



President's Message: End of Life Care

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

A few days ago, in the surgeons' lounge at my community hospital, a family physician asked a cardiovascular surgeon: "what do you do if you were asked to do a coronary bypass on a DNR patient?" Before getting a chance to answer, the family physician asked an orthopedic surgeon who was also there: "what would you do if you were asked to pin a broken hip of a DNR patient?"

The orthopedic surgeon's answer was unequivocal: "I'd do it."

The cardiovascular surgeon's answer was more nuanced: "I'd ask his physicians to change his code status, then, operate on him."

Clearly, the orthopedic surgeon wants to decrease the patient's pain and suffering and wants to make his care easier for the health care providers: nurses, therapists, aides and family members.

However, the cardiovascular surgeon's response was puzzling.

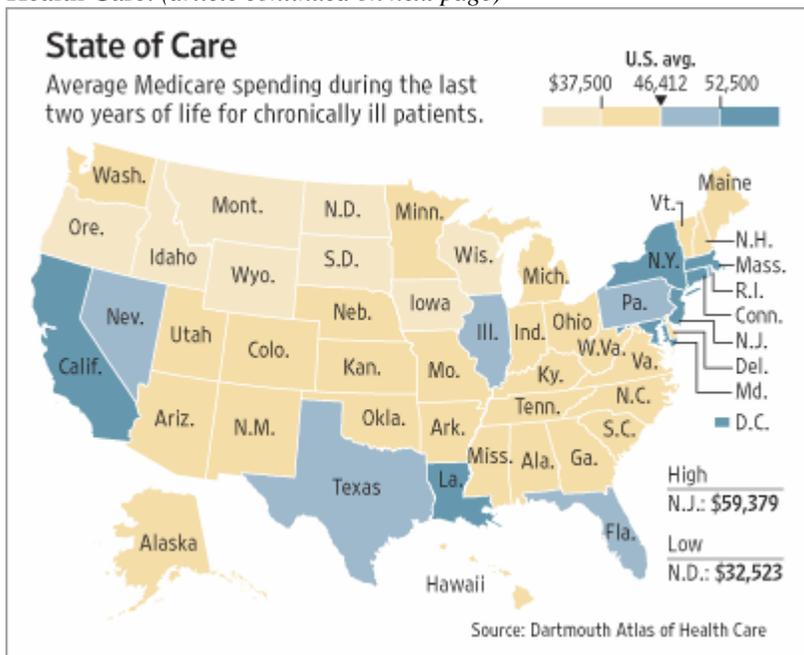
Is it ever appropriate to say that the patient should be allowed to die without surgery? When is it acceptable?

End of life care is gaining more attention as the debate about health care rages on. Everyone is familiar with the statistics that 12% of all health care related expenditures are incurred during the last year of life. Similarly, Medicare spends 27% of its budget during the same period. 25% of Medicare spending on acute hospital care is also spent during the last year of life.

What is interesting about this is the fact that people are not happy with the care they are receiving; often, they feel that doctors are quick to order expensive tests and invasive procedures as they take care of them, while realizing that they are dying.

There is a strong interest among patients who are approaching the end of their life to adopt "slow Medicine", a more holistic approach to the issue (Please see [LA Times article by Carol Mithers, May 26, 2008.](#)) She gives several examples where care should have been different, or slow if you wish. Each of us has experienced first hand similar cases, but often, we are impotent to reverse the direction of the care that has already been prescribed by other physicians for a particular patient. Frequently, we strongly believe that the care is futile!

Nor is the amount of dollars spent for end of life care constant: it varies tremendously from state to state-*please see graph below.* This graph is taken from an often quoted Dartmouth Study, summarized in the Dartmouth Atlas of Health Care. (*article continued on next page*)



Inside this issue:

You, the Internet & Nastygrams – page 2

EMTALA Rules (one's a bummer) – page 3

Executive Office Report – page 5

Oregon Trail Looks Good – page 6

ACS a Skill for PQRI – page 6

Letter to Editor – page 6

USC Training Program – page 7

Peer Reviewers Wanted – page 9

Additionally, there are a lot of variations based on ethnic and racial backgrounds. This has been documented here in California, by the California HealthCare Foundation in a report whose lead author is LaVera Crawley, M.D., M.P.H., a Stanford University medical ethics researcher.

