CANS newsletter

Spring Board of Directors Meeting

Randall W. Smith, MD, Editor

Attending the BOD meeting on April 1st in Oakland was no fool's errand as some substantial goings on occurred. The meeting, ably chaired by President Ken Blumenfeld, was attended by Drs. Holly, Linskey, Mummaneni, Panchal and Rhoten, Directors Drs. Asgarzadie, Chen, Helib and Siddiqi (via phone), past president Dr. Kissel, resident members Drs. Hariri and Wang and consultants Drs., Bonner, Kaczmar, Lippe, Page, Smith and Wade along with Executive Secretary Emily Schile and Historian Dr. Prolo.

BarbaraWeissman, a psychiatrist from the bay area, was also present in the role of liaison from the Board of Trustees (BOT) of the CMA. Her Board position is to represent the specialty societies in the state and she has chosen to attend as many state specialty society's Board meetings as she can on the whopping $150 the CMA Board gives her annually to carry out her job. She was an attentive guest but had to leave before some of the discussion about the CMA by Lippe (see below).

Dr. Blumenfeld announced that the **CANS annual meeting on January 12-14, 2018** will be held at the US Grant Hotel in San Diego. The Grant is an elegant boutique hotel with a long colorful history and is located in the heart of downtown San Diego and within easy walking distance of the Gaslamp district with its vibrant night life. The room rate will be $249/night. The meeting's speakers and topics are a work in progress.

INSIDE THIS ISSUE:

Secretary **Mark Linskey,** MD, reported that membership numbers are stable and presented two neurosurgeons applying for membership: **Sumeet Vadera, MD,** from UC Irvine and **Paul Kalooshan**, MD, from UC Riverside. They were voted into the Association as active members. It was noted with sadness that CANS founding member and long time Berkley area private practice neurosurgeon **Robert Fink**, MD died in January 2016. A full moment of silence in his memory was observed.

Treasurer **Ripul Panchal,** DO, reported that the 2017 annual meeting in January was attended by almost 90 neurosurgeons plus 12 residents and that the meeting generated a record profit of nearly $60,000 largely due to the presence of 36 exhibitors, also a record. Executive Secretary Emily Schile was hired for another year with a 5% increase in salary. Dr. Panchal also announced he will be moving to Dallas in August and the Board appointed Ted Kaczmar, MD, to take over as Treasurer at that point.

Consultant **Phil Lippe, MD,** noted that the CMA Executive Committee's report to the Specialty Delegation (one of the largest of the CMA delegations) included concerns that the Governor will violate the wording of **Proposition 56** and try to use the money generated from the new tax on cigarettes for general state purposes instead of for improving the Medicaid system. CMA will be lobbying legislators to not approve the budget unless that is rectified. The report also noted that the American Association of Physicians and Surgeons has filed a lawsuit claiming that the balanced billing prohibition in California violates the constitution.

In addition to noting that there is a move to try to get the CURES system for opioid monitoring out of the Department of Justice and into a more appropriate overseer group (the Pharmacy Board has volunteered), Dr. Lippe lamented what he sees as the CMA structure becoming a one-way street between the CMA leadership and the docs it represents. He feels that many to most CMA positions and CMA sponsored legislation emanate from the very competent CMA non-doctor staff with approval by the CMA BOT after less than thorough review and analysis and without consulting the doctor groups most likely to be affected by such positions and legislation. He also has been surprised by the CMA silence on the proposed single-payor health insurance for all Californians currently being proposed in the legislature.

Finally, the Board appointed Drs. Blumenfeld, Linskey and Patrick Wade, Praveen Mummaneni, Randall Smith, Marc Vanefsky and Deborah Henry as delegates to the Council of State Neurosurgical Societies meeting in Los Angeles on April 21-22. The Board also discussed the 10 resolutions to be debated at the meeting and took the following positions indicated **in bold**. Any CANS member can contact Ms. Schile (emily@cans1.org) if they have any thoughts on the resolutions and those comments will be forwarded to our delegate assigned to speak on behalf of CANS regarding each resolution.

