

CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

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PRESIDENT'S MESSAGE

David G. Scheetz, M.D.

A TIME FOR CHANGE—Change comes with each day, whether we as neurosurgeons choose to accept and adapt to or reject and ignore it. If we move too quickly in a new direction, we may be seen as radical. If we are too slow to change, we are not considered current. The "golden mean" is ever to be maintained.

A current problem, as seen by the California Association of Neurological Surgeons (**CANS**), is the effort to continue to practice quality neurological surgery in today's climate of criticism. This criticism comes from governmental agencies, third party carriers, the legal profession, surgical colleagues, and even from patients.

The rewards of our practice are changing with each new external force. One unchanging reward remains in taking time to hear the words of the patients and their families.

When should we allow a change in our patient referral pattern? In the past, our patients have been screened by referring physicians, saving the patient the cost of an inappropriate consultation as well as our time in a busy practice.

The current views of **CANS** members ranges from strict physician referral to an open door policy. With an open door policy, patients frequently refer friends and relatives with similar complaints, allowing marginal problems to be seen. This may or may not be fruitful for the patient and/or the neurosurgeon.

A similar non-physician referral source may be chiropractors, nurses and physical therapists. Second opinions sought by insurance carriers, patients, and attorneys (seeking opinions to fit their need) are in vogue. This new referral source must be a wave of the future.

Our surgical colleagues are increasingly encroaching on many areas, once considered to be primarily neurological surgery. This impingement on our "turf" requires that we change our concept of everyday neurosurgery.

Sixty five percent of the patients seen in a general neurosurgical practice have pain in the cervical and lumbar spine regions. Thirty percent have

secondary neurosurgical complaints, five percent have complaints of true neurosurgical interest.

If one practices only to clip aneurysms or excise intracranial neoplasms, he will be frustrated by this referral pattern. Our continuing challenge is to meet the needs of the public within the framework of the neurosurgical expertise. We have the ability to evaluate these problems from a neurological surgeon's viewpoint and to offer the most conservative, and most effective regimen of care, with consideration of cost effectiveness.

New diagnostic and operative ideas are of concern to members of **CANS**. Where can we learn about and develop the skill to use new neurosurgical techniques? CME credits to answer this need are available through our teaching centers. **CANS** is considering the development of small informal meetings to expand our neurodiagnostic and neurosurgical skills.

When and how can neurosurgeons advertise their own expertise and specific interests? The marketplace will determine who shall see patients in the future. A schedule of our interests made available to other neurosurgeons and referring physicians would be an acceptable initial step to the maintenance of our practices. Don't be afraid or unwilling to refer a patient to a colleague more skilled in a given procedure.

Developing a network of intraspecialty referrals in California will offer a visible response to infringing surgical specialties and to increasingly impinging government controls.

While we have been guarding the front door of direct fee regulation, control has been slipping through the side door in the form of Workman's Compensation and Medicare fee control. We are facing total financial control of neurosurgical practice at this time.

The private practice of neurosurgery is heading in a new direction, whether it is working in groups or as employers of an existing and yet to be developed health care organization. Only a few will be able to maintain large practices as more neurosurgeons enter the field. Will an area/population quota, as developed and present in Canada, be considered?

We are faced with an increasing number of problematic changes in the field of neurological sur-

gery. These are not of our choosing and may tend to interfere with the enjoyment of our chosen profession.

Now is the time for us to unite and work together to maintain the quality of patient care we have strived so hard to achieve. With unity and purpose, we can regain satisfaction in our profession. To paraphrase the Bard: "Without pleasures in one's labor, there is no profit".

