



## President's Message

### Changing Needs of an Evolving Profession Javed Siddiqi, M.D., DPhil (Oxon) - President

In the 9 years prior to my appointment as Chief of Neurosurgery at Arrowhead Regional Medical Center, the institution had 13 neurosurgeons who came and left. When I was leaving London, Ontario for the USA after completing my neurosurgery residency, a couple of my mentors described American neurosurgeons as 'restless', perpetually changing jobs in search of greener grass, and rarely finishing their careers where they started them.

While my own 25 years' practice at the same hospital where I started right out of fellowship seems atypical, with the exception of a few retirements, I observed that much of what I had been told was true (outside my own team). In my backyard, the Inland Empire and Coachella Valley, I witnessed a huge turnover of neurosurgeons, with near 100% relocation of the neurosurgeons who were present upon my arrival. Certainly, many of my own graduates have changed jobs, some fairly regularly. One other observation I have made is that the most lauded leaders of our profession—Drake, Yasargil, Steinberg among them—burnt their boats upon arriving at their destination. Times have changed. The paradigm of completing your career where you started it is becoming rare in the USA, with a very high proportion of new graduates relocating within one year of accepting their first job. Clearly, a significant proportion of American neurosurgeons do not feel the need to hold their ground to make meaningful contributions to their field, and the peripatetic aspect of the current neurosurgery profession mandates a reassessment of how organized neurosurgery can best serve its constituents.

CANS also needs to consider the modern reality of the differing expectations for neurosurgeons at early, vs. mid, vs. late career. While there are many overlapping concerns for all neurosurgeons, what a new graduate needs from CANS may not be the same as what a mid-career colleague values, which may be unique from what a senior colleague contemplating retirement could benefit from. One thing we all seem to have in common, irrespective of the stage of our career, is limited knowledge of economics (which they never taught us in med school, and we did not have the time to learn in residency). The erosion of physician autonomy with a yawning hospital employment model makes our CANS constituency even more diverse in practice paradigm than ever before. The traditional categories of 'academic' vs. 'private practice' are clearly insufficient today; we now have to include the 'foundation-employed physician', the 'priva-demic' neurosurgeon, the hybrid model of academic-affiliated private practice neurosurgeon, and the expanding component of our colleagues (at various stages of their careers) who consider locums tenens as a practice pattern (vs. a stop-gap measure).

The primary raison d'être of CANS was to address the socioeconomic issues relevant to the practice of neurosurgery. The scope of this original mandate included the establishment of the RVU scale for reimbursement, and the successful response to the malpractice crisis of 1975; not unsurprisingly, the interests of California neurosurgeons continue to evolve with ever-changing threats and challenges. I ask all CANS members to accept this President's Message as a call for engagement to influence your organization in how you envision it for our second half-century. While CANS continues to advocate for neurosurgery and neurosurgeons, please reach out to me on what you see as the most valuable aspect of CANS advocacy for you individually; what is missing; what we can do better; and, how we can engage your families in our work. I would love to see CANS initiatives culminate in our annual meeting that is a family reunion of sorts: a chance to renew kinship, learn from each other, remark on how well the children are doing, support those who need it, and grow the family with new additions. I look forward to your great ideas! ❖

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## Editor's Corner

### Planning the Direction of the Newsletter

*Moustapha Abou-Samra, MD*

**A**s Editor of CANS Newsletter, I am fortunate to have the help of my amazing Associate Editors and the strong support of our President.

We are all also fortunate that our late Founding Editor Randy Smith left a strong foundation. In order to honor his memory, hard work, and dedication, we will do our best as a team to build upon this foundation.

The Publications Committee/ Editorial staff met by zoom on February 9. Our President attended the meeting. A strong desire to add social media, much like mentioned in Anthony DiGiorgio's essay last month, and consider creating a CANS podcast became obvious. Dr. Siddiqi appointed Dr. DiGiorgio and Dr. Hariri to the Website committee that so far has been ably and single handedly managed and chaired by Dr. Kevin Chao, with the plan to closely coordinate the work of both committees.

Our additional plans for the newsletter include:

- Sending the Newsletter to all California Neurosurgeons, and not just CANS members. It would be helpful if you know a specific colleagues in your community who is not a member of CANS, to provide us with his or her address.
- One of our Presidents priorities is to increase female neurosurgeons' involvement in CANS. We will ask female Board Members, female California neurosurgeons and female residents to submit their perspectives to be published regularly in the newsletter. See this month "Changing Times" essay entitled "Women Surgeons," and the Female Neurosurgeons' Corner.
- Another of our President's priorities is to involve younger neurosurgeons. We will feature a monthly "Residents Corner." Our Residents Board members will help enlist the help of residents from the 11 training programs in California. See this month's essay by Stanford PGY-2 Resident John Choi.
- We plan monthly columns about young neurosurgeons; neurosurgeons in small or solo practice settings; as well as neurosurgeons in large groups. Each will have a different perspective.
- We have invited a monthly contribution from CANS Board Members in addition to our monthly President's message.
- We are, here, inviting CANS members at large to submit essays that our editorial committee will consider publishing as often as possible. So please start submitting your essays.
- Also, we would really appreciate your feedback, so please start submitting letters to the editor, we will publish them.
- And finally, for now, and since neurosurgeons are such a multi-talented group, we would like to publish photos taken by CANS members. Debbie Henry will curate this photographic corner, so start submitting photos. We envision nature or travel photos as well artistic children's photos... your talent has no limits.
- We will continue to publish CMA and AMA reports as needed.
- We will continue to publish reports about Board actions, particularly positions taken regarding CSNS resolutions.
- We will continue to publish all other sections that were always featured in our Newsletter.