What this actually is telling us is that the amount of spending during the end of life is not based on scientific and medical need; rather, it is based on personalities, location and style.

An article in the latest AARP magazine, July & August, 2008, by Shannon Browlee, a Senior Schwartz Fellow at the New America Foundation claims that we spend \$500,000,000,000.00 on unnecessary care in this Country. She may be right, and if she is, then this abuse is most flagrant during the end of life.

What do we do about this?

- Physicians need to realize that when they order “stuff” that is not needed and that will not make a difference in the long term for a patient who entered the end of his life, they are actually spending their own money. It is our own money since we pay more than our share in taxes.
- Patients have to take some of the responsibility as well. Perhaps each individual should be expected to execute a detailed health care directive before their Medicare benefits are activated. And they should really understand what it means to go to the hospital Emergency Room in the middle of the night.
- Patients’ families must be willing to become educated regarding their loved-ones’ condition, have realistic expectations and be prepared to make the tough calls that they usually shift to physicians that are not as familiar with the patient. “Do everything” is a cop-out. Blaming the doctors, in retrospect, for prolonging the agony is easy, but it is not the responsible thing to do. Understanding what “doing everything” means is an absolute must for patients and families.
- Hospitals must have a sophisticated social service and spiritual care service that can function as a team to help physicians interact with patients who are approaching their end of life, as well as their families.

This is one National issue that must be solved on a personal level! ❖

You, the Internet and Nastygrams

Randall W. Smith, M.D., Editor

The internet appears to have spawned any number of doc rating sites apart from those proposed by insurance companies and Zagat based upon patient surveys. These free-wheeling rating sites, in the name of the “any information is better than no information” mantra, are immune from defamation lawsuits and a defamatory posting is hard to counter because of the general difficulty in successfully prosecuting these suits and the anonymity of those submitting the posting. Many say the reviews on sites such as RateMDs.com, Vitals.com, DrScore.com and others are skewed by disgruntled patients and are thus unfair, pushing some doctors to near-ruin after a single post.

That the posting of a nastygram can be potentially harmful is demonstrated by the case of Dr. Richard Fischel, a thoracic surgeon in Orange, whose life was jumbled after a patient decided his life was ruined because he experienced a pre-surgically discussed side effect of an elective procedure Fischel performed. Fischel, who graduated from UCLA medical school in 1984 and is now director of thoracic oncology at Hoag Hospital in Newport Beach, says the patient posted “slandorous rants and raves.” Fischel says that his business was severely affected and that he suffered significant monetary and emotional costs because of the patient's postings. Fischel hired a lawyer to try to make the patient stop writing about him and became so depressed he considered leaving medicine.

So is there anything for a doc to do besides play defense and hope posted comments are laudatory? Dr. Jeff Segal thinks so. This is the Dr. Segal who is CEO of Medical Justice Inc., a company whose concept of fighting meritless malpractice suits we have mentioned before in this newsletter. He feels a better option is to treat the problem before it is a problem; a reputational vaccine of sorts. The details: Patients, when first seen, are asked to sign a contract of mutual privacy. The patient and the doctor agree to maintain reasonable confidences. For the patient, they are foreclosed from postings on the web about the doctor’s care without the doctor’s permission. One could easily imagine many situations

where such permission would be reasonably and readily granted. This contract is implemented as a matter of policy for most, if not all, patients. If an anonymous posting appears on a ratings site, the next step involves sending a template of the privacy contract to the site. An accompanying letter explains that the poster represents he is your patient. Like all patients, this patient signed an agreement to maintain confidentiality. If the ratings site does not remove the posting, the site may be at risk for tortious interference with your contract.

Medical Justice's value will be the template mutual privacy contract, the wherewithal to monitor the numerous rating sites and appropriate follow-up. Medical Justice is still in the process of formulating just how much of the above monitoring and follow-up they will do and the pricing for the service.

A more complete reporting about Dr. Fischel's case and others like it can be found on the LA Times Web site at <http://www.latimes.com/features/health/la-he-docratings19-2008may19,0,6851576.story> and Medical Justice's site is www.medicaljustice.com. ❖

Proposed New EMTALA Rules—One a BUMMER

Randall W. Smith, M.D., Editor

Neurosurgery's EMTALA man is John A Kusske, M.D. who served as the AANS/CNS Health Policy Liaison and EMTALA TAG member and Chairman of the TAG On-Call Subcommittee. John worked hard for us to make the rules better and as can be seen in his somewhat edited report that follows, he hit a double.

