CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

JANUARY 1984 VOL. X, NO. 3

PRESIDENTIAL ADDRESS

WILLIAM H. WRIGHT, M.D.

In my inaugural message this year, I expressed my opinion how important it was for us to have a voice in the national neurosurgical organization which is a spokesperson for neurosurgery in the United States. Your elected representatives went to Washington, D.C. in April of this year, and at the second business meeting, with the aid of other state societies, were able to muster two-thirds majority vote necessary to change the bylaws of the AANS and again establish quadrant representation on the Board.

It appears now that even though the intent of our vote is known we are again facing staunch resistance to change by the existing Board - in fact, they have subverted our wishes by delaying establishment of quadrant representation immediately. Though there are now three at-large delegate positions open for election at the next annual meeting in San Francisco, only one of these positions on the Board of AANS will be considered as open for election by the quadrant representatives.

To understand the frustration of those who have carried forth the battle for grass roots representation on the Board, a historical review, I feel, is necessary. Many of you may not know that four and a half years ago, in April 1979, when the AANS met in L.A., attempts were made to alter the bylaws through the so-called "Loffman amendment." The changes proposed were felt to be progressive, constructive, and designed only to strengthen the association so it could be truly a leader and spokesman for all organized neurosurgery. The major problem that we perceived at that time was that there was a subtle class distinction of members, whereby it appeared that there were members whose vote carried 3-4 times the weight of others. This was because of the unique system of appointment to the Board of Directors from the standing neurosurgical societies in the United States and Canada at that time, namely the American Academy of Neurological Surgeons, The Canadian Neurosurgical Society, The Congress of Neurological Surgeons, the Neurosurgical Society of America and the Society of Neurological Surgeons. The people who had membership in these organizations could nominate a member to the Board, and if he belonged to all of these organizations, his representation was that many times greater than, say, that of a member who was only a member of the AANS and the Congress of Neurological Surgeons. It should also be remembered, however, that we had members-at-large on the Board at that time from the Southwest region, the Northeast region, the Northwest region and the Southeast region. Proponents of the new bylaws amendment were requested to compromise because the Long Range Planning Committee of the AANS was already planning a bylaws revision which would take care of all of our objections. A compromise was struck, and everyone knows what happened. Next year (1980) in New York, our reward for compromise was complete loss of all quadrant representation and a set of bylaws which centralized power again in the hands of a few, and gave dictatorial veto by the Board to any nomination offered that did not please them. It was from this background that the set of bylaws changes were drawn which were passed in Washington this year.

There have been complaints in the AANS Newsletter that the bylaw vote was unfair, since too few people were there. I actualy felt the same way. In fact, I rose to the floor and tried to have these bylaws changes mailed to all members of the Society, but this was defeated. I was amazed to see that the bylaws did pass, but I think what it does represent is not any sense of power or politics, but a real sense of feeling by those present that these bylaws are only fair and just, and because most neurosurgeons have those qualities, that and that alone is the reason the bylaw amendment passed.

Given this historical perspective, one can understand the anger and frustration of those who have carried forth the battle for grass roots representation in the national neurosurgical organization which is the spokesman for neurosurgery in the United States, to again see our efforts subverted. It was not the intent to delay this change for four years and the national leaders are well aware of this. Yet they continued to cling to their positions on the Board, even though they claim there is nothing they can do for us in such important areas as the excessive number of neurosurgeons being trained in the United States today.

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I would also like to point out to you that another one of the bylaws changes proposed on Tuesday, April 24, 1979 was in regards to annual meetings, in that, "The business meeting of the Association shall be held in two sessions, on separate days of the annual meeting, and shall be so designated in the advance program of the annual meeting." For those of you who have received the advance program of the annual meetings since 1979, you will note that on not one occasion has there been in the advance program of the annual meeting, any notification as to the items on the agenda, nor to the time and place of these meetings. I would submit to those of you in the past who have attended meetings even prior to 1979, you may well understand why such lack of information is available.

But finally, the reason the latter is somewhat important is that when you get to San Francisco in April, 1984, you will again be asked to vote on a change. On the surface, this change appears to be very democratic in nature, because it is calling for a mail ballot on all future bylaws changes which are not passed unanimously at the business meetings. I'm all for a mail ballot. I'm all for democratic participation by all members of the organization, and this is what we have fought for. However, I think you have to read clearly between the lines and understand exactly how the mechanism of this vote is going to take place, both from the standpoint of the presentation of issues, as well as the time allowed to return the vote. One needs only to read the last issue of the AANS Newsletter to understand that for the uninformed, there will be no pro and con presentation.

