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TUMULTUOUS TIMES

Kenneth Blumenfeld, MD, President

Division, division, division. What ever happened to cooperation, compromise, and common good. The house of medicine, as does our country, stands divided and at odds with respect to many healthcare issues. Yet with all the division there remains so much that we all can agree on.

When it comes to healthcare policy we should all be doctors and not democrats or republicans. We need to speak with one voice and most importantly try to regain the public trust. For too long we have let bureaucrats with little or no understanding of healthcare determine the fates of our profession and the patients we serve.

From my perspective, no administration has approached healthcare in an entirely rational fashion. The ACA has some laudable goals buried in over 2700 pages of pork and politics. It was a partisan taxation plan sold as an individual mandate that was anything but affordable. Truth be told it has been as Bill Clinton publically stated "a disaster". All on Capitol Hill know that is not viable as written even with delayed implementation and executive modifications. Not surprisingly no political party wants to take the blame.

So, if repealed will the Republican replacement plan be any better? In my opinion likely not unless we can get the partisan politicians and their special interest backers barred from the stakeholder table.

Perhaps we can agree on some basic tenants. Here are a few of my thoughts (not to be construed as representative of any organization or comprehensive in nature):

- 1) Everyone should be covered by a safety net form of coverage. As a modern industrialized country, I feel we should choose to provide these services. In making this choice we must recognized the cost as it is not free.
- 2) Everyone must contribute. I would like to get away from a mandate but if there is a mandate to treat there must be a mandate to pay. Too many have claimed they shouldn't be forced to pay for "something they don't want" but the system can't

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refuse to treat those in need regardless of their ability to pay. Much as someone can't refuse to have their money go to law enforcement, fire departments, or national security all in this country must contribute as their means allow.

- 3) We need to get rid of costs that add little or no value.
 - a. Tort reform immediately comes to mind. Although there are exceptions medical malpractice law suits do little to improve the quality or safety of patient care. More importantly they drive medical decision making thereby unnecessarily escalating costs.
 - b. How insurance companies improve healthcare and why anyone would think a corporation cares more about their wellbeing than a doctor is just baffling. That said true insurance reform needs to happen. We can no longer afford to line the pockets of CEO's and shareholders of insurance companies. Enough said.
- 4) A rational and balanced approach needs to be taken in controlling the costs of pharmaceuticals and medical devices. Although handsome profit need to be the carrot of innovation two things are also true. The carrots have gotten too big and real innovation as opposed to incremental advances often comes from underfunded academic research and not industry.
- 5) Healthcare will have to be rationed in an evidence based fashion. This is a scary and difficult concept. Its initial implementation will involve choosing not to provide futile or unproven care but is an admittedly slippery slope that will need to be navigated much as it has been in the UK and elsewhere.
- 6) Since this is the USA our system will need to be multi-tiered. In simple terms those who can afford more and better should be allowed to do so. I know this is distasteful to some but is a reality.

We are in for contentious debate. I am hopeful that organized medicine can have a unified voice. I like to think of tumultuous times as providing opportunity and strongly believe that our country needs our help and wisdom. ❖



Ken Blumenfeld, MD,
CANS 2017 President

Council of State Neurosurgical Societies Meeting

Randall W. Smith, MD, Editor

Atending the CSNS meeting on April 21-22 in Los Angeles as CANS' 7 delegates were Drs. Kenneth Blumenfeld, Mark Linskey, Patrick Wade, John Ratliff, Randall Smith, Marc Vanefsky and Deborah Henry each spending an extra 2 days before the AANS meeting to voluntarily represent CANS.

The CSNS meeting included a number of reports on previous resolutions plus current CSNS leadership and national reports by the AANS, CNS and Washington Committee. **Josh Rosenow**, MD, from Northwestern was elected to the two year chairmanship and **John Ratliff**, MD, from Stanford was elected as Treasurer. John also serves as Washington Committee Appointee and was previously on the Executive Committee of the Congress of Neurological Surgeons, is AANS RUC Advisor, previously served as Delegate to the AMA House of Delegates (representing the AANS), serves on the AANS Neurosurgeon Editorial Board and is immediate past-chairman of the joint AANS/CNS Neurosurgery Quality Council.

The Southwest Quadrant meeting was ably chaired by Mark Linskey, MD, from UC Irvine. The Quadrant elected the following residents for the three Quadrant fellowships for 2017-2018: **Celene Mulholland**, MD, Barrow Neurological Institute, PGY 5; **Daniel Nagasawa**, MD, UCLA, PGY 5; **Jessica Stark**, MD, UT Houston, PGY 5.



Mark Linskey, MD

Mark Linskey, MD, also was honored by receiving the Lyal Leibrock Lifetime Achievement Award recognizing his many years of service to the CSNS including being its immediate past chairman and spearheading the formation of the NERVES organization of neurosurgical practice managers. Oddly, Mark never served as SW Quadrant chair which he is now rectifying.

Also noted during the AANS meeting was the announcement by the CNS nominating committee of **Praveen Mummaneni** (UCSF), immediate past President of CANS, as the official nominee for CNS Treasurer, the election of **Moose Abou-Samra** (Ventura) as AANS

Vice-President and the appointment of **Deborah Henry** (Los Angeles) to the AANS Medical Ethics Committee.

The 10 resolutions debated at the meeting resulted in the following actions:

RESOLUTION I

ACTION: Combined with Resolution X - Adopted amended resolution

Title: Implications of Prescription Drug Monitoring Programs for Neurological Surgery

BE IT RESOLVED, that the CSNS survey neurosurgeons as to the impact, both positive and negative, created by laws that mandate verification of the PDMP; and

BE IT FURTHER RESOLVED, that the results of the PDMP survey be used to develop a white paper regarding possible measures to mitigate these burdens.

RESOLUTION II

ACTION: Rejected

Title: A Policy on Physician Use of Mobile Devices while Driving

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

ACTION: Adopted Amended Resolution

Title: Insurance denial of surveillance imaging prior to return clinical visits

BE IT RESOLVED, that the CSNS petition the AANS and CNS to work with the Washington Committee on advocacy efforts and produce a statement against the insurance requirement of clinical follow-ups prior to planned surveillance imaging studies in return patients.

RESOLUTION IV

ACTION: Rejected

Title: Evaluation of potential changes to the Affordable Care Act and the implications on Neurosurgery

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 care 2) the impact on delivery of neurosurgical care and 3) changes to reimbursement patterns and payer requirements.

RESOLUTION V

ACTION: Rejected

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

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 FURTHER 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

ACTION: Adopted

Title: The "Disruptive Physician" label and its impact on Neurosurgery

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

ACTION: Adopted

Title: Boot Camp for Advanced Practice Providers (Nurse Practitioners and Physician Assistants)

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 Practitioners 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 Practitioners and Physician Assistants) who work with neurosurgical teams.

RESOLUTION VIII

ACTION: Adopted

Title: Identifying the Economic Impact of Mobilization and Deployment on the Reserve Neurosurgeon

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

ACTION: Adopted

Title: Following longitudinal burnout among Neurosurgery Residents

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

ACTION: Combined with Resolution I

Title: The Impact of the Prescription Drug Monitoring Program on Neurosurgical Workflow ❖

CANS MISSION STATEMENT

‘TO ADVOCATE FOR THE PRACTICE OF CALIFORNIA NEUROSURGERY
BENEFITTING OUR PATIENTS AND PROFESSION’

Brain Waves

Deborah C. Henry, MD, Associate Editor

The Council of State Neurosurgical Societies (CSNS) is celebrating their 40th anniversary this year of identifying the socioeconomic issues of the neurosurgeon and bringing it to the eyes of our parent organizations. The CSNS meeting this past weekend was rather subdued compared to many that I have attended in the past dozen years. Perhaps that is a sign of physicians feeling worn down from the constant infringement on their practices. The 10 resolutions debated ran the gambit from a big brother one wanting to know how we use our technology while driving (rejected), to looking at how deployment economically affects the reserve neurosurgeon (unanimously approved), and to how changes in the ACA may impact the neurosurgeon (deemed premature and therefore defeated).

A resolution that received some deliberation was one on insurance denial of surveillance imaging prior to return clinic visits. Requiring a patient to see a doctor before they order a routine follow up study (of perhaps tumor surveillance) is both inconvenient and unnecessary. This resolution, asking for the AANS and CNS to create a policy statement against this insurance requirement, was accepted. But this resolution and related follow up talks brought about a debate of how narrow networks are harming patient access to doctors.