The Department of Health and Human Services (HHS) convened the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG) to gather input on how revised regulations and enforcement, of the EMTALA statute, are working in practice. The TAG, over its 30-month charter discussed concerns about EMTALA raised by TAG members as well as public testifiers. Deliberations were aimed at the best approach to revise the EMTALA statute, regulations, and Interpretive Guidelines, to address those concerns. In the course of its work the TAG submitted 55 recommendations to the Centers for Medicare and Medicaid Services (CMS) and five of those have already been implemented by CMS.

At present CMS has published Proposed Changes as noted below and plans to adopt more of the TAG's recommendations in the future.

CMS is proposing to amend EMTALA regulations to add a provision that asserts that when a patient covered by EMTALA is admitted as an inpatient and remains unstabilized with an Emergency Medical Condition (EMC), a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual assuming that it is an appropriate transfer and the recipient hospital with specialized capabilities has the capacity to treat the patient. This was one of the TAG's most contested recommendations and was **strongly opposed by eight members of the TAG**. They voiced their objection by writing a formal letter to the TAG's chair expressing their concerns. When CMS revised the EMTALA Interpretive Guidelines in 2003, the agency established a new policy that a hospital's EMTALA obligation ends when that hospital admits an individual with an unstable EMC as an inpatient. This policy was adopted to clarify whether or not EMTALA applied to inpatients and to establish a clear cut rule. This topic was discussed, in detail, at the TAG meetings, and it was not clear to all members that evidence was presented to warrant the proposed CMS change. The American Hospital Association maintained that the present regulations are adequate because hospitals are required to render appropriate care to inpatients by other statutes. Further, the opinion was asserted that the policy could be abused and the number of patients "dumped" from one hospital to another would increase. Concern remains that if this recommendation is approved, there will be an adverse effect on patient care and the number of unnecessary patient transfers will increase. **All of the practicing surgical specialty physicians on the panel as well as all the hospital representatives on the panel were opposed. The AANS and CNS have strongly recommended that CMS not adopt this proposed policy.**

The TAG recommended that CMS move the regulation that discusses the hospital's obligation to maintain an on-call list from the EMTALA regulations to the regulations implementing provider agreements. CMS, in the proposed rule, agrees with the TAG and proposes to delete the provision relating to maintaining a list of on-call physicians from §489.24(j)(1) and replace it with new §489.20(r)(2) language, which would require hospitals to maintain:

"An on-call list of physicians on its medical staff available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under [EMTALA] in accordance with resources available to the hospital."

This change is important because it also removes “best meets the needs of the hospital’s patients” language in the present regulations. As was stated earlier, in AANS/CNS testimony the “best meets the needs” requirement is a vague standard, which may invite a whole new body of litigation defining this requirement. One of the purposes for revising the EMTALA regulations and guidelines was to better clarify the law’s requirements. The proposed language is better than the vague “best meets the needs” standard. In testimony before the TAG it was apparent that the best meets the need standard was the basis for increasing numbers of law suits against hospitals.

Shared/Community Call, while not exactly regionalization, addresses some of the challenges that hospitals and on-call specialists must deal with when providing adequate on-call coverage. The Institute of Medicine in its Future of Emergency Care series notes that the current EMTALA rules may be hampering the adoption of regionalization or community call arrangements because even with the 2003 EMTALA rule changes, “uncertainty surrounding the interpretation and enforcement of EMTALA remains a damper to the development of coordinated, integrated emergency care systems.” CMS has acknowledged that community call would “afford additional flexibility to hospitals providing on-call services and improve access to specialty hospital services for individuals in an emergency department.” Specifically, **CMS has proposed to define community call as a “formal on-call plan that permits a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both.”**

It is thought that such an arrangement will allow physicians in a particular specialty to better provide 24/7/365 emergency call coverage, without putting a continuous obligation on any one physician or group of physicians. It is hoped that because CMS has endorsed the concept of community call and removed the EMTALA impediments to formulating such shared call plans, that patient access to timely emergency care will be improved.

