President’s Message
Javed Siddiqi, M.D., DPhil (Oxon) – President
The Great Abdication

My last book, “Neurosurgical Intensive Care”, was well received as the English language edition (number 7 in the “100 Best Neurology Books of All Time”, https://bookauthority.org/books/best-neurology-books), and sold out in the Chinese language edition. My ABNS board certification confirms neurocritical care as an integral part of my residency training. Sadly, a combination of avoidable factors have conspired to dilute the standards of neurocritical care in the USA, and I find myself having to justify my credibility as a neurointensivist to bureaucrats and consultants lacking any frontline expertise—some of this is the fault of organized neurosurgery, which has served this ball into the net, thus abdicating our claim of a central role for the neurosurgeon in neurocritical care. To be clear, this is my opinion, albeit it reflects discussion with numerous colleagues, so I know that I am not alone in this perspective.

When I was a neurosurgery resident in the early 1990’s, dedicated “stroke unit” was an emerging concept, supported by improved outcomes for the sick patients that were admitted there (vs. in a general medical unit); now, having a dedicated stroke unit is a prerequisite for any hospital seeking stroke accreditation. Neurocritical care was done largely by the neurosurgery residents, supervised by anesthesia attendings who primarily staffed the ICU. We all agreed that the neuro-anesthesiologists were the ideal anesthesiologists to manage neurosurgery patients because they had a nuanced understanding of the brain (vs. lung), and because they routinely dealt with ICP and related issues in the OR. A lot has changed from those early days, much for the worse.

Neurocritical care initially evolved in a manner analogous to stroke units, which had proven benefit over general wards for those specific patients. The Neurocritical Care Society (NCS) was founded in 2002, as a reaction to a perceived global need to address the limitations of general or pulmonary critical care as the standard for neurological patients. Prior to the founding of NCS, neurology residents did not routinely get exposure to neurocritical care (unless they did a general critical care rotation, which the NCS felt was not ideal). Neurosurgery residents had significant exposure to neurocritical care, and the ACGME standards continue to include that subspecialty as a required component of neurosurgery training. As neurocritical care gained momentum as a distinct subspecialty of neurosurgery and neurology, the United Council of Neurological Subspecialties (UCNS) came into being in 2006, and presented a challenge to the ACGME/ABMS status quo by offering their own two-year neurocritical care fellowship. UCNS was not part of the American Board of Medical Specialties (ABMS), so it offered an alternate pathway, and having joined forces with the consumer group Leapfrog, it advocated for the “UCNS-certified” neurointensivist as the national standard. The first UCNS neurocritical care board certification exam was held in 2007, and currently there are over 1,000 certified diplomates.

The UCNS neurocritical care fellowships, supported by Leapfrog recommendations to hospitals, led to neurosurgeons being excluded from the treatment of their own patients in the neuro ICU. In 2009, the AANS and CNS released a joint “Position Statement” stating what was obvious to us, but not self-evident to our hospitals or their consultants: “Accreditation Council for Graduate Medical Education (ACGME)-approved neurosurgical residency training includes critical care management of patients with neurological disorders. Neurosurgeons are fully trained in neurointensive care by reason of training program requirements, and upon completion of training are competent to independently manage and direct treatment of patients with neurological disorders requiring critical care. Additional training in critical care is optional, but not necessary for neurosurgeons to manage neurocritical care patients following residency training.”

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Recognizing the importance of neurosurgeons retaining the option to manage their own patients in the ICU, the Society of Neurological Surgeons (SNS) created what we now know as CAST (Committee on Advanced Subspecialty Training), which created subspecialty certification process in various areas of neurosurgery training, including neurocritical care. CAST chose to throw the net very widely, and included neurologists, general intensivists, and others in their own neurocritical care certification pathway. This CAST decision to accredit non-neurosurgeons through their own process was not well-received by other specialty boards, who responded with their own pathway for board certification in neurocritical care. In 2019 the ACGME approved the American Board of Psychiatry and Neurology (ABPN) proposal to accredit fellowship programs in the “new subspecialty of Neurocritical Care” at its February 2019 meeting—clearly, the ABPN felt that the history of neurocritical care started the day they discovered that subspecialty! This ABPN expanded the eligibility for its certification pathway beyond neurology and neurosurgery to anesthesiology, emergency medicine, surgery, and internal medicine, and subsumed all prior certifications by UCNS, CAST, and other non-accredited fellowships under its requirements. To be eligible for this new subspecialty certification, “eligible physician must sit for and pass the ABPN NCC examination regardless of past/other certifications in NCC.” UCNS refused to fade away or accept the supremacy of the ABPN neurocritical care certification process, and their website listed their intention to continue “business as usual including offering a UCNS Neurocritical Care Certification Examination” https://www.ucns.org/Online/About/NCC_FAQs.aspx. The American Osteopathic Association also got in the game, as their DO graduates were being excluded from some of the other pathways; they have declared their intention to offer their DO graduates a neurocritical care certification process that will commence in January 2023.

While well intentioned, the UCNS, CAST, and most recently the ABPN and AOA certifications for neurocritical care have opened the floodgates to have the opposite outcome to what the Neuro Critical Care Society was originally formed to avoid—the substandard neurocritical care by non-neurointensivists. With the new “grand-fathering” into neurocritical care of multiple specialties, some of them not remotely involved in the ICU, we will rapidly progress to a situation in which the majority of “neurointensivists” in the USA will not be neurosurgeons, neurologists or neuroanesthesiologists; indeed, the majority will not have done a neurocritical care fellowship at all—they will have taken a quiz, and paid a fee to be designated as “neurointensivists” (a title with diminishing meaning). As neurocritical care becomes a highly sought-after subspecialty for hospital stroke accreditation and other standards that affect the hospital’s bottom line, the proliferation of physicians grandfathered to neurocritical care has expanded considerably, diluting the standards. We have come full circle from the original intention of the founders of the Neurocritical Care Society. It is no longer a joke that if you throw a stone in any random direction, you will hit two neurointensivists! It is hard to imagine how this could be good for our patients.

How did organized neurosurgery contribute to this dilution phenomenon? Largely because neurosurgeons abdicated the care of their patients to intensivists as a way of avoiding “non-surgical” responsibilities (perhaps to some extent because the ICU care was included in the 90-day global period in our surgical fee?). We also threw our net too broadly, as CAST neurocritical care offered a pathway to subspecialty certification to non-neurosurgeons (who did not take too kindly to a neurosurgery body trying to subsume internists and neurologists under its purview). Now we find ourselves in a confusing set of dueling neurocritical care board certification options (UCNS, CAST, ABPN, AOA), each declaring supremacy over other options, and presenting an intuitively dubious relevance for those who actually care about patient outcomes.

Most neurosurgeons will agree that our worst outcomes occur in the ICU due to challenging fluid and electrolyte management, status epilepticus, uncontrolled ICP/CPP, and ventilator issues; most neurosurgeons can’t remember the last time a patient died in the operating room! Assuming a well-qualified neurosurgeon doing the operation, our outcomes are largely dictated by the severity of the condition and the quality of the ICU care. We are not serving our patients and community by realizing too late that neurosurgery patients should be managed comprehensively by neurosurgeons, or at the minimum by neurointensivists who have formal neurocritical care training (vs. a certificate from having taken a quiz). We have left a vacuum, and lesser qualified people are filling it. We are at a serious juncture for neurocritical care in the USA—either neurosurgeons take a stand to maintain standards by taking an interest in genuine neurocritical care, or allow the dilution of the specialty so our hospitals can claim to have met some accreditation standard set by ….
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This issue of CANS Newsletter is really full. In addition to the routine topics that are usually addressed, you will find reports on the spring CANS Board of Directors Meeting that took place by zoom on April 10, as well as the CSNS Spring meeting that just took place in advance of the AANS annual Meeting in Philadelphia on April 28 and 29.

It also includes reports from CMA and CAPP about an agreement reached with the authors of FIPA, a proposition that is written to eliminate MICRA as we know it. The Proposition would have appeared on the ballot in November of this year. This agreement was made public on April 27. Please read the relevant documents under CMA Reports, immediately following this column. It must be noted that CANS Board was not included in the deliberations leading to this.

At the Board meeting on April 10, CANS Board, however, reviewed all routine matters; we are on solid financial footing. Membership is expanding, though a stronger effort to recruit additional members is planned. Bylaws changes were reviewed. Our president appointed Debbie Henry and Moustapha AbouSamra to the Awards Committee, chaired by Immediate Past President Mark Linskey.

CANS well represented at the CSNS meeting. Our delegates presented CANS positions on various resolutions as previously decided at the Board meeting. Final adopted resolutions by CSNS are listed below.

We continue to feature “Women in Neurosurgery” Column. This month we are fortunate to have the contribution of Aviva Aboch, MD., PhD., a supremely qualified Neurosurgeon-Scientist and Chair of the Neurological Surgery Department at the University of Nebraska Medical Center. Despite her amazing qualifications, Aviva describes how she is sometimes mistaken for a nurse or a staff member. The biases resulting in this as well as the inequity that our female colleagues endure persist, though progress has been made. A JAMA article from 2016 points out that our female colleagues, not only have similar successes when compared to our male colleagues, but often deliver better results - with lower mortality and lower readmission rates - and are viewed by patients in a better light. Please see: JAMA Intern Med. 2017;177(2):206-213. doi:10.1001/jamainternmed.2016.7875

A pet peeve of mine is addressed in my column “Changing Times.” Are we mere providers? I explored this “word” and the origins of its use. Indeed, words matter. Should we insist on being called Doctors?

Steve Giannotta’s Historical Vignette is very informative. In it he points out that the History of LA County/USC Medical Center and the origins of the City of Angels are intertwined.

I’d like to bring your attention to a special essay by Adela Wu, an amazing PGY4 neurosurgery resident at Stanford. In addition to doing her lab work this year, Adela has written about healthcare for newspapers and NPR through the AAAS Mass Media Science and Engineering Fellowship. I know you will find her essay of great interest.

Please direct your comments to me at mabousamra@aol.com. Or call me at 805-701-7007. CANS’ editorial committee and I would love to hear your thoughts and critiques.

I hope you enjoy reading this issue!
CMA Reports

PIFA/ MICRA/ MICRA Modernization/AB 35
April 26/27/28
Moustapha AbouSamra, MD
Chairman, Council on Ethical, Judicial and Legal Affairs, CMA

Please read below three documents. A statement by CAAP, an organization we have supported and an organization whose logo includes "THE COALITION TO PROTECT MICRA," a statement by CMA President Robert E. Wailes, MD., and a summary of Assembly Bill 35 being introduced April 28, 2022. These documents are now in the public domain and CANS would like its members to be aware of them.

As a Council chairman, I was invited to attend an emergency zoom meeting led by Dustin Cochran CEO of CMA and Robert Wailes, MD., President of CMA at 7 PM on April 26. Other council chairs in attendance and I were informed that in fact there have been negotiations between CAAP and the authors of FIPA and that an agreement was reached and that would be made public the next day. Further, an assembly Bill was crafted to reflect this agreement. It was also my understanding that discussions with Governor Newsom concerning this have already taken place.

CMA’s decision was obviously approved by its Board of Trustees. CMA BOT is considering this a positive development. Looking at how MICRA is affected as we go forward as “Modernizing MICRA,” is a reflection of that.

CANS as an organization was not involved in these negotiations, nor in reaching this agreement. CANS Board has not yet discussed this development.

As more developments happen in this “breaking story” we will keep you informed.

California’s Legislative Leaders Join Health Care Providers, Consumer Attorneys and Patient Advocates in Announcing Landmark Agreement to Modernize California’s Medical Injury Compensation Reform Act (MICRA)

In a historic agreement, California’s legislative leaders today joined with Californians Allied for Patient Protection, Consumer Attorneys of California and both the Yes and No campaigns of a scheduled November ballot measure to announce a new consensus has been reached between health care, legal and consumer advocates on legislation to modernize the Medical Injury Compensation Reform Act (MICRA).

MICRA, first passed and signed into law by Governor Jerry Brown in 1975, was established to set limits on medical malpractice awards, balancing compensatory justice for injured patients against important legal and financial protections for health care providers. After decades of political debate, this updated framework will extend the long-term predictability and affordability of medical liability protections for those providing medical care in California while providing a fair and reasonable increase to limits on non-economic damages for medical negligence beginning January 1, 2023, with gradual increases thereafter.

“This bill will go a long way to help patients and their families seek justice when injured after obtaining care,” said Senate President pro Tempore Toni G. Atkins (D-San Diego). "The collaborative effort from all sides will ultimately strengthen protections for Californians and I’m appreciative to my colleagues, Assemblymember Eloise Gómez Reyes
and Senator Tom Umberg, for their leadership, and to the coalition, Governor Gavin Newsom, and Speaker Anthony Rendon, for their dedication to help settle this issue for the public good."

“This is a strong accomplishment and I want to thank all parties for working out a deal,” said Assembly Speaker Anthony Rendon (D-Lakewood). “This includes Majority Leader Eloise Reyes for her hand in the process. This is a great example of what can be accomplished when historically opposing sides talk with one another. The people of California benefit.”

“We have long advocated for policies that protect both patients and the essential guardrails established under MICRA that ensure broad-based access to care for all Californians,” said Lisa Maas, Executive Director, Californians Allied for Patient Protection. “Today’s announcement demonstrates a unified commitment by all stakeholders to put the interests and wellbeing of Californians first.”

The legislation will most notably adjust MICRA’s cap on non-economic damages, which is currently limited to $250,000. This new law will increase the existing limit to $350,000 for non-death cases and $500,000 for wrongful death cases on the effective date January 1, 2023, followed by incremental increases over 10 years to $750,000 for non-death cases and $1,000,000 for wrongful death cases, after which a 2.0% annual inflationary adjustment will apply.

“After nearly 50 years of inaction on a law that capped the value of human life and losing my own son to medical negligence, I wrote and funded the Fairness for Injured Patients Act to effectuate much-needed change,” said Nick Rowley, author and primary funder of the November ballot measure. “I never envisioned a legislative compromise, but I’m very proud that our work has led us to this point. When this becomes law, we will have changed history for the better.”

“CAOC has fought tirelessly alongside thousands of injured patients for the last fifty years to make sure they are fairly compensated when their rights have been violated,” said Craig Peters, President, Consumer Attorneys of California. “After decades of impasse, we have finally reached an historic agreement with medical providers that finally updates California’s Medical Injury Compensation Act of 1975 to prioritize patients’ access to justice and quality health care.”

“This balanced proposal modernizes and updates MICRA while preserving its essential guardrails, strengthening provider protections and providing for fair compensation for injured patients,” said Dustin Corcoran, CEO of the California Medical Association and Chair of the Campaign to Protect Access and Contain Costs. “This framework is essential to our shared goal of health access for all Californians. We look forward to working with the Legislature and the Newsom Administration to enact this historic proposal.”

The proposal will also create three separate categories of caps, which could apply depending on the facts of each case. Additionally, a health care provider or health care institution can only be held liable for damages under one category regardless of how the categories are applied or combined. The new categories include:

- One cap for health care providers (regardless of the number of providers or causes of action)
- One cap for health care institutions (regardless of the number of providers or causes of action)
- One cap for unaffiliated health care institutions or providers at that institution that commit a separate and independent negligent act

“Times have changed, but MICRA hasn’t. Although there have been countless efforts to update the language in the Medical Injury Compensation Reform Act, there has been little success,” said Assembly Majority Leader Eloise Gomez Reyes (D-Inland Empire), the enabling bill’s lead author. “This year, the stakeholders representing patients and the medical community were determined to provide a balanced and equitable solution. They have succeeded. The result is AB 35, which represents a monumental agreement for the benefit of all involved.”

“As Chair of the Senate Judiciary Committee and a practicing attorney, I know first-hand that an update to California’s medical malpractice statutes is long overdue,” said the bill’s Senate author, Senator Tom Umberg (D-Santa Ana). “I’m impressed with the work that has gone into this proposal by all stakeholders and proud to be playing a role in restructuring the system in a manner that is fair to all parties.”
“This is about justice for families, especially women of color who experience more medical negligence in a biased health care system and then are denied accountability because of California’s outdated cap,” said Charles Johnson, Chair of the Fairness for Injured Patients Act. “When the Legislature approves this compromise, families will finally be able to find an attorney and have their day in court. That’s what I wanted for Kira. I want to be able to tell my sons that we restored Californians’ access to justice.”

“This compromise will help to ensure that community health centers across California that serve some of our state’s most vulnerable patients, will have continued access to safe, affordable health care,” said Jodi Hicks, Planned Parenthood Affiliates of California President and CEO. “It was important for Planned Parenthood to have a voice in this process because the proposed initiative would have caused significant harm to California’s safety net. We’re pleased to see a solution that creates long term stability and protects access to care for those who need it most.”

Once passed and signed by the Governor, this legislative framework will preclude a costly ballot measure that was set to appear on the November ballot.

**CMA President Message**

Dear CMA Members,

For decades, California’s landmark medical malpractice laws have successfully struck a balance between compensatory justice for injured patients while maintaining an overall health care system that is accessible and affordable for Californians.