On one of my drives this month while listening to the news radio channel, I caught the tail end of a survey discussion on what keeps people up at night. Apparently the interviewee does a yearly analysis of those problems that vex us at nighttime, from job, family, mortgage worries among others. This year, for the first time, concerns on health care kept most from a good night's sleep. To us on the medical battlefield, this is not surprising given all the uncertainty of where we are going as a nation with our health care system. For example, I have a friend who signed up for the Silver Plan in the Affordable Care Act. What I learned at the CSNS meeting is that this is the most popular plan, as it is one of the least expensive, but it does not cover much. My friend is often stuck in the both the narrow network loop and the must return to clinic before authorization for a procedure can be done circle. Having grown up in Southern California and having the genes for very fair skin, she has developed basal cell carcinomas on her face. She sees the primary care doctor who is overburdened with patients and eventually gets a referral to a dermatologist 50 miles away in downtown LA. She drives 2 hours in traffic, waits for the visit, is told the lesions need removed, waits 2-3 months for authorization, comes back for the procedure for one of the basal cells, waits for authorization for a visit for the second.... I think you get the picture. She is a victim of our broken health care system.

At the end of the radio show on what keeps us up at night, the interviewer asked the surveyor what surprised him most about this year's study. He said that it was that health care is now the number one cause of angst for the sleepless. It had never been number one in all the years of his surveys. Unfortunately, I suspect that it will be number one now for quite a few years to come. ❖

**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

Brain death is a seemingly straightforward medical diagnosis. It is determined by various standardized tests which are widely accepted by hospitals and doctors across the country. However, in some cases, brain death can become tangled in emotional religious, legal and financial issues that may be traumatic for all involved.

Arthur Caplan, M.D., Director of Medical Ethics for the NYU School of Medicine, states that the concept of brain death can cause persistent problems, as people in hospital settings occasionally misuse terminology. Some consider the brain only a component of the living body so that a patient may recover even if brain dead because the rest of the patient is considered to be still alive. However, there has been no known case of anyone recovering after brain death. Dr. Wade Smith, Director of Neurological Intensive Care for the University of California, notes that brain death is the end of life, and such finding is widely accepted among all neurologists. Nonetheless, some family and friends of the patient may insist on continued care despite the patient being declared brain dead. I'm sure all of us have encountered such sensitive difficulties in our practices.

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A March 4, 2017 Wall Street Journal article noted that heart attacks can occur in very young, healthy individuals, many without apparent heart abnormalities. The article described an 18-year old man who, without any previous heart problems, suddenly collapsed, his heart stopping. Fortunately, this particular young man was successfully revived and, following a 20-day hospitalization, improved significantly -- which is apparently a rather unusual outcome.

According to the American Heart Association, the fatality rate for cardiac arrest is upwards of 90% (50% if someone capably administers CPR). The AHA estimates that more than 350,000 people experience out of hospital cardiac arrest each year, commenting that the 350,000 estimate is probably a low estimate. Further, the AHA determined that around 1% of young people have abnormal heart conditions, including cardiomyopathy, long QT syndrome and other heart arrhythmias -- so early intervention could save lives. Despite the scary statistics of cardiac episodes, even occurring in those young, presumably healthy individuals, less than 1% of schools are prepared to address cardiac arrest. Such efforts are cost-effective: volunteer-run screening, including a 12-lead EKG, costs about \$13,000 for 750 students, or about \$20 per student. Yet, schools and the NCAA have resisted such screening due to the high occurrence of false positives (around 25% of tests flag problems when only 1% are truly accurate). Subjecting 24 percent to further, expensive and emotionally-distressing testing in order to find that one percent is currently a sufficient deterrent so that many avoid testing altogether. ❖

Tidbits from the Editor

CAP HR Manual released in the clear

Managing medical practice personnel is more complex than ever. That's why CAP just released its 2017 Human Resources Manual, a comprehensive Word document that can be customized to a practice of any size.