There are several other EMTALA TAG recommendations that are not addressed in this proposed regulation but are supported by organized neurosurgery. These recommendations are listed below and can also be found in the *Final Report of the Emergency Medical Treatment and Labor Act Technical Advisory Group* to the Secretary U.S. Department of Health and Human Services at www.cms.hhs.gov/FACA/07_emptalatag.asp. The AANS/CNS has urged CMS to adopt the below recommendations as soon as possible.

The TAG recommends that CMS continue to not require physicians to take emergency call as a Condition of Participation in Medicare.

The following statements represent the consensus of the TAG, which **recommends that CMS incorporate the(se) concepts** into Interpretive Guidelines for 489.24(f), recipient hospital responsibilities:

- The presence of a specialty physician on the call roster is not, by itself, sufficient to be considered a specialized capability. At the time of the transfer, the receiving hospital should also have available the necessary equipment, space, staff, etc. to accommodate the patient transfer.
- The presence of a physician who has privileges at the receiving hospital but is not on the call roster or who is not on call at the time of the transfer should not be considered a specialized capability.

The TAG recommends that 489.20(4)(2) be interpreted by CMS as meaning that all hospitals, including specialty hospitals, should maintain a call list in accordance with the statute and provider agreement. If necessary, the Interpretive Guidelines at TAG 404A should be revised to clarify this point.

The following statements represent the consensus of the TAG, which **recommends that CMS incorporate these comments** into the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

- Response times should be defined in a range of minutes, not a single number of minutes.
- Response time should refer to the initial response by the physician on call.
- Through their medical staff bylaws, hospitals may define who may respond on behalf of the on-call physician (i.e., physician’s designated representative).
- The initial response may occur by phone (or other means).
- Hospitals should develop policies and procedures to address the response time and appropriate exemptions.
- A physician’s failure to respond when called or failure to arrive at the hospital when requested may be a violation of EMTALA.

The TAG recommends that CMS delete the following paragraph in the Interpretive Guidelines for 489-24(j), availability of on-call physicians:

Physicians that refuse to be included on a hospital's on-call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable) may violate EMTALA. If a hospital permits physicians to selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

The following statements represent the consensus of the TAG, which recommends that CMS incorporate these concepts into the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

- When a physician takes call for patients with whom he/she has a preexisting medical relationship, that is not considered "selective call."
- When a physician is not on the call roster, he/she is not obligated to provide call coverage (e.g., when he/she is in the hospital seeing patients).
- If the EMTALA-related call list is adequate and meets the requirements of the statute, physicians may see patients in the hospital as they see fit.
- A physician on call must see patients without regard for any patient's ability to pay.
- If a physician volunteers to see patients in the ED while not participating in the call list, the physician must agree to see patients regardless of any patient's ability to pay.
- If a surveyor identifies a discriminatory or disparate pattern of selective referral for specialty care on the basis of patients' ability to pay, that is potentially a violation of EMTALA.
- Hospitals should be reminded of their obligation to fulfill call coverage duties, e.g., they should not permit discrimination to occur.

The TAG recommends that HHS amend the Interpretive Guidelines with respect to follow-up care to clarify that once a patient has been stabilized, the hospital and physician have no further follow-up care obligation under EMTALA. The hospital must, however, comply with applicable Medicare Conditions of Participation. The TAG believes this interpretation is more consistent with the EMTALA statute and regulations, which no longer apply once the patient is stabilized and current CMS interpretation.

The TAG recommends HHS change the Interpretive Guidelines to state the following:

The hospital must have a **backup plan for patient care** when it lacks capacity to provide services or on-call physician coverage is not available. The backup plan should consist of viable patient care options, such as the following:

- Telemedicine
- Other staff physicians
- Transfer agreements designed to ensure that the patient will receive care in a timely manner
- Regional or community coverage arrangements

The TAG recognizes that reimbursement is a major factor that impacts hospitals' and physicians' ability to provide emergency care and recommends that HHS act to support amending the EMTALA statute to include a funding mechanism for hospitals and physicians. ❖

Executive Office Report

Janine Tash

Annual Meeting

Plans are underway for a stimulating program next January at the [Quail Lodge Resort and Golf Club](#) in Carmel. The CANS meeting will take place Saturday and Sunday mornings (January 17-18, 2009). This will leave the afternoons free for golf or any other of a multitude of activities in the area. Dr. Abou-Samra is actively recruiting some excellent speakers and these will be announced in the next couple of issues of this newsletter. Hotel reservations can be made now (the sooner the better since the deadline is December 15, 2008); see attached form (last page).

Nominations

Please remember to return your nominations for **2009 CANS officers** as well as candidates for the **Pevehouse** and **Ablin Awards**. The deadline was July 1 but nominations will be accepted until Monday, July 7th. Contact the CANS office if you have misplaced your nomination forms. ❖

More News from the Editor

The Oregon Trail Looks Good From Here

Just as most politics are local, so too is the definition of bad news. It seems that the state of Oregon is in the throes of adjusting their Work Comp payments to favor E&M codes and reduce surgical fees. Oregon already has adopted the RBRVS, but as noted in last month's newsletter, the devil is in the details of the conversion factor used to calculate reimbursement. Surgeons in Oregon have enjoyed a conversion factor of \$93.66 per RVU (versus \$59.79 for E&M codes) or about 250% of Medicare. The new payment rules will drop the surgical conversion factor to \$86.44 and the surgeons are howling. Oh that California surgeons should have this problem! Our present Work Comp conversion factor is about \$150% of Medicare and as further noted last month, that is in danger of falling further what with the likely adoption of the RBRVS system—again with the conversion factor for surgery still an unknown. Maybe we should send a bus to Oregon.

Additionally, Oregon's new Comp rules totally prohibit compensation for artificial disc replacement surgery on the advice of its Medical Advisory Committee which is almost totally populated by docs. One wonders if California's Medical Advisory Committee, presumably looking at the same medical evidence, will reach the same conclusion. ❖

The ACS a Shill for PQRI

The Executive Director (ED) of the American College of Surgeons, in the June 2008 issue of the ACS Bulletin, encourages us all to participate in the Medicare PQRI program. The ACS actually produced 6 measures applicable to surgery including neurosurgery. He reported that 99,000 Medicare participating physicians, practitioners and therapists played the PGRI game in 2007 with about half qualifying for the 1.5% Medicare payment bonus (one wonders about the reasons for the other half not qualifying). Since the PQRI program has been renewed for 2008, he feels that "Clearly the PQRI and its related programs are here to stay." He feels that "... there is no going back (to the ways of the past), so we have no choice but to move forward." One presumes his comments reflect ACS policy.

Juxtaposed to this ACS position is the Quality Improvement Workgroup of the AANS/CNS Washington Committee which, while not taking a position on the merits or lack thereof of the PQRI program, advises that the bonus payment is unlikely to cover the costs of participating in the program, an issue the ACS ED does not address.

One harkens back to the 1980's when the Professional Standards Review Organizations (PSROs) were the latest and greatest way to get all us docs to hew to the quality line. The PSRO movement died a natural death predominantly because it was promulgated by the same CMS and national legislators, intimately uninvolved in the delivery of healthcare, that are sure the PQRI initiative is the way to go. How about the Feds asking the troops in the trenches to devise what approach to quality makes some real sense and then implementing it rather than making pronouncements from on high? Perish the thought. ❖

Letter to the Editor: Corporate Bar of Medicine

John T. Bonner, M.D., CANS Past President

In a few days, my wife, one of my daughters and I will drive north to my home state of Montana. I am always impressed that the structures, trees and other environmental items in Montana appear more three-dimensional – they are exceptionally clear due to the altitude and lack of pollution. But, some years ago, the physicians of Montana lost their professional clarity by allowing the corporate bar of medicine to be eliminated.

Here in California, we have maintained the corporate bar of medicine, which is so important to physician autonomy in patient care. Indeed, the corporate bar of medicine issue is a contemporary concern. On June 20, 2008, AB 1944 (Swanson) was killed in the Senate Health Committee. This bill would have allowed district hospitals to directly hire physicians, eroding the corporate bar of medicine in California. We should be very grateful to the CMA and its lobbyists for their great work in defeating further consideration of this bill. Unfortunately, the existence and importance of the corporate bar of medicine is not known or recognized by many of our physicians, especially the younger ones.

The corporate bar of medicine in California serves to protect against inappropriate non-physician control and influences on the practice of medicine. The policy, in Business and Professional Code Sections 2400 and 2052, protects physicians from the interference and influence on physician practice and judgment by medically unlicensed persons. It directs that health care decisions should be made by licensed physicians only. Under the corporate bar of medicine, lay entities cannot hire or employ physicians or interfere with their practice of medicine. Certainly there are physicians directly employed by hospitals and other corporate or business entities, but they cannot be hired to practice medicine, and many such physicians are in teaching, administrative, research or other non-direct medical practice positions. Groups such as Kaiser and Sutter are not in violation of the corporate bar of medicine as they are physician groups who organize to practice medicine, and their group contracts with the hospital or business entity to deliver medical care.

Nonetheless, I am concerned that many young physicians do not have such concern for the independent practice of medicine, and would be happy to be directly employed, as so many are disinterested in the independent practice of medicine, especially since so few are now entering private practice. Consideration of lifestyle issues, including family and mutual economic concerns, often take precedence over more important ultimate professional consideration.

Many physicians who have lost the corporate bar of medicine, such as those in Montana, are directly employed by hospitals and delivery systems, and end up very dependent on their employers, who can hire and let physicians go as they desire. Most communities in areas such as Montana practice in cities with only one hospital, so they are dependent and influenced by their employer. If one does not agree with medical and hospital care, the option of moving one's practice to another local facility is rarely available, so medical delivery control is very prominent. Physician profiling in areas such as Montana, in contrast to California -- where it is supposed to mean the measure of efficient and economic delivery of care -- often is dependent on whether the physician has invested in a facility, such as an imaging or surgical center, that the hospital considers itself to be in competition with. *On that basis alone*, the physician can be stripped of hospital privileges, which many specialty physicians need to remain in active practice. Also in Montana, nurse practitioners and physician assistants often independently practice; and in Butte, Montana a nurse practitioner has brought legal action against Butte's only hospital and some of its physicians since she was denied independent hospital admitting privileges.

Neurosurgical practice in Montana is somewhat different than ours in California. In Montana there are 25 neurological surgeons serving a population of 915,000 in a state next in geographical size to California. Montana, being 145,556 square miles -- has only 6.2 persons per square mile with no Level I trauma centers in the state, and only four Level II trauma centers (Great Falls, Missoula and two in Billings). Yet, Montana is a high trauma area. There are many miles of highways utilized at high speed (which I myself occasionally enjoy). There is high ATV use, and motorcycle riders who disdain the use of a helmet. And, Montana has one of the largest number of guns per capita in the country, but proportionately much less gunshot wounds than California and most of the nation (not much gang activity or strife between population or ethnic groups). But transportation to medical care, as necessary, is a big problem in many areas, particularly with long distances and the long, harsh winter which comes early and exceeds the usual winter season.

We in California have it easy. Our access to facilities, emergency transportation systems and expert specialized care, MICRA and, especially, the corporate bar of medicine are features that facilitate our delivery of care and our lifestyle. I often wonder if physicians in California appreciate the importance of these institutions. It would be a travesty should California abandon the corporate bar of medicine, which protects and promotes physician independence from influence and interference in patient care. ❖

USC Neurosurgery Training Program

Randall W. Smith, M.D.

(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: USC. -Ed.)

The first academic neurosurgical service in the state of California was established by Carl Rand back in 1919 in Los Angeles. The Residency Training Program at USC was established in 1927. There have been three subsequent Chairmen of the training program between 1954 and 2004: Frank Anderson, Ted Kurze, and Martin Weiss all of whom have made major contributions to neurosurgery. The Neurosurgery Service became a full-fledged Department of

The USC Keck School of Medicine in 1980. In 2004, Steve Giannotta assumed the Chairmanship of the Department. There are currently thirteen full-time faculty members, two resident supervisors, three Clinical Assistant Professors and a number of Voluntary Faculty.

As with virtually all academic departments in the State of California, the USC Department is organized along subspecialty lines. **The Pituitary/Endocrine Service Line** was established and is led by **Marty Weiss**. Along with Charles Liu the service has operated on over 4500 pituitary tumors and produced over 75 major publications in the literature dealing with endocrine aspects, approaches, craniopharyngiomas and Rathke's Cleft Cysts.

The **Pediatric Neurosurgery Service** is housed at Childrens Hospital of Los Angeles under the leadership of **Gordon McComb**. Mark Krieger, who trained at USC and did his fellowship with Gordon, shoulders half the load of a very busy clinical service performing over 700 cases/year. They have trained 12 pediatric neurosurgical fellows and produced over 150 manuscripts in the pediatric neurosurgical literature.

Mike Apuzzo has established one of the most clinically and academically prolific **Radiosurgical Centers** in the country. Starting in 1983 with Linear Accelerator based treatment at the Norris Cancer Hospital, the Service has expanded to include all models of the Gamma Knife Technology and as of 2003, introduction of the Cyberknife Technology at USC. Currently the Perfection Model Gamma Knife is being installed at USC University Hospital. In his spare time, Dr. Apuzzo serves as editor of the journal *Neurosurgery*.

The **Vascular Service Line**, headed by Dr. Giannotta, was one of the first in the country to embrace Interventional Neuroradiology as full-fledged Neurosurgical Department members. George Teitelbaum and Don Larsen joined the Department in the mid 1990s, added Charles Liu in 2003 with over 2500 aneurysms and 500 arteriovenous malformations treated.

Thomas Chen, MD, PhD heads the **Neuro-oncology Service Line**. He has organized a multidisciplinary and multi-institutional research team to tackle some of the most vexing problems in Neuro-oncology. Innovative ideas for future treatment paradigms that have emerged include modulation of ER stress, targeting the glioblastoma endothelial cell, using a retrovirus for delivery of antitumor agents, development of intranasal delivery of chemotherapy and nanotubes for the possible employment of hyperthermia in tumor treatment.

Dr. **Peter Gruen** leads the **Trauma/Critical Care Service and Peripheral Nerve Service**. He is the Director of the Brain Injury Clinic at LAC+USC Medical Center and is a collaborator in our medical center wide brachial plexus program. He is the former Chief Medical Officer of County General Hospital and is actively engaged in producing complex management protocols for the Neurosurgical ICUs both at County General and USC University Hospital.

The **Adult Epilepsy Program** is headed by **Charles Liu**. Along with a high output practice at USC University Hospital the multi-disciplinary comprehensive adult epilepsy group is now providing its services County wide both at LAC+USC Medical Center and Rancho Los Amigos National Rehabilitation Center.

Thomas Chen heads the **Spine Stabilization Service**. He was trained in Milwaukee in spinal stabilization and spinal oncology. A Minimally Invasive Spine Program will be led by new faculty member Patrick Hsieh upon his arrival in July.

A **Movement Disorder Program** is headed by **Mark Liker**, Assistant Clinical Professor, and his partner, **Sherwin Hua**. The Service performed over 30 implants last year for movement disorders including Parkinsons tremor and dystonia.

Steve Giannotta has developed a service line specifically for the management of **trigeminal neuralgia and hemifacial spasm**. The service offers microvascular decompression for both conditions along with the Gamma Knife Radiosurgery and balloon microcompression for trigeminal neuralgia.

Stefan Lee, PhD is the Director of the **Neurosurgical Research Labs** at USC. He has formed multidisciplinary teams which that include neurosciences on USC's main campus. Projects include a neurochip prosthesis, glutamate electrodes for assessing brain chemistry and MRI/DTI imaging tractography in patients with cognitive impairment.

The Neurosurgery Department's **Residency Training Program** attracts applicants from Columbia, Johns Hopkins, UCSF, Stanford, USC and others. In the past academic year, residents have produced 30 peer reviewed manuscripts and presented 33 oral or poster presentations at national meetings. They have been the recipients of a number of awards and fellowships including the Academy of Neurology Research Fellowship, the CSNS Resident Fellowship, Richter Fellowships and Howard Hughes Research Fellowships. Since 1992, 23 of 28 USC residency graduates have taken academic positions, most of them outside of the state of California. USC-trained faculty serve at Columbia, Barrow Neurological Institute, MD Anderson, Mt. Sinai Medical Center, Yale, UCLA, Case Western Reserve, University of Utah and others. Recent graduates include three Neurosurgical Department Chairs and four Neurosurgical Program Directors among the current 97 US Training Program for Neurological Surgery.

The affiliated training sites for the USC Residency Program are about to undergo dramatic changes. The replacement facility for the County General Hospital is due to be occupied within the next three to four months. This will be a notable event in the history of Los Angeles given the fact that the current County facility opened in 1932 and has cared for millions of patients and trained thousands of California physicians. USC University Hospital, by virtue of its Norris Wing, will grow to over 400 beds and incorporate the operations of the Norris Cancer Center within one University Hospital setting. And finally, Childrens Hospital of Los Angeles will open a replacement facility within the next two years.

Clinical Trials Available at USC (Contact Judy Mao 323-442-7544, judy.mao@surgery.usc.edu)

1. Delivery of 131I-antibody to tenascin for newly diagnosed malignant gliomas (Bradmer Pharmaceuticals).
2. Vaccine therapy for malignant gliomas with EGFR mutations (Celldex Pharmaceuticals).
3. Use of synthetic hCRF for steroid weaning in malignant brain tumors (Celtic Pharmaceuticals).

Faculty (phone number and E-mail addresses available on the USC Neurosurgery Web site at http://www.usc.edu/schools/medicine/departments/neurological_surgery/)

Martin Weiss
 Michael Apuzzo
 Gordon McComb
 Steven Giannotta
 George Teitelbaum
 Tom Chen
 Don Larsen

Peter Gruen
 Cheng Yu PhD
 Srinath Samudrala
 Mark Krieger
 Charles Liu
 Stephan Lee PhD



Peer Reviewers Needed

Lumetra, the Quality Improvement Organization (QIO) for Medicare in California, needs physicians to perform peer reviews of medical care issues under. These cases usually involve a complaint (by a beneficiary or other source) regarding quality of care, or, less frequently, a utilization management issue and generally entail an implicit medical review of medical records. Lumetra prepares questions based on the complaint or other issue to be addressed and sends the query along with pertinent medical records to the reviewer, who will then answer these questions in writing. The handling of these cases must be prompt, usually within five days, sometimes less, depending on the question.

If the reviewer identifies quality concerns or utilization management issues, a letter is sent to the appropriate parties to give them an opportunity to present their side of the story. If they respond, the original reviewer (if possible) reviews the additional information in order to produce a determination that includes as much input as possible. Of course, there is an opportunity for appeal if the peer review is not acceptable to the involved facility or practitioner.

Peer reviewers remain anonymous outside of Lumetra, and will not be involved in any litigation that may follow a review. Most reviews require about 45-60 minutes, depending on the questions involved. Reimbursement is \$90/hour for time spent doing the review. There is no up-front time commitment for the program; if someone is available when a case comes up, they will be sent the case. If not, someone else is called.

To become a peer reviewer with Lumetra, practitioners must be board certified, have hospital privileges, and be in active clinical practice seeing patients at least 20 hours per week. To apply, contact Lumetra at the address below or go to the Lumetra website at <http://www.lumetra.com/programs/index.aspx?id=61&rpID1=239>. ❖

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*January 17-18, 2009
CANS Annual Meeting
Banquet at Monterey Bay Aquarium*

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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Editorial Assistant: Janine M. Tash



Group Reservation Request

*** Reservations: 888.828.8787 Guest Fax: 831.624.3726

California Association of Neurological Surgeons

Group Arrival Date: 01/15/2009

Group Departure Date: 01/19/2009

Nightly Rate: Luxury Room \$160.00

Group Code: CAL0109

Reservation Deadline: December 15, 2008

IMPORTANT NOTE: After December 15th reservations will be made based upon the hotel's availability and at the hotel's prevailing rate.

Please provide the following information:

Your Arrival Date:

Your Departure Date:

Name:

Telephone:

Company:

Number of Guests:

Mailing Address:

Send confirmation via e-mail Fax

e-Mail address:

Fax Number:

Room Type request:

Luxury room facilities include:

One King or Two queen-size (based upon availability) pillow-top bed with Italian linens, Expansive bathroom , Luxurious bath products, 42-inch oversize plasma screen TV, DVD and CD player, High-speed Internet access, Brand name honor bar and fitness center.

Deposit:

A deposit of the first night is required at the time of reservation. Please complete the information below. Rates are exclusive of a 10.5% occupancy tax, \$20.00 nightly resort fee and \$1.00 nightly county tourism assessment that will be added to each night's stay. Resort fee will be used towards Front Services & Housekeeping employee gratuities.

Cancellation:

Cancellation of a reservation made prior to **30 days** of arrival will receive a full refund. Cancellations made within 30 days will be charged a one-night cancellation fee.

Credit Card Type (please circle one): Visa MasterCard American Express Discover Diners Club

Card Number:

Expiration Date:

Full Name on Credit Card: