CANS newsletter

California Association of Neurological Surgeons
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President's Message: It's All in the Story: Why We Were Given 2 Ears and One Mouth

Brian Gantwerker, MD

"We have two ears and one mouth so we may listen more and talk the less."

-Epictetus

"Listening is an art that requires attention over talent, spirit over ego, others over self."

-Dean Jackson

Not too long ago, I was interviewing a colleague for a podcast and he made a very wise comment. Elad Levy is one of the younger chairmen out there. He is around my age, very accomplished, ambitious, and well-liked. There is a very encouraging crop of younger chairpeople that seem to have their stuff together. My co-host and I were asking him questions about how he had gotten everyone on board with what he wanted to accomplish and how he got his junior colleagues through challenging times. The question spurned a really unusual answer. He responded in a very unusual, almost Talmudic way: we were given 2 ears and one mouth for a reason.

I was in the throes of the live recording, but I filed it away --a sound and sage thought. It was correct, not just in listening to colleagues and letting them vent, but possibly a technique to become and to remain a good clinician.

We are placed on a hamster wheel in medicine. Our practices in some cases have become a marathon of seeing new and old patients in our practices. Some of my colleagues see (and brag) about seeing 10-20 new patients and up to 30 follow-ups in a day. Their very salaries are dependent upon keeping that pace, consistently. This is conveniently called "productivity." Now, my pop-culture reference here might be lost on some of my more senior and very, very junior colleagues but my mind immediately travels to the scene in the movie "The Matrix." The hero Neo's guide, Morpheus, explains "the endless fields" where human beings are used as energy sources to power the machines and networks of the future. Their realities are an experienced Metaverse that exists only in their minds. The people not plugged in refer to those still plugged in as "copper tops." Everything is simulated, hence that is why everything tastes like chicken.

In any case, you are taught that you must work harder and faster or otherwise you are a bad battery. If you are bad, or reach the end of your life, you are switched out, tossed out, and replaced. We are a modular cog of the wheel and at the end, don't matter.

This is not true, but my point here is not another pep talk, I promise. In this process, though, there is a patient on this wheel with you. Each turn of it, someone is running on it for a cycle and you meet them, ask them, examine them, look at their scans, write stuff or recommend tests for them, then they get sometimes flung off in one direction or another and another patient gets placed on it to replace them.

It sounds dehumanizing - and it is. Unfortunately, numerous legislations and our own complacency, fear, and the rise of a doctor-managerial class to lord over us has allowed this, and one day we just might be able to stagger it and stop it. But for now, it is what it is. What happens in this "chart churning," as my brother and I have deemed it (he sometimes sees up to 90 patients in a day), is that you can miss the point of their visit. In some specialties that are straight forward, it is less likely. They have a cough, runny nose, no fever, they probably have a URI - don't give them antibiotics, support them, keep them home a day, watch for a fever, or rash, or other symptoms, they should be good.

Without touting our own complexities and education, we do experience something very different in our clinics, depending on our own lanes. People sometimes come in <u>without</u> a diagnosis, or scans. Even in our vaunted academic centers that happens, and we have to get the story and do the work-up. Most importantly, we have to *understand why* they are there in the first place. That means getting down to the core reasons and complaints of why they came to the doctor. Sometimes that can take a whole 15 minutes, or even longer.

Now, I am not saying everyone should get an hour long first patient visit. That is not a realistic expectation and a myopic and inefficient use of my busier colleagues' time. Especially in very busy urban or rural communities when you all are IT. I remember staffing a prison clinic near Bakersfield when we had little to zero time per patient. I had to move quickly and had to ask very direct questions and physical exams were extremely limited due to literal handcuffs. Some of you all may still have clinics like that. I am not here to stand on some ceremony.

Listening should remain an important skill for the surgeon if for no other reason other than to understand what the patient needs and what they want: their raison d'être. My argument is if you can distill down their visit to what is really bothering them (it's my leg, not my back) and what they want to get out of you (I really just want to walk down to my neighbor's and BS with them in the evenings - not run a 5K) you just might become and stay a good doctor.

When my grandfather (of blessed memory) was alive, he was a notoriously bad patient. He was tough, a child of the depression.

Born in 1923 to immigrant parents, 1 of 4 kids, he was taught to ask for and expect nothing. He became very successful and eventually left a very successful career in insurance sales to start his own independent practice and was again successful. He never built an empire, but truly, as his favorite crooner said, did it "his way."

Much later in his life, he got sick on a cruise ship in the middle of the Caribbean, went into heart failure, and almost died. Years prior, he had had an unruptured AAA that had to be repaired open, which had been missed by his cardiologist but caught by a very astute VA doctor that had *listened* to his abdomen and found a huge, thankfully contained, aneurysm. I still remember seeing his enormous scar in a giant inverted Y going into his thighs and up his abdomen, looping around his navel, stopping just below his rib cage and the orange bumpers on his skin. This was way before the days of endovascular grafts.

He was the toughest of the tough guys. He was knocked for a loop though with this illness. He got weaker and weaker as the years went on after he got over his cruise ship pneumonia. My intern year, he helped my dad and me move me into my first apartment in the attic of a 3-story house in Cleveland Heights that had no air conditioning and a small space heater, where I lived for a year until moving in with my co-resident the following year. He could barely get up the stairs, but nevertheless he came to see his oldest grandson start his internship. In May of 2003, in my 3rd year, I had been to visit him at their home in the Chicago suburbs and his breathing was crappy. I could hear he was having a hard time. I put my ear to the back of his chest and he sounded junky. My grandmother looked at me concerned and I told them he should go to the hospital. He had just gotten back and he said, "no way José." Knowing better than to fight with this 5'4" of pure will and grit who had endured the Depression, the Nazis and liberating Bergen-Belsen, then the Pacific, and my grandmother, I relented and took my flight back to Cleveland that night. They lived close to the airport and they were on my way.

He went to the hospital a day later. The day after, I was operating with one of our peds people, and I got a call from my mother whilst I was operating. I got that tugging, awful feeling. When I was done, I scrubbed out of my case, knowing what it was about. He had died that morning.

I remember already really struggling during that time in residency. I had lost my joy in my work for some time. One of my general surgery attendings at one point had threatened to strike me during a procedure – suffice it to say it took one look from me across the table to "discourage him" from doing it. There were discouraging moments as a junior where the gears weren't clicking for me. I felt I was out of sync with myself and everything around me.

Struggling with my why and on top of it, now this - I hadn't been there when he died and I felt if I had pushed more - questions, guilt, imposter syndrome - it was all there. At some point, and I cannot remember when, after the funeral which was only a few days later (in the Jewish tradition, we bury people as soon as possible after they pass), my grandmother seemed to somehow know my conflict with continuing on in training.

I had not spoken to her about this at all. She looked at me and simply said, "You're going to finish this." My mind flashed back to what one of my interviewers said to me - someone whom I will not name, but he wrote one of our vaunted textbooks. He said that it struck him that I was doing neurosurgery because it was hard, not because I loved it. I retorted that I did love it and in not so many words and ever so politely to f*&k off. Suffice it to say, I didn't match there.

I promised my grandmother that I would go back. But also made a promise to myself - that I would remain a good listener. And that I would really listen to my patients and to make sure I took a little time to just listen. Maybe I was thinking about that VA doctor that saved my grandfather's life. Or at the end, wanting to know I could be a better doctor because I wanted to be a surgeon who could find joy in my work and my interactions with my patients. Or, it was just my own stubbornness not wanting to prove that schlemiel that interviewed me right. Getting to my rock bottom of almost quitting found me my why again.

My grandmother passed from a heart attack about 4 years later after leaving their home in Chicago to be with my uncle in Atlanta. She was stubborn and refused to go with the paramedics the first time that day she suffered a massive MI and then the subsequent MI the same day that forced her into the ambulance and she ended up intubated on prolonged life support. I flew down with my then fiancé, now wife, so my grandmother could meet her before inevitably passing away. She met her and passed away a few days after we returned to Cleveland.

When I started writing this piece, I didn't mean for it to end up being so personal, but I guess it ended up being that way. For me, medicine is very personal because I wanted to do it so badly, and it has been so central to many moments in my life. In my patients' lives, it has been a great honor being allowed to take care of them, asked to do their surgeries, and sometimes even taking care of *their* family. You sometimes end up becoming a part of that family and it has been one of the greatest things I've ever been able to do.

I hope to see a lot of you at our meeting this coming January. You might get to meet some of my actual family. They are truly an inspiration to me and the fuel in my tank.

Chazak (strength),

Brian

Editorial

Gratitude, Listening, and the Future of Neurosurgery

Namath Hussain, MD, MBA
Editor, CANS Newsletter

Dear CANS Colleagues,

November invites us to pause and reflect on the people who have shaped our lives and careers. In neurosurgery, gratitude is often rooted in the relationships that sustain us: the patients who trust us, the colleagues who stand beside us, the families who support us, and the mentors who invest in our growth. This month's issue brings those relationships into focus while asking us to consider how we can protect the human connection at the center of medicine.

In his President's Message, Dr. Brian Gantwerker reminds us of the importance of listening. His reflections on his family, his training, and the patients he serves are a powerful reminder that a patient's story is more than a diagnosis or an imaging finding. Taking the time to understand what matters most to a patient can change how we define success. Sometimes that goal is not a perfect scan or a return to strenuous activity, but the ability to walk comfortably to a neighbor's house and enjoy a conversation.

Khalifa Elmagarmid's essay on gratitude celebrates the mentors who have guided him, from his parents and coaches to the physicians who opened their doors and shared their time. His story reminds us that mentorship is not limited to teaching a technique or reviewing a presentation. It can be a word of encouragement, an honest conversation, or an invitation that helps a student feel that they belong. These acts can have an impact far beyond the moment in which they are offered.

Our specialty remains an apprenticeship, and each of us carries lessons passed down by those who came before us. As we reflect on the people who helped us along the way, I encourage you to reach out and thank a mentor—and to consider how you might pay that generosity forward to a student, resident, fellow, or junior colleague.

This issue also includes Dr. Anthony DiGiorgio's perspective on Medicare, administrative burden, and physician autonomy. He challenges us to examine how payment policy and regulatory demands shape the practice of medicine and argues that expanding Medicare would not solve physician burnout. Members may hold different views on the best path forward, but his article raises questions worthy of thoughtful discussion: How do we preserve access and accountability while giving physicians more time for patients and a meaningful voice in the systems in which they work?

These contributions share a concern for the future of our profession. Listening, mentorship, and the freedom to exercise sound clinical judgment all require time and attention. As CANS continues to advocate for neurosurgeons and our patients, we must keep those human needs in view alongside the policies and practical challenges facing our specialty.

Thank you to our contributors for sharing their perspectives, and to all of you for the care, teaching, and leadership you provide every day. I am grateful for the opportunity to serve this community. I wish you and your families a happy Thanksgiving and look forward to seeing many of you at the CANS Annual Meeting in January.

Neurosurgical Economics:

More Medicare, Fewer Physicians

M4A Proponents Are Wrong About the Causes of Burnout

Anthony DiGiorgio, DO, MHA

Originally published in Off Label Ideas on October 24, 2026.

Having trouble finding a doctor?

Medicare is to blame, and Medicare for All would only worsen it.

There are many reasons for the physician shortage, but burnout and early exits from clinical medicine are major drivers. These physicians who leave practice blame administrative hassle as a leading reason.

Medicare for All advocates claim that removing private insurance would alleviate this burden, allowing doctors to practice medicine again. This is a dangerous misconception, and I warn my fellow physicians not to be taken in by this siren's song. Most of the micromanagement in the working life of physicians comes not from private insurance, but from Medicare.

Like most physicians, I deal with the administrative hassle imposed by private insurance: the prior authorization, the claims denials. But those are just a minuscule part of the problem. I spend more hours of my day glued to a computer to satisfy Medicare's rules.

Medicare sets the "conditions of participation" for hospitals and payment rules for doctors. These regulations give administrators sovereignty over the practice of medicine. When Medicare is the major source of revenue, it is the primary customer, and its preferences must be given priority. For example, doctors' concerns over non-working operating room equipment are ignored while administrators threaten them for not copy-pasting the correct checklist into their computerized notes. Medicare prioritizes the checklists more than the working operating room equipment. Administrators take up hours of clinicians' time hounding them about documenting quality scores. Medicare prioritizes computerized data input over face-to-face patient care.

When Medicare pays a hospital, it relies on very specific documentation from the doctor. Does the patient meet inpatient criteria? What diagnosis category are they in? Do they have a "major complication or comorbidity"? This all relies on if certain words were in the physician notes. So hospitals hire teams of consultants to comb through patient charts, then harass the doctors to edit their notes, making sure the hospital maximizes billing.

Medicare's quality metrics add even more demands. These schemes, intended to reward hospitals with the best outcomes, have become exercises in metric manipulation and coding games, again largely falling on the doctors. A 2016 study found physicians spent 2.6 hours a week on quality reporting. A study of heart-failure patients even linked a readmission-reduction program to increased mortality. MedPAC, which advises Congress on Medicare policy, recommended replacing many of the programs. Yet, Medicare continues them.

Physicians have also seen their independence vanish due to Medicare rules. In 2024, 57.5% of physicians were employees of large hospital systems, up from 41.8% in 2012. Adjusted for inflation in practice costs, Medicare physician payment has fallen 33% from 2001 to 2026, while the cost to operate a practice has gone up. Meanwhile, federal policy gives hospitals financial advantages, such as facility fees and 340B benefits, that are unavailable to independent practices. Thus, many doctors, unable to maintain their overhead costs, sell to hospitals who have these financial arbitrage opportunities.

Medicare also restricts physicians from building alternatives. Section 6001 of the Affordable Care Act bars new physician-owned hospitals from billing Medicare. Stark Law restricts physicians from referring Medicare patients to ancillary services they own, such as an MRI or physical therapy clinic. Medicare favors large, consolidated hospital systems over independent practices, steadily eroding physician autonomy.

So why would physicians want MORE of Medicare?

I can see the allure. After a particularly frustrating experience with private insurance, doctors might be excused for wanting to eliminate those complex middlemen with their utilization management rules. Indeed, Medicare for All supporters promise simpler billing. They promise they will get rid of the quality metrics, the declining reimbursement, and the complexity.

But this is not realistic. Healthcare utilization would increase under Medicare for All. The CBO predicts this. We have multiple randomized studies which show utilization goes up as patients' out-of-pocket costs go down, and the increased utilization is in both less-effective and more-effective care. So, to reduce the use of that low-value care and keep from overwhelming the system there must be some sort of utilization management.

We ran this experiment in the early days of Medicare. The original rules for doctors had no modern quality metrics and far simpler coding and utilization controls. Doctors could bill Medicare based on their "customary" charges. Costs rose rapidly. Over the years, Medicare slowly added all the utilization control schemes outlined above. They implemented price controls. They cut reimbursement. They restricted doctors from self-referral. They added quality metrics.

Medicare for All might promise simplification and high reimbursement for doctors. It won't deliver. Not without blowing an even bigger hole in the federal deficit. It's an economic impossibility.

The answer for physician burnout and the resulting shortage is not going to be an expansion of Medicare. It's going to be deregulation, allowing physician ownership and autonomy to once again flourish. Doctors are doing this outside the system right now, offering low-price and high-quality alternatives. Physician-owned hospitals have high patient-experience scores. Direct primary care doctors report high practice satisfaction. Cash-pay surgery centers are thriving.

Doctors working in these environments, outside Medicare, report huge reductions in compliance costs and office staff. They aren't micromanaged by administrators. They aren't glued to a computer instead of taking care of patients.

They're just practicing medicine again.

Doctors need that to stay committed to clinical medicine. More Medicare would only make the doctor shortage worse.

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Socioeconomic Journal Club – Gratitude

Khalifa Elmagarmid, Medical Student

As a pre-med student, I had the chance to interview Dr. David Langer, and the conversation has stayed with me ever since. I still picture him in scrubs at his office, head shaved in support of a cancer donation drive, talking about how his support system carried him through the lows. He described an earlier era of neurosurgery before the neuronavigation software that is now used in every OR. The mental challenges of difficult cases and uncertain outcomes made having a strong support system especially important. His smile grew widest when he talked about his support system: building a neurosurgery program with his friends or taking his daughter to a concert. It reminded me that, for all the advances in this field, the people we surround ourselves with remain a big part of what sustains us.
This is a dedication to the mentors who have made me the person I am today.

My story begins with my parents, who instilled their values in me without ever talking about them explicitly.

My father came to the United States from Libya on a full scholarship, awarded for the highest math and physics scores on the national exam. His only knowledge of America came from Clint Eastwood movies and a fascination with computers that ran a close second to Hollywood. His cohort landed in Boston in January with no expectations, and he stepped out into the blistering cold protected by an afro and a half-buttoned shirt, ready to blend in with the early ’70s. Years later, his path eventually took him across the country to an interview for an associate professorship at Indiana University. As it wrapped up, the interviewer offered one last piece of advice, “Fill up your gas and don’t stop driving. The KKK’s dragon is on your way.” My father is a quiet man, and he tells this story only in passing, as if it were a normal part of the drive. From stories like these and watching him in person, I learned to keep my eyes on the journey ahead, whatever lies along it.

My mother is a pediatrician who moved to America and rebuilt her career in a language that was not her own. Rosetta Stone was all over our house, and her old USMLE books are still filled, margin to margin, with notes in Arabic, the record of someone learning medicine and English at the same time. After everything it took to earn her place in American medicine, she stepped away just two years in to raise my sister and I. Now that I am preparing for the same exams, I understand a little better what she gave up. My sister, an intern neurology resident on the East Coast, embodies my mother’s best qualities and is one of the kindest souls I’ve met.

My first real lesson in discipline came from competitive soccer and Coach Akram. I loved the game as a kid, but I came to dread the routine: two hours of training and an hour of film every day, with a bus ride to the training grounds in between. Coach didn’t make it any easier. He constantly demanded more, and if I showed up tired from a late night of studying, he didn’t care. One day, he kept me after practice to drill headers alone for an hour. By the end, I felt concussed, could barely breathe, and was clinging to my inhaler for dear life. The next game, I scored the only two goals of my entire season as a center back. Both were headers.