I hope that you, our readership, will receive this information with the same enthusiasm our committee is feeling. ❖

Please note Randy Smith's Celebration of Life Evite: San Diego 2-4:30PM on March 19, 2022  
Please RSVP if you plan to attend. <http://evite.me/6d8NWSmcfJ>

## Changing Times

*Moustapha Abou-Samra, MD*

I wrote the following essay to commemorate Mother's Day last spring. I submitted it for publication and entered it in the Grand Competition for Hektoen International, a Journal of Medical Humanities. It was published <https://hekint.org/2021/09/10/women-surgeons/> and won an honorable mention. Randy, our late editor, encouraged me to publish it in this newsletter. Here is a modified version:

### Women Surgeons



Last spring, I spent three months in the Texas Hill Country. It is a place that at once can be beautiful and hostile. The beauty of the fields of blue bonnets in full bloom is breathtaking and simply indescribable. The cacti that abound around barbed wire fences give an ominous aura particularly if one gets close to see their threatening thorns. But wait a bit and you will be dazzled with cactus flowers, a multitude on every paddle, mostly pure bright yellow, but occasionally speckled with orange or red. Please enjoy the included photos.

These flowers made me think of women surgeons. During my career as a neurosurgeon, I mentored, among several young surgeons, two exceptional women neurosurgeons. They have gone on to accomplish wonderful and very successful careers. Additionally, I have gotten to know several amazing women neurosurgeons as colleagues. Our profession is better because of each of them.

I was always impressed with the fact that my female colleagues had to work harder to reach their well-deserved positions in our medical practices, academic institutions, and professional societies. The inimitable former Governor of Texas Ann Richards expressed it accurately and with humor when she said "After all, Ginger Rogers did everything that Fred Astaire did. She just did it backwards and in high heels." But they persisted and the number of women in surgery and surgical subspecialty is increasing.

It must be said, however, that although it is getting easier for female surgeons to thrive in a male dominated field, it has not been always easy. At first, women were not encouraged to become physicians and their work was not even recognized. Everyone knows Hippocrates and his role in establishing Medicine as a profession, but few know who Metrodora is. A Greek woman of Egyptian origin, who was born between 200 and 400 AD, she is credited for establishing Obstetrics & Gynecology as a specialty. She wrote a comprehensive two-volume book – 63 chapters – some still relevant. It was called "On the Diseases and Cures of Women." She invented the speculum to conduct her examinations.

Even though the oldest medical school in the world, the Schola Medica Salernitana, in Salerno, Italy, was established in the XIth Century, it was not until 1754 that Dorothea Christiane Erleben became the first female medical doctor in Germany and the first female physician in the world, credentialed by a licensing body to practice medicine. Why? It certainly is not because women lacked talent.

Yes, it has been difficult for women in general and women in Medicine and Surgery in particular. One of the problems is that Society expects them to be in charge of the bulk of the home responsibility, while their male partners are free to pursue their "job" responsibilities outside the home; after all they are considered the bread winners. This is getting better but has not been resolved equitably. Additionally, the responsibilities of child rearing are considered the mother's duty, and even though we see more and more fathers becoming intimately involved in taking care of their children's daily needs, the bulk of the responsibilities remain on the shoulders of women.

Another issue they face is stereotypes, and there are many.

Consider the following: men are tough; women are in touch with their feelings. Men are providers; women are nurturers. Men should punch back when provoked; women should be physically attractive ...

These are findings from a Pew Research article published in 2017. It was titled "On Gender Differences, No Consensus on Nature vs. Nurture." With a subtitle of: "Americans say society places a higher premium on masculinity than on femininity."

Some stereotypes, however, are used in a positive way. Lord Berkley Moynihan 1865-1936, a famous and amazing English surgeon and teacher said: "The perfect surgeon must have the heart of a lion and the hands of a lady, not the claws of a lion and the heart of a sheep."

I am not here to discuss differences between men and women. I am here to indicate my conviction that men and women are absolutely capable of accomplishing the same tasks at work, particularly when it comes to Medicine and Surgery.

In fact, I think women have several advantages over us men. They have more empathy, a crucial quality in doctors. They are more flexible, where men can be more rigid. They do not look at every encounter in a winning or losing context, whereas men tend to do that, a negative quality in rendering care to another human being.

I agree with Lord Moynihan. A surgeon should have the heart of a lion and the hands of a lady. Indeed, women surgeons have both!

No, I do not think that physical beauty is important for women physicians; their ability to care and listen is the beautiful perspective they bring to our profession. We are indeed better with women around; they keep us grounded.

