CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

JUNE 1982 **VOL. IX, NO. 2**

PRESIDENT'S INAUGURATION MESSAGE

The impetus for the formation of the California Association of Neurological Surgeons was the malpractice crisis of 1974. However, I suspect that CANS would have evolved regardless, because the leadership of this association in many other problem arenas is sorely needed and has become fundamental. CANS has been instrumental in the restructuring of the AANS and nurtured the Council of State Neurosurgical Societies: endeavors which will result in better "grass roots" representation for practicing neurosurgeons nationwide.

From chairman of the Socio-Economic Committee through a long stint as Secretary, to Vice-President and President-Elect, I have had eight years of close working relationship with the leadership of CANS. I have observed this organization change and conform to face disparate tasks and challenges with a flexibility that accomplished the goal efficiently and accurately. This ability to be pertinent in structure is part of the strength of CANS.

But the greater revelation has been the observation of the "Minute-Man" qualities of the men that compose that leadership of CANS. Neurosurgeons come on the Board or on Committees, display brilliant insight and work products, then step back into the "ranks", only to be replaced by men of similar calibre. This is the real ground-rock strength of CANS. Involvement in the workings of CANS by each member is vital. Neurosurgery remains a minority discipline and all should be participating in some capacity in our only socio-economic bulwark. Sometime during this year a CANS committee or service could and should play a role in helping your neurosurgical practice.

Besides her "Minute Men", CANS has been fortunate to retain ongoing counselors as well. They provide the very necessary continuity of in-depth knowledge which derives only from tenure and experience. Many of them have attained CMA and national organization stature, which enhances the effectiveness of CANS. In turn, CANS has provided some of the foundation for their positions.

This year we will again face old enemies of inadequate and tardy reimbursement for our services; a reborn malpractice crisis looms ahead but this time without the buffer of the large monetary reserves of the former insurance carriers. And in the thicket of medical manpower overabundance, the turf battle will become more acute. Soon chymopapain will be released for general use and orthopedists are trained to utilize it. Further, orthopedists are urged to "take over" spinal trauma altogether and increase their hold on peripheral nerve surgery.

Vascular surgeons now wish to stake out carotid endarterectomy and vertebral artery surgery as their exclusive domain by means of forming a certifying board. In some locales brain tumors are managed by oncologists and radiologists.

Finally, a great movement is afoot to direct trauma victims to just a few chosen "Centers". Will all neurosurgery, as we know it, be similarly concentrated in a few such centers?

These threats can be faced effectively by an all-inclusive society of California neurosurgeons, welded into a structured, cohesive unit with common direction, called CANS. Recall once again that neurosurgeons represent but 1% of the M.D.s in this State.

CANS impact is being felt; Blue Shield, Workmen's Compensation, and other intermediaries increasingly seek our opinion. Peer review and the standards of neurosurgical practice form the subject of more and more CANS deliberations as new mechanisms for liability immunity are found.

Our Member Services Committee concerns itself with the socio-economic factors, continuing medical education, and manpower. The Community Relations Committee is our liaison with the media, hospitals, legal profession, government, and the lay public. The Professional Relations and Peer Review Committee is instrumental in helping members with professional conduct and competence problems, court testimony and the curse of the professional witness.

We have Special Committees on Emergency Medical Services, a task force on Medi-Cal reimbursement, and ad hoc committee on peer review mechanisms, and others that form as the challenge arises.

Our members are Councilors of the CMA, on the Board of Directors of the AANS, and serve on scientific panels to include the Scientific Advisory Panel to the CMA. CANS sits the largest delegation to JSEC and CSNS of the AANS-CNS national organizations.

Input and involvement comes through working with and on these committees or publishing in the Newsletter. Committee membership is not exclusive—it just requires desire and work.

In sum, everyone should get involved. We must work as a team. WE, as neurosurgeons, are a minority in troublesome times. I humbly seek your help in this year ahead. Edmund Burke, writing in April, 1770, concluded thusly: "When bad men combine, the good must associate; else they will fall, one by one, an unpitied sacrifice in a contemptible struggle."

Douglas M. Enoch, M.D.
President

BOARD OF DIRECTORS MEETING NOTICE

The next meeting of the Board of Directors will be held on Saturday, August 7, 1982, at the Marriott Hotel, Los Angeles Airport, beginning at 10:00 A.M. All Standing and Special Committee Chairmen are urged to attend.

ANNUAL MEETING OF CANS 1983 THE LODGE AT PEBBLE BEACH

At the recent meeting of the CANS Board of Directors, the consensus was against having our next annual meeting at an airport hotel. We have been most fortunate to secure reservations at The Lodge at Pebble Beach for February 25 - 27, 1983. The accommodations at the Lodge are unsurpassed, at a competitive rate. The meeting facilities are excellent, and there are outstanding opportunities for touring areas such as Carmel and Cannery Row, to say nothing about the top level tennis and golf available.

The general format will be for arrival on Friday, February 25, 1983, with a welcoming cocktail party and dinner at the Beach and Tennis Club, overlooking the beautiful Stillwater Cove and adjacent Pebble Beach Golf Links. This will replace the noon luncheon meeting. Program Chairman, Paul Chodroff, will arrange the meeting sessions, allowing time for R. and R.

Reservation forms will be mailed to you early, so that they may be returned to The Lodge two months prior to arrival. Start making your plans now. There will be an opportunity for some to gain an early arrival, or stay on a day or two longer. This promises to be one of the finest meetings of our association, and we look forward to the best attendance ever.

BE CAREFUL ABOUT A "HOLD HARMLESS" AGREEMENT

As more and more doctors are going to be approached about signing with a total care HMO program, it becomes increasingly important for each physician to ascertain if and how his malpractice insurance covers him. He must check his own policy.

An analysis of the issues, presented to the CMA Committee on Occupational Health, is reported as follows: Physicians "currently face a potential lack of insurance coverage due to the existence of two exclusions in most, if not all, malpractice policies presently available. They may conveniently be referred to as 'contractural' and 'administrative' liability exclusions. An understanding of both is necessary in order for physicians to properly transfer or avoid liability in these areas which is not covered by the physician's own malpractice policy.

Most insurance policies exclude coverage for any liability the physician assumes under a contract or agreement. It is irrelevant, generally, whether the contract is oral or written. Typically, a problem arises where a physician signs a contract with a 'hold harmless' provision, which is an agreement that the physician will indemnify or hold harmless the other party for certain contingencies that are the subject of the contract. Most insurance companies do not indemnify a physician for his agreement to indemnify or hold harmless the other party to the contract. Therefore, physicians should not agree, orally or in writing, to a contract with a so-called 'hold harmless' provision. As a matter of fact, it is a good idea to check with your attorney before entering any agreement that affects your practice."

In addition to the above, CMA legal counsel provides warning as follows: "Physicians signing IPA agreements or other HMO contracts should be particularly watchful for 'Hold Harmless' provisions. Generally, the physician's professional liability carrier will not be obligated to defend the HMO or indemnify it, and the physician will be assuming personal, uninsured responsibility." As a practical matter, a "Hold Harmless" provision probably offers no or little advantage to the IPA, and may even deny the IPA benefits of coverage which would otherwise be available.

Philipp M. Lippe, M.D.

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.

PROPOSED AMENDMENT TO BYLAWS OF AANS

Pursuant to the Resolution passed by JSEC, at its recent meeting in Hawaii, relative to restoring the quadrantic representatives to the Board of Directors of AANS, a specific format has been circulated by the Chairman and Vice Chairman of CSNS so that various members of state societies who are also members of AANS, may review the details of the matter and express opinion accordingly. A copy of the proposed changes in Bylaws of AANS is enclosed, as an insert, with this Newsletter.

Please feel free to express any pros or cons in this matter. Those in favor of the proposal may sign accordingly and mail the form to Dr. Harold A. Wilkinson, 330 Brookline Avenue, Boston, Mass. 02215.

PROPOSED AMENDMENTS TO BYLAWS OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

We, the undersigned active members in good standing of the AANS, propose the following Amendments to the Bylaws of the American Association of Neurological Surgeons (deletions are crossed out, additions are underlined):

ARTICLE IV — Board of Directors

Section 2

The Board of Directors shall consist of the 5 elected Officers (President, President-Elect, Vice-President, Secretary and Treasurer), the Past President, ~~and 9~~ 5 Directors-at-large and 4 Regional Directors, each of whom shall represent one of the 4 Regions as defined by JSEC. The 5 Officers ~~and the 9~~ 5 Directors-at-large and the 4 Regional Directors shall be nominated (as provided in Article VIII) and then elected by the members of the Association at the Annual Business Meeting.

Substitutes 4 Regional Directors for 4 of the Directors-at-large.

ARTICLE VIII — Nominating Committee, Nomination and Election of Officers, Director and Nominating Committee. Vacancies

Section 1

Paragraph 2

It shall be the duty of the Nominating Committee to seek extensively and receive information and suggestions for nominations for Officers, Directors-at-large, and Nominating Committee members from:

(a) - (h) (unchanged)

Nominating Committee nominates Directors-at-large, not Regional Directors.

Paragraph 4

Each nominee for Regional Director shall be selected by the duly elected State Delegates from their respective Region. The names of these nominees shall be forwarded to the Nominating Committee for circularization to the membership.

Insert new Paragraph specifying selection of nominees for Regional Directors.

Paragraph ~~4~~ 5

~~This~~ The entire slate of nominees shall be circularized to the entire voting Membership at least 60 days before the Annual Business Meeting of the Association.

Requires circularization of nominees derived both from Nominating Committee and from Regions.

Paragraph ~~5~~ 6

Additional nominations for Officers, Directors, and Nominating Committee members may be made only in writing by the voting Membership. Such nominations shall be submitted to the Secretary of the Association in writing not less than 30 days before the Annual Business Meeting and shall require the signature of not less than 20 voting Members of the Association as well as the written consent of the nominee. Nominees for Regional Director received in this manner must be from the Region they are to represent.

Additional nominees for Regional director must be from the Region they are to represent.

Approval of the above PROPOSED AMENDMENTS TO BYLAWS is documented by signature, date and statement of voting member status in AANS:

	Signature	Date	Voting member status:
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(20 Signatures required - additional optional)

CSNS AND JSEC MEETINGS OF AANS
Honolulu - April 24-25, 1982

The California Association of Neurological Surgeons was represented by twelve delegates at the recent CSNS-JSEC sessions in Hawaii. President of CANS, Dr. Douglas Enoch, presented a detailed report of various activities of CANS in the past year and emphasized problems facing neurosurgeons in the future. Dr. Philipp M. Lippe reported the various deliberations of the Sub-Committee on Medical Organization, of which he is chairman. This included cognizance of the "perennial frustration" felt by members of CSNS-JSEC arising from unawareness or lack of concern of national leaders of neurological surgery, particularly the AANS, relative to the needs and problems of practicing neurosurgeons at large. From the background of this feeling of frustration came three expressed goals, not necessarily endorsed by the sub-committee, but listed as follows:

(1) Quadrant representation on the Board of Directors of the AANS.

(2) A reconstitution of CSNS, so that it would be separate from JSEC, incorporated within the AANS, accountable to the Board of Directors, and composed of membership elected by the state neurosurgical societies.

(3) Formation of a Federation of State Representatives, as a separate, autonomous organization composed of duly elected state representatives and designated as the sole spokesman for neurological surgery in socio-economic and political issues. After the various preliminary sessions, the CSNS business meeting, and multiple subcommittee reports, the JSEC met in summary review of various recommendations and passed four major Resolutions, summarized as follows:

(1) No neurosurgical resident in training be considered to have finished his educational requirements until he has successfully passed Part 1 of the examination of the American Board of Neurological Surgery.

(2) The AANS and CSNS be asked to prepare model programs and plans to assist in educating the public and physicians in general as to the scope of neurological surgery.

(3) The Board of Directors of the AANS be requested to establish an Interspecialty Liaison Committee for the purpose of studying the problems of excess manpower and outlining steps for appropriate measures to be taken.

(4) The Board of Directors of the AANS instruct the Bylaws Committee to present an appropriate Bylaws amendment at the next meeting to provide for quadrant representative members of the Board of Directors, to be elected by quadrant delegates.

These various resolutions were to be presented by the Co-Chairman for AANS, Dr. Clark Watts, at the meeting of the Board of Directors of AANS on April 29, 1982. The next meetings of CSNS and JSEC will be held in Toronto, Canada, October 1-3, 1982, preceding the Annual Meeting of the Congress of Neurological Surgeons.

EDITORIAL — "THE SLEEPING GIANT"

Just as the origin of the California Association of Neurological Surgeons was forged in the fire and brimstone of medical malpractice issues, we are now seeing a cyclic return of the same problems, in terms of a sleeping giant, potentially destructive to all. Almost a decade ago, we neurosurgeons were cast adrift by insurance carriers, somewhat like the biblical baby Moses, only to be rescued from the water and reeds by our own doctor-organized companies. There has been somewhat of an escape from the perils of medico-legal bondage, but the Red Sea has really not opened, and we find ourselves in jeopardy now, joined by multitudes of other "providers" who outnumber us many times.

Whereas the medical malpractice issues began with a surgeon leaving in a sponge or an instrument while performing a surgical procedure, the potential liability involvement has been accelerated to include even the most sophisticated variations in judgement, most of which have not been decided on a scientific basis. There have been huge financial awards in court because of the histrionics of attorneys, skilled in the art of preying upon impressionable jurors.

When one extends the study, one finds that there are far greater misadventures in areas other than the health field. The problems involved with the Pinto, and accidents incurred on public property have far surpassed medical issues. In fact, the total bundle of annual liability represents fifteen billion dollars, of which medical tabs have involved about one and one-half billion.

Let us not become complacent in the relative relief expressed in these figures. We physicians, and particularly we neurosurgeons suffering with the highest insurance rates, are about to become the victims in an open season proclaimed by the legal hunters who have been having target practice on auto makers, owners of restaurants and apartment houses, as well as on architects — and even on some of their own colleagues in the practice of law.

There are several factors that are going to arouse the sleeping giant of medical malpractice. First of all, the tremendous over-supply of attorneys is going to require pursuit of any possible revenue, and the availability of recovery from medical malpractice is an obvious target. Secondly, the negative balance in the general economy will alert patients and their relatives to the possibility of paying medical bills and balancing indebtedness in general. Thirdly, the excessive medical manpower, with fewer bona fide surgical cases available to any surgeon, will provide a tendency to operate on borderline

situations. This type of surgical care provides less than satisfactory results. The primary factor in an adverse result is whether or not there were proper indications for the surgical procedure in the first place. We have seen a recent half million dollar settlement where the anterior interbody fusion resulted in quadraparesis secondary to thrust by the dowel graft against the spinal cord. The injury was not the issue in itself. The real problem was that the cervical myelogram was normal, and the question of indication for surgery was what prompted the settlement. This serves as a warning to all that you may find recourse, if "the knife slips," but you had better have documented indications for the necessity of the operation.

We shall be hearing more about malpractice lawsuits directed against various professions. The diversity of issues have been well described by Frederick R. Hodosh, secretary and general counsel for the American Institute for Property and Liability Underwriters. In reference to this, he has stated that the liability suits are "limited only by the imagination of a resourceful attorney." Does the parlay of common problems to other professions leave the physician in more or less jeopardy? We would like to think that there could be some relief. But, as indicated above, we can only anticipate that the worries of New York State carriers may be justifiable in increasing their rates by seventy per cent.

An acknowledged authority, Best's Review, has stated as of January 1982, in reference to malpractice insurance, it "is once again in trouble at a level that can be described as nothing less than critical." The report indicates that doctor-owned insurance companies have losses in 1981 that range from 11 per cent to 54 per cent. This is not a situation that augers for financial balance, and may foretell the real issue of too many attorneys and too many physicians.

We should recognize that the sleeping giant of medical malpractice cannot be contained by the Lilliputian efforts described by Jonathan Swift. The multiple strings being provided in minuscule measures by various legislators are bound to be broken by aroused efforts of adversaries. There must be a combination of self-protective measures by the medical profession itself, including address to the various issues of excessive manpower, and organizational control of those on the firing line, where the big responsibilities occur. This relates to an Emergency Room physician, as well as to a medical practitioner involved in a critical situation, let alone a surgical specialist performing a difficult and unpredictable operation. There is no minor medical practice. We are all involved.

It is inconceivable that the medical profession could revert to the "conspiracy of silence" that allegedly obviated any exposure of medical malpractice in the past. By the same token, it would seem to be appropriate for the average physician, in his own erudite image to avoid an expression such as "how come?", or "Why didn't they do a scan?", etc. etc., before he has had any information of the medical pre-existing status. So often, the complaining physician regrets his explosive reaction, but by then the damage has been done. The patient has consulted legal advice, and the ingenious techniques of an attorney take all of the issues out of medical expertise, and provide orientation to laymens' concept, with a poor understanding of the situation.

Sooner or later, the ravages of the aroused giant may serve to awake the right people in legislative bodies to revise the laws in reference to tort. As long as those legislatures are comprised of attorneys who feed on the system, doctors and other professionals will be wise to protect each other, and hopefully, control professional manpower, so that there will not be encouragement to gain from destroying each other.

Frank P. Smith, M.D.
Editor

TIME TO STRAIN THE ALPHABET SOUP JSEC AND CSNS?

It has become increasingly apparent that more widespread understanding of the present structure of JSEC and CSNS is necessary if neurosurgeons are going to be able to register their opinion relative to any reorganization in the future. This comes into focus now because there are pressures to change the current status of CSNS.

Longer ago than most can remember, the AANS and the CNS agreed to pool their interests in the mundane aspects of neurological surgery, in the formation of the Joint Socio-Economics Committee. This was to be the sounding board of controversial matters that would present a distillate to each parent organization. In line with other subcommittees already established, and responsive to the demands of practicing neurosurgeons for input, balancing the central core of AANS, controlled by academic neurosurgeons, a new subcommittee, the Council of State Neurosurgical Societies (CSNS) was established just a few years ago.

As the Joint Socio-Economic Committee became more secure by succeeding in getting quadrant representatives on the Board of Directors of the AANS, the CSNS began spreading its wings, even to the point of pressing for the formation of a House of Delegates, representing neurosurgeons in all states of the union, within the total structure of the AANS.

All of the above came to a complete standstill when the Board of Directors of the AANS decided to be responsive to the need for democratization in having all members of the Board of Directors elected at large, through a central nominating committee. Arrangements were made for alternate nominations through a process of signature petition.

Now we see new forces on the horizon, regretting the loss of quadrantic representatives on the Board of Directors of the AANS, and there are those who favor more autonomy for CSNS within the AANS, as well as those who advocate a new Federation of Neurological

Surgery, completely independent, that would be the spokesman for neurological surgery in socio-economic matters.

In light of all of the above, it does seem to be important that California neurosurgeons understand the present make-up of JSEC and CSNS relative to decision or any change. Quoting from update, April 1982, of Rules and Regulations of AANS and CNS, JSEC is constituted as follows:

"All members of the JSEC shall be approved and appointed jointly by the Presidents of the AANS or CNS. There shall be two sources for these members (See A & B below.)

A. (1) The first source shall be composed of members of either society, the AANS or CNS, who are selected by the various duly constituted state and Canadian neurosurgical societies in the manner described in the next paragraph.

(2) Each state and Canadian neurosurgical society will select from its own roster a nominee or nominees for membership to the JSEC in accordance with a formula of one member for each fifty (50) (or fraction thereof) neurological surgeons in that state or region as listed in the then most current edition of the WDNS. Part I, published by the CNS or the official census of neurological surgeons published by that state or regional organization. Representatives should be nominated by the states or regions for three (3) year terms, staggered.

(3) In the case of disapproval, for good cause by either executive body, the nominating society, after discussion with the executive body, shall propose another nominee. Society presidents may appoint members of their state or regional society to the JSEC at any single meeting to replace an absentee representative from a given meeting. A pre-selected alternate for each representative shall ordinarily be provided by the state and Canadian societies.

(4) In the event there is no organized neurosurgical society for a state or region, the Presidents of the AANS and CNS shall appoint the proper number of members from that area as area representative(s).

(B) The second source shall be composed of either society appointed by the Presidents of the AANS or CNS, equal to one-half the number of members selected by the state and Canadian societies (if not an even number, then one additional appointee).

The Council of State Neurosurgical Societies is mandated as a subcommittee of JSEC by the following organizational procedures:

A. The state regional representatives as selected above in A.(1) shall meet in council to communicate, discuss and prepare recommendations on socio-economic matters of concern to neurosurgeons practicing in the various states and regions. These meetings shall occur at or adjacent to the time and place of the AANS and CNS Annual Meetings. The group assembled shall be called the Council of State Neurosurgical Societies (CSNS) and shall be an integral part of the activities of the JSEC. The CSNS shall be made up of approximately two-thirds (2/3) of the membership of JSEC and is, in fact, the major component of that duly constituted Joint Committee of the AANS-CNS.

All of the above is provided as informational material to those interested to gain perspective for any changes in organization that may be made in the future. Tragic developments occur mainly when the most people concerned are unaware of the basic issues involved.

Frank P. Smith, M.D.

CHANGE OF ADDRESS

Please notify the Executive Office of any change of address, including county, or telephone number, so that we might keep our membership records current.

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, CA 95841, or telephone (916) 966-9760.

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