I look forward to seeing many members of CANS at the next AANS business meeting in San Francisco, in April 1984, regardless of your position on these issues.

EDITORIAL

The "Winds of War" In Medical Care

FRANK P. SMITH, M.D.

Major changes of a catastrophic nature do not take place because of the immediate issue. There is always a background of events leading to the critical enthusiasm that precipitates the crisis. One can find the analogy in various social revolutions in past history, or even in the major military conflagrations that enveloped the world, phase One, and then, 25 years later, phase Two. There is no way that an assassination of a royal duke in Southern Europe could precipitate a world war. This would be only the spark that would touch off the pile of tinder accumulating over a period of years. As one reviews the various conflicts involving all those engaged in medical care in the United States, one senses that we are building up various super-energized processes that are bound to explode into open warfare in the health care system.

Within the medical profession, we are faced with the continued attack of those who have been waging a long-term battle to subject medical care to an entitlement type of benefit, much the same as retirement. It is unfortunate that politicians have concentrated on free medical care, rather than free housing or free food service. Either of those could be provided on a straightforward economic basis without requiring scientific knowledge or dedicated service. When the politicians devised the Medicare program, approximately 20 years ago, doctors went along because they have always taken care of senior citizens on a reduced cost basis. This was a form of entrapment that will eventually prove to be the Catch-22 not only for the doctor, but also for the patient who really wants good medical care.

Unfortunately, the politicians have always been interested in getting elected, and they have gone along with the coalition of labor, business and the "Blues" who have decided to extend benefits above and beyond what had been arranged for senior citizens. As labor leaders gained power, they learned that most employees wanted to be taken care of by their doctor. This became a rather vague but admirable goal. The insurance "Blues" found themselves being threatened by various fiscal problems, and suddenly big business lobbyists became allies with the insurance companies in getting health care provided by an organized system which would not only control medical fees, but might also offer an incentive to those doctors who could perform some type of medical care that would not be very expensive. From all of this, we have seen the concoction of various HMO's, PPO's, and various alphabetical arrangements being provided. In general, they add up to the general concept of providing less medical care on a lower cost basis. The system has attracted private investment in terms of supporting a given program that will essentially sell a health care policy which clearly outlines in "small print," that there are various limitations in regard to "authorized medical care," and limitations in regard to the medical doctors who would be available for providing the care. The systems tend to favor development of a closed panel system of physicians who will work either on a fixed salary, with potential dividends, or a so-called "capitation" program in which the budget will allow certain fees for certain authorized procedures, and then the possibility of a dividend if the cost of the "capitation" program allows. These comments are not "scare" issues, but represent actual programs that are now in existence in many areas.

The prevailing element of doom and gloom is that the average person does not consider himself able to pay the relatively high cost of medical insurance, so that something must be done to provide him or her with protection. There are no statistics to prove that a bona fide medical insurance program is any more unaffordable to the average person than his expenditures for various other essentials in life, such as

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housing, food, and recreation, let alone clothing, cosmetics, and attending football games or purchasing a recreational vehicle or outboard motor boat. In reference to the indigent population, health care was traditionally provided by a County hospital system until the eager politicans decided that they would pass laws that would bring everyone up to the highest standard of health care. They should have known that this would only result in the total standard of health care being lowered to the level that would not even be desired by those who would ordinarily be treated at the finest County hospital level. Governmental supported health care results in a system that is no better than socialization of any other form of activity.

Out of the Federal bureaucracy in Washington, we see the program of "DRG's" coming into reality for Medicare patients, and it is entirely foreseeable that this type of formula could be expanded to cover all patient care. The theory is that something has to be done to rescue the Medicare program from its deficit spending. Certainly, the most logical first move would be to remove from Medicare benefits those who are able to pay for their own private medical insurance. Why should doctors or hospitals subsidize the medical care of people over 65 who are fully able to pay for their own treatment? This is a crucial issue that could be cited at some time later for providing a great deal of abrasiveness where inflammable issues rub incessantly, and finally end up in the fire.

