons per 100,000 patients was 7.68 which was down to 5.69 by 2005. During that same time period, the number of active practicing neurosurgeons has remained generally unchanged at about 3,000 while the population has increased by 66 million. Harkin back to 1981 when a national GME advisory committee predicted a 145,000 physician surplus by the year 2000. At that time there were repeated requests by the socioeconomic committees of the AANS and CNS to reduce the number of graduating residents each year by 25% to alleviate a perceived glut of neurosurgeons. No such 25% reduction ever happened and doom was inevitable.

Fast forward to this century - The somewhat less than 3000 active neurosurgeons are just barely able to cover today's 1500 trauma centers and cannot hope to service the 4000 or so hospital emergency departments in the US. A 2002 report using a far different and theoretically more accurate method than that used in 1981 predicted a shortage of 50,000 physicians, particularly primary care docs, by 2010. It is hard to criticize the 1981 crowd for not anticipating the physician income squeeze over the past 25 years led by Medicare, Medicaid and the blues. Graduating docs are opting for higher paying specialties with lower on-call requirements such as interventional radiology, dermatology, procedural cardiology and plastic surgery. Aging docs are tiring of the higher overhead lower payment spiral and retiring in droves. Women physicians dislike this general angst and are quitting medicine or opting for part-time work.

So now what should neurosurgery do? The same thing we did the last time we got the sky is falling message--not much. Add a few resident slots in established programs, maybe a new program or two and get regionalized so that there will be enough of us to go around. And wait for the next swing of the pendulum. Perfect Storm: National Health Insurance, mandatory 20 years in practice if the feds help pay for your MD, make that 30 if they help pay for your residency, salary to be determined by Congress and required ED coverage if asked. Where did I put that list of law schools? ❖

When the Accused may be Accused

In the April 21st issue of American Medical News an article describes the rather disturbing news that an ophthalmologist, who had his testimony subjected to review by the American Academy of Ophthalmology upon a grievance filed by two Academy members, has been allowed to proceed with a defamation lawsuit against the two complainants. Although the ophthalmology Academy may have different ethical rules about expert testimony than the AANS, and other specifics in the case may make it a unique situation, the question does arise as to the risk to AANS member complainants when they file a grievance against another AANS member for expert testimony. Ben Blackett, chairman of the AANS Professional Conduct Committee (PCC), points out that if a complaint filed by one AANS member against another results in an AANS sanction, that result should be solid protection against a defamation suit brought by the accused. What litigation risk might occur if the PCC and the AANS Board find inadequate justification for sanctions potentially becomes another matter. Is the fact of filing a complaint that is rejected by the PCC and AANS Board as not violating its expert testimony ethical guidelines enough justification for a defamation lawsuit? The rejected cases are never published, so is the person who feels defamed justified in bringing a suit when only the PCC and AANS Board know about the accusation? Dr. Blackett's opinion is that since a complaint by one AANS member about another is among two members of a voluntary organization that has mandatory rules about expert testimony and since a complaint not felt warranted by the PCC and Board is not published, making it hard to demonstrate that any damage occurred to the accused, he feels that a defamation lawsuit would have little chance of success. ❖

Uncle Sam wants your Opinion

The CMS has contracted with L&M Policy Research and their partners to come up with some recommendations for imaging guidelines and is requesting input from anyone interested. CANS will respond, but anyone who reads the message reproduced below is free to chime in. There is no real structure to the request and each respondent is left with recommending a guideline that might pertain to one of the 6 broad areas of interest. National Imaging Associates, one of

L&M's partners, is a cost containment UR group, so one presumes they have a set of guidelines to work from and want to see if they missed anything. It would seem more transparent to share with us grunts the guidelines they have in mind rather than only provide a blank slate to write upon.

Dear interested party:

L&M Policy Research, LLC, and its partners, the National Imaging Associates and the Lewin Group, have been contracted by the Centers for Medicare & Medicaid Services to develop imaging efficiency measures. In preparation for additional work on this project, L&M would like to take the opportunity to ask the public for suggestions for imaging efficiency measures that could potentially be considered for development. For this project, the development of the efficiency measures is focused on applying evidence-based medicine to improve the efficient use of imaging technologies based on clinical practice guidelines and tied to health care quality outcomes. Specifically, these measures address one or more of the following types of domains:

- **Duplication** - imaging studies that are duplicative within a short time of each other without identified clinical indication, representing a potential source of waste and inefficiency.
- **Overlap** - imaging studies using different imaging modalities, on the same area of the body, within a short time of each other that serve the same clinical purpose, without an identified clinical indication for such overlapping studies.
- **Screening** - imaging studies that are solely for screening purposes without identified clinical indications for such services based on symptoms or existing diagnoses.
- **Negative Studies or Clinically non-contributory studies** - imaging studies that are negative in a large percentage of the cases, or that are clinically non-contributory to the subsequent clinical course of care.
- **Studies with and without contrast** - imaging studies repeated in a short period of time on the same body area differing only in whether contrast is used.
- **Adjacent Body Areas** - Imaging studies repeated in a short time on adjacent body areas.
- **Coordination of Care**