RESOLUTION I (CANS Board Position: Await debate, seems too far reaching)
Title: Implications of Prescription Drug Monitoring Programs for Neurological Surgery
Submitted By: Nitin Agarwal, Prateek Agarwal, Pratik Rohatgi, Robert F. Heary, Andrew E. Wakefield, Clemens M. Schirmer, on behalf of the Northeast Quadrant
WHEREAS, opioids are commonly used for pain management in the United States and use of opioids, along with rates of opioid abuse and death, has significantly increased since the 1990s; and
WHEREAS, it is imperative for neurosurgical providers to have the ability to manage our patients' genuine pain with opioids as our patient population has the second highest prevalence of chronic opioid usage amongst surgical specialties; and
WHEREAS, many of the possible implications on neurosurgical practice of mandatory prescription-drug monitoring programs (PDMPs) are unclear; therefore
BE IT RESOLVED, that the CSNS investigate whether there is any evidence that would support the notion that reductions in the rate of opioid prescribing by providers translates to reductions in opioid abuse and death; and
BE IT FURTHER RESOLVED, that the CSNS evaluate the implications of mandatory PDMPs on neurosurgical practice with regards to rate of peri-operative and chronic opioid prescribing by providers and changes made to prescribing habits after PDMPs were started; and

BE IT FURTHER RESOLVED, that the CSNS establish a working relationship with the AMA's Task Force to Reduce Opioid Abuse to obtain data on the effectiveness of PDMPs for neurosurgical practice, from both a provider and patient standpoint; and
BE IT FURTHER RESOLVED, that the CSNS write a consensus statement as to level of involvement a neurosurgeon should be obligated towards a patient's pain management with opioids, and
BE IT FURTHER RESOLVED, that the CSNS collaborate with the parent organizations to communicate the position of the CSNS for consideration of a formal paper.

RESOLUTION II (Oppose—docs need to receive and make calls while driving)
Title: A Policy on Physician Use of Mobile Devices while Driving
Submitted by: Jeremy Amps and the CSNS Safety Committee
WHEREAS, compelling evidence has established an increased risk of serious injury and death for persons using electronic mobile devices while driving—including those designated hands-free; and
WHEREAS, a vast majority of physicians carry cell phones with an increasing number of them reporting it as their primary means of communication when on call; and
WHEREAS, physicians have an obligation not only to patients on their service, but to all potential patients in the community—specifically those with whom they might be sharing the road; and
WHEREAS, a physician who is personally injured in an automotive accident may be unable to provide patient care for an extended period of time and further stress the healthcare delivery system; therefore,
BE IT RESOLVED, that the CSNS request its parent bodies to adopt a policy statement against usage of mobile electronic devices while operating a motor vehicle. This should include, but not be limited to, texting, accessing email, sending calls, receiving calls, and accessing the internet; and
BE IT FURTHER RESOLVED, that the CSNS recommend administration of an anonymous national survey to all practicing neurosurgeons regarding their personal habits with respect to electronic device usage while operating a motor vehicle. The data collected may be used to assess behavior of the group and to help drive local policies in states and hospitals.

RESOLUTION III (Support)
Title: Insurance denial of surveillance imaging prior to return clinical visits
Submitted by: Charles Rosen and Cara Sedney
WHEREAS, surveillance imaging studies are commonly used in the management of many neurosurgical conditions (tumors, etc); and
WHEREAS, insurance companies have increasingly required a clinical visit prior to the approval of these surveillance imaging studies, effectively doubling the number of clinical visits by patient and provider; and
WHEREAS, this new trend does not change patient management, while increasing cost to the patient and society and decreasing the availability of neurosurgical services to other patients by utilizing clinical time needlessly; and
WHEREAS, particularly in rural areas, the extra clinical visits impose a hardship on our patients; therefore
BE IT RESOLVED, that the CSNS petition the AANS and CNS to produce a statement against the insurance requirement of clinical follow-ups prior to planned surveillance imaging studies in return patients.

