CANS newsletter

3-year med school: Its about time

Randall W. Smith, MD, Editor

For those of us who spent 4 years in medical school, which is nearly all of us, knocking off a year of that enjoyable experience certainly would catch the attention of a whole lot of students. UC Davis and Kaiser have begun a program designed to make med school a three year sojurn. Since a year of med school at Davis costs about $40,000 annually for California residents and $52,000 for other students, there are savings to be had. Davis joins a dozen medical schools in the nation that now offer a three-year medical degree program.

As usual, there are some devilish details. Most of the three year programs are aimed at students who commit to primary care. Davis takes 6 students a year into their 3-year program officially called the Accelerated Competency-based Education in Primary Care program offered in conjunction with Kaiser Permanente. Those enrolled in the program are treated differently in that they skip summer break and get a guaranteed a primary care residency at the UC Davis Medical Center, Kaiser Permanente Napa-Solano, Kaiser Permanente Santa Clara and other regional hospitals. Started in 2014, the Davis program, which gets several hundred applicants per year just graduated its first six 3-year students who are all now in the pre-arranged residencies.

Some old-guard medical school educators have concerns about whether adequate training can be accomplished in three years. This writer feels that by the end of their residencies, the 3-year folk will be indistinguishable from the 4-year crowd. Time to move on, America. ❖

INSIDE THIS ISSUE:

CANS MISSION STATEMENT

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

Brain Waves

Deborah C. Henry, MD, Associate Editor

Unless you have been locked in that proverbial silo or out of the country, you probably have not missed the ongoing saga of the recently fired USC dean of the medical school. An *LA Times* article broke over a week ago the story of the hidden shenanigans of the renown eye surgeon Carmen Puliafito who allegedly partied and used illicit drugs with criminals. The *LA Times* has followed their eye-popping article with almost daily updates, but the one most pertinent to fellow doctors occurred this past Monday, July 24. Here, journalist Soumya Karlamangla looked at physician impairment.

One of her sources, Dr. Lisa Merlo from the University of Florida College of Medicine, states that approximately 10% of the population develop a substance abuse problem, including doctors, the most likely being ER physicians, anesthesiologists, and psychiatrists. She also said that men are more likely to be *referred* than women (no note on if women and men are equally affected or not).

Physicians who know the signs of addiction are perhaps better at hiding those signs than the layperson. Furthermore, it often is difficult for a physician to ask for intervention for fear of losing his/her license, and it may be almost as difficult for the hospital staff to offer help. According to Dr. Martin Sepala from the Hazelden Betty Ford Foundation, "a neurosurgeon…that's a big income producer for the hospital, they [the hospital] may be really resistant to putting that person into treatment."

The *Western Journal of Medicine* in 1990 reported that California had the country's first medical board run physician impairment program (WJM 152: 617-621, 1990). By the time this article was in print, the California's program had been in place 10 years with a 72% completion rate. Only 618 physicians participated over those 10 years. The program consisted of volunteer physician addiction specialists serving on an evaluation committee, a drug-free contract signed by the physician-patient, group meetings of 6-15 affected physicians, and a case manager who oversaw 50-60 physician cases. In 2008, the California physician impairment program was disbanded for poor oversight and participation. At least five attempts at passing a new bill for a new program have appeared in California legislature since 2008. Physician intervention in California remains at a standstill.

The *LA Times* article further stated that in the 2015-2016 fiscal year, the California Medical Board revoked or suspended 43 physician licenses for substance abuse. When I search the Medical Board website, I see only 18 reports of impaired physicians during this time. (https://tinyurl.com/2015-16medicalboard). What has happened to the rest of the predicted10% of impaired physicians?

The warning signs were clearly there for USC to recognize in Carmen Puliafito's case. According to Sunday, July 30, 2017 *LA Times* article, there were numerous faculty evaluations and reports to human resources regarding Dr. Puliafito's behavior, but no intervention for him from the school. That is until now after the damage has been done. ❖

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

Attention Members:
Please use form attached to the newsletter email to submit your nominations for the CANS 2018 Board member positions open. Also, nominations are being taken for a possible Pevehouse Award winner and for the Ablin Award (Distinguished public service award).

