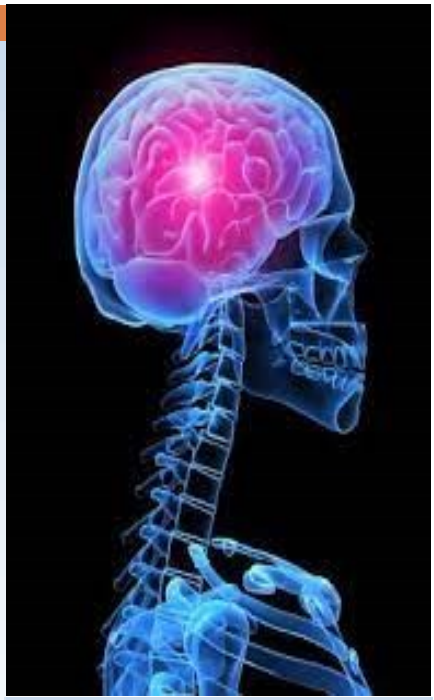
SPRING 2022

MICHIGAN ASSOCIATION
OF
NEUROLOGICAL SURGEONS

SPRING Newsletter



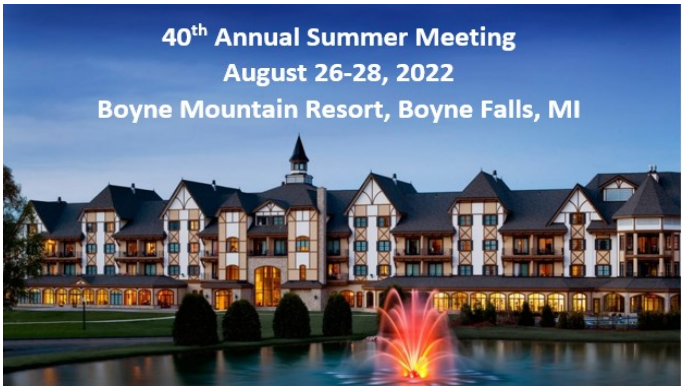
A Message from the President……

Jason Schwalb, MD

It is an honor to be leading the Michigan Association of Neurological Surgeons as their current president and I am excited to see everyone at the summer meeting this year. It has been my privilege to follow the footsteps of our past-president, Dr. Hazem Eltahawy, to ensure that our association continues to grow and serve as the preeminent voice of neurosurgery in the state of Michigan.

Dr. Ann Stroink, the incoming President of the AANS, will be our honored guest speaker. The Board, our Executive Director, Cindy Wickstrom, and I are excited to bring the meeting to Northern Michigan and hope that you and your families will enjoy a weekend of fun, fellowship, and continued learning.
If you have any questions, please do not hesitate to contact me directly. I appreciate your generosity and continued support of MANS and look forward to welcoming you to northern Michigan in August.

Click on image below to REGISTER



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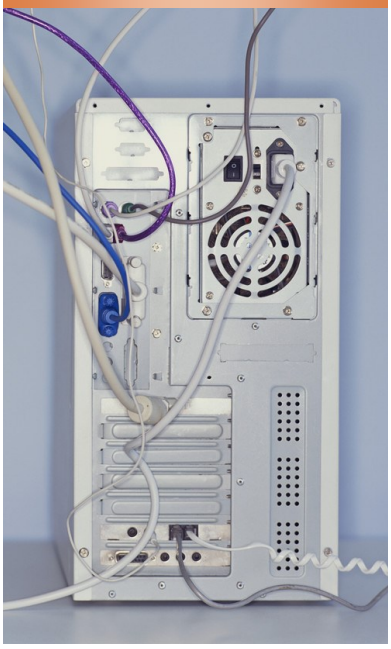

The Council of State Neurosurgical Societies (CSNS): The Organization That Many Don't Know but Should

By Mick Perez-Cruet, MD, MS

The Council of State Neurosurgical Societies (CSNS) is an organization made of neurosurgery delegates from across the United States. These delegates are chosen through the Congress of Neurological Surgeons (CNS) and American Association of Neurological Surgeons (AANS), however other neurosurgeons become involved through their desire and participation in organized neurosurgery. Delegates are both from academic and private practices and comprise individuals truly interested in the welfare of neurosurgery. The CSNS represents State Neurosurgical Societies and encourages and fosters them. The Michigan Association of Neurological Surgeons (MANS) and California Association of Neurological Surgeons (CANS) are excellent representations of productive and effective state neurosurgical societies. Both organizations hold outstanding annual meetings that foster state neurosurgical accomplishments, improve collaboration between various practice groups, and promote productive collegial behavior. The CSNS is divided into four representative quadrants (i.e., Northeast, Northwest, Southeast, Southwest). For each 50 neurosurgeons in a state, one delegate can be selected to the CSNS.

"The CSNS fosters involvement on a grass roots level to bring to light socioeconomic issues that affect all of us ."

FOR MORE INFORMATION

You can find additional information on the CSNS including fellowship applications, meeting dates, and contact information go to:

Www.csnsonline.org

WE INVITE YOU

TO BECOME INVOLVED

Unlike the focus of our parent organizations, the CNS and AANS, the CSNS deals primary with socioeconomic issues effecting neurosurgery. Through a resolution-based system, socioeconomic issues are addressed. These issues may include resolutions adopted to improve state neurosurgical societies (SNS). The CSNS recognizes that not every state has a SNS. A resolution submitted in the past produced a video that instructs neurosurgeons how to establish a productive SNS. This informative video, based on experience with establishing MANS, can be viewed on www.csnsonline.org by going to the Digital Resources tab to the left and click on one of the video links for **Establishing an Effective State Neurosurgical Society**. There is also additional information on the CSNS website including Medical Student Guide to Neurosurgery, Guidelines, helpful links, NERVES resources, and various white papers. The CSNS meets bi-annually just proceeding the CNS and AANS annual meeting. Resolutions are submitted weeks before the meeting and assigned to various committees within the CSNS to discuss, vet and vote upon whether to support or reject. The following CSNS committees include Communication and Education, Medical Practices, Medical Legal, Neurotrauma and Emergency Neurosurgery, Patient Safety, Reimbursement, Workforce, and Young Neurosurgeons Section. At the plenary session during the CSNS meeting, delegates further discuss each resolution and vote to support or reject. The leadership of both the CNS and AANS are also present to give their views on resolutions. Therefore, full neurosurgical representation is present to review and discuss submitted resolutions. These discussions are often heated and provide an outstanding opportunity for frank discussion that often leads to changes that positively affect our neurosurgical community. These changes have been seen in the establishment of NERVES, various programs offered by our parent organization at our national meetings, and even legislation that is brought to legislators in Washington DC via our Washington Committee or the AMA. A recent example is the use of telemedicine in neurosurgery. In essence the CSNS has touched all of us who practice neurosurgery. It fosters involvement on a grass roots level to bring to light socioeconomic issues that affect all of us and in my opinion is one of the most valuable organizations in medicine. Since the outcomes not only effect neurosurgeons, but the patients we treat and other specialties within medicine. The CSNS has representation in the CNS, AANS, Washington Committee and AMA. However, its members are not looking for recognition. You could say they are "the silent leaders of organized neurosurgery", yet their impact is far reaching. There is also a process for incorporating up and coming leaders of organized neurosurgery through the CSNS sponsored fellowship program offered to residents in training. These individuals are selected based on applications received from across the country and I would encourage all programs to participate in the process.

You're Looking, But Do You See Me?

By Lynn Mubita, MD

I spent most of my education in the USA blissfully ignorant of racism (and other discriminatory -isms) that are deeply engrained in the culture and systems of this country. The reason for this ignorance? I was born in Kitwe, Zambia, a small city in Sub-Saharan Africa to a Zambian father and an American mother and lived there until my first day in college in Providence, Rhode Island at the age of 18. I therefore did not have the same racial experiences and points of view that Black people in the USA have. Although Zambians have their own post-colonial demons to battle, the infrastructure and systems are not set up in a way that results in inherent discrimination among peoples based on race. There is not the slow, widespread cultural white washing on TV, radio and other media sources that creates in its citizens the perception that Black and Brown people are not the standard, that they are "other" as is normal in the USA. This is likely because Black and Brown people ARE the standard in Zambia and not, as in the USA, in the minority.

