CANS newsletter

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A Man for all Seasons

Randall W. Smith, MD, Editor

CANS Immediate Past President **Ken Blumenfeld** is running for the Presidency of the California Medical Association. To our knowledge, no other California neurosurgeon has ever done that. Which is not surprising considering the time required to be involved in the CMA at levels that can qualify one to run for the presidency. Ken has certainly put in that time which is quite noteworthy because he was in solo private practice until 2016. Now that he is with the Palo Alto Medical Group, he will have the support he needs to be CMA Prez. So why does he want to run this gauntlet?

Well, as he says, " . . since starting out as a House of Delegates member from Santa Clara County Medical Association back in the 1990's and through all the CMA committees upon which I have served or chaired, I have learned that the House of Delegates establishes policy and the Council on Legislation provides an advisory report but it is the board of trustees that makes the decisions. From there it is the efforts of the Executive Committee and its leader the President of CMA that must represent the organization and champion advocacy." He wants to be at that decision-making level and feels his background in private practice and now as member of a large group will stand him in good stead to pursue his primary goal as President which would be to enhance the practice of medicine in California and to champion patient care issues.

So, what does it take to be elected to the CMA presidency? It takes a vote of the CMA House of Delegates when they meet on October 14th. The seated, voting delegates come from the various County societies, the specialty delegations, sections and forums. Ken asks that CANS members who wish to support him should contact their local medical society's voting CMA delegates and express their support for him.

Now, why would any neurosurgeon want to support Dr. Blumenfeld besides the obvious clan issue? Well, I have known Ken since he began his early sojourn into the CANS Board of Directors in the late 1990's and have the perspective of comparing him to all the CANS Presidents I have seen in action from the mid-1980's on including myself. He is by far the most committed and engaged, energetic, even-tempered, well spoken and sensible of the lot. CANS can rest assured that with him at the CMA helm, we would have a reliable voice for what all us docs do and how best to do it.

What follows is Dr. Blumenfeld's background statement. Considering what he has done, I presume he doesn't sleep and has no family. ❖

INSIDE THIS ISSUE:

Kenneth S. Blumenfeld, M.D., FAANS

Kenneth S. Blumenfeld, M.D is a board-certified neurosurgeon practicing in San Jose, CA. He was in solo practice from 1992 to 2016. Since 2016 he has been with the Palo Alto Foundation Medical Group as a full-time neurosurgeon and Tier 1 administrator. Dr. Blumenfeld has worked at, as well as served on the medical executive committees of multiple hospitals north and south of the Golden Gate. He is a past Chief of Staff at Good Samaritan Hospital in San Jose and an UCSF Adjunct Clinical Professor. He is currently a member of the medical staffs of Regional Medical Center of San Jose, El Camino Hospital of Los Gatos and Mountain View, O'Connor Hospital of San Jose, and Dominican Hospital of Santa Cruz. Dr. Blumenfeld is a former shareholder of the National Ambulatory Surgery Center and former partner of the Akira ACO. He has helped build and establish several Level II Trauma Centers as well as Comprehensive Stroke Centers. Having a clinical interest in neurotrauma and sports related injuries in neurosurgery he has cared for professional athletes and provided services for the Sharks, Saber Cats, and UFC. Under the Brown Administration he carried a nomination to the California Athletic Commission. From 2003 to 2015 Dr. Blumenfeld was on the Santa Clara County Emergency Medical Services Trauma Audit Committee.

Dr. Blumenfeld has a long history of service in organized medicine having joined the Santa Clara County Medical Association and California Medical Association in 1993. Within SCCMA he has served as a delegate for both the SSGPF and his district. He has been a VP of external affairs, SACPAC chair, and is currently the President. His activities within CMA have included being Vice Chair and Chair of the Council on Legislation. He has been a CALPAC board member and currently serves as a Trustee from District VII. Dr. Blumenfeld is a member of numerous specialty societies including the California Association of Neurological Surgery (CANS), American Association of Neurological Surgery, Western Neurosurgery Society, and Council of State Neurological Societies. He is an Immediate Past President of CANS, Executive Council Liaison to the National Joint Section on Neurotrauma and Neurocritical Care, Liaison to the Washington Committee for neurosurgery, Neurosurgery PAC board member, AANS delegate to the AMA, and Southwest Quadrant Director nominee to the AANS board.