Still, soccer took over everything. I studied through lunch in high school and missed hangouts with my friends. Eventually, I quit, for the first time in my life, and switched to basketball, where the coach was a lot easier. I racked an obscene number of technical fouls that made Dennis Rodman look like a ballet dancer. For months, a nagging guilt followed me: I had traded something hard for something easy, not for something I loved. I called Coach Akram, who invited me for dinner. He told me simply that expectations are different if you want to win. I went back, and by the next year, I had been promoted to the first team on a professional contract at Al-Gharafa, where I got to play with and learn from Wesley Sneijder. That dinner taught me that the people who demand the most of us are often the ones who believe in us most.

At the University of Southern California, Dr. Susie Kim was at the center of my development. She ran her classroom around discussion and critical thinking, and hers was the only class in college I truly looked forward to. I enjoyed it so much that I audited her classes just to sit in on the discussions. Truth be told, I couldn’t tell you the name of the course today, only that I was so engaged and wanted to be like her. As a pre-med living a sixteen-hour flight from family and friends, I had no one senior to ask what medical school and medicine were really like. She became that person. Dr. Kim transformed my college experience, and she still offers me guidance throughout medical school.

At Arrowhead Regional, Drs. Arshad, Hadi, and Shafizadeh let me into their environment as a first-year medical student with very little to offer. They invited me to skull base dissection courses, residency dinners, and personal celebrations, despite the ocean of experience between us. Dr. Shafizadeh, an attending whose generosity I appreciate, helped make a field that can feel difficult to break into feel a little more accessible. As they have each moved into different jobs across the country, I’m fortunate to call them mentors, but also friends.

The same can be said of Dr. Martin Pham at UC San Diego and Dr. Vivek Buch at Stanford, who have each shown me a different dimension of the specialty. Dr. Pham schedules regular check-ins with me simply because I'm a student navigating neurosurgery without a home program. He doesn't have to do that, but he makes the time anyway. Dr. Vivek Buch has advocated for me on multiple occasions and the first formal research lab I join throughout medical school.

At Cleveland Clinic, Dr. Lilyana Angelov and Dr. Varun Kshettry have shaped my experience further. Dr. Angelov's patient care is special, her smile is infectious, and she is brutally honest. While preparing for an oral presentation, she spent countless hours helping me perfect every aspect of my presentation. The size of the period, the indentations, the color choices, and everything else imaginable. She could have let me present on my own. Instead, she invested the time to make sure I was prepared and had a strong foundation to work independently moving forward. I have come to appreciate that kind of honesty because I know how much care sits behind it.

Dr. Kshettry has also opened his door to teaching, spending hours with me in the skull base lab working through nuances that are difficult to pick up from a textbook. One project involved building a three-dimensional anatomy presentation using cadaveric models. We spent hours supergluing the pieces together and perfecting the lighting. At times, it felt like playing LEGOs. As I reflect on my experience in Cleveland, I can't help but feel fortunate to have met an incredible department who was willing to invest in my training and expect nothing in return.

Mentorship also has a socioeconomic dimension. Much of what shapes a path in medicine is never formally taught: how to find a research mentor, whom to ask about away rotations, how to tell whether a field like neurosurgery is the right fit. Educators have long called this the hidden curriculum (Hafferty & Franks, 1994). More than half of U.S. medical matriculants come from households in the top fifth of income, compared with about 6% from the bottom fifth (Shahriar et al., 2022). First-generation college graduates make up only about 7% of matriculants nationally, a share that has declined over time (Kamran et al., 2025), while roughly one in seven U.S. medical graduates has a physician parent (Ladak et al., 2026).

One of the things I love most about neurosurgery is that it is still, at heart, an apprenticeship. Nearly every piece of advice I receive can be traced back through generations: a lesson my mentor learned from theirs, who learned it from theirs. I have come to believe the same is true outside the operating room. My father's focus, my mother's sacrifices, Coach Akram's expectations, Dr. Kim's questions, and the generosity of the surgeons who have taken me under their wing are all something I hope to one day pass along.

To every mentor who has given me their time and taught me something along the way, thank you.

A final thanks to Dr. Gantwerker and Dr. DiGiorgio for allowing me to participate in this newsletter almost a year ago. To the entire CANS team, including Dr. Hussain and Karen Plante for facilitating and editing my articles. It has been wonderful to be a part of and I look forward to meeting everyone at the conference.

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