CANS newsletter

President's Message

Mark E. Linskey, M.D. - President

It has been an eventful month since my last CANS newsletter message. On Saturday April 17th CANS held its Spring Board of Directors meeting. We were once again able to demonstrate that virtual Zoom board meetings are efficient and effective while saving our organization a significant amount of money compared with in-person meetings. In addition to taking care of the business of our organization, we were able to vote on seven resolutions to be considered at the upcoming Council of State Neurosurgical Societies (CSNS) meeting and organize our eight CANS CSNS delegates under the guidance and leadership of Dr Patrick Wade, our senior CANS CSNS delegate. I wish to personally thank all members of the CANS Board for their continued hard work and dedication to CANS.

During the CSNS virtual Zoom meeting Friday and Saturday, April 23-24, CANS was very well represented. I am happy to announce that during the Southwest Quadrant meeting California UC Irvine resident Jordan Xu, MD was chosen as one of the three CSNS Resident Fellows for 2021-22. Congratulations to Dr Xu! Our eight delegates each gave testimony before the CSNS Reference committee on the seven standard, and one emergency resolution under consideration. Both during Friday's Reference Committee testimony and Saturday's plenary session the CANS Resolution VI – Improving Diversity, Equity and Inclusion within the Congress of Neurological Surgeons (CNS) Leadership, triggered extensive discussion and debate. I am happy to report that our resolution asking the CNS to remove the age restriction for their President officer eligibility, and thus on their upstream Executive Committee choices, passed by a vote of 43-23. We successfully argued that the age restriction not only represented age discrimination, but that it had a disproportionate negative impact on the career path and organized neurosurgery service opportunities available to our female neurosurgery colleagues, as well as depriving the CNS of excellent talented and deserving individuals who simply fell 1-5 years outside their current goal posts. This was a very important CANS initiative that will hopefully have a significant and positive impact on one of our two major national neurosurgery organizations going forward.

During the CSNS Southwest Quadrant meeting it was pointed out that CA bill AB2114 – Higher Education Employer-Employee Relations Act: procedures relating to employee termination or discipline https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2114) seeking to amend the existing law to interject union representation into the house officer discipline and/or termination processes at the University of CA, which had passed the State Assembly and Senate only to be vetoed by the Governor last September, was re-introduced February 12, 2021 as AB 615 (https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB615). As many of you know all University of CA residents are represented by the Service Employee International Union (SEIU). This union, has worked with Democratic State Assembly member Freddie Rodriguez https://en.wikipedia.org/wiki/Freddie_Rodriguez, to get both AB 2114 and now AB 615 introduced. In the past, the University of CA came out strongly opposed to AB2114. More importantly the American Board of Medical Specialties (ABMS) of which the American Board of Neurological Surgeons (ABNS) is a part came out in writing opposing this bill and notifying of potentially undesirable consequences for our residency graduates if the bill goes on to pass. They have each now taken the same position opposing newly submitted AB 615. In essence, if this new bill passes, the ABMS has threatened to not accept as qualified for board certification any residency graduate from a residency training program where their continued employment was subject to the oversight or decision reversal by any body or individual external to the GME Training Program and/or Sponsoring Institution. Clearly this could affect the future ability of residents graduating from any UC Neurosurgery residency training program from being able to be ABNS-Certified. It is also clear that the UC and ABMS opposition letters did not stop AB 2114 from being passed by both the

Senate and the Assembly last August. If it were not for the Governor's veto in September, it would now be law. What will now happen with the new AB 615 remains to be seen.

Beginning on March 30, the Governor's office finally began to relent on the California Covid-19 lockdown. On March 30, both LA county and Orange County were moved from the red-to-the-orange tier, and on April 6, San Diego County also transitioned. As of April 27, this is still where we stand without further transition yet to the yellow tier. Most importantly the State of CA finally allowed industry opening for "Private Venues and Events" on April 14, 2021. The most recent information/restrictions/regulations in place can be found at https://covid19.ca.gov and https://covid19.ca.gov/industry-guidance/ (Covid-19 Industry Guidance: Private Venues and Events). Additional California Hotel & Lodging Association (CHLA) information/restrictions/regulations currently in place can be found at (https://calodging.com , https://calodging.com/coronavirus-information-resources.

Now that we finally have some guidance of parameters for negotiating our next planned Annual Meeting in January 2022, we can finally move forward with planning and venue negotiation. On April 29th we sent out a survey to our industry vendor partners that have supported our in-person meetings from 2018-2020 (three years) assessing their level of interest in sponsoring and/or exhibiting at a proposed CANS meeting under Orange, Yellow and Green Tier conditions. This week we will be sending out requests for proposals to 3-4 venues in Orange and San Diego Counties asking them to submit proposals for hosting our proposed meeting also under Orange, Yellow and Green Tier conditions. We should be touring these venues and reviewing these proposals in May. Once we have allowed additional time to pass to see how other Neurosurgery in-person meetings as well as in-state other medical in-person profession meetings, and before any un-refundable deposits come due, we will also be polling each of our CANS members to assess your interest in attending the proposed meeting with, or without your families.