There seems to be no doubt about the fact that we are really seeing "winds of war" - much the same as those that blew in the late 1930's and were apparently regrettable only in retrospect, since those who were fully capable of doing something about the nefarious breezes did nothing as a deterrant against Hitler. Now, we see the alleged "need for good medical care" serving as the juggernaut of bureaucrats in their drive to provide medical care to all people at all levels. The goal may be admirable, but the practicability advises that socialization of medical care is inappropriate in a society enjoying the total benefits, such as in the United State of America. It is difficult to conceive that this could be a precursor to similar involvement by other areas of professional and business enterprise.

Physicians and surgeons as a group do not like to "stonewall" against progress in the development of appropriate medical care. However, over a period of many years, there have been many sacrifices, individually and collectively, by families throughout this country to produce that hard-working individual known as "my son the doctor." It seems unlikely that the national grassroots feeling, and the very basic professional ambiance of physicians and surgeons will tolerate economic slavery, such as the present plans tend to prophesy. Whether the professional reaction will be in terms of an all-out "strike," or whether some type of sensible compromise for comprehensive medical care can be developed, is unpredictable at this time. There is no question that this is the critical time for physicians to rise up and present their side of the issues involved with health care. It must be a comprehensive educational process to preserve the integrity and professional standards of health care in our country, which are the highest in the entire world.

Possible Professional Liability Exposure In Reference To "Contracting" For Medical Care

Abstract of a detailed comprehensive letter submitted by Attorney David E. Willett to the Manager of Contract Evaluation and Negotiation Service of the California Medical Association indicates some very important problems that will be of concern to neurosurgeons of the State of California. First of all, it is stated that: "A carrier's refusal to authorize or pay for care which ought to be rendered, in good medical practice, does not, of itself, excuse the physician who fails to render or offer such care." It is further stated that, "That responsibility remains with the physician." It is further stated that, "Even physicians who acquaint their patient with the problem, exhausting all available administrative remedies without avail on the patient's behalf, may be sued."

The letter of Mr. Willett states that, "Even where there is no personal injury, physicians may be sued by patients who suffer economic loss because of the physician's alleged failure to work within the PPO arrangement."

There is reference to the problem of the attending contracting physicians requesting care of the patient from non-contracting physicians. It is stated that "These patients may blame their own physicians for arranging coverage by non-contracting physicians, and contend that this is a breach of their contractual responsibilities. Fee disputes foment professional liability litigation."

A final summary of the various types of "exposure" is given as follows, "A final ground of additional exposure by reason of participation in PPO efforts is anti-trust exposure. Liability on anti-trust grounds will depend entirely upon the structure of the plan, and the physician's role in implementing or overseeing its operation. Cases of this sort are just beginning to emerge, but accusations of price-fixing, boycott, attempts to monopolize, or other anti-trust violations should be anticipated."

NOTICE
New Telephone Number

The Executive Office telephone number has been changed to (916) 781-3318. Any calls placed to the previous number will be referred to the new telephone number.

JSEC Meetings In Chicago

OCTOBER 27-28, 1983

FRANK P. SMITH, M.D.

The customary semi-annual meeting of the Joint Socio-Economics Committee of the AANS and the CNS was held just prior to the Annual Meeting of the CNS in Chicago, and your California delegates, headed by CANS President, Dr. William H. Wright, included Drs. Ablin, Gifford, Lippe, F.P. Smith, and Sukoff.

In conjunction with the JSEC meeting, there is always a session reserved for the Council of State Neurosurgical Societies, with various reports from the four quadrants in which the various state societies are segmented. The opening sessions consist of caucuses by the four sectional groups, with various state representatives presenting primary problems of a socio-economic nature. Then, after a light dinner is served on Friday evening, the various quadrantic reports are given by the chairmen of each of the quadrants. We have noted each year that the problems from each quadrant do not seem to change very much. However, a new issue has developed in terms of moving forward with the change in the Bylaws of the AANS in reference to election of quadrantic representatives on the Board of Directors. Those of us who listened very patiently to the various proposals for electing quadrantic members to fill positions on the Board of Directors of the AANS were impressed with the complexities involved. It was actually impossible to gain a consensus of opinion as to how these potential members should be properly elected. Apparently it had been the assumption that each quadrant would nominate a candidate, by vote of the delegates from the state societies of that quadrant, and this would be tantamount to the candidate being elected to the Board. However, a significant group of those attending felt that a group of candidates should be named for each quadrant, and that a ballot should be sent out to all of the neurosurgeons in that quadrant, and then the final voting should possibly be on the basis of some one candidate obtaining a majority of votes. The entire process became so complicated in terms of various suggestions, that no final decision was made. It was agreed that a Committee on "Rules and Regulations" would go into special session and come up with an ultimate program for election of these quadrantic Board members. Probably an outside observer looking in would be impressed with the uniform dedication of the group to conduct a completely democratic election of members of the Board of Directors of the AANS.

