CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

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COMMENTS OF INCOMING PRESIDENT OF CANS

"Look to the Renaissance" — Frank P. Smith, M.D.

If we were to become depressed about all of the current socio-economic pressures facing us physicians, we could adopt an attitude of "Abandon Hope, All Ye Who Enter Here." Since the history of our civilization has tended to be cyclic, possibly we could look to the past for some projection regarding the future.

As one recalls the great culture of Greco-Roman life at its finest, one might find some allegorical comparison to the shining era of high-level medical care espoused by such dignitaries as Sir William Osler and Harvey Cushing, at a time when the total health care system was moving to the finest level that the world has ever known. Just as the gates of Rome fell, secondary to the problems within and from without, so has the health care system been wrought asunder by many forces. Largely, these have resulted from an alliance of those who seek cost containment without any primary concern about quality of care.

Now, allegorically again, we are in the Dark Ages, with feudalistic entities striving to build their castles and attract regional serfs. There are strong physician movements, somewhat like Cromwell, waging a demolition process, which in itself can be fatalistic if we are left only with a lot of historic ruins.

Just as intelligence arose in Florence, Milan, and other cultural centers in the sixteenth century to bring us out of the dark ages of civilization we look for some inspired movement for health care. There will not be an early reversal of trends made by politicians who promise great benefits in the welfare state. The coalition of corporate leaders and labor unions will not easily surrender their standards for concentrating on cost reduction. Also, there will be a tendency for those physicians currently being trained to go along with a semi-socialized health care system because they have not really known anything different. But, as sluggish inertia fails to provide motivation, the effervescent intuition of mankind will rise again. Civilization itself will look to dedicated physicians who can provide the care necessary for survival. It shall be a renaissance for the art and science of medicine.

In the meantime, we must maintain the highest standard of care of our patients, for which we have trained ourselves as our ultimate destiny. Your California Association of Neurological Surgeons was originated and structured for maintaining the optimal survival of neurological surgery in this State, and for providing delegate representation to the CMA and the two large national neurosurgical societies. We have various **Standing Committees**, such as the Community Relations Committee and the Member Services Committee, and **Special Committees**, such as the Emergency Medical Services Committee and the Steering Committee on Negotiations. These are staffed by diligent, dedicated neurosurgeons who have the expertise, ready and willing to help you with problems that may arise in your practice. Our By-Laws have been revised to broaden membership in **CANS**, requiring Board eligibility, rather than Board certification. We need the participation of all qualified neurosurgeons in California, not only for their benefit but also that we may have proper constituency as a basis for delegate quotas representing California at the national level. Your Administration this year plans to continue the drive already established to enlarge our active membership, and we look forward to all of you taking advantage of the services that we offer. ■

POSSIBLE RELOCATION OF CANS EXECUTIVE OFFICE

The Board of Directors of **CANS** is considering a proposal to join other medical specialty societies in establishing executive office in the new, spacious headquarters building of the California Medical Association at 44 Gough Street in San Francisco. There is commitment that **CANS** would not lose its autonomy, or the same services currently provided to its members. The concept has been presented that with the broadly-based facilities offered in the new location, we would have multiple resources and continued consulting expertise, greater than available at present.

Comparative cost basis is under research at the present time, and all members of **CANS** are encouraged to write to President Frank P. Smith, M.D., if interested in more information or to express comments one way or the other. The matter will come up for more definite type of decision at the next Board of Directors meeting of **CANS** on May 17, 1986. ■

RESOLUTIONS RE: AANS CANDIDATES FOR 1986 ELECTION CANS BOARD OF DIRECTORS MEETING — FEBRUARY 15, 1986

WHEREAS, the AANS By-laws were completed after considerable deliberation; and,

WHEREAS, the By-laws, among other things, carefully specify:

a. 3 year terms for the offices of Secretary, Treasurer, Director and Nominating Committee Member,
b. terms of office that are staggered,
c. in the case of Secretary and Treasurer, that they not be elected and start their terms of office in the same year,
d. that when and if vacancies occur in any office or directorship that the Board of Directors may declare (and announce) the vacancy,
e. that, thereafter, the vacancy is filled either by temporary appointment by the Board or with election by the Members at the next Annual Meeting of the Association; and,

WHEREAS, the staggering of the terms of office of the Nominating Committee members was intended to give continuity to its concepts, long term planning and to avoid such things as unexpired terms (except for illness, demise or unexpected personal reasons); and,

WHEREAS, there is a strong, implied contract, on the part of the elected person and on the part of the Association, that the elected person is obliged to complete his full term (except for good reason) and that the Association honor its same contract to the elected person (as has been done in the past); thereby avoiding sudden changes and possible or perceived political changes in the carefully planned leadership of the Association; and,

WHEREAS, a number of these important considerations are not fulfilled in the recently proposed slate of nominees, now, therefore, be it

Resolved: That the **CANS** go on record as reaffirming the principles embodied in the By-Laws of the Association regarding the nominations and elections of its various officials.