I think that everyone at the recent CANS Board meeting expressed their sincere hope that the January 2022 CANS meeting under consideration will be able to be an in-person meeting. We all recognize the desirability of social interaction and re-connection on a professional and personal level, the need to network, and the utility and desirability of industry and vendor product and services updates. I truly hope that with continued improvement in vaccine supply and availability that "herd immunity" in California will be reached by this summer. It is certainly been a pleasure to finally walk around outdoors this week without a mask. I hope everyone will please reserve Saturday and Sunday January 15-16, 2022 for our 2022 CANS meeting. Please stay tuned to monthly newsletter messages updating everyone on our course and progress as we work towards this date for our meeting.

I would like to once again remind all CANS members of their 2021 Annual Dues commitment. Many of us use the CANS Annual Session registration opportunity as the time where we pay our outstanding CANS dues to allow us to register. This year we did not be have a 2021 formal CANS Annual Session, and as a result, many members missed this opportunity this year. We derive a significant income for our operational budget from our Annual Meeting which did not occur. Thus, this year *it is extremely critical that every member take the time to follow this hyperlink to our CANS website and pay our CANS annual dues* [*INSERT HYPERLINK HERE*]. I would ask every CANS member to **please do this right now** as you are reading this in order to help our organization remain fiscally healthy going forward. This is extremely important, and your participation and support of our organization is greatly appreciated!

I continue to hope that all of our members continue to remain healthy and safe during this trying time with Covid-19. CANS has yet to hear of any member who has been sick with Covid-19, but we very much want to know and keep track of any such event(s) to measure and document the direct personal impact of the pandemic among individual California Neurosurgeons. Anyone who knows of a CANS member, or any

California neurosurgeon, for that matter, who has been sick with Covid-19, please contact our executive secretary Emily Schile with the particulars at emily@cans1.org .

Please stay safe everyone. Please support CANS and the CMA, they are fighting for you. All the best! ❖

Last Minute Repreive-Part 2!

Randall W. Smith, MD – Editor

House extends moratorium on 2% Medicare sequester cuts through 2021

In a vote of 384-38, the House on Tuesday April 13th passed a bill that eliminates the 2% cut to Medicare payments until the end of 2021. President Biden signed the bill into law.
on April 15th.

The Centers for Medicare and Medicaid Services had instructed Medicare administrative contractors to hold all claims with dates of service on or after April 1 until the bill was signed by President Biden. Thus the claims will now be processed.

And so we wait until December to see what will really happen. In the meantime, enjoy the current fantastic reimbursement rate for Medicare patient services.

Where there is smoke . . .

The publication *Health Affairs* (Volume 40, No. 4 (2021): 603-612) has reported on medical device company's payments to physicians are 7 times higher than drug company physician payments. They used federal data freely available.

Turns out neurosurgeons and orthopods got the most money and that about 70% of all docs in those specialties got some payments. The average payments were less than 10K which suggests there were some docs that got a lot more.

The presumption is that the payments were for legitimate assistance in product creation or evaluation or for attending training programs in device usage.

Hard to imagine this data will not attract some governmental attention since this info might raise the specter of kick-back schemes.

Careful out there! ❖

One of our own got severe COVID and survived!

Like a lot of us, I suspect, I was hoping that since there are so few neurosurgeons as compared to the population in general, no neurosurgeon I know would get a real case of COVID-19. CANS President Mark Linskey has been asking for over a year to have any member of CANS report getting COVID-19 or hearing of someone who did—with no response.

Well, the second shoe dropped when Jay Levy from Napa let us know about his saga with the virus plus a bout of Guillain-Barre. Here is his story:

Jay Levy here.

I had Covid, and because it was complicated by a neurological disease I'll tell the whole long story for the interest of CANS members.

I'm 86 years old, in good health, and did not retire from neurosurgery until I was 81 years old. I did my last surgery working as a locum's in North Dakota and retired in 2017 just before my house and property burned in the wild fire.

I'm now 86 , and considered myself to be in fine health before any symptoms began.

On September 11 I had my annual influenza vaccination.

Two weeks later I began to notice weakness in my hamstrings and quadriceps on both sides.

The last week in September I had to walk off the golf course in the middle of a round because my legs were weak and I simply couldn't hit the ball.

In July 2019 I had a decompressive laminectomy at L3 for spinal stenosis with symptoms that were mostly weakness of the L4 and L5 innervated leg muscles and little of the usual pain.

For this reason I contacted my surgeon and a lumbar MRI was done the following week with no evidence of recurrent stenosis.