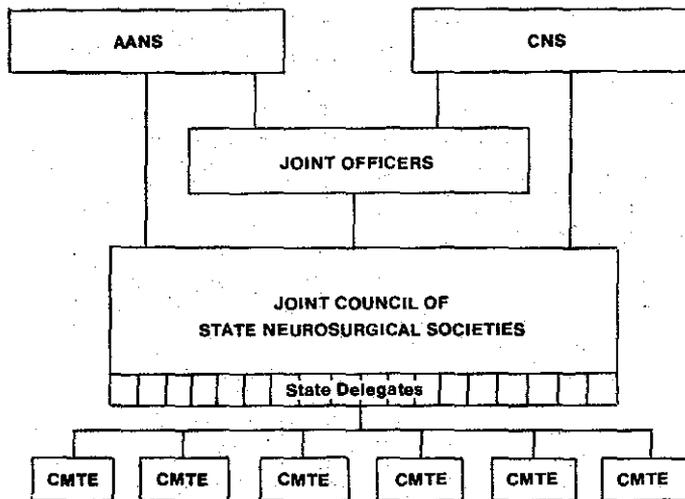
SOUTHWEST QUADRANT AANS DIRECTOR REPORT

Sidney Tolchin, M.D.

AANS Board of Directors Meeting in Chicago June 15-16, 1984

A special meeting was called by President Goldring to respond to the request of the JSEC Committee resolution of April, 1984, for revision of the status of JSEC and CSNS. A plan was proposed for the formation of a Joint Council of State Neurosurgical Societies (JCSNS) responsible to both parent groups, the AANS and the CNS. Rules and regulations for the structure of the new organization were approved. There was minority concern on the part of each Quadrant Director that a great deal of work will be required in setting up each committee under the guidelines of the accepted rules and regulations. (See Diagram)

Joint Council of State Neurosurgical Societies



Other JSEC resolutions presented to the Board in April, 1984, were reviewed. The survey of Senior neurosurgical residents was referred back to the Manpower Committee of JSEC for further discussion. The issue of monitoring the quality of care under DRG's was referred back to subcommittee to develop a method of monitoring. The chymopapain issue was referred to the Joint Section on Spine. Each of the resolutions of the Ad Hoc Committee on Trauma regarding involvement of neurosurgeons in relationships with intensivists, on bypass of certain hospitals and on implementation was referred to the Joint Section on Trauma.

Sessions of JSEC and CSNS, in New York City September 28-30, 1984

Following the usual Quadrant Caucus meetings and various Subcommittee parlays, summaries of the deliberations were presented to the general sessions. These included: problems in the economics of HMO's, proprietary hospitals, PPO's and the effect of DRG's with consideration based on aggressive marketing and acquisition techniques of hospital systems; a discussion of subspecialty PPO and possible entities of National Neurosurgical PPO for bargaining; the effect of DRG's for physicians; appointment of a nine member Ad Hoc Committee to consider non-conventional actions to alleviate professional liability; the unacceptability of no neurosurgical involvement in establishment of guidelines having economic impact on neurosurgery; the concern of Australian neurosurgeons regarding future potential migration of American neurosurgeons to Australia; the Florida experience with the Hospital Cost-containment Board and Rate-setting Commission; the Pennsylvania Cost-containment report by Blue Shield suggesting that reduction of the number of physicians licensed in the state was a key to cost control and the California Supreme Court establishment of Constitutionality of structured payment awards.

Resolutions passed at that meeting included: Cognitive services associated with surgical practices should be recognized and compensated. The activities of the Washington Committee were discussed by Mr. Charles Plante who noted that he did not expect National legislation to help with professional liability problems and that this action would have to occur at a state level. He also noted that stroke centers have been reduced from 18 to 9, but soon would increase up to 14. Dr. Mark Kubala provided interesting facts: in 1982, health care was 322 billion dollars for 10.5 percent of Gross National Product. Hospital costs accounted for 41.2 percent of the total and physician services 19.1 percent. The physician share of total health care costs had declined from 72 percent in 1932 to 17 percent in 1982. Mr. Louis Orsini presented the insurance industry perspective that between 1980 and 1982 health care costs to every employer had doubled. He noted that the hospital industry had made a profit of 4.5 billion dollars. Sheila Burke of the Finance Committee of the U.S. Senate stated that 30 million Americans were covered by Medicare. Unless considerable changes occur, the program would be insolvent in the next ten years.

