CANS newsletter

Less Medical Student Debt Says Rich Crowding Out Poor. Not

Randall W. Smith, MD, Editor

On September 05, 2017, Marcia Frellick of *Medscape* reported that between 2010 and 2016, the proportion of medical school students who graduated without educational loans increased from 16.1% to 26.9% despite steady tuition hikes, according to new research.

Within the debt-free cohort, scholarship funds actually took a steep dive from $135,186 in 2010 to $52,718 in 2016, the investigators report in an article published online September 5 in a research letter in JAMA Internal Medicine. (Figures were adjusted to 2016 dollars.)

That may seem like good news, the authors write. However, because there was no substantial increase in scholarships in that time, the data suggest that more wealthy students are entering medical schools, which could exacerbate inequities.

"[A]s we consider increasing the diversity of the physician workforce, this would suggest that we're not moving in the right direction in terms of income," senior author David A. Asch, MD, from the Penn Medicine Center for Health Care Innovation, in Philadelphia, Pennsylvania, told Medscape Medical News.

Meanwhile, among medical school graduates who do report debt, the average increased to $190,000 by 2016, according to the Association of American Medical Colleges (AAMC).

It appears to this writer that the concept that the increased percent of med students who are debt free signifies that students from rich families are crowding out students from poor families presupposes that there is a cadre of poor but otherwise competitive students who either don't apply to med school because they can't afford to or that they are discriminated in the application process because they are poor.

This writer thinks that it is unlikely that any poor med school applicant decides to not apply because of inability to afford med school and does indeed still get in but does likely become one of the med school graduates with significant debt. The increase in debt free graduates may reflect the richness of parents but may well indicate that med students are wary of the well publicized debt load of many students and work hard to not

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borrow from the feds. The availability of easy money from the feds and others sure tends to generate debt. This writer worked hard during med school with part-time jobs and frugal living, minor scholarship help and a new wife's income as a nurse to graduate debt free (no one would have loaned me any money anyhow since there was no federal loan option and private money for such endeavors was non-existent).

Further, I have never heard of any med school using monetary criteria as a criterion for admission. I was chairman of the UCSD admissions committee for 18 months in the 1970's and we never remotely used any monetary criterion for admission—in fact we didn't have any information about any applicant's monetary situation. It was and must still be: Who is best qualified by previous academic performance plus personality to become a doctor?

One suspects that the authors of the article, who jumped to the deplorable rich vs poor explanation for the increase in those who are debt free, are reflecting their liberal inclinations rather than hewing to what the facts might really mean. ❖

CANS MISSION STATEMENT

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

Brain Waves

Deborah C. Henry, MD, Associate Editor

In 1978, Jimmy Carter signed into law the Court Interpreters Act. This rather lengthy section of the United States Code provides for certified interpreters in US district courts for those who speak a primary language other than English and for those who suffer from hearing impairment. This law stems from the Civil Rights Act of 1964 that prohibits discrimination on the basis of race, color, and *national origin* in programs and activities receiving financial aid.

In January 2015 California, who as we know likes to be the first, expanded this law with AB 1657 that provides interpreters to all parties in civil matters, regardless of income. This bill led to the development of a task force to oversee the needed changes in the court system. How many people are we talking about? The estimate is that nearly seven million people in California speak or understand English "less than very well" (www.courts.ca.gov).

In 2000, the Feds began an investigation of California court interpreter system after the Legal Aid Foundation of Los Angeles filed a complaint for two Korean women who were denied a court interpreter in two separate cases. There are reportedly 220 different languages spoken in California. There are 8 million court cases in California yearly. No wonder that there is a shortage of certified interpreters. (LA Times, September 5, 2017)