The second day of the combined sessions began with early morning meetings of the various subcommittees of JSEC, and, after a coffee break, the various sub-committee reports were provided. The Treasurer's report indicated a favorable balance of assets, and then the report of the Subcommittee on Neurosurgical Manpower reviewed the experience with getting publication of the results of the national questionnaire on manpower in the Journal of Neurosurgery, namely that the paper was denied access as a scientific report, but was accepted as a "long Letter to the Editor." This seemed to be a bit unrealistic, since it was the "scientific paper" published in the May issue, 1982, of the Journal of Neurosurgery stating that the number of neurosurgeons practicing was "about right," which led to the peer review type of questionnaire. However, one cannot argue with an editorial board, particularly when the results of the questionnaire appear in the Neurosurgical Forum section of the November 1983 issue, page 911, of the Journal of Neurosurgery.

The report of the Manpower Committee was largely directed along the lines of reviewing the numbers of neurosurgical residents in training in neurosurgery, neurology, and orthopedic surgery in recent years, and slides were presented accordingly. Whereas in 1982, there were 93 neurosurgical training programs with 621 residents in attendance, in the specialty of neurology there were 124 programs with 1,276 residents, and in orthopedic surgery, there were 178 programs with 2,733 residents in attendance. These figures indicate that neurosurgical programs tend to have six or seven residents each in attendance, whereas neurology and orthopedic programs tend to have 14 to 15 residents in training at any one time. One is naturally concerned about what these residents are doing, and how much practical training they are getting, with particular reference as to whether or not they are servicing satellite hospitals where the training may or may not be appropriate.

The various other special committee reports included pertinent problems that can be studied by those interested in writing Dr. John Thompson, 2000 Blossom Way South, St. Petersburg, Florida, 33712, for a complete report. The total document occupies 135 closely typewritten pages, so that it is obvious that a brief abstract would be impossible.

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 a request for an application form to: Executive Office, California Association of Neurological Surgeons, Inc., P.O. Box 41761, Sacramento, California 95841, or telephone (916) 781-3318.

BOARD OF DIRECTORS MEETING NOTICE

The next meeting of the Board of Directors will be held on Saturday, February 4, 1984, at the Los Angeles Marriott Hotel beginning at 10:00 A.M. All Standing and Special Committee Chairmen are urged to attend.

Proposed Revision of CANS Bylaws Election of Officers By Mail Ballot

The present Bylaw, Section 4.03 states: "The Nominating Committee shall prepare and submit its slate of nominees of officers to be elected to the Secretary not less than ninety (90) days prior to the first day of the annual session . . . . . ."

It is proposed by the Bylaws Committee, with notice hereby given to the members of CANS, that Section 4.03 be replaced by the following:

"The Nominating Committee shall prepare and submit its slate of nominees of officers to be elected to the Secretary not less than ninety (90) days prior to the first day of the annual session. Not less than sixty (60) days prior to the annual session, the Secretary shall circulate the slate to the membership. Further nominations may be accepted by the Secretary up to the interval of forty-five (45) days prior to the annual meeting. Each of these nominations must have three supporting signatures of active CANS members, and written permission of the candidate for placement on the slate. At the thirty (30) day interval indicated above, ballots will be mailed to active members of CANS, and the candidate for each office receiving the majority vote of active members by mail ballot, received up to the time of the annual meeting, will be elected."

Submitted by David G. Scheetz, M.D.
Chairman of the Bylaws Committee

Annual Meeting of CANS - March 9-11, 1984

The Marriott - Newport Beach, California

Program Chairman Ned Edalatpour and Local Arrangements Chairman Mike Sukoff are putting together all of the essentials for a most interesting, informative and enjoyable meeting.

The program on Saturday morning will feature a detailed update on "DRG's," followed by a potpourri of socio-economic issues, such as uninsured colleagues, chemonucleolysis, and how to cope with Med Data in securing payment of fees. Saturday afternoon will be free for golf, tennis, or special local attractions of a nautical nature. You will be hearing more about the latter.

