CANS newsletter

Med students, Med students everywhere--with no place to go

Randall W. Smith, MD, Editor

The Association of American Medical Colleges has published their 13th annual AAMC Survey of Medical School Enrollment Plans. Their report examines first-year medical school matriculants over the past decade and projects first-year matriculants through 2025. Each fall, the survey is sent to deans at all MD-granting U.S. medical schools with preliminary accreditation or higher. This most recent survey was conducted between October 2016 and January 2017.

In 2006, in response to concerns of a likely future physician shortage, the AAMC recommended a 30 percent increase in first-year medical school enrollment by the 2015–2016 academic year (over 2002–2003 levels).

The latest survey shows that medical school enrollment has grown 28 percent since 2002–2003 and 30 percent growth will be achieved by 2017–2018. Using the baseline of the 2002–2003 first-year enrollment of 16,488 students, a 30 percent increase corresponds to an increase of 4,946 students. That expected total of 21,434 was almost reached in the recent survey which showed 21,030 students matriculated this academic year. The survey results indicate that the 30 percent goal will be attained by 2017–2018 and exceeded in future years.

If one adds the 7,369 students that matriculated at DO medical schools this academic year, it would seem the country has initiated a very distinct increase in physician production. Combined first-year enrollment at existing MD-granting and DO-granting medical schools is projected to reach 31,025 by 2021–2022, an increase of 59 percent compared with 2002–2003.

California has played a significant role in the increased matriculation by starting two new medical schools; one at UC Riverside (enrolling students now), California Northstate University College of Medicine (Sacramento- enrolling students now) and applications in progress for medical schools at California University of Science and Medicine (San Bernardino) and Kaiser Permanente School of Medicine (Pasadena).

INSIDE THIS ISSUE:

The last time this writer checked, granting an MD degree does not immediately translate into a practicing physician. All medical students feel the need of a residency from general/family practice (2 years minimum) to neurosurgery (7 years). This oncoming onrush of newly minted docs has not been met with a significant increase in residency slots.

It is unclear that the federal government has the will to pay for the increased residency slots needed. It is also unclear to this writer just why the needed residency slots are solely a federal problem only solved by the federal budget. Maybe the time has come for universities to get grateful donors to endow some residency slots rather than professorial chairs and for NREF to fund a few as well. Considering how Washington is being run at the moment, we better start looking out for ourselves. ❖

CANS MISSION STATEMENT

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

Brain Waves

Deborah C. Henry, MD, Associate Editor

I read two interesting articles this past week. The first article was "$200 Billion is Wasted on Medical Tests" (LA Times, Saturday, May 27, 2017), and the second was "Organizing the Disenfranchised is the Key to Success" (California Teacher, April-May 2017). At first glance, these two editorials appear as different as republicans and democrats, but they are actually not that far apart.

It's no surprise to any of us that billions of dollars are squandered on medical tests. This article concentrated on the overuse of routine labs drawn daily in the hospital to the need for preoperative testing in the uneventful cataract surgery. Other sources of extravagant spending included the practice of defensive medicine and the benefit financially to hospitals for increased testing. I will never forget the time I saw a patient admitted from the emergency room with back pain after a car accident. Her plain X-rays showed a compression fracture of a lumbar vertebra. The radiologist could not tell if it was an old or new fracture. She had a past history of breast cancer and was one of those patients who wanted everything done. A CT scan, MRI, and bone scan later showed that this was an old, non-pathological compression. I had felt bad at the time for ordering so many tests, but not several months later when I received a notice from the State Board of California who were investigating this patient's complaint that not enough testing was done at the time. Whew, was I thankful for ordering everything but the kitchen sink.

The article from the California Teachers journal looked, in part, on student evaluations of teachers and how they impact part time teachers in the classroom. The supposition was that teachers without tenure, whose jobs depend partially on student evaluations, must practice "defensive teaching," whether through grade inflation or other nonacademic methods, in order to advance to the next semester.

So, here's to another source of increased medical spending: the happy patient. As more and more physicians are headed towards employment, their jobs and often their "tenure" in the practice depend on the satisfaction of their patients. Institutions, such as Kaiser, send out patient evaluations repetitively as a mechanism of assuring happy patients. Like the student who wants the A, what better way to make a patient happy than to give them the MRI, the referral, the lab test that they deem appropriate (as I surreptitiously did above). After all, the employed physician has limited avenues to succeed in making

the patient happy. Often they have no control over the front office, the wait time, the schedule, or the interruptions, all which can make for an unhappy patient.