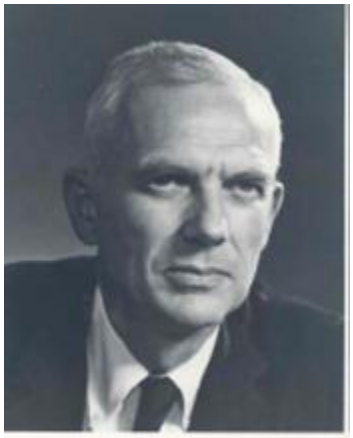
In February of 2003, State Bill 853 in California required health care service plans to provide enrollees with "language assistance". The amount of services needed depends on the percentage of limited English proficiency (LEP) people that one serves. The general rule is that written translation of vital documents should be available for 5% or 1000 LEP persons served, which ever is less, and that if the 5% includes less than 50 people, oral interpretation of the written material and notification of this should be provided (National Council on Interpreting in Health Care).

Many years ago, I read that the DMV of California offered the driving test in 35 languages. Online, I find DMV test booklet in 10 languages other than English. I often wondered if there would be a time that highway directions would need to be in all these languages. Maybe the self-driving cars will save us from that. Maybe in the future we will have an AI robot in our offices interpreting those 220 languages. ❖

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

In Memorium

Walter Eugene Stern Jr. 1920-2017



On July 27, 2017, the world of Medicine and Surgery lost a towering neurosurgical pioneer who left his mark not only neurosurgery but also surgery.

Walter Eugene Stern Jr. was the founding chairman of the Division of Neurosurgery at UCLA and the last living Founding Father of the Western Neurosurgical Society.

Dr. Stern was born in Portland, Oregon but grew up in Southern California. He attended college at Berkeley and received his Medical Degree as well as his neurosurgical training at UCSF, under the direction of Dr. Howard C. Naffziger.

While at UCLA, he helped build the renowned program with which we are familiar today. He then assumed the Chairmanship of Surgery, a position he held until his retirement.

The W. Eugene Stern Endowed Chair of neurosurgery was dedicated in his honor at UCLA upon his retirement.

He was a dedicated clinician and researcher with wide areas of interest. Additionally, he was a meticulous teacher and a demanding neurosurgeon; he held himself to the highest of standards, before expecting the same from his students and trainees.

Dr. Stern held many distinguished positions in organized neurosurgery and surgery: He was chairman of the editorial board of the Journal of Neurosurgery, Vice Chairman of the American Board of Neurological Surgery, Secretary of the American College of Surgeons, President of the Western Neurosurgical Society, President of the Society of Neurological Surgeons and President of the American Association of Neurological Surgeons. He received many great honors including: The Cushing Medal from the American Association of Neurological Surgeons and the Byron C. Pevehouse Distinguished Service Award from the California Association of Neurological Surgeons.

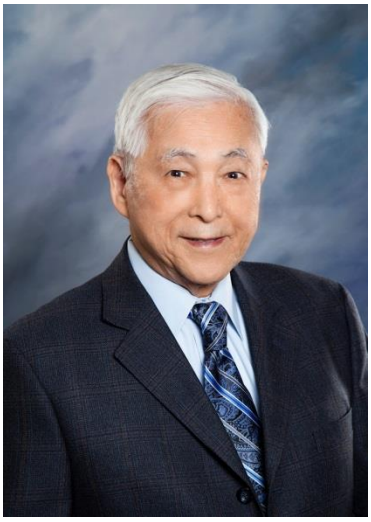
Dr. Stern managed, during his demanding neurosurgical training in San Francisco, to meet, date, fall in love and marry his chairman's daughter, Elizabeth Naffziger in 1946. She preceded him in death in 1989. Four children survive them: Geoffrey Alexander, Howard Christian, Eugenia Louise, and Walter Eugene III.

He was very much involved in his local community and served on the board of trustees of Harvard-Westlake high school for 12 years, a reflection of his strong commitment to education. He also served as Senior Warden at St. Augustine-by-the-Sea in Santa Monica and later in the same capacity at St. Matthew's Parish in Pacific Palisades, where his memorial service was held on August 19, 2017.

He was a true gentleman and was always welcoming to new members of the neurosurgical community in Southern California, and this writer remembers him fondly. He was very gracious when I met him for the first time after moving to Ventura, and at every subsequent encounter.