If you doubt my words, here are two examples that describe how White skin is the standard in the USA and Black or Brown skin "other". Think about deodorant. Specifically, invisible or "no residue" deodorant. Have you ever considered how exclusive invisible deodorant is to Black and Brown people when the secret in the invisibility relies on it being applied white? It is common for Black women such as myself to worry about what to do with their natural hair on job interviews because our hair, in its natural state, is considered unprofessional. However, the more straight my hair becomes (either chemically or with heat), that is, the more it approximates White hair, the more professional it is considered.

Another example to consider is how foreign sounding names are also "othered". After graduation from medical school, I considered introducing myself as Dr. Lynn rather than Dr. Mubita, to make it easier for people to pronounce my name. I wanted to avoid the inevitable questions about where I was *really* from, why my English was so good and why I did not have an accent. This reflex is common among Black and Brown people with foreign sounding names although not among White people with difficult sounding names.

Thus, I always believed that if I worked hard, I could accomplish as much as anyone else that worked hard in this country. I always believed that I was being judged based on who I was and not what. Studies on racial bias and racism have shown this to be untrue. To be born and raised in the USA (or to have lived several years in the USA) is to have internalized some form of racial prejudice. Black and Brown students are more likely to be suspended from pre-school than White students. Black and Brown high school students are suspended three times more often than White students for the same offences. College professors respond more consistently to students with White sounding names. Knowing what I know now, I am not entirely sure that I would have made it through a bachelor's degree and medical school without the protection my ignorance afforded me, that when I received a bad grade due to lack of participation, that when my ambitions were questioned, when assumptions were made, it was because of who I was and not what.

Today, I have been a Neurosurgery Attending for just over two years. I work in a smaller, more rural, satellite hospital affiliated with a larger, academic hospital. My every day, overall professional life is rewarding. What is not so rewarding are the smaller, every day microaggressions I experience. These microaggressions are like tiny paper cuts into the skin of my sanity. Each cut does not hurt, but the sum of them do, day after month. They make me question whether it is *I* that is overreacting. They gaslight me into thinking it is *I* that is the problem. Am I too sensitive? Am I seeing an issue where there really is no issue? I still get confused with the custodial staff, but this is not new, or particular to my location. It comes with the territory of being a Black woman in a field that is dominated, even today, by White men. I often must explain to my patients (especially ones that I have just met) that I am, indeed, their surgeon, that the doctor is not still coming and that they have just been talking to her for the past 30 minutes. Is this because I am a woman, am Black, am young? Or is it some unfortunate intersectional combination of all three?

More recently, the USA has been incredibly divided. Racism (and other discriminatory -isms) is more blatant and performed out in the open. Questions about basic human rights have become "political issues" so that a statement such as Black Lives Matter is considered by many to be inflammatory. When a Black man is killed by the very service that is designed to serve and protect him, the entire altercation captured on camera and it still takes months for the offensive parties to be brought to justice, it makes being a Black person at a time like this exhausting. When a Black woman is killed in her own home, having been woken up during sleep, again, by the very service that is designed to serve and protect her and no charges are brought against the offensive parties about her death, it makes me feel that my humanity does not matter. It puts me on the defensive. It adds an extra layer of stress to my daily interaction at work. Am I speaking with someone who feels that the Black Lives Matter movement is a terrorist organization? Do they see me for who I am and not what I am? And yet, I must continue with my patients, with my staff, in clinic, in the operating room, on call as though everything is normal. When I take care of a patient proudly wearing a "Make America Great Again" cap, or a "Blue Lives Matter" shirt, I have to act as though I am not hurting inside and fearful for what they think about me as a Black woman. I have never been so attuned to the color of my skin as I am now.

And yet, this is an opportunity to speak out despite this angst. This is a historical opportunity to give voice to the voiceless so that everyone, no matter their color, sexual orientation, place of birth or religion can feel safe in the USA. The fact that I can articulate my thoughts and fears in this newsletter is proof of that. Now, more than ever, systemic racism is being exposed for what it is. Change is coming. People like me are speaking out – and people like you are listening.

A Resident's Perspective on Social Justice & Physician Awareness

By Travis M. Hamilton, MD

"With this knowledge we can then prepare to overcome some of the systemic affects and even develop infrastructure so that it continuously becomes easier for future generations to overcome similar obstacles."

Social justice issues have dilapidated to the point where now they are considered political issues and have become taboo in the workplace. Most places recognize that these issues are, in fact, an innate right and is worth bringing to the forefront of public awareness. However there still seems to be a guarded connotation towards becoming widely recognized and highly regarded in general. When I was at Cincinnati Children's Hospital during the height of the COVID-19 pandemic and during the peak of the George Floyd protests, there was a huge effort towards encouraging social diversity and inclusion and within the workplace. Undoubtedly the general make up of an entire hospital is relatively diverse, with a considerable number of black employees in blue collar position, the majority of the hired professionals were still relatively homogeneous. An announcement was made via email to all the employees recognizing a moment of silence for George Floyd's death. Nonetheless, there was an impressively large and diverse number of employees, who took time out of their busy schedules to recognize this event. It was extremely beautiful, encouraging, and touching to see and be a part of. I thought this social rights recognition campaign was a relative success. However, when speaking with one of the administrators who happened to be a huge proponent of diversity and inclusion, mentioned to me that the announcement was not made as widely as it could've been.

She approached me, Black male, to see if I felt comfortable within this environment - in consideration to the racial and political climate. I could certainly tell that she was very uncomfortable with this conversation; however, she forced herself to inquire about my sentiments being a part of this minority group. I could also see through her demeanor and body language, though irrespective of how uncomfortable she was, she did recognize the higher importance of reaching out to me. Needless to say she was one of the very few staff to have done this. She continued to tell me how disappointed she was that a hospital wide announcement was not made over the PA system to recognize this event at the time as a reminder to everyone capable of participating. She casually laughs and jokes that it's OK for fire drills to take a hospital wide stage but not a monumental event such as this occasion.

To be perfectly honest, I have never even thought about this announcement and effort to recognize a non-political issue was broadcasted. It should certainly be said that the fact that there was an organized recognition for Mr. Floyd's untimely passing, and even more so the tense social climate during this time, was memorable.

However, when considering the extreme scenario, where everyone is made aware, for instance, over an intercom system, it does force the listener to choose, in that moment, what is most important. It is difficult to accomplish complete compliance with scenarios that require full concentration and attention to the patient in a hospital setting. However, subconsciously, we fear that not committing to participate in this could be misconstrued as lack of interest or outright opposition.

As a society, we are perpetually inhibited by an organizational structure and culture of silence and non-involvement to assuage any political extreme, whether it be morally correct or outright deplorable. At times, I tend to think that we have a culture that shies away from the difficult, where it is easiest to wish things away. Unfortunately, as seen with the Covid pandemic, no matter how much you try to ignore it or wish it away, if it is not dealt with in the proper manner, the problem will still persist and affect individuals relentlessly and without prejudice (except for social justice issues).

As physicians, we certainly must be aware of the overarching systemic bias present that prevents equality and accessibility of care for those that are disadvantaged. Health disparities and racism, much like any other systemic diseases are multifactorial, largely precipitated by our socioeconomic and cultural constructs. America thrives as a melting pot of various cultures and ethnicities, which makes it a great country. But as long as there are inherent differences among people, there will always be some degree of inherent prejudice, whether it is malicious or not. There are groups of patients at risk that span further than race/ethnicity, but affects those with lower socioeconomic status (a product of both family income, education, and insurance status). Whether or not you belong to or have personal experience with these demographics, we must recognize disparity as a disease.

And much like any other systemic disease like diabetes, it will not be completely eradicated from our society. However, as minorities and champions of diversity, we have to continuously educate each other on the effects and nuances of the disease of disparity – the presentation and treatment. We have to charge ourselves with increasing awareness and decreasing public aversion, at least making an effort to make a common layperson aware. With this knowledge, we can then prepare to overcome some of the systemic affects and even develop infrastructure so that it continuously becomes easier for future generations to overcome similar obstacles. I implore you to step outside of your comfort zone, erase cultural taboo, and engage in that which promotes the appropriate treatment of our patients. As Neurosurgeons, the tip of the spear and leaders in medicine, we can also lead the way in our efforts to truly provide equality in the care of our patients.

Resident Reflections on the Socioeconomic Fellowship

By Sam Haider, MD MBA

Learning about neurosurgical anatomy, approaches, and developing sound clinical judgment are foundational to Neurosurgical training. Once that foundation is established, the learner then starts examining how the complex care they have learned about is delivered and practiced in world we live in.

As I learned more about practice delivery, I realized that my exposure to neurosurgical care has mainly been limited to academic centers. Despite my proficiency in navigating the inpatient setting, I felt disconnected from how the majority of neurosurgical care was delivered in the United States. Recognizing these deficiencies led me to turn to the Council of State Neurosurgical Societies (CSNS) Socioeconomic Fellowship to enrich my knowledge base and learn more about socioeconomic and administrative aspects of caring for our patients.

While other organized neurosurgical societies may herald advancements in our clinical understanding and operative abilities. The CSNS concentrates its attention on the maintenance of our profession, advocating for neurosurgical patients, and addressing key concerns as they pertain to care delivery, such as onerous prior authorizations, reimbursement cuts, scope of practice, and neurosurgical education. The CSNS socioeconomic fellowship is a competitive 1-year position, accepting only 13 residents annually. Historical review of prior fellow cohorts will show most CSNS fellows remain active members of the CSNS and go on to be leaders within the AANS and CNS.

The first in-person meeting for my cohort of CSNS socioeconomic fellows took place last Fall in Austin during the annual CNS meeting. In contrast to the many virtual meetings that preceded this, our in-person meeting had an electrifying energy. I knew many of the fellows from past national meetings; some were friends from the residency interview trail eons ago (eons = 7 years). As we sat in on various subcommittee meetings, like Workforce, Patient Safety, Medico-Legal, Communication & Education, we were exposed to the many past and active projects underway to research, report, and advice policy for socioeconomic issues. This further inspired us to launch our own projects—within hours we would be working with each other, finding mentors, drawing resolutions, and planning follow-up meetings. We successfully delivered a nationwide survey of telehealth implementation among neurosurgeons during the COVID-19 pandemic. Findings from this study will prove valuable in advocating for reimbursement parity between telehealth and in-office visits. Additionally, I've contributed as an ad-hoc reviewer for socioeconomic journal submissions. As a next order of business, we'll be reexamining how national trends in neurosurgical subspecialties (endovascular, minimally invasive spine surgery, etc.) impact recent graduates perceptions of practice readiness compared to the CSNS's findings a decade ago (Mazzola et a. 2010, Caruso et al. 2021).

When working together and networking in person, the whole is greater than the sum of its parts. The CSNS fellowship provided an amazing conduit to be at the table with mentors from all backgrounds: chairpersons, lawyers, rural neurosurgeons, urban neurosurgeons, private practice, and leadership from most state neurosurgical societies. I look forward to meeting again in Philadelphia 2022 where we will share findings from our research, generate new resolutions, and continue to examine the gamut of socioeconomic issues impacting neurosurgery.

The Michigan Spine Surgery Improvement Collaborative (MSSIC)

By Victor Chang, MD

The Michigan Spine Surgery Improvement Collaborative (MSSIC) is part of Blue Cross Blue Shield of Michigan (BCBSM) Value Partnerships and is one of the many hospital based Collaborative Quality Initiatives (CQI) funded by BCBSM. At its core, MSSIC is a multicenter quality improvement enterprise, currently consisting of 29 hospitals across the state of Michigan, as well as two free standing Ambulatory Surgery Centers, representing over 200 orthopedic spine and neurosurgeons. Surgeries of the cervical and lumbar spine from common degenerative disorders are considered within the scope of MSSIC. Any trauma, infection, tumor or "deformity-related" pathologies are excluded. MSSIC originally started in 2014 and consisted of seven hospitals at the time. The coordinating center for MSSIC is housed at Henry Ford Hospital which oversees all administrative aspects of MSSIC and oversees collaborative wide quality improvement. Each MSSIC site consists of two surgeon champions, orthopedic spine and/or neurosurgeons as well as up to two nurse abstractors and an administrative lead. For every surgery that is performed, baseline demographic information is collected in addition to specific elements of the medical and surgical history. In addition, patient reported outcomes (PROs) are collected at baseline prior to surgery as well. The purpose of PROs is to quantify the amount of improvement one has after spine surgery. Surgical details as well as features of the inpatient stay are collected, and any morbidity within 90 days of surgery is also collected. Post-operative outcomes are collected at 90-days, 1-year, and two-years after surgery and consist of PROs, patient satisfaction and return to work status.

Funding for the abstractors is provided by BCBSM and is linked to performance measures that are determined ahead of time by the coordinating center. Early on within the lifetime of the collaborative the performance measures were linked to primarily participation based benchmarks. As the collaborative has matured, quality improvement based benchmarks have been introduced in an effort to reduce the rate of surgical site infections, post-operative urinary retention as well as all cause hospital readmission within 90-days of surgery. In addition, performance measures have also been introduced to encourage early ambulation the day of surgery, and more recently within eight hours of surgery in an effort to improve outcome. As a result of these interventions, the rate of readmissions, post-operative urinary retention and surgical site infection have decreased since the implementation of quality improvement measures in 2017.

The Michigan Spine Surgery Improvement Collaborative (MSSIC) Cont. from pg. 5

By Victor Chang, MD

Since 2021, MSSIC has shifted its attention toward Enhanced Recovery After Surgery (ERAS). While ERAS can be implemented in a host of different ways depending on what surgical discipline, the core tenet of ERAS is to reduce the physiological derangement as a result of surgery in an effort to accelerate if possible the return to normal function. Phase 1 of this implementation involved documented multidisciplinary engagement as well as documentation of a roadmap to implement core pre-operative, intra-operative, and post-operative interventions. Phase 2 consists of actual implementation of ERAS elements into surgical pathways with measured compliance has a performance measure starting in 2022.

Central to MSSICs goal is the engagement and collaboration of surgeon champions at each site. The coordinating center is tasked with organizing three collaborative-wide meetings where analytic content geared toward quality improvement is presented and discussed with all of the participating sites. A vital part of the process is a sharing of best practices across the collaborative to drive a consensus of interventions across MSSIC. In addition to sharing of best practices at the collaborative wide meetings, is the organization of site visits that are open to all MSSIC participating sites. Prior to COVID, Mercy Health Grand Rapids as well as Henry Ford West Bloomfield Hospital have welcomed representatives from other MSSIC participating sites to visit and see in person different aspects of the spine surgery care center to implement as they see fit in their home institutions. The overarching philosophy here is to "float all boats" by sharing best practices. Beyond that, the coordinating center also helps to link private communication between sites in an effort to improve patient care.

The data structure of MSSIC has evolved over time as well. At the time of inception, our data set closely matched that of what was then the National Neurosurgical Quality Outcomes Database (N2QOD). As the collaborative has evolved there have been refinements to variables as well as additions that the coordinating center and collaborative deem relevant to quality improvement and continuing the core mission of MSSIC. As an example, while diabetes history has been collected at the outset of MSSIC, the value of percentage of glycosylated hemoglobin A1C has been added as a tool for risk assessment. In response to the opiate epidemic, MSSIC has also added greater granularity to opioids prescribed at discharge as well as current opiate use after surgery.

Finally, while not a core part of its mission, MSSIC has been a fruitful source for academic research given the extensive data set and longitudinal follow-up that is built into our database. To date, MSSIC has published 16 peer-reviewed publications as well as numerous podium presentations at national and international scientific meetings. Central to the spirit of collaboration to date all MSSIC studies have involved authors at multiple institutions. In addition, MSSIC has been a rich source of resident education where both neurosurgery and orthopedic residents at University of Michigan, William Beaumont Hospital Royal Oak and Troy, Ascension Providence and Henry Ford Hospital have featured as first or co-authors in a number of publications and research studies.

As much as MSSIC has accomplished in the past 7 years the best is yet to come. In addition, to statewide ERAS we anticipate procedure based opiate prescribing guidelines. With COVID, MSSIC has gone to entirely virtual meetings with anticipation that our August Collaborative meeting in 2022 will be our first in-person meeting since the fall of 2019.

What is Brain Awareness Week?

Brain Awareness Week is the global campaign to foster public enthusiasm and support for brain science. Every March, partners host imaginative activities in their communities that share the wonders of the brain and the impact brain science has on our everyday lives.

When and why did Brain Awareness Week start?

Brain Awareness Week began in 1996 as a modest effort involving just 160 organizations in the United States. DABI organized the first Brain Awareness Week to bring together diverse groups with different interests from academia, government, and professional and advocacy organizations. The goal was to unite them with the common theme that brain research is the hope for treatments, preventions, and possible cures for brain diseases and disorders and to ensure a better quality of life at all ages.