This was during the Covid epidemic and no one had seen me to examine me.

The second week of October I saw my family practitioner and we decided that I could very well have Guillain Barre syndrome with symptoms of ascending weakness with minimal sensory loss.

An EMG was scheduled for the next week for 21 October.

At that time I could still ambulate and could climb two flights of stairs but with severe muscle fatigue

On Sunday the 18th I happen to use my pulse oximeter and it read 90 instead of the usual 97.

As usually happens when physicians are trying to treat themselves I thought this was a mechanical failure and not pertinent.

Monday I was confused and Tuesday I really could not think straight, but with no fever, no pulmonary symptoms of any sort and on Wednesday the 21st the day my EMG had been scheduled I had to go to the hospital for confusion and increasing weakness.

When they examined my lungs prior to admission there were abnormal findings and I was taken to the emergency room for a chest x-ray which revealed a Covid type pneumonia.

I saw this x-ray and it looked pretty serious to me.

That is the last thing I remember the five weeks.

Because I had Covid the thought of Guillain Barre was ignored and I was sent home.

By the time I got home, a 15 minute ride, I was unable to walk and it was necessary to get help and carry me into my home in a chair.

An ambulance was called and I was returned to the hospital and placed in ICU.

During five weeks in the acute-care hospital including ICU time, I was intubated for a week and subsequently had a tracheostomy placed.

It's difficult to say how much Covid symptoms were involved in my treatment but clearly the tracheostomy was required because of ascending paralysis.

I did have the usual prescribed treatment for Guillain Barre.

The first memory I have after seeing my chest x-ray on 21 October was being wheeled into the acute rehabilitation units on the last day of November.

At that time I had marked atrophy of my hand muscles but had recovered reasonable strength in my upper extremities and the tracheostomy had been removed.

At that time, however, I was unable to move my lower extremities.

I was in the hospital rehabilitation for a month, and then skilled nursing rehabilitation for two months

Now, with April Fools Day approaching, over five months after Guillain Barre onset, and over four months after exacerbation by Covid I have had gradual improvement every day and am now able to ambulate short distances with ski poles.

My grip strength is now 91 pounds, up from 51 pounds when I first left the acute hospital and though I sometimes use a wheelchair or a walker I am totally independent in all of my dressing and bathroom needs.

I intend to recover and go back to the golf course, but will just have to be patient and see how long that takes.

A friend of mine from Arkansas told me he knew I would get well because he described me as being "tough as woodpecker lips".

I offer this long story because the rapid exacerbation of my weakness related to the onset of the Covid virus infection might be of interest to neurological surgeons.

Also, my ultimate good recovery, particularly at my age, is encouraging.

Jay Levy

Jay's long suffering wife Jodi had a miserable 5 months as one might imagine and was unable to visit Jay or even communicate with him during his extensive ICU stay. She was alone at their home for 4 months but like most neurosurgeon's wives, she toughed it out and kept the home fires burning until her man came home. ❖

Brain Waves

Deborah Henry, MD – Associate Editor

My first job other than babysitting and house-cleaning was at Dairy Queen. At sixteen, I was ready to earn a real paycheck, one that was typed out with my name. At our introductory work meeting, the DQ manager's final words to us was to define the word "assume". Not waiting for an answer, she said, "If you assume, you make an "ass" out of "u" and "me". That phrase has stayed with me, likely because I had never said the word "ass" but too for its meaning of the mistakes we make when we assume.

In the *LA Times*, (April 13, 2021, p. A11), Pauline Chen writes on being an Asian-American woman surgeon and that when in an OR with an unknown male scrub nurse, the white male resident was offered the gown before her, a breech in the established etiquette of gowning the chief surgeon first. She makes a point that it is her race that makes people assume she is not the surgeon. She does not even suggest that her gender may be a factor. As I, a white female, have often been mistaken as not being the primary surgeon, I would beg to differ that it is her gender rather than her race. After all, I suspect that most registered nurse first assistants (RNFAs) are female as the percent of female RNs in 2020 was between 88-91% (depending on the source). Faced with the dilemma of whom to gown first, this scrub nurse went with the gender odds that the woman was a nurse assistant and the male a surgeon. Indeed, there were many times early in my career that when asked my profession and when I answered neurosurgeon, what was heard was "nurse." Later, I would often say brain surgeon as that was rarely misunderstood and sometimes, I was treated with a moment of awe and ah. Of course, it is equally challenging for the nurse. One of my students when asked what his eventual career goal was, answered, "I want to be a male nurse." I quipped back that he was halfway there.

As a child, we identify with gender before we identify with race. Young children tend to play with their same gender without regards to skin color. I knew early on that I was a girl before I realized that my skin color put me in a special category known as white. We are later taught that skin color divides us into racial groups. I cannot *assume* what it feels like to be male or to be a different race. I can only listen from the experiences of others and learn.