--Moustapha Abou-Samra
Associate Editor

Yamada Death a Loss to Neurosurgery



CANS was saddened to learn of the death of a founding member and longtime friend, Shokei Yamada, M.D., PhD of Loma Linda University School of Medicine on August 31, 2017 at the age of 91.

Dr. Yamada received his M.D. and Ph.D. in physiology from Jikei University in Tokyo, Japan in 1954. He began his neurosurgery training at the University of Toronto, then continued at the University of Chicago, and completed his residency at the Oregon Health Science University in 1962. In 1964 he joined the Medical University of South Carolina as an Associate Professor, serving as co-director of residency training and Chief of VA Neurosurgery. In 1973, he came to Loma Linda University School of Medicine where he spent the next 26 years. From 1989 to 1995 he served as Chair man of Neurosurgery at Loma Linda. He retired in 1999 and since then participated in teaching and research. He continued to consult on clinical cases nationally and internationally until his death.

Shokei had an illustrious career spanning six decades. Due to his innovation and expertise in treating adult tethered cord syndrome, many of his patients came from as far away as Europe, China, Australia, and South America to seek his medical care. He received

numerous rewards and honors over the years, including the Distinguished Neurosurgeon Award of the CNS. Remarkably at age 89, he received first place for his poster presentation on Spindle Cells in Glioblastomas at the 2015 Pediatric Neurological Surgery Conference. Dr. Yamada published over 175 articles and book chapters. He was regarded as the preeminent authority on adult tethered cord syndrome and leaves his mark in the field of neurosurgery in his book "Tethered Cord Syndrome" which is in its 2nd edition.

In addition to his many professional accomplishments, Shokei was a dedicated husband, father and grandfather. He was married to Rachel Thomasson of York, SC, enjoying almost 50 years together. They had two daughters, Vivian and Cheryl, and one son, Brian.

Shokei had a deep love of classical music, in particular the violin, which he played. He was a devoted Angels fan and attended many games over the years with Rachel and the children. Shokei spoke and read four languages: Japanese, English, French and German.

Dr. Yamada was the consummate gentleman and was always pleasant and interested in any topic presented. He will leave a void not likely to be filled by anyone soon. ❖

Tidbits from the Editor

Docs doing Work Comp will need a guidelines license

Any CANS member who is still treating Work Comp patients has a new hurdle to clear. California providers must purchase a license from Reed Group to use its treatment guidelines after they're incorporated into the state's Medical Treatment Utilization Schedule.

Division of Workers' Compensation Executive Medical Director Dr. Raymond Meister confirmed that, because the proposed MTUS updates and the formulary are based on the ACOEM guidelines, "a commercial license from Reed Group is required when providers use the guidelines to treat patients". Reed Group, which publishes the ACOEM recommendations in its MD Guidelines, in June announced it would sell commercial licenses to California providers at a discounted rate of $100 per year. The company charges ACOEM members $175 for a one-year license, while non-members pay $675.

Reed Group said the question of commercial use comes down to whether a person using the guidelines is being paid for services rendered. They feel that a physician being paid for the treatment of a patient is considered commercial use. One presumes that this would apply to AME and QME evaluations as well as to all treating and consulting physicians.

Although a doc could go to the DWC Website and view the entire MTUS and then go to the upcoming formulary to determine meds allowed to be used, purchasing the license allows the doc the ability to interact between the drug formulary and the treatment guidelines. Providers who buy a license will be able to look up a drug in the formulary and follow a link to various recommendations throughout the guidelines for when the drug is appropriate. Without a license, doctors would be required to sift through files the division posts online.

CANS Board meets in LA

The CANS Board of Directors held its fall meeting in the Los Angeles area on Saturday, September 23rd. In attendance were 7 of the 8 officers: Blumenfeld, Holly, Ratliff, Linskey, Kaczmar, Mummaneni and Kissel; 3 of the 7 directors: Asgarzadie, Chen and Harraher; both resident consultants: Linda XU from Stanford and Joel Beckett from UCLA and 8 of the 11 consultants: Abou-Samra, Bonner, Colohan, Lippe, Shuer, Smith, Wade and Henry.