Download

Employment Manual http://www2.capphysicians.com/HRManual?utm_source=Link1

An up-to-date employee handbook and management guide is essential to:

Reduce your chances of being sued by staying compliant with the latest laws and regulations

Establish office policies specific to your practice

Foster positive employee relations by documenting paid benefits and establishing policies of expectations from staff

Prevent minor issues from escalating into a major crisis by having HR guidelines in place to address the situation

CAP, a leading provider of medical malpractice protection in California and sponsor of the CANS newsletter, helps its 12,000 members run safe and successful medical practices by providing no-cost educational programs and other practice management benefits like this HR Manual. For a limited time, CAP is making this Employment Manual available to non-member physicians to experience the added value of CAP membership.

To learn more about CAP and our value added benefits, please contact us at 800-356-5672 or MD@CAPphysicians.com or Request an Instant Quote.

Watch what you do with online reviews—good or bad

eMerit –the neurosurgery practice support company founded and run by neurosurgeon and friend Jeff Segal, posted this first of a number of advisories about Online Reviews.

Beware of Responding to Online Reviews – Diffusing HIPAA Landmines – Part 1 of 5

Maintaining compliance with HIPAA, TCPA, the FTC, and the host of other regulatory boards is complicated. An inadvertent error can result in massive fines, but there is much to be gained from a smart online strategy if you avoid the minefield of potential violations. For the next five weeks, we're breaking down five marketing landmines that risk HIPAA and regulatory compliance. Each article will cover one of the five landmines, and each article will conclude with an opportunity for readers to download a white paper that explains all five landmines in greater detail. Our goal is to help you ask the right questions about your practice; and ask your vendors the right questions. If they get HIPAA wrong, you will be the person who burns. Let's get started.

Landmine #1 – Beware of responding to online reviews; consider if HIPAA applies.

It is never productive to engage in a detailed, prolonged back and forth online debate with a negative reviewer. There are two main categories of negative reviews:

You know the patient – Best practice is to reach out to the patient directly, not online. Most patients are receptive to your call if their problem can be solved. It is an opportunity to turn a negative into a positive. If their initial review created mischief on the Internet, and remains unchanged even after you resolve the issue, send a private note: "I hope I addressed your concern. Would you be kind enough to remove or update your Yelp review?" These are the magic words: "Please treat this as a request; and not a demand." The patient should always have choice. Most patients do react positively to this type of request.

You don't know the patient – Reach out to public at large when responding online, and speak in general (not specific) terms to correct the record, explain your practice philosophy, and how you typically handle such situations.

Real life example: Patient complains online about a "botched plastic surgery outcome." She writes the surgeon is "demanding another \$10k to fix the problem he created." Without getting into the details of this specific case, the surgeon can promote his practice by explaining that he typically waives his professional fee for any surgical revisions because he wants as many patients as possible to be satisfied with their outcomes. It's a way to debate without debating. Nobody is accusing the patient of lying. Simply describe what's true about your practice. This negative review created an opportunity to promote a positive feature of the practice.

Some debate whether responding to positive reviews makes sense. My vote is no. Why? First, many reviews will be positive. So, you are thanking someone for the thanks. Coming up with original material to appear authentic and avoid sounding canned will be exhausting. For anyone other than a Hollywood writer, you'll quickly run out of material. Stick to religiously addressing the occasional negative review.

Many doctors believe if patients identify them as their doctor in an online review, they have the right to respond in detail. In fact, responding to the patient, even an expression of gratitude, could acknowledge the doctor-patient relationship without the patient's written authorization; a HIPAA violation. In most other industries when your reputation is threatened in an online review, you can address it immediately and publicly. For healthcare providers, however, HIPAA has your hands tied.

Real Life example: A patient posts a glowing online review and you respond.

Patient review: I cannot thank Dr. Jones enough for helping me when I was in the intensive care unit. (Includes picture of Mary Smith's face and byline is 'Mary S.')

Dr. Jones' response: Mary, it's a pleasure taking care of patients like you. Glad you are feeling better.

While 'Mary S.' is not an identifier, her picture is. You have breached her private health information and HIPAA penalties are potentially forthcoming.

What is considered PHI? Download the full white paper below and look to Appendix A for an exhaustive list.

So, in conclusion, what's the key to diffusing this landmine? Don't debate a negative reviewer online and don't respond to positive patient reviews.