Our history and the history of medicine are replete with examples of discrimination against women and minorities.

Muslim women healers in the XIVth century, the early days of the Ottoman Empire, practiced folk medicine, midwifery, and gynecology. They were referred to as "tabiba," female for "tabib," the Arabic word for physician. They had an important role in the medical establishment, and although appreciated by the public, they were not formally recognized. They had no access to formal medical education and had to practice in the shadows of their male

colleagues, who commanded the respect and stature.

Margret Ann Bulkley was born in 1789 in Cork, Ireland. She decided to disguise as a male in order to be accepted to medical school at the University of Edinburgh. She lived the rest of her private and professional life as a male under the pseudonym of Dr. James Miranda Steuart Barry, who became a successful military surgeon. Dr. Barry rose to the rank of Inspector General, in charge of military hospitals, the second highest medical office in the British Army. The fact that Dr. Barry was a female was not discovered until a post-mortem examination.

But the history of female physicians is surprisingly one of sporadic inclusion. Thankfully, progress has been made and is moving at a faster pace. We cannot slow down now.

And we need to recruit more women into our ranks, otherwise we are depriving our specialty of an amazing pool of talent.



So, what do women surgeons have to do with these beautiful cactus flowers? Think about it. The flower in the first photo is flanked by three equally beautiful buds much like children, and in the second photo the flower and a single bud are surrounded by thorns. I don't mean to say that the thorns represent their male colleagues although some of us behave like thorns; I think that the thorns represent the work environment in which women physicians often find themselves.

Women and women surgeons have an amazing ability to focus and persevere. They are succeeding and as they do, they are showing us how to be at once gentle and tough. They make us better. They make our profession better. ❖

## Female Neurosurgeon's Corner

### Gender Discrimination- A Mixed Experience

**M**y mother in Canada loves to mail me newspaper clippings. Most of the time the content is light-hearted and humorous. However, the last article she sent provoked enough frustration that I decided to act on it. This article, which was on the front page of Canada's national newspaper, The Globe and Mail, documents the ongoing discrimination against female surgeons and trainees. The punch line is that women are paid less for the same work and struggle to get promoted to leadership positions. Below is my letter to the editor:

RE: Dec 31<sup>st</sup>, 2021, Medicine's Gender Power Gap

*I am a Canadian-trained neurosurgeon who lives and works in the US. I was not "forced" to leave due to lack of a job in Canada. I left because when I came to Stanford University to pursue a fellowship, I encountered a place where I felt that the culture supported my growth as a female surgeon. I am now a Professor and have felt extremely supported by my department every step of the way.*

*Despite that, a few years ago I pursued a position back in Canada. This was mainly for personal reasons and due to the political turmoil at the time in the US. I have never been treated so poorly in my entire professional life. I was told that there were men in the department that "weren't comfortable" working with a woman and might "feel threatened". I ultimately did not get offered this position which I was more than qualified for. I was never actually called by anyone to tell me this but heard through the grapevine that the position was given to a far less experienced male colleague.*

*There needs to be more transparency in how surgeons are hired, paid, and promoted. Otherwise, I would predict that, like most patriarchal systems, it will continue to benefit those in power. That will be a loss for patients. A recent study published in the medical journal JAMA Surgery found that both male and female patients experienced better health outcomes with women surgeons. In addition, a 2017 study found that patients of women surgeons have **lower death rates**, fewer health complications and lower rates of readmission than those of male surgeons. To those surgeons in power, I'm sorry if this news makes you "uncomfortable."*

Ciara D. Harragher, MD, MPH, FRCSC  
Clinical Professor, Neurosurgery  
Stanford University

This letter was published in the Globe and Mail on Feb 6, 2022. As a female surgeon it can be exhausting as just when you feel that you have made some progress, you read the data that shows how far you still need to go. Having female medical students and female neurosurgery residents is progress. I wonder in my lifetime if the concept of female department chairs or leaders of our national organizations will not seem so revolutionary? ❖

## Historical Vignette

### History of Neurosurgery in Fresno

*John P. Slater, MD*

**B**efore WW2 there were no neurosurgeons in Fresno. Dr. George Hashiba, a scholarly general surgeon, was encouraged to learn basic neurosurgery so he could help in emergency situations. He maintained a cadaver at Stanford where he would dissect on weekends. During WW2 Dr. Hashiba along with other Japanese Americans were sent to internment camps. If there was a neurosurgical emergency, the military police would get Dr. Hashiba out of the camp and take him to the hospital in downtown Fresno. After the surgery, MPs would then escort Dr. Hashiba back to the camp. Dr. Hashiba complained very little, but he did object to a letter published in the Fresno newspaper. A patient complained that she had weird thoughts and dreams since she had brain surgery by a Japanese neurosurgeon. She was convinced he had written a hostile message and left it inside her head at the end of the operation.

After WW2 a neurosurgeon was briefly in practice. He was so incompetent that members of the medical community asked Prof. Edgar Kahn of the Univ. of Michigan to evaluate the neurosurgeon's work. Dr. Kahn wrote to the effect that "Fresno could not afford to have Dr. X as a neurosurgeon. In fact, Dr. Kahn could not think of any community that could afford Dr. X as its neurosurgeon."