AANS Board of Directors Meeting in Chicago December 8-9, 1984

In reference to resolutions submitted from JSEC, the Board approved a resolution opposing lump sum payments to hospitals that would include physician reimbursement. A resolution regarding misuse of documents establishing guidelines by Blue-

Cross/Blue Shield in Massachusetts was not accepted by the Board. A Manpower resolution that "a Program Director should require the passing of the written examination of credit prior to issuing a certificate of completion" to a neurosurgical resident was submitted for review to the Residency Review Committee and the American Board of Neurological Surgeons. Matters included attempts at resolution of the JSEC meeting-time conflict with Board meetings so that Quadrant Representatives would have adequate exposure to the JCSNS deliberations. A discussion as to a possible dues change was held. It was noted that most of the Joint Sections assess their own dues and that, in essence, additional dues are already being extracted by these means. Tentative meeting sites were established for Toronto in 1988 and Washington D.C. in 1989; the Joint Section of Sports Medicine was not approved. The establishment of a Joint Military Liaison Committee was approved with unlimited membership for active or reserve military neurosurgeons who would receive their appointment by application. An outside firm will not be hired by AANS at this time for Public Relations. Dr. Clark Watts presented an update on chemonucleolysis. He noted that Collagenase was removed from even investigative approval by the FDA and that approximately 85,000 procedures had been performed using the Smith product in the United States, accounting for one-half of the world experience. He noted that the initial 10,000 units per month sold initially had dropped to a current 3,000 units per month. Based upon this report, the AANS will request additional data covering the two years of use of chemonucleolysis.

NEUROSURGICAL PROGRAM

at the

CMA — SAN DIEGO MEETING

March 8, 1985

Moderator: George Austin, M.D., Santa Barbara

8:35 a.m.

Giant Intracranial Aneurysms

Posterior Fossa Aneurysms

Both by Thor Sundt, M.D., The Mayo Clinic

9:30 a.m.

Nuclear Magnetic Scanning in Strokes

N.M.I. Spectroscopy in Neurologic Science

Both by William Bradley, M.D., Pasadena

10:35 a.m.

Balloon Embolization of A-V Malformations

Balloon Embolization of Giant Intracranial Aneurysms

Both by Grant Hieshima, M.D., Los Angeles

EDITORIAL

FROM CAMELOT TO CAVEAT

Frank P. Smith, M.D.

The transition that we are seeing in the practice of medicine might strike one as being quite similar to the denouement of the idyllic life of King Arthur and his Round Table, as described by Alfred Lord Tennyson. He stated that "The old order changeth, giving way to new." There was the allegorical tossing of the sword Excalibur into the waters, hopefully to be retrieved by some knight in shining armor in the future, directed to set things right anew and ultimately find the Holy Grail.

The exalted knights of King Arthur's Round Table reached a level of chivalry to be admired for ever after. But the Camelot culture succumbed to the exigencies of everyday life that have a way of cyclic repetition. Now we physicians are faced with the very stringent limitations being imposed by a triumvirate of forces. The time has come when the Blues, the labor unions, and the business interests have all collaborated, convinced that they must arrive at the ultimate of cost containment. They have a crusade to provide the image of medical care at the least possible cost to all population groups. However, the main pillars of this alliance do have some divergent concepts. The "Blues" want to balance their budget, whereas the labor unions couldn't care less. Business interests are cruising at a higher level, willing to collaborate with various types of so-called "medical providers" or preferred units of various types who present contractual possibilities. Apparently a corporation faced with the concept of providing total medical coverage for employees can hire an expert who will design a total package for health care. It can be that simple on the surface. We see that company stockholders don't seem to complain, and business executives may make general medical facilities available to themselves, or they may resort to some private clinic in more or less of a "two tier system." The latter is the type of system that has developed in England.

The advances made by HMO's, PPO's and other alphabet arrangements have become accepted, and even advanced, by the Federal system. Medicare and Medicaid-MediCal have come up with hospital admission criteria that could eventually become the formula for all private health insurance programs. Things are really on the move. We do see a real problem developing for the so-called consumer of this total health care, in that most people do not realize how the various efficiency organizers are playing around with the delicacy of total health care. Moves for cost containment may require omission of relatively high standards that ordinarily would be deemed essential in health care. Because of this, there is a definite caveat — a warning that is not very much different from the alert provided by Paul Revere on horseback. In this case, the cry would be that "The Feds are coming!" There seems to be no doubt that the drastic changes could seriously ham-

per, if not almost destroy, the quality of health care as we have known it in the United States. It is not easy to make this known because of the political expediency enjoyed by most national figures in their desire to gain votes by endorsing this concept of availability of total health care.