A full moment of silence was observed in the memory of CANS members Eugene Stern and Shokei Yamada, both of whom had recently died (details elsewhere in this newsletter).

Dr. Colohan demonstrated the new CANS Website which stimulated comments of appreciation and suggestions for improvement.

To CANS current membership of 395 docs (157 active, 59 senior, 150 residents, 20 Honorary and 9 inactive) were added the following as new active members: **Tanya Minasian, DO** and **Namath Syed Husian, MD**, both from Loma Linda; **Omid Hariri, DO,** Stanford and **Raj Murali, MD,** Carlsbad.

As usual, the Treasurer, Ted Kaczmar, reported that a goodly number of CANS members have yet to pay their dues for 2017 and as usual, additional attempts will be made to get these tardy docs up to date. CANS' rule on delinquent dues is to drop from membership any active or senior member who is 2 years in arrears on dues payment. As of the Board meeting, 16 active and 10 senior members fall into this about-to-be-cut-loose category.

The Board addressed numerous issues related to monetary data, nominations for next year's CANS elections and the Pevehouse and Ablin awards, CANS role in the CMA and interaction with insurance carriers and potential by-laws changes but no specific actions were taken.

It was decided that CANS members who are directors of educational offerings which are sponsored by California academic institutions will be, upon request, afforded support on our Website and in the newsletter at no charge.

As a finale to a 5 hour BOD meeting, those assembled discussed all of the CSNS resolutions to be considered at the CSNS meeting on October 6-7 in Boston. Drs. Blumenfeld, Abou-Samra, Ratliff, Linskey and Vanefsky were appointed to act as CANS delegates at that meeting (our membership numbers allow us to field 7 delegates). As usual, it is difficult to get CANS members to travel east of the Mississippi, on their own dime for an additional two days of time and expenses, for a CSNS meeting.

The Board voted to take the positions noted on each resolution.

RESOLUTION I (CANS Board: neutral—await debate)
Title: A Single Neurosurgical Board Certification System
Submitted by: Gary Simonds MD MHCDS FAANS
WHEREAS, the "Single GME Accreditation System" has assured that by 2020 all American neurosurgical programs will seek accreditation from only the ACGME; and
WHEREAS, the Single GME Accreditation System therefore assures that all graduates from American neurosurgical training programs will soon be eligible for ABNS board certification; and
WHEREAS, incongruently, there still exists, and will still exist, two separate neurosurgical board certification entities in the form of the ABNS and the AOBNS; and
WHEREAS, despite the establishment of a single, unified, GME accreditation system, osteopathic graduates of neurosurgical training programs would ostensibly be eligible to seek board certification through two separate entities (ABNS and AOBNS); and
WHEREAS, despite the establishment of a single GME accreditation system, allopathic graduates of neurosurgical programs would ostensibly be eligible to seek board certification solely through a single entity (ABNS); and

WHEREAS, in the spirit of the Single GME Accreditations System, and in the spirit of promotion of unity within the specialty, it would stand to reason to process all graduates of neurosurgical training programs through the same board certification process, overseen by a single certifying body; therefore

BE IT RESOLVED, that the CSNS calls for the AANS and CNS to petition the ABNS and AOBNS to seek an agreement on a single neurosurgical board certification system, under a single certifying body.