Dr. Jack Pace, a fully trained neurosurgeon (UCSF Professor Nafziger and Boldrey) came to Fresno on a trial basis in the early '50's. The understanding was that Dr. Zealear, also from UCSF, would join him in a few months if there was enough work to do. They were the only fully trained neurosurgeons between San Francisco and Los Angeles. Of course, they were incredibly busy. On at least one occasion, Dr. Zealear operated in Modesto in the morning and in Bakersfield in the afternoon. He drove a Jaguar or other fast European car on the 2-lane highway 99 (at least 8 hours driving time plus surgeries). One day Dr. Pace was operating in Bakersfield when he was told that a doctor (Dr. Ablin) would like to talk with him after the case. Dr. Pace demurred, explaining he had to get back to Fresno that night. On hearing that Dr. Ablin was a neurosurgeon looking for a job, Pace responded: "Send him right up!!"

Dr. Robert Lippert had neurosurgical training at the Mayo Clinic. When Dr. Lippert arrived, Pace and Zealear gave him a list of 60 hospital patients and several valley hospitals. They then left Fresno on a golf vacation. On one occasion, Dr. Lippert was greeted in Visalia by a huge man holding what appeared to be a toy Hudson Brace and Bit. It was no toy. The man was Dr. Mathias, Olympian Bob Mathias's brother. Dr. Lippert asked Dr. Mathias "Are you a qualified neurosurgeon?" Dr. Mathias explained that he was a general surgeon who assisted Dr. Zealear when neurosurgery was performed in Visalia. Dr. Lippert responded, "I am a fully-trained neurosurgeon from the Mayo Clinic." To which Mathias answered "Well, you can overcome that!!"

In 1958 John P. Slater (Univ. of Vermont by way of US Army Japan) joined P.Z.&L. Dr. Richard Thorp, whose neurosurgical training was at Dartmouth, came several months later. Roughly one year later, Dr. John Bonner (Univ. of Chicago) came to Fresno and joined Dr. Thorp in an independent practice. Dr. V. Roy Smith (Mayo Clinic) came to join P.Z.L.&S. Dr. Robert Simons returned to the valley after completing his residence at the Univ. of Washington. He quickly built a large private practice. Dr. Simons shared call with P.Z.L.S.&S.

For a number of years, each Fresno surgeon covered all types of cases. That system fell apart when some surgeons refused to care for pediatric cases.

Dr. Slater was trained in microsurgery by Drs. Donaghy and Yasargil. He tried to get other neurosurgeons to use the microscope. Others were rarely interested until Medicare paid a premium to neurosurgeons who used the microscope. Suddenly everyone became experienced micro neurosurgeons.

Doctors Slater and Smith, the last 2 members of the original Fresno Neurosurgical Group, retired in 2006. Now, in 2022, there are 9 or more doctors in the Fresno area that call themselves neurosurgeons. Two who service Children's Hospital in Madera do intracranial surgery. Two will occasionally do intracranial cases. One of two others work with catheters as vascular interventionists. Dr. Simons restricts himself to spinal work. The others restrict themselves to spinal work and peripheral nerve surgery. ❖

## Young Academic Neurosurgeons' Corner

### How CANS Helped Me

*Anthony M. DiGiorgio, DO, MHA*

I spent 7 years learning neurosurgery. Anatomy, physiology, and surgical technique were drilled in me for countless hours.

Now, suddenly, I'm expected to know what the difference is between a [99221](#) and a [99223](#).

I learned to perform research, run stats, and publish papers. Now, I need to know what the No Surprises Act is, and, more importantly, why organized medicine is [up in arms against the final rule](#).

Few residents come out of training knowing the answers to these important questions. Yet, as young attendings, we are thrust into this world of CPT, RVU, contracts and regulations.

From basic things like billing, coding, and reimbursement to more complex topics, CANS has much to offer young neurosurgeons. We have representation from all types of practice in California, private independent, employed, large group and academic. The [wisdom of those who have been through payor contracts, labor disputes and grassroots advocacy](#) must be disseminated to those of us who are just starting out.

As new faculty, I struggled with my coding & billing. Why was I getting so many coding queries and clinical documentation improvement requests? Why am I and my fellow doctors spending [twice as much time on the computer](#) than with patients? I had been exposed to some of those things as a resident, but as a young attending trying to build a practice, these issues moved to the forefront.

This led me directly to CANS. The neurosurgical organization for policy and socioeconomics not only helps explain [why](#) I face these quotidian bureaucratic annoyances but also what can be done to improve neurosurgical practice. By improving the practice of neurosurgery, it directly improves our patients' care.

While I marvel how the geniuses at my institution make breakthroughs in GBM treatment, DBS applications and machine-brain interfaces, I know that policy research and advocacy can affect our patients lives just as much. CANS makes me appreciate the complexity of healthcare economics.