Federal funding of health care for the indigent was probably necessary when state and county sources failed to meet the issue. However, the poorly designed Medicare program initiated in the late 1960's led to a series of problems which have become so compounded up to the present time that many "catch-up" items are being introduced in a stop gap type of activity. It was interesting that prior to the Medicare programs, doctors were taking care of senior citizens who could not afford to pay, and those senior citizens with adequate resources and insurance programs took care of themselves without the need for any governmental subsidy. The Medicare program, initiated for political expediency, served to ruin the entire process. In reality, politicians sponsored a project that they really couldn't afford, on a long-term basis. Even in a Camelot medical world, Merlin himself could not design the magic to cover the political goals, and certainly even Sir Lancelot would not be able to use Excalibur to slay all of the dragons arising in the political health care system.

Hopefully, in our medical profession, we have the potential wisdom and strength to re-evaluate all of the issues facing us as practicing physicians. We must stand on the line of combat and present our expertise to the national entrepreneurs who would be willing to sacrifice most any standards in order to achieve budgetary balance. Unfortunately, we doctors have been too busy taking care of our patients, so that we have not paid enough attention to the important socio-economic development. Our scientific goals have kept us somewhat aloof from the mundane issues of the day. Now there is a great need for action and organization to provide appropriate health care at an affordable level. We physicians must take part in this organization of a framework that will provide health care at the highest professional level. We must have a system that will be attractive to the best minds of those coming after us, who will take our places in providing medical care.

CANS ANNUAL SESSION

Silverado Country Club
Napa, California

March 22 - 24, 1985

Mark your calendar
and plan to attend.

Details of program and reservations
are coming.

CANS NOMINATING COMMITTEE REPORT

William H. Wright, M.D., Chairman

The Nominating Committee, consisting of Dr. William Wright, Chairman and members Drs. Ulrich Batzdorf and John Clark met via conference call Tuesday, December 11, 1984, at 7:00 A.M. The following members of CANS were nominated for the positions as listed herein. All nominees were contacted and have agreed to serve in these positions.

One Year Terms

President-Elect..... Frank P. Smith, M.D.
 First Vice-President..... Melvin L. Cheatham, M.D.
 Second Vice-President..... DeWitt B. Gifford, M.D.

Two Year Term

Treasurer..... Michael H. Sukoff, M.D.

Three Year Terms

Director, Northern California - Gerald D. Silverberg, M.D.
 Director, Southern California - William O. Wild, M.D.

Delegates to CSNS:

DeWitt B. Gifford, M.D.
 David G. Scheetz, M.D.
 William H. Wright, M.D.

Alternate Delegates to CSNS:

John P. Slater, M.D.
 Frank P. Smith, M.D.
 Melvin L. Cheatham, M.D.

Further nominations may be accepted from CANS members by the Secretary up to February 8, 1985. Each nomination must have three supporting signatures of active CANS members, and written permission of the candidate for placement on the slate. Send nominations to the Secretary, Dr. N. Edalatpour, care of CANS Executive Office.

SKI ALERT

U.C. Davis - Tahoe Neurosurgical Ski Conference

February 7-10, 1985

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| Accommodations and Conferences: | Harvey's Resort Hotel South Lake Tahoe |
| Skiing: | Heavenly Valley |
| Welcoming Cocktail Party: | February 7 |
| Paper Presentations: | February 8 and 9 7-9 a.m. and 5-7 p.m. |
| Skiing: | February 8 and 9 9:30 a.m.-4:30 p.m. |

Special events include a dinner cruise on the "Tahoe Queen."

**Call Harvey's Resort Hotel for reservations
(702) 588-2411.**

Send paper abstracts to:

Dr. Barry Chehraz

U.C. Davis Medical Center

4301 X Street

Sacramento, California 95825

— Call Dr. John B. Harris (916) 541-8222 regarding details. —