CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

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PRESIDENT'S MESSAGE

Melvin L. Cheatham, M.D.

The **California Association of Neurological Surgeons** remains committed to maintaining the highest possible standard of neurosurgical care for people of the State of California. At the same time, we continue our efforts in dealing with matters of socio-economic importance of our members and the patients they serve.

California has the largest peer review organization (PRO) in the United States, the California Medical Review, Inc. (C.M.R.I.). **CANS** maintains a strong working relationship with C.M.R.I. and has been able to monitor its peer review activities so that neurosurgical review is usually done by a neurological surgeon recommended by **CANS**. Efforts by our state PRO to modify standards of neurosurgical care into administrative DRG molds have been resisted by **CANS**. With active, firm and proper pressure, we have been successful in reversing the attempt to force admissions for myelography and subsequent admission for laminectomy into a single DRG admission and charge.

CANS has been very active in the policymaking process of the California Medical Association. Members of the **CANS** leadership sit with the specialty delegation of the California Medical Association, which is made up of some 25 medical and surgical specialty societies that are organized in our state. During the past annual meeting of the California Medical Association, 10 resolutions were submitted through **CANS** of which 8 were accepted as CMA policy.

CANS, working through the California Medical Association, is working to defeat the proposal to include physicians (radiologists, anesthesiologists and pathologists) in DRG payments. Strong efforts are also being undertaken to seek legislative and/or judicial relief for physicians (including neurological surgeons) from the unfair and inappropriate Medicare regulations regarding "maximum allowable actual charges" (M.A.A.C.)

In reference to the problem of manpower, **CANS** has been very much interested in and supportive of the official position taken by the California Medical Association. This position acknowledges that there is an overall surplus of physicians in the United States, but recognizes a continuing problem of maldistribution of physicians in inner cities and rural areas. **CANS** has exhibited a special interest in trying to maintain and preserve the "turf" of the neurosurgeon in our state against threat of encroachment by other specialty groups.

CANS is also working to contain the costs of professional liability insurance by holding risk prevention seminars as part of our annual membership meeting. Furthermore, it is our intent to explore ways to try not only to "hold the line" on professional liability rates but, if possible, to effect reductions by assisting members in identifying ways to avoid problem areas which may result in claims.

The threats and problems facing us as neurosurgeons have never been greater. Traditional health care delivery is under attack and each of us as individual physicians is being threatened. Our one chance for putting the best possible face on the future of the practice of neurosurgery is to work within the framework of the Joint Council of State Neurosurgical Societies.■

NEUROSURGICAL SECTION OF CMA ANNUAL MEETING PROGRAM

The neurosurgical section of the Scientific program at Anaheim, CA in March 1987 featuring various factors of dementia gained the highest attendance on record. Program Chairman for this was Sidney Tolchin, M.D.

Neurosurgery will be represented again at the Annual CMA Session to be held March 4 - 9, 1988 in Reno, Nevada, "the biggest little city in the world." A program on the diagnosis and management of cerebrovascular disorders in being formulated by W. O. Wild, M.D., Program Chairman. Further details will be provided at a later date. We hope to see you in the future.

POSITION ON MYELOGRAPHY AS APPROVED BY THE BOARD OF DIRECTORS OF CANS

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 consulations, 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 judgement, 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 a 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 bureaucratic process of predetermined generic screens.■

KUDOS FOR CANS MEMBERS

George Ablin, M.D.

New member of the Board of Directors of CMRI. Recently elected to be a Councilor for CMA.

N. Edalatpour, M.D.

New member of Advisory Panel on Neurosurgery for CMA and Program Chairman in 1990 for Neurosurgical section at the CMA Annual Meeting.

Philipp Lippe, M.D.

Elected Southwest Quadrant Director of AANS. Benjamin J. Cory Awardee of the Santa Clara Medical Society as exemplifying "forward looking, pioneering ideas, enterprise, enthusiasm, and prolonged professional stature and ability.