In the 26 years since its founding, Brain Awareness Week has evolved into a global education initiative that has included the participation of more than 7,300 partners in 120 countries. During the 2021 campaign, partner events were held in 45 countries and 32 states.

Who participates?

Brain Awareness Week partners include colleges and universities, hospitals, medical research facilities, K-12 schools, advocacy groups, outreach organizations, professional associations, government agencies, corporations, and more. View the Partner List to see who's involved, and visit Become a Partner to register.

Partners bring to the campaign their own unique perspectives and messages about the brain: an interest in a specific disease or disorder; a concern for early childhood development; a focus on successful aging; or a concern for the future of medical research funding. As a collaborative effort, Brain Awareness Week offers its partners an opportunity to focus national and international attention on these specific messages within the broader context of our shared interest in brain science.

MANS transition from a 501(c)3 to a 501(c)6 organization

By Hazem Eltahawy, MD

According to article II of its articles of incorporation, MANS' mission is to promote, develop, and support neurosurgery and the betterment of public health in the State of Michigan.

ARTICLE II

The purpose or purposes for which the corporation is formed are:
To promote neurosurgery and the betterment of public health by encouraging unity and cooperation, improving business conditions and foster the common business interests of members of the medical profession residing in the State of Michigan specializing in neurological surgery; and
To promote scientific knowledge in the field of neurosurgery and to represent neurosurgeons in Michigan in all scientific and economic matters.
To exercise generally any power which is consistent with the purposes described above and which a nonprofit corporation organized under the provision of the Michigan Nonprofit Corporation Act may exercise.

MANS was incorporated more than 40 years ago in the state of Michigan as a non profit organization that is tax exempt as a 501(c)3 organization.

A 501(c) organization is a nonprofit organization in the federal law of the United States according to Internal Revenue Code Section 501(c) (26 U.S.C. § 501 (c)) that is exempt from federal income taxes. Many states refer to Section 501(c) for definitions of organizations exempt from state taxation as well. 501(c) organizations can receive unlimited contributions from individuals, corporations, and unions.(1)
And a 501(c)3 organization is a nonprofit that focuses on charitable activities to promote public interest. Examples of such charitable activities include (1, 2)

- Relief of the poor, the distressed, or the underprivileged,
- Advancement of religion,
- Advancement of education or science,
- Erection or maintenance of public buildings, monuments, or works,
- Lessening the burdens of government

An organization applying for tax exemption under this category would need to provide evidence of support activities such as scholarships, endowed chair contributions or teachers' salary support. In the past few years, it became clear that most of MANS activities are less aligned with the description of a charitable organization. In fact its mission is best described as a business league.
'A business league, in general, is an association of persons having some common business interest, the purpose of which is to promote that common interest and not to engage in a regular business of a kind ordinarily carried on for profit. Trade associations and professional associations are considered business leagues.' (1) Such nonprofits typically apply for tax exemption as 501(c)6 organizations.
Examples of activities performed by a business league include:

- Promotion of higher business standards and better business methods and encouragement of uniformity and cooperation,
- Improvement of business conditions,
- Operation of a trade publication primarily intended to benefit an entire industry,
- Establishment and maintenance of the integrity of a local commercial market

The decision to transition our organization from a C501(c)3 to a C501(C)6 was made by the MANS Board in 2015 during Dr Robert Johnson's term as president. This led to a series of complex legal and accounting preparations that culminated in the application for new C501(c)6 status submitted to the State during my term and is currently pending approval.

Among the most exciting benefits of this transition is that it enables our organization to truly play its role in improving our practices and business conditions through having our voice heard by the state elected officials and law makers. Lobbying is very limited for C501(c)3 compared to C501(C)6 organizations. Furthermore C501(c)3 organizations are prohibited from political campaign interventions while C501(C)6 can participate in political campaigns as long as it is not their main activity. This can be interpreted as not more than 49% of the resources of the organization could be directed towards political campaign interventions. (3)

References:
1-Publication 557: Tax-Exempt Status For Your Organization" (PDF). Internal Revenue Service. June 2008. pp. 65–66.
2-https://en.wikipedia.org/wiki/501(c)_organization#501(c)(3)
3- https://nonprofitlawblog.com/comparing-501c3-vs-501c6-for-nonprofit-startups/