RESOLUTION II (CANS Board: neutral—await debate)

Title: A Single Neurosurgical Maintenance of Certification System

Submitted By**:** Gary Simonds MD MHCDS FAANS

WHEREAS, the Single GME Accreditation System has assured that by 2020 all American neurosurgical programs will seek accreditation from only the ACGME; and

WHEREAS, the Single GME Accreditation System therefore assures that all graduates from American neurosurgical training programs will soon be eligible for ABNS board certification; and

WHEREAS, incongruently, there still exists, and will still exist, a separate neurosurgical board certification and maintenance of certification entity in the form of the AOBNS (under the aegis of the AOA); and

WHEREAS, even, hypothetically, if there came about a cessation of AOBNS new certification activities, there will exist a number of neurosurgeons, boarded previously by the AOBNS, who will require a system for maintenance of certification; and

WHEREAS, under current circumstances, a second board certifying neurosurgical body (AOBNS) will be required to remain active, potentially for multiple decades, solely for the mechanism of providing a maintenance of certification process for a diminishing cohort of AOBNS board certified neurosurgeons; and

WHEREAS, in the spirit of the Single Accreditations System, and promotion of unity within the specialty, it would stand to reason to process all board certified graduates of American neurosurgical training programs through the same maintenance of certification process; therefore

BE IT RESOLVED, that the CSNS calls for the AANS and CNS to petition the ABNS and AOBNS to seek an agreement on a unified neurosurgical maintenance of board certification process, under a single certifying entity.

RESOLUTION III (CANS Board: support; Dr. Linskey to present our position)

Title: Realistic Analysis of Value versus Detriment of Neurophysiological Monitoring in Spinal Surgeries

Submitted By: Gary Simonds MD MHCDS FAANS

WHERAS, there has been a rampant proliferation in the employment of neurophysiological monitoring in spinal operations over the past decade; and

WHEREAS, evidence-based indications for employment of neurophysiological monitoring in spinal procedures is limited to a potentially small number of specific spinal procedures; and

WHEREAS, false positive and false negative neurophysiological readings can occur in a sizeable portion of spinal procedures and can result in significant alterations in the conduct of said procedures, abortion of said procedures, and/or significant and unnecessary surgeon stress; and

WHEREAS, neurophysiological monitoring in spinal procedures can result in increased anesthetic time, increased difficulty in dissection with increased operative time, and increased O.R. personnel needle sticks; and

WHEREAS, the proliferation of neurophysiological monitoring for spinal surgeries has created pseudo-community "standards of care" that put surgeons at risk who may more sparingly apply the technology to their spinal surgeries; and

WHEREAS, neurophysiological monitoring adds $700 to $1500 in charges to every procedure in which it is employed, helping to drive up the overall cost of spinal surgery without concomitant proven improvement in outcomes (decreasing value of the care); and

WHEREAS, current neurosurgical professional society guidelines on the employment of neurophysiological monitoring are vague, reference the array of spinal procedures in which it may be employed; therefore
BE IT RESOLVED, that the CSNS seeks to better understand the impact of employment of neurophysiological monitoring in spinal surgery through study and survey (to include: depth of penetrance, justifications for its employment, procedures in which it is employed, prevalence of false positive and false negative results, changes in length of surgery, associated patient and health care worker complications, perceived change in procedural difficulty, blood loss in surgery, associated surgeon stress, impact on cost of care, related litigation, etc.); and
BE IT FURTHER RESOLVED, that entities of the CSNS generate a white paper on the current status of employment of neurophysiological monitoring in spinal surgery in the United States

RESOLUTION IV (CANS Board: support; Dr. Abou-Samra to present our position)
Title: Exploring the Role and Limits of Palliative Care in the Management of Neurosurgical Patients
Submitted By: Gary Simonds, MD MHCDS FAANS
WHEREAS, neurosurgical patients are often afflicted with incurable and/or permanently debilitating illnesses and injuries; and
WHEREAS, "palliative" measures are often invoked in the care of neurosurgical patients; and
WHEREAS, the term "palliative care" may represent a broad and poorly defined range of medical interventions (or lack thereof); and
WHEREAS, palliative care teams may exist as separate and independent entities from neurosurgical services in modern medical institutions; and
WHEREAS, palliative management of neurosurgical patients may be highly controversial, may result in profound ethical quandaries, may result in heated conflict within and/or between medical services; as potentially seen for example in:

- The withdrawal of supportive care in an acutely quadriplegic patient.
- The active suppression of respiration and pulmonary toilet via sedative medications in viable patients (leading to patient demise).
- The rapid declaration of medical "hopelessness" in the acutely recovering post-operative and/or post-neurological-insult patient (stroke, trauma, hemorrhage etc.).
- The withdrawal of care in the profoundly affected neonate.
- The solicitation of palliative care team intervention in primary neurosurgical patients by co-managing teams (critical care, internal medicine, neonatology, etc.).
- The tendency to resort to palliative measures more readily in the aged.
- The aggressive discussion of palliative measures with patients and/or families in the acute stages of psychological shock and grief; and

WHEREAS, there is a huge degree of uncertainty in the prognostication of eventual outcome, quality of life, and patient-perceived enjoyment of life in neurosurgical patients who are recovering from major neurological insults; and
WHEREAS, there is little available material on the interface of neurosurgery with palliative patient care; therefore
BE IT RESOLVED, that the CSNS seeks to study and better understand the nature, implications, limits, and role of palliative care in neurosurgical patients; and
BE IT FURTHER RESOLVED, that the CSNS develops a survey of practicing neurosurgeons to explore their experience with, and attitudes and concerns about, the role of palliative care in neurosurgical patients; and
BE IT FURTHER RESOLVED, that the CSNS creates a white paper that discusses the nature, implications, limits, role, ethical considerations, legal ramifications, and critical aspects of palliative care in neurosurgical patients; and

BE IT FURTHER RESOLVED, that the CSNS explores potential guidelines for the employment of palliative care in the management of neurosurgical patients.

RESOLUTION V (CANS Board: support; Dr. Linskey to present our position)
Title: Evaluation of the practice of balanced billing in neurosurgery
Submitted by: Vincent Y. Wang on behalf of the Medical Practice Committee
WHEREAS, balanced billing, defined as billing a patient the difference between the provider's charge and the allowed amount by the patient's insurance plan, has become a focus of many policymakers and the media over the past few years; and
WHEREAS, there are increased number of state legislations passed related to the practice of balanced billing; and
WHEREAS, balanced billing is an especially acute issue in cases of emergency care, and that many neurosurgeons provided care in emergency setting; and
WHEREAS, balanced billing is a sequela of narrow networks that has become a more significant problem recently; therefore
BE IT RESOLVED, that CSNS survey the neurosurgery community to learn about the common practice of balanced billing among different neurosurgery practices, that CSNS develop a white paper to help the neurosurgery community to understand the issue of balanced billing including the most updated state regulations, and
BE IT FURTHER RESOLVED that CSNS develop a white paper to help the neurosurgery community to understand the issue of balanced billing including the most updated state regulations, and
BE IT FURTHER RESOLVED that CSNS petitioned AANS/CNS to work with other organized medicine institutions to develop a consensus position on the issue of balanced billing.

RESOLUTION VI (CANS Board: opposed; Dr. Blumenfeld to present our position)
Title: Evaluation of Resident Attitudes and Perceptions of Research in Neurosurgery
Submitted by: Michael Karsy, Steven Tenny, Fraser Henderson, Jeremy Amps
WHEREAS, continued research is pivotal to the advancement of neurosurgery with today's residents becoming some of tomorrow's researchers; and
WHEREAS, current clinical demands, resident interest, faculty mentorship, varying institutional opportunities, and limited funding are just some many challenges in neurosurgical residents pursuing research; and
WHEREAS, limitations in time and funding for residents present worsening issues for the field of neurosurgery; therefore
BE IT RESOLVED, that the CSNS utilize a survey of neurosurgical resident attitudes and perception towards research in residency to identify limitations factors for residents; and
BE IT FURTHER RESOLVED, that a sub-committee of AANS, CNS and Senior Society identify limiting factors in resident research and potential strategies to improve opportunities for research collaboration, support, and funding; and
BE IT FURTHER RESOLVED, findings of this survey and sub-committee to be formalized into a guidance document for residents and training programs.
FISCAL NOTE: Funded by an unrestricted education grant from the South Carolina Department of Neurosurgery for a total of $6,000.