Dr. Blumenfeld obtained his medical degree from the Johns Hopkins School of Medicine in 1986 and completed his neurosurgical residency at the University of Pennsylvania in 1992. He obtained his board certification in 1995 and remains a diplomat and Fellow of the American Association of Neurological Surgery. Through his involvement in organized medicine Dr. Blumenfeld has had the opportunity to mentor students and residents. This mentorship has extended to his son who is currently a third-year medical student at Wayne State University. He has been married for 28 years to Ellen who is an RN as well as yoga, tai chi and qigong instructor who provides cancer care services. He also has a daughter who is a biological engineer and neuroscientist working for Denali, a San Francisco biotech company, and another son who is an economist and data scientist employed at Booz-Allen in Washington, D.C.

CMA Corner: September 2018

Ciara Harraher, MD – Contributing Editor Covering CMA Topics

It goes without saying that the most exciting thing happening at the CMA that is relevant to neurosurgery is the recent announcement that Ken Blumenfeld, neurosurgeon from San Jose, is running for CMA president. Other areas in this newsletter are already devoted to giving you his credentials but I thought it would be interesting to dig a little deeper into his decision to run and his plan for the campaign and presidency. These are the highlights of our conversation.

CH: Ken, you have been involved with the CMA for many years and have seen Past-Presidents both succeed and fail. What do you think are the most important qualities of a CMA president or presidency that will make it successful?

KB: You need to be able to listen and find consensus amongst many stakeholders. This involves interacting with medical and consumer groups, government, lawyers, politicians, economists and the list continues. Pushing your agenda forward is challenging and often means making compromises and forming alliances. There's a learning curve to playing the game. The skill set is very different than what we use as clinicians. Then it's about advocacy and education. CMA staff provides a lot of support, but it takes a well- spoken well- informed energetic president to makes things happen and convey our message effectively. Lastly, I believe the president should be a practicing physician. It's important to be in the trenches.

CH: What should be the priorities for the next CMA president? How does your platform differ from the other candidates?

KB: There's a long list of priorities but Universal Access to healthcare in California is top of the list. Universal access is not the same as Universal coverage. In my opinion, having coverage isn't enough if there aren't providers or hospitals in an area for example. We also have a new Governor who is more focused on addressing healthcare issues. As president during this transition, I will have an opportunity to directly participate in creating a system that will try to reign in healthcare costs and solve the problem in accessing care. This is a huge responsibility and I believe I am the only candidate with the right experience and skillset to strongly represent CMA.

Unlike a political campaign I don't have a personal platform that I am campaigning on as ultimately, I will represent the consensus position of the CMA. There are two other candidates, and both are good people who have paid their dues and are more senior in the organization than myself. However, I believe that I will do a far better job at accomplishing the advocacy, education and representation that the doctors and patients of California need and deserve.

To broker deals with the new governor will require overcoming significant legislative and regulatory challenges and I have more experience lobbying in the political sphere. Furthermore, I bring diversity. I have a son in medical school and am acutely aware of the priorities and concerns of the younger physician population who are also very involved in the CMA. They are motivated to make changes and improve policy. I have also worked in different types of practices throughout my career, so I can relate to a broader physician population.

CH: Why did you decide to run now and how do you plan to balance this with your clinical and other administrative duties?

KB: My decision to run now is complicated. It's the culmination of a career in organized medicine, personal timing, and a political process. Maybe most importantly I have people in leadership who are encouraging me to pursue the presidency at this time for all the right reasons. I have always "burned the midnight oil" and never considered not maintaining a full-time practice. Other presidents have done it. As president elect and a past president it shouldn't be a problem. During the president year it will depend on what happens. Conceivably I will have to cut back to a .8 FTE by reducing my call as most of this work happens outside of regular business hours.

CH: What is the plan for your campaign? ex. visiting county medical societies, eblasts, etc. Did you need to obtain external funding?

KB: When you look at the organizational structure of the CMA with the districts, delegations and groups and so forth, I basically have to meet with them all before the House of delegates (HOD) meeting in October. In many cases, we meet by webinar or tele-conference but I have also been traveling around the state. The campaigning will intensify as the HOD approaches. There are set election rules, for example, you may only contact the house of delegates by email/mail up to 3 times before the HOD meeting and CMA helps with providing addresses. I can have some "meet and greet" receptions but they must be set at a reasonable cost and have a cash bar. There cannot be any suggestion of "buying" votes. I have a team that is working on the materials that I am just starting to circulate. My county medical society will cover some basic printing costs but much of what I do will be out-of-pocket expenses.

CH: How will Neurosurgery as a specialty <u>specifically</u> stand to benefit from having you as CMA President?