There is an Excel spreadsheet that should be used to submit your input. Given the scope of this request, L&M will only be able to accept suggestions provided in that format. The Excel spreadsheet can be downloaded at the following website: http://www.imagingmeasures.com

Suggestions submitted in this form should be sent no later than June 9, 2008. ❖

Highlights of CSNS Meeting April 25-26, Chicago, Illinois

The recently concluded meeting of the Council of State Neurosurgical Societies was well attended by 74 delegates representing 28 states and the AANS and CNS plus 9 resident delegates. As is usual, the focus was on resolutions to be considered plus reports by various committees and individuals. First, the resolutions:

1. **RESOLUTION I—Referred to Medical Practices Committee to study**

Title: A Neurosurgical Code of Ethics for the Practice of Spinal Surgery
Submitted by: Gary R. Simonds, M.D.
BE IT RESOLVED, that the CSNS produces a series of ethical guidelines for the practice of spinal surgery to be endorsed by the AANS and CNS and, to be disseminated to all neurosurgeons; and
BE IT FURTHER RESOLVED, that these guidelines should be collated into a publishable "Code of Ethical Behavior" that can be readily displayed by neurosurgeons in their offices. Such a publication could be produced in paper form or, at less expense, could be made downloadable from the CSNS website; and
BE IT FURTHER RESOLVED, that the Medical Practices Committee develops said guidelines- to be approved by the CSNS body; and
BE IT FURTHER RESOLVED, that said ethical guidelines are offered to the representative bodies of Orthopedic Surgery in order to include Orthopedic "Spine Surgeons," and General Orthopedic Surgeons who practice spinal surgery, in their dissemination.

2. **RESOLUTION II—Adopted and sent to Rules and Regulations Committee**
   Title: Armed Forces Delegates to the CSNS
   Submitted by: CSNS Membership Ad Hoc Committee
   BE IT RESOLVED, that the CSNS establish membership for delegates from the Armed Forces as follows:
   1. There will be 3 delegates representing the Armed Forces to be chosen by the Joint Committee of Military Neurosurgeons by whatever method they choose. Alternate delegates may be selected. The delegates must be active members of the AANS or CNS. The Chairman of the Joint Committee shall submit the names of the delegates annually to the Recording Secretary of the CSNS.
   2. The delegates shall be voting members of the Quadrant in which they are primarily stationed. They shall vote in all matters pertaining to both the Council and in deliberations of their own Quadrant.

3. **RESOLUTION III regarding establishing a CSNS Military Committee was withdrawn by author**

4. **RESOLUTION IV—Adopted. Letter to be sent to AANS/CNS**
   Title: Re-Authorizing Balance Billing
   Submitted by: David McKalip, M.D.
   BE IT RESOLVED, that our CSNS asks the Boards of the CNS and the AANS to continue to work via the Washington Committee to advocate for national legislation to implement Medicare balance billing and the restructuring of the current Medicare Physician Payment formula; and
   BE IT FURTHER RESOLVED, that this national legislation be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.

5. **RESOLUTION V—Rejected as not reasonably attainable**
   Title: Ending the Global Period and the RBRVS System for Medicare
   Submitted by: David McKalip, M.D.
   BE IT RESOLVED, that our CSNS asks the Board of our AANS and CNS to take all necessary action within its means to end the global period for surgery in Medicare and work with allies within and outside organized medicine to do so; and
   BE IT FURTHER RESOLVED, that our CSNS asks the Board of our AANS and CNS to take all necessary action within its means to and end the RBRVS payment system and to return free market principles to the health care economy; and
   BE IT FURTHER RESOLVED, that our CSNS asks the Board of the AANS and CNS to direct its delegates to the AMA and all other representatives of the AANS and CNS to various groups in the private and public sector to support such action.

6. **RESOLUTION VI—Referred to Communication and Education Committee for study**
   Title: Neurosurgery Employment and Contracting Educational Campaign
   Submitted by: David McKalip, M.D.
   BE IT RESOLVED, that our CSNS develop an educational campaign designed to ensure that neurosurgeons are able to form contractual relationships that provide them the most benefit to their practice; and
   BE IT FURTHER RESOLVED, that our CSNS work with partners, such as the AANS, CNS and state neurosurgical societies, and consultants to enable them to develop such a campaign; and
   BE IT FURTHER RESOLVED, that the campaign emphasize clinical autonomy for the benefit of patients and the best possible economic value for neurosurgeons.