RESOLUTION VII (CANS Board: support; Dr. Blumenfeld to present our position)
Title: Survey of Neurosurgeons to Access for Factors Affecting Attrition
Submitted By: Steven Tenny, Karin Swartz, Michael Karsy, Jessica Stark, Workforce Committee

WHEREAS, adequate neurosurgical training is a time intensive and lengthy process; and
WHEREAS, the replacement of a practicing neurosurgeon due to attrition takes over a decade; and
WHEREAS, there is no published data regarding factors neurosurgeons identify as affecting their attrition which could be addressed by organized neurosurgery; therefore
BE IT RESOLVED, that the CSNS conduct an online survey of a large sample of currently practicing neurosurgeons to identify common factors, and their importance, on the attrition of practicing neurosurgeons in order to help guide future efforts of organized neurosurgery to address issues practicing neurosurgeons find increasing the likelihood of their own attrition.

RESOLUTION VIII (CANS Board: support; Dr. Vanefsky to present our position)
Title: Current Practice Patterns in Preoperative Patient Education
Submitted by: Cara Marie Rogers and Jeremy Phelps, on behalf of the Medical Practices Committee
WHEREAS, preoperative patient education regarding pathology, treatment options, and risks versus benefits of a proposed neurosurgical procedure are a fundamental principle of informed consent and evidence suggests that it has a direct impact on quality of care; and
WHEREAS, patient comprehension and information retention rates for neurosurgical patients varies widely in the literature it is likely suboptimal and consistently reported to decline over time; and
WHEREAS, methods used for patient education in the neurosurgical community (verbal, written, audiovisual), are not standardized, may vary significantly, and it is unknown which method is superior; therefore
BE IT RESOLVED, that the CSNS seek study the current practice patterns among neurosurgeons regarding preoperative patient education through creation of a survey to inquire about materials and methods utilized, delegated educators, and opinions regarding potential value of formalized materials; and
BE IT FURTHER RESOLVED, that the CSNS generate a white paper using the data from this survey to highlight current practice patterns and comparison to current best practices in the literature.

RESOLUTION IX (CANS Board: support; Dr. Vanefsky to present our position)
A position statement on network adequacy for access to neurosurgical care
Submitted by: L.M. Tumialán, C.M. Schirmer, C. Mulholland, B.A. McCutcheon, R.H. Dossani, C.A. Miller, P.V. Mummaneni and the Coding and Reimbursement Committee.
WHEREAS, nearly 12 million individuals have enrolled in coverage through the Patient Protection Affordable Care Act's insurance marketplaces; and
WHEREAS, despite the U.S. Department of Health and Human Services regulating plans applying a "reasonable access" standards to ensure access to a sufficient number and type of providers, evidence has demonstrated a significant number of neurosurgery deficient plans (1-3); and
WHEREAS, CSNS white papers have examined access to neurosurgical care in Louisiana and Arizona and have confirmed neurosurgical deficient plans (3); and
WHEREAS, narrowing the network of providers, neurosurgeons in particular, has become the only fiscally viable vehicle to ensure the sustainability of the federal marketplace plans and will be an element of the healthcare landscape for the foreseeable future; therefore
BE IT RESOLVED, that the CSNS petition the AANS and CNS to produce a statement that acknowledges the inequity of narrow networks regarding access to neurosurgical care; and
BE IT FURTHER RESOLVED, that the AANS and CNS produce a statement regarding network adequacy.

RESOLUTION X (CANS Board: oppose; Dr. Linskey to present our position)
Title: Establishing a fellowship match for all neurosurgical subspecialties

Submitted by: Rimal H. Dossani, MD, Richard Menger, MD, Catherine Mazzola, MD, Lawrence Shuer, MD, & Bharat Guthikonda, MD

WHEREAS, none of the neurosurgical subspecialties (excluding pediatrics) has a standardized process for selecting candidates applying for postgraduate fellowships,

WHEREAS, postgraduate fellowship programs starting on the same calendar date have application deadlines as far as one to two years apart or select candidates on a rolling basis; such disparities in application deadlines raise candidates' anxiety about the fellowship selection process,