Perhaps the customer service motto where the customer is always right does not work in education or in medicine. The California Teacher's article's position on part time teachers' evaluations was to eliminate the value of the student evaluation in determining whether the teacher is hired the next semester. Instead, the article suggested replacing student evaluations with peer assessments. In medicine, we have done this to some extent with the proctoring of surgeries. In both situations, a negative assessment may be detrimental to one's career; thus peers are reluctant to give a negative evaluation unless the situation is egregious. Until we figure out a better way to assess quality teaching and quality medicine, defensive teaching will continue to lead to grade inflation and defensive medicine to increase cost. ❖

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

The discovery of medicine to treat infectious disease is certainly of interest to many, but I am particularly concerned because of the significant effect it had on my family. My father contracted pneumonia in 1938 (when I was a year old). At that time, there was little that could be done to treat pneumonia – penicillin had yet to be produced and distributed in large scale -- and my father succumbed as a result of the infection. Recently, however, I came across a very good article that specifically detailed the discovery of penicillin in "Medicine's Age of Wonders" (WSJ, May 20-21, 2017, p. C6). Actually, the article is a book review of *Miracle Cure: The Creation of Antibiotics and the Birth of Modern Medicine* by William Rosen. *Miracle Cure* appears to be similar to the classic *Microbe Hunters* from Paul DeKruif, as several examples that illustrate the human side of antibiotic discovery are provided -- from the perspectives of scientists, doctors and patients.

The article notes an example from *Miracle Cure* of a policeman from Oxford England, Albert Alexander, who became the first patient ever treated with Penicillin in 1941. The result? As stated in the article: "One day after the intravenous therapy was started, [Alexander's] fever had vanished, the abscesses had stopped oozing pus, his face was no longer swollen and he was able to eat." Yet, the supply of penicillin at that time was so tiny -- his urine was collected after each dose and the drug recycled – that Alexander died a short month after the first introduction of penicillin into his system. This advancement in treatment was nonetheless duly noted as a "public triumph", and the drug was eventually able to be produced in industrial scale quantities, "just in time for D-Day." Howard Florey and Ernst Chain (leaders of the Oxford group), along with Alexander Fleming (who first discovered penicillin in 1928), were awarded the Nobel Prize in 1945 for their efforts.

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I like neurosurgical history, particularly that of neurosurgical pioneers who developed our profession. Recently, I re-read *Journal of a Neurosurgeon* by Edgar A. Kahn, M.D., published in 1972. Dr. Kahn's *Journal of Neurosurgery* is interesting reading. The book discusses Kahn's time at University Hospital in Ann Arbor, Michigan, where he honed his neurosurgical skills, first as a junior intern in 1925, and later as a professor. Yet, Kahn was not the average neurosurgical intern or resident. Kahn was independently wealthy, having inherited considerable means from his father. This wealth allowed Kahn to delay responsibilities and travel frequently (which is not something many of us could do). For example, Kahn traveled to Russia (for his father's tractor factory), to Persia (to be with a friend) and to France from 1940-45 (and for his honeymoon). However, Kahn must have enjoyed his time at the University of Michigan as he was, for many years, Chief of Neurosurgery, collecting a salary of $1 per year (yes, you read that right, Dr. Kahn decided that he would work for $1 a year in order to continue to teach and help his residents). It turns out that Dr. Kahn was the real life neurosurgical example used by his student, Lloyd Douglas, M.D. in Douglas's fictional account of neurosurgery, *Magnificent Obsession (*which was made into a movie starring Rock Hudson as the leading neurosurgeon). Apparently, Dr. Kahn provided an interesting character study for Dr. Douglas. ❖

Tidbits from the Editor

CMS to issue MIPS participation status letters

Starting in late April, the Centers for Medicare & Medicaid Services (CMS) began notifying physicians whether they will be subject to Medicare's new Merit-Based Incentive Payment System (MIPS). MIPS is part of the new Medicare Quality Payment Program established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Providers with less than $30,000 in Medicare payments or fewer than 100 Medicare patients are exempt from the MIPS reporting requirements. Physicians who exceed this threshold are subject to MIPS and are encouraged to participate in MIPS for the 2017 transition year to avoid a negative payment adjustment.

Over the next month, physicians will be receiving letters from CMS informing them if they, or the individuals in their group, are exempt from MIPS. The letter also advises physicians to review their information and determine whether they plan to participate as an individual physician or as a group, how to avoid a penalty or possibly earn a positive adjustment, and includes an FAQ with additional information. For clinicians participating under multiple TINs, a separate notification will be sent to reflect each TIN.

If you did not receive a letter, you can confirm your participation status using the CMS MIPS participation lookup tool.

The Centers for Medicare & Medicaid Services has created several short educational videos on getting started with the new Medicare Quality Payment Program, specifically targeting small, rural and underserved practices. The videos, each only up to 15 minutes long, focus on participation in the Merit-Based Incentive Payment System (MIPS), which was established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Video topics are as follows:

- Part 1: Getting started with the Quality Payment Program

- Part 2: Participating in MIPS
- Part 3: How to Participate in MIPS
- Part 4: MIPS Reporting Options and Data Submission Methods
- Part 5: MIPS Performance Categories
- Part 6: MIPS Scoring Methodology
- Part 7: Checklist for Preparing and Participating in MIPS

The Centers for Medicare & Medicaid Services (CMS) has exempted about two thirds of physicians and other clinicians who provide care to Medicare beneficiaries from the Merit-based Incentive Payment System (MIPS), a pay-for-performance scheme that will determine part of physicians' Medicare payments, starting in 2019.