KB: Neurosurgery has been fortunate that even with a small specialty size, we have historically had proportionally increased influence on national healthcare policy mainly due to exceptional lobbying and leadership by a few. As president of CMA, I would amplify our voice and could potentially form powerful coalitions. Simply put, the issues facing our specialty will be more promptly addressed than they have in the past. ❖

The Way it Was

Moustapha Abou-Samra, MD, Associate Editor

When I finished my training in Neurological Surgery, I became a specialist in Neurosurgery. I was invited to join the faculty at the University of Texas Health Science Center in San Antonio, where I always had mentors and colleagues who were available to help with cases that are difficult and not commonly dealt with. Then, it was uncommon to have a subspecialty. Pediatric Neurosurgery was an exception. A few Pediatric Neurosurgeons were charting new territories. My department chairman recruited one of them. He helped train me.

In 1981 I moved to Ventura and I joined a wonderful group of general neurosurgeons. As I did at the University, I always asked one of my partners to help with anything that was either difficult or unusual. I soon realized that it takes several years of "practice" to reach the level of experience and judgment needed in an independent neurosurgeon: training only provides the tools; practicing with seasoned colleagues provides the environment to grow and mature.

We took care of all pediatric cases at our County Hospital. There, I met Dr. Charlie, director of Pediatrics. Eventually, I was selected by my group to do all the pediatric cases. So I worked on building a strong relationship with Charlie. I soon realized that he was no ordinary pediatrician. He was an amazing physician and human being: he really cared about his "kids" and was so good in communicating with their parent. He made himself available at all hours for his colleagues and nurses. He was an exceptional teacher, and he practiced what he preached.

I started doing more and more routine cases: shunts, repair of meningomyeloceles, brain tumors and the occasional cranial synostosis. Of course, I also dealt with various traumatic brain injuries.

One day, Charlie called me from the clinic and asked me to join him, immediately to meet Gaby, a happy 8-year-old girl with a beautiful smile. Gaby had not been acting normally, and according to her parents, she had stopped growing about two years earlier. Recently she started losing her vision, rapidly. I examined her and reviewed the CAT scan that Charlie had obtained on an emergency basis.

She clearly had a very large cystic craniopharyngioma with early hydrocephalus.

So, I thought that this falls in the category of "uncommon" in a general neurosurgical practice setting. And although, histologically benign, it is malignant in its course and location. Rarely one can accomplish a complete resection without inflicting harm to the hypothalamus.

Several members of her family surrounded Gaby: mom and dad, three older brothers and a younger sister, a typical migrant worker's family. Only Gaby and her youngest sister spoke any English.

I thought quickly about what would be involved if I accepted her care. Usually the surgical procedure is difficult, but I had done similar cases at the University and I had capable partners who could help me. Most likely the postoperative course would be difficult. We did not have a neuro intensive care unit, nor did we have a pediatric intensive care unit. Our nursing staff was not experienced in caring for really sick children.

My ego, as a young and daring neurosurgeon, wanted me to rise to the challenge and accept her care. But my rational brain told me not to. It was a case that should have been referred to the Children's Hospital in LA, an excellent place for her.

Transferring a sick child, who is uninsured, to another hospital, is difficult even now, but it was almost impossible in those days.

Charlie and I retreated to the hallway to discuss our options. Gaby must undergo an urgent surgery, if we were to restore some of her vision and prevent further damage. She needed extensive preparations and I was really worried about her postoperative care. I told Charlie that this is one situation where I felt it would be best to refer to a tertiary center.

Charlie reached a different conclusion based on his concern for the family; it would be a great hardship for them to have Gaby in Los Angeles while recovering from surgery for a period of time that may extend several weeks. He felt that he could provide the support needed from a pediatric perspective if I

were willing to oversee all the neurosurgical intricacies of her post operative care. Between the two of us we should have been able to manage the situation.

Charlie was almost 20 years my senior with many more years of practical experience. He convinced me that we should proceed with her surgery at our small County Hospital. The family was relieved.

Surgery went smoothly. One of my senior partners helped me. We drained a large cyst and removed a very large part of the tumor and decompressed her optic chiasm, but we decided to leave a small component of the tumor that was very adherent to her hypothalamus.

Gaby woke up with much better vision. But her postoperative course was what I can accurately describe as stormy. Diabetes Insipidus required a very close management of her fluid intake. Her temperature regulation was a problem and she needed steroids replacement, just to name a few problems.

Charlie stayed at her bedside the first 48 hours, and was available immediately, every day, as she recovered. His home was walking distance from the hospital. My home was only three minutes drive, without the need to get on any highways. The County Hospital was walking distance from my office. I saw her several times a day and frequently, if needed, at night.

She recovered … the family was grateful, and Gaby's smile was unforgettable and delightful.

Gaby lived ten more years. I operated on her one more time, draining a large recurrent cyst. But she eventually died at age 18. I, much like everyone else loved her. And I got to know her family very well.