On Saturday evening there will be informal cocktails and dinner at The Marriott.

The Sunday morning program will feature discussion of contracting and professional affiliations, with orientation as to the various malpractice issues.

You will be receiving registration material in January, 1984. In the meantime, mark your calendar and plan to attend.

FOR MEMBERSHIP VOTING AT ANNUAL SESSION

Agenda items for the Business Meeting of CANS at the Annual Session in March, 1984, requiring voting of the membership are as follows:

NOMINEES/BOARD OF DIRECTORS

President Elect ____ George Ablin, M.D., Bakersfield
1st Vice President ___ Frank P. Smith, M.D., Monterey
(1 year term)
2nd Vice President _ Bert G. Leigh, M.D., Carmichael
(1 year term)
Secretary ____ Ned Edalatpour, M.D., Newport Beach
(2 year term)
Director _____ Paul D. Forrest, M.D., Sacramento
(3 year term — Northern California)
Director _____ Morris D. Loffman, M.D., Van Nuys
(3 year term — Southern California)
Consultant _____ Philipp M. Lippe, M.D., San Jose
Historian _ Byron C. Pevehouse, M.D., San Francisco

NOMINEES/DELEGATES TO CSNS

Delegate Nominees (3 year term)	John R. Clark, M.D. Frank P. Smith, M.D. Philipp M. Lippe, M.D. George Ablin, M.D. Michael H. Sukoff, M.D.
Current Delegates	David G. Scheetz, M.D. William H. Wright, M.D. DeWitt B. Gifford, M.D. Randall W. Smith, M.D. Paul D. Forrest, M.D.
Alternate Delegate Nominees (3 year term)	Douglas M. Enoch, M.D. Ulrich Batzdorf, M.D. Morris D. Loffman, M.D. Ned Edalatpour, M.D.

NOMINEES/CMA HOUSE OF DELEGATES

(2 year term)

Delegate	George Ablin, M.D.
Alternate Delegate	Sidney Tolchin, M.D.

Douglas M. Enoch, M.D., Chairman
Nominating Committee

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.

How CANS Provides Neurosurgical Peer Review

The Bylaws of CANS provide for the presence and actions of the Professional Relations and Peer Review Committee under Section 7.06-8. The Board of Directors of CANS has outlined the procedural steps, abbreviated, as follows:

1. Once CANS receives a request for peer review of a neurosurgeon, the Peer Review Committee Chairman may approve the proposed review.

2. In reaching his decision, the Peer Review Committee Chairman will keep in mind that other local review mechanisms should have already been employed and exhausted, and that usually the problem for review is not in litigation at the time.

3. The Chairman will then select two impartial neurosurgeons with some practice experience, one in private practice and one in academic practice, who will work as a review team. The CANS itself will not participate in the review as an organization, but rather as a resource and selector of the review team. The neurosurgical review team will become part of the Peer Review Committee of the hospital concerned, or of the medical society, or other requesting organization, and will function as an assigned arm of the local organization or institution.

4. After appropriate arrangements, the neurosurgical review team, as part of the local review committee, will interview those who wish to be interviewed in this regard, as well as the neurosurgeon under review. The latter will be allowed ample time to express his views, and have his attorney available as may be desired.

5. The neurosurgical review team may then request and review as many additional details as it feels needed in charts or other sources. Thereafter, the team deliberates individually and in consultation, reaching a consensus in evaluation and in making recommendations.

6. The written summary is then sent to the chairman of the local peer review committee of the requesting institution or organization for consideration, implementation or modification.

7. All material developed in the course of this review is kept confidential thereafter.

N. Edalatpour, M.D.
Chairman of Peer Review Committee

Suggestions For CANS Members

1. Send to the Chairman of the CANS Nominating Committee, Douglas M. Enoch, M.D., the names of any members you would like to have considered for nomination to the state of Officers and Directors of CANS, to be elected at the Annual Meeting, March 10, 1984.

2. Write to your U.S. Senators and Representatives as to how you feel about Federal involvement in "Baby Doe" matters.

3. Check with your malpractice insurance carrier regarding your coverage before becoming involved in peer review, with a PPO or similar group. AB 1516, the "Lippe Bill," passed recently, will provide immunity, after January 1, 1984, against lawsuit resulting from peer review under auspices of a medical specialty society. Eligibility for such immunity is dependent upon the specialty societies having as members at least 25% of the eligible physicians in the geographical area it serves.

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