You may know the riddle, which I must admit stumped me long ago when I first heard it.

There once was a father and son who were traveling on the interstate. A car swerved in front of them, and they crashed into the concrete barricade. The father was killed instantly. The son was transported by ambulance to the nearest hospital. He had severe abdominal injuries that required emergency surgery. The surgeon on call came down to the emergency room. On seeing the patient, the surgeon remarked, "I cannot operate on him. He is my son."

How can this be?

Of course, the surgeon was the son's mother. ❖

Homelessness *Do we have the will to eradicate it?*

Moustapha Abou-Samra, MD Associate Editor

On a recent trip to Austin, Texas, I was struck by the number of homeless people on the streets. They were everywhere, at every corner and under every bridge. This reminded me of Los Angeles' skid row and the tenderloin in San Francisco. Of course, I haven't been to either location since before the pandemic started. Somehow, during the pandemic, the homeless became less visible in Ventura, where I live. I was hoping that homelessness, somehow decreased during the pandemic … but no such luck, it was simply wishful thinking.

California has had a serious problem with homelessness for a while, and it seems to be getting worse.

The start of homelessness in California can be traced back to the de-institutionalization of the mentally ill from State Hospitals. This was under Governor Ronald Reagan when he signed the Lanterman-Petris-Short Act in 1967, thus ending the practice of institutionalizing patients against their will. This was compounded by "prison reform" under Governor Jerry Brown; it significantly decreased the prison population but increased the number of the homeless. Both actions were well intended but also poorly executed.

When California de-institutionalized the patients of State Hospitals, the plan was to care for these patients in community treatment facilities. However, these were never built. During the following year, the number of the mentally ill entering the criminal system doubled. This created a vicious cycle. A patient would commit a low-level crime and land in jail where he or she is stabilized and released, only to decompensate and do it again. Police preferred taking offenders to jail, with the notion that it is a safer environment for them. Alternatives were not available.

In 1978, the prison population in California was about 25,000. By 2006, it had grown to over 170,000 and 30 percent of the prison population needed mental health services.

By the end of Governor Brown's term, the prison population decreased by a third, but the percentage of prisoners who needed mental health services increased significantly and the number of inmates who are now deemed incompetent to stand trial increased by 60%. This, clearly, puts a strain on the prisons and courts.

In 2020 the number of homeless in Los Angeles was estimated to be 66,000.

Who are the homeless?

According to the Canadian Homelessness Research Network-CHRN-"Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioral or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing." Indeed, a thoughtful and well-crafted definition.

So, the homeless is not a uniform group. However, I think they mostly fall into three categories: the mentally ill, the drug addict, and increasingly, the low-income individual who cannot afford the rising cost of housing; this is particularly acute in California and other expensive cities like Austin.

There are potentially many ways to tackle and hopefully solve this problem, which is a stain on us as a Society.

In Austin, Texas, Proposition B is on the ballot. The vote is scheduled for May 1, 2021. {A "yes" vote supports making it a criminal offense (Class C misdemeanor punishable by a fine) for anyone to sit, lie down, or camp in public areas and prohibiting solicitation of money or other things of value at specific hours and locations.} As you can imagine, the city is divided on this issue. But is this a solution for homelessness? I don't think it is.

Here in California, there is a significant effort to build more affordable housing units throughout the state; this should be helpful, but it is a short-term solution.

Drug addiction was recently addressed in a New York Times article. It described the problems in San Francisco and indicated that the drug epidemic claimed 713 lives in 2020, more than twice as many as died from the coronavirus in the city. Thomas Wolf, one of the loudest critics of the city's policies was quoted as saying: "It's not enough to just hand out clean needles. We need to take it a step further and get you off the street." He went on to say: "What I'm pushing for is an urgency for the city to expand and promote drug treatment for people." I agree that drug addicts should be off the streets, but not in jail.

As to mental illness, treatment facilities and supervised environments where patients can receive their medications are essential. But, to me, a percentage of patients are incapable of functioning on their own. Such patients need to be committed to modern day State Hospitals where they can be treated with dignity.

No matter the cause of homelessness, let us not forget that the homeless are people and they should be treated as human beings.

A recuring thought that haunts me, is this: was the medical profession responsible for the de-institutionalization of the mentally ill. I'd have to say: to some degree, yes. Maybe we should have been more forceful in advocating for the institutional humane treatment of those who were and are not able to function independently. But this should be the topic of another essay.