7. **RESOLUTION VII—Referred to Reimbursement Committee for study**
   Title: Opposition to Med PAC Bundled Payment Proposal
   Submitted by: Illinois State Neurosurgical Society
   BE IT RESOLVED, that the CSNS ask the AANS Board of Directors and the CNS Executive Committee to instruct the Washington Committee to vigorously oppose this idea of bundled payments to be shared between physicians and hospitals. The Washington Committee should actively use its influence at Med PAC, AMA, ACS, CMS and Congress to oppose this idea.

Now for a few of the reports/events of interest:

1. The Neurosurgery Executives' Resource Value and Education Society **(NERVES)** reported they now have over 200 members, adding 88 this last year and held their 7th meeting during which they reported on their 4th annual survey which documents just how hard their members work, how they are paid and how much, their specific overhead costs and the range of costs of providing an RVU. Their report can be obtained by non-NERVES members at a cost of $1000 (nervesadmin.com).
2. The **ACS report by Dom Esposito** included an update on the acute care surgeon concept being considered for implementation by the general surgeons who continue to experience trouble reaching a consensus on the issue. The amount of additional training in orthopedics and neurosurgery that would be necessary for acute care surgeons to operate as they propose has been a discouraging eye opener for them. Dr. Esposito along with Drs. Shelly Timmons maintain a strong CSNS neurosurgical monitoring presence at the ACS on this issue.
3. The **Workforce Committee** reported that in the near future, neurosurgery training programs will take control of the PGY1 (internship) year as part of their residency training program. The neurosurgical residency match will include this year which will be filled with rotations each program director deems best for the resident rather than rotations that satisfy the manpower needs of the various other specialties.
4. The **Determination of Brain Death in Adults and Children** report is still a work in progress by Katherine Mazzola and her CSNS Young Physicians/Resident Committee. She reports there is no national or real state mandated standards and that most protocols are generated by hospitals, many using a protocol published by the neurologists some years ago. She feels the neurology protocol could be improved and will invite neurologists, pediatricians and transplant surgeons to work on a new document that could function as a national resource.
5. **Dr. Peter Carmel**, the only neurosurgical AMA trustee (and recipient of the 2008 AANS Distinguished Service Award) reports that neurosurgeons are viewed by others as the biggest problem in the delivery of ED services. He encouraged organized neurosurgery to develop a solution before outside forces do it for us. He felt that regionalization of acute neurosurgical care would be the best and most immediate solution to the mismatch of ED numbers (4K), trauma centers (1.5K) to neurosurgeons (<3K). He also reported that the Baucus suggestion of increasing primary care payments at the expense of specialty payments has probably been stifled.
6. The **CSNS Reimbursement Committee**, which works hand in glove with the AANS/CNS Coding and Reimbursement Committee, has been sorting out the codes for stereotaxic radiosurgery and has sent to CMS a set of sensible codes that allow treatment of up to 5 lesions at one setting in the brain and spine plus a separate code for placement of head holder. If accepted, the codes will go into effect 1/1/09.
7. The **Washington Committee** reported that the Institute of Medicine is actively considering making a recommendation to reduce the resident work week hours to 56 from the current 80. They anticipate that the ACGME will follow their recommendations so if the 56 hour week is mandated by the ACGME, neurosurgery will strongly consider resigning as a member of the National Board of Medical Specialties and the ACGME it embraces. The Committee also will work toward getting CMS to moderate its position on not paying for "never" events such as a complicating wound infection since the incidence of the latter is never zero even under the best of protocols.
8. Speaking of residents, 12 new resident fellows were elected to serve a one year term as CSNS delegates with full voting privileges. Each quadrant elects three fellows and the new **Southwest Quadrant** fellows from California are Nandan Lad from Stanford and Charles Newman from UCSD. Many thanks to the SW quadrant resident delegates who have just completed their one year term: Drs. Azzie Farin, Chiraq Patil and Alex Khalessi, all from California training programs.
9. The **Quality Improvement Workgroup** of the Washington Committee continues to feel that the costs involved in partaking in the Medicare PQRI process will not be covered by the bonuses to be paid.