De. Charles B. Fletcher died on June 26, 2018, and I attended his Funeral Mass last week. It was a beautiful and warm service, well attended by family, friends, colleagues, patients and parents. Each of his children spoke and recalled him as a father, as a husband, as a coach, as a friend, as a teacher, as a physician, as a grandfather, and as a human being who cared and was empathetic to others and who put the interests of his patients before his own.

I also went a reception that Charlie's family held at their home. It was good to visit with them. One of them is a general surgeon, another a family physician with whom I worked during my career in Ventura. His wife still enjoys an amazing memory and it was great to visit with her about the past.

The family arranged a display of photographs of family, friends and residents on a beautiful tabletop in the hallway. All the photos included Charlie with his familiar and beautiful crooked smile. I remembered him as if I saw him yesterday.

On that tabletop, front and center, was a small plaque given to Charlie by Gaby's parents, after she died. They spoke about his dedication and about his care and about their gratitude. I did not realize that such a plaque was given to Charlie. All of a sudden, I remembered that the family gave me an identical plaque, one that I treasured and proudly displayed in my office until I retired. And after I retired, I moved it to my study at home where it burned in the Thomas Fire. It was a sweet memory. It was particularly special since it was written and designed by Gaby's younger sister Yolanda, now a young lady.

Another memory that is not so sweet kept recurring: the fact that as soon as Charlie retired, a younger director was appointed. He decided shortly after, that the County Hospital was not equipped to take care of "sick children" and that we must transfer all of them to a tertiary center. This came as subspecialty in neurosurgery was becoming more and more common and as the medico-legal realities made it almost impossible to care for sick children at a small County Hospital. I felt bad then. I always worried about the families. I learned that from Charlie.

Do the pediatric patients receive better care now? I am not that certain. Did Gaby and many others that Charlie and I cared for, receive lesser care? Absolutely not, I say emphatically.

Charlie's retirement and death signaled the passing of an era, an era when we were less constrained and one that I still remember fondly.

Rest in Peace Charlie. You were a mentor, a friend and an example to us all. You were one of my favorite colleagues. I miss you and I miss the way I practiced neurosurgery. ❖

CANS MISSION STATEMENT

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

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SAVE the DATE!

CANS Annual Meeting January 18 – 20, 2019

Residents: Please consider submitting an abstract to your Program Director for consideration to present in Los Angeles!
Active Members: Please mark your calendars for this meeting!
Exhibitors: Please consider supporting this meeting! Contact, emily@cans1.org or 916-457-2267 for more details!

Brain Waves

Deborah C. Henry, MD, Associate Editor

Recently, an article in the BMJ (BMJ 2018;362:k2486) reported on how a mother's health habits relate to the development of obesity in their children in the United States. The authors from the Boston area and Canada tracked almost 17,000 nurses and their nearly 25,000 children, ages 9 to 14 who were initially not obese, for a median of five years. The health habits examined included the mother's body mass index, her exercise amount of at least 150 minutes/week, her smoking status, alcoholic intake (moderate versus none), and quality of her diet. Over the course of the study, 1282 (5.3%) of the children became obese. The first four factors listed influenced the rate of childhood obesity the most. Surprisingly, what the mother ate had little effect on her child's weight, and a moderate intake of alcohol (1-7 servings per week) lowered the obesity rate of her children 11-20%. Also, the child's lifestyle did not significantly account for any weight gain, though if both mother and child adhered to a healthy life style, there was an 82% lower risk of obesity. Since approximately 1/3 of a child's calories are eaten away from home, this may be why a mother's diet did not play a major role in the development of obesity in her children.

We know that moms influence their children in many ways. I have often wondered if physicians with minimal input into a patient's life can influence them as well? Early in my practice, a woman came to me with back pain. I did not think surgery would help, but I recommended that she lose 50 pounds. She returned to see me 50 pounds lighter and free of her nagging back pain. At that moment, I realized I could make a difference. So as physicians, do we role model for our patients?

If I were to pick a medical field which role models for their patients, I would have to go with cardiology. I don't think I have ever seen an obese cardiologist. I know they believe statins should be in our drinking water, but do they influence their patient's health decisions? My first experience with cardiologists was as an intern at St. Luke's Hospital in Houston. As this was the land of Denton Cooley, these physicians upped the ante on the word busy. They were all in tip-top shape and would walk up the 20 or so flights of stairs to see their first hospitalized patients, then take the stairs the rest of the way down. Me, age 26, would tire out around flight 11 and opt for the elevator. Luckily, I was not evaluated on my physical abilities. On the opposite spectrum was my oncology elective where Methodist Hospital's premiered oncologist's ashtray and cigarettes accompanied us on the chart rack during rounds.