We live in an affluent Country. We can afford to eradicate homelessness. The question is: do we have the will to do it? ❖

CANS MISSION STATEMENT

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

Guest Editorial
Covid Re-entry

Now that I and most of my friends and family are vaccinated, life is starting to edge slowly toward normality. I am still not quite ready to rip my mask off and head into a crowded shopping mall, but I am starting to get excited about the prospect of getting back to more of the things I enjoy and that includes seeing my colleagues in Neurosurgery. There is a high likelihood that by Fall we will be resuming in-person meetings and with that there will be a shift in what has become my "new" norm. I have still gone into my hospital and clinic regularly throughout the pandemic, but my family has also gotten used to me at home more. I spend frequent evenings and some weekends in my home office on "zoom" but my children can still come in for a quick kiss, let me do their hair for ballet, or show me their homework. That will all change when I start travelling to meetings again, often more than 10 times per year. Or will it?

I think we have all learned that some things can be accomplished just as well using a virtual format. Do we need to all meet in an airport hotel twice a year for a board meeting that takes a few hours in most cases? Probably not. However, I do think that most scientific meetings are more worthwhile in person and I look forward to getting back to them. When I travel for work, I have a separation between being a mother and being a neurosurgeon. I have time to think about improving my practice, learning new skills or taking on an interesting project. I get to connect with colleagues, share a drink and a laugh and occasionally commiserate about something that only another neurosurgeon can understand. I also get to sleep in a nice bed with no child or dog crawling on top of me. I may even get to sneak in a hotel workout or watch a movie that isn't animated. It reminds me of something Ruth Bader Ginsburg was quoted as saying some years ago about juggling motherhood and work: "Each part of my life gave me respite from the other". When she was home and her children were there, she was a mother and that alone. That break from work allowed her to go back to it re-energized and more focused.

RBG was also very open about shared parenting duties. She didn't cook and neither do I. Her husband was a true partner in managing their children, as is my husband. The world, however, and especially the world in COVID, does not always assume those roles. When schools closed in March, I was definitely the one contacted about homeschooling and expected to be on top of their daily lesson plans. I felt at times like quoting RBG who had been known to tell her children's school that "This child has two parents, please alternate calls". People still assume, and often rightly so, that the mother will take care of everything related to their children. In truth, many more women have had to drop out of the workforce during Covid and who knows the longer-term career consequences on those of us that stayed but had to take on more responsibilities at home. The pandemic has forced the boundaries between work and home to become less clear.

So, will I be happy to have some of my time back to grow professionally and indulge my career passions? Yes. Will I still wish at times I could zoom in my PJS with my son snuggling on my lap? Yes, of course!

-Ciara Harraher MD
CANS Treasurer and CMA liaison ❖

IN MEMORIAM

Spiridon Koulouris, long time CANS member and surgeon at Kaiser, has died. He asked for no obituary. Our condolences to his family.

Tidbits

The meeting was virtual—the issues were real

The CANS Board of Directors met via Zoom on Saturday morning the 17th of April.

Noteworthy were the following:

1. Plans for the annual CANS meeting in January 2022 are still fluid but it appears that physical meetings are likely to be allowed. Venues being considered are the Laguna Cliffs Marriott, the Westin Carlsbad Marriott and the San Diego Hotel Del Coronado. The CNS meeting in October will be a bellwether for physical vs virtual meetings in Texas but we will need to sign a venue contract earlier than that so meetings in California in late summer will be more telling. The travel restrictions on employees of the University of California as well as Stanford and USC will need to be lifted if we want our academic colleagues to attend.
2. The board decided to strongly support Dr. Richard Pan to head the HHS Health and Resources Service Administration which administers various maternal and child health programs as well as trauma and GME issues. Dr. Pan, a practicing pediatrician in Sacrament and member of the California Senate, has received the CANS public service award for his efforts to assure vaccinations for children.
3. The CANS virtual Special Session meeting in January was supported by 6 companies: **BK Medical, DePuy, Globus, Medtronic, NuVasive and Stryker** to the tune of $18,000 with basically no overhead so that plus expected dues for 2021 will leave about a 25K shortfall in covering the costs of running CANS for 2021, the deficit being covered by about 140K in reserves.
4. The Board voted to create as policy that the recipients of the Resident Awards for papers presented at the annual meeting shall be determined by the Program Committee and not the Awards Committee.
5. The Board congratulated CANS Treasurer Ciara Harraher on her nomination to be President of the Santa Cruz County Medical Society.
6. Finally, the Board took positions on the seven Resolutions to be debated at the virtual Council of State Neurosurgical Societies on April 23-24. Those positions are indicated in the article on the CSNS meeting elsewhere in this newsletter.

CSNS meeting on the 23rd and 24th

Another virtual meeting but well attended by Council of State Neurosurgical Societies officers, delegates, and guests. Of the 12 resident fellows, only made it implying that one's day job can be demanding. All eight of CANS delegates attended.

Elections were held for officers with **Joe Cheng** being elected President, our **John Ratliff** elected Vice-chairman and **Jeremy Phelps, Luis Tumialan and Cathy Mazzola** respectively elected to Recording Secretary, Corresponding Secretary and Treasurer.

