CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

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PRESIDENT'S MESSAGE

Frank P. Smith, M.D.

There has probably been no more misunderstood group of surgeons in the United States of America than the California Association of Neurological Surgeons. And, in somewhat of a contrast, there is no neurosurgical group known to me that has worked more together to combat the great problems that struck neurosurgery first in California and then gradually moved throughout the rest of the country. We try to create an awareness of all neurosurgeons in the United States regarding malpractice insurance and various other socio-economic problems. We are looked upon as being some combination of harbingers of gloom and rabble-rousers, for agitation to expand notoriety.

But the tidal wave of multiple problems, casting itself first on our golden Western shores, has spread to the rest of America. During a decade of concerted effort with our legislators, California has carved out a sculpture of legal structure, namely the Medical Injury Recovery Act, otherwise know as MICRA. This has been tested through challenges in the courts, and finally has survived judgment of the Supreme Court of the United States. More recently, the voters of California have approved a referendum that removes the "deep pocket" concept from the maximum $250,000 for pain and suffering. This represents a great awakening of people in California regarding the financial atrocities that have been imposed upon them. It represents a defeat for the California Trial Lawyers Association, which spent a great deal of money in trying to maintain its financial interests.

Some states in our union have enacted laws to control excessive awards for so-called medical injury, but judicial reviews are placing some of these advances in jeopardy. The total thrust seems to be for a major effort to have Congress enact a law that will cover the problems in all states. This type of federal control would be counter-current to the concept of states' rights as they have previously been established. It will be a very slow process, unless there is a reverse type of groundswell from the Atlantic to the Pacific, and from the Canadian border to the Rio Grande. It will require national awareness of the issues involved. We cannot continue with the present format in which specially trained attorneys can raid the pocketbooks of all citizens, above and beyond what the country can afford. It was a relatively difficult and lonely situation for us when we physicians were out there subject to the legalistic claims of very sharp attorneys who played upon the sympathy of juries. But now, when this type of tort responsibility has spread to all of the exigencies of potential liability for counties, cities, and various units of state organizations, it becomes a much more important issue for all citizens. When the pony ride at the county fair can no longer afford liability insurance, more people come into the problem. Also, when various insurance companies decide that they do not want to get involved with liability insurance at any rate, more problems develop.

Now we are faced with clarification of all of the issues involved relative to responsibility. The tort laws need review, particularly when they are so different in different states. In California, we have developed the MICRA and it is now a matter for Congress to decide whether or not this type of program could be put into a Federal law that would apply to all states. We are being asked to write to various members of Congress in this regard, and here in California, we must be sure to keep the pressure on our state legislators so that there is no potential for reversing the great advances that have been made with the law covering the medical injury recovery. This law provides the essential benefits for those who have been injuired, and it provides just reimbursement for the attorneys who do the work in the courts. It does limit some of the financial atrocities that have been extremely beneficial to some of the attorneys involved. ■

NEUROSURGERY AT THE ANNUAL MEETING OF CMA IN AHAHEIM — MARCH 1987

Chairman of the neurosurgical program to be presented at the annual meeting of CMA during March, 1987, is Dr. Sidney Tolchin, past President of **CANS**, who has arranged presentations concentrating on dementia, with a particular focus on Alzheimer's disease. The orientation is for physicians in general, but participation by neurological surgeons is extremely important. **CANS** will have a much more prominent image in the program than previously, and this will include sponsorship of hospitality refreshments for those attending.

You are asked to look for the published program when it appears on your desk, and make every effort to attend, particularly if you are in the Los Angeles Basin area where you can make just a little extra effort to be there in a supportive fashion. It is extremely important for neurological surgeons to make themselves visible, and participate in the type of education program that has been arranged by Dr. Tolchin. ■

Editorial

HOSPITAL AND MEDICAL STAFFS

Frank P. Smith, M.D.

A recent News Release from CMA, November 10, 1986, points out the challenge for continued amicable relationships between hospitals and physicians. Dr. Phillip R. Alper of Burlingame has apparently stated that "The sense of common purpose we have known for many years does seem to be unraveling. Hospital prose increasingly seems to be written in code. It is harder to know who is doing what, and how well it is being done, let alone to what end." The inference is that hospitals are faced with economic threats to their survival, and are organizing themselves along business-like lines. This involves increased authority of managers at the expense of board members, physicians, and other clinical personnel.