CANS is my resource for policy. When I want to know why organized neurosurgery opposes the [California Single Payor bill](#) and [supports MICRA](#): CANS. When I want to know the rationale behind the fight against HHS's IFR on the No Surprises Act: CANS.

I learn from discussing with leadership, great talks at meetings and by following members who [comment on these issues on social media](#).

Through this column and social media, I hope to show how CANS can enrich the lives of our younger members. CANS has much to offer. ❖

## Brain Waves February 2022

### Calculus in Medicine

Deborah C. Henry, MD

Calculus is no longer required for medical school admission. I'm of that age when calculus was only taught as a large-lecture freshman college course (my high school offered math only to analytical geometry) for those on a science, math, or pre-med track. Sitting in the second to last row of a classroom of 200 students, I could barely see the board. It was the second "C" that I earned in my lifetime. The first "C" was in fourth-grade spelling, a subject I still struggle with. I thought I earned that first "C" in penmanship, prescient for a career in medicine, which led me to spend the summer following fourth grade working on the obsoleting cursive writing.

Calculus is a Latin word that means "pebble often used as a reckoning counter." Shepherds would take a pebble from a basket and place it in a pile to represent each sheep left out to graze. In the evening when the sheep returned from pasture, a pebble was replaced in the basket. Having never done a differential equation or integral after freshman year of college, I used calculus in medicine only to describe kidney stones or those pebbles in our body.

With passage of time, I regret not having a deeper comprehension of what mathematical calculus is about. During my high school senior year analytical geometry class, I wrote a term paper on mathematical paradoxes. Zeno's paradoxes of not being able to travel or measure time as one always needs to go half the distance infinitely, have stayed with me all these years. Algebraically they cannot be proven wrong. They need calculus. Every second can be subdivided into smaller amounts until there is no movement of time.

In 1980 when I was interviewing for medical school, I traveled to the University of Texas Medical Branch at Galveston. Here, in an isolated lab on the island, a researcher asked me when time began. Not the typical "why you want to go to medical school" question. I thought for a moment then answered, "When man developed a measurement for time." Using the base of 60 for time came from the ancient Babylonian astronomers as 60 is divisible by 1, 2, 5, 10, and 12. However, the measurement of time did not occur until the advent of the clock in the 14<sup>th</sup> century. Until then, days had 24 hours divided into 12 hours of light and 12 hours of darkness. Therefore, the length of an hour depended on the amount of daylight. During European summers, an hour grew longer until the summer solstice then the hour shortened until the winter solstice. The idea of seconds happened two centuries later when timepieces could measure this entity.

Still, with or without calculus or even Einstein, I find time relative. It expands and contracts with what needs to be done. The days are longer in childhood, shorter in fun, variable in adulthood. I can lose time or gain time when I travel. But like the counter-current system in the nephron, if returning to the same place, I eventually must repay any time (energy) gained or used. I can predict the time it takes to do a lumbar discectomy but not always the time it takes to remove a brain tumor. Even after decades, I still remember a paraphrase from a Laura Ingalls Wilder book of a Horace Mann quote (*Thoughts Selected from the Writings of Horace Mann*, published in 1872) regarding the loss of time:

Lost, between sunrise and sunset,  
One golden hour, set with sixty diamond minutes.  
No reward is offered, for it is gone forever.

Not only time is lost but also is the need for calculus to apply to medical school. Lost is my ability to determine an integral. Calculus in medicine reverts to its original meaning: a pebble. ❖

## Residents' Corner

### A Junior Resident's Reflection on Call

*John Choi, MD Stanford, PGY-2 Resident*

I was six years old when I saw my first episode of Power Rangers. The formulaic premise had quite an impression on me; every year through the rest of elementary school I wrote that my career aspiration was to become the red ranger and fight monsters. The easily recognizable ring of the communicator watch summoning the hero to fight crime with the inevitable resolution of an epic fight of literally gigantic proportions was awe inspiring to say the least. Fast forward twenty-five years—instead of a watch I have a pager and instead of monsters I take call, to fight neurosurgical diseases.

I recently tried to explain "call" to my friends who did not have experience working in medicine. When dissected in rote, it is not too dissimilar from my above imaginings; the emergency department or some other medical team has a question or concern that involves the central nervous system, and they page you to offer a simple answer: surgery vs. no surgery. If intervention is needed—electively or emergently. Sometimes the challenge with taking call is obvious: the sheer number of consults—my current record is 26 on a shift—or the fact that you are also the primary resident in charge of the ICU during the day and the entire neurosurgical service at night. But this is usually as far as I go when trying to describe "call" to people outside of medicine.

What I cannot share so easily are the stories that each consult brings, and not just for HIPPA reasons. Stephen King describes the sentiment well. "The most important things are the hardest to say. They are the things you get ashamed of because words diminish them -- words shrink things that seemed limitless when they were in your head to no more than living size when they're brought out. But it's more than that, isn't it? The most important things lie too close to wherever your secret heart is buried, like landmarks to a treasure your enemies would love to steal away. And you may make revelations that cost you dearly only to have people look at you in a funny way, not understanding what you've said at all, or why you thought it was so important that you almost cried while you were saying it."