Check the 1985 Directory, if your picture is not there please send us one. (Black and white, 4" x 5", upper torso and head only.) Please note any corrections and let us know that as well.

CANS POLICY ON DIAGNOSTIC STUDIES IN SPINAL SURGERY

The diagnosis of spinal disorders is established by the clinician utilizing the patient's history, the physical examination and appropriate tests. The tests that are frequently used include plain spine radiographs, CT scans (with or without contrast injection), myelography and magnetic resonance imaging (MRI). Each test has inherent advantages and disadvantages which must be weighed against the patient's particular problem. No single test can be considered as routinely done "first" or as a "screening" test for every case.

The decision as to which test(s) to order can only be made, ethically and legally, by the clinician who is attending the patient based upon his or her personal medical knowledge of the case. Any "requirement" by an indemnifying agency that a certain diagnostic test **must** be done, constitutes the practice of medicine by an unlicensed party and is proscribed by the laws of the State of California.

Adopted by the Board of Directors of **CANS**, May 16, 1987.■

POLICY ON SEQUENTIAL ADMISSIONS FOR MYELOGRAPHY AND LAMINECTOMY JUNE 10, 1987

John T. Kelly, M.D., Acting Medical Director, CMRI

CMRI recognizes that there are variations in the standard of medical practice throughout the state and has recently implemented a policy clarifying that myelography and laminectomy may be considered staged procedures. Thus, in situations in which patients are admitted on an inpatient basis for myelography, discharged, and readmitted for laminectomy, each admission will be reviewed separately regarding the indications for the procedure and the necessity for inpatient care. If myelography is necessary and inpatient hospital admission is necessary for the performance of the procedure, the admission will be approved. If laminectomy is indicated the admission will be approved for reimbursement whether the laminectomy is performed during the same hospital admission as a myelogram or during a subsequent hospital admission.■

EDITORIAL

IS THERE WISDOM IN MERGING AANS AND CNS?

Frank P. Smith, M.D.

At the 1974 annual meeting of **CANS**, which was an S.F. Airport fly-in, one day session, the guest speaker, Dr. Paul C. Bucy, eloquently expounded the concept of merging the American Association of Neurological Surgeons with the Congress of Neurological Surgeons. He commented on the broad overlap of membership in the two organizations, and the weaknesses related to a dual approach to problems relating to neurosurgery of the future. Some now would say that he was extremely clairvoyant then.

It would be difficult for the two organizations to think of either one losing its identity and more pertinently its hierarchy, but a merger for strength could be beneficial for all. The two scientific journals could be maintained as separate entities, and the clinical teaching programs of the Congress could be continued as interim sessions, similar to the format of the American College of Surgeons. When the Congress of Neurological Surgeons was formed decades ago, there was a need for a national forum for neurosurgeons not Board-certified. But now that has changed, as the American Association of Neurological Surgeons has invited all neurosurgeons to its meetings, and its membership requirements could be changed further in the future. Another important change has been the development of state neurosurgical societies, which should attract the participation of all neurosurgeons, since so many important issues must be faced regarding the formulas differing in different states. Ultimately the two factors looming in the future that justify a hard look at merging the two organizations into one, strong neurosurgical unit relate to the so-called "marketplace." First, the new income tax law is going to curtail a formerly generous write-off schedule. Secondly, the decreasing net income of physicians is going to make them more cautious about spending $1,500 or $2,000 or more on a medical meeting. The tab will be borne more by the doctor than by Uncle Sam. The financial pinch is foreseeable.

Certainly orthpedic surgery has thrived with its one strong Academy of Orthopedic Surgeons. In fact, some think they have clobbered us in spinal surgery, while we have worked hard to forge decisions in liaison between the AANS and the CNS.