Each quadrant held a meeting and the Southwest quadrant in which CANS is a member chose three new resident fellows for the forthcoming year: **Jordan Xu** from UC Irvine, **James Caruso** from Univ. of Texas Southwestern, **Akal Sethi** from the U. of Colorado and **Mauricio Avila** from the U. of Arizona as an alternate.

There were 7 resolutions presented and debated and the following were the outcomes (CANS BOD position in bold parenthesis)

RESOLUTION I (Approve)
TITLE: **Understanding and Facilitating the Process of Retiring From a Career in Neurosurgery**
SUBMITTED BY: Gary Simonds MD MS FAANS
WHEREAS, a growing number of neurosurgeons are reaching the age of retirement, or are seeking to retire early; and
WHEREAS, there will likely be increasing societal and legal pressure for neurosurgeons to retire from surgical and clinical duties in their early senior years; and
WHEREAS, retirement is a major epoch in a neurosurgeon's life and can be fraught with psychological destabilization, loss of a sense of financial security, loss of motivation, loss of direction, loss of selfworth, loss of identity, loss of sense of purpose, and more; and WHEREAS, retired neurosurgeons can be anticipated to remain highly creative, highly productive, highly motivated, highly invested, and highly contributory, potentially for decades following their retirement; and
WHEREAS, retired neurosurgeons constitute a relatively "untapped" resource in graduate medical, resident, medical student, allied health, undergraduate, patient and community education; medical-legal analysis and advising; research; socioeconomic analysis and advocacy; practice advising; wellness promotion; ethics analysis and advising; public relations and more; and
WHEREAS, the CSNS has committed by resolution to create a Senior Neurosurgeons Representative Section within CSNS, "so that Senior Neurosurgeons may continue to contribute to Neurosurgery, our Societies, and the next generation;" therefore
BE IT RESOLVED, that the CNS commits to studying, through surveys, interviews, analysis of scholarly material and discussion with experts, the overall impact of retirement on neurosurgeons, the experience of retiring from neurosurgery, the disengagement pathways chosen by retiring neurosurgeons, and the post-neurosurgical career and lifestyle choices made by retired neurosurgeons; and
BE IT FURTHER RESOLVED, that the CSNS generates an index of retired neurosurgeons who wish to advise and assist newly retiring neurosurgeons; and
BE IT FURTHER RESOLVED, that the CSNS commits to a regular educational program on the process of retirement from a career in neurosurgery, the maintenance of well-being and resilience after retirement from a career in neurosurgery, and the potential career, lifestyle options, and activity pathways available to the retiring neurosurgeon.

RESOLUTION II (Divided)

TITLE: A Call for Organized Neurosurgery to Divest Itself of any Relationship with Elected Officials Who Helped Incite the Violent Civil Unrest of January 6, 2021

SUBMITTED BY: Gary Simonds MD MS, Cara Rogers DO, Richard Ellenbogen MD, William Monacci MD, Stephen Ondra MD

WHEREAS, on January 6, 2021, a violent insurrection took place in the United States Capitol building; and WHEREAS, said violent civil unrest was at least in part incited by the words and behaviors of various members of the executive and legislative branches of our federal government; and WHEREAS, the insurrection was at least in part a result of a persistent false messaging to the American public that the 2020 Presidential Election was fraudulent and invalid; and WHEREAS, persistent disingenuous assertions about the validity of the 2020 presidential election has contributed to public distrust in the electoral process and democracy as a whole, and has contributed to a dangerous sense disenfranchisement amongst a considerable percentage of the electorate; and

WHEREAS, various neurosurgical organizations have known ties and affiliations with several politicians who in one form or another contributed to this cynical false narrative about the 2020 Presidential Election and/or to the violent civil unrest of January 6, 2021; and

WHEREAS, various neurosurgical organizations have made financial contributions to politicians who in one form or another contributed to this cynical false narrative about the 2020 Presidential Election and/or to the violent civil unrest of January 6, 2021; and

WHEREAS, it is unconscionable for our representative neurosurgical organizations to be affiliated with or support any governmental actor(s) who has or will perpetuate such false narratives about the 2020 Presidential Election, promote rejection of the results of the presidential election, and/or contribute to violent civil unrest in the name of said false narratives; therefore

BE IT RESOLVED, that the CSNS asks its parent organizations to publicly divest themselves of any official relationship with, or support of, any elected official who helped incite the insurrection of January 6, 2021, officially contested the validity of the results of the 2020 Presidential Election, and/or have repeatedly asserted that the presidential election was fraudulent, and its results illegitimate; and,

BE IT FURTHER RESOLVED, that the CSNS requests that the Neurosurgery PAC ceases any relationship with, and financial support of, any elected official who has helped incite the insurrection of January 6, 2021, officially contested validity of the results of the 2020 Presidential Election, and/or have repeatedly asserted that the presidential election was fraudulent, and its results illegitimate.