WHEREAS, the present By-Laws of the AANS provide that the Nominating Committee may propose one or more nominees for each office; and,

WHEREAS, the large size of the Association offers many talented potential officers; and,

WHEREAS, there are also other good reasons for offering the membership a choice of leadership; and,

WHEREAS, the **CANS** recognizes, also, the above not withstanding, that the present proposed slate of nominees are (without exception) fine and capable leaders; now, therefore, be it

Resolved: that the **CANS** encourage additional nominations in writing for the 1986 election so as to establish this precendent of offering a choice of nominees. ■

GROUP TRAVEL FOR CANS MEMBERS

Comments have been made relative to the advantages of sharing neurosurgical experiences with neurosurgeons in other countries, to the extent that **CANS** has established a Travel Committee, with Dr. David G. Scheetz as Chairman. Now, there is a need for expression from **CANS** members as to how many would really like to take part in a group venture to an area such as Australia or Russia, for mutual neurosurgical enrichment, as well as cultural education in general. Please call or write Dr. David G. Scheetz in Santa Rosa, if you are interested in possible developments. ■

SUMMARY OF PROGRAM OF THE ANNUAL SESSION OF CANS SANTA BARBARA — JANUARY 24-26, 1986

Frank P. Smith, M.D. — Editor

SATURDAY MORNING:

1. The first session consisted of the "Great Debate" between Dr. Larry Pitts and Dr. Michael Sukoff relative to the use of CT brain scan before or after emergency craniotomy for severe head trauma.

   Dr. Pitts started the discussion, presenting results in the surgical treatment of 100 patients who had sustained severe head trauma, placing them in the category of "herniation." 77% of these were males, and 61% of them had sustained head injury in association with a vehicular accident. They were all in severely altered mental status, with pupillary dilatation either unilaterally or bilaterally, and the average Glasgow coma scale was 4.4. The patients were taken promptly to the operating room and had bilateral temporal burr holes placed in exploration for epidural or subdural hematoma, and then a bone flap was performed on one or both sides depending on the findings with the exploratory burr holes. The end results were obviously poor. CT brain scans were performed post-operatively, and five of the patients had subdural hematomas identified on the CT scan that had been missed in the exploration. There were three intracerebral hematomas identified on the brain scan after craniotomy. 70% of the patients died. Nine of them had a result which was classed as "good." There were obvious compromises in other patients who survived. The impact of Dr. Pitts' proposal was that the very prompt surgical exploratory treatment avoided the worsening of the patient's condition during any delay in obtaining a CT brain scan. Dr. Pitts cited reports that indicated the longer the delay in diagnosis and treatment, the worse would be the result. He felt that the prompt surgical drainage of hematoma offered the best possible result for patients in the category of severe status, as outlined.

   Dr. Sukoff presented a survey of 30 patients with an appropriate protocol, where CT brain scan had been performed, and surgery followed when indicated. Thirteen of the patients were found to not need craniotomy or other surgical treatment, and thereby were spared the excessive costs of operating room charges and surgical fees for exploratory surgery. He cited the time interval of 30

SUMMARY OF ANNUAL SESSION

SATURDAY MORNING: Continued

minutes, or possibly less for obtaining a CT brain scan as not being a significant factor in providing worsening of the patient.

In the discussion that ensued, it became apparent that the emergency management of serious head injury cases might vary from one hospital to another, particularly if one were comparing a large general hospital with a smaller unit in a community setting.

2. The second part of the program related to physician responses to various organizations of health care, such as HMO's, by Dr. Robert Florin. This was introduced in a flurry of cost accounting relative to the escalation of total health care in the United States, and then the more recent paradox in hospital bed census dropping down to relatively low levels in the past year or two. Dr. Florin talked about the various issues contributing to the problem, with reference to Federal costs, state costs, hospital economics and insurance company problems. He mentioned the role of unions representing consumer groups, and pointed out that we are now involved in a competition among physicians as to who is going to provide the medical care in the newly-developing programs. From there, he described what happened in his home area, namely Whittier, California, where doctors developed a health care network and ran into all kinds of legal problems from various competing agencies. The so-called "mesh"of the medical staff and hospital affiliation seems to have been worked out for maintaining the posture of each group. The advice presented by Dr. Florin in his summary was that physicians should adapt to the forces and changes taking place, and should learn about the various systems involved, so that they may get qualified, professional help and legal assistance to work out a program best suited to the needs of any particular community or area.

3. The next presentation was by Mr. John G. Gray, representative of the Equitable Life Insurance Company, who spoke on "New Dimensions in the Health Insurance Field for Physicians." He gave a very nice survey of the organizational problems for health care, and indicated that HMO's are as much a threat to insurance companies as they are to physicians. He outlined the needs of major corporations as they are demanding a health care advisory service, as well as case management for special matters including provision of "second opinion," review of actual need for continued care, and then, discharging planning. He emphasized that corporate policy is now one of monitoring all aspects of health care, particularly within the hospital arena. Dental care seems to have become an accepted requirement. Mr. Gray pointed out the escalation of various health care programs. He warned about the problems with state boundaries having a negative aspect, as well as the financial risk for survival of the various plans as related to the premium cost and the expense in delivering the care that would be expected by the policy holders.

4. Following the coffee break, the subject of organ transplant was presented by Dr. Donald J. Prolo and Dr. Oscar Salvatierra. This was oriented to the relatively new State law which mandates that physicians will provide advice to a patient's family relative to the protocol for organ donations, where the patient has been judged to be suffering cerebral death. Dr. Prolo showed slides relative to the various types of transplantation materials available, and Dr. Salvatierra reviewed progress made with transplantation of organs such as kidney, heart, liver, and heart-lung preparations, related to the relatively new use of cyclosporin. Dr. Salvatierra pointed out the relatively low number of organs being donated for transplant, as one considers the total reservoir available. He emphasized the role of the attending physician, and in many cases the neurosurgeon, in orienting the patient's family as to what could be accomplished in terms of organ donations for transplantation in a patient who has been judged to have sustained cerebral death.

5. The medical legal issues facing neurosurgeons, in terms of professional liability, were very well described by Judge Gordon Cologne, a retired Justice of the Appelate Court of California. He emphasized the need for physicians to have clear direction as to various elements of responsibility from the legal standpoint.

6. The final presentation of the morning consisted of a panel discussion on neurosurgical manpower problems. Dr. Frank P. Smith reviewed the activities of the Manpower Committee of JSEC over the past two and a half years, and indicated that there seems to be a general acceptance now in the higher echelons of the AANS and the CNS that there is a problem with neurosurgical manpower. The concept of having a liaison committee with neurosurgery, orthopedic surgery, and neurology, seems to be gaining some momentum, and there has been acceptance of sending a questionnaire to the graduating neurosurgical residents in each of the U.S. training programs, as to whether or not there has been ample opportunity to find a position of choice for practicing neurosurgery. Dr. Donald Becker, the new Chairman of Neurological Surgery at U.C.L.A., presented his concept of definitely recognizing that there is a problem of excessive number of neurosurgeons, whereas there seems to be many openings in various areas. He talked about the need for more younger neurosurgeons going into the academia type of practice, and how it would be difficult to cut down on the number of residents in his program, since he needs a significant number of residents to keep various functions in proper perspective. Dr. Martin Weiss, who was scheduled to be a member of the panel, was unable to attend because of illness. Dr. George Ablin as moderator, summarized the various issues and opened the period of questions and answers, all indicating that the time has come for more detailed analysis, and possibly some programming other than waiting for the "marketplace" to solve the problem.

SUNDAY MORNING PROGRAM:

1. The important and fairly complex problems associated with neurosurgical fee structure were described by Dr. DeWitt B. Gifford and Dr. Philipp Lippe. It became apparent that these two essayists have been performing an extremely important service in representing neurosurgeons of California for maintaining the best possible fee structures with the Workmens' Compensation authorities, as well as with third party insurance carriers. Dr. Lippe reviewed the contract status between Harvard and HCFA for developing a relative value schedule at some time in the future. The determining factors relative to considerations are such things as time required to deliver the service, complexity in performing the service, length of training required to equip the person performing the service, and that rather intangible factor, namely the cost of overhead for performance, which would include liability insurance costs. The guiding factor in all of these matters has been recognized as now accepting the concept that "cognitive services" have not been adequately reimbursed in the past. This has led to a struggle between surgeons and those in the medical areas who are pressing for increased reimbursement of "cognitive skills." In closing, Dr. Lippe asked the rhetorical question as to what will be the posture of neurosurgeons in this matter, and Dr. Gifford concluded his remarks by suggesting that the American Medical Association has not protected the role of surgeons relative to their status in the total programming of fee structures.

2. Probably one of the more provocative presentations was given by Ms. Deborah McFarland, an officer in the National Medical Enterprises, Inc., who talked on the corporate practice of medicine - vertical integration of health care. She summarized changes that have developed in hospitals in the past 25 years. As hospitals gained their patients from various doctors in solo practice 25 years ago, they now depend upon receiving admissions from the various subsidized units of the health care network, which really are interested in saving money, with all of the monitoring and discounting of charges for various services provided by the hospitals. She also indicated that physicians are going to have to recognize that they are being challenged by the same restrictions, and they are going to have to themselves with provider types of organizations, with the acceptance of the concept of discounting their fees accordingly. In addition, she prophesied that before long, HMO's are going to be the source of most all hospital patients, and doctors should be prepared to become involved in the process.

3. The legal responsibility of third party insurance carriers to providers was very nicely presented by Patricia Ray, practicing attorney in San Diego, California. In beginning her presentation, Ms. Ray reviewed her training, first as a nurse, then in law school, moving into a legal firm where she became involved with defending insurance carriers against various claims. She has just changed her status, and is now involved in her own practice which concentrates upon claims between insured individuals and insurance carriers. She covered the elements of responsibility of insurance carriers for providing coverage of hospital and medical charges, and she described the concept of so-called "bad faith" of the insurance carriers in performing their responsibilities. She clarified the status of the unfair practice act, passed by the California legislature, and identified by a code number, 790.03 (H). This was given as a point of reference for those who would seek more information relative to any claim that might be made against an insurance carrier for failure to fulfill responsibility.

4. The last presentation of the program was truly a grand finale. Mr. Grant Cattaneo provided what most listeners described as the best orientation that they have ever heard, relative to the most confusing "alphabet soup" -HMO's, IPA's, PPO's, and EPO's. Mr. Cattaneo analyzed the role of the HMO in trying to parlay the element of risk for financial survival by becoming involved with the IPA concept, namely independent practice association. This involved essentially what he described as a "group practice without walls." In other words, this is an arrangement where, through interested entrepreneurs, various physicians with various qualifications could be brought together to provide medical and surgical care that would survive only if there would be adequate constraints on utilization. The physicians selected to take part in the program would be those who could be expected to be competent, efficient, and effective. Mr. Cattaneo showed the figures necessary for maintaining efficiency and solvency in the medical activities, which would involve primary care physicians at 36%, specialty participation at 50%, and ancillary services, such as x-ray and laboratory services, at 24%. This, of course, would not allow any budget for overhead, so that all the figures would required readjustment, thus reducing the total figure to 85%, allowing 15% for overhead, with the concept of referring any surplus back to the three groups where indicated. Probably the greatest impact of this presentation by Mr. Cattaneo was that health care programs, by any nomenclature, must have detailed organization, much the same as any corporate business, in order to survive from the financial standpoint. In addition to his statement about controlling overhead for any health care program, Mr. Cattaneo emphasized the basic elements for controlling utilization as being capitation of the primary care physician role, as well as the need for prior authorization of any specialized services or surgery, and the need to have capitation of laboratory and x-ray services, all followed by continued review of the various expenses with education of those participating, and a willingness to expel those physicians or providers who are not following the requirements of the program. In addition to this type of monitoring of those providers internally involved in the program, he cited the need to have constraints on those subscribing to the health care benefits, to the extent that there could be a structure for a $100.00 deductible, if the individual goes to a participating hospital, whereas there would be a $1,000.00 deductible if the patient goes to a non-participating hospital. This served to emphasize the need for a structure that would place the patients, the doctors, and the hospitals, all within alignment for providing health care on the most efficient basis from the standpoint of cost containment. Some listening in the audience might have been concerned about the lack of emphasis on quality of care, but those who entered into the discussion were obviously more impressed with their understanding of the intricacies of the various programs as presented by Mr. Cattaneo. It really was an educational experience, because it clearly outlined how the HMO's work through the basic function of the IPA's. It proved to be a very good analysis of HMO socio-economic issues, to the extent that through this better understanding of the processes involved, we can still maintain our posture for our basic interest in providing the best medical care for our patients. ■