WHEREAS, certain fellowship programs may have application deadlines as early as three years prior to start of fellowship, forcing candidates to determine their fellowship choice at a junior residency level (for example, PGY-4); as a result, candidates who determine fellowship choice at a senior residency level (PGY5, 6, or 7) are at a disadvantage,

WHEREAS, fellowship agreements between candidates and programs are not binding; as a result, candidates have reported instances of programs retracting offers without due cause, and programs have reported instances of candidates who broke their fellowship agreements,

BE IT RESOLVED, that the CSNS petition the AANS to recommend SNS to establish a standardized match process (for example, the SF Match provides matching services for both orthopedic spine surgery and pediatric neurosurgery fellowships) for selection of candidates for postgraduate neurosurgical fellowships.

RESOLUTION XI (CANS Board: support; Dr. Blumenfeld to present our position)

Title: A Call to Protect Patient Safety Data from Legal Discovery

Submitted by: Tyler Schmidt, Kristopher T. Kimmell, G.E. Vates, and the Patient Safety Committee

WHEREAS, the Federal government in 2005 passed the Patient Safety and Quality Improvement Act (PSQIA), which established a system of Patient Safety Organizations (PSOs) contributing patient safety work product (PSWP) to a national database with the goal of improving safety and quality of care[1]; and

WHEREAS, the PSQIA set up confidentiality provisions for patient safety work products being collected in order to encourage full participation by providers and hospitals systems; and

WHEREAS, the Patient Safety and Affordable Care Act signed into law in 2010 mandated that hospitals with >50 beds participate in a PSO in order to be included in the health insurance exchanges[3]; and

WHEREAS, a recent ruling by the Florida Supreme Court, *Charles v. Southern Baptist Hosp. of Fla., Inc*[2], stated that the Florida Constitutional Amendment 7, which required broad access to incident reports of adverse medical events for malpractice cases, is not preempted by the PSQIA federal confidentiality mandate; and

WHEREAS, similar court challenges in other states could derail patient safety and quality improvement efforts by institutions across the country by threatening their confidential nature and exemption from legal discovery; therefore

BE IT RESOLVED, that the CSNS study the impact of this legal decision on neurosurgeons and their participation in patient safety and quality improvement reporting at their local facilities; and

BE IT FURTHER RESOLVED, that the CSNS work with the Washington Committee to raise awareness among neurosurgeons that their participation in PSOs should generate patient safety data exclusive to federally mandated safety reporting thus rendering it protected from legal discovery due to PSQIA federal confidentiality provisions.

Bonner steps down after long newsletter career

Jack Bonner, MD, former CANS President and Associate Editor of the CANS newsletter since 2010, has reluctantly resigned his editorship. Dr. Bonner's contributions were predominantly of the big picture variety as he waxed eloquent on national and statewide issues impacting the practice of medicine, particularly neurosurgery. A recent head injury has made writing difficult although he still does well in conversation and continues as a consultant to the CANS Board. We will miss his monthly thoughts and his insight and wish him well. Dr. Moustapha Abou-Samra has been appointed to replace Dr. Bonner as Associate Editor. ❖

Thought for the Month:

I'm not afraid of death; I just don't want to be there when it happens— Woody Allen

ATTENTION EXHIBITORS:

The CANS Annual Meeting is fast approaching and we want to see your company there! We have **redesigned our website** and our top sponsors will be featured prominently on the home page! Check it out at www.cans1.org

Please contact emily@cans1.org for more information!

The meeting will be held at the historic U.S. Grant hotel in downtown San Diego, CA

Meetings of Interest for the next 12 months:

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
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, Date TBA
AANS: Annual Meeting, April 28-May 2, 2018, New Orleans, LA
California Neurology Society: Ann. Meeting, 2018, TBA
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
Western Neurosurgical Society: Annual Meeting, September 14-17, 2018, Kona Coast, Hawaii, HI

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.

CANS Board of Directors

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