It is hard to describe what it's truly like being on call. To be the first and last person to tell a family member that their mother has no chance of meaningful recovery while your pager is ringing constantly in the background—when a grieving daughter, despite you having told her the worst news of her life, urges you to go take care of other patients. When you stand in solidarity with family members as their father takes his last breath after you had convinced them to let him go peacefully. And with that last breath they immediately grab you by the collar and cry, asking if this was the right decision after all.

Most days on call I do not feel like the red ranger. But looking back, the Power Rangers never worked alone. They were a team. The solidarity within neurosurgery is one that cannot be overemphasized. My co-residents, chiefs, and attendings all understand my daily struggles implicitly and support me unconditionally. The humanity of this job would be lost so much more easily if not for my colleagues. And finally, there are those halcyon days. There are those moments when you find yourself releasing a breath you hadn't known you were holding during a hemicraniectomy after a pupil that was 5mm and fixed becomes reactive again at 3mm. When that expanse of 2mm cautiously promises the waking of a once obtunded patient.

And sometimes, this job does make you feel like a Power Ranger. ❖

## Large Group Corner

### My Goals

*Omid R. Hariri, D.O., MS.c., FACS*

Permanente Medicine is currently the largest neurosurgery group in California. It is important to note that Southern California Permanente Medical Group (SCPMG, Pasadena, CA) and The Permanente Medical Group (TPMG, Oakland, CA) are two different entities for Southern and Northern California, respectively. There are currently five Kaiser Permanente (KP) neurosurgery centers in Southern California. These centers are located at: Anaheim/Irvine, Fontana/Ontario, Los Angeles, Woodland Hills, and San Diego. Almost all neurosurgical subspecialties are covered amongst these centers. Currently, Los Angeles and Fontana are the two designated pediatrics neurosurgery centers for Southern California KP members. Overall, our neurosurgery group consists of 34 neurosurgeons. Interventional/Endovascular Neurosurgery is also covered by Neuro-Interventional Neurologist, as well as Neuro-Endovascular Radiologists.

In this issue of CANS newsletter, I would like to introduce our leadership team for SCPMG-Neurosurgery. SCPMG's leadership structure for Neurosurgery consists of one regional chief, as well as five local chiefs.

#### **Regional Chief of Neurosurgery for SCPMG: Sooho Choi, MD**

Regional chief of neurosurgery for Southern California since January of 2021. One of his main objectives for SCPMG Neurosurgery is advancement of evidence-based care in neurosurgery and spine surgery. Moreover, implantation of a Virtual Medical Center (VMC) specifically for neurosurgery to reduce on-call burden and physician burnout is another priority for our current regional chief.

#### **Local chiefs of Neurosurgery:**

Orange County (Anaheim/Irvine): Sooho Choi, MD-Skull base Neurosurgeon

San Bernardino (Fontana/Ontario): Paulino Yanez, MD-Neurosurgery-Spine Surgery

Los Angeles: Brain K. Pikul, MD-Neurosurgical Oncology

Woodland Hills: Ajay K. Ananda-Functional Neurosurgeon

San Diego: Greg Gerras, MD- Skull Base Neurosurgeon

I joined the SCPMG Neurosurgery in 2018. My main region of practice is Orange County. Initially out of fellowship, I had three main goals in mind for my ideal practice.

Most importantly, I did not want to get labeled as just a "spine surgeon." It was very important to me to continue to have a robust cranial practice, even after my complex spine fellowship. Many other groups/practices in California, with whom I interviewed, were looking for just a spine surgeon to focus on spine surgery. In my current practice, I continue to do many of the cranial surgeries for which I was well-trained. Moreover, given the strong mentorship within my group, I knew that I never have to shy away even from the more complex cases that I would encounter.

My second goal was to be able to build a spine center. Kaiser Orange County did not have a complex spine program, thus it provided me an opportunity to be able to implement one. I knew that for my personal growth and career satisfaction I would need to be an essential part of building a new program, rather than just walking into another established one. Thus far, there have been many challenges that we have encountered. However, we are getting closer to having a robust complex spine program.

Lastly, my main area of interest and research in spine surgery has always been spine oncology. Spine oncology was not a program that I would have been able to build in a smaller practice. Since Kaiser Orange County is a regional radiation center, I knew that the referral base would be strong, and I would be able to establish an evidence-based spine oncology program and tumor board.

In the upcoming issues, I plan to share more of my personal experiences as a neurosurgeon-partner within SCPMG, as well as some of the main socioeconomic challenges that we face as a large group partnership. ❖

***Special gratitude to NuVasive for their platinum Sponsorship!***



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## Private Practice Corner

### The Unbearable Lightness of Coming into Being

*Brian R. Gantwerker, MD, FAANS, FACS*

When I finished up my fellowship at the Barrow Neurological Institute in the Summer of 2009, I had no intention of starting my own practice. It was our second summer on the surface of the sun, that was Sun Valley. I started looking for jobs, but the nation was just rounding the corner of the economic downturn of the 2008 market crash. Good jobs in either of our hometowns (mine was Chicago, my wife's Los Angeles) were not coming to fruition. We wanted to be close to family because we were trying to start a family.