This type of warning by Dr. Alper can be related to situations we see developing in some areas where one hospital is competing with another relative to what can be offered to the public subscriber for health care, and what is available to physicians if they bring patients to one hospital, rather than to the other. It does appear to be a competitive situation, and one which could destroy the role of the medical staff in effectively maintaining policies, procedures, and standards of health care.

Probably the solution is for physicians as a group to take a more active role in hospital matters, in terms of maintaining strong committee posture, as well as an active membership in hospital boards, and maintaining an image with patients for guarding the essentials in health care maintenance. We can no longer be classified and thereby divided as to which one of us does not treat Medi-Cal or Medicare patients, and we cannot continue to dodge the responsibility of accountability. We must be willing to maintain detailed hospital records, with documentation of progress notes as to just what is being done. Utilization investigators have a penchant for disallowing reimbursement because the doctors haven't put in the records just what was done, or was not done, and why. If we ultimately lose our control of providing health care, particularly in hospitals, we will have no one else to blame other than ourselves for apparently being too busy to make ourselves accountable in the appropriate hospital records in an appropriate time frame. We no longer can explain why everything was done or not done by dictating our records two or three weeks after the patient has left the hospital.

Hospital administrators want to work with physicians. They need us, and we need them. There will be some hospital health plans that will bring in outside physicians, where the local physicians will not enter into prepaid service programs. Each situation will rest on its own merits. The good ones will succeed, and the bad ones will fail, such as we have already seen in various areas. The real challenge is presented to the medical profession, to the extent that it must maintain control in providing health care services in hospitals. We physicians must be flexible and responsive, as we realize that those who are known as "people" are really those whom we have always looked up as being our patients. ■

TANCC

Donald J. Prolo, M.D.

What's TANCC? Not an armored personnel carrier! The purposes of the TRANSPLANTATION ASSOCIATION OF NORTHERN AND CENTRAL CALIFORNIA are: (1) to meet the public's need for organ and tissue donation; (2) to assure the equitable distribution of organs and tissues to all qualified transplant centers; (3) to facilitate referral of potential organ and tissue donors through a single "800" number; and (4) to comply with the spirit and intent of the National Organ Transplant Act (Public law 98-507).

The TANCC has adopted the 800-55-DONOR telephone number to cover California as far south as San Luis Obispo-Fresno. Institutions participating in TANCC include Stanford University (heart, heart-lung, kidney, cornea), UC San Francisco (kidney, pancreas, cornea), UC Davis (liver, kidney, bone, cartilage, cornea), Santa Rosa Memorial Hospital (kidney), Project HEAR (ear) and the Neuroskeletal Transplantation Laboratory (bone, dura, fascia).

With a grant from the U.S. Public Health Service, TANCC is conducting intensive two day courses at San Francisco's Hyatt Regency, Union Square. Hospitals of over 100 beds in Northern and Central California may send four nurses (all expenses paid) to learn principles and methodology and effective interaction with donor families. Since the routine inquire law (AB 631 Leonard) became effective in all hospitals in California, January 1, 1986, donorship has increased twenty percent. Neurosurgeons can facilitate their hospital's participation in this bimonthly Liaison Training Program by calling Amy Peele, R.N., 800-55-DONOR. Call this number for information or assistance in any phase of transplantation. ■

EXECUTIVE OFFICE OF CANS

Many of you recall that the Executive Office of **CANS** was originally in San Francisco, and then shifted to Sacramento, for multiple reasons, including better office facilities and staff employment potential.

Approximately one year ago, we were invited by CMA to consider moving our Executive Office to CMA headquarters in San Francisco, 44 Gough Street, in conjunction with the overall plan to bring the executive offices of multiple medical specialties together in CMA. The Board of Directors of **CANS** would like to inform you at this time that we have spent many months considering the proposition. We have made personal tours to 44 Gough Street, and we have extremely detailed proposals from executives at the CMA headquarters, all of which have been oriented to our potential needs and performance. There are a great many factors involved, much too complex to define in detail in the type of release. We want members of **CANS** to know that we continue to study various factors related to our executive office. We have a significant investment in office equipment, and we maintain very close relationships between our Officers, members, and outside agencies with our Executive Secretary. There is going to be a change in personnel relative to our Executive Secretary, but replacement with competent personnel is no problem. Mrs. Deborah Smith, who has served so effectively with us on a part-time basis for approximately four years, has an opportunity to move into a challenging position in full-time employment, and we wish her the very best. You will be hearing and seeing more about our new Executive Secretary at our annual sessions in January, 1987, at The Lodge at Pebble Beach. ■