It would be foolish to expect an early "friendly takeover" or the loyal aspirants of the AANS or the CNS to rush into an alliance that might dim future personal prospects. But we should expect some wisdom of our leaders in anticipating what is best for neurological surgery at a national level in the future. Alfred Lord Tennyson said that "The old order changeth, giving way to new." We may find this developing for neurosurgery, as it did for Camelot.

ABSURDITY IN MEDICAL SOCIO-ECONOMICS

Michael H. Sukoff, M.D.

The absurdity that characterizes today's medical economics has never been greater. Two decades ago the medical profession was given a mandate with the words and finances to elevate standards and results of health care. Our success has been clear and dramatic. 1986 statistics reveal significant improvements have increased. There has been a marked decrease in deaths from cardiovascular disease and our ability to treat both infections and trauma has been greatly enhanced.

The medical community has been rewarded for these remarkable efforts by a penalty; a new breed of so-called medical economists has decided to both limit and control our fees. There has also emerged a large group of medical entrepreneurs who are utilizing the "competition concept" given to them by the government to create the age of "corporate medicine." Fundamentally this means undermining the independence of physicians and causing them to be employees of those that would administrate them; and requiring them to reduce fees. No one has demonstrated any benefits to the patient.

The essence of all these activities is clearly financial. Treating sick people generates large sums of money. Those incapable of being termed "health providers" seek other means to become financially involved; a form of parasitism. The federal Goverment, gargantuan insurance industry and their hirelings have declared, and insist that all agree, that too much money is spent on medicine. Many in our profession concur.

The specific neurosurgical interaction with all this has been clear and overt. We have utilized the funds made available to develop and propogate the current state-of-the-art neurodiagnostic and therapeutic modalities. Neurosurgeons have made their contributions to the greying of America and have been rewarded with a penalty; restrictions of their freedom and fee structures.

How shall we respond? Those of us with the capacity to tolerate the politics of medicine must maintain our interest, insight and influence in that regard. The all consuming problems of medical malpractice must be battled by our Societies. With the direct and active support of all neurosurgeons, they can be successful. Equal representation of community neurosurgeons with those primarily involved in academics is a requirement for both scientific and socio-economic organizations. Excessive numbers of physicians in all specialties not only undermines each one from a quality standpoint, but allows all of them and their patients to be controlled by federal and corporate elements. Neurological surgery will be severely undermined and reduced as a profession along with the remainder of medicine if remedies to the current absurdities are not enacted. We are obliged to support and encourage our societies to be fully representative of all neurosurgeons, restrict the number of neurosurgical trainees, require tort reform and the avoidance of rationing health care.■

BILLING TECHNIQUE SEMINARS

The first seminar on billing technique for members and their office staff will be presented by **CANS** on Saturday, **October 10, 1987**, prior to the American College of Surgeons Congress in San Francisco, at the **Ramada Renaissance Hotel**.

CANS is preparing these seminars as a service to its members with the anticipation that the information presented will aid billing procedures. Presenters include Blue Shield, Blue Shield Medicare Liason, CMRI, CMA, Medical Bureau-Division of Industrial Accidents. Mark your calendar and plan to attend. Details, agenda and registration forms to be mailed later.

A second seminar will be held January 15, at the Ritz Carlton Hotel in Laguna Niguel for the convenience of our southern California members.■

Your Letters Make a Difference!

Write to your Congressman and Senators if you oppose legislation for DRG payment for physician care.

SOCIO-ECONOMIC SURVEY

Philipp M. Lippe, M.D.

CANS is in the process of sending its annual socio-economic survey to neurosurgeons in California. This will be a more extensive survey than in years past, and will include professional liability and reimbursement. You are urged to take time to complete the survey and return it promptly. It is appreciated that this will require a certain amount of effort and time, however, the information is vital for maintaining a proper perspective in socio-economic matters.■

ANNUAL MEETING OF CANS

The Ritz Carlton Hotel
Laguna Niguel, California
January 15 - 17, 1988

Make your plans **now** to attend,
for a great program
at a super place!

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