RESOLUTION III (Approve)

TITLE: Establishing Curriculum for the Practice of Neurological Surgery During Residency Training

SUBMITTED BY: Nitin Agarwal, M.D., Robert F. Heary, M.D., John K. Ratliff, M.D., Praveen V. Mummaneni, M.D., M.B.A.

WHEREAS, the practice of medicine is continuing to evolve with a greater focus on value-based care; and WHEREAS, trainees may not be exposed to formal training regarding neurosurgical practice either at their local training program or as part of boot camps; and

WHEREAS, a solid foundation is essential for success as an independent practitioner as identified by prior resolutions with interest from members to create surveys and fund workshops; therefore

BE IT RESOLVED, that the CSNS work with the parent bodies to establish and distribute a formal curriculum for trainees geared towards neurosurgical practice management, including billing, coding, and compliance; and

BE IT FURTHER RESOLVED, that the content from this curriculum be incorporated into the written ABNS primary examination and further emphasized in the oral examination to highlight the importance of this knowledge; and

BE IT FURTHER RESOLVED, that in the meantime the CSNS work with the parent bodies to integrate chief residents and fellows into ongoing practice management and coding courses.

RESOLUTION IV (Oppose)
TITLE: Defining Veritable Legal and Fiscal Counseling
SUBMITTED BY: Nitin Agarwal, M.D., Ann R. Stroink, M.D., Catherine A. Mazzola, M.D., Robert F. Heary, M.D., on behalf of the Medico-Legal Committee
WHEREAS, many trainees may not be well versed in contract negotiation or wealth management; and
WHEREAS, upon transition from residency and fellowship to the workforce, trainees may seek legal counsel or financial advice but do not know where to find veritable information or advocates; and
WHEREAS, all healthcare providers should have easy access to a true fiduciary; therefore
BE IT RESOLVED, that the CSNS form a task force to identify veritable sources of legal and fiscal counseling for trainees and those transitioning jobs; and
BE IT FURTHER RESOLVED, that the CSNS works towards dissemination of these resources both through training programs but also online within the dedicated education sections of the parent bodies

RESOLUTION V (Approve)
TITLE: Publication of Patient Generated Outcome Measures
SUBMITTED BY: Mick Perez-Cruet, M.D., M.S., Ann Parr, M.D., Catherine Mazzola, M.D., on behalf of the Medico-Legal Committee
WHEREAS, Patient generated outcomes and surveys are rapidly becoming standard of care in many neurosurgical practices and are particularly important in validating spinal procedures; and
WHEREAS, Quality improvement methods to improve health care quality and safety often do not require Institutional review board (IRB) approval; and
WHEREAS, Data and publications that demonstrate the effectiveness and safety of neurosurgi- cal treatment is paramount to payers (insurance companies) reimbursement for neurosurgical services; and
WHEREAS, Many neurosurgical practices, both academic and private, do not have ready access to administrative personnel for internal review board (IRB) peer review publication of patient generated outcomes focused on quality improvement of patient care and safety, and are uncertain which types of patient generated data/ surveys need IRB approval; therefore
BE IT RESOLVED, that the CSNS form a task force to identify IRB requirements for neurosurgical practice publication of patient generated outcomes and surveys; and
BE IT FURTHER RESOLVED, that the CSNS works towards mechanisms that facilitate publication of patient generated outcomes studies and surveys without administrative demands required by IRB approval.

RESOLUTION VI (Approve)
TITLE: IMPROVING DIVERSITY, EQUITY AND INCLUSION WITHIN THE CONGRESS OF NEUROLOGICAL SURGEONS (CNS) LEADERSHIP
SUBMITTED BY: The California Association of Neurological Surgeons (CANS)
WHEREAS, in Article III, Executive Committee (Board of Directors), Section 2, Number and Election, paragraph C, the Congress of Neurological Surgeons (CNS) bylaws states that …." No person shall be nominated as a member of the Executive Committee after such person reaches the age of forty-nine (49) years", and
WHEREAS, age is considered a protected category against employment discrimination under most Equal Employment Opportunity Laws with age discrimination illegal for employment and frowned upon for service organizational inclusion purposes, and WHEREAS, age cut-offs disproportionately negatively impact, and differentially discriminate against, the professional service careers of women in neurosurgery as they