10. The **AANS/CNS Joint Guidelines Committee** continues to monitor all published or in progress guidelines and will not approve any that don't adhere to our recommendations. The committee is also starting to write a few guidelines of its own for consideration of adoption by the AANS/CNS.
11. The **Leibrock Lifetime Achievement Award** was presented to **Edwin Amyes** of Los Angeles for his herculean efforts on behalf of neurosurgery in the 1960s and 70s. Ed was a long term co-chairman of the Joint Section on Socio-Economics of the AANS/CNS, a recipient of the CNS Distinguished Service Award and was a driving force behind the formation of our grass roots organization, the Council of State Neurosurgical Societies, and served as its first chairman from 1977 to 1980.
12. The CSNS **Robert Florin Young Neurosurgeon Award** was won by **Zachary Litvak** from the University of Oregon who presented a study of what neurosurgeons in tort stressed states actually did following completing a CSNS survey in 2004 in which 30% said they would retire early, 19% said they would leave the state and over 40% said they would limit their practices. They noted that about 30% did retire but instead of an exodus of neurosurgeons there was a net increase in the state neurosurgical numbers in many states that were stressed in 2004 and remained so in 2007 which they felt was due to neurosurgeons filling the void created by those who limited their practices or retired. Of note was that the paper was part of the prime Monday morning AANS Plenary Session program and not relegated to the Socioeconomic program on Thursday (at which the CSNS Cone Pevehouse Resident Award paper by Shearwood McClelland from the University of Minnesota on Postoperative Intracranial Infection Rates in North America Versus Europe was presented).
13. **Jon Robertson, AANS President**, gave an address about ethics in our dealings with the medical device community. The AANS has had a very strict policy in place since 2004 governing their relationship with industry sponsors and our educational programs which should withstand major scrutiny. A recent set of guidelines governing the ethics of relations between the practicing neurosurgeon and medical device companies has been adopted by the Board of Directors and is listed on the AANS Web site and is reproduced as follows:

GUIDELINES ON NEUROSURGEON-INDUSTRY CONFLICTS OF INTEREST

The physician-patient relationship is the central focus of all ethical concerns.
A neurosurgeon shall, while caring for and treating a patient, regard his or her responsibility to the patient as paramount.
A neurosurgeon shall prescribe drugs, devices, and other treatments on the basis of medical considerations and patient needs, regardless of any direct or indirect interests in or benefit from industry.
The practice of medicine may present potential conflicts of interest. When a conflict of interest arises, it must be resolved in the best interest of the patient. If the conflict of interest cannot be resolved, the neurosurgeon should notify the patient of his or her intention to withdraw from the relationship.
A neurosurgeon shall, when treating a patient, resolve conflicts of interest in accordance with the best interest of the patient, respecting a patient's autonomy to make health care decisions.
When a neurosurgeon has a financial interest (as defined in Appendix A) that is related to any aspect of a patient's evaluation and care, a potential conflict exists which should be disclosed to the patient. It is unethical for a neurosurgeon to receive compensation of any kind from industry in exchange for using a particular device or medication in clinical practice. Reimbursement at fair market value for documented administrative costs in conducting or participating in a scientifically sound research clinical trial is acceptable.
A neurosurgeon who has influence in selecting a particular product or service for an entity (organization, institution) shall disclose any relationship with industry to colleagues, the institution and other affected entities.
A neurosurgeon shall enter into consulting agreements with industry only when such arrangements are established in advance and in writing to include evidence of the following:
• Documentation of an actual need for the service;
• Proof that the service was provided;
• Evidence that physician reimbursement for consulting services is consistent with fair market value; and
• Not based on the volume or value of business he or she generates for the corporate industrial entity.
A neurosurgeon shall participate in or consult at only those meetings at which CME is awarded when they are conducted in clinical, educational, or conference settings conducive to fair, balanced, and accurate exchange of information.

A neurosurgeon shall accept no financial support from industry to attend industry-related social functions without a related educational element.
A neurosurgeon who is attending a CME activity shall accept no industry financial support for attendance at a CME activity. Residents and neurosurgeons-in-training may accept an industry grant to attend a CME activity if they are selected by their training institution or CME sponsor and the payment is made by the training program or CME sponsor. *Bona fide* faculty members at a CME activity may accept industry-supported reasonable honoraria, travel expenses, lodging and meals from the conference sponsors. Industry shall have no involvement in the selection of faculty, topics, location, or venues for CME events; that is the sole responsibility of the sponsoring organization.
A neurosurgeon, when attending an industry-sponsored non-CME educational activity, shall accept only tuition, travel and modest hospitality, including meals and receptions; the time and focus of the activity must be for education or training. When appropriate, faculty may receive a reasonable honorarium, which may include reasonable travel expenses.
A neurosurgeon, when attending an industry-sponsored non-CME educational activity, shall accept no financial support for meals, hospitality, travel, or other expenses for his or her guests or for any other person who does not have a *bona fide* professional interest in the information being shared at the meeting.
A neurosurgeon, when reporting on clinical research or experience with a given procedure or device, shall disclose any financial interest in that procedure or device if he or she or any institution with which he or she is connected has received anything of value from its inventor or manufacturer.
A neurosurgeon who is the principal investigator shall make his or her best efforts to ensure at the completion of the study that relevant research results are reported truthfully and honestly with no bias or influence from funding sources, regardless of positive or negative finding. ❖

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).

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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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