CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

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MESSAGE FROM A PAST PRESIDENT

Abstract of a speech given by **Melvin L. Cheatham, M.D.** at the luncheon meeting of the Joint Council of State Neurosurgical Societies in Washington, D.C., April 1, 1989.

THE S.S. NEUROSURGERY: ANOTHER TITANTIC?

On April 10, 1912, the legendary SS Titanic sailed from Southhampton on its maiden voyage to New York City. It was a mighty vessel, billed as the "The Unsinkable Ship." At the time it was the largest moving structure ever constructed by man, and the ultimate in comfort and elegance.

The Captain was Edward J. Smith, a man of incomparable experience, in command of a highly experienced crew. Yet, just four days into its maiden voyage, that great ship, its approximately 1500 passengers and crew went to their deaths in the icy ocean depths. What went wrong? The Titanic disaster continues to be one of the great stories of our time.

The Titanic did not sink because of an unseen iceberg in the Labrador Straits. It sank because safety, skill, reason and good judgment had become hopelessly obscured by a cloud of pride, arrogance, carelessness, complacency and unconcern. The cellars of the ship were filled with fine French wines and caviar but the lookouts in the crow's nest did not have a simple pair of binoculars to aid them in scanning the waters ahead. Communication between the dining room stewards and the passengers was excellent because such was demanded. But communication between the wireless room and the bridge; between the officers and men charged with the responsibility of sailing that mighty ship, were woefully inadequate.

The Titanic was fitted with enough life-boats to carry no more than half of the passengers and crew, should disaster strike. And strike it did, and in so-doing the Captain and the crew were caught very much off-guard. They responded with too little — and they responded too late. Even as the great vessel was sinking, many on board could not quite grasp or accept the tragedy that was unfolding. Some simply retreated to the lounge to have a drink and play cards.

The great ship Neurosurgery is now sailing through difficult, hazardous, uncertain waters. We sail surrounded by lurking, ever-growing icebergs which threaten our very survival. Professional liability, peer review, prior authorization, rising costs, falling reimbursement, government intervention, the Hsiao Report and other issues lie dead ahead. Will we fare better than the Titanic? There can be no argument concerning how great our ship has become. Neurosurgery has become perhaps the greatest medical specialty of all. With CT, MRI and other developing techniques, expertise and surgical equipment, we move forward conquering problems for which solutions were not thought possible a few years ago.

As we look to the disastrous experience of the Titanic, perhaps we can gain some wisdom which will save us from a similar fate. We, as organized Neurosurgeons, need to steer clear of the trap of complacency. We need to avoid the dangers which come with arrogance. We need to make sure our great ship is fully equipped and always prepared. It is critical that we continue to have good leaders at the helm, and that we constantly have fresh talent and leadership coming up through the ranks, bringing with them new ideas, new vision and new enthusiasm for dealing with what lies ahead. We need to remember that the passengers of the ship Neurosurgery are our patients, and that they have entrusted us with their very lives and well-being. It is an awesome responsibility that we carry.

NEUROLOGICAL PRACTICE SURVEYS

By Philipp M. Lippe, M.D., FACS

The 1987 *Comprehensive Neurosurgical Practice Survey* was mailed several weeks ago and undoubtedly has been received by all of you. This monumental task represents the first comprehensive survey of neurosurgery in the United States. I trust that you will keep this document as a reference source, but also that you will feel stimulated to browse through it.

The development of this survey came about in response to the recognized need for a reliable data base in the area of professional liability, manpower and socio-economics. The document represents a major cooperative effort of many individuals in the AANS and the CNS.

At this time I would like to call your attention to several items:

The survey is an historical document dated 1987. Nevertheless, it represents a valid "snapshot" of neurosurgery.

The survey recognizes 490 neurosurgeons practicing in California which equates to one neurosurgeon for 56,000 people. However, the CMA reports 607 neurosurgeons in California which would equate to one neurosurgeon for 45,000 people.

The average neurosurgeon devotes 69 hours per week to professional activities. Although neurosurgeons are well compensated, making allowances for time and a half for overtime, the average hourly reimbursement is approximately $60.00

The average neurosurgeon spends approximately 25% of the time in surgery. However, 75% of the income is derived from surgical practice. This has major implications for the future.

Approximately 35% of the neurosurgeons include less than one month follow-up care in the surgical fee.

Finally, 45% of neurosurgeons in the United States responded to the survey. In California, however, the response rate was only 30%. This is distressing and difficult to understand.

CANS is about to launch its own 1989 practice survey. The information is absolutely necessary in order to establish a reliable data base. This can only be accomplished with the full cooperation of every neurosurgeon. Nothing less than 100% response is acceptable. I urge every one of you to rise to the challenge and accept this responsibility.

EDITORIAL

RATABLE AS PERMANENT AND STATIONARY

Editor - Frank P. Smith, M.D.

The management of workmen's compensation cases in the State of California has become so hopelessly involved in a complex network of allowable policies and procedures that the system really needs survey and reform. Whereas the original statutes were designed to protect the rights of injured employees, the continued band-aid type of amendments have created great protection to the insurance carriers and labor unions, as well as generous reward to examining physicians and the attorneys representing all sides. Among the various cases, there may be a gross contrast. Some workmen are greatly overcompensated, and yet others "fall between the cracks" of the system, and suffer neglect in treatment and compensation.