Tidbits from the Editor

Work Comp QME exam in October

The Division of Workers' Compensation is accepting applications for the qualified medical evaluator exam to be held Oct. 21.

Physicians must complete a 12-hour course in disability evaluation report writing and sit for the exam to be certified by the DWC to perform medical evaluations on injured workers.

The Oct. 21 exam will be held in Northern and Southern California at locations that will be identified in confirmation letters sent to physicians who register.

Providers must pay a non-refundable $125 fee to sit for the exam. Applications for the October exam must be postmarked by Sept. 7.

More information, including a registration form for the October exam, is here.

Got a bitch? Air it out!

The Council of State Neurosurgical Societies will hold its next meeting in conjunction with the Congress of Neurological Surgeons meeting in Boston on October 6-7, 2017. That meeting offers an opportunity for any idea about neurosurgery to be debated and potentially acted upon.

Any CANS member who wishes to bring an issue to the attention of the AANS and CNS can formulate a resolution about any topic and submit it to CANS for sponsorship. Guidelines for creating a resolution, taken from the CSNS Web site (https://csnsonline.org), are reproduced here:

Guidelines and Hints for Resolution Submission to the Council of State Neurosurgical Societies

INTRODUCTION

Resolutions are the life-blood of the CSNS. Resolutions drive the process of the organization and direct it in its interaction with the parent bodies of Neurosurgery (AANS, CNS). Formal resolution submission guidelines can be accessed in the Procedures Section of Appendix A of the CSNS Rules and Regulations. A Resolution may be generated by any member of a state neurosurgical society, the AANS, or the CNS; but actual submission of a resolution to the Council must be by a CSNS delegate (see membership section of CSNS Rules and Regulations). Resolutions that are adopted are binding on the CSNS, advisory to the parent bodies and informational to state societies.

The following tutorial was produced to assist in construction and submission of resolutions. The goal is to create a smooth and efficient process of communication between individual neurosurgeons or their state societies and the CSNS through resolution generation and submission.

GENERATING A RESOLUTION

A resolution should be generated by an individual neurosurgeon, or State Neurosurgical Society, out of a desire to positively influence the course of Neurosurgery in the socioeconomic sphere. Although often arising out of a concern about the negative impact of external or internal forces upon our discipline, it should not be used simply as an opportunity to vent, particularly when a desired outcome is way beyond the capabilities of the CSNS, AANS and CNS (e.g.: Resolved-Abolish Medicare). It therefore should extend beyond a single individual's "axe to grind."

A resolution should be crafted in a concise but cogent fashion. To heighten its impact, it should be well researched, well though out, well worded and explicit. It should be precise in its focus and justification. Many resolutions are tabled on the basis of vagueness or a meandering focus. The resolution must pertain to the socioeconomic world of neurosurgery. Its goals must be realistic and accomplishable (a demand for the end of all lawsuits, for example, may be desirable but is not realistic or accomplishable).

The Rationale

A resolution is constructed in two parts- the "rationale" first and the "resolve" to follow. The rationale section presents supporting evidence for the action(s) requested or desired by the author(s) in the resolution. It is essentially an argument or justification for said actions. It should list the most pertinent information that would lead to and support the action(s) requested (in the following section). It

should be succinct but complete and convincing. A meandering, vitriolic, verbose, vague rationale will harm a resolution no matter how good the intentions behind it. A resolution with a minimal supporting or unconvincing rationale may similarly fail.

Wording of the rationale section follows a formalized pattern. Each supportive statement, idea, or paragraph must begin with ***"Whereas,"***. If multiple justifications are to be presented, the end of each justification will end with ***";and"***. The final justification will end with ***" ;therefore"*** to lead into the resolve section.

Example:

WHEREAS, neurological surgeons coping with managed care organizations, are often negotiating economic matters based on relative value scales; and

WHEREAS, neurological surgeons are in need of assess practice costs against individual work activity; and

WHEREAS, neurological surgeons in practices without electronic medical records and office management software are at a disadvantage in the marketplace; therefore

BE IT RESOLVED, that the CSNS develop a web-based tool that is accessible for neurological surgeons that will help them to determine on generally accepted principles the determination of total work unit per unit time and the ratio of relative value units to practice cost.