I finally took a job in Los Angeles, and started practice with a group in Los Angeles. As my year end approached, it became clear I wanted to practice a different kind of medicine. I did not renew my contract, but as I was deciding a next move, my wife and I had a heart-to-heart talk about next steps.

In many towns, hospitals were suddenly somehow able to employ neurosurgeons and the now prevalent trend of employment was in full swing. However, I was still not finding a good opportunity that did not seem to involve some sort of servitude.

There were not a lot of prospects out there in Los Angeles, let alone anywhere else in America where we wanted to live. Our families were still pretty solidly in either larger metropolitan areas. I made phone calls, had coffee meetings, sent emails and ... nada. Prospects were still thin and I made a decision to try to hang my shingle

I had no experience in setting up a business. My grandfather of blessed memory had been an extremely successful insurance agent, working his way up to the President's Club of Mutual of Omaha. His signed stone is still in the foyer of the company's HQ. But then, for reasons unknown, he went off on his own. He was an industrious child of the depression, with barely a 6<sup>th</sup> grade education and veteran of World War II.

By the time matriculation from my fellowship arrived, he had been gone for 5 years. There was no sage counsel, no wise mind to guide me. Chances seemed super slim of actually doing it, as most of the private neurosurgeons I know had started fleeing into hospital employment.

Starting a business was something so outré, so out of my realm it never crossed my mind that I would need to be doing it less than 2 years after fellowship graduation. Bucking the trend seemed according to "most people" a mistake. My wife and I sat down and I asked her if she would put her faith in me and start our own practice. We were both over our heads swimming from the danger of the unknown working world. I was willingly becoming an anachronism – a rotary phone in the age of 3G. Somehow, though I thought it was doable.

People might, it seemed, want an "old style" surgeon with modern skills. We would do it together, with all the accountability and responsibility on me. But also, the opportunity to create something unique, flexible, responsive, and enjoyable place for patients to go.

Truth is, I had no clue what it took to even make a first step. After I was done separating from my own employed position, I had to start from less than zero. I had to get funds, get my Medicare provider status up and running, get an office, get my staff privileges and on and on. The monolith was daunting. Knowing of no blueprint, I made a list of things to accomplish. Not that this helped decrease my anxiety, but it was better than just running around in circles.

First, I created a corporation and obtained a Tax ID number. Next, I applied for my own PTAN (Medicare) number. I made sure I had things like my NPI enumerators for myself and my "group." Simultaneously, I obtained malpractice coverage after doing some shopping. I initially stuck with my previous one, to avoid paying for tail coverage until I was on more solid footing. One of the most important things I did was get a line of credit. I do not recommend getting an SBA loan, and instead get a revolving line of credit to help make up for shortfalls. The list of to-dos was daunting: getting a payroll company that won't rob you blind, worker's compensation insurances, insurance contracts, Medicare numbers (PTAN), and general liability coverage for the practice. And finding a decent biller or EMR, that is an article unto itself.

But these are all cookbook steps to take. The most important piece of advice I got was from a plastic surgery colleague. He stated that, to become established in a community was to put myself where I wanted to be. Competitive spaces tend to be, well, competitive. Colleagues can sometimes be anything but collegial. To find your space it is important to put yourself where you want to be.

I found out long ago, that just going where there is money to be made, or where the "streets are paved with gold" is not a way to have a healthy or sustainable practice. You end up looking like a carpetbagger and lose local legitimacy. Making a living is paramount, and by working hard at whatever it is you are doing is not always enough. However, if you like where you live, there is no better way to show your commitment to it than opening a business there.

Coming into being in a new or previous area as a new entity is often anything but smooth. You will get pushback from the local folks and the local hospitals may not be too hospitable either. Independent surgeons represent an inherent threat to their employed physicians colleagues. You should not get discouraged. It is the time to find your place, your niche and what makes what you special. There may also be a time, when you realize things are not working out, and it may be time to bow out and search for greener pastures. One certainly needs a fairly large supply of stubborn to be sure (I have it in spades).

So, the lesson here was simply - be bold and stubborn enough. No one has all the answers, and there is bad advice aplenty out there. It is possible to do things differently, to buck the trend, and to still do good medicine without uprooting your family or selling your soul. And to be a success in private practice you first have to be brave and perceptive enough to listen to that little voice that encourages that you can do better. ❖

## **CANS MISSION STATEMENT**

**'TO ADVOCATE FOR THE PRACTICE OF CALIFORNIA NEUROSURGERY  
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## Tidbits February

