CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

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PRESIDENTIAL ADDRESS

Douglas M. Enoch, M.D.

My address will be *brief* - not because there are *few* CANS accomplishments or future problems to describe for the year, but because our time at this meeting should be allocated to our program regarding AB 3480.

I assumed this presidency with certain awe and trepidation and I continue to have those feelings. From the pinnacle of this office one can fully observe the power and prestige of this organization - and, believe me, it *does* influence your world of neurological surgery.

This year would undoubtedly have been chaotic without the superb and faithful help of Marian O'Dell, our Executive Secretary; Mrs. Adrienne Jones, my office manager, and my wife, Sylvia Anne. If the President is the *guiding* force, then the *moving* force that actually does the work is certainly the Board of Directors. Each member of the Board heads an important committee. Kudos are due them for a job well done this year.

CANS was busy and creative this year. We continued active *peer review* activities when asked, and we expect to do more in the future. There were frequent interactions with BMQA. *Strong* input to *Blue Shield* deliberations continued. We have been *monitoring* the California Society of Industrial Medicine and Surgery. CANS now has *three members* on the *FDA Advisory Panel* in *Washington*. We have had increased communication and cooperation with the State Associations of Anesthesiology, Ophthalmology and Plastic Surgery. We began the practice of inviting controversial people or resource persons to the Board luncheons. Input was gained to the American College of Surgeons Trauma Committee through one of the luncheon seminars.

At the *AANS meeting in Hawaii in April*, we came *very* close to placing Bill Wright on the Nominating Committee of AANS - this would have succeeded if just a few more CANS members had appeared at the business meeting. An admonishment is therefore in order here: The AANS business meeting may appear to be boring and trivial, but it is vital and important to you to be there to vote on this type of issue.

CANS sent a *complete slate* of nominees *to the AANS in June*, and we were pleased to have *Dr. Lippe* placed as candidate for Board of Directors.

CANS is the source for placing neurosurgeons on CMA committees. CANS members sit on the CMA Advisory Panel for Neurosurgery. This year, for the first time, we have a *delegation* to the *CMA Committee on State Legislation*, a very important watchdog organization.

As in the past, CANS, through representatives, is drafting and supporting CMA resolutions in an ongoing effort to *maintain* and *improve superior neurosurgical care* for the people of California.

This year three *new* and *exciting endeavors* were begun:

1. The *task force on negotiations* or "ad hoc steering committee" chaired by Philipp Lippe became active and it laid the groundwork for this meeting, which speaks for itself.

2. In the past few months a mechanism and structure has been developed with a law firm for the neurosurgeon to act *as the patient's advocate* in *tardy* and *inadequate fee payments* from insurance carriers. Through "bad faith" and *breach of contract law*, proper settlements will be obtained. The pilot program will utilize Board members initially.

3. Finally, the *Public Education Committee was formed* to develop, expand and implement knowledge of the *concept* of neurological surgery. In other words, we must *define* our specialty and then *advertise* it. I am frequently appalled and dismayed by comments from patients and doctors alike such as: "I didn't know neurosurgeons were interested in that!" or "I thought the orthopods or plastic surgeons or ENT men or vascular surgeons or neurologists (you fill in your favorite specialty) did that sort of thing!" We must *describe* our specialty. *What* do neurosurgeons do? *What diseases* do we treat? *How do* we treat them? *What is the extent* of our turf? Why do we do it *better?* We need to develop an image of *neurosurgery and neurosurgeons.* We need to develop an accurate compendium of *facts* about neurosurgery that is unimpeachable. It has been said that we would have no overabundance of neurosurgeons if we utilized our own true turf.

In the *past*, when we were a small band of elite surgeons, fully occupied with ample brain tumor and aneurysm patients, perhaps we were too aloof to communicate to our colleagues and patients our *activities, goals* and *ideals.* Now communication is *mandatory* for numerous reasons, perhaps even survival of our specialty. We need to communicate effectively, widely and frequently. In the months ahead you will probably be asked to contribute to this cause, in both *energy, expertise* and *money.* Our target people are the laity, our colleagues of other disciplines of medicine, and, perhaps most importantly, *ourselves.* We hope to accomplish our goal through a multifaceted approach of a speakers' bureau, press releases, position white papers, pamphlets, and even handbooks on use of the media. We will need professional help from public relations personnel in developing these programs. This will require funding. The specialty associations in Anesthesiology, Plastic Surgery and Ophthalmology are already deeply involved in this activity, and have set a pattern to follow.

The fruits of these labors should be many, including improved colleague cooperation and better patient care and understanding.

I am pleased to have helped initiate the three new endeavors described above, which should provide CANS members with better communication among themselves and improved relations with other physicians and with patients.

I thank you for the honor and privilege of having served as your President this past year.

PRESIDENT'S INAUGURATION MESSAGE

William H. Wright, M.D.

"There is an old saying that interest does not bind men together: interest separates men; there is only one thing that can effectively bind people, and that is a common devotion." Many of you may recognize that quotation. It is the opening line of Harvey Cushing's graduation address to the graduates of Jefferson Medical College on June 5, 1926. Cushing's remarks and the purpose of his address to these graduating young physicians 57 years ago have even more meaning to us here today.

We here in this room this morning and the neurosurgeons throughout the United States certainly have a common interest. Most would agree it is the care of the neurologically sick patient. Yet, when it comes to our professional brethren, there is, in my opinion, a very definite lack of common devotion. Our doctor-to-patient relationship is being seriously hampered by our doctor-to-doctor relationship.

The most recent and glaring example appeared in the editorial in the February Bulletin of the American College of Surgeons. As you know, the J.C.A.H. Accreditation Manual for Hospitals is being revised again substituting the term *"Organized Staff"* for *"Medical Staff."* This will significantly weaken our position in policy-making, and apparently, this change was whole-heartedly supported by the commissioner from the *AMA* and AHA. It reminded me of several years ago when a CMA surveyor was visiting our hospital. He was an acquaintance I had known for some time. He said, "Bill, medicine is becoming a team effort, and I'm not certain in my mind that a physician should be captain of the team."

It is time that we demand common devotion from our medical leaders; and it is time that the system which allows physicians to remain in leadership roles while consistently weakening our position with their policies and programs comes to an end. For several years now, your delegates have attended the Congress of State Neurosurgical Societies and (Joint SocioEconomic Committee). We have presented over and over to our national leaders, to the organization that is our spokesperson in neurosurgery, our concerns regarding manpower and other issues vital to the practice of quality neurosurgery, only to be turned away. In fact, the promised revision in the bylaws that was to grant more voice in our own affairs turned out to be a review resulting in more central control.

It is not my position that one can demand devotion or respect, but one can, in the old Smith-Barney tradition "earn it." One of the best ways to make certain we earn ours will be to re-establish quadrant representation on the board of directors of the AANS. I hope as many of you as can will be in Washington for this issue.

Starting out my year, I want you to know that your Board of Directors is devoted to you; we will work hard, and we not only appreciate, but expect your input and active support.

Thank You.

AANS 1983 ANNUAL MEETING

The AANS 1983 annual meeting will be held April 24-28, at the Sheraton Washington Hotel in Washington, D.C. CANS delegates and members are encouraged to attend the business meeting which begins at 4:00 p.m. on Monday and Tuesday, April 25 & 26, 1983.

COMPLIMENTARY NEWSLETTER

Complimentary Newsletters are being mailed to non-members of the California Association of Neurological Surgeons, Inc. Those interested in becoming a member of the Association may send request for an application form to: Executive Office, California Association of Neurological Surgeons, Inc., P.O. Box 41761, Sacramento, CA 95841, or telephone (916) 966-9760.

REVIEW OF ANNUAL MEETING
The Lodge at Pebble Beach
February 25-27, 1983
Frank P. Smith, M.D.

The Annual Meeting of 1983 proved to bring the greatest number of neurosurgeons and wives together at The Lodge in Pebble Beach, with respect to previous annual sessions. The social program began with the welcoming cocktail party on Friday, February 25, 1983, and then the sessions began promptly at 8:00 a.m. on Saturday. In the afternoon, some took the scenic tour, some played golf, and some played tennis. The evening event, the banquet in the Pebble Beach Room at the Lodge, brought everyone together for a most pleasant occasion. Sunday morning offered the second part of the program, which was extremely well attended.

The main subject of the program on Saturday morning and Sunday morning related to issues of "negotiated medical contracts, as provided by the legislative act, AB3480." On Saturday morning, the essayists spoke to the "origin and issues of AB3480," and on Sunday morning, speakers provided "answers to the threats of AB3480." The Saturday morning program started with a discussion by Dr. Phillip M. Lippe, which he entitled "Clouds of Competition." Dr. Lippe clearly indicated that the major issue is Cost! He pointed out that 250 billion dollars being spent nationally on health care resulted from increased technology, increased numbers of people in the aging process with new problems, increased demands on insurance companies and industry to give coverage, as well as an apparent surplus of physicians who are ready, willing and able to provide increased amounts of medical care. Reference was made to the multi-billion dollar deficit in State finances, so that there was direct pressure to cut the cost of medical care. This led to the development of AB3480 which allowed insurance companies to negotiate for lower fees. This was intended to provide the "ripple effect" so that there would be controlled care, limited access, and certain turf problems that would create competition, thereby reducing costs. Dr. Lippe stated that he could foresee that the patient might be the real loser in the program, suffering from decreased access, as well as decreased quality of medical care, and that there would be involvement of all parties in the possibility of increasing medical malpractice.

The next participant on the program, Mr. Steve Rosinski, representing the business side of the push for AB3480, clearly stated that he spoke on behalf of the "buyers" of medical care coverage and not as a representative of insurance companies. He clearly invited physicians to become involved with the free enterprise system, and to look at the health care cost problems from the "buyers'" point of view. He stated that business and industry are impatient and angry about the escalating costs of health care. He listed a 46% increase in insurance premiums, as well as a 20% annual rate of increase in hospital care costs. There were some rapid-fire statements about multi-billion dollar shifts in Medicare costs, with the potential for industry and business absorbing a very large increase during the year of 1983. He stated that business and industry just cannot absorb the escalating costs of health care, and that there must be some arrangement in the economy in health care for insurance programs not covering the "first dollar."

Mr. Rosinski outlined the development of a coalition including representatives of business, labor, and senior citizens, making every effort to reduce health care costs. He stated that the first group of this type was developed in 1978, and that there are now twelve similar units operating with the expectation that soon there will be fifteen similar groups, organized along county lines, and dealing with county medical societies. The assumption was that this all began in San Diego, and has spread to other parts of California.

The goals of the Health Care Coalition were listed as (1) Working with medical care foundations: (2) Having a plan for preferred providers relative to hospital and physician care, stressing selection of those who are basically cost-effective: (3) Studying abuses of processes arising from patients, such as those having co-insurance and benefiting from illness: and (4) Physical fitness programs with weight reduction programs, as well as encouraging prescriptions providing generic drugs and other means to reduce health care costs.

It is extremely interesting that Mr. Rosinski clearly stated that business and industry were looking for a "well-designed product" in terms of health care. He acknowledged that Rohr Industries, which he represents, has had its problems with various items such as the Bart car in San Francisco. He further stated that in the San Diego area, there are ten HMO programs, but only one has a good enrollment. He offered solutions to the problem as probably including a realistic per diem payment for hospital care, with diagnosis-related payments coming into the picture, and possibly some discount arrangement on an agreed basis. He felt that all specialists should be selected by the primary care physicians, and that he would like to see the private sector of patients pay the same fees as allowed by Medi-Cal and Medicare schedules. He postulated that the appropriate program would select hospitals that would be willing to engage in strict utilization programs with efficient processing and sharing of medical records, not only from the hospital but also from the doctor. Needless to say, there was very little applause when Mr. Rosinski finished his presentation.

The next speaker, Mr. Lewis Keller, representative of the insurance industry, stated at the beginning that his position was "in the middle" between industry and health care providers. He said that insurance companies must save some money from what comes in and what goes out. He covered the expansion of health care delivery systems very well. Labor unions have required employees to go to the first dollar

coverage, and this may be on the way out. Mr. Keller gave several illustrations of the total health insurance problem, not only in relation to the demands of labor and business, but also in reference to a Federal pre-emption of the States' power to regulate pension plans in terms of providing total health coverage during retirement. Apparently multiple employers' trust funds have taken the form of an insurance program, and have not been truly established as an insurance program. He mentioned the role of providers of health care in squeezing excessive eggs from the golden goose, but he inadvertently confused term "proctology" with "gynecology." This served to illustrate, to many listening, that so many laymen involved in the total problems are quite confused relative to the differences between reproduction and excretion.

Mr. Keller suggested that the processes leading to AB3480 were driven by necessity "to get a free and open policy for competition in the marketplace." He prophesied that closed panel coverages for medical care may be available on a wide-spread basis, and that there would be a lot of interest among life insurance companies, as well as among various types of providers, in the issues allowed by AB3480.

The next speaker, Dr. Robert D. Burnett, President-Elect of the California Medical Association, gave a chronological report on the various factors leading to the rather abrupt development of AB3480. He reviewed the various efforts of the CMA over a period of years, and then asked the rhetorical question, "Where was the CMA in Sacramento at the time of passage of AB3480?" Dr. Burnett listed various statistics indicating the financial pressures involved and then he reported the rapid process directed by those concerned, and stated that all of this was "done in clandestine fashion." He stated that this was a defeat for the people of California. It was extremely interesting to the physicians attending that Dr. Burnett clearly outlined the conditions for providing health care systems before AB3480. He stated the problems that had developed with HMO programs in Southern California, leading to the passage of the Knox-Keene Act, which provided certain regulations on health care systems by various alphabet arrangements. He described the legal restrictions on abuses, and he pointed out that the advocates for AB3480 had their primary direction in getting health care closed panel systems without any regulations to prevent abuses. In other words, the average listener was impressed that Dr. Burnett was saying that those who pushed through AB3480 in a rather abrupt fashion were trying to railroad a system for regulating health care without the various guarantees and regulations that had been provided in the Knox-Keene Act, that became law. Dr. Burnett also pointed out that after the AB3480 was made into law, the CMA went to work and developed a trailer bill, so that any closed panel must have third-party health peer review. Whether or not this will control abuses that are allowed under AB3480 remains to be seen. Dr. Burnett indicated that one of the greatest potential abuses that could be allowed under AB3480 would be that a health care system provided by a given business or industry could go to a hospital and get a discount for all of its patients, thereby shifting costs to the private sector, or to other programs that would not be able to wield that influence. He pointed out the difference in the philosophy expounded by Mr. Rosinski, who advised physicians to "get into the marketplace," whereas he pointed out to Mr. Rosinski that taking care of patients is not the same as the production and sale of stoves or refrigerators. He indicated that the quality of health care is the main issue.

Second Session, Sunday Morning:

In the Sunday morning sessions, Dr. Lippe started the discussion, emphasizing that in any total health care system, the patients have a right to free choice of physicians, and physicians have a right to their choice of patients. He ventilated a lack of credibility for various statistics that have been presented in terms of health care costs by those who would serve to regulate medical programs. In recognizing that there is some "fat" in health care costs, Dr. Lippe stated that AB3480 not only provides decreased income for physicians, but also offers possibilities for fragmentation among medical doctors, as well as the non-collegio approach to the care of patients. The gatekeeper concept for primary care physicians would lead to competition in a hostile climate among physicians, and the various ethical and professional standards as we have known them might suffer irreparable changes. He did not provide any definite solutions other than to "not panic." He warned physicians about barriers to free survival, and to beware of discounts and "hold harmless" contracts. Various steps were recommended for keeping close communication among physicians with reference to our California Association of Neurological Surgeons, as well as with the California Medical Association.

The next essayist, Jerry P. Clousson, attorney, presented subject material entitled "Techniques and Organizations for Negotiation with Insurance Carriers." Mr. Clousson asked the general question, "Will the line hold?" He cited the various characteristics that have made our country what it is in terms of independence, self-reliance, and general personal development, with risk of being controlled by third parties. He asked whether or not the power in medicine is shifting to labor and business, and whether or not the insurance companies and politicians are conspiring to establish their own controls. He related the experiences of citizens of our country in the 19th Century, when there was an industrial revolution leading to recovery from the various sweatshops and abuses of labor in general. He advocated that physicians must join a crusade to avoide monopolies, and to avoid standardization of prices. He argued against a uniform fee schedule, and said that surgeons should realize that there could be a different fee schedule for those on Medi-Cal, Medicare, or in the private sector. He recommended that we should let the public know the importance of our interest in their care, and that it would be the patients themselves who would eventually suffer

from the abuses of the program. He stated that the newer developments are really working on the rationing of medical care, and that the public does not understand this. He warned that the developments related to AB3480 are really forms of socialization, whereas they are really being called industrialization, and that we should make every effort to work against these.

The third and last speaker on the Sunday morning program was Dr. David S. Rubsamen, who is also an attorney. He spoke to the issue of "the malpractice and other problems arising from AB3480." Dr. Rubsamen began with a warning that the major problems will come about through "pressures" that we as physicians will feel at the mercy of skillful organizers. He emphasized the need to maintain "quality of care" and that we physicians should be greatly concerned about the possible elements of patient injury.

Dr. Rubsamen described a case of detailed supervision in terms of hospitalization by Medi-Cal regimentation, leading to complications with amputation of a lower extremity and a hefty financial verdict against the system. All of this served to convince Dr. Rubsamen that the system may be providing its own "bear trap" for its own foot. He described the various legalistic issues relative to the responsibility of the Medi-Cal consultant in authorizing additional days of hospitalization. It was quite revealing for all those attending this session to hear Dr. Rubsamen list the various issues relative to responsibilities of various parties involved in providing appropriate medical care. He not only described the issues in this country, which are still to be decided by various higher court decisions, but he also illustrated the problem that has developed in Canada, where medical care may be delayed, or even disallowed, in the last few years of a person's life when it may be decided by certain individuals in the paying position that there comes a time when an individual should be allowed to die without excessive expenditure of available funds. The situation was apparently summarized in one case where it had been the general reaction that the patient was "an old man whose time had come to die."

The direct presentations on Saturday and Sunday morning were each followed by an hour period for questions and answers from the speakers. These open discussion periods indicated the need for further delineation of the role of the physician in cooperating with the new legislation, and there were multiple suggestions and prospective plans for keeping the public better informed relative to the actual role and income of physicians, as well as the need for patients to maintain their ability to receive appropriate and highest quality medical care.

BOARD OF DIRECTORS 1983-1984
**Newly elected*

Officers:

President	William H. Wright, M.D.
*President Elect	David G. Scheetz, M.D.
Secretary	Frank P. Smith, M.D.
*Treasurer	Melvin L. Cheatham, M.D.
*First Vice President	DeWitt B. Gifford, M.D.
*Second Vice President	Morris D. Loffman, M.D.
Immediate Past President	Douglas M. Enoch, M.D.
Past President	Sidney Tolchin, M.D.
Director	N. Edalatpour, M.D.
Director	Gail A. Magid, M.D.
Director	Ulrich Batzdorf, M.D.
Director	Paul H. Chodroff, M.D.
*Director	John R. Clark, M.D.
*Director	Randall W. Smith, M.D.

CSNS

Delegate	***Alternate Delegate***
*Randall W. Smith, M.D.	*Donald J. Prolo, M.D.
*Paul D. Forrest, M.D.	*Joseph P. Coladonato, M.D.
	*Stanley A. Rouhe, M.D.

New Active Members:

Bruce L. Burke, M.D.	Chico, CA
Donald E. Pryor, M.D.	Thousand Oaks, CA
Dennis R. Malkasian, M.D.	Huntington Beach, CA
Francisco Sanchez, M.D.	Montebello, CA
Myles L. Saunders, M.D.	Los Angeles, CA
Joel M. Steinberg, M.D.	Visalia, CA
George C. Stevenson, M.D.	Redding, CA

Bylaw Amendments Adopted
(Members will receive copy of new bylaws booklet in April)

1. Amendment to Article III (page 6) Adding: "Section 3.03-6. Inactive. If any member of the California Association of Neurological Surgeons shall absent himself from the practice of neurological surgery for a greater part of the year by reason of illness, post-graduate studies, or other reasons acceptable to the Board of Directors, he may apply, in writing, to the Board of Directors for transfer to inactive status.

Members approved for inactive status shall not be required to pay dues, may not hold office, serve on the Board of Directors, or be appointed as Chairman of any committee in this association.

Upon return to active practice, the member must, within ninety (90) days, apply, in writing, to the Board of Directors for transfer back to his original status. All privileges held before transfer to inactive status shall be restored, unless altered by specific action of the Board of Directors." (Editorial change Section 3.02, 3.08-2 and 3.11)

2. Amendment to Article VIII, Section 8.05 (page 18) Delete last sentence (If a number of vacancies, etc.) and add "The delegation shall annually elect a chairman from its membership. The President is empowered to appoint substitute delegates, pro tem, to replace elected delegates who find it impossible to attend certain Joint Socio-Economic Committee meetings."

REVISION OF CALIFORNIA STANDARD NOMENCLATURE

James B. Golden, M.D., Chairman

The CMA recently began preparations for revision of the California Standard Nomenclature (CSN). The CSN Subcommittee on neurological surgery consists of Doctors N. Edalatpour, De Witt Gifford, James Golden, and Sidney Tolchin. In carrying out this revision, the committee will observe the following recommendations from the CMA:

1. that addition of descriptors be restricted to procedures developed since the prior revision.

2. that expansion in descriptors used for already coded procedures be discouraged.

3. that the number of descriptors in the current CSN be reduced whenever possible by telescoping existing service descriptors and deleting of obsolete procedures.

Please send your suggestions for any revisions of CSN to a member of the above committee.

We are aware of the incidentally concurrent revision of CPT4 by the AMA and the possibility that this document could supplant CSN in the future. The descriptors in both documents are very similar, and we believe that it is important to revise the descriptors at this time.

UP-DATE ON PUBLIC EDUCATION

Robert E. Florin, M.D.

The Public Education Committee of CANS has been formed in an effort to develop a program that will be of value in promoting the interests of our members engaged in the practice of neurosurgery in California. The AANS and CNS have formed a Joint Committee on Education which has, through its Subcommittee on Public Education, issued a series of informational news releases through the National Safety Council. Despite the excellence of the textual material, releases have not gained wide circulation or recognition, and the National Committee has been concerned with the effectiveness of its efforts.

Our investigation in this area has included contact with several well-established public relations firms, and we have learned that several other specialty organizations have already entered the arena of public relations on behalf of their membership. For example, the plastic surgeons were represented during their successful fight with the FTC several years ago by a large New York public relations firm. The California Society of Anesthesiologists has had an active Committee on Public Education for some time, through a professional public relations office in San Francisco. They have developed a Press Kit for distribution to major media sources in the State, which contains fact sheets on "Know Your Anesthesiologist" and "What Happens in the Operating Room," as well as other similar topics. They have developed a speakers' bureau that can call upon members who have been prepared to deal effectively with the media, and to get their viewpoints across, by specific training of those members for media encounters and speaking engagements.

The California Association of Ophthalmology has an active Public Education Committee, and has developed a wide-reaching program. It appears that this approach has been quite successful.

The Public Education Committee, at the direction of the Board, plans to develop programs to improve the understanding of the practice of neurosurgery in the State with two particular targets: (1) The general practitioners and other non-surgical specialists in order to increase recognition of the scope of services that we provide to the professional community; and (2) The general public, to improve the image of neurosurgery as a specialty. Such a program could aid in the decision when a consultant is selected for diagnosis and treatment of a medical or surgical problem that might be of a neurosurgical type. Too often, extra-cranial vascular problems are referred to a vascular surgeon, rather than to a neurological surgeon.

The cost of developing a comprehensive program described above could be substantial, and will require the support of the entire membership of CANS in order to provide adequate financing. Our first project will be the development of a pamphlet or brochure containing information on the scope of neurosurgical services. This could be used by all of our members in their offices, and could be directed to referral sources. Your comments and questions are invited.

In addition, we are considering development of a Speakers' Bureau, so that we would have neurosurgeons available to speak on subjects of current interest whenever we might receive a request from groups interested in certain health care programs of a neurosurgical nature. Please let us know if you would be willing and available for this type of service in a Speakers' Bureau. Write to CANS Executive Office, P.O. Box 41761, Sacramento, CA 95841 c/o Public Education Committee.

NEWS OF THE MEMBERSHIP

Philipp M. Lippe, M.D. of San Jose, CMA secretary and a specialty society representative on the CMA Council, has been named to serve on the AMA Council on Scientific Affairs' Advisory Panel on the Management of Chronic Pain.

George Ablin, M.D. of Bakersfield, has just been appointed by the Senate Rules Committee to serve a four year term on the California Health Facilities Commission. CHFC is the organization that develops standards of effectiveness for hospitals and long term care facilities and provides annual estimates of expenditures for hospital Medi-Cal services.

A TRADITIONAL REPLY TO COMMERCIALIZATION

Jerry P. Clousson, J.D., L.L.M.

Collective response to overwhelming outside forces always has been socially acceptable conduct. One relevant analogy is today's labor organization. Through the mid nineteenth century, third parties, including financial and distribution institutions, interjected themselves between producer and consumer. The institutions used politicians and courts to achieve prosecution, with the result of much social turmoil. These stresses brought exclusion from anti-trust laws for the collective groups of producers, which now appear as the labor organization exemptions. These exemptions occurred because of producer political influence. That influence resulted from the recognition that the individuals were the *only producers* and, therefore, were *needed*. Similarly, physicians are the *only producers* of quality patient care services.

The analogy with the attempted industrialization of the health care delivery system is obvious. Erosion of the traditional professional physician-patient relationship is being stimulated by outside forces. Third party payors and provider institutions are becoming economic forces too strong for the individual physician to cope with alone. Many institutional providers consider patient care a product to be produced by the provider with the use of physicians, and to be marketed as any commercial product. Some payors seek to improve their own financial position by reducing the cost of their subscriber product with subsidization by physicians. Now, many employers and unions seek to exploit physicians in order to satisfy the needs of their employees and members.

California is offering one prototype for the future of Medicaid. Medi-Cal now seeks bids for institutional health services similar to a request for bids from contractors to build highways. When lowest bids are negotiated and accepted, all other bidders are excluded from the market. Such concepts must create stresses with physicians' attempts to provide patient care in a professional environment. Medical staffs will be increasingly hard-pressed to maintain quality patient care.

How can the individual physician preserve his professionalism and serve his patients in a commercial environment? Patients deserve single-tier, quality patient care with free choice of physicians. Payors have cost concerns and expect quality care. Physicians naturally seek to avoid an erosion of their patient base, professional freedom and jurisdiction. No one will benefit from fragmentization of the medical community.

NEW NAME FOR TIA

N. Edalatpour, M.D.

It is proposed here that a term such as Acute Brain Dysfunction (ABD) be used in place of Transient Ischemic Attack (TIA) for patients having a variety of focal neurosurgical symptoms. These patients are presenting to physicians complaints and findings in a syndrome that should be recognized as a problem relating to the *brain*. The syndrome may be brief or lengthy, with full, partial, or minimal recovery. "Transient Ischemic Attack" as an initial impression imprints an unwarranted finality on the diagnosis. TIA directs the physician in a narrow testing pattern designed to confirm or negate that single thought of ischemia. The unexplained syndrome, in fact, needs a more broad-minded investigation to explore the wide variety of causes that may be the source of the *brain* disorder.

The TIA narrow-minded approach to extracranial arteries deprives patients of the deserved full attention of those who, by interest and learning, are best equipped to decipher the likely cause of the syndrome. The TIA simplistic approach often enough leads to premature surgical decisions and ill-advised operations.

Diagnostic impressions such as Acute Brain Dysfunction may in time alert those physicians who first see these patients to direct them to doctors interested in the brain, i.e., neurosurgeons, both for reasonable diagnosis and any indicated surgical care. Perhaps in the future, the interested and able neurosurgeon will no longer be bypassed. Please forgive the pun.

LETTERS TO THE EDITOR

Over the past several years we have from time to time received letters which are quite pertinent and feel that this information should be disseminated throughout the membership. Members are invited to participate in this portion of the newsletter. These letters will not necessarily represent the opinions of the editorial staff or of the CANS Board, but will reflect opinions of the membership on pertinent issues. Send your comments to Frank P. Smith, M.D., Editor, 880 Cass Street, No. 101, Monterey, CA 93940.

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