In most cases, injured employees rely on doctors to diagnose and successfully treat employment injuries, with the ultimate goal of returning to employment status in the appropriate category. We sense that benevolence demanded by labor unions began the tendency to bend the rules to compensate almost any injury or illness, including stress, that could possibly be related, even indirectly, to the job. There have been attorneys available to litigate and prove the rights of the employee disabled for any reason, and there has been an adequate supply of attorneys to defend insurance carriers. The various attorneys have been able to secure a predetermined opinion from doctors, often carpet-bagging orthopedists and neurologists, willing to review multiple records and submit a multi-page report — with the opinion that the patient is ratable as being permanent and stationary. This opinion is the Open Sesame for allowing a lump sum settlement to the patient, involving a handsome fee to the carpet-bagging doctors and a significant reward to the attorney, if he handles enough similar cases.

More recently, the insurance carriers have come to like these cases being rated as permanent and stationary. They have found their own medical experts, quite apt to give the desired opinion. The carriers can shop around, if necessary, to obtain the desired opinion.

Disposition of the case may be to the satisfaction of all concerned at the moment. Unfortunately, the injured employee may later need proper diagnosis and treatment, with long-term medical care required. He is initially mesmerized by his attorney, who may suggest that a $25,000 lump sum would offer the patient an adjustment, so that he can pay his bills and buy a new car. It is further suggested that any future

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RATABLE *(Cont. from page 2)*

medical bills would be covered by Medi-Cal or Medicare. The average, uneducated employee jumps at the opportunity to have more tax-free cash than he ever had in his life, and he actually enjoys the new affluence, until the cold reality of continued disability unfolds for him.

We are not complaining about a **theoretical** abuse of a health care system. Most of the reports providing an opinion for **permanent and stationary** status are heavily weighted with filler space, reviewing various medical reports already submitted in the file. An abstract of each report in the file can be made by a secretary, as if the predictable examiner had done it himself. So often, the multi-page report includes very little detail about the current clinical history taken by the examiner, or the findings coming from his examination. The diagnosis is usually a random collection, and there is usually a so-called "Discussion" which adds nothing other than the optimal solution for rating the patient as being permanent and stationary.

Now, all of the above might not be so bad if there were agreement on the definition and criteria for the status of permanent and stationary. There is some assumption that the reference indicates that no further treatment for the condition is necessary.

There is considerable disagreement on whether or not a satisfactory state of rehabilitation should have been reached. The big issue is whether or not the patient will accept his lump sum payment, and then be responsible for any further costs relative to the injury for which he is rated.

The attorneys for the workers claim that it is an irresponsible system, and that the insurance carriers are at fault. The injured workers, after being rated and spending their lump sum, want to have their cases re-opened on the basis that they didn't realize they were signing off long-term benefits. The insurance carriers don't say very much, other than that they acted within the law, and they do cite a significant number of cases that are allowed contingency for long-term care. The big issue seems to be which ones have this beneficial tail. The labor unions seem to worry more about the cases coming up for benefits, than about the ones that have been settled. It all seems to be such a mess that no rational solution could be obtained. There are often reports from itinerant orthopedists or neurologists, giving opinions on complex disc cases, who wouldn't know a herniated disc if they saw one in their soup. It is unfortunate that attorneys, carriers, employees, and even some judges, do not know (or care about) the difference in qualifications between a neurologist and a neurosurgeon. They just want to get the damn case settled!

It is reported that key legislators, the CMA, and even the Governor himself, would like a survey in reform of the present workmens' compensation program. Sooner or later, this must happen. We could begin with establishing definition and criteria for the rating of permanent and stationary.

Various criteria could be presented from all sides listed above. There is one, unalterable standard, namely, we must have a system that will elicit proper medical opinion, and not one inviting collusion.

LETTERS TO THE EDITOR

Members are invited to participate in the newsletter. Letters will not necessarily represent the opinions of the editorial staff of CANS Board, but will reflect opinions of the membership on pertinent issues. Send comments to:

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NEUROSURGICAL MEETINGS

The Travel Committee for CANS continues to gather information on world class meetings of interest to neurological surgery. The IX International Congress of Neurological Surgery will be held in New Delhi, India, October 8-13, 1989. Preceding the International Congress of Neurological Surgery Meeting in India, the Ministry of Health in Singapore is offering a course, *Neurosurgery and Neuroscience, The Challenges.* This is between October 4-6, 1989.

Professor Mario Brock is offering a course on Percutaneous Lumbar Discectomy in Berlin at the meeting regarding New Procedures and Techniques in Operative Medicine in Berlin between November 6-11, 1989.

In Adelaide, Australia, on April 1-6, 1990, the VI World Congress of Pain will be meeting. In Auckland and Christchurch, New Zealand, a conference on Pain and Rehabilitation will take place between March 26-29, 1990, preceding the World Congress on Pain.

If there is any interest among members of CANS in attending these meetings, please contact David G. Scheetz, M.D., 990 Sonoma Avenue, Suite 10, Santa Rosa, CA 95404, (707) 544-5487.

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ANNUAL MEETING OF CANS

Four Seasons Biltmore Hotel

Santa Barbara, California

January 26-28, 1990

Make your plans **NOW** to attend!

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ASSISTANCE IN ANALYSIS OF CONTRACTS

To help physicians and medical groups understand the obligations assumed by Hospital, HMO, PPO, IPA or other third-party payor contracting, the California Medical Association will analyze professional service contracts for a fee of $50 per analysis. Contracts are analyzed by attorneys. To request a detailed, objective analysis of the issues, inconsistencies and ramifications of a specific contract, **send a copy** of any IPA, PPO, HMO or other business entity contract, including hospital contracts, along with a check **payable to CMA**:

Contract Evaluation
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