Medtronic recalls shunt valve

Joe Carlson of the *Minneapolis Star Tribune* penned the following report on April 6, 2017. We reproduce that article without permission in the interest of patient safety.

Medtronic has announced a worldwide recall of an implantable medical device used to relieve fluid pressure from the brain following an increase in complaints about the product, including a patient death that may be related to the problem.

*The global device maker, run from executive offices in Minnesota, said on Thursday that doctors should stop using a device called the **StrataMR adjustable pressure valve** (bolding ours), and return all unused product to the company. The company news release said 2,622 StrataMR valves manufactured between October 2015 and November 2016 were affected by the worldwide voluntary recall.*

As of April 1, the product had a complaint rate of 2.75 percent of all units distributed. Although one patient has died, the product alert said the fatality has not been confirmed to be related to the issue.

The StrataMR, which is intended to be safe for use with magnetic-resonance imaging scanners, received sales clearance from the FDA in May 2016.

The recall announced Thursday does not affect the similarly named Strata II or Strata NSC hydrocephalus valves.

However, in February the U.S. Food and Drug Administration announced more than 300,000 units of those devices were the subject of a voluntary field action that updated the device's instructions after Medtronic received five reports of discrepancies between the valve's pressure setting and the actual reading determined via X-ray.

“Desktop Medicine” Takes Up 50% of Physicians’ Time

Time spent by physicians is a key resource in healthcare delivery. This is the focus of a study published April 3 that investigated how physicians split their time between patient visits and computer tasks and found, on average, physicians spent slightly more than 50% of their time on “desktop medicine” each day.

The abstract for the study published online in *Health Affairs* — led by Ming Tai-Seale, PhD, associate director of the Mountain View-based Palo Alto Medical Foundation Research Institute — explains: “We used data on physicians’ time allocation patterns captured by over thirty-one million EHR transactions in the period 2011–14 recorded by 471 primary care physicians, who collectively worked on 765,129 patients’ EHRs. This study used data captured by the access time stamp functionality of an electronic health record (EHR) to examine physician work effort. This is a potentially powerful, yet unobtrusive, way to study physicians’ use of time. Our results suggest that the physicians logged an average of 3.08 hours on office visits and 3.17 hours on desktop medicine each day. Desktop medicine consists of activities such as communicating with patients through a secure patient portal, responding to patients’ online requests for prescription refills or medical advice, ordering tests, sending staff messages, and reviewing test results. Over time, log records from physicians showed a decline in the time allocated to face-to-face visits, accompanied by an increase in time allocated to desktop medicine. Staffing and scheduling in the physician’s office, as well as provider payment models for primary care practice, should account for these desktop medicine efforts.”

The study is one of the first to look at how established doctors — as opposed to trainees — use EHRs, and it is also among the first to use the time stamps in EHR access logs to measure physician work effort. Most similar studies have relied on physician reports, time and motion studies, or video and audio recordings, according to Medscape.

According to the researchers, “The logs suggest that physicians allocate equal amounts of their clinically active time to desktop medicine work and to face-to-face ambulatory care visits. While working on progress notes could be considered pre- or post-service efforts, desktop medicine activities not linked to a face-to-face visit are not reimbursable under typical fee-for-service contractual and regulatory arrangements. Many of those activities — such as care coordination and responding to patients’ e-mail — are of high value to the delivery system and to patients, so the staffing, scheduling, and design of primary care practices should reflect this value.”

The authors emphasize that such nonpatient time must be accounted for in compensation models going forward and recommended “staffing and scheduling in the physician’s office, as well as provider payment models for primary care practice, should account for these desktop medicine efforts.”

The researchers noted that new healthcare policy programs for Medicare clinicians, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and CMS’ Comprehensive Primary Care Plus model, will allow practices the flexibility to deliver care in the way that best meets patients’ needs, without being tied to the office visit. “This is an explicit move away from payment for visits only, and an acknowledgment that critical aspects of patient care that happen outside the visit require appropriate compensation,” the authors wrote. ❖

Quotation for the Month:

**Everything that counts is not counted; not everything that is counted, counts
—Albert Einstein**

Meetings of Interest for the next 12 months:

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 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; Hotel TBA, 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, 2018, TBA
 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

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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