- USS Constitution's first female commanding officer took command of Old Ironsides during a change-of-command ceremony, held on Friday, Jan. 21, at noon.  
As the 77th commanding officer of USS Constitution, Commander Billie J. Farrell became the first woman to serve as captain in the ship's 224-year history, dating back to 1797.
- A bill that would have created the nation's only government-funded universal health care system died in the California Assembly on Monday as Democrats could not gather enough support to bring it for a vote ahead of a legislative deadline- January 31.
- Moderna's Covid-19 vaccine has received full approval from the US Food and Drug Administration for use in people ages 18 and older. The vaccine, named Spikevax, is the second coronavirus vaccine to receive full approval from the FDA behind Pfizer's Comirnaty vaccine- January 31.
- California Gov. Gavin Newsom, who three years ago placed a moratorium on executions, now is moving to dismantle the United States' largest death row by moving all condemned inmates to other prisons within two years- February 1.
- Boeing has donated \$1 million toward construction of a bridge over a Southern California highway to allow mountain lions and other animals to move between fragmented wilderness areas. The planned wildlife crossing would be built west of Los Angeles at Liberty Canyon, stretching over 10 lanes of heavily traveled U.S. 101 to connect the coastal Santa Monica Mountains on the south to hill country to the north- February 3.
- Some Native Americans want the bells that mark El Camino Real in California removed. They say the highway markers symbolize the painful history of the missions. Others say removal erases history.
- U.S. COVID Death Toll Surpasses 900,000- February 4
- The world surpassed 400 million known coronavirus cases on Tuesday Feb 8, just one month after reaching 300 million, a staggering increase driven by the highly transmissible Omicron variant as governments and individuals worldwide wrestle with how to confront the next stage of the pandemic.
- California's first surgeon general resigned, saying that she is "prioritizing care for myself and my family" three years after taking the position February 11.
- 300,000 jobs have been affected by the US suspension of avocado imports from Mexico according to an organization representing avocado farmers. The suspension was initiated by U.S. officials after one of its officers received a threatening call to his cell phone while completing inspection work. An investigation into the threat is currently underway.
- In 2021, the California Medical Association (CMA) recovered nearly \$3.2 million from payors on behalf of physician members. This is money that would have likely gone unrecouped if not for CMA's direct intervention. That's because California physicians have a powerful ally when it comes to dealing with problematic payors—CMA's Center for Economic Services (CES). February 16.

- February 15 Disneyland lifts mask requirements: Face coverings will be optional for vaccinated guests at the "happiest place on Earth." February 16
- Disney introduced a new initiative called Storyliving. The house of Mickey Mouse is planning to build a community in southern California for those who can't get enough of all things Mickey and Minnie in their lives. The community will be built in Rancho Mirage in the Coachella Valley and will be known as Cofino. February 16
- California became the first state to formally shift to an "endemic" approach to the coronavirus with Gov. Gavin Newsom's announcement Thursday of a plan that emphasizes prevention and quick reaction to outbreaks over mandated masking and business shutdowns. February 17
- Gov. Gavin Newsom on Sunday February 20, described the new pandemic plan he released last week as a "more sensible and sustainable" approach that would lead the state out of "crisis mode" now that Omicron cases had dropped significantly and many residents were eager to move on.
- A massive 500 lbs. black bear known as Hank the Tank has broken into at least 28 homes in search of food in South Lake Tahoe.
- Paul Farmer, a physician, anthropologist and humanitarian who gained global acclaim for his work delivering high-quality health care to some of the world's poorest people, died on Monday on the grounds of a hospital and university he had helped establish in Butaro, Rwanda. He was 62.
- A six-year fight over equal pay that had pitted key members of the World Cup-winning United States women's soccer team against their sport's national governing body ended on Tuesday morning with a settlement that included a 24-million-dollar payment to the players and a promise by their federation to equalize pay between the men's and women's national teams. February 22
- And for those old-fashioned souls:
- AT&T is shutting down its 3G network on February 22, 2022. The move will impact people still using 3G Kindles, 3G flip phones, the iPhone 5 and older models, various Android phones and some wearable devices. It will also affect some home alarm systems and medical devices such as fall detectors. Some in-car crash notification and roadside assistance systems like OnStar will also need to be updated or replaced. ❖

## Quote of the Month:

***True love is inexhaustible; the more you give, the more you have.***  
*-Antoine de Saint-Exupery*

# Photo of the Month:



*Penguin Family*

*Photo taken on December 28, 2021, by Deborah Henry, MD, in Antarctica using a Canon Camera with telephoto lens*

## CALENDAR

CSNS Spring Meeting, April 28-29, 2022, Philadelphia, PA  
AANS: Annual Meeting, April 29-May 2, 2022, Philadelphia, PA  
Neurosurgical Society of America: Annual Meeting, June 12-15, 2022, Maui, HI  
Rocky Mountain Neurosurgical Society: Ann. Meet., June 18-20, 2022, Coeur D'Alene, ID  
New England Neurosurgical Society: Annual Meeting, June 23-25, 2022, Chatham, MA  
Western Neurosurgical Society: Annual Meeting, September 9-12, 2022, Kona, Hawai'i, HI  
CSNS Fall Meeting October 7-9, 2022 San Francisco, CA  
CNS Annual Meeting October, 9-15, 2022 San Francisco  
**CANS, Annual Meeting, January 13-15, 2023 – Riverside, CA The Mission Inn (pending)**

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](mailto:emily@cans1.org)) or fax (916-457-8202)—Ed. ❖

**T**he assistance of Emily Schile and Dr. Javed Siddiqi in the preparation of this newsletter is acknowledged and appreciated.

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