LENGTH OF HOSPITAL STAY BETWEEN MYELOGRAM AND LAMINECTOMY

Utilization studies have raised questions about the justification for delay between the time of myelography and performance of lumbar laminectomy, so that the Board of Directors of the California Association of Neurological Surgeons has taken the entire matter under study, and after exchange of information from various sources, the following Position Statement was approved at the meeting of the Board of Directors of **CANS** on November 8, 1986.

"Myelography, an invasive neurodiagnostic procedure, provides useful information about intraspinal pathology, and complements other tests to refine the clinical diagnosis.

In certain situations, following myelography, surgery is performed on the same or on the following day. In other situations, elective surgery is deferred for several days or weeks. This permits adequate time prior to surgery to obtain additional consultations, perform appropriate studies, plan family conferences, arrange the surgical schedule and circumstances, and stabilize the patient. The decision whether or not the patient remains in the hospital between myelography and subsequent surgery must be made by the attending physician using sound medical judgment, based upon the patient's condition and need for continued acute hospital care.

It is inappropriate to write specific criteria that would restrict deviations from a prescribed routine. Good medical practice demands flexibility for determining the timing of myelography and spinal surgery.

When there is question of performance of care in any given case, there must be a review by those who are professionally qualified to give an opinion, rather than following a bureaucractic process of predetermined generic screens!" ■

ANNUAL SESSIONS - CANS • THE LODGE AT PEBBLE BEACH
January 9 - 11, 1987

Friday, January 9, 1987:

6:30 p.m. Welcoming Cocktail Party
- Pebble Beach Room

Saturday, January 10, 1987:

8:00 a.m. Continental Breakfast
- *Conference Room*

Seminar on Medical Malpractice Loss Prevention Program
NorCal Mutual Insurance Company

Review of Neurosurgical Fee Schedules Past, Present and Future
Byron C. Pevehouse, M.D.
Philipp M. Lippe, M.D.
DeWitt B. Gifford, M.D.

AFTERNOON FREE

6:30 p.m. Cocktail - *Pebble Beach Room*
Dinner - Informal

Sunday, January 11, 1987:

8:30 a.m. Continental Breakfast
- *Conference Room*

Review of Experiences with HMO's
Alan H. Goodman, M.D.

Report on the AANS Washington Committee - W. Kemp Clark, M.D.

~~Report on~~ JCSNS Questionnaire to ~~Senior Neurosurgical~~ Residents
Frank P. Smith, M.D.

Update on ~~California Medical Review, Inc. Activities~~ CNRI
George Ablin, M.D.

Economics of Medical Practice in the Future - Mr. Will Bishop

11:15 a.m. Annual Business Meeting for Members

12:00 noon Adjournment

Nominees for Election at Annual Session, 1987

In accordance with our Bylaws, the below list was sent to our members on November 13, 1986.
~~In as much as~~ no other canidates were nominated, ~~the below slate is~~

PRESIDENT ELECT:	DeWitt B. Gifford, M.D.
FIRST VICE PRESIDENT:	N. Edalatpour, M.D.
SECOND VICE PRESIDENT:	Ulrich Batzdorf, M.D.
TREASURER (2 year term):	Morris D. Loffman, M.D.
SECRETARY (2 year term):	Currently the Secretary is serving the 2 year term ending in 1988

DIRECTORS

Northern California:	George H. Koenig, M.D.
Southern California:	Edwin W. Amyes, M.D.

JCSNS DELEGATES (3 year terms)

Delegates:	Ulrich Batzdorf, M.D.	Alternates:	Sidney Tolchin, M.D.
	Melvin L. Cheatham, M.D.		N. Edalatpour, M.D.
	Frank P. Smith, M.D.		Joseph L. Izzo, M.D.
	Michael H. Sukoff, M.D.		Morris Loffman, M.D.
			Barry N. French, M.D.
			Fredrick L. Edelman, M.D.
			David N. Brown, M.D.
			Paul D. Forrest, M.D.
			Randall W. Smith, M.D.

California Association of Neurological Surgeons, Inc.
P.O. BOX 1395
ROSEVILLE, CA 95661