often delay professional and service itineraries for personal and family reasons, whereas men in neurosurgery do not usually suffer from similar constraints and/or choice requirements, and
WHEREAS, the CNS has never had a woman neurosurgeon President, and
WHEREAS, none of the eight current CNS officers are woman, and
WHEREAS, only three of the current 12 voting members of the CNS Executive Committee (EC) are woman, and
WHEREAS, the historical reason(s) for this age criteria cut off, to create a professional society allowing access and priority to younger neurosurgeons where those opportunities did not exist elsewhere in organized neurosurgery, no longer exists, as the American Association of Neurological Surgeons (AANS) now offers classes of membership as well as leadership potential to neurosurgeons of all ages, and
WHEREAS, even the CNS, themselves, has within the recent past "moved the goal posts" for EC age cutoff several times using bylaws changes to extend the age cutoff to allow selected members of the CNS EC to ascend to the Presidency position in the CNS, and
WHEREAS, a CNS EC age cut-off is not only no longer necessary, but actually robs the CNS of the potential executive committee and leadership service of some highly experienced, talented, and service-dedicated neurosurgeons who are Active Members of the CNS, but happen to be over age 49; therefore
BE IT RESOLVED that the Council of State Neurosurgical Societies formally petition the Congress of Neurological Surgeons (CNS) to eliminate their current age restriction for CNS Executive Committee membership from their bylaws to allow potential CNS leadership position access, and EC service opportunities to all Active CNS members regardless of age.

RESOLUTION VII (Approve)
TITLE: Maintaining Surgical Cadaveric Training
SUBMITTED BY: Cletus Cheyuo, Redi Rahmani, Kris Kimmell, Bharat Guthikonda WHEREAS, there is an increasing reliance on imaging and navigation for procedures in neurosurgery eroding knowledge of anatomy; and
WHEREAS, an increasing number of surgical specialties, including neurosurgery, are experimenting with 3-D printing and virtual simulators for surgical teaching; and
WHEREAS, these technologies while adaptive, will not be able to, in the foreseeable future, mimic real tissue qualities and normal anatomic variants of cadaveric specimen or the ability to dissect surrounding anatomy with alacrity; and
WHEREAS, the continued push for technology-based learning will lead to a decrease in cadaveric learning, leading to loss of benefits of such learning; therefore
BE IT RESOLVED, that the CSNS conduct a survey to evaluate the number of cadaveric learning opportunities each program has over a one-year period; and
BE IT FURTHER RESOLVED, that the CSNS encourage the parent bodies to work with the SNS to create a standardized cadaveric curriculum for neurosurgery programs.

A Gift from CAP

Free Webinar: Thriving in Independent Practice

During this free one-hour webinar, practice management expert Debra Phairas will address the top challenges physicians experience to preserve their valued autonomy and will discuss key considerations for

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Skills to Survive and Thrive in Private Practice
Date: Thursday, May 6
Time: 12:00 p.m. – 1:00 p.m. PDT

All registrants will receive the recording and slides once they are available.

Register now to access these materials automatically after the live webinar.

This webinar will address:

- Specific strategies to implement in independent private practices to remain strong and viable
- Key Financial, Accounts Receivable, and staffing ratios to maintain profitability
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- Opportunities that can be found by merging practices
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- How technology, telemedicine, and ancillary services can increase your practice's success

CAP, a leading provider of medical malpractice coverage for California physicians, offers a wide array of risk management and practice management benefits, such as these free educational programs. ❖

Observation for the Month:

Quarantine coffee is like normal coffee but add margarita and leave out the coffee.

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Meetings of Interest for the next 12 months:

Neurosurgical Society of America: Annual Meeting, June 20-23, 2021, Lake Tahoe, NV
Rocky Mountain Neurosurgical Society: Ann. Meet., June 19-23, 2021, Jackson, WY
New England Neurosurgical Society: Annual Meeting, June 2021, Wequassett, MA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, July 26-30, 2021, Colorado Springs, CO
AANS/CNS Joint Spine Section: Annual Meeting, July 28-31,2021, San Diego CA
AANS: Annual Meeting, August 21-25, 2021, Orlando, FL
CSNS Meeting, August 20-21, 2021, Orlando, FL
NERVES Annual Meeting, August 18-20, 2021, Orlando, FL
Western Neurosurgical Society: Annual Meeting, Santa Ana Pueblo, NM, September 10-13, 2021
North American Spine Society: Annual Meeting, September 29-Oct. 2, 2021, Boston, MA
Congress of Neurological Surgeons: Annual Meeting, October 16–20, 2021 Austin, TX
CSNS Meeting, October 15-16, 2021, Austin, TX
International Society for Pediatric Neurosurgery: Annual Meeting, November 14-18, 2021, Singapore
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 7-10, 2021, Salt Lake City, UT
Cervical Spine Research Society: Annual Meeting, December 2-4, 2021, Atlanta, GA
CANS, Annual Meeting, January 15-16, 2022; Location TBA
North American Neuromodulation Society: Ann. Meeting, 2022, TBA
Southern Neurosurgical Society: Annual Meeting, 2022, TBA
California Neurology Society: Annual Meeting, 2022, TBA
AANS/CNS Joint Section on Pain: Annual Meeting, 2022, 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. Mark Linskey 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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