The Resolve

The resolve section is the ***only part of the resolution that is actually subject to revision and indeed voted upon*** by the assembly at the CSNS meeting (the rationale section is dropped after initial review and testimony). The resolve should therefore be very specific in detailing the action(s) desired by the author(s). Again vagueness and poorly chosen wording may be lethal to the resolution. Wandering, poorly associated resolves are in equal jeopardy. Keep the desired goal or action limited and specific. Don't use the resolution as a multi-warhead ICBM attack on all that is wrong with neurosurgery.

The resolve should follow a logical progression from the rationale. In other words, after reviewing the rationale, the resolve should make sense. Remember that the desired actions proposed in the resolve must be within the scope of the CSNS and indeed its parent bodies. It should be realizable in its desired effects.

Ideally, the resolves should contain an action plan for implementation of its desired effects. Simply stating that "the CSNS should...", or "the AANS/CNS and ABNS should..." may lead to an impression that the author is just throwing out a problem for others to solve, and may therefore diminish the resolution's desirability. A reality-tested action plan makes the resolution far more palatable and easier to envision its cost and its benefit. Again, thoughtful, complete, concise, well-crafted resolves carry significant impact.

Like the rationale, the resolve follows a formal pattern of presentation. The lead statement is begun with the term ***"Be it resolved"***. Subsequent statements are begun with ***"Be it further resolved"***. Separate statements or paragraphs are joined with an ***";and"*** at their termination with the exception of the final statement/paragraph.

Example:

BE IT RESOLVED, that the CSNS develop a comprehensive, socioeconomic core curriculum including both topics and skills; and

BE IT FURTHER RESOLVED, that the CSNS request the AANS, CNS, and ABNS work with the CSNS to establish and recognize a single core socioeconomic curriculum to be the foundation of these topics for neurosurgical education and MOC; and

BE IT FURTHER RESOLVED, that the CSNS then establish mechanisms to provide that there are educational opportunities to cover all components of the core socioeconomic curriculum; and

BE IT FURTHER RESOLVED, that having established the core socioeconomic curriculum, the CSNS will provide additional assistance to the AANS, CNS, and ABNS on these topics, including required board questions.

Fiscal Note

The final step in the preparation of a resolution is the fiscal note. Here the author is asked to assign an estimation of the cost of enacting their resolution. In the past the fiscal notes have been somewhat fanciful. We ask that some good thought is put into this note as it essentially acts as an initial budget. Having a well-designed action plan should greatly facilitate the calculation of a budget. If the projected cost is extreme, a plan for its acquisition and/or generation should be included in the resolves.

Final Thoughts on Resolution Preparation

The CSNS can be considered the socioeconomic conscience of neurosurgery. The twice yearly assembly of its members is essentially Neurosurgery's town meeting. It is wonderfully democratic and driven by Neurosurgery's "rank and file." The agenda is set by the submitted resolutions. ***The better the resolutions, the better the agenda, the more productive the meeting***. Here is the opportunity for every neurosurgeon to participate in the process of organized neurosurgery. Here is an amazing opportunity to affect positive change.

Go ahead, generate a resolution. Make sure it is well written, well thought out, concise, complete and goal oriented. Research and vet it. Bring it to your state society and get it submitted. It is o.k. to be controversial but you better make it to the meeting "loaded for bear" in order to defend it. Have fun being part of the solution! ❖

Quotation for the Month:

Politics is the gentle art of getting votes from the poor and campaign funds from the rich, by promising to protect each from the other--Oscar Ameringer

Meetings of Interest for the next 12 months:

Western Neurosurgical Society: Annual Meeting, September 8-11, 2017, Banff, Alberta, Canada
CANS, Fall Board Meeting, September 23rd, 2017 Sheraton Gateway LAX, Los Angeles, CA
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, Jan. 22-23, 2018, Los Angeles, CA
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, New Orleans, LA, April, 2018, DateTBA
AANS: Annual Meeting, April 28-May 2, 2018, New Orleans, LA
AANS/CNS Joint Pain Section Bi-Annual Meeting, 2018, TBA.
Rocky Mountain Neurosurgical Society: Ann. Meeting, 2018, TBA
New England Neurosurgical Society: 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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