Studies have shown that who we are as physicians may determine what we say. Thirty percent of physicians with a normal BMI will discuss healthy choices with their patients compared to about half that amount for obese or overweight physicians. As neurosurgeons, we are somewhat immune to needing to be an ideal role model of health unlike a dermatologist who must have translucent skin or a dentist with the necessary perfect pearly whites. But just like the moms and their children, we do influence our patients by both who we are and how we act. I don't think I'll ever walk those 20 flights of stairs like my cardiology friends, but perhaps just taking the stairs instead of the elevator will influence someone else to do the same. ❖

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!

Tidbits from the Editor

More Med Schools, More Docs—the right kind?

The Claremont Colleges plans to open a medical school, the fourth new campus designed to produce physicians for parts of Southern California struggling with shortages. The Keck Graduate Institute School of Medicine will focus on primary care and treating the growing Latino population in California, institute officials announced this week. The school hopes to hire its founding dean by next summer and open a few years after that.

The Institute hopes many of the graduates will stay to practice medicine in eastern Los Angeles County or the Inland Empire, an ethnically diverse region that encompasses Riverside and San Bernardino counties and is home to about 4 million people. "Our goal is to recruit them from here, train them here and keep them here," said Sheldon Schuster, president of the Keck Graduate Institute. The institute is part of the Claremont Colleges, a consortium of five undergraduate and two graduate institutions about 35 miles east of Los Angeles. The institute already has a pharmacy school.

New California medical schools are not a rarity. The California University of Science and Medicine, funded by the Prime Healthcare Foundation, is debuting this summer in Colton, in San Bernardino County, with a class of 60. The University of California-Riverside School of Medicine, which opened in 2013, recently graduated its second class, made up of 49 medical students.

Kaiser Permanente's medical school in Pasadena is under construction and expected to welcome its first class next year.

Only about 5 percent of physicians in California are Latino, though Latinos make up about 38 percent of the population, according to a recent report by University of California researchers and funded by the California Health Care Foundation. The new medical schools, though smaller than established Southern California institutions such as Loma Linda University School of Medicine and Keck School of Medicine of USC, could help change that and expand the limited supply of doctors in the Inland Empire. The ratio of both primary care doctors and specialists per 100,000 residents in the area is roughly half that in the greater Bay Area, according to the University of California-San Francisco Healthforce Center.

Just how the Institute plans to push for Latino medical school students is yet to be detailed. And how the abysmal rate of black medical students in medical school classes (about 5%) remains yet another conundrum awaiting solution. ❖

Quotation of the Month (reminder to Dr. Blumenfeld)

It's not enough that we do our best; sometimes we have to do what's required.—*Winston Churchill*

Meetings of Interest for the next 12 months:

Western Neurosurgical Society: Annual Meeting, September 14-17, 2018, Kona Coast, Hawaii, HI
CSNS Meeting, October 5-6, 2018, Houston, Texas
Congress of Neurological Surgeons: Annual Meeting, October 6-10, 2018, Houston, Texas
International Society for Pediatric Neurosurgery: Annual meeting, October 7-11, 2018, Tel Aviv, Israel
North American Spine Society: Annual Meeting, October 26-29, 2018, Los Angeles, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 6-9, 2018, Nashville, TN
Cervical Spine Research Society: Annual Meeting, December 6-8, 2018, Scottsdale, AZ
North American Neuromodulation Society: Ann. Meet., January 17-20, 2019, Las Vegas, NV
CANS, Annual Meeting, January 18-20, 2019; Sheraton Universal Hotel, Universal City/Burbank, CA
AANS/CNS Joint Cerebrovascular Section: Ann. Meeting, February 4-5, 2019, Honolulu, HI
Southern Neurosurgical Society: Ann. Meeting, February 20-23, 2019, Key Largo, FL
AANS/CNS Joint Spine Section: Annual Meeting, March 14-17, 2019, Miami Beach, FL
CSNS Meeting, April 12-13, 2019, San Diego, CA
AANS: Annual Meeting, April 13-17, 2019, San Diego, CA
NERVES Annual meeting, 2019, TBA
California Neurology Society: Ann. Meeting, 2019, TBA
Neurosurgical Society of America: Annual Meeting, June 16-19, 2019, Banff, Alberta, Canada
Rocky Mountain Neurosurgical Society: Ann. Meeting, 2019, TBA
New England Neurosurgical Society: Annual Meeting, 2019, 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. Langston Holly in the preparation of this newsletter is acknowledged and appreciated.

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