A CMS spokesman told *Medscape Medical News*, "CMS mailed approximately 280,000 letters to practices using the Taxpayer Identification Number (TIN). The letter includes the MIPS participation status of each clinician associated with that practice's TIN. In terms of the number of clinicians, 418,849 will receive notification that they are participating in MIPS. And 806,879 will be notified that they are not participating in MIPS."

Watch what you do with online reviews—good or bad

Our friends at eMerit, who look out for the average doc, published this useful piece on vendors and HIPAA:

If you work with a third party vendor (also known as Third Party Administrators or Business Associates) to capture reviews for posting online, HIPAA applies. With the potential for steep consequences, covered entities should be vigilant about third party business agreements. This means the vendor should be a formal HIPAA Business Associate with signed documentation acknowledging as such and they must securely store and transmit Protected Health Information (PHI). We already know random HIPAA audits are here. Do NOT take shortcuts.

If the vendor is not a HIPAA Business Associate, and you provide PHI to this vendor, you need a valid HIPAA compliant authorization from each patient to disclose Protected Health Information to this vendor. Even if a vendor IS a HIPAA Business Associate, they will still need a valid HIPAA compliant authorization if they disclose PHI to the public – a patient review, for example. Make sure your Business Associate agreement indemnifies you if the vendor creates a HIPAA problem.

Consider this real life example…

A plastic surgeon took before and after pictures of his patient. The patient gave written authorization to use these photos on his website. The patient's only restrictions: Her eyes must be covered with black stripe and her name not be revealed. The surgeon's vendor had software to make these changes for upload. While the doctor's website (also managed by the vendor) honored these requests, Google indexed the full set of pictures exposing the patient's full face and her name. Both were revealed in a search of the patient's name. Perhaps the vendor's software was inadequate. The practice had properly engaged the vendor with a formal HIPAA Business Associate Agreement obligating it to appropriately safeguard protected health information as required by HIPAA and HITECH. The agreement also indemnified the surgeon for any legal or regulatory fallout.

Practice Arrangements: Physician Ownership Drops Below 50 Percent

Carol K. Kane, PhD of the AMA penned this partially reproduced article:

Using data from the American Medical Association's (AMA's) Physician Practice Benchmark Surveys, this Policy Research Perspective (PRP) describes the practice arrangements of physicians over the period from 2012 to 2016. The Benchmark Surveys include physicians who provide at least 20 hours of patient care per week, are not employed by the federal government, and practice in one of the 50 states or the District of Columbia. They collect information on four aspects of physician practice arrangements: whether physicians are owners, employees or independent contractors with their main practice; the type of practice that they work in (e.g., single specialty group); the ownership structure of their main practice (e.g., whether owned by a hospital); and how many physicians are in their main practice.

Previous research has documented the long term trend away from physicians being practice owners and toward being employees as well as toward larger practice sizes (Kane, 2015). The new Benchmark data show that this trend continued through 2016. In fact, 2016 marked the first year in which less than half of practicing physicians owned their own practice—47.1 percent. This was about 6 percentage points lower than in 2012. Similarly, practice size also continued to increase although the shifts in size distribution were small. Sixty-one percent of physicians worked in practices with 10 or fewer physicians in 2012 but only 57.8 percent were in practices of that size in 2016.

Practices with at least 50 physicians increased their share of physicians from 12.2 percent in 2012 to 13.8 percent in 2016. Hospital ownership of physician practices and direct employment of physicians by hospitals, on the other hand, appears to have stalled after 2014. The percentage of physicians in hospital-owned practices or who were employed directly by a hospital was the same in 2016 as in 2014 (32.8 percent) but higher than in 2012 (29.0 percent). ❖

Quotation for the Month:

Life would be infinitely happier if we could only be born at the age of eighty and gradually approach eighteen — Mark Twain

Meetings of Interest for the next 12 months:

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 26-28, 2017, San Francisco, 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; US Grant Hotel, San Diego, CA
North American Neuromodulation Society: Ann. Meet., January. 11-14, 2018, Las Vegas, NV
AANS/CNS Joint Cerebrovascular Section: Ann. Meeting, 2018 TBA
Southern Neurosurgical Society: Ann. Meeting, Feb. 28-March 3, 2018, San Juan, Puerto Rico
AANS/CNS Joint Spine Section: Annual Meeting, March 14-17, 2018, Orlando, FL
Neurosurgical Society of America: Annual Meeting, June 10 - 13, 2018 Jackson Hole, Wyoming
CSNS Meeting, April 27-28, 2018, New Orleans, LA
NERVES Annual meeting, 2018, TBA
AANS: Annual Meeting, April 28-May 2, 2018, New Orleans, LA
AANS/CNS Joint Pain Section Bi-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. ❖

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- Past newsletter issues are available on the CANS website at www.cans1.org.
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