RESOLUTION IV (Await debate—potential changes unclear at present)
Title: Evaluation of potential changes to the Affordable Care Act and the implications on Neurosurgery
Submitted by: Vivek Mehta, Richard Menger, Rimal Hanif, Richard Wohns & Bharat Guthikonda on behalf of the Medicolegal Committee

WHEREAS, the Patient Protection and Affordable Care Act is a United States federal statute enacted by the 111th United States Congress and signed into law on March 23, 2010 which has had far reaching implications for patients, physicians, and payers in the United States; and
WHEREAS, it is anticipated that the new presidential administration and the majority Republican control in the House of Representative and Senate will make changes to the Patient Protection and Affordable Care Act; and
WHEREAS, it remains largely unclear what exact changes will be proposed, the timeline in which they will be initiated, and how these changes will impact Neurosurgery; any
WHEREAS, national changes to healthcare can have a profound impact on the delivery of neurosurgical care in the United States; and
WHEREAS, the individual mandate component of the Patient Protection and Affordable Care Act is one of the most contentious and impactful elements which has had a profound impact on patients, physicians and payers; therefore
BE IT RESOLVED, that the CSNS formally study the potential changes to the Patient Protection and Affordable Care Act, specifically the individual mandate and possible changes to that element, in the context of 1) patient access to neurosurgical are 2) the impact on delivery of neurosurgical care and 3) changes to reimbursement patterns and payer requirements.

RESOLUTION V (Oppose—stay away from guidelines and NASS)
Title: Reconciling differences between criteria used by insurance companies to approve spinal/cranial neurosurgical procedures and published AANS/CNS/NASS guidelines for spinal/cranial surgery
Submitted By: Rimal H. Dossani, Richard Menger, Vivek Mehta, Richard Wohns, & Bharat Guthikonda, on behalf of the CSNS Medicolegal Committee
WHEREAS, published AANS/CNS/NASS guidelines for cranial/spinal surgery can be considered standard of care. Criteria used by insurance companies to approve or deny cranial/spinal neurosurgical procedures are frequently in conflict due to disagreement with published AANS/CNS/NASS guidelines for cranial/spinal surgery; and
WHEREAS, neurosurgeons may be susceptible to increased malpractice claims as a result of patient care being compromised due to disagreement between standard of care and approval/denial criteria used by insurance companies; and
WHEREAS, neurosurgeons risk being eliminated from insurance contracts, face dropped payments and receive reprimanding letters from insurance companies for performing procedures considered standard of care but not approved for payment by insurance companies; and
BE IT RESOLVED, that the CSNS recommend to and collaborate with the AANS/CNS to advise major insurance providers regarding published AANS/CNS/NASS guidelines to reconcile differences between insurance approval/denial criteria and standard of care; therefore
BE IT FURTER RESOLVED, that the CSNS collaborate with AANS/CNS and recommend the Combined Spine Section work with NASS Evidence-based Guideline Development Committee to modify current guidelines into a format applicable and accessible to insurance companies for approval/denial of spinal/cranial surgery.

RESOLUTION VI (Support)
Title: The "Disruptive Physician" label and its impact on Neurosurgery
Submitted by: Cati Miller, Jeremy Phelps, Darlene Lobel, on behalf of the Medical Practices Committee and the CNS Caucus
WHEREAS, the term "disruptive physician" has been reported in the medical literature for the past several decades; and

WHEREAS, the term was originally developed to describe bullying physicians, with the intent to limit such behavior; and
WHEREAS, the label is now being used by hospital administrators as a basis to police, monitor, or discipline physicians; and
WHEREAS, "disruptive" incidences are reported to be higher in frequency in surgical specialties and occur more often in stressful and intensive areas such as the operating room, intensive care unit, and emergency room; and
WHEREAS, state and federal agencies can discipline a physician for engaging in disruptive behavior if it is found to impact the quality of patient care or if it suggests moral, ethical or professional shortcomings; therefore,
BE IT RESOLVED, that the CSNS develop a white paper to outline criteria used to define a "disruptive physician", report on the prevalence of "disruptive physician" behavior in the neurosurgical community, describe policies in place to address disruptive behavior, and address potential professional and personal consequences for being labeled a "disruptive" physician.

RESOLUTION VII (Support—smarter NPs and PAs a good thing)
Title: Boot Camp for Advanced Practice Providers (Nurse Practioners and Physician Assistants)
Submitted By: Thomas Origitano, Darlene Lobel, Deborah Benzil
WHEREAS, Advanced Practice Providers (Nurse Practioners and Physician Assistants) are playing an increasingly significant role in patient care and triage due to changes in resident work hours, population health, and sub- specialization; and,
WHEREAS, their core training requires 12 months of basic sciences and 12 months of clinical experience often with little exposure to neurosurgery; and,
WHEREAS, the SNS has demonstrated the clear effectiveness of the Boot Camp for training of neurosurgical residents; and
WHEREAS, there is no formal training available for physician extenders who choose to work with a neurosurgical team; and
WHEREAS, a test Boot Camp for 125 physician extenders was successful; therefore
BE IT RESOLVED, that the CSNS work with the AANS and CNS to develop a Boot Camp curriculum and program open to Advanced Practice Providers (Nurse Practioners and Physician Assistants) to include rigorous evaluation of the educational value; and
BE IT FURTHER RESOLVED, that once the Boot Camp achieves appropriate evaluations, the program be expanded for availability to any Advanced Practice Providers (Nurse Practioners and Physician Assistants) who work with neurosurgical teams.

RESOLUTION VIII (Support)
Title: Identifying the Economic Impact of Mobilization and Deployment on the Reserve Neurosurgeon
Submitted By: Richard Menger, Charles Miller, Will Robbins, Randy Bell
WHEREAS, military reserve neurosurgeons experience workplace challenges unique from their full-time military and full-time civilian counterparts; and
WHEREAS, maintaining an adequate pool of reserve neurosurgeons is critical to meet the always changing deployment needs of the military; and
WHEREAS, at different times, reserve neurosurgeons in all three services have been mobilized or deployed in service of their country; therefore
BE IT RESOLVED, that the CSNS research information regarding the impact of mobilization and deployment on the reserve neurosurgeon in both academic and private practice by means of a continued and expanded workplace survey of current and past reservist neurosurgeons.

RESOLUTION IX (Oppose—what is "emotional intelligence?")
Title: Following longitudinal burnout among Neurosurgery Residents
Submitted by: Vivek Mehta MD, Aaron Cohen-Gadol MD, Paul Klimo MD, Frank Attenello MD, J. Adair Prall MD
WHEREAS, a well-received CSNS sponsored survey of neurosurgery residents (n=398) revealed a 67% burnout rate and mentorship showed protective effects against burnout; and
WHEREAS, the prior CSNS burnout study contained an individualized anonymous identification to allow for longitudinal follow up; and WHEREAS, new studies show emotional intelligence to correlate with success and burnout in clinical and non-clinical fields,
WHEREAS, resident and physician burnout have been designated as a priority by the surgeon general; therefore
BE IT RESOLVED, that the CSNS will redistribute a burnout study, now also including emotional intelligence evaluation, to specifically assess longitudinal resident burnout now including emotional intelligence, to better understand factors involved in resident success.

RESOLUTION X (Support—makes better sense than Resolution I)
Title: The Impact of the Prescription Drug Monitoring Program on Neurosurgical Workflow
Submitted By: Maya Babu MD, MBA; Robert F. Heary MD; Brian V. Nahed MD, Msc
WHEREAS, the prescription opioid drug crisis has garnered tremendous national media, Congressional, and lay public attention; and
WHEREAS, there are sixteen states that mandate physicians and other healthcare providers check the state PDMP before prescribing a controlled substance; and
WHEREAS, there are reports from physicians that checking the PDMP takes minutes away from patient visits, and adds to the administrative hassles practices face; and
WHEREAS, the impact on neurosurgical practices of this additional administrative burden remains to be documented; therefore
BE IT RESOLVED, that the CSNS survey neurosurgeons as to the administrative burdens created by laws that mandate verification of the PDMP. ❖

CANS MISSION STATEMENT

'To Advocate for the Practice of California Neurosurgery Benefitting our Patients and Profession'

Letter to the Editor

It finally came...

I have been expecting to get a bill for my coronary event related treatment that happened in November 2016 and that I reported on in the CANS January newsletter. I had not heard from my family physician, my cardiologist, or the hospital. Could it be that I was not being charged as a professional courtesy? Nah, it is illegal to do so by Medicare rules!

I finally received a statement from Medicare labeled "this is not a bill" outlining the charges I generated...

Typically the statement has several columns. This was no exception. The first column is what is the nature of the charge, let's say a stent, the second is the actual $ amount charged by the physician or hospital, the third is whether or not the charge was approved by Medicare, the fourth is how much, if any, Medicare approved, the fifth is how much Medicare actually paid-about 85% of what they approved and finally how much does the patient owe-usually 15% of the approved amount. You must realize that what I am expected to pay as a Medicare recipient has nothing to do with the actual charge, it is only a percentage of what Medicare deems reasonable for the service in question. My portion is then submitted to my "secondary" insurance that is expected to pay it.

I've known all along that the system is puzzling and, in a lot of ways, doesn't make sense, but this actual notice brought into focus several significant issues.

Health care is too expensive: I can never afford to pay my bill in its entirety. The pricing varies unreasonably between providers and facilities; there simply is no rhyme or reason for it. The way services are billed make no sense either, since the people submitting the bill know in advance how much is Medicare going to cover. In reality the large difference is not intended to someone like me who has coverage, but it is billed in its entirety to the unfortunate individual who has no insurance or whose insurance is not comprehensive. What a shameful practice, since the self pay patient has to come up with a large sum of money and in many cases the hospital takes a lean on that person's home. Medical bills are frequently the reason for individuals to declare bankruptcy.

Let's start with the variability of cost between provider: look at a very common procedure, an EKG, which is done thousands and thousands of times every day in this country.

- My family physician charged $21.42 that Medicare did not approve at all, and obviously paid nothing and told me that I owe nothing. Why not?
- My cardiologist charged $66.00 for the absolute same procedure. The amount of $19.12 was approved by Medicare. And they paid $14.99. Why the difference in treatment of my family physician versus my cardiologist' by Medicare? And why did they pay my cardiologist so little?

As to how expensive is the system: the hospital charged for many things including IVs. I'm listing some of the more significant charges:

- My stent cost $24,742.00, yes almost 25K. I am absolutely certain that this stent, state of the art and all, did not cost the hospital anywhere close to that number. And the truth is hospitals keep the information about their cost private.
- They charged for the catheter used for my angiogram that was done at the same time $7,620.00
- The guide wire $5,140:00
- A percutaneous Transcatheter placement of stent system $30,186.00, yes, 30K and this was charged twice because they used two catheters. so a little over 60K.
- Ultrasound evaluation $8,311.00
- Injection of 1mg of Bivaluridin $5,750.58-OK, maybe this is an expensive drug.
- Injection of 1000 units of heparin $223.26. No, this is not expensive and it costs close to nothing.

- Recovery room: $2,576.00. I stayed there about 6 hours after my stent. It is a unit called CRU Coronary Recovery Unit, where I received excellent care; my superb nurse kept an eye on me. Nothing more needed to be done. I even declined to have lunch there as my daughter brought me a sandwich from our favorite sandwich shop located close to the hospital-we shared it. $2500?
- The total hospital charge was $132,293.52, of which they approved $131,860.44 and they paid a whopping $15,650.82. My responsibility? $1288.00; I hope my secondary insurance is going to pay it.

As to billing practices, why bill $132,293,52 if you know that you are going to get paid $15,650.82? Why not charge a flat fee of say $16 to 20K or even 25K and be done with it? I understand that hospitals have to make money so that they can survive and keep up to date, and I also understand that they often provide uncompensated care, but if we have a reasonable system, we shouldn't have any uncompensated care, only reasonably compensated care ... a totally different story.

I am glad this episode is over and I am feeling well. This itemized statement gives me another strong reason to stay away from hospitals. So off to walk up and down the hills in our beautiful town, I go!

Moustapha Abou-Samra, MD
Ventura ❖

Brain Waves

Deborah C. Henry, MD, Associate Editor

I haven't googled myself in awhile, but I will never forget the first time I did. Physician sites had not yet become popular, so there was limited professional information about me. However, my parents and siblings, their ages and birthdates were listed with my information. At the time, your mother's maiden name was a popular default password for social security and bank accounts. Well, my mother's maiden name was right there along with my personal information. Needless to say, that is no longer a password.

I searched my name again a few years ago and found more business information. Surprisingly, the personal information was now harder to find, perhaps as there were now many sites that wanted to charge for the facts, presenting teaser information first then inviting you to pay to learn more. What amazed me was how many pictures of me were on the internet. As I have a miniscule amount of social media online, this discovery was rather disturbing.

Over the years, many sites (Health Grades, Vitals) have popped up with ratings for doctors. Many are fraught with errors. Amongst the public sector and these sites, there is still little distinction between a neurologist and a neurosurgeon. According to a March 29th *LA Times* article, a nonprofit California organization is set to remedy this with a website dedicated to accurately rating doctors. Caqualityratings.org is the website enacted by the California Healthcare Performance Information System. According to the article, both health insurers and physicians worked together to create ratings on 10,000 California doctors over eight specialties. Doctors are compared to each other, not to a norm, and are scored between 1 to 4 stars. One star means that the doctor is in the lower quartile of

performance measures compared to others in the same area; the article infers that this does not mean the doctor does a "bad job".

The health insurance data used in making this website comes from the California Blues, United Healthcare, and Medicare. The next participants are expected to be Kaiser, Aetna, Cignet, and Health Net. There also may be attempts to add other quality measures such as patient experience, timeliness of care and mortality rates. So I checked the website out. On the homepage is a wordy disclaimer: the information is from 2014, the majority of the information has not been verified by each doctor, most of the information is from insurance claims, however, the claims may not accurately reflect what happened. The last disclaimer states: "This report measures how physicians performed in providing particular recommended tests in 2014. It is not intended to be an indication of overall physician quality." The eight specialties listed to select from do not include neurological surgeons. I randomly selected three family practice physicians from Hoag Hospital and searched their names on the site. All three came up "selection not found, search again".

Indeed rating doctors via quasi-important measures continues to be a work in progress. I think I will continue to follow the tried and true way: word of mouth. It's worked so far. ❖

DO YOU KNOW A NEUROSURGEON NEW TO CALIFORNIA? TELL THEM ABOUT CANS AND DIRECT THEM TO THE CANS WEBSITE: WWW.CANS1.ORG! THERE IS A MEMBERSHIP APPLICATION ON THE SITE

Transitions in Neurosurgery

John T. Bonner, MD, Associate Editor

Who to treat and how long to treat patients with cancer have long been difficult decisions. Usually, such patients required referral to specialty hospitals, but no longer. Now, cancer treatment has been more easily accessed closer to home. Variable and changeable approaches to patient care have become commonplace. Genetic testing for tumors has spread to community hospitals so that referrals to specialty hospitals has become less necessary. Precision medicine, as it is known, allows patients to receive cutting edge testing to guide successful treatment of cancers in patients' own home towns.

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Overuse of narcotics by patients and physicians has remained a prominent issue in medicine. The Wall Street Journal (February 4-5, 2017) indicated that, according to the Centers for Disease Control and Prevention, there was a 16% increase from 2015 to 2016 in deaths from opioid overdoses. Much of the increase was attributed to illicitly-made Fentanyl, but legally-manufactured products are also abused. Physician over-prescribing of opioids has drawn significant attention from law enforcement, leading to some physicians being criminally charged.

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Republican efforts at repealing the Affordable Care Act recently failed, but such efforts are said to be revived soon. Goals include lower premiums and deductibles, expanded patient choice, returned control to the states, and increased patient access to care. Who knows whether such efforts will be successful, and what reforms will survive and be put into place? ❖

Exhibitor Gold Sponsor COOK MEDICAL features dural graft

Alison Mahan and Drew Gidish eagerly demonstrated family owned Cook Medical's **Biodesign Duraplasty Graft** made from cell-free porcine small intestine submucosa which is radiated and supplied in a number of sizes from 1x2 cm to 7x8.5 cm. When the grafts are moistened they are quite pliable and smooth, handle like fresh dura and hold sutures just as well.

Tidbits from the Editor

Free Pocket Guide to Tapering Opioids for Chronic Pain Available from CDC

The Centers for Disease Control and Prevention (CDC) has prepared a free pocket guide to help physicians considering reducing or eliminating opioid dosage to chronic pain patients. The guide aims to help physicians understand how and when to begin the tapering process and minimize withdrawal symptoms while maximizing non-opioid pain treatments. The guide is available at https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf.

For additional information regarding prescription medication misuse and overdose prevention, visit the Board's website at: http://www.mbc.ca.gov/Licensees/Prescribing/Overdose_Prevention.aspx. ❖

NOTATIONS FOR THE MONTH:

"When the smog lifts in Los Angeles U.C.L.A." and "With her marriage, she got a new name and a dress."—submissions in the annual Lexophilia (those who love words) contest.

Meetings of Interest for the next 12 months:

Neurosurgical Society of America: Annual Meeting, April 2-5, 2017, Jacksonville, FL
CSNS Meeting, April 21-22, 2017, Los Angeles, CA
NERVES Annual meeting, April 21-22, 2017, Loews Hollywood Hotel, Los Angeles, CA
AANS: Annual Meeting, April 22-26, 2017, Los Angeles, CA
AANS/CNS Joint Pain Section Bi-Annual Meeting, May 19-20, 2017 Chicago, IL.
Rocky Mountain Neurosurgical Society: Ann. Meeting, June 15-19, 2017, Lake Tahoe, CA
New England Neurosurgical Society: Annual Meeting, June 22-24,2017, Chatham, MA
Western Neurosurgical Society: Annual Meeting, September 8-11, 2017, Banff, Alberta, Canada
CSNS Meeting, October 6-7, 2017, Boston, MA
Congress of Neurological Surgeons: Annual Meeting, October 7-11, 2017, Boston, MA
International Society for Pediatric Neurosurgery: Annual meeting, October 8-12, Denver, CO
North American Spine Society: Annual Meeting, October 25-28, 2017, Orlando, FL
California Neurology Society: Ann. Meeting, May 19-21, 2017, Hyatt San Francisco Airport, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, Nov. 28-Dec. 1, 2017, Houston, TX.
Cervical Spine Research Society: Annual Meeting, Nov. 30 – Dec. 2, 2017, Hollywood, FL
CANS, Annual Meeting, January 12-14, 2018; Hotel TBA, San Diego, CA
North American Neuromodulation Society: Ann. Meet., 2018, TBA
AANS/CNS Joint Cerebrovascular Section: Ann. Meeting, 2018 TBA
Southern Neurosurgical Society: Annual Meeting, 2018 TBA
AANS/CNS Joint Spine Section: Annual Meeting, 2018, TBA

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. Kenneth Blumenfeld 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, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net 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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