During that time, California’s physician and provider communities, through Californians Allied for Patient Protection (CAPP), have defended the Medical Injury Compensation Reform Act (MICRA) through expensive battles at the ballot, in the courtroom, and in the legislature. CAPP is the large and diverse coalition working to protect access to health care through MICRA. Its membership includes the California Medical Association (CMA), California Hospital Association, California Dental Association, CMA’s component medical societies, medical malpractice insurance carriers, community clinics, Planned Parenthood Affiliates of California and many more.

This year, with the so-called Fairness for Injured Patients Act (FIPA) slated for the November ballot, we are again facing another costly initiative battle that could obliterate existing safeguards for out-of-control medical lawsuits and result in skyrocketing health care costs.

Now, for the first time in a generation, we were met with an opportunity to achieve a meaningful consensus between competing interests through a revised framework that could protect both the rights of injured patients while keeping MICRA’s essential guardrails solidly in place for patients and providers alike.

At times like these, we have an obligation to protect patient care and to seize a historic opportunity for a brighter future for California’s health delivery system.

To that end and at long last, a historic agreement to modernize MICRA is on the horizon. The two sides of the ballot measure campaign have committed to putting patients first, to prioritizing the stability of affordable access to health care, and to set aside differences to do what’s right for all Californians.

As part of this modernization of MICRA, it was important that the underlying principles be preserved – ensuring access to care and protecting our health care delivery system from runaway costs. Important guardrails of MICRA will continue unchanged, including advance notice of a claim, the one-year statute of limitations to file a case, the option of binding arbitration, early offers of proof for making punitive damages allegations and allowing other sources of compensation to be considered in award determinations.
The element likely to garner the most interest surrounds changes to the limit on non-economic damages in medical malpractice cases, which is currently $250k. As opposed to the ballot measure, which would have effectively eliminated the cap on non-economic damages entirely, under the agreement:

- Cases not involving a patient death will have a limit of $350k on the effective date of January 1, 2023, with an incremental increase over the next 10 years to $750k and a 2.0% annual inflationary adjustment thereafter.
- Cases involving a patient death will have a limit of $500k on the effective date of January 1, 2023, with an incremental increase over the next 10 years to $1 million and a 2.0% annual inflationary adjustment thereafter.

Critical MICRA guardrails that will remain in place with modest updates include the ability to pay awards of future damages over time and limits on plaintiff’s attorney’s contingency fees.

Our coalition is working with the Newsom Administration and leaders of the California Legislature to pass legislation that will make this new policy California law. Under the agreement, the initiative will be withdrawn from the ballot and this watershed agreement will preclude another costly fight.

Best wishes for a healthy future,

-Robert E. Wailes, M.D., President, California Medical Association

**Essential Elements of AB 35**

*Introduced 04-27-22*

AB 35 (Reyes and Umberg), the agreement which will amend California’s Medical Injury Compensation Reform Act of 1975 (MICRA). AB 35 will extend the long-term predictability and sustainability of the state’s medical malpractice laws and settle a decades-long divide on the issue. The compromise reflected in this legislation will ensure that health care is accessible and affordable while providing fair and reasonable compensation for Californians who have experienced health care related injury or death. The passage of AB 35 will begin a new and sustained era of stability around malpractice liability and fair compensation for injured patients.

**Limits on Recovery of Non-Economic Damages**

The current law limits recovery of non-economic damages to $250,000, regardless of the number of defendants in a civil action for a person seeking damages against a health care provider for alleged medical negligence. AB 35 will increase the existing limit to $350,000 for non-death cases and $500,000 for wrongful death cases on the effective date of January 1, 2023, followed by incremental increases over ten years to $750,000 for non-death cases and $1,000,000 for wrongful death cases, after which a 2.0% annual inflationary adjustment will apply.

AB 35 also creates three categories which may apply depending on the facts of a particular case. A health care provider or health care institution can only be held liable for damages under one category regardless of how the categories are applied or combined. The new categories include:
- One cap for health care providers (regardless of the number of providers or causes of action);
- One cap for health care institutions (regardless of the number of providers or causes of action);
- One cap for unaffiliated health care institutions or providers at that institution that commit a separate and independent negligent act

**Additional Changes to MICRA**

In addition to changes to the cap on non-economic damages, AB 35 will make adjustments to periodic payment rules and limits on attorney contingency fees and will establish a new statute that ensures protections for benevolent gestures and statements of fault by health care providers.

- Periodic Payment of Future Economic Damages: at the request of either party, periodic payments can be utilized for future economic damages starting at $250,000 (presently at $50,000).
- Limits on Attorney Contingency Fees: creates a simplified two-tiered system (from a four-tiered) with the option to petition courts for a higher contingency fee for cases that go to trial or arbitration. 25% contingency fee limit for claims resolved PRIOR to a civil complaint being filed or arbitration demand being made. 33% contingency fee limit for claims resolved AFTER a civil complaint is filed or arbitration demand is made.
• Protections for Benevolent Gestures and Statements of Fault by Health Care Providers: Establishes new discovery and evidentiary protections for all pre-litigation expressions of sympathy, regret, or benevolence, including statements of fault, by a health care provider to an injured patient or their family in relation to the pain, suffering, or death of a person or an adverse patient safety event or unexpected medical outcome. AB 35 protects the rights of patients and Californians while preserving MICRA’s essential guardrails, ensuring broad-based health access. The passage of AB 35 will also result in the withdrawal of a November 2022 ballot measure that would dismantle the MICRA law.

**CMA Council on Legislation**

March 18, 2022

Ciara Harraher, MD.

The Council on Legislation met in Sacramento for the first time in three years. Our packet of bills included close to 100 pieces of legislation so for the purposes of this summary, I will focus on the items that were extracted for further discussion.

The main issues surrounded three main themes:

1. **Unprofessional conduct:** How this relates to the Medical Board of California (MBC) and affects the upcoming attack on MICRA
2. **COVID 19:** school vaccine mandates, disciplinary actions against those disseminating misinformation
3. **Healthcare Affordability:** prior authorization reform, increased regulation

**Unprofessional Conduct:**

- AB 1636 (Weber, co-sponsored by CMA) that ensures physicians and surgeons who have committed sexual misconduct with a patient or client are prohibited from acquiring or reinstating their license
- AB 2098 (Low, co-sponsored by CMA) that deems it unprofessional conduct for a physician to disseminate misinformation related to COVID-19
- AB 2060 (Quirk) which would change the composition of the MBC to a public member majority

The discussion around these bills centered on how on the face of it, these bills are frankly punitive towards physicians. Some felt that doctors should not be penalized for having doubts about the science behind COVID-19 and vaccination. This was a minority but a vocal contingent throughout the meeting. The proposed change in MBC composition was very controversial as this is a big shift from prior CMA policy. It was argued that in a year where we may be facing an attack on MICRA, our historic malpractice protection legislation, that this is politically a smart move and will ensure that the board regains public confidence. They have been under scrutiny since a recent LA times article reported that physicians who were convicted of sexual misconduct were re-instated. CMA also requested that legislation be amended to allow the disciplinary panels to remain a physician majority and require that the public members have some relevant health care, patient safety or legal experience.

**COVID-19:**

- SB 871 (Pan) seeks to add COVID-19 to the list of diseases that a student of any age must be immunized against before being allowed to attend in-person instruction at a private or public school, child-care setting. This would remove the personal belief exemption for the COVID-19 vaccine
- AB 2098 (Low): see above

Again, the vocal minority of physicians were against these bills as they question the science behind COVID-19. Of note, the Pan bill would not come into effect until the COVID vaccine is FDA-approved for children <12.

The arguments made in support highlighted that CMA and physicians have broadly supported Pan’s previous efforts related to vaccines and how would public perception view the CMA opposing a vaccine bill?
Healthcare Affordability:

- SB 250 (Pan) reforms the prior authorization process by requiring that physicians be included in developing and updating plan utilization management criteria. Require plans to create a prior authorization exemption program that allows physicians that are practicing with in criteria 80% of the time to get a blanket exemption for 2 years. For physicians without this exemption, he/she has the right to have an appeal conducted by a physician in the same or similar specialty.
- AB 1130 (Wood) creating the Office of Healthcare Affordability giving it broad authority to set cost-growth targets for the state, collect any data needed to set these targets and penalize those entities that do not meet those cost targets
- AB 2080 (Wood) Would require a health care practitioner, medical group, hospital, insurer to provide written notice to the Attorney general at least 90 days before entering into an agreement to make a material change to the organizational or corporate structure with a value of $5 million or more

CMA is opposed to both the “Wood” bills as they are both felt to be burdensome to physicians and not actually target the true cost drivers. AB 2080 could stifle innovation and further restrict the flexibility and resources health care providers need to keep their doors open during a health care financial crisis. The “Pan” bill is supported and was recently lobbied on during CMA legislative advocacy day. ❖
Imposter Syndrome

I had never heard the term until I was reading the Chat Box during a Zoom presentation on healthcare careers to a budding group of future doctors and nurses. Imposter syndrome. On the sidebar, they were chatting about the phenomenon of feeling as they did not belong and of having a different persona. It’s a sensation that others perceive you as more competent than you feel. In other words, you feel like an imposter, a Frank Abagnale “Catch Me If You Can” person, who is pretending to be smarter, more talented, and more knowledgeable.

The term imposter phenomenon was first introduced by Dr. Paulene Rose Clance and Dr. Suzanne Imes in Psychotherapy in 1978. Dr. Clance was plagued with self-doubts during graduate-school. Later, when she taught at Oberlin College, she heard similar views especially from the women students who felt that they did not belong and that they were not smart enough to be pursuing their degrees. In other words, they felt like an imposter. Those with Imposter Phenomenon tend to be high achieving persons who struggle with perfectionism and when not perfect, become anxious and feel incompetent. Approximately 70% of individuals will experience this imposter sensation at some point in their lives (Gravois, 2007). The trademark characteristics include the need to be special or the best, superman/superwoman persona, the fear of failure, the discounting of praise and competence, and guilt over or fear of success. Many think that their accomplishments are due to luck rather than hard work.

This month I read an enlightening article in American Educator on the “Five Freedoms That All Math Explorers Should Enjoy.” I loved math until freshman calculus literally sucked it out of me. Sitting in the back row of a 200-seat classroom with a professor talking at me for an hour and introducing concepts I did not understand made me feel like an imposter among the overachieving pre-meds in the class. The author Francis Su relates a similar experience in her first college math class; “I looked around and assumed that everyone else knew what was going on. I was intimidated, fearful of asking any questions because no one else was and the professor wasn’t inviting them.” Despite this, she later took those courses that welcomed questions and subsequently, she became a math major.

Being the single female neurosurgery resident at my program in the 1980s meant in part that I could not ask questions if my male colleagues were not. I knew I was being judged by separate standards. During my junior neurosurgical year, the Chairman opened the written Boards up to all residents by offering to pay for them. As this might have been a one-time deal, I signed up for the exam to count. I created flashcards that I carried in my white-coat pocket and studied waiting at hospital elevators. I passed the Boards. This finally gave me a sense of belonging that at least I was smart enough by neurosurgical testing standards and not an imposter.

Part of becoming more knowledgeable is the awareness of what one doesn’t know. I remember my dad telling me when I was a teenager that when you are young your circle of knowledge is big because you think you know everything, but as you age, that circle becomes smaller. As I age, I think of my knowledge as Swiss cheese. I am more aware of the holes in it. At a neurosurgical meeting years ago after a talk on Chiari malformation, our dear Dr. Randy Smith stood up and remarked that he never knew there were two layers to the dura: the periosteal layer and the meningeal layer. His frankness took a weight off my chest. I had not learned those layers during residency but much later. I realized then and there that no one knows everything, not even neurosurgeons.

With information at our fingertips, we can look it up. I employed this once with a patient who came to me with spinal lipomatosis. I knew of the condition and that one could do a lumbar laminectomy, but I was not up to date with any other current treatment options. So, I brought the patient back to my office, and we did a Google-search together. I don’t remember what I found or said, but the patient never came back. He likely did not want a neurosurgeon who would look up the answers because there were holes in her knowledge.
The history of the LAC/USC Department of Neurological Surgery is inextricably entwined with not only the establishment of the Los Angeles County Hospital and the USC Medical School, but also the beginnings of the City of Angels. Shortly after the Mexican American War, California gained admission to the union (1850). Los Angeles county had only 3500 people and problems with sanitation and a lack of clean water sources. The State legislature opened a series of indigent care hospitals, one of which was set up in a mansion in LA to become LAC hospital. Nursing was provided by the Daughters of Charity of St Vincent De Paul and opened in 1858.

By the 1870s Los Angeles had transformed from a frontier town to an American commonwealth, spurred on by the advent of the telegraph and the completion of the Southern Pacific Railway. The decade also witnessed the official charter of LACMA and erection of the purpose-built LAC hospital, adjacent to the site of the current structure. In 1885, a 13-member faculty opened the USC College of Medicine in a brick building in downtown LA. However, in 1909 the medical school dissociated form USC due to economic hardship and transferred to the UC training system. Dr Charles Bryson had developed a second medical school in Los Angeles which was quickly assumed by USC with clinical rotations at LAC hospital.

After 10 years of planning, the iconic 20 story LAC General Hospital opened its doors on Dec 12, 1933. By the end of WWII occupancy maxed out at 3784 beds.

In 1919, Dr Carl Rand, a 1912 graduate of Johns Hopkins Medical School and a 1913-1914 graduate of Dr Harvey Cushing’s training program; established the first neurosurgical service at LAC Hospital. He became a consultant for virtually every reputable hospital in southern California and served as Chief of Service for 35 years. The first neurosurgical training program in California was inaugurated in 1927 under Dr Rand’s leadership. Dr Frank Anderson, a trainee of Dr Rand’s, took over the department in 1954 and then transferred leadership to Dr Theodore Kurze in 1963, another Rand trainee.

Ted Kurze is generally recognized as the person who introduced Neurosurgery to the operating microscope. His relationships with Dr Bill House and Jack Urban combined with the energy of a young associate named Peter Jannetta, ensured that Neurosurgery would fully embrace microsurgery and take it to unprecedented levels. Of equal importance to the specialty, Ted recruited 3 young faculty who would catalyze the growth and stature of the USC department and American Neurological Surgery.

Martin Weiss led the department from 1978 until 2004. He lent his leadership skills to the ABNS, AANS, JNS, AAcNS, Neurosurgical RRC, and CNS. He thus established a legacy of leadership within the department that our faculty have used as a guidepost for their future goals.

Michael Appuzzo set a new standard for Editorial innovation with his helmsmanship of NEUROSURGERY and WORLD NEUROSURGERY.

Gordon McComb was pivotal in developing quality of care guidelines that ultimately resulted in Pediatric Neurosurgery’s development of a proprietary fellowship and Board exam.

The residency program has grown and morphed over time. Originally based at LAC with rotations at Huntington Memorial and CHLA, the advent of the USC University Hospital (Keck) in 1991 set the stage for rotations at a dedicated academic medical center. We train 21 residents (complement of 3/yr) who generate over 100 peer reviewed manuscripts per year. Our grads have gone on to Chair Neurosurgery departments at Med College of NY, U of Utah, U of Missouri, UCSD, U of Arkansas, U of Texas Austin, and Upstate NY. Larry Chin is now the Dean at Syracuse. With close to 30 clinical faculty and 83 employees, USC is one of the larger departments in the country. We have a $14 million research budget with much of it coming from Federal sources.
Changing Times
Moustapha AbouSamra, M.D.
Are we Doctors, or mere … Providers?

My brother-in-law was one of the first responders at 9/11. A year ago, he developed symptoms that led to the diagnosis of pulmonary fibrosis. He was evaluated and was found to qualify for a lung transplant. He was very optimistic, even enthusiastic, hoping that with the transplant he might regain his normal ability to enjoy the outdoors in his home in Northern New Jersey. Jim, a retired RN enjoys fishing and hunting.

He chose one of the leading transplant centers in the Nation at the Hospital of University of Pennsylvania. He was accepted and placed on the waiting list. He was very impressed when he met the transplant surgeon, one of the best lung transplant surgeons in the Country.

A year later, he underwent his transplant uneventfully in the early hours of March 27, 2022; by then he needed supplemental oxygen 24/7 and could no longer exert himself. When I visited him on March 29, he was already extubated, on low flow nasal oxygen and doing very well. A veritable medical miracle!

The Hospital of The University of Pennsylvania is brand new. Jim enjoyed a spectacular view from his Cardiac Intensive Care Unit Private Room, which was equipped with the latest of modern monitoring equipment. One prominent feature was the very large TV that displayed on its right side, the names of the individuals involved in his care as well as his status and restrictions. Also listed were the plans for him: he was still on bed rest with three chest tubes. At the very top of this list, the name and a photo of his surgeon were displayed. But his surgeon was not referred to as “his surgeon,” rather he was listed as “Medical Provider.”


This reminded me of an article in American Journal of Medicine titled: “The Word Game: We are Physicians, Not Providers,” https://doi.org/10.1016/j.amjmed.2021.06.031. In this article, the authors discussed how the word “provider” has crept up in our medical lexicon. They indicated that “The term “provider(s)” first appeared in Medline English-language articles only 55 years ago in 1965, primarily in reference to group practices, hospitals, and networks. Yet, as of April 2021 we found 24,692 Medline entries that included “provider(s)” in their title. Of these, 193 were published in the 1970s; 1044 in the 1980s; 3049 in the 1990s; 4854 in the first decade of this century; and 12,256 in the second one.”

More concerning was what the authors discovered when they researched the history of the use of this “neutral” word. A word that is used to imply “inclusivity, wrapping all members of a “health care team” in a cloak of equality in purpose.”

They found that “The term was first introduced by the Nazis in the 1930s when trying to debase German physicians of Jewish descent. There were 1253 pediatricians in Hitler’s Reich, and almost half were considered Jewish by the Nuremberg Laws of 1935. When the Nazis ascended to power in 1933, the German Society of Pediatrics asked these physicians to resign. By 1938 the government simply revoked their licenses, so that instead of being called “Arzt” (ie, “doctors”) they were demoted to “Krankenbehandler,” that is, mere “practitioners” or “health care providers.” The term “Krankenbehandler” ultimately was applied to all German physicians of Jewish descent. Not only did they have to put it on their prescription pads, letterheads, and practice signs, but they also had to display it with a Star of David and the specification that they could only treat Jews.”

I am not surprised to learn that the Nazis were the first to apply the term “Providers” to “Doctors,” but I continue to be shocked to see how this term has gained acceptance by our colleagues, particularly from the younger generation of physicians. More disturbing is how widespread is the use of “providers” by insurance companies, hospitals, and even allied medical specialties.

I may be old fashioned, but I view this word/term in the same light as referring to our “patients” as “clients, customers, or consumers.”

The real purpose is to view the relationship between a doctor and his or her patient as a business relationship, and not the sacred professional relationship that it actually is. By doing so, the standing of the doctor is degraded: he or she...
becomes a commodity that has no “special” significance or standing, one can be easily replaced by another “provider.”

Indeed, words do matter.

I refuse to be called a “provider,” and I invite my medical colleagues of any specialty to insist on being called “Doctors.” ✤

Photo of the Month

California Poppies, our State Flower; Photo taken on April 11, at 2PM in Ventura with i-Phone X by Moustapha AbouSamra, MD
As with most of us, there are many facets to my existence, and I play many roles. But professionally, I am a neurosurgeon. Neurosurgery has been my calling since returning to medical school after completing a PhD in neuroscience. And despite the highs and lows of patient care and an ever-changing healthcare environment, I have never regretted my decision.

I am also a surgeon-scientist, with active funding from the NIH and industry for my research efforts.

I am also a woman. I have a husband and two teenage children, whom I adore. Without question, my gender, my upbringing, and the experiences I have had throughout my life, influence how I approach my profession.

I am also Chair of the Department of Neurosurgery at the University of Nebraska Medical Center (UNMC) in Omaha. The UNMC Division of Neurosurgery became a free-standing department when I arrived here in July of 2019. Together, the faculty, residents, and staff of this department have not only survived what the Universe has thrown at us...but thrived during the Pandemic. I am both proud and awed by our accomplishments and our collective commitment to excellent patient care, training the next generation of neurosurgeons, and pushing forward therapies for our future patients.

Despite my optimism over what we are achieving here in Omaha, for the continued vigor and future of our profession, neurosurgery as a career choice needs to reflect more the populations we serve. Separate from the crucial issue of fairness, diversity of experience and background brings fresh approaches to old problems. In order to achieve this diversity in our profession and its leadership, opportunities for STEM education in K-12, university education, and medical school, should be available to all who are interested in pursuing this track and in investing the time required to develop the necessary knowledge base for pursuing careers in the clinical neurosciences.

It is easy to focus on self-doubts and detractors: Have I—and am I—receiving the same opportunities, support, and compensation as my male colleagues and peer chairs? Do people—patients, staff, search committees—view me the same as my male colleagues? Unlikely. After a recent 72-hour stint on call at UNMC/Nebraska Medicine, I walked into a patient’s room—my badge showing, my coat emblazoned with my name and credentials, and the residents in tow—to hear the patient’s adult son tell his mother to end her phone conversation because “the nurse” had just entered the room. Although the incidence of this sort of erroneous assumption has decreased since I was a resident, it has never ceased. I suspect that this same experience does not happen to my male colleagues. I always pause for a second, then reintroduce myself slowly and distinctly, before launching into questions about how the patient is faring. I am always reminded of a similar episode as an intern rounding with Dr. Nancy Asher, who was then Chief of Transplant at UCSF. The
patient whom we had operated on the previous night, mistook Dr. Asher for his nurse, and asked her to help get him off the bed pan. Dr. Asher put on gloves and helped the patient with his request. When she saw the amazement on my face—I was in complete awe of her surgical abilities and academic accomplishments and could not imagine mistaking her for staff—she quietly pointed out that there would be many such episodes during my professional life and getting angry about it each time would necessitate spending much of my professional existence in anger. This is one anecdote among many, but I use it to illustrate the point that like it or not, humans view one another through filters that are informed by their own biases and life experiences.

So, when I reflect back over my career, I am at peace with the fact that there have been many “firsts” over this time—an African American US President, a female Chair of the US Fed, a female President of the AANS. Society and its mores change slowly and incrementally—and needs to change further. Undoubtedly, though, because of the ongoing efforts, fortitude, and accomplishments of so many individuals, my 15-year-old daughter will have opportunities available to her that I never dreamed of.

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**Quote of the Month**

*Patience is also a form of action.* —Auguste Rodin
Large Group Corner
Omid R Hariri, DO
SCPMG Neurosurgery Virtualist Pilot (April 2022)

Neurosurgery call can be one of the top causes of burnout in neurosurgeons. In Permanente Medicine’s ongoing mission to deliver high quality, innovative, patient-centered care while balancing physician wellness, Southern California Permanente Medical Group (SCPMG) was thrilled to pilot a brand-new virtual care model to help reduce neurosurgery call burnout. Launched in July 2021, this revolutionary pilot aims to optimize the Emergency Department (ED) disposition time of patients potentially needing neurosurgical care or intervention, by providing consistent and expedient access to a centralized regional point of contact (a.k.a. Neurosurgery Virtualist MD) for Neurosurgical transfers and consult in the overnight hours (9PM to 6AM).

The initial scope of this pilot was started by 3 neurosurgeons and 2 neuro-intensivist. I was honored to be part of this team. Initially, we covered ED consults at KP non-neurosurgical facilities. Gradually, we expanded this service to include KP neurosurgical facilities as well. Fundamentally, this model is designed to have one dedicated Neurosurgery Virtualist take first call coverage for the Southern California region during the overnight hours. If a transfer or in-person care is indicated, then the designated on-call local Neurosurgeon would be contacted to address the consult. This unique model has generated several benefits:

- Improve quality by decreasing practice variation and facilitate transfers when necessary
- Increase service and access by providing consistent availability to address calls
- Address affordability by preventing unnecessary transfers and costly out-of-plan transfers (close to 15% reduction in transfer rates based on initial data)
- Promote interdependence and reduce call burden by leveraging a single virtualist physician to provide regional coverage

The mid-point evaluation comparing pre-pilot to pilot time frames yielded favorable outcomes, including a reduction in transfers, a reduction in Neurosurgeon overnight in-person call backs, as well as reduction in outside transfers of Kaiser Permanente members. Furthermore, we surveyed all neurosurgeons. This survey indicated positive feedback, with neurosurgeons confirming greater relief during their on-call shifts on nights the Neurosurgery Virtualist was scheduled.

After 9 months of this pilot program, I have been on both sides of this model, both as a virtualist and the local neurosurgeon. I have noticed a significant reduction of overnight calls, which leaves me with more time to be ready for my cases or a full clinic in the morning of my post call. I found myself more productive and energized post call.

Given the pilot’s promising progress thus far, it has been granted an extension through the end of the year. SCPMG Neurosurgery is excited to continue refining the model and pave the way to pioneer novel and sustainable practices to deliver neurosurgical care.
2022S Final Resolutions

RESOLUTION I - 2022S
Action: Adopted Amended Resolution
Title: Optimization of Child Care and Pregnancy Accommodation in Neurosurgery Residency Programs to Improve Equality and Gender Diversity among Neurosurgery Residents

BE IT RESOLVED, that the CSNS construct a survey addressing how and to what degree Neurosurgery may benefit from availability of on-site childcare programs and parental leave.

FISCAL NOTE: None

RESOLUTION II – 2022S
Action: Refer to EC
Title: Cost Awareness Amongst Neurosurgeon Faculty and Residents: A Need for Health Care Sustainability Education

BE IT RESOLVED, that the CSNS research the current nationwide understanding regarding operating room costs and waste amongst neurosurgeons; and

BE IT FURTHER RESOLVED, that CSNS compose a white paper on the current state of neurosurgeon awareness of OR costs and OR waste.

Fiscal Note: None

RESOLUTION III – 2022S
Action: Adopted
Title: Concussion Screening in Domestic, Partner, Intimate Partner and Family Violence
BE IT RESOLVED, that the CSNS ask the AANS and CNS to develop a joint position statement in support of concussion screening for people who have experienced domestic, partner, intimate partner and/or family violence as a first step towards addressing this important problem.

FISCAL NOTE: None

RESOLUTION IV-2022S
Action: Adopted Amended Resolution
Title: Post-Residency Evaluation of Neurosurgical Education and Practice Preparedness
BE IT RESOLVED, the CSNS periodically create a survey for recent board-eligible graduates of neurosurgery residency programs to assess perceptions of preparedness for practice; and
BE IT FURTHER RESOLVED, that the CSNS requests AANS & CNS work with the ABNS and SNS to support and facilitate dissemination of this survey among recent board-eligible graduates at a minimum of every 5 years, as needed.
FISCAL NOTE: $200 or inclusion into extant survey distribution platform/license

RESOLUTION V-2022S
Action: Adopted Amended Resolution
Title: Medical Student CSNS Fellowship
BE IT RESOLVED, the CSNS recommend that the CNS/CSNS Medical Student Summer Fellow be invited to serve a one-year term on a CSNS committee of their choice, with no additional funding, and no additional mandated meeting attendance.
Financial Disclosure: None

RESOLUTION VI – 2022S
Title: WINS Medical Student
Action: Not Adopted
BE IT RESOLVED, that the CSNS request Women in Neurosurgery to create an unfunded summer “Women in Neurosurgery Medical Student Fellowship” be created to encourage research focused on understanding and promoting the status of women in neurosurgery; and
BE IT FURTHER RESOLVED, that the CSNS encourage female medical students to research the socioeconomic and medical-legal barriers that may discourage female medical students from seeking or following a career in neurosurgery.
Financial Disclosure: None

RESOLUTION VII – 2022S
Action: Not Adopted
Title: Medical Student Inclusion on Editorial Boards
BE IT RESOLVED, that the CSNS request the AANS publishers and editors of the Journal of Neurosurgery (JNS) to establish a year-long medical student position on their editorial board, similar to the Editorial Board Resident Fellowship for NEUROSURGERY®, and
BE IT FURTHER RESOLVED, CSNS further request that in this editorial board position, the medical student would act as a liaison between the JNS publication office and medical student researchers, be provided mentorship, and be involved in the peer-review process, as appropriate.

Financial Disclosure: None

RESOLUTION VIII-2022S

Action: Adopted Amended Resolution
Title: Medical Student Conference Registration Fees

BE IT RESOLVED, that the CSNS requests the AANS and CNS charge reduced fees for in-person resident and medical student registration, mitigating barriers for academic involvement disproportionately affecting underrepresented minority group members.

Financial Disclosure: None

RESOLUTION IX-2022S

Action: Adopted Amended Resolution
Title: Case Minimum and Credentialing Requirements

BE IT RESOLVED, the CSNS survey neurosurgeons and hospitals to examine the practice of requiring case minimums for credentialing and maintenance of privileges and then report its findings to the CSNS.

FISCAL NOTE: ***

RESOLUTION X-2022S

Action: Adopted Amended Resolution
Title: CSNS Fellow Appointments for AANS/CNS Joint Section Executive Committees

BE IT FURTHER RESOLVED, the CSNS develop a process where the Fellows or other CSNS liaisons can assist with the programming of socioeconomic content within the respective Joint Section Meetings.

FISCAL NOTE: None

RESOLUTION XI-2022S

Action: Adopted Amended Resolution
Title: Formation of a CSNS Diversity Task-Force

BE IT RESOLVED, the CSNS formalize a Diversity Task Force with the purpose of identifying areas of DEI within the CSNS and Neurosurgery that may warrant attention; and

FISCAL NOTE: None
RESOLUTION XII-2022S
Action: Adopted Amended Resolution
Title: Maintaining Engagement with CSNS Fellowship Applicants
BE IT RESOLVED, applicants who are not selected will be sent a letter to encourage their continued interest and future involvement, to join committees, invite their participation in projects, and be welcomed to attend the CSNS meetings as specially designated guests. Non-selected applicants will be encouraged to re-apply.
Fiscal Note: None

RESOLUTION XIII – 2022S
Action: Not Adopted
Title: Stroke Triage, Prioritization, and Standardization in Emergency Medical Transport Services
BE IT RESOLVED, the CSNS work with the American Heart Association (AHA) / American Stroke Association (ASA) and local stakeholders to study issues surrounding the emergency medical transport of stroke patients, namely transfer times, door-in-door-out times for transferring facilities, bypassing non-stroke centers or low level stroke centers, and stroke patient prioritization.
FISCAL NOTE: ***

RESOLUTION XIV-2022S
Action: Adopted Amended Resolution
Title: Quantitative Study on Attitudes and Barriers among Neurosurgeons for Surgical Safety Checklist and Recorded Time-in/out
BE IT RESOLVED, the CSNS develop a survey of neurosurgeons to identify current practice and utilization of checklists, barriers of safety, logging of time-in and time-out of neurosurgeons, and that this data be reported back to the CSNS at a plenary session.
FISCAL NOTE: None

RESOLUTION XV-2022S
Action: Adopted Substitute Resolution
Title: Creating Sustainable Reimbursement for the Physician Workforce of the Future
BE IT RESOLVED, that the CSNS collaborate with the AMA delegation of the CNS and AANS to request that the AMA launch a public communications and advocacy campaign to support legislation that prevents Medicare payment cuts and reforms the Medicare physician payment system to ensure financial stability and predictability; and
BE IT FURTHER RESOLVED, that the CSNS ask the CNS and AANS to pursue legislation that incorporates positive annual updates reflecting inflation in practice costs, and eliminate, replace or revise budget neutrality requirements.

RESOLUTION XVI – 2022S
Action: Adopted
Title: Assessing the current status of procedural pauses for bedside procedures
BE IT RESOLVED, that the CSNS will ascertain the current status of bedside procedural pauses in neurosurgical programs through a survey assessing hospital practices with regards to beside procedural pauses.

**EMERGENCY RESOLUTION-2022S**

**Action:** Adopted Amended Resolution

**Title:** Evaluating Medical Error Reporting Practices in Neurological Intensive Care Units

**BE IT RESOLVED,** that the CSNS survey neurosurgeons to evaluate medical error reporting practices in their hospitals, departments and offices, including incentives and deterrents to error reporting; and

**BE IT FURTHER RESOLVED,** that the CSNS survey medical malpractice insurance companies and carriers, to determine the possible effect on malpractice premiums, and

**BE IT FURTHER RESOLVED,** that the CSNS ask the AANS/ CNS to develop a position statement about the criminalization of medical errors and omissions, and

**BE IT FURTHER RESOLVED,** that the CSNS ask the AANS/ CNS to task their respective AMA delegates to develop a position statement or resolution addressing the criminalization of medical errors.

**FISCAL NOTE:** None
In the world of business idioms, “find your niche” has to be one of the most tired, overused, and pre-Cambrian members of the family. It is also one of the most poorly heeded and truest. As part of the ancient tribe of neurosurgeon, private practice people still function on the most basic of fuel: Fee for Service.

True, we all know that “it’s going away” and “you need to find another way” tune, and we are all aware we are kind of like the Far Side cartoon depicting the two dinosaurs chatting on a hilltop during the Great Flood and Noah’s Ark floating off in the distance saying “Oh *&^$, that was today?” But until that door closes and we evolve into our next iteration, or perish, we can still run on the old stuff.

The question becomes how to make room around you in the primordial ooze and subsist. At the risk of carrying the evolution metaphor too far, and squeezing the last little bit out of it, (I swear I’m almost done with it) you can get certain adaptations and differentiate yourself to do things, no one else can.

It is possible to go to those out-of-town courses to learn new things: getting certified on the latest disc prosthesis and listen to someone proselytize and evangelize about how they use it on virtually everything and that it never, ever fails (hint: 1 - don’t) and (hint 2 - it will sometimes). You can also try out new skills like spinal endoscopy. This is a very marketable skill and cool as all get out, but the problem is that the CPT codes are still the same. So, although you do some things through a tiny, and I mean tiny hole, you still get paid the same – there is no skill differential on the payment. Although getting better or doing surgeries via a different approach or corridor can become a marketable asset, this one has the longest run-up and investment of time. You will likely not reap the benefits of this one for some time. Case in point, I have been doing lateral approaches to lumbar spine for about 10 years or so, and I feel like I am just starting to get fast at them. Entirely my own fault, incidentally, because I am really picky about case selection.

The other kind of differentiation one may accomplish is in yourself.

More specifically, how you are as a surgeon and physician. They are interrelated, extant, but they are also divergent. The way to think about this is to think of it the way my Catholic friends describe the Holy Trinity. They are leaves of the same flower. None of the leaves can exist on its own and is interdependent with the other.

The surgeon is a proceduralist, an operator. You are operating in a flow state most of your time in the operating room, your sense highly attuned and your mind existing both very much in the now, but also 3-4 steps ahead, in a chess game with yourself. This tends to be exhausting, as I am sure most of you agree, at least those of you who are not Captain America, if you do your surgeries from start to finish like I do, you are kind of spent at the end of the day. You are no doubt excellent at operating as most of us are, albeit not perfect. The surgeon strives to each time get better, faster, more accurate and render a flawless outcome every time. Few if any achieve it. I think the better of us realize it and are humbled when they do not. After spending some precious and occasional time with Dr. Robert Spetzler during my spine fellowship, I began to realize that he was hardest on no one more than himself. What made him most unique was he was kind to everyone, kindly ribbing when needed but also pulling the best out of everyone, because he did that with himself.

He had that rare balance of supreme confidence and modesty and self-reflection. It made him a consummate surgeon and mentor. Trying to bringing something similar into yourself and striving to really do...
better as you operate will build your reputation and your outcomes. Indubitably, you will be busy in your community and hopefully do well with each patient case.

The physician is the probably the older of the twins. As a physician, you are a healer. The operator fixes things and is able to execute the surgery from start to finish. By contrast, the healer sits down and understands. This skill is the one is really not taught in our training and often has to be brought in from the outside world. That is to say, your heart.

Before you talk about distancing, and boundaries which are all necessary to take care of yourself and mitigate risk, it is important to know the difference. Putting you into your practice and practicing being another human being in the room with your patients will help you connect and truly understand the nature of their problem. Relating to your patients and really listening and comprehending their issues allows you to connect in a way that people will value.

In many ways, this skill is the most at risk as we try to crank out more cases and cram more patients into clinic. It is also the most amazing and fulfilling part of the humanistic science we practice. While not every patient will form a bond with you, and you definitely do not want to be the “emotional” surgeon, finding some sort of common ground and remembering small personal details of your patients will help.

The years of your practice will bring reward and ultimately fulfillment. Patients will find you because you are you, not what widget you slam into their spine. Perhaps that will be enough, maybe it will not be. And in the end, what dreams might come, it will be worth it.
Tidbits

March 30 - As expected, the FDA has authorized a second Covid-19 booster shot for adults over the age of 50 as soon as four months after their initial booster dose.

March 31 - Betty Reid Soskin retired after more than 15 years at the Rosie the Riveter/WWII Home Front National Historical Park in Richmond, California. Soskin won a temporary Park Service position at the age of 84 and became a permanent Park Service employee in 2011. She celebrated her 100th birthday last September.

April 1 - The origin of April Fool’s Day: according to Wikipedia, In 1508, French poet Eloy d’Amerval referred to a poisson d’avril (April fool, literally "April’s fish"), possibly the first reference to the celebration in France.

April 2 - Ramadan, the holiest month in the Islamic calendar begins. Muslims are supposed to fast, abstaining from food and water, from sunrise to sunset for the entire month.

April 4 - At least 34 people statewide have contracted norovirus in the past few weeks in California after eating raw oysters harvested in British Columbia. The state Department of Health issued a warning not to eat raw oysters imported from British Columbia where officials have closed multiple growing regions for sanitary contamination.

April 5 - Rep. Dr. Ami Bera, D-Calif., whom we know well, learned firsthand Monday evening while walking to the Capitol for votes. Now he’s undergoing a series of four rabies shots out of an abundance of caution. Bera said he felt something lunge at him from behind as he walked near one of the Senate office buildings. He turned and used his umbrella to fend off what he thought would be a small dog, but he soon realized he was tangling with a fox. Authorities later found out that this fox that bit at least eight other people near the U.S. Capitol has tested positive for rabies and was euthanized. A FOX problem of a different kind.

April 6 - For nearly two years, costumed characters at U.S. Disney parks have kept their distance from visitors because of the pandemic. That is about to change when the parks reintroduce traditional character greetings. As soon as mid-April, personal interaction between visitors and costumed characters will be allowed again at Disneyland in California, Walt Disney World in Florida and on Disney cruises. Mickey Mouse will soon be able to hug again in the Happiest Place on Earth.

April 7 – Big Day
- Opening Day for the 2022 Baseball Season – Let’s Play Ball!
- World Health Organization’s World Health Day 2022 - Let’s hope for a healthy future for our world.
- National Beer Day in the US - now we know our American Priorities.
- Medicare officials announced their final decision regarding a controversial Alzheimer’s drug. Though the Food and Drug Administration has approved Aduhelm for some 1.5 million people, Medicare will cover it only for people who receive it as participants in a clinical trial.

April 14 - A bill that would have required all California students to be vaccinated against the coronavirus, eliminating a personal belief exemption that has been used to circumvent similar mandates, was pulled by its legislative sponsor, Dr. Richard Pan.

April 15 - The Centers for Medicare and Medicaid Services (CMS) opened the long-awaited federal Independent Dispute Resolution (IDR) process called for under the No Surprises Act (NSA), through which providers and payors can resolve payment disputes for certain out-of-network charges.

April 15, sundown – Passover is the Jewish festival celebrating the exodus of the Israelites from Egyptian slavery in 1200s BC. The story is chronicled in the Old Testament book of Exodus. In the book, Israelites marked their
doorposts with lamb’s blood to protect children from the tenth plague: the slaughter of the first born. With the protective mark, the destruction would “pass over” the house.

April 17 – Easter is the day Christians celebrate the resurrection of Jesus Christ on the third day after his crucifixion. It also marks the end of the 40-day period of penance called Lent. Easter is considered to be the most important season of the Christian year. It is also celebrated as a day of rebirth. Here are some fun facts about eggs, bunnies, and Jellybeans, adopted from CNN.

- Eggs have long been a symbol of life and rebirth. Painting and dying eggs pre-dates Christianity. Polish folklore has the Virgin Mary offering eggs to the soldiers guarding Christ on the cross, as she begged them to be merciful, her tears left stains on the eggs. The Czar of Russia commissions the jeweler Faberge to design an enameled egg each Easter in 1885. The first Faberge egg contained a diamond miniature of the crown and a tiny ruby egg. Of the 50 Imperial Easter Eggs made, most are now in museums.

- Origins of the Easter Bunny are unclear, but he appears in early German writings. The first edible Easter bunnies appeared in Germany in the 1800s and were made from sugar and pastry.

- Jellybeans first became part of Easter celebrations in the 1930s.

April 18 - Philadelphia will reinstate indoor mask mandates, as its Covid-19 cases quickly rise. The city is the first major US metropolitan area to bring back masking requirements after a slew of cities and states dropped restrictions as cases began trending downward in January. Yogi Berra said it best in 1973: “It ain’t over till it’s over.”

April 18 – Tax Day! If you haven’t sent in your documents yet, you can file for an extension, but since you are dealing with Feds, if you owe money, you still have to pay up. Unless you are Jeff Bezos or Elon Musk.

April 18 - A federal judge in Florida struck down the mask requirement on airplanes, trains, buses and other public transportation, less than a week after the Centers for Disease Control and Prevention had extended it through May 3. Immediately, all major airlines as well as Amtrak and Uber canceled their mask requirements.

April 22 – Earth Day! This year the theme is “Invest in Our planet.” The holiday was created in the United States to increase public awareness of environmental problems and is now celebrated around the world.

April 25 - This year’s edition of California’s beloved Gilroy Garlic Festival has been canceled and the annual event’s future is uncertain, organizers announced. The celebration of the pungent vegetable has been held for more than 40 years, drawing huge crowds. “Due to lingering uncertainties from the pandemic, along with the prohibitive insurance requirements by the City of Gilroy, the Gilroy Garlic Festival Board has decided not to move ahead with a traditional festival for 2022 — and perhaps the foreseeable future,” the festival association said in a social media post Friday.

April 25 - About 5,000 nurses at Stanford and Packard Children’s Hospital began a strike Monday. They say they’re fighting for a fair contract after their contracts expired on March 31. In a news release, members of the nurse’s union, called the Committee for Recognition of Nursing Achievement known as CRONA, say they want Stanford and Packard to solve the burnout and exhaustion that’s driving many nurses to reconsider their professions.

April 28 - Federal investigators concluded that every year, tens of thousands of people enrolled in private Medicare Advantage plans are denied necessary care that should be covered under the program.
Academic Surgeons’ Corner
Anthony DiGiorgio, DO
CANS is a Resource for my Health Policy Interests

A neurosurgical policy research voice.

It turns out that some of the connections I made within CANS led to my first ever research grant, awarded to me just last month. It is a small award, but it will cover some of my policy research goals at UCSF. Of course, I hope to use that to apply for more funding, eventually building a research career in healthcare policy.

As a young academic neurosurgeon, it can occasionally be difficult to find a research focus. Finding funding for it is even more challenging. I came from a residency without a strong research department, so my naivete often shows regarding grants, research funding and building a successful academic career. This grant is a nice, first, small win.

On a larger scale, I hope to bring the values of CANS and a strong neurosurgical voice to the healthcare policy research arena. It is important that neurosurgeons routinely publish articles in policy journals, such as Health Affairs and JAMA Health Forum. While those journals may not have a glamorous impact factor, they are widely read by people who influence policy. The prominent voices there aren’t always friendly to neurosurgery.

For example, this article from JAMA Health Forum which examined “appropriateness of care” variation throughout the United States. The two metrics for evaluating low-value care within spine surgery are “spine fusion for low back pain” and “surgery without physical therapy for new cervical spine pain” upon being seen by a neurosurgeon. It is doubtful a neurosurgeon would consider those metrics indicative of “low value” care.

That article is just one referring to spine surgery as “low value” care. For example, this Health Affairs article targets spine surgery as a low-value intervention to be cut under a single payor model and another one from JAMA Health Forum blames spine surgery as a driver of “low value” care which leads to unnecessary harm and higher costs. Neurosurgical voices are needed to provide another point of view. These are undoubtedly well-meaning and intelligent policy researchers, but they lack the perspective of a surgical subspecialist.

This little award will not change the prevailing policy narratives. There is hope that it could lead to bigger awards and more policy research from a neurosurgical perspective. At the very least, I hope someone from my research group is presenting our findings at a future CANS meeting, giving appropriate thanks and credit to the organization that helped launch this research.
Residents’ Essay
Adela Wu, M.D.-PGY 4- Stanford University
Gazing into the Geyser: Memories of Neurosurgery Intern Year

Neurosurgeons—in training or in practice—are no strangers to challenges. The days can be long, the diseases difficult to manage. The surgeries are complex, where each step and movement is etched by a calculated accumulation of decisions. To me, the field ultimately appears to demand a demeanor that embodies aequanimitas, which, according to famed physician Sir William Osler, conveys “coolness and presence of mind under all circumstances.”

When I was a medical student, we used to joke with each other that preclinical classes were like drinking from a fire hydrant, due to the sheer amount of material we needed to learn in a short amount of time. If medical school were the fire hydrant, then residency—even just intern year on its own—must be a geyser.

Suddenly, by July of intern year, the weight of responsibility becomes all too real for newly minted doctors. I am signing medication orders. I am discharging patients. I am consenting people for surgeries. I remember one Saturday, as the neurosurgery intern in charge of the ward, hemming and hawing about whether it would be fine to discontinue a Foley catheter order for a freshly post-operative patient.

Still, while the learning curve is steep, I know that we can rely on time, experience, and support from each other to rise to the challenge. With my height and physique, I’d been anxious about my ability to perform bedside burr holes for external ventricular drains as an intern. Somehow, I had assumed a demoralizing conviction that I could not break through the skull’s inner table with a hand-cranked drill…and, what then of the comatose patients lying before me?

I expressed my worries to my senior resident at the time. And, it is a testament to the culture of the program that my query was met with kindness, understanding, and concrete suggestions. He suggested multiple ergonomic changes: dropping the bed’s level, requesting extra footstools, optimally positioning the patient. It was fantastic advice. Placing a bedside drain or monitor was not necessarily a matter of physicality but a series of conscious decisions to optimize effort. Every bedside procedure involving the hand drill went smoothly, even if I had to modify the recommendations somewhat. For a while, I found it actually easiest to clamber and stand on the patient’s bed frame itself.

Another seminal memory I have of my intern year happened near its end. I was learning how to take care of our sickest in the neurologic intensive care unit. And, among these particular patients, one of the sickest was a young patient who suffered a ruptured aneurysm with brain hemorrhage and strokes. We did everything, including a hemicraniectomy, but to no avail.

Eventually, I was asked to hold a family meeting to convey news of poor prognosis and to discuss goals of care and end-of-life preferences—certainly a circumstance that called for coolness and presence of mind. I was the one guiding this young family through a space between life, albeit artificially sustained by this point, and death. I thought. Here, every word choice counted...every pause to allow for listening and processing, critical. The experience cemented in me a realization of the unique role neurosurgeons—indeed, physicians as a whole—had. Even outside of the operating room, our actions, words, and the decisions that we make and present hold so much importance for our patients and their families.

With time and training, some of these decisions (like completing bedside procedures efficiently or even deleting a Foley order and putting in a “straight catheter as needed” order in its stead) become second nature. Until then, I look forward to rising to the challenges wrought by the geyser of neurosurgery training.
Clipping An Aneurysm at Midnight: Nowhere I Would Rather Be!

It was eight o’clock at night on the second day of my neurosurgery rotation. My feet were dragging, and my stomach was growling. Then, all of a sudden, we received a page. A patient had just presented to the emergency department with acute onset diplopia and evidence of a cerebral aneurysm upon imaging. I did not know whether to feel excited or dispirited. Just moments before, I had ignorantly assumed our workday was ending ... I had been at the hospital since four in the morning and I knew that I was not going home anytime soon.

One hour later, in conjunction with the patient’s wishes, the senior surgeon in charge decided that we would be operating that very night. The experience of being in the operating room in the middle of the night had always been a dream of mine. Now it was becoming a reality. Yet, my abrupt change in schedule, lack of sleep, and physically tiring day was catching up to me as exhaustion slowly attempted to overtake my body.

Fast forward three hours and there I was, scrubbing into surgery at midnight. The excitement began to grow in my body and before I knew it, I felt as if I had just drunk 3 cups of coffee as the operation began, and the first incision was made. The rest was a blur of anxiety, excitement, worry, and triumph as the surgeon successfully clipped the patient’s PCOM aneurysm. Never before in my life would I have ever thought to find myself in such a place and at such a time of night. For the typical person, an experience like this would cause one to succumb to fatigue or withdraw due to anxiety, but not me. No, I was at full attention. My brain was more alert and attentive than it had ever been before. I was soaking up every moment of that night, taking small mental images with every passing second. There was not a thing in the world that could have pulled me away from that operating room, except perhaps another aneurysm clipping.

After many hours of riding on a metaphorical rollercoaster, the operation was over. However, it was now 4:30am and the next workday was just starting. So, I did the only logical thing to do and rounded on my patients, ultimately staying late again for another exciting operation. I had never gone so long without sleep. But, in the end of the day, I would do it again, over, and over, as long as it meant I could experience more neurosurgery. This specialty gripped me like nothing else ever has. The satisfaction of operating on terribly sick patients with debilitating disease fulfilled every desire that drove me to pursue medicine in the first place. At last, it was confirmed, neurosurgery was every bit as enthralling and captivating as I had always dreamt it would be and I have no plans on looking back.
Job Available

A British charity is seeking workers to temporarily staff the world’s most remote post office, at Port Lockroy in Antarctica. The position runs during the continent’s summer—November to March. In addition to postal duties, candidates will be required to welcome visitors to the small on-site museum and conduct counts of the colony of Gentoo penguins nearby. Successful applicants should have skills in retail, heritage, conservation and building maintenance, and leadership or management, according to Lauren Luscombe the charity’s Antarctic operations manager. Any neurosurgeon would qualify since they usually have the required skills!

CALENDAR

AANS: Annual Meeting, April 29-May 2, 2022, Philadelphia, PA
Neurosurgical Society of America: Annual Meeting, June 12-15, 2022, Maui, HI
Western Neurosurgical Society: Annual Meeting, September 9-12, 2022, Kona, Hawai’i, HI
CSNS Fall Meeting October 7-9, 2022 San Francisco, CA
CNS Annual Meeting October, 9-15, 2022 San Francisco

Any CANS member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one’s qualifications for a two month posting in this newsletter. Submit your text to the CANS office by E-mail (emily@cans1.org) or fax (916-457-8202)—Ed.

The assistance of Emily Schile and Dr. Javed Siddiqi in the preparation of this newsletter is acknowledged and appreciated.

- To place a newsletter ad, contact the executive office for complete price list and details.
- Comments can be sent to the editor, Moustapha AbouSamra, M.D., at mabousamra@aol.com or to the CANS office emily@cans1.org.
- Past newsletter issues are available on the CANS website at www.cans1.org.
- If you do not wish to receive this newsletter in the future, please E-mail, phone or fax Emily Schile (emily@cans1.org, 916-457-2267 t, 916-457-8202 f) with the